

**Assessing the Management of Public Private Partnerships in Infrastructure Procurement:
A Complex Evolutionary Systems Theory Perspective**

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Assessing the Management of Public Private Partnerships in Infrastructure Procurement: A Complex Evolutionary Systems Theory Perspective

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Abstract

This dissertation focuses on the findings of a multi-case study centered around two public-private partnership (P3s) projects in Ontario: the Royal Ottawa Hospital and the Brampton Civic Hospital. Partnerships have become particularly important as a part of infrastructure procurement for all levels of government in Canada. While infrastructure public-private partnerships have grown in popularity, they remain a controversial means of procuring public assets. Considerable questions remain as to whether the mechanisms related to partnerships with the private sector represent a sufficient response to the challenges facing health care systems. As such, major avenues exist for contributions in the form of evidence-based examinations to the field of knowledge pertaining to hospital procurement.

A body of research literature and review of public-private partnerships, including those with a particular focus on health-sector projects in Canada, has grown over the past two decades. This study contributes an analysis of the relationship between public and private partners to that literature, utilizing a conceptual lens developed out of complex evolutionary systems theory. The study is intended to examine the capacity of public managers entering into a public-private partnership arrangement to successfully activate agents and utilize the skill and knowledge of these agents, conduct joint fact finding and consensus building, and better understand how they have arranged and organized joint interactions between the public and private sector.

The two case studies demonstrate the key inputs into the decision-making processes for what were formative health infrastructure partnership projects in Ontario, providing an assessment of the degree to which the government of Ontario was successful in managing a cooperative decision-making process that stressed inclusion and horizontal steering. Results find that public managers struggled in some ways to leverage an effective horizontal management style and engage in smart interventions to utilize expert knowledge to address knowledge gaps, contributing to stagnating negotiations and driving up transaction costs for the projects. Some noteworthy successes were experienced in the case of the Royal Ottawa Hospital in leveraging private-sector knowledge to develop performance metrics, and the approach to stakeholder engagement in this case presents positive lessons-learned for future P3 infrastructure projects.

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List of Acronyms

AFP	alternative financing and procurement
BOO	build, own, and operate
BOLB	buy, own, and lease back
BOT	build, operate, and transfer
BOOT	build, own, operate and transfer
CCPPP	Canadian Council for Public-Private Partnerships
DBO	design, build, and operate
DBFO	design, build, finance and operate
DBFMO	design, build, finance, maintain and operate
FIPPA	Freedom of Information and Protection of Privacy Act
GTA	Greater Toronto Area
HRSC	Health Services Restructuring Commission
IT	Information Technology
MBC	Management Board of Cabinet
NDP	New Democratic Party
NPM	New Public Management
OECD	Organization for Economic Co-Operation and Development
OFA	Ontario Financing Authority
OHC	Ontario Health Coalition
OPSEU	Ontario Public Service Employees Union
P3/PPP	public-private partnership
PC	Progressive Conservative
PCOP	post-construction operating plan
PFI	private financing initiative
RFI	request for information

RFEI	request for expression of interest
RFP	request for proposal
RFQ	request for qualifications
ROHGC	Royal Ottawa Health Care Group
TBS	Treasury Board of Secretariat
THICC	The Healthcare Infrastructure Company of Canada
VFM	value for money
WOHC	William Osler Health Centre

Chapter One: Introduction to Study

Public-private partnerships (P3s) and government business enterprises have undergone a significant period of expansion in Canada over the last few decades. One explanation for this phenomenon is the increasing return to traditional policies of business liberalism that have become prominent since the early 1990s. This is referring to the emergence of neo-liberalism as the dominant paradigm for fiscal and economic policies in Canada throughout the previous few electoral cycles, with particular considerations towards the growth of these ideals under the Chrétien and Mulroney administrations. This era saw a significant growth of private investment promotion and business expansion (Hale, 2006). Alongside the emergence of this paradigm for fiscal and economic policy in Canada has been an increased emphasis on the practice of engaging in government business enterprises and P3s (Hale, 2006).

A number of justifications have emerged for the increasing establishment of public-private partnerships as a mode of alternative service delivery in general. The involvement of the private sector is perceived as an alternative to the traditional trappings of service delivery in the public sector. The mutual benefits that can result from such a partnership have led to a great deal of competition between business organizations seeking alliances with public organizations (Kernaghan et al., 2002). In their assessment of the experiences of the ‘first wave’ of P3 projects across Canada, Vining and Boardman (2008) outline a series of rationale commonly presented as justification for an increased role of P3s in public infrastructure procurement:

“The first rationale is the minimization of on-budget government expenditures and/or the desire not to increase current debt levels. The second derives from the private sector’s ability to provide both infrastructure and services at lower cost due to economies of scale, more experience, better incentives and greater ability to innovate. The third rationale relates to the government’s desire to reduce risk, especially during the design and construction phase, but also during the operating phase” (Vining and Boardman, 2008).

P3s are, in theory, an innovative and competitive means of solving the issues that face the public sector. They can demonstrate value for money, allocate risk to partners best suited to manage and mitigate it, and provide an open, fair and transparent process of operation (Carr, 1998). P3s are seen as a multi-faceted tool for government that can help them to develop projects of public interest while at the same time bringing added value through the expertise and investment potential of the private sector (Carr, 1998).

A number of different features of P3s help them to accomplish goals that could, theoretically, be seen as a boon to the development of infrastructure in Canada. First, public-private partnerships help government to innovate by transferring some of the risk involved in endeavors of public innovation onto the private sector (Carr, 1998). P3s represent an attractive option for government when the major risks for a project, for example construction-delay risks, are of the kind that can be managed by a private actor as well as, or better than, government could (de Bettignies and Ross, 2004). Arguably, risk-taking is not something commonly associated with the public sector, and P3s allow for an infusion of new ideas into service delivery by sharing the risks involved in investing in innovation (Carr, 1998; Murphy, 2008; Watkinson, 2008). Additionally, P3s enable government to limit recourse to the public purse due to the fact that public-private partnerships share with the private sector the financial burden involved in

providing services to the public (Robillard, 2001). This can help to ensure value for money spent in services by supposedly reducing public funding into projects through mutual investment from interested private organizations. P3s are touted as a means of alternative service delivery that can help to ensure citizen-centered service provision that meets public demand. The pursuit of improved citizen-centered service, value for money, and balance between innovation and preservation of values is believed to result in more cost-effective service delivery, changes to organizational structures to improve efficiency, and greater authority for managers (Treasury Board of Canada Secretariat [TBS], 2002).

P3s are also noted as having a number of inherent issues, and “emerging evidence from a number of countries suggests considerable dissatisfaction with the outcomes of many P3s” (Vining and Boardman, 2008, p.10). In particular, evidence suggests that the proposed risk-transfer in the negotiation and re-negotiation of P3s has not been as significant as initially anticipated. Government has had difficulty in achieving any real risk transfer to the private sector, and revenue risk for the public sector in partnerships remains high (Vining and Boardman, 2008). Additionally, the transaction costs associated with P3s are often significant. Transaction costs can include costs associated with contracting, negotiation, monitoring, re-negotiation, and termination costs. These costs are often borne by the public sector, and “represent real social costs that must be considered in assessing the benefits of P3s” (Vining and Boardman, 2008, p. 11). In addition to transaction costs, P3s are said to be more expensive due to a “triple hurdle – the higher cost of private borrowing; the need to make a profit and associated other potential inefficiencies; and higher procurements costs” (Auerbach, 2002, p.19). It is argued that the profit motive of the private sector can lead to a reduction in quality and design in infrastructure projects, as well (Murphy, 2008).

Service contracts in P3s are also problematic in the limits they set. The service contract itself can become an obstacle, in that those service delivery problems not addressed within the agreement will most likely be forced upon the public sector to handle. It is highly difficult to resolve areas of control during contract negotiations as unanticipated issues can arise later on (Carr, 1998).

Finally, criticisms have been levied against P3s from a perceived lack of accountability in partnerships. Standards of disclosure vary between the private and public sector, and private sector partners are perceived as more secretive and, concurrently, less accountable (Auerbach, 2002). When a public organization is providing a service, there are laws to protect access to information. With a P3, there is no such protection. Private organizations often demand their information be protected or that access be severely limited on the grounds that it may undermine the profitability and commercial stability of its endeavors (Auerbach, 2002). This limits the public's ability to judge the appropriateness of a P3, and makes it difficult to hold the private partner accountable for any negative impact on service delivery or to the community. As such, the restrictive nature of the contract sets a number of goals and pragmatic norms for what can be considered a successful partnership. However, these norms take into account the requirements of the political system as stated by the service contract, which may not be entirely representative of that which clients may find useful.

Despite a lack of consensus towards the effectiveness of P3s as a service delivery mechanism, the role of P3s has increased as they are “quickly becoming an important part of infrastructure procurement for all Canadian governments” (Murphy, 2008). Public organizations recognize the need for alternative financing options and have accepted P3s as a viable option for public innovation (Carr, 1998; Murphy, 2008). As an increasingly established aspect of the

current landscape of Canadian public service procurement, additional insight into this method of delivering public goods and services is warranted to determine the advantages they may offer, and the limitations to their scope of use.

In the Canadian context, two P3 projects undertaken in Ontario, the Brampton Civic Hospital and Royal Ottawa Hospital, present a significant opportunity for lessons learned relating to the use of P3s in health infrastructure procurement. These two large infrastructure procurements were undertaken within a nascent policy framework (Whiteside, 2015) at a time when the province of Ontario lacked any recent experience and expertise in the execution of major health infrastructure projects (Health Services Restructuring Commission, 2000). The delivery of a project of the size and scope as initially proposed for these two hospitals posed a significant challenge for the involved provincial ministries. Public sector decision-makers would need to navigate a complex network of interactions between health sector institutions, government, the hospitals, private sector partners, and the general public while leading the development of policy norms and best practices for P3s in Ontario throughout the course of these projects. To better understand the successes and challenges faced for these two formative P3 procurement projects, this research study undertakes a multiple-case study to examine the management process for the Brampton Civic Hospital and Royal Ottawa Hospital, with a particular focus lent to the networked relationships between those involved in procurement and delivery of the two projects.

The two cases to be studied, the Royal Ottawa Hospital and Brampton Civic Hospital, have been previously examined. A fair amount of secondary data is available for both cases, due in part to the high profile nature of these cases, the contentiousness of P3s as a mechanism for health infrastructure procurement, and government audits focusing on some of the challenges or

failings encountered in the pilot process. This research study adopts a complex evolutionary systems theory perspective to the study of P3s; an approach that has scarcely been used to this point in the study of P3s in the Canadian context. It is contended in this study that an examination of these two formative cases in Canadian healthcare infrastructure procurement through a complex evolutionary systems theory perspective can reveal new and noteworthy observations relating to these two projects. In particular, this research should provide additional insight into the associated effects of the actions of actors who would have had a part in these two projects, the structure of relationships, and how the interconnectivity and interdependence of actors ultimately shaped the final direction of both projects.

The method of this research involves a multiple-case study design utilizing available secondary data and primary data obtained from eight semi-structured interviews with key individuals who worked on the projects to build an understanding of and compare power structures, relationships between actors, and the framework for interaction between public and private actors. A comparative examination of the cases through a multiple-case study design will serve to build a greater understanding of influences on the decision-making processes for these projects, and whether their capacity to utilize horizontal steering, effectively activate the unique skills of experts, and manage a complex operating environment contributed to successes or challenges experienced over the course of the procurement projects. The comparative analysis of this study should make a contribution to the growing knowledge base pertaining to large-scale hospital infrastructure projects in Ontario specifically, and public-private partnerships for health infrastructure in general.

1.1 Research Problem

As noted above, P3s can, in theory, offer additional value for money, risk allocation, and competition for public sector infrastructure procurement projects (Carr, 1998). These purported benefits are highly attractive to governments in Canada, who enter into partnership arrangements hoping to mitigate the negative consequences inherent in major projects. It is stated that governments “enter into P3s or AFPs because they provide an opportunity to transfer risks to the private sector, allow both sectors to focus on what they do best, and accelerate investment” (Auditor General, 2008).

Given the purported benefits of P3 arrangements, it is no surprise that they have proliferated. Since the mid-1990s, it is noteworthy that the majority of infrastructure P3s in North America reflect some variation of the aforementioned arrangement with partnerships utilized most frequently in the areas of transportation, water and wastewater, power and energy, or hospital facility procurement (Vining and Boardman, 2008). One finds numerous examples of procurement projects with private sector involvement within the sub-field of partnerships relating to hospital infrastructure projects. Public-private partnerships have increasingly been involved as a feature of both the operation and construction of health infrastructure in mixed economies around the world (McKee et al., 2006). Domestically, Ontario, Quebec and British Columbia have all engaged in partnerships with private sector consortia to build, design, finance or operate large hospitals in their provinces. It is believed that partnerships allow for the utilization of marketplace concepts to improve performance while still respecting the fact that health is a public good of which the public sector must, to some extent, remain a steward (Vining and Boardman, 2008).

The risks of operating in a partnership with the private sector are great, however, and can often outweigh the potential benefits that come with P3 service delivery (Wilkins 2003). As will be discussed in Chapter Two, as the P3 mechanism has become increasingly popular for public infrastructure development in Canada, so too have P3 projects become the subject of increased scrutiny. Current research has highlighted some of the significant challenges throughout various stages of the lifecycle of partnership projects, and projects in Canada's first experiences in P3 infrastructure procurement (the 'first wave' of Canadian P3s)¹ have experienced difficulties in effectively reducing both total costs related to the sum of production or transaction costs, and budgetary risk exposure via transferring revenue risk through the use of P3s (Vining et al., 2005; Vining and Boardman, 2008).

Based on the often ad hoc management structures overseeing the 'first wave' of Canadian P3 experience, these projects have been noted as providing teachable lessons for future projects and have informed frameworks for partnerships across Canada. The study of the 'first wave' of Canadian P3 projects "continues to provide valuable lessons for public sector owners and private sector participants" (Conference Board of Canada, 2010, p.7), and could offer some unique insights into the kinds of challenges faced in early attempts at large scale P3 health infrastructure procurement. Many of the lapses in judgment over the course of the 'first wave' of Canadian P3 projects, or challenges experienced during these projects "occurred in an environment where many public sector owners—from hospitals to cities and even provincial departments—were

¹ According to the Conference Board of Canada (2010), first wave of P3s in Canada were projects undertaken between 1990 and reaching financial close prior to 2004. This includes the Confederation Bridge (1993); the Charleswood Bridge (1995); Highway 104 (1996); the Government of Nunavut buildings (1996); several Nova Scotia schools (1997); the Fredericton-Montcon Highway (1998); the Highway 407 ETR (1999); the Bruce Nuclear Generating Station (2001); the John Labatt Centre (2001); the York Region VIVA transit system (2002); Ontario's DriveTest Examination Services (2003); the Calgary Courts Centre (2004); and finally, the Brampton Civic Hospital and Royal Ottawa Mental Health Centre (2004).

required to act as their own P3 procurement authorities for the first time (and sometimes their only time)” (Conference Board of Canada, 2010, p.6).

In Ontario, the case of the Brampton Civic Hospital stands out as prominent example of a ‘first wave’ P3 project in Canada that demonstrates the challenges that can be experienced over the course of large-scale P3 hospital procurement project. This project has been the subject of scrutiny in the Canadian media (Picard, 2009; Walkom, 2008; Talaga, 2008; Gilbert, 2009), by interest groups, unions, or professional associations (Auerbach, 2007; Ontario Health Coalition [OHC], 2008a; Mehra, 2008), or by government itself (Auditor General, 2008; Auditor General, 2010; Hansard Official Report of Debates, 2009; Standing Committee on Public Accounts, 2009). As noted in the Auditor General’s 2008 Annual Report, the Brampton Civic Hospital project experienced challenges at multiple stages of development: insufficient or poor information alongside specious decision-making at the first announcement of the project, poor assessments of market readiness in the selection process, and ultimately cost overruns² and delays in completion (Auditor General, 2008). This project was not delivered on time, nor on budget, and the 2008 report pointed to deficiencies in the approach to public-private partnerships in the province as a core reason for the challenges experienced by the William Osler Health Centre (WOHC) in building the Brampton Civic Hospital (Auditor General, 2008).

Concurrent to the development of the Brampton Civic Hospital, the Royal Ottawa Health Care Group (ROHGC) undertook another major P3 project in developing the Royal Ottawa Hospital. While the Royal Ottawa Hospital project was not without its own challenges (Laird and

² A consulting firm contacted by the WOHC estimated in September 2000 that the costs for designing and building a new hospital would be approximately \$357 million. This figure was updated to \$381 million in 2001. A second consulting firm utilized similar assessment approaches in January 2003, and estimated the costs of the hospital to be \$507 million. Over the course of the construction period, the total cost for the hospital came to \$614 million. It was later estimated that the government had spent more than \$50 million in excess of what should have been necessary to build the hospital (Auditor General, 2008).

Langill, 2005), ultimately the project was touted as being delivered on-time³ and on-budget by the government of Ontario (Murphy, 2008).

Given the apparent differences in outcome between the two projects, further research is warranted in order to examine the nature of partnerships in the Ontario health sector and examine some of the potential reasons for success and failures within procurement projects of this kind. In particular, opportunities exist for expanding the breadth of knowledge about the management structure and relationship between public and private partners in Ontario's first forays into large-scale P3 hospital infrastructure procurement.

1.2 Research Questions

The questions at the core of this research were informed by complex evolutionary systems theory based on the work of Eve Mitleton-Kelly, Erik-Hans Klijn and Geert R. Teisman; research that seeks to apply the main tenets of complexity theory to the study of systems in a public administration context. Critically, the research questions for this project attempt to address the key aspects of what a 'complexity theory researcher' may apply to the study of a public system or organization. Complex evolutionary theory posits that systems, or organizations, are seen as ideally involving themselves in a continual scanning process throughout their lifecycle. This process is seen as reducing the significant risks associated with the commitment to a particular strategy too early in the development process. In social systems, these mechanisms tend to comprise of social processes with numerous actors involving and reacting to the process (Mitleton-Kelly, 2003, p.15). If public managers ignore the complex web of interactions surrounding public organizations, one can imagine decision-making capacity decreasing

³ The project was ultimately delivered six weeks in advance of the initially anticipated date of completion (Murphy, 2008).

significantly as the system finds itself “in an equilibrium that has the character of a locked-in situation” as various actors operating within the same environment “employ different but conflicting strategies that act against each other and sustain the deadlock” (Mitleton-Kelly, 2003, p.15).

In order to understand the cases in question through the lens of complexity theory, this study will examine the recurrent interactions between the various actors engaged in the projects in question (Mitleton-Kelly, 2003, p.59). Through a multiple-case design, this research project will then attempt to understand the ability of the public actors in each project to engage with their broader operating environment and design and implement “governing mechanisms and strategies that are specifically targeted at the situation and characteristics of the process” (Klijn and Teisman, 2006, p.12). A research project examining the capacity of a public organization to manage for a complex environment through a governance approach should observe the successes and failures in successful activation of agents and utilization of the skill and knowledge of these agents, how conduct joint fact finding and consensus building was conducted, and the arrangement and organization of joint interactions (Klijn and Teisman, 2006).

To this end, the four key research questions to be compared across cases as part of this study include the following:

- Who were the key actors involved at each stage of the procurement process?
- What were the main considerations and sources of information in the decision-making process at each stage of the procurement process?
- How were key stakeholders and partners engaged throughout the procurement process?
- How did consultations with key stakeholders and partners shape the final project?

1.3 Research Objectives

It is the intent of this research project to provide a detailed overview of the management structure and procurement process of two formative cases in the development of hospital infrastructure in Ontario. This research project is to be exploratory in nature, and will provide insights into the complex system interactions of public and private actors in the formation of agreements to build and operate major infrastructure projects, along with capacity of these agreements to manage for complex and changing operating environments to the satisfaction of all involved parties.

This study aims to explore the capacity for managers and public actors to navigate the complex environment of large-scale P3 procurement projects. Complexity is a noted feature of large-scale infrastructure projects (McKee et al., 2006). These kinds of projects have a bifurcated management structure, necessitating the development of complex agreements between public and private partners, often at significant cost. Various agents in the public and private sphere are engaged over the course of a P3 project, with varying (or even competing) interests between public and private agents (Vining and Boardman, 2008). Prior research examining the strengths or weaknesses of public-private partnerships in the hospital infrastructure development has identified issues of complexity relating to these kinds of projects as being a potential inhibitor to the successful undertaking of a health partnership arrangement. It is suggested that “the additional complexity of public-private partnerships makes all but the most straightforward projects just too difficult” (McKee et al., 2006, p.894). The core objective of this research study, then, is to gain additional insight into the way in which public managers may navigate this

complex operating environment, and to learn from the successes or challenges faced in some of the ‘first wave’ P3 projects in Ontario.

Research literature relating to public-partner partnerships, including those with a particular focus on health-sector projects in Canada, has grown significantly over the past two decades. This study contributes an analysis of the relationship between public and private partners to that literature, utilizing a conceptual lens developed out of complex evolutionary systems theory. As will be detailed in the discussion of theoretical prepositions of the study in Chapter Three, the work of Eve Mitleton-Kelly, Erik-Hans Klijn, and Geert R. Teisman on complex systems theory and governance theory, and the application of the concepts of complex evolutionary systems theory to a public administration context, will inform the way in which the study understands the capacity of public managers to navigate a complex operating environment. This entails a focus on the reciprocal influence between a system and its environment, degrees of self-organization between actors in the system, and the nature of relationships between agents. All of these factors enter into the assessment of organizational fitness from a complex evolutionary systems perspective (Mitleton-Kelly, 2003). Klijn and Teisman (2006) adapt the complex evolutionary systems theory to a public administration context through a governance model. In this model, cooperative approaches that stress inclusion and horizontal steering as key elements of the decision-making process are seen as conferring legitimacy to decisions and subsequently increasing the chance that actions stemming from the decision will be undertaken to full effect (Klijn and Teisman, 2006). Collective decision-making is, of course, not necessarily deemed to be ‘better’ or ‘correct,’ but rather this approach acknowledges the challenges associated with managing human systems with myriad actors, each with their own interests pertaining to a particular project. Key factors in successful management of a complex operating

environment are stated as including selecting appropriate evaluation criteria, securing visible support, and effectively engaging the unique skills of other actors through a horizontal management structure (Klijn and Teisman, 2006).

In light of this, the primary focus of this research study is to observe the way in which consultation, horizon-scanning, and engagement of key partners and stakeholders were undertaken throughout the ‘first wave’ of P3 hospital infrastructure procurement in Ontario. The findings of this study should provide insights into whether the government of Ontario engaged in a cooperative decision-making process that stressed inclusion and horizontal steering in two formative health infrastructure public-private partnership projects. The results of this study should also shed light onto some of the ‘lessons learned’ from these two pilot projects in regards to cooperative decision-making and horizontal steering, which subsequently would have informed the current operating model for public-private partnerships provincially.

1.4 Organization of the Dissertation

A written report such as this dissertation would appear to portray a linear progression in research, wherein each stage of the thesis is developed in order and is completed sequentially. Research projects of this kind, however, are more frequently developed through an iterative approach that evolves over the course of the project. Each stage and chapter is visited multiple times without any set order of progression. To this point, the research problem and research question of this chapter were revisited and informed by both the literature review and the theoretical framework developed for this study. From this, a methodology was developed to structure data collection for the study. Synthesis as part of the cross-case analysis throughout the course of the multiple-case study design was subsequently informed by the theoretical

framework. The conclusions drawn at the end of the study are a result of the analysis and synthesis of the case studies, with a mind to the key concerns identified through the theoretical framework. The following figure (Figure 1) demonstrates some of the inputs, outputs, and relationships between the various chapters of this project:

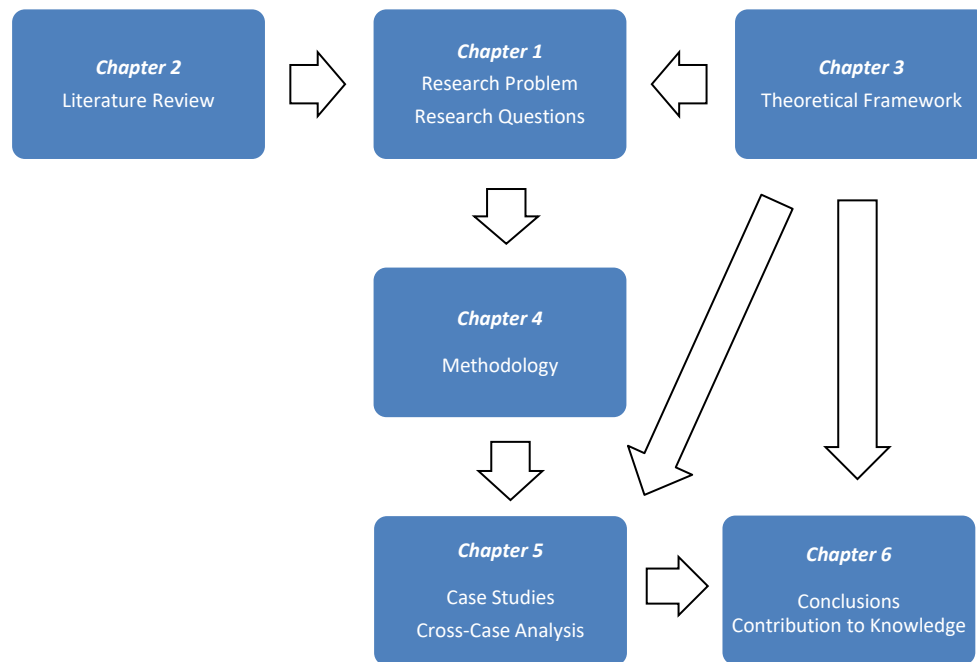


Figure 1: Relationships between the different chapters in the thesis

This thesis is divided into six chapters in total, including this introduction. Up to this point, the topic has been introduced, with contextual background and discussion of the core questions and research problem to be examined throughout the study. The second chapter includes a detailed a review of literature relevant to this study. This review will begin with common definitions of partnerships across the literature, and will examine how this form of alternative service delivery is applied in practice. This chapter will also examine the positive and negative aspects of partnerships identified across the literature as it relates to this study, and reflect on the potential contributions of this research project.

The third chapter of this study outlines the conceptual framework to be applied across this research, relating back to the core research questions. This framework builds off of complex evolutionary systems theory and governance approaches to public administration. This framework will guide the process, analysis, and interpretation of the findings throughout the study.

The fourth chapter outlines the case study method to be applied in this study, with an overview of the multi-case design, data sources, the interview method, and discussion of the limitations of this research design. Chapter Four describes and analyses the intended multi-case design for the study, informed in part by the work of Robert K. Yin (2014) on the designs and methodology of case study research.

Chapter Five includes analysis and synthesis of the data on the two case studies. Within-case studies will be conducted in accordance with a linear progression through project planning stages, with review and synthesis at each phase to reflect upon the main research questions comparatively across the cases. The two case studies will provide an overview of the project in question, and will look at specific elements of the partnership process relevant to this study. As will be discussed in the multi-case study analysis and synthesis in the fifth chapter, these projects spanned a significant period of time, and endured a number of changes to the environment in which they were operating and to the projects overall. These case studies, and the subsequent cross-case analysis and synthesis, will examine how each project engaged in horizontal steering and activating the specialized knowledge of involved actors over the course of the procurement from conception, to construction, to negotiations, to after project completion. Through interviews with key participants and reflection upon the results of the partnership, these case studies will provide an analysis of how these partnerships evolved and adapted over time, how they

structured interactions with other actors, and how they were influenced by the complex environment in which they operated.

The concluding chapter summarizes the key empirical findings discussed throughout the case studies and reflects on how the results of the study can inform policy and practice in the public sector.

Chapter Two: Analytical Literature Review

Infrastructure public-private partnerships (alternatively referred to as P3s in this study) have grown in popularity, but remain a controversial means of procuring public assets. Public-private partnerships can be a means for governments to raise capital for infrastructure investments while maintaining some austerity, and to transfer risks to private partners (Vining and Boardman, 2008). Opponents of public-private partnerships decry the limit to public involvement in decision-making and issues with the long-term flexibility of the public sector in partnerships that produce significant profits for private partners (Auerbach, 2002). This chapter will examine public-private partnerships and the implications of delivering public infrastructure through competitive market models that represent a fundamental structural shift in the relationship between public and private actors.

Public-private partnerships are the central subject of focus of this research study, and it is the intent of this literature review to provide background on partnerships as context for the remainder of the research. This literature review will include an overview of public-private partnerships in general, with a look into the various definitions of public-private partnerships, key elements of these arrangements, and the structural form of partnership arrangements that can be anticipated to be examined in the course of this research. This review will also examine the various benefits and issues noted with partnerships across the literature, and identify how these features of public-private partnerships may contribute to a broader assessment of the core research questions of this study. The overall intent of this chapter is to clearly define the added

value of this thesis by reflecting on the empirical literature considered in this analysis of P3s and identifying how this research study may offer novel insights into study in this field that would not have otherwise been captured in the literature. This will entail providing an analytical perspective on the various theoretical approaches that are applied to the study of P3s and a discussion of the respective merits of these approaches, while also considering what this research study contributes to the study of P3s.

2.1 Situating This Research Study Within the Literature

This chapter aims to provide a clear definition of P3s as described in the literature and scan the horizon of research in the field, and also to provide an analysis of the different approaches and theory mobilized within the current landscape of literature in the study of public-private partnerships. Defining the strengths and weaknesses of current approaches to the study of P3s from the available literature in this section will set the stage for discussion later in this chapter around identifying potential areas wherein this study may contribute to knowledge in this field of research. This section contrasts the kinds of observations offered through complex network theory in the study of partnerships against two other theoretical perspectives mobilized in the broader literature on P3s, namely positive theory and transaction-cost models of study, and political economic perspectives on privatization and P3s.

Vining and Boardman's (1989, 2008) studies of Canadian P3 projects and Vining, Boardman, and Poschmann's (2005) analysis of P3s across the United States and Canada outline the theoretical framework of what is referred to as a positive theory perspective on P3s. This approach, according to the authors, "is based on an eclectic mix of public choice theory, transaction cost economics, and past experience with contracting-out government services,

“mixed” enterprises and P3s” (p. 10). These models of study look to build understanding around the motivations of partners and examine the impact of divergent goals upon transaction costs, production costs, and other concerns associated with externalities in the subjects of study (Vining and Boardman, 1989). Studies from this perspective have lent useful frameworks through which to assess the governance costs incurred with public sector contracting-out, and provide a mechanism to assess the capacity for projects to improve upon management and decision-making processes through effective risk mitigation and management of the divergent motivations of key actors (Globerman and Vining, 1996).

These studies have been inarguably influential on this research project in defining the key concepts, strengths, and challenges of P3s as an approach to public service delivery and infrastructure development, and later in this chapter an overview will be provided of findings that demonstrate how divergent motivations of public and private partners can define the success (or failings) of such projects. This body of research further helps to situate dialogue on the subject of P3s within a Canadian context, with cases of study in the literature including examples such as the Highway 407 Express Toll Route, Confederation Bridge, and other high-profile projects that would be highly recognizable and important to any Canadian researcher in this field (Vining et al., 2005).

Studies conducted from the positive theory or transaction cost model are effective in identifying and exploring the kinds of challenges that can be faced when the public sector “partners” with others with conflicting goals and approaches. Critically, these studies take into account the divergent goals of the partners, broken down largely into goals of profit maximization on the part of the private partner and political goals of the public partner. According to the authors, these are ultimately the (fundamentally divergent) goals and objectives

between partners that would shape the nature of interactions and set the terms of how these relationships are structured (Vining and Boardman, 2008). This approach is well suited to the study of P3s, and can offer insight into the reasons behind particular outcomes for networked relationships such as a partnership. The transaction-cost model as presented in the literature is particularly effective at assessing the costs and challenges associated with the definition, negotiation, enforcement and monitoring of agreements and interactions between partners; a necessary element of a partnership (Boardman and Hewitt, 2004). The literature from these theoretical perspectives as reviewed in this research study set out clear and defined factors correlated with the success, or, more commonly, failings of P3 projects to deliver expected results on time and on budget.

While this theoretical perspective may provide many highly relevant insights into the study of P3s, it can be argued that complexity theory may offer different observations that enrich the study of the subject and compliment the observations provided by a transaction cost model. The organizational whole is more than the sum of its parts, and transaction-cost models may not provide a sufficient understanding of the organizational environment, routines, networks of interactions, and non-formal structures that may shape a particular subject of study. While the authors above would be unlikely to view the subjects of their research as existing in isolation from a complex operating environment or other environmental factors, these studies do not fully explain why an approach to setting agreements, production, negotiation, and monitoring for one project may produce results that are considered productive and effective while another approach utilizing similar strategies and, in some cases, even some of the same actors, may produce less desirable results. A complexity theory perspective, properly applied, should provide additional understanding comparative to the transaction-cost model regarding the context-specific nature of

organizational decision-making by looking at the structure of networked interactions between actors and their interactions with their broader operating environment. By understanding individual decisions and outcomes as context dependent, it is possible that a complex network theory perspective may offer new observations relating to P3s within the Canadian context that had not previously been offered through the transaction-cost model.

Political economy theory, as a complimentary (or successor) paradigm to public choice theory or rational choice theory, studies how economic theory influences ideology. In doing so, this paradigm aims to focus “on governments’ and firms’ actual motivations and behaviour” (Boardman and Vining, 2012, p.122), namely the economic ideological underpinnings that drive public and private sector behaviour . Analysis conducted from this perspective will relate the behaviour and decision-making processes of agents and their role as a businessman, bureaucrat, politician, or member of a political party to the outcomes observed in the subject of study. The political economic literature on P3s often attempts to situate alternative service delivery within a spectrum of perspectives relating to the nature of business-government relations. Authors writing from this theoretical perspective examine the political, societal, and economic ideas behind decision-making for P3 projects, usually as part of a broader assessment of the preferred role of business in public service delivery and the influence of private sector interests over the public sector.

Political economy perspectives can vary significantly, and as such vastly different understandings of the utility of partnerships as an alternative service delivery mechanism can be found within the political economy literature. These studies tend to be “heavily influenced by the ideological assumptions of those studying the issue and the level of analysis at which these studies take place” (Hale, 2006, p.94). For example, authors such as Hale offer that while the

influence of neoliberal concepts of government policy have grown significantly in Canada over the past three decades, including the rise of partnerships as a service delivery mechanism, “the Canadian state has scarcely withered into a shadow of its former self” (p.58). This assessment varies drastically from that of Whiteside (2015) and others, wherein the use of P3s in health infrastructure is perceived as the most recent step in the erosion of “one of the few robust elements of the tattered welfare state” (p.18).

Authors critical of P3s, particularly those that may see alternative service delivery mechanisms as ideologically-driven approaches to the delivery public services (Whiteside, 2015), would understand partnerships as a re-engineering of public services to satisfy a neoliberal agenda for increased disengagement or non-engagement of the state (Coulter, 2009). In this research, little distinction is seen between P3s as a service delivery mechanism and outright privatization, and authors may characterize this form of alternative service delivery as a “Trojan Horse” for the supplanting of public services and values with market fundamentalism and neoliberal values (Miraftab, 2004). Political motivation to attain what appears to be a ‘free lunch’ for the public sector ensures ample opportunity for private vendors to take advantage in an attempt to maximize profitability (Boardman and Vining, 2012). Partnerships are like to be categorized alongside service delisting, shifting care to the home, budget cuts, private health service provision, and other aspects of what is seen as the erosion of the public health care system. Research of this kind situates P3s within a broader context of increased normalization of market-oriented policy restructuring, with partnerships as one of the many politically-motivated approaches to ensuring that the private sector is a central part of the ‘new traditional’ way of delivering public services and infrastructure (Coulter, 2009).

Reviewing political economic studies of P3s in the Canadian context, Whiteside (2015) and Coulter (2009) present a political economy view of a variety of health care partnership projects in Canada (or in Coulter's case, Ontario specifically), including the two cases that are the subject of this study, and question whether the P3 model is the ideal way of delivering what is inarguably needed infrastructure. Both authors describe "Third Way" politics, the purported agendas of the prior Progressive Conservative and Liberal governments of Ontario, as a nonaggressive approach to ensuring that values of neoliberalism supplant political ideals of universality and collectivity in the province. Other sources, including those from the Ontario Health Coalition (2008a, 2008b) and the Ontario Public Sector Employees Union (2007), all of which also have produced literature pertaining to the two cases of this research study, share similar sentiments in their examination of the impact of P3s on health service delivery and procurement in the province of Ontario. While not explicitly employing a political economy perspective in their analysis, these sources do still base their research on a political perspective of the role that government should play in the economy and service delivery.

Political economic perspectives of study, similar to complex adaptive systems theory, build and enrich understanding around the various influences that shape the decision-making process. Political economic analysis of the dialectical attributes of the cases of study, similar to the research of Whiteside (2015), shares a number of areas of focus to the approach to study employed in this research paper, including an interest process changes and transformation over time, as well as the policies, frameworks, and operating environments of these projects. Political economic theory provides an effective mechanism to study how policy is created and implemented, with a clear set of criteria by which to evaluate the motivations of actors. Understanding the interplay between economics, politics, and the development of institutions

within a socio-economic system can reveal important observations around why decisions were made for a P3 project.

Political economic literature, however, often seems primarily concerned with proving the contribution of partnerships to a broader narrative of business-government relations, marketization and privatization of public services and property. While this study is certainly interested in understanding the motivations at the core of the decision-making process, this research is less interested in situating particular partnership projects within an expanding normalization of market approaches to public service delivery and infrastructure development (Whiteside, 2015). This research study does not seek to identify general or universal observations or laws pertaining to public-private partnerships or privatization, nor to place partnerships within a narrative of increasing marketization and privatization of the public sector. Rather, this research attempts to better understand the process of partnering and situate P3s within the array of policy and procurement options available for public infrastructure development. By approaching the two cases from the perspective of complexity theory, this should help to build insight into some of the ‘lessons learned’ from what were two formative P3 projects in Ontario in regards to cooperative decision-making and horizontal steering. In describing how complex networked theories reconcile with the politics of representative democracy, Klijn (2008b) states that “[o]ften the implicit assumption seems to be that if there is an initiative from a public actor to contract a public service to a private actor there is also a political decision about goals and conditions. Complexity in such situations is seen more as a problem of co-ordination, how to connect the various actors in an efficient way, than as a value problem, how to connect and bridge the different value judgments of the actors involved” (p.518). Comparative to a political economy approach to study, complex network theory focuses

more on the tensions that exist between governance networks, democratic actors, and an overarching need to include horizontal accountability structures through stakeholder involvement in decision-making (Klijn, 2008b), as opposed to tensions between ideologies specifically. While this research will certainly attempt to better understand the political motivations for increasingly market-oriented approaches to public service delivery, it will also recognize the complex operating environments and conditions in which these projects were undertaken and observe how this environment, in particular, ultimately shaped the direction of the projects.

The research conducted for this study most closely aligns with network and governance perspective literature on partnerships; this theoretical perspective will be defined in additional detail Chapter Three, but will be reviewed here for comparison. Some examples of this theoretical perspective as applied to P3 research includes Klijn and Teisman's 2002 case study of partnerships as governance schemes in the planning and decision-making processes for Mainport Rotterdam, a P3 harbor project in the Netherlands (and Van Gils and Klijn's subsequent 2007 study on the same projects), or the same authors' 2003 analysis of other Dutch P3 projects utilizing network governance theories, and also Koppenjan's 2005 study of P3s in transport infrastructure. Edelenbos, Van Buuren, and Klijn's 2013 study of connective management styles as a network management strategy across a series of regional government examples is conducted from a similar theoretical perspective, and includes the examination a few projects that involved partnerships with the private sector.

Chapter Three provides a more detailed overview of how this body of literature relates to complexity science in the study of public administration. However, as it applies to P3s specifically, these studies understand partnerships as a cooperative endeavor between public and private actors with a durable character, wherein actors are networked and dependent upon each

other to develop products and deliver services with some sharing of risk, cost, and benefits (Klijn and Teisman, 2003). Policy networks are understood as involving a multiplicity of actors and environments, interacting at an intersection of varying interests, ideas, values, methods, perceptions, and strategies, with the level of complexity increasing exponentially dependent upon the number of actors or institutional contexts involved (Klijn and Teisman, 2003). The case studies in the Netherlands explored in the literature provide some salient, comparable examples of the successes and failures in partnerships to manage a complex operating environment consisting of ‘games’ and ‘arenas’ (Van Gils and Klijn, 2007), with varying degrees of political-administrative commitment and tensions between actors (Koppenjan, 2005). These case studies assess the capacity of actors to engage in joint-image building and intensive interaction (Koppenjan, 2005), create incentives and positions to foster interaction (Van Gils and Klijn, 2007), and conduct joint decision-making effectively (Klijn and Teisman, 2003).

Research in the study of P3s conducted from this theoretical perspective offer observations pertaining to the capacity for public sector managers to properly manage complex networks and develop meaningful, adaptive relationships within their governance network. Research questions at the core of these studies would attempt to understand the nature of relationships between partners in projects, application of connective styles of management for projects, and what way the capacity to manage networked interactions related to substantive outcomes for the projects (Edelenbos et al., 2013). In examining the interconnected networks that form in a partnership between public and private partners, build understanding around the core business objectives for each actor, the key values underpinning the decision-making processes of both public and private partners, strategies undertaken, and the tensions between public and

private partners in terms of problem definition, confrontation, and challenges that occur when cross-network interaction is not realized (Klijn and Teisman, 2003).

It has been rare to this point for research from this particular perspective to have been applied to the study of Canadian P3 partnership projects. Authors in the field note the potential limits to the scope of observations provided in what largely have been, thus far, Dutch examples of case studies on P3 from a complex networked theory perspective, adding that “[t]he results may differ in other countries with different decision-making cultures” (Edelenbos et al., 2013, p.153). The study of the Brampton Civic Hospital and Royal Ottawa Hospital projects from a complex network theory perspective would not only help to address some of the gaps in knowledge relating to these particular cases around the structure of relationships between public and private partners and decision-making processes, but also would represent a novel application of this theoretical model to a Canadian context.

2.2 Public-Private Partnerships as Defined in the Literature

There are a multitude of means by which governments may deliver goods and services. Increasingly, governments have come to favor P3s as a means for procurement of goods and services over the past two decades (Organization for Economic Co-Operation and Development [OECD], 2008). Public sector actors now frequently look to market-oriented solutions such as P3s for government service provision and infrastructure development. The Organization for Economic Co-Operation and Development (OECD), in their report “Public-Private Partnerships: In Pursuit Of Risk Sharing and Value For Money” (2008) observe that this trend has occurred for two main reasons: “both for ideological reasons and in the pursuit of value for money, i.e. how to improve the use of resources” (p.3). Defining what constitutes a public-private partnership

arrangement, however, is a tricky proposition due in part to the lack of a consensus definition on the subject (OECD, 2008).

Public service provision does not necessarily entail wholesale government design, construction, financing, or operation for public assets or services to the public. For that matter, “most government services are provided with assets that governments procure from the private sector or through contracts where private companies build the assets, usually according to government specifications” (OECD, 2008, p.16). Public assets, including buildings, transportation infrastructure, computers, and military equipment are regularly procured from the private sector or through contracts with private companies. Government frequently contracts out with private actors for advisory services as well. None of these public-private interactions are necessarily a public-private partnership, however, and for the purposes of this paper, the aforementioned procurement methods will be understood as a ‘traditional’ procurement method (OECD, 2008).

Broadly speaking, public-private partnerships “...fill a space between traditionally procured government projects and full privatization” (Grimsey and Lewis, 2005, p.346). However, given the fact that the ‘space’ between a traditional procurement method as described above and full private-sector ownership is vast, additional consideration must be given towards defining what constitutes a P3 arrangement, and what a P3 arrangement would entail for infrastructure procurement in particular.

2.2.1 Definition

It is well known that debate surrounds the definition of public-private partnerships in the literature. What a partnership can entail may be different depending on the jurisdiction and

context. They are loosely understood as a form of cooperative institutional arrangement between actors of the public and private sector (Hodge and Greve, 2005) wherein public sector actors “share power with others in the pursuit of joint goals and/or mutual benefits” (Kernaghan, 1993, p.61). The key elements of partnerships, then, include joint action, power sharing, and mutual benefits for the actors involved. Seidle (1995) provides an overview definition of partnerships as fundamentally including the following elements:

“...agreement between a public-sector and private-sector (commercial) organization. The purpose of such partnerships is often fairly specific - for example to implement information technology systems within the public sector or to improve transportation infrastructure through construction of roads, bridges, etc. Some public-private partnerships do not continue once the particular purpose has been achieved” (p.141).

However, beyond these core assumptions, particular elements of what a partnership entails may vary. The term ‘public-private partnership’ within the Canadian context can refer to the provision of public services by a private partner or the development of public infrastructure that necessitates a transfer of risk between public and private partners. Arrangements not including these two concepts, that being private-sector provision of public goods or, at minimum, risk transfer, cannot technically be considered a partnership, and as such would not fall within the definition of partnership as it is applied in this research study (Canadian Council for Public-Private Partnerships [CCPPP], 2005). P3’s are described by the Canadian Council for Public-Private Partnerships (CCPPP) as “a cooperative venture between public and private sectors, built on expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of risks, rewards, and responsibilities” (CCPPP, 2005). Partnerships British Columbia, a crown corporation responsible for public-private partnerships in BC, defines P3s as “a

partnership arrangement in the form of a long-term performance-based contract between the public sector (any level of government) and the private sector (usually a team of private sector companies working together) to deliver public infrastructure for citizens” (Partnerships BC, 2006).

Some authors go so far as to view P3s as no more than a rebranding of older or current methods of public service delivery involving the private sector as an actor. As stated previously, P3s are but one of a number of different means by which government may engage with the private sector (Hale, 2006), and there does exist some confusion between partnerships and other public-private arrangements. Linder (1999) conceives of partnerships as a rebranding of other methods of engagement between public and private actors. Using the term partnership to describe this arrangement, as opposed to privatization, is seen as in some way avoiding the stigmas associated with privatization as a form of service delivery. Some authors would go so far as to state that the ambiguity around the definition of a partnership relative to other forms of public and private sector interaction is deliberate (Miraftab, 2004), an obfuscation to hide the creeping advance of neoliberalism in the public sphere (Coulter, 2009). Other authors, including myself, disagree with this assertion. There are some clear definitions to discern public-private partnerships from other forms of arrangements between the public and private sectors. One critical feature of partnerships that distinguishes them from other arrangements is the implied long-term nature of a partnership. P3s are expected to operate as an ongoing relationship with joint decision-making and an even sharing of financial risk and exposure for involved parties (Globerman and Vining, 1996). Unlike privatization or other arrangements between public and private actors, a public-private partnership may be understood as being more akin to a long-term

‘marriage’ between government and a private partner, thereby implying an on-going relationship with some level of joint decision-making and shared risk (Globerman and Vining, 1996).⁴

A partnership should be a long-term relationship between public and private actors that enables those involved to “accomplish more than could be achieved by independent action alone” (Brewer and Hayllar, 2005, p.477). The long-term nature and sharing of risk, responsibility, and decision-making differentiates P3s from other relationships such as service contracts and contracting-out, privatization or the sale of public assets, regulation and franchise contracting of privately owned natural monopolies, or public sector leasing or purchase of private sector assets (Vining et al., 2005). Cooperative ventures such as public-private partnerships are expected to utilize the expertise of each individual partner. These partnerships are designed to meet the needs of the public sector in regards to service provision, while also allocating risks, rewards, and responsibilities evenly with a private actor (Kernaghan et al., 2002).

Partnerships represent a changing set of values in the public service. In examining public sector values and the New Public Organization, Kenneth Kernaghan et al. (2002) outline the values connected with partnerships and how they may represent a new direction for government values. They note the emergence of changing values in the public sector, stating that “new values have emerged that either compliment or clash with traditional values.”⁵ Among the most popular

⁴ The works of Bloomfield (2006), Globerman and Vining (1996), and others mobilized within this paper discuss some of the significant challenges associated with enforcing a project agreement over the term of a P3 project, including risks from changing circumstances and the capacity of the private partner for risk avoidance. To truly delve into the problem associated with long-term partnerships, it would be most interesting to examine cases that do include a significant operational and maintenance component (DBFOM projects). Given that the two cases of study maintained public paramountcy for operations and maintenance, the content for study would be less rich for analysis relating to long-term issues arising beyond the design, building, and financing phases of the projects.

⁵ Kernaghan et al. (2002) contrasts the organizational profile and values of both traditional and post-bureaucratic organizations in examining the New Public Organization. Their profile of a traditional bureaucratic organization is

new values are service, quality, teamwork, innovation and openness” (p.47). Kernaghan et al. (2002) find the new values to be “generally more compatible with the formation and maintenance of partnerships than are the traditional values. Indeed, partnerships are widely viewed as a means of fostering such values as service, quality and innovation” (p.204).

The Conference Board of Canada illustrates some differences between a conventional public sector project and a public-private partnership in infrastructure development by outlining a number of key features inherent to both (Iacobacci, 2010). Conventional public sector projects involve project stewardship largely under public actors or a contract management firm acting on behalf of a public sector owner. The execution and control of the project, and subsequently ownership of the project, would have engineers on site to direct and inspect the project as it works towards set completion milestones. A public-private partnership project entails private sector stewardship, and the overall control of the project is transferred largely to the private sector partner. The public sector remains an owner in this scenario; however, they must allow the private partner and its contractors the freedom to manage the project within the constraints of the contractual obligations. The public sector owner does retain ownership of the asset and has the right to change the project requirements or terminate the project altogether (Iacobacci, 2010).

As noted, the key distinguishing feature between a conventional project and a public-private partnership project, according to the Conference Board of Canada report, is the transfer of risk from the public sector to a private partner. By taking on stewardship and responsibility for the successful execution of the project, the private partner, in theory, also assumes the majority of risks associated with the project.

characterized as being organization-centred, process-oriented, centralized, budget-driven, and monopolistic. These organizations are seen as having traditional values of “integrity, accountability, efficiency, effectiveness, responsiveness, representativeness, neutrality, fairness and equity” (p.46).

2.2.2 In Practice

Three jurisdictions in Canada have specialized infrastructure bodies that support the development of public-private markets and handle procurements. Other provinces may have offices within their provincial government's central agencies that work in an equivalent function. Most jurisdictions within Canada have guidelines in place that dictate the conditions under which a public-private partnership is worth being considered as a delivery mechanism for a public infrastructure project. The typical features of these guidelines, as identified by the Conference Board of Canada's 2010 report, *Dispelling the Myths: Pan-Canadian Assessment of Public-Private Partnerships for Infrastructure Investments*, includes: a mechanism for developing performance requirements and outputs for the project that ensure effective risk transfer to a private partner; a ceiling on the size of the deal including construction, operation, and maintenance costs; a means of accounting for project complexity in design, construction, operation and maintenance phases, allowing for private partners to capitalize on opportunities for innovation or means to integrate work across different phases of the project; and a competitive market that can produce a minimum number of bids for the project. A project failing to meet these guidelines generally, or any one of these requirements in particular, may indicate that the project is unlikely to generate value for money, and could end up being a bad investment for the public sector.

Partnerships exist in a number of different forms of arrangements with varying levels of risk transfer and ownership for public and private partners. These arrangements span a spectrum of models that progressively entail a greater shift in responsibility and ownership from public to private partners. Kernaghan (1993) outlines four general purposes for partnerships, including collaborative arrangements, wherein parties pool resources and pursue shared goals; operational,

wherein decision-making authority is retained by the public sector; contributory, where financial sponsorship is shared; and consultative, wherein merely advice is solicited. These represent a number of different purposes for which a public and private partner may wish to enter into an arrangement, with each spanning a spectrum of varying responsibilities for each actor. At one end are arrangements that are entirely administered by the public sector but administered within a framework that allow for the private finance, design, building, operation, and ownership on a temporary basis of an asset. The other end of the spectrum entails full private sector ownership of a project. In terms of the arrangements generally seen between public and private partners, they tend to follow a model of privatization, concession, or operation and maintenance (CCPPP, 2003). Understanding these various models and the particular arrangements that they can entail is important context to be reviewed prior to conducting the multiple-case design of this study.

As it is understood in Canada, privatization represents the furthest point on the partnership spectrum, with the majority or totality of assets being held by the private sector. Privatization can refer to full divestiture, or specific functions that are turned over in full to the private partner, with the public sector taking over more of a regulatory role (CCPPP, 2005). Privatization will usually entail a build, own, and operate (BOO) project, wherein the public sector purchases services from the private sector, with the eventual private ownership of the asset (CCPPP, 2005).

Moving back along the spectrum of levels of public and private involvement, a concession approach in this vein would be a build, operate, and transfer (BOT) project, or a build, own, operate, and transfer (BOOT) project, wherein the private sector is obligated to meet a set of particular responsibilities for an agreed-upon period of time, and eventual ownership is transferred back to the public sector. The private sector actor may also buy, own, and lease back

(BOLB) facilities, wherein they build the infrastructure and facility, and then lease it back to the public sector to manage (CCPPP, 2005).

Other concession projects include design-build, wherein the private sector designs and builds infrastructure according to the public sector's specifications. A private actor may design, build, and operate (DBO), or design, build, finance and operate (DBFO), or design, build, finance, maintain, and operate (DBFMO) a public-private infrastructure project. These entail increasing levels of stewardship on the part of the private partner, as they can operate beyond the design process into operations, maintenance, and financing (Kwak, Chih and Ibbs, 2009; Iacobacci, 2010).

Operations and maintenance partnerships can include franchising arrangements, wherein a private entity is contracted to manage the operations of existing infrastructure. The private sector can be responsible for all aspects of operations and maintenance. Private partners may not take responsibility for financing of these projects, but may manage capital investment funds in input from public partners.

2.3 Risk Sharing and Value for Money

Political proponents for partnerships tend to be neoliberal or fiscally conservative contingents and include such examples as Ontario's Progressive Conservative party under Mike Harris: a backer of methods of alternative service delivery during the 1995 elections (Hale, 2006). Upon victory and during the government's first throne speech, the new government promised that it would "pursue alternatives such as partnerships between government and private businesses and opening government operations to outside competition" (Legislative Assembly of

Ontario, 1995, p.5). The stated benefit of opening administrative operations to outside competition has been to “save taxpayers’ money, while protecting privacy and the public interest” (Legislative Assembly of Ontario, 1995, p.1112). Across the literature, one sees numerous examples of advocates for public-private partnerships describing alternative service delivery as a mechanism of delivering service while saving money and better meeting public demand. The following section will outline the purported benefits of the utilization of P3s, including the potential accounting incentives, private sector expertise, risk sharing, and cost savings. This will entail an examination of how partnerships can (purportedly) operate in a fashion that opens government to competition, and how this can save taxpayers money and demonstrate service efficiency. This will help to explain why P3s represent an attractive option for the public sector, and why they have been looked to by actors across the academic and political spectrums as a method of alternative service delivery.

Collaborative P3 arrangements to provide public services have become increasingly popular as a means of meeting the demands placed upon the modern public sector; namely, meeting the demands of the public while at the same time working within the increasingly scarce resources afforded to government. Governments may see partnerships “as a way of getting infrastructure costs off the public balance sheet, keeping investment levels up, cutting public spending and avoiding the constraints of public sector borrowing limits” (Bing, 2005, p.25).

Partnerships have been looked to, particularly in Canada, to address what is considered to be a significant infrastructure deficit, estimated in Canada as being well over \$130 billion. It is arguable that government cannot afford to address this deficit without exploring innovative financing schemes such as partnerships (Watkinson, 2008). Working within this political and economic climate, the public sector looks to work with private sector partners with the

expectation that they can not only finance projects that would not be possible otherwise, but also that the private sector actors are more capable of managing risks and working smarter, faster, and cheaper, than the public sector (Watkinson, 2008).

The purported benefits of partnerships have made them highly attractive to governments in Canada as a mechanism of public infrastructure procurement. Public sector managers enter into partnership arrangements hoping to mitigate the negative consequences inherent in major projects (Wilkins 2003). The opportunity to achieve a higher value for government investments and reduce risk make partnerships an attractive option, and as such particular forms of projects have become increasingly associated with P3 arrangements. The OECD identifies value for money (VFM) as the primary objective in any P3 design. VFM entails horizon scanning and analysis to find the highest possible level of both quality and effectiveness and the best possible price. This does not, however, entail selection of the cheapest option, as VFM attempts to make considerations for the quality of an asset and, for example, maintenance costs over the operating term of the asset (OECD, 2008). One additional advantage pertaining to value for a project that is particularly relevant to ‘first wave’ P3 projects in Canada is the fact that P3s theoretically allow for “off-book financing” (Murphy, 2008; Conference Board of Canada, 2010; Silversides, 2008); a method of financing that allows public sector budgets and deficits to be kept to a minimum, which is noted for having political benefits (Marlow and Joulfaian, 1989). Annual lease payments made to private actors are considered more palatable than recording the full cost of expenditures for a given project in the budget of a particular year as it postpones financial obligations and permits government to begin projects earlier and pay later. As governments deal with increasingly constrained resources, these kinds of arrangements are considered to be significantly advantageous for the public sector (Murphy, 2008). Changes to accounting systems

in the federal accounting regime and in many provinces has negated many of the accounting incentives of P3s, but it is noteworthy as a prior perceived advantage that likely influenced many current or past P3 projects (Murphy, 2008). “Off-book financing” was certainly part of the incentive for utilization of a P3 procurement approach in the ‘first wave’ of Canadian P3 projects, including the cases to be examined in this research study (Barrows et al., 2012).

Another commonly identified advantage for public-private partnerships is the fact that these arrangements can help government to innovate by transferring some of the risk involved in endeavours of public enterprise onto the private sector (Carr, 1998). The OECD (2008) finds risk transfer to be synonymous with P3 arrangements, and identifies sufficient risk transfer as “the distinguishing feature that determines whether a project is defined as traditional public procurement or as a Public Private Partnership (PPP)” (p.20). Risk sharing is one of the most frequently cited reasons for engaging in a P3 project, as public sector actors maintain that traditional project delivery models saddle the public sector with responsibility for risky cost overruns, delays, and a substandard level of quality in design (Watkinson, 2008). Through public-private partnerships, public and private actors are able to engage in risk-sharing wherein both partners individually assume risks, as well as some shared risks. Project risks, or those around implementation, tend to be assumed by private partners. Risks associated with site availability and political risks are often assumed by the public actors. Both actors will assume some risk associated with maintaining the relationship overall and those related to any required legislative changes (Li et al., 2005). When the major project risks that are better handled by private actors are involved, such as significant construction-delay risks, P3s become a particularly attractive option.

The ability to transfer risks related to design, construction, operation, and other project risks to the private sector make partnerships a highly attractive option for government. The public sector is seen as being able to hedge “against the failings of government” (Murphy, 2008) in partnerships by shifting design risks, standards of delivery, risks of cost overrun, market risks, and other project risks onto private partners.

In major public sector projects, pressures from political or budgetary concerns can lead to under-investment as the issues facing the government of the day could outweigh those of the maintenance of public assets. This could theoretically lead to issues in projects currently underway, or to the deterioration of an asset over a protracted period of time (Murphy, 2008). Involving private sector partners to maintain public assets distances the political or budgetary concerns of the public sector from the arrangement. Private sector actors have added financial incentives and penalties for non-compliance that the public sector does not, thereby mitigating such risks (de Bettignies and Ross, 2004).

Public-private partnerships are also seen as a means of both providing services and developing infrastructure at a lower cost than the public sector would be capable of doing when operating on its own (Brewer and Hayllar, 2005). Private sector organizations, according to some, are generally associated with an increase in cost-effectiveness and efficiency comparative to public organizations, largely due to the lack of competition and lack of incentives for efficiency maximizing behavior in the public sector. Government does not have any profit motivation and rarely faces the kind of competition that private-sector actors would (Murphy, 2008). Private sector actors, meanwhile, are focused primarily on profit maximization, and as such are incentivized to minimize costs and provide efficient services (Rosenau, 1999).

Another advantage to partnerships is the ability for government to operate in areas in which it may not have any particular expertise. Public sector actors engage in diverse service areas and tend to have less specific expertise and experience with relevant technology or activities. In a partnership, public sector actors can leverage the pre-developed capacity of private actors to provide services. This can account for significant cost advantages, particularly for smaller governments that may have only limited capacities to begin with. The specialized nature of private-sector firms are viewed as more capable of delivering services in an efficient manner due to their superior scale, scope, and learning economies and due to their more specialized nature, more developed capacities, and experience in relevant operations (Vining and Boardman, 2008). The expertise and technical efficiency of private sector partners provides a significant advantage to public partners in both the development of infrastructure and the provision of on-going services in the form of lower costs for the development of public resources or provision of public services through a partnership.

As touched-on previously, public private partnerships are a means by which competition can be injected into the provision of public services. Competition is core to a P3 arrangement in that “in the absence of competition, effective risk transfer will not occur, which in turn means that the intended VFM will not be realized” (OECD, 2008, p.134). Competition between business organizations vying for the business of public organizations can work to the mutual benefit of both the public and private sector, and ensure that projects operate within VFM targets (Kernaghan et al., 2002). Government-provided services are perceived as lacking any natural form of competition, and “as governments are often monopoly suppliers, there is no built-in incentive to innovate or control costs” (Murphy, 2008, p.103). In this sense, partnerships provide an opportunity for government to take advantage of the lower prices and innovative thinking

provided through a market approach, wherein multiple vendors compete for the opportunity to provide a public service or develop public infrastructure. Obviously, not all government services can or should be delivered in a competitive context. However, an effective procurement process and well-managed contract monitoring can introduce a number of competitive elements into the partnership process, thereby providing the benefits of competition to the pricing of the goods or services being provided (Murphy, 2008).

In summary, partnerships can bring the benefits of competition, risk mitigation, improved efficiency, and alternative financing options to public sector infrastructure projects, making them an attractive option for public actors. Despite this, it should be acknowledged that partnerships have some undeniable issues with consequences for both public and private partners. The following section will examine some of the main points raised in literature in critique of partnerships as a mechanism of service delivery and infrastructure procurement.

2.4 Limitations of P3s as Defined in the Literature

Public-private partnerships are not appropriate for all infrastructure projects, and in many jurisdictions these types of procurements would account for no more than 20 per cent of total capital spending on public infrastructure projects (Iacobacci, 2010). P3s have a number of limitations that bound their usefulness as a means of procuring and operating public infrastructure projects. This section will examine limitations as identified in the literature to provide a balanced perspective towards this new and, often, controversial form of developing public infrastructure.

As explored previously in this chapter, public-private partnerships have become increasingly prevalent in the Canadian public service, touting benefits of value-for-dollar and risk transference for large infrastructure projects such as those in hospital procurement. In practice, however, P3s can in many ways be found to be unaccountable, risky, undemocratic, and frequently undesirable as a means of providing public services (Wilkins, 2003). There is well-established skepticism regarding the use of private financing and service delivery for public goods and infrastructure in general, as well as pointed criticism of the use of P3s to develop health infrastructure. Critics of P3 approaches to public infrastructure and service delivery reject the view of the public sector as a common or unsophisticated service provider, and perceive a deficit in governance for public-private arrangements such as P3s (Rouillard et al., 2004). This further entails a rejection the inherent notion within literature supportive of P3s that assumes that a private sector partner is, in some way, fundamentally better equipped to deliver public goods and services with increased efficiency, effectiveness, and at a lower cost than government could (Rouillard et al., 2004). In regards to the use of P3s in health infrastructure in Ontario specifically, critics stress the need for reexamination of the use of P3s in the province to address any perceived gaps in hospital infrastructure development, particularly given the long length of contracts and considerable financial investment involved in health sector infrastructure development (Auerbach, 2002). Auerbach (2002) points to instances wherein P3s were utilized for hospital procurement that serve as illustrations of why such a re-examination is warranted, citing significant challenges and a failure to deliver on stated benefits for the Brampton Civic Hospital project in particular, one of the two cases evaluated in this study.

The potential dangers of operating in a partnership with the private sector are great, and can often outweigh the purported benefits that come with P3 service delivery (Wilkins, 2003). In

particular, one finds significant evidence to suggest that the stated benefits of partnerships are often not achieved. Canadian governments have frequently experienced difficulties in effectively reducing both total costs related to the sum of production or transaction costs, and budgetary risk exposure via transferring revenue risk through the use of P3s. These problems are exacerbated by the difficulties inherent in managing complex relationships over protracted periods of time. The considerable challenges associated with long-term public-private partnerships can serve to undermine public sector efforts to capture the proposed benefits that are supposedly inherent within these kinds of arrangements (Bloomfield, 2006). Significant evidence exists to indicate that while long-term public private partnership arrangements may be touted as low-risk and cost-saving at their inception, despite this a number of partnership arrangements have caused taxpayers to be saddled with high-risk and costly obligations to private actors for protracted periods of time; as long as a decade or more (Bloomfield, 2006). One finds that in circumstances wherein contract risks cannot be adequately assessed or properly controlled, such as in long-term arrangements in complex and changing environments, the risks associated with unexpected developments tend to be shifted to the involved party that is capable of bearing said risks at the lower cost. As a result of this, public actors, regardless of their own position of financial stability, are often in a position that finds them assuming high risks associated with changing circumstances, while private actors are found to be capable of avoiding responsibility for such risk (Bloomfield, 2006). As such, partnership arrangements can become problematic over time as conditions change. Furthermore, as circumstances emerge to create problematic issues within the arrangement, the public sector seems to be held responsible for accounting for such developments (Bloomfield, 2006).

Reviewing the experiences with P3 projects, one finds that extensive amounts of time tend to be allotted for the bidding process for P3 projects. This is coupled with negotiation time between project advisors and the client over the terms and conditions of the contract (Bing, 2005). Given the long-term nature of these kinds of arrangements, a contract process that appreciates the full complexity of the arrangements between public and private partners while sufficiently taking into consideration unanticipated or emerging issues over the course of the project can be expected to be a hurdle that takes some time to complete. One finds that many of the negative factors associated with public-private partnerships and procurement are in the amount of time and costs associated with contract transaction, delays in negotiation, and high participation costs (Bing, 2005).

Both for-profit private partners and public sector partners have experienced difficulties in attaining the purported advantages related to risk minimization, mitigated financial exposure, and cost-savings through the utilization of P3s. Some negative outcomes for partnerships include the dissolution of the partnership more quickly than envisioned in the initial contract through government buy-out, bankruptcy of the private actor, or protracted conflict between partners leading to a partnership breakdown (Vining et al., 2005). This is symptomatic of a conflict of goals, or goal displacement, between public and private actors.

Public and private partners engaged with one another in a partnership arrangement can have dissimilar goals or expectations, thus creating a wedge between the actors involved. Some common elements are noted within partnership arrangements that can cause the interests of the involved partners to potentially be in conflict with each other. Public sector organizations are noted as attempting to retain some level of primacy in the partnership arrangements. One sees government as recognizing the need for cooperation, but being unwilling to accept the

consequences of full commitment to the shared responsibility and decision-making of a partnership arrangement (Teisman and Klijn, 2002). Public sector actors maintain levels of control, in many cases, in an effort to mitigate any kinds of political costs or negative exposure. This is tied with goals to minimize expected short-term expenditures and on-the-budget expenditures. One may find the goals of private sector actors to be quite different, however. Private-sector partners on the whole tend to be more accustomed to arrangements that entail maximizing risk-adjusted profits throughout the life of an arrangement (Vining and Boardman, 2008). While in many cases these goals are not in conflict and partnerships often serve as a vehicle to meet the above goals and expectations of both partners, these two inherent dissimilar sets of goals and expectations can come into conflict, thereby creating a relationship that is mutually disadvantageous, or is exploitive towards one of the involved partners. These kinds of conflicts arise as the public sector enters into the arrangement with an expectation of minimizing expenditures and visible costs, whereas the private sector partner is interested primarily in maximizing their own profits (Vining et al., 2005).

The emergence of conflicting goals between partners has been noted as having a significantly detrimental impact on the effectiveness of the partnership. Joint ownership of projects can potentially break down as levels of dissonance increase between public and private actors, thereby fouling the partnership (Vining and Boardman, 1989). This can take the form of high transaction costs, particularly for public partners, failure to achieve common or individual goals, and opportunistic behavior on the part of one or both partners. These represent significant issues observed in joint-ownership arrangements between the public and private sector that have led to poor profitability for private sector partners, and an inability to meet social needs for public sector actors (Vining and Boardman, 1989).

While effective risk mitigation, brought on by the sharing of risk between partners, is touted as a potential advantage to public-private partnerships, in practice these arrangements may not be as successful at mitigating risk evenly as initially hoped. It is acknowledged in the literature that private sector actors tend to be adept at mitigating risk while maximizing private gain, and the public partner often finds itself carrying substantially greater risk under most circumstances in P3 arrangements (Rouillard et al, 2004). Evidence suggests that the assumed risk-transfer that occurs in the negotiation and re-negotiation of public-private partnerships has not been as effective as it was initially thought. Public sector actors have had difficulty in many cases achieving effective risk-transfer to the private sector, as government can in some situations be forced to continue to assume significant revenue risk in partnership arrangements (Vining and Boardman, 2008). Private sector actors, meanwhile, are quite capable of minimizing risk exposure through strategic measures including the formation of stand-alone corporations isolated from other corporate activities to reduce bankruptcy costs if necessary, and the utilization of extensive third-party debt financing (Vining et al., 2005). This disparity between partners can create a position of significant disadvantage for public sector partners when entering into a partnership with the private sector.

Transaction costs present another significant problem that can create difficulties for effective risk-sharing in public-private partnerships. Transaction costs include those costs associated with the contracting, negotiation, monitoring, re-negotiation, or termination costs incurred in dealings with private partners (Vining and Boardman, 2008). Transaction costs tend to be borne by the public sector, particularly in larger infrastructure projects (Rosenau 1999). Transaction costs tend to escalate in cases where the projects are particularly complex, where there is a high level of asset specificity, and in circumstances where there is a low level of

competitiveness. Large-scale public projects can be quite complex with contextually-specific aspects unique to the project that vary based on jurisdiction, the level of government involved, and needs. Asset specificity refers to the limited usefulness of design work for a project, and is common within public sector infrastructure projects such as roads, hospitals, and schools wherein the designs are unlikely to be utilized in a multipurpose function. Finally, competitiveness and contestability can suffer in cases wherein partnerships are arranged around new technology or particular specialized skills, as few alternatives may exist for private actors in terms of construction or maintenance (Vining and Boardman, 2008).

High transaction costs can result from difficulties in formulating arrangements between partners, design issues resulting from overwhelming complexity, and difficulties in reaching agreements. Many of the same factors leading to higher transaction costs may also cause revenue uncertainty, thereby insuring that a lower level of risk is assumed on the part of private actors (Vining et al., 2005). Utilizing P3s and achieving public sector goals for infrastructure or service projects can become increasingly difficult when faced with high transaction costs and poor risk transfers due to goal conflict with private actors.

Difficulties in managing transaction costs can be further exacerbated by contract management issues. Contractual relationships, an element of partnerships, can be particularly complicated. Issues relating to specialized functions or experience and subject matter expertise can further complicate contractual issues (Boardman and Hewitt, 2004). With private actors often brought in to serve the function of subject area experts, as well as generally being considered as having more experience with contracts than public actors, the public sector is seen at a disadvantage in some partnership arrangements. While private sector expertise is a key reason to engage private partners in the first place, the disparity in knowledge and expertise

between public and private actors can create significant problems in terms of transaction costs. Public sector actors with limited experience may be incapable of fully appreciating the extent of issues that may arise during the course of complex transactions with their private sector partners (Shelanski and Klein, 1995). As such, public actors are placed into a position of disadvantage in the contract development stage, re-negotiations, and more. Issues with contracts in partnerships can place private actors in a position of significant advantage in a partnership arrangement, and contract termination is an expensive transaction cost that would have to be paid for through the public purse (Boardman and Hewitt, 2004).

Opportunistic behavior on the part of private sector actors represents another obstacle for partnerships. While it is inaccurate to assume that private partners are predisposed to negotiating partnerships with government in bad faith, the fact remains that profit motivation for private actors is not shared by public actors. Profit motivations on the part of the private sector are at the core of opportunistic behaviour, thereby creating major hurdles for public partners that can drive up transaction costs and increase public risk (Boardman and Hewitt, 2004). The opportunistic behaviour and profit motivations of the private sector ensure that, when it comes to P3s, “there are no free lunches” (Vining et al., 2005, p.199).

Partnership projects also struggle with trade-offs between flexibility in the project and long-term contractual certainty. Some level of security in project contractual arrangements is required for partnerships using a project finance structure. Flexibility can increase the overall risk profile for the private sector, and the price of the project is expected to increase. As a result, highly changeable environments may represent a challenge to longer-term partnership arrangements (Murphy, 2008). Governments may change policies over the course of the partnership, the operating environment may change in any number of ways, and the preference of

the public at large can also change. It is expected that if a project maintains a particular sensitivity to change over the course of the contract term, it can lead to substantial unanticipated costs over the duration of the partnership. For example, early termination of a project, or including provisions for such, can lead to higher costs for the project overall (Iacobacci, 2010).

Opposition to P3s, both in literature and public discourse, is well developed and points to some legitimate concerns and challenges associated with this approach to infrastructure procurement for major public infrastructure projects. As well, P3 has become an established mechanism for delivery of Ontario's public infrastructure sector needs. Given the established concerns with this procurement approach, it is incumbent upon researchers in this field of study to seek to better understand how this procurement mechanism is employed within the Ontario context and build knowledge around the successes and challenges of past projects to inform future public infrastructure procurement projects through P3.

2.5 Contribution to Knowledge

This chapter has demonstrated the significantly developed field of literature pertaining to the studies of P3s through an analytical literature review and inventory of key aspects of partnerships and risks associated with this form of infrastructure procurement. It is the intent of this section to further situate this research study within the above analyzed literature and provide comment on what this research contributes to the broader dialogue on public-private partnerships in particular and public administration in general.

As was discussed in this chapter, despite the utility of partnerships as a mechanism to address Canada's infrastructure deficit (Watkinson, 2008), P3s as a mechanism for delivery public goods can be plagued by challenges in governance (Rouillard et al., 2004), high

transaction costs (Vining et al., 2005), profit motivation and opportunistic behaviour on the part of private partners (Boardman and Hewitt, 2004). Partnerships can be seen as inherently complex relationships (Bloomfield, 2006) between a multitude of actors with potentially varying goals and approaches (Vining and Boardman, 2003), and there is a considerable challenge associated with effectively undertaking a successful long-term P3 project to deliver public goods and services.

Knowing the landscape of limitations of P3s as a procurement mechanism, and understanding the significant body of literature already existing that examines the risks and challenges offered by alternative service delivery, it may be asked: what contribution may this research study offer beyond restating how these particular shortcomings do or do not exist within the two cases to be studied in this research? It is contended that the originality and contribution of this thesis to the advancement of knowledge in the literature around public-private partnerships in health care procurement is dependent largely upon the observations offered by the theoretical approaches applied in this paper, that being complex evolutionary systems theory.

While authors have previously adopted a complex network theory perspective for P3 research that examines partnerships as cooperative, networked projects, and seek to build understanding around the structure and governance of these projects (Klijn and Teisman, 2002, 2003; Koppenjan and Enserink, 2009), this theoretical perspective has not oft been applied to the Canadian experience with public-private partnerships. Application of this theoretical model to the study of the Brampton Civic Hospital and Royal Ottawa Hospital projects should offer novel observations regarding these two formative projects in the fledgling Ontario health infrastructure P3 landscape. In doing so, this research study will help to build upon currently available

knowledge relating to these cases around the structure of relationships between public and private partners and decision-making processes throughout the course of these project.

2.6 Summary and Conclusion

Partnerships have become particularly important as one part of the broader field of infrastructure procurement for all levels of government in Canada. Infrastructure P3s are structured through explicit contracts between government entities and one or more private firms. The private entity is engaged in building, designing, financing, and operating the facility for a specified period of time. Government may operate as an intermediate customer for the project's outputs, and as such be responsible for user fees, or instead may negotiate the contract and specify unit prices while passing user fees onto direct users. Health infrastructure procurement through partnerships has become increasingly common worldwide, and some forms of public–private partnerships are a feature of hospital construction and operation in all countries with mixed economies. Domestically, Ontario, Quebec and British Columbia engaged in partnerships with private sector consortia to build, design, finance or operate large hospitals in their provinces. Despite this, some noted issues exist with partnerships that need to be acknowledged in understanding their utility in Canada.

As per the core research questions stated in Chapter One, this research project will examine the Brampton Civic Hospital and Royal Ottawa Hospital partnership projects to build on available literature that considers the reasons why partnerships health infrastructure procurement in Ontario have succeeded or failed in realizing the benefits that partnerships are supposed to bring to such projects. The case of the Brampton Civic Hospital exists as a prominent case to study the kinds of issues that can arise in large infrastructure projects

generally, and partnerships in hospital procurement specifically. A consulting firm contacted by the WOHC estimated in September 2000 that the costs for designing and building a new hospital would be approximately \$357 million. This figure was updated to \$381 million in 2001. A second consulting firm utilized similar assessment approaches in January 2003, and estimated the costs of the hospital to be \$507 million. While there had certainly been increases in labour and material costs over that span of time, the increases from these costs and inflation alone could not account for the disparate differences between the two estimates. Over the course of the construction period, the total cost for the hospital came to \$614 million. It was later estimated that the government had spent more than \$50 million in excess of what should have been necessary to build the hospital (Auditor General, 2008). The Royal Ottawa Hospital project, in comparison, was seen as much more successful at delivering upon stated goals on time and within the defined budget (Laird and Langill, 2005). This raises questions regarding what aspects of the two projects would have been handled differently, and the impact that such would have had on outcomes. This research project seeks to build additional knowledge about these cases, answering questions about the projects that focus largely on the structure of relationships between key actors. How did the relationships between public managers and private partners, experts, and stakeholders shape the directions of these projects? Did differences in how these projects established and leveraged networks of interaction with key actors lead to varying outcomes? How did Ontario's first forays into public-private partnerships for major health infrastructure procurement engage and consult throughout the process? These are the potential areas wherein this research may contribute to the broader literature regarding the experience of public-private partnerships in Ontario.

The following section will establish a theoretical framework to examine the two cases to be studied in the multiple-case design. Applying this theoretical framework to a system-level examination of hospital procurement processes in Ontario should offer new observations pertaining to the study of the two cases. As detailed in this section, there has been a significant focus on the benefits and challenges facing partnership projects in the literature, and P3s remain the subject of significant discourse and consideration. As offered in Section 2.5, “Contribution to Knowledge,” and as will be further explored in Chapter Three, complexity theory offers some unique insights not entirely captured in the literature considered above. Through this lens, new insights can be made into how partnerships evolve and adapt, interact with other systems such as the political sphere and beyond, and are influenced by the complex environment in which they operate. Utilizing this framework to study public-private partnerships within the Canadian context should reveal new observations around the capacity for P3 projects to manage complex and evolving operating environments, and whether or not their ability, or inability, to manage these operating environments, engage actors, and conduct effective horizon scanning is linked to the success or failure of a partnership.

Chapter Three: Theoretical Framework

One of the initial phases of any research project in the social sciences is to present and explain the viewpoint from which the study will be based. As such, this theoretical framework and the subsequent conceptual framework have been developed in advance of a methodological approach or data collection, and will serve as an explicit description of the lens through which this study will be conducted.

The theoretical framework for a study entails a representation of the relationships between the phenomena in a study. It is to provide a broader understanding of the environment in which the subjects of study operate. The framework is developed in review of literature that broadly investigates cause and effect relationships that explain, in many ways, the workings of the world. Studies at a theoretical level present “a representational system at a higher level of abstraction that can inform and be informed by alternative theories” (Rudestam and Newton, 2007, p.24). In this case, the work of Eve Mitleton Kelly on complexity theory and governance perspectives of complex evolutionary systems theory based on the works of Erik-Hans Klijn and Geert R. Teisman serve as the core theoretical worldviews that inform the study.

The conceptual framework of the project outlines the relationship between the variables identified in the study. The conceptual framework is founded on the tenets and worldview of the theoretical framework, and “lays out the key factors, constructs, or variables, and presumes relationships among them” (Miles and Huberman, 1994, p.440). Matthew B. Miles and A. Michael Huberman (1994) describe the conceptual framework of a study as being “the current version of the researcher’s map of the territory being investigated” (p.20). The conceptual

framework of this study is a means by which the ideas and principles of the study are analyzed and developed, providing explicit detail of the theoretical assumptions at the core of the research while setting the primary objectives of the study (Miles and Huberman 1994).

This study intends to look at the two identified case studies through a governance perspective of complex evolutionary systems theory based on the works of Erik-Hans Klijn and Geert R. Teisman. These authors have looked into the dynamics in governance systems, and apply complexity theory to governance processes in what is referred to as “an evolutionary approach to public administration” (Teisman and Klijn, 2008a, p.290). Governance processes explain the normal societal and physical landscapes of an organization, or as it will be understood in this paper, the public sector. This understanding of governance through complexity theory uses a number of central concepts from complexity science such as self-organization, co-evolution, and fitness landscapes to understand governance processes (Teisman and Klijn, 2008a).

Contributions to governance activities in the field of public administration, as is the focus of this paper, are concerned more with “creating circumstances for improvement than on direct improvements aimed at by public management” (Teisman and Klijn, 2008a, p.290). As such, this section will focus on providing an overview of the key inputs to complexity theory, and then apply these inputs to governance systems to provide an idea of the circumstances that allow a public organization to improve relationships between actors and adequately manage partnerships in the health sector to manage for complexity in the operating environment.

3.1 Complexity Theory

Modern society, it is argued, can be understood as trending towards increasing complexity. Modern societies have an increasing number of embedded social systems emerging as a byproduct of increased functional specialization. The roles from which particular social systems emerge have become ever more specialized with their own identities and linguistic structures (Mitleton-Kelly, 2005). This functional specialization occurs in an increasingly interconnected world where systems interconnect and interact with each other, shaping and adapting to the environment around them.

It is said that “seventeenth-, eighteenth-, and nineteenth-century science succeeded in solving problems of simplicity, while the science of the first half of the twentieth century learned, by means of statistical analysis and probability theory, to deal with problems of disorganized complexity” (Rasch, 1991, p.65). Complexity theory can work as a lens, or conceptual framework, to be used as a means of understanding an increasingly complex and interconnected world. It provides tools and methodologies towards this purpose, and strives to help us explain and understand the nature of the world and organizations we live in (Mitleton-Kelly, 2003, p.4). Complexity theory provides a potential vantage point from which to develop perspective towards understanding the world in whole or in part as an interconnected and ever-changing connection of systems and subsystems.

Social phenomena have been recognized as complex phenomena for a long time, providing a challenge in understanding them; given that this is the case, complexity theory is able to offer a great deal in terms of possible application to the study of public administration. Public sector institutions themselves can be understood as complex, consisting of a number of

interacting agents that make up a complex system and subsystems. Complexity theory provides insight into the interconnected and complex reality of modern organizations, and as such can offer potentially important insights to enrich understanding in the study of public administration (Rhodes, 2003).

One finds the primary areas of focus of complexity to be quite divergent from that of traditional worldviews, and those who utilize complexity science tend to see it as quite different from positivist, Newtonian approaches to science (Morçöl, 2001). It has been argued that “the continuing dominance of the Newtonian epistemology and methodology in public administration and policy and related areas is not in sync with the recent developments in the natural sciences” (Morçöl, 2005a, p.4) and that complexity theory offers to fill some of the gaps in knowledge that prior positivist worldviews may have omitted (Weber, 2005). The insights provided by complexity theory can be quite different than those provided by traditional methods, looking into the ability of organizations to adapt to emergent situations and complex working arrangements (Klijn, 2008a). Complexity science tends to reject the overly empiricist approaches entailing broad generalizations relating to social phenomena (Morçöl, 2001) of traditional approaches to study that are seen as emphasizing “reductionism, objective observation, linear causation, entity as unit of analysis,” (Dent, 1999, p.5) and other related aspects of theory. Conversely, complexity science stresses “holism, perspectival observation, mutual causation [and] relationship as unit of analysis,” (Dent, 1999, p.5). Complexity approaches to science are significantly more contextual than positivist approaches, and reject broad generalizations on the basis of emergent holistic systems being incompatible with reductionist approaches to research that attempt to study particular aspects of a system (Morçöl, 2001). The attempt to maintain a central stable equilibrium, as is the case in traditional positivist approaches, is rejected (Morçöl,

2005b). Instead, managing for complexity is seen as occurring in a state of increasing disorder towards the edge of chaos (Anderson, 1999). Complexity theory recognizes the fact that equilibrium will never reach a stable state in the public sector (Morçöl, 2005b). Self-organization is seen as a means of dealing with this issue, and the issues relating to steering are transformed into a realization of actual co-evolution between sub-systems (Klijn, 2008a). Knowing that governance within the system and the environment will never reach a stable equilibrium, less emphasis is placed upon actual steering, and more is placed upon self-organizing behaviour and co-evolution between sub-systems. This ability to create new order and new modes of thinking and working, emergent from the co-evolution between subsystems, is seen as “the distinctive characteristic of complex systems” (Mitleton-Kelly, 2011, p.52). This goes beyond the traditional ideas of public management wherein the central focus is the hierarchical relationship between public services and their context. Complexity theory replaces hierarchical steering with co-evolution between systems to attain mutual improvements (Mitleton-Kelly, 2003). In doing so, managing for complexity represents a divergence from the traditional positivist approach, with additional focus on relationships as the subject of analysis to gain a greater appreciation of how interconnected elements within a system create specific outcomes (Dent, 1999).

In the following section, I will look to define the origins of complexity theory and, from the theoretical foundations of complexity theory, draw out the key elements of this field of study; namely the indeterminate and shifting nature of the world, an acute focus on the interaction between actors as the unit of study, recognizing the self-organizing and evolving behavior of actors, and understanding the context and environment in which actors operate.

3.1.1 Theoretical Inputs Into Complexity Theory

The concepts relating to complexity are derived from a wide ranging set of theories that have developed in a number of scientific fields. Complexity theory is, as such, a collection of aspects of other theories and areas of research. These theoretical inputs include concepts based upon ideas drawn from “definitions of algorithmic complexity, deriving largely from computer mathematics; and organizational complexity, deriving from the new biology and a revived systems theory” (Stewart, 2001, p.326). These inputs, and their contribution to the broader understanding of complexity, are distinguished by their areas of origin by Mitleton-Kelly (2003) as such: complex adaptive systems (Kaufmann), autopoiesis theory (Luhmann), dissipative structures (Prigogine), and chaos theory (Arthur, 1994).

While the theoretical origins do have particularly vast differences and stem from highly divergent areas of study, there emerges a common theme present between these theoretical origins that state that any system is greater than the sum of its parts or the individual agents within it. Developments within a system at the macro level are related to interaction at the micro level. Overall, complexity theory stresses that systems develop in a non-linear fashion and are subject to feedback mechanisms. As previously noted, co-evolution and self-organization are central features of complexity theory (Klijn, 2008a). These theoretical origins each offer a number of particular key principles that have conceptual and practical value in the study of complex systems.

The connected nature of a complex system represents a key facet of complexity theory. Systems are seen as highly interconnected, with the actions of agents within the system affecting others and changing the system on the whole. These observations of a complex system derive

from various inputs such as anthropological science, the ideas of adaptation and co-evolution, and also algorithmic complexity and computer sciences.

The complex behavior of a system is seen to stem, from the most part, from the interaction and interconnections of actors within it. This stresses an understanding of the actors and their environments, be they ecological, economic, or social systems. The actual or anticipated actions or decisions of one actor within the system may have an impact on other actors or other systems, often in ways that are difficult to predict. It is in this sense that connectivity and interdependence are key features of complexity (Mitleton-Kelly, 2003, p.5), pertaining to elements within single systems or the relations between various systems.

The developments within systems and the trajectory of change of systems are seen to stem from co-evolution between a system and other systems within its environment. This concept is based upon the theoretical traditions of evolutionary biology, which observe the adaptation of an organism in relation to its environment. The influences upon the evolution of an organism can span the entirety of the environment, as too does the evolution and adaptation influence the environment around it. Organisms are noted as co-evolving with each other and their environment simultaneously (Mitleton-Kelly, 2003).

Applied to the social domain, all actors have the potential of exercising influence and causing change to occur in the social ecosystem. Co-evolution explains the inter-related relationships and interactions between complex systems influencing each other in ways that are both direct and indirect (Klijn, 2008a). This understanding of complexity theory, as applied to the social sciences, demands an appreciation of the organization's role within the context of the broader system in which it operates, or rather to be in touch with the outside environment and

other actors within the system. When utilizing these concepts in the study of social phenomena, one should apply “subtler ‘sensitivity’ and awareness of both changes in the environment and the possible consequences of actions”, while advancing “a deeper understanding of reciprocal change and the way it affects the totality” (Mitleton-Kelly, 2005, p.9). Given the interconnected nature of systems, it is only by understanding the broader context in which organizations operate and the nature of connections between the actors within the system that one can understand how change and adaptation occur. Networked forms of organization, for example, are viewed as more effective in turbulent, uncertain contexts, while bureaucracies are seen to fit predictable and stable ones (Koppenjan and Klijn, 2004). Drawn from evolutionary theory, ideas about adaption that occurs at different scales in ecological systems have been used to think about the health and resilience of organizations in the complex ecology of their broader natural, social and economic contexts (Holling, 1986, 2001; Morgan, 2005). Organizations have the capability of conserving varying aspects of their organizational identity that they consider to be worthy of conserving. Deciding what, in particular, is to be conserved is a critical aspect of organizational learning. A system that is able to adapt and learn will be able to maintain stability and conserve its identity as an organization (Koppenjan and Klijn, 2004).

While systems and the actors within them are seen as being governed by a spontaneous and self-organizing order from this description, it is also important to note the role of context and environment. A common metaphor for the operation of actors within context is that of a fitness landscape, which refers to the surroundings in which living beings exist and operate. The landscape in which actors operate is seen as changing continuously as a result of the choices of both agents within the system and external pressures (Klijn, 2008a). The ability of actors within the system to operate effectively is seen as being dependent on their ability to operate within the

fitness landscape and account for the actions of other actors and external pressure. Systems, from this point of view, are governed by a self-organizing and spontaneous⁶ order. The interactions within the system are seen as directly connected to the overall state and direction of the system. Top-down steering is seen as less of a focus as it is not necessarily required when the macrostructure of the system relates to its micro-structure without active direction (Klijn, 2008a).

From this, one can posit that “it is socially necessary ‘to see and develop systems’ going beyond thinking just in terms of institutions” (Mitleton-Kelly, 2003, p.61). Organizations that are seen as being incapable of doing so are seen as rigid and struggling against adaptation and co-evolution, thereby causing the organization to fail to adapt to their environment and adding to the cost of producing a desirable, working organization (Mitleton-Kelly, 2003).

Another related feature of theoretical approaches to complexity, borrowed from algorithmic complexity and computer sciences, is the idea that systems are seen to have self-organizing capabilities (Klijn, 2008a). This means that entities or actors in them do not only behave according to known laws and principles, or prescribed rules and scripted relationships (Stacey, 1995). They also act in new, sometimes unpredictable ways, recombine in surprising new relationships, and spontaneously create new structures and order (Kauffman, 1993). Based on this understanding, actors within the system and the system itself will operate within a spontaneous and difficult to predict manner, as actors operate within a changing environment while creating their own understanding, rules, and relationships. This makes predictive approaches to complex arrangements quite challenging. When applied to social sciences, these

⁶ Spontaneity, as it is understood in this study, refers to the way in which self-organization within a system may occur. A spontaneous new order may emerge within the system as a result of decisions and preferences of actors within it. Klijn (2008a) refers to spontaneity as a phenomenon wherein the macrostructure of the system relates to its micro-structure without active direction.

theoretical approaches make the argument that change within organizations is a challenging endeavour due to the complex, shifting, and unpredictable nature of systems. In understanding social phenomena such as a public system, these inputs of complexity theory posit that change “cannot be designed top-down and cannot be determined in advance in full detail. The constant failure of major restructuring initiatives and of merger and acquisition activity, where a highly specified organizational design is involved, indicates that the approach may be flawed” (Keskinen, 2003). Emphasis is instead placed on flexible adaptation and sensitive co-evolution within a shifting ecosystem, as “unstable environments and rapidly changing markets require flexible approaches based on requisite variety” (Mitleton-Kelly, 2003, p.14).

Mathematical approaches to complexity, such as chaos theory, offer a number of other inputs important to the overall understanding of complexity in a social science setting. Chaos theory is a mathematical theory concerned with identifying a set of core mathematical algorithms or simple rules of interaction guiding the complex and chaotic behavior of a system, and is related to complexity in the state that it studies the movement of a system between a state of order or disorder. During transition phases, patterns of order emerge within the disorder and a paradox is formulated wherein order and disorder coexist. This can be described as disorder at the “edge of chaos” (Anderson, 1999, p.220).

The ideas of chaos theory have certainly influenced thinking around complex systems, but they are not synonymous with complexity theory overall, and particularly not when studying social or human systems (Morgan, 2005). It can be difficult to apply chaos theory directly to human systems. Debatably, social or human systems do not exhibit central mathematical algorithms. It is argued that humans have the cognitive abilities that allow them to change the rules of interaction, and as such it can be difficult to distill any kind of central constants relating

to their behavior (Mitleton-Kelly, 2003). This problem pertains to the direct application of any theory to the social sciences; however, there are still particular themes, elements, and concepts of chaos theory and mathematics that can be applied to the study of organizations. Despite this, it warrants acknowledgement that these theories are not adopted in their entirety in the understanding complexity theory provides to the study of human organization and systems (Haynes, 2007; Morgan, 2005).

One example of a concept from these theories that is adaptable to understanding complexity and social systems is that of bifurcation points. Bifurcations represent sensitive decision points. Complex systems encounter bifurcations, leading either to order or chaos. As a complex system functions, over time tiny alterations or perturbations can be amplified and repeated to a point where a bifurcation will occur, causing the system to move in an entirely new direction (Briggs and Peat, 1989). Far away from a bifurcation point, a system can be well behaved and operate in a stable manner. As the system approaches a bifurcation point, however, the trajectory of the system overall can become random and unpredictable (Dixon, 1993). The notion of bifurcation points can be used to understand how critical decisions may dramatically alter the direction of a system and cause it to enter a qualitatively different state (Morgan, 2005).

Complexity theory draws from chemistry and non-equilibrium thermodynamics in the means by which it encourages exploration of the interaction between open systems and their environment, and how far-from-equilibrium systems create new structures and order. Ideas stemming from these theoretical inputs, such as path dependency and increasing returns, have long been applied to social sciences and public administration. These inputs provide an understanding of the “lock in situation of governors or governments or the trajectory in which governance institutions are formed” (Klijn, 2008a, p.3). When an organization moves away from

equilibrium and established patterns of behaviour, new means are developed and, resultantly, new forms of organization may emerge. Based upon the self-organizing concepts present in complexity theory, it appears these emerging trends are best suited by enabling infrastructures that permit and encourage new patterns of relationships to develop, resulting in new forms of organization that, ideally, will operate in a more robust and sustainable manner (Mitleton-Kelly, 2003). If a system is unable to adapt in spite of changes occurring around it, the cost of maintaining the system is likely to be high. “The system needs capacity to challenge its established values and norms in order to increase its flexibility in its medium” (Mitleton-Kelly, 2003, p.61).

Utilizing the concepts of thermodynamics and equilibrium, complexity science posits that “the search for a single 'optimum' strategy may neither be possible nor desirable” (Mitleton-Kelly, 2003, p.14). This stresses a notion of exploration of the realm of possibilities, as organizations engage in a satisficing process to address change within the complex system or organizational change. Systems, or organizations, are seen as ideally involving themselves in a continual scanning process in search of new and effective strategies for addressing emergent issues. This process is seen as reducing the significant risks associated with the commitment to a particular strategy too early in the development process.

Feedback mechanisms represent another feature of complex systems. Positive feedback, or reinforcing feedback, drives change in the system while negative feedback, or balancing or moderating tendencies, maintain system wide stability (Prigogine & Stengers, 1985). When dealing with human or social systems, feedback is rarely straightforward and often does not feed into a linear form such as input, process, and then output. Rather, feedback mechanisms in social systems tend to comprise of a variety of actors involved in and reacting to a social process. This

makes the entire process complex and indeterminate. Contingent factors such as the degree of connectivity or interaction within and between various systems determine the strength of feedback (Mitleton-Kelly, 2003).

In social systems, these mechanisms tend to comprise of social processes with numerous actors involving and reacting to the process. “Translated to the public administration context, one can imagine decision-making being completely blocked (the system finding itself in an equilibrium that has the character of a locked-in situation), because several (groups of) actors employ different but conflicting strategies that act against each other and sustain the deadlock” (Mitleton-Kelly, 2003, p.15).

The theoretical inputs into complexity theory provide a view of systems that are self-organizing, operating at varying degrees of stability, and indeterminate. These systems are highly connected and subject to shocks from their environment or other actors within the system, path dependency, and co-evolution. These inputs make up some of the foundations of complexity theory. In the following section, I will define complexity theory and identify some of the key concepts that emerge from these theoretical inputs to provide insight into the key concepts from this theory that can apply to the study of governance in the public sector.

3.1.2 Definition of Complexity

Complexity science is not a cohesive or unified field of study. The definitions of what is entailed in ‘complexity’ differ significantly, and as such there can be some major disagreements about the basic principles and understandings of complexity theory (Morçöl, 2001). Despite this, all of the variations begin with the concept of complexity, and there is a generally accepted foundation of ideas relating to complexity to which proponents refer.

One idea at the core of complexity theory is that the understanding of systems as merely closed systems with stable equilibrium is restricting and only represents a fraction of the overall totality of systems that exist. Complexity theory, rather, sees phenomena as more dynamic than a closed or stable approach to systems. Whereas many positivistic approaches to study would rely on the stability of their research phenomena as they draw observed causal relations, complexity theories will focus instead on the dynamics of the phenomena they examine (Klijn, 2008a). Complexity science strives to demonstrate the indeterminate nature of a universe comprised of open systems that trend towards a state of disequilibrium (Morçöl, 2005b). When one understands an organization as a complex system, one views it as a phenomenon that is “non-linear, subject to system pressure, shocks, chance events, path-dependency and self-organization” (Klijn and Teisman, 2006, p.2). Complexity theory assumes that phenomena, like a public sector organization or arrangement, has an evolving process of decision-making and consists of changing institutions. In terms of what we can view from this, Klijn (2008a) offers a useful analogy: “A picture just gives information about a certain moment and place. A complexity theory is more focused on making films of how phenomena develop under a variety of influences” (p.288). This is not to discount the fact that developments within a system cannot be guided from a top-down structured arrangement or a single dominant force with a powerful causal relationship; rather, complexity theory seeks to understand the majority of developments that occur in a non-linear fashion with a wide-ranging spectrum of actors applying influence in the system. Complexity theory “focuses on storylines through time, different from place to place and evolving in an often surprising way” (p.288). This provides an interesting view of public administration, as it allows us to gain a broad understanding of the workings of governance processes based on the complex arrangements and influences that contribute to them.

Key to complexity theory is the behavior of actors (also referred to as agents). Klijn and Teisman (2006) state that “the adjective ‘complex’ indicate situations where the whole is more than the sum of the parts, but at the same time that developments of the whole stem from the parts of the whole” (p.2). This represents a profound shift in focus from the system as a whole to the actors within the system, and how the interactions of these actors create and shape the system around them. Actors are seen in complexity theory as operating within a shifting, self-organizing landscape with complex dynamics. The actors themselves are also self-organizing, creating their own inferences as to what they are viewing around them, their own languages, and path. Knowledge itself is understood as socially constructed and subject to continual change in this context.

Given that “complex behavior arises from the inter-relationship, interaction, and inter-connectivity of elements within a system and its environment” (Mitleton-Kelly, 2003, p.26), most elements of complexity theory stress the understanding of how agents interact within a system and what impact that may have on other agents within that system, and complexity theories tend to see social systems themselves as emerging from the relationships between individuals. As such, understanding of the interactions between actors is central to the way in which complexity observes social phenomena. Systems are seen as emerging on the basis of recurrent interaction between individuals. The shared or competing values, norms, and linguistic structures of individuals shape the social system itself. Shared interactive spaces and structural contexts provide an environment for these recurrent interactions to occur. The interaction of these agents over a prolonged period of time preserves the social system (Maturana, 1988). “It is only the recurrent interaction that defines that a system exists, and is not otherwise merely a collective of individuals without connection” (Mitleton-Kelly, 2003, p.57). If the agents within

the system were unsuccessful in maintaining recurrent interaction, that social system would cease to exist. “Systems are not perpetuated without human resources. The system is produced by the roles of interaction. Various individuals within the system will take on various roles. The individual actors engaged within these roles may change, however the roles that make up a particular system are likely to remain consistent” (Mitleton-Kelly, 2003, p.57).

The means by which complexity theory understands systems is scale-invariant, and the characteristics of a complex system can be used to understand all scales; from an individual, to a broader system, or systems at different scales such as a team, organization, economy, or industry. Complexity theory would understand a public organization as a closed network of agents that interact with one another to create, regulate, and implement social meanings. Their shared public sector setting represents the context in which they operate. The key understanding, however, would be that the social meanings are not strictly ascribed by those agents within the public sector; rather, they emerge as a result of the interactions of the components within the network. Understanding public sector phenomena through complexity theory would entail examining the recurrent interactions between the various actors engaged in a particular project, program, department, ministry, or otherwise (Mitleton-Kelly, 2003, p.59).

Another notion in complexity theory is that context is important, and that the study of a phenomenon will need to include an appreciation of the contextual environment in which it operates. Drawing ideas from evolutionary biology, the surroundings of a particular system consists of living beings or actors that evolve and, in doing so, modify the landscape or environment. The landscape is engaged in a state of continual change as a result of the behavior of actors and other external pressures (Klijn, 2008a). This strong emphasis on context and

exploration of the environment has particular implications for study in the field of public administration.

Having identified the key aspects of complexity theory, the following section will provide a more thorough examination of how these ideas can be applied into a public sector context and the study of public governance for the purposes of this research.

3.2 Conceptual Framework: Governance Perspectives of Complexity

The previously discussed aspects of complex systems represent a number of potential core principles to be considered as a broader synthesis of complexity theory into public administration. The following section outlines approaches to managing for complexity as synthesized by the authors within the social sciences, including public administration. This section also draws a contrast between the study of public governance processes through the lens of complexity theory as opposed to other methods of observation.

Complexity theory certainly posits a challenge to public administrators, as they are, to a degree, asked to manage the unmanageable. The acceptance of complex behaviors and emergent properties as being the norm within public organizations is problematic due to the sheer number of voices, competing perspectives, and complex arrangements that must be taken into consideration at any given time. The actors within systems operate within complex dynamics and self-organizing landscapes. Contextuality becomes a point of emphasis, creating a challenge for public managers. Success is understood as context dependent, and copying best practices, the “what” and “how” of a particular project, into a new context, seems unlikely to work (Mitleton-

Kelly, 2011). Simple explanations with clear causal relationships no longer suffice in solving the problems of a complex organization; rather, administrators must take into account the broader interconnected environment in which a public organization operates, and the many inputs that could be connected to any particular issue (Klijn and Teisman, 2006). Policy networks can be understood as ‘games’ undertaken by a multiplicity of actors and their varied and, frequently, conflicting interests, ideas, perceptions, and strategies in ‘arenas’ of operational environments and rules. The level of complexity to be managed increases exponentially as additional actors and ‘arenas’ of networks are introduced (Klijn and Teisman, 2003).

Managing for complexity entails public managers not only looking at the system as a whole, but also understanding how the various components interact with each other. Effectiveness becomes more to do with the ability to understand and adjust to external forces and changes within the complex operating landscape, and adaptive behavior becomes an important function of agents within the public sector. Operating in such a manner is, by no means, a simple proposition (Klijn and Teisman, 2006). In this, complexity theory posits an alternative approach for knowledge transfer and best practices for public managers; that of understanding “why” a project would have had success within a particular context, and then working to adapt any insights or principles that are relevant into the new context and operating environment (Mitleton-Kelly, 2011).

While it may present a challenge, the rewards of managing for complexity are potentially significant and worthwhile. If public managers ignore the complex interactions surrounding public organizations, one can imagine decision-making capacity decreasing significantly as the system finds itself “in an equilibrium that has the character of a locked-in situation” as various actors operating within the same environment “employ different but conflicting strategies that act

against each other and sustain the deadlock” (Mitleton-Kelly, 2003, p.15). Becoming increasingly competent at managing for complexity can help to minimize the possibility of organizational slowdown in dealing with the emergent or unanticipated issues that inevitably emerge to become public policy or administrative problems.

There is not a definitive consensus as to what role theories of complexity, deriving largely from physical and natural science, can and should play as applied to the social sciences. As stated by Mitleton-Kelly (2003):

Complexity is not a methodology or a set of tools (although it does provide both). It certainly is not a ‘management fad’. The theories of complexity provide a conceptual framework, a way of thinking, and a way of seeing the world.” (p.4).

Many authors utilize complexity theory as a metaphor or lens as a means to examine social phenomena from a deeper, more robust, or practical understanding around the interactions of organizations and social processes (Morgan, 2005).

Network theory, or a “governance approach,” can be adopted as a means of understanding how organizations manage complexity (Duit and Galaz, 2008). This approach to the study of public administration varies greatly from other approaches that examine public sector effectiveness; however, it remains a measure of the ability of an organization to operate effectively. For example, sharp contrasts can be drawn between the study of public organizations through a positivistic or measurement-centric view and that of complexity theory from a governance approach. In understanding the different ways by which a measurement-centric New Public Management (NPM) approach to public organizations view public organizations as compared to a complex system understanding, or “New Public Governance”, one can draw

inference into how to apply complexity theory to the study of public sector phenomena (Klijn and Koppenjan, 2012). Klijn and Teisman (2006) state that “in the new public management the manager tries to keep as far as possible from the complex interaction system itself” (p.11). New Public Management approaches to the study of public sector phenomena attempt to reduce the complex nature of an organizational environment into a smaller subset of manageable and comprehensible figures. This represents a struggle versus complexity, as the complex nature of the organization is seen as an obstacle to understanding that must be reduced to a few observable elements. Complex systems of government are observed through ‘black boxes’ that measure outputs, while broader systemic operating structures are seen as overly complex and difficult to be understood or managed (Klijn and Teisman, 2006).

Understanding organizations from a traditional approach that studies structured hierarchy in organizations largely entails a perspective that seeks some kind of linear causality. This linear understanding relies upon predictable change, and can struggle with complex environments. These models are seen as inaccurately simplistic in a complex environment because they tend to suggest that actors can understand the state of the system by assessing current conditions, when in reality an understanding of evolving conditions is often significantly more important. Looking at an organization as a complex system, however, entails recognizing mutual causality as the core phenomenon of study. Concepts such as co-evolution, emergence, shifting dynamics, and self-organization, seen at the core of complexity theory, are often incompatible with linear causal explanations of public sector phenomena. This form of analysis assumes that the organization is an active player in creating opportunities and threats within the environment (Dent, 1999). Approaches to the study of public administration that incorporate mutual causality require the acceptance of the role the organization has in influencing and shaping relationships and events in

its environment, just as, in turn, those relationships and events shape the organization. The organization has a shared past with coevolving partners, a complex operating environment, and a capacity to adapt the emergent phenomena caused by its own actions and the actions of others (Dent, 1999).

Understanding an organization as a complex system entails examining the interactions within and changes to an organization and constituent departments, within the defined boundaries of the subject of study. This system-level analysis will examine how the elements within the system, usually individuals, agents, or subsets of the broader organization, “interact at the micro-level to produce radical and often surprising global outcomes at the macro-level” (MacLean and MacIntosh, 2008 p.51). The governance perspective focuses on particular aspects of the complex system, and attempts to understand the ability of an organization to manage complexity by “stepping into the complex system and designing governing mechanisms and strategies that are specifically targeted at the situation and characteristics of the process” (Klijn and Teisman, 2006, p.12). Complexity theory from a governance perspective is fundamentally interested in the way in which public institutions connect and improve inter-organizational coordination, improve the quality of decisions by enhancing the knowledge of agents, and how these complex interactions are managed. By approaching the study of public organizations in this manner, one is provided an alternative perspective and understanding in regards to the capacity for public sector organizations to deal with uncertain developments and risk in the public sphere through an examination of their levels of inter-organizational coordination and horizontal orientation (Wagenaar, 2007). Examining the capacity of a public organization to manage for a complex environment through a governance approach involves studying the ability of a system to successfully activate agents and utilize the skill and knowledge of these agents, conduct joint

fact finding and consensus building, and the method of arranging and organizing joint interactions (Klijn and Teisman, 2006). By studying these features of public organizations, one can draw inferences about their overall ability to manage for complexity and the adaptive capacity to deal with the unknown.

Governance approaches to study entail the observation of horizontal forms of coordination. Organizations that engage in effective horizontal coordination are seen as being better positioned to engage the support of, and collaborate with, a wide range of actors who have a stake in the future of the public institution or organization. Outside actors within the environment around a public organization can provide knowledge to help improve policy and public services, and encourage innovation and change to adapt to phenomena emerging from the environment that would be otherwise difficult to predict or plan for. Improvement is seen as a byproduct of cooperation, as private agents or others provide information and context on markets and emerging phenomena outside the public sector, while public organizations provide knowledge outwardly pertaining to the preferences of citizens and service users. In addition to increasing the effectiveness of the organization, this process is also seen as adding a sense of enhanced legitimacy to decisions as changes in government to react to emerging phenomena are linked to improving the relationship between the public sector and broader society (Klijn and Teisman, 2006).

Governance approaches can be a complimentary theory in the understanding of complexity (and vice versa), and may be utilized to understand complexity in public organizations. A governance perspective on complexity would focus on how government can or should behave as an agent within the scope of complex horizontal governance arrangements (Klijn and Koppenjan, 2012). In their overview of governance network theory, Klijn and

Koppenjan (2012) identify the possible opportunities in research to bridge the gap between the understanding of networks and complexity:

“In an attempt to address the challenges of future public administration, network theory may be connected with other theories and new approaches. A likely transcending pathway might be that of the advancement of ideas derived from complexity theory. The adoption of complexity ideas by network theorists might propel attention to emergence, self-regulation and adaptive governance, enriching the explanatory power of governance network theory beyond its current scope. This may result in the identification of innovative and promising governance perspectives” (Klijn and Koppenjan, 2012).

Understanding public sector governance through complexity theory would entail understanding the evolution of public organizations through their capacity for self-organization once they are connected. Understanding the networks of interaction is seen as more important than understanding any kind of hierarchical designs, structures, or management systems. Hierarchical management may, in some ways, only provide contextual insight into the actual goings-on of the public organization, and instead a focus would be placed upon how agents within the system create and change relationships with one another (Mitleton-Kelly, 2003). Complexity theory provides additional insight at various levels of organization, and one can see within micro-levels of organization, such as project teams, how understanding relationships may take predominance over a detailed understanding of the hierarchical structure of the organization itself. Integrated project teams, one form of a complex evolutionary system, may include representatives from a broad range of other organizations who can have widely varying functions. As an example, picture members of a project team who are brought together to implement a new project. In doing so, an individual who is an executive outside the team may

not hold a leadership role within the team; rather, a junior employee may operate as team-leader due to their qualifications and specialized knowledge in relation to that particular integrated project team (Mitleton-Kelly, 2003). These forms of networked interaction also occur at a more macro-level, and there is a high level of cross-scale potential for non-hierarchical, networked forms of governance.

Managing for shifting dynamics, self-organization, and emergence requires adjustment and adaptation more than direction, and understanding whether an organization is capable of managing for complexity reflects a need to understand how the organization adapts and changes in an interconnected manner when faced with emergent phenomena. Public administration tends to often focus on steering and the influence of superior entities imposing various models of organization upon subordinated entities. Self-organization throws into question this common way of envisioning change in the public sector, as phenomena develop in ways other than by external force being imposed upon them. Actors in the public sector have self-organizing capacities in addition to the laws and principles that are imposed upon them. As such, the self-organizing behavior of a variety of interrelated public sector actors can create a chaotic context in which traditional, top-down steering may not be effective. Understanding this can help to address perceived implementation problems that authors have noted in modern public administration (Pressman and Wildavsky, 1973; Teisman and Klijn, 2008a). Managing within complex human environments can require practical, contingent and inclusive approaches that acknowledge the interconnected nature of the organization. Instead of rationalizing perfect answers and delivering them in a top-down hierarchical manner, cooperative approaches give actors an opportunity to confer legitimacy and increase the chances that actions will take effect by stressing inclusion and horizontal steering as key elements of the decision-making process.

This is not due to an objective sense of collective decisions being better or correct, but rather because the actions are deemed legitimate by the group in question. As it may be expected, it is difficult to define absolutes of right and wrong when studying human systems. These systems are too complex to be understood properly as fundamentally correct or flawed. Rather, the challenge that presents itself in attempting to manage for complexity is to strive towards selecting the appropriate evaluation criteria and secure visible support amongst vested agents throughout the system (Maguire and McKelvey, 1999, p.47).

Complexity theory does not argue that systems should seek to achieve an ever-increasing level of inter-connectivity, or conversely a greater deal of independence. Positive or negative connotations are not associated with the interconnected nature of modern systems. Instead, complexity theory provides a lens through which to view systems that are, by nature, interdependent. The increased level of interdependence between agents within a system, or between systems themselves, is seen as resulting in a greater degree of co-evolution and change. The ripple-effect caused by a perturbation or disturbances by the actions of any one particular actor can have a significant impact on all of the other actors that are connected to within a system. This is not necessarily a negative or undesired phenomenon, nor is it a desirable one. Rather, it is an observable interconnected system which complexity theory allows us to understand. High levels of interdependence can have both positive and negative impacts on the broader system of interconnected agents, and the attempts of one actor to improve its position or evolve can create worsening, or merely changing, conditions for other actors with whom they are connected. It is a central goal of complexity theory to understand the associated effects of actors within a system on other actors or connected systems (Mitleton-Kelly, 2003).

To assess the ability of an organization to effectively manage for complexity, an understanding is needed of the interactions of actors within the system and with the broader context as well. Given that complexity theory often understands systems within the metaphor of a fitness landscape, one must maintain an understanding of the surroundings in which actors within the system exist and operate. The landscape can be expected to change continuously as a result of the choices of actors within the public sector and external pressures. Public sector actors traditionally would be focused on their own abilities and goals to change or operate within a system, but this, to a degree, overestimates their own impact on the system relative to the other actors and external pressures around them. Complexity theory, and exploring the fitness landscape, emphasizes instead the importance of context. The landscape around public managers will be constantly changing, and the fit between the changes occurring within this context and the actions of the individual actor will be key to determining effectiveness (Klijn and Teisman, 2008). From this perspective, exploring the broader context in which one operates and making decisions based upon the information gained from exploring the fitness landscape is key to maximizing the effectiveness of actors within a public system. Viewing public sector phenomena through the lens of complexity theory, one should look for “smart interventions” (Klijn, 2008a) of actors within the system to achieve desired outcomes. As complex systems tend to be unpredictable, it appears evident that the observation of linear organizational structures and top-down management strategies, often a key focus in studies of public organization and management, may not provide a particularly rich understanding as to whether or not a system is operating in an effective manner with an appreciation for the complexity of the environment in which it operates. As such, a focus on the ability of actors within the system to connect in a meaningful way and establish patterns of interactions can help to provide some insight into the

reasons why a public organization was effective or ineffective at moving towards its desired outcomes. Understanding the actors within the system as facilitators who must effectively listen, observe, scan, and connect actors, problems, and solutions at opportune times is quite different than seeing those actors in a command and control environment (Klijn, 2008a). When applying this aspect of complexity theory to organizations, one assumes that all interactions within an organizational system are mutually influencing, and choices and events regularly reshape the positions and attitudes of actors. Actors must maintain an acute awareness of other actors and opportunities within the system and utilize these resources in ways that fit the environment. By understanding the broader system of interactions that make up their environment, actors are better positioned to take advantage of emerging situations within the environment (Pascale, 1999).

Given this application of complexity theory to public sector governance, one sees the circumstances that best promote effectiveness in the operations of the public sector as being related to conditions that encourage the ability of public sector actors or organizations to successfully activate agents and utilize the skill and knowledge of these agents, conduct joint fact finding and consensus building, understand the context in which decisions are made, and effectively arrange and organize joint interactions. The following two sections will provide an assessment of how this theoretical basis may be applied to the subject of study for this research.

3.3 Rationale for the use of Complexity Theory in this Research

For a researcher interested in the study of interactions between government and private industry, complexity theory has much to contribute to the observation of interconnectivity between public and private partners, the structure of relationships in a partnership, and key inputs

into decision-making process and formation of institutions. The ideas of complexity theory appear to be, in many ways, a natural fit with the desire to better understand the complex decision-making and strategies that characterize the study of modern public administration (Klijn, 2008a). The concepts of co-evolution, non-linearity, horizontal steering and smart interventions applied in a public administration context can reveal unique and interesting observations about public institutions and projects and contribute to advancing understanding of the effects of networked interactions and formal and informal power structures on outcomes for public projects.

It is posited that the contributions offered by complexity theory to the study of public administration can be exponentially greater in value when a researcher in this field utilizes this theoretical approach towards better understanding the interaction between public institutions and partners, stakeholders, and other systems. As explored in Chapter Two, public-private partnerships are often characterized by highly complex relationships that exist over a protracted period of time involving varying levels of authority, risk, knowledge, and interconnectivity between the two partners (Bloomfield, 2006). Furthermore, the stakes for such projects can be significant; when said relationships are poorly managed, the outcomes can be to the lasting detriment of government and the public (Wilkins, 2003). Theoretical inputs that help to advance an understanding of the governance and interconnectivity of complex and changing relationships could be useful in observing the management of relationships for long-term partnerships between the public and private sector. While there do not appear to be any necessary preconditions to warrant the utilization of complexity theory in the study of public administration, the fact that public-private partnerships fundamentally involve interaction, negotiation, and shared decision-

making between multiple actors suggests that complex systems theory could play a significant role in advancing knowledge relating to these kinds of projects.

Complexity theory is ultimately interested in the study of interdependencies between actors, the variety of perceptions, information, and strategies they rely on, and the complex interactions and negotiating patterns that emerge within the process of problem solving, implementation, and delivery (Klijn and Koppenjan, 2012). Governance network approaches to complexity stress the role that interaction between actors can play in the ultimate outcomes and choices that are made (Klijn and Koppenjan, 2012). The study of the Brampton Civic Hospital and Royal Ottawa Hospital projects through the lens of complexity theory should contribute to the development of a greater overall understanding of the relationships between actors, interdependencies, system interactions, and environmental influences for two formative projects in Ontario's history of partnerships with the private sector (McDaniel, 2004). It is in this sense that it was determined that complexity theory may offer a rich and detailed understanding of the network of interactions and structure of relationships between public and private partners in the two cases to be studied as part of the multiple case design, offering new insights into the projects that go beyond the observations available in current literature on the two projects.

As stated earlier in this chapter, this does not suggest that complexity theory, as understood within the context of this research, seeks to argue in favour of a greater degree of interconnectivity between actors, or greater levels of interdependence between public and private partners for the two projects in question. Complexity theory offers a perspective from which to view systems that are already, to some degree, interconnected and interdependent. It is acknowledged that high levels of interdependence can have both positive and negative impacts for networked systems; as described within this chapter, disruptions within a networked system

that demonstrates high levels of interconnectivity but low levels of adaptive capacity can be problematic (Mittleton-Kelly, 2003). Rather, this research study seeks to utilize complexity theory as a means to better understand the associated effects of the actions of actors who would have had a part in these two projects, and how the interconnected nature of these two projects did, or did not, shape the decision-making process. Proper management of complex networks necessitates public managers to realize meaningful connections with actors within their system, acknowledging the capacity of partners, and their interests and values to help develop strong, adaptive governance networks (Edelenbos et al., 2013).⁷ This study will contribute to the available knowledge pertaining to the Brampton Civic Hospital and Royal Ottawa Hospital projects by building additional understanding regarding how interactions were structured between public and private partners for these two formative projects and examining the successes and failings of networked interactions for the cases of study.

3.4 Summary and Conclusion

The central question to be addressed through this research paper is whether or not ‘first wave’ procurement arrangements in Ontario’s hospital sector were sufficiently capable of managing for complex and evolving operating environments. A key question to be examined is whether or not the hospital infrastructure projects managed sufficiently for complexity, and if not, what impact such had on the outcome of the project. The theoretical predispositions of

⁷ In reflection, the theoretical approach utilized in this study does run the risk of focusing too much attention upon the relational aspects of the two cases of study at the expense of understanding the institutional structures in place. In case studies wherein the organizational institutions are well developed and relationships are in a significant state of maturity, this could represent a significant limitation to research. However, given that many of the institutional structures relating to these two particular cases were still developing at this time, this particular limitation may be somewhat mitigated in this study. In Chapter 5, some significant attention is paid to the institutional context in which these projects operated in order to stress the ‘proto enabling’ framework for P3 procurement projects in the province at the time (Whiteside, 2016) and establish the importance of understanding the still-developing relationships and structures for these two early cases.

complexity theory, as has been presented in this section, provide key areas of focus to operate as a foundation to the study of public sector phenomena.

The application of complex adaptive systems theory to a research study has significant implications for the methodology of the study. Given the fact that systems may be understood as having system boundaries, complexity theory researchers both recognize and embrace the role of a researcher as an agent that can operate as both an objective observer and an intervening experimenter, stepping in and out of the organizational boundaries as required. These kinds of studies further rely on concepts such as emergence and self-organization in analysis, thus tending to avoid process research with the role and approach of the researcher fully specified at the onset of the project (Maclean and MacIntosh, 2008). As such, “complexity theory casts management research itself as a complex dynamic phenomenon - an unpredictable and creative process of human interaction producing surprising results when and if they happen to emerge” (Maclean and MacIntosh, 2008, p.51). The inductive approach to this multi-case research design, which relies on a more subjective form of reflexive inquiry in its analytical method, is further outlined in Chapter Four.

Governance perspectives on public sector organizations represent the key link between complex adaptive systems theory and the research questions at the heart of this study. This research study will attempt to gain an understanding of the management processes of two ‘first wave’ P3 projects in Ontario with a particular focus on the capacity of the management structures to navigate a complex, shifting operating environment. It is suggested that “the additional complexity of public–private partnerships makes all but the most straightforward projects just too difficult” (McKee et al., 2006, p.894). Klijn (2008a) posits that it is the capacity of key actors within a system to connect in a meaningful way, establish patterns and structures of

interaction, and conduct “smart interventions” that allow them to navigate a complex operating environment. A researcher observing the behaviours of actors within a system would look for the capacity of facilitators of interactions to listen, observe, conduct horizon scanning, and make connections with other actors as required (Klijn, 2008a). These elements of the theoretical framework for this study have informed the core research questions, as per Chapter One, to be addressed through the multiple case study design.

These questions seek to assess at each stage of the procurement project who the key actors and facilitators are that are managing interactions between other actors within the system, how decisions were made at each stage of the process, and to provide an assessment of the capacity of facilitators to consult with and activate the skills of stakeholders and private partners to the purpose of horizontally steering the decision-making process.

A system-level examination of hospital procurement processes in Ontario utilizing complexity theory will entail an understanding of how these systems evolve and adapt, interact with other systems such as the political sphere and beyond, and are influenced by the complex environment in which they operate. Understanding the capability of these partnerships to succeed, or the problems that arise, in light of this complex operating environment will be central to understanding how capable such partnerships are at managing complex, evolving environments.

In conclusion, identifying the strength of reciprocal influence between a system and its environment, degrees of self-organization, and the nature of relationship between agents are key identifiable factors of organizational fitness from a complex evolutionary systems perspective. Given the issues arising in the proposed case, examining these particular features of the complex

evolutionary systems within Ontario's hospital sector, along with considerations as to whether or not these systems are properly managed for complexity, can provide valuable insights into both the nature of alternative service delivery in infrastructure procurement in the public sector.

Chapter Four: Methodology

The purpose of this chapter is to establish the theoretical, conceptual, and structural outlines of the research method and data synthesis and analysis to be utilized for the purposes of this study.

The goal of this study is to provide theoretically sound and empirically rigorous understanding of the two first forays into large scale infrastructure procurement for health infrastructure in Ontario through the use of public-private partnerships. In particular, this project is interested in the capacity of the management process for procurement and resultant negotiations towards the development of an agreement to manage for change and adaptability. This involves an examination of the capacity of the various actors within the system to operate as facilitators, and effectively listen, observe, scan, and connect actors, problems, and solutions at opportune times, rather than operate in a more traditional command and control environment. By examining the capacity of the management structure for procurement of this partnership to successfully activate agents and utilize the skill and knowledge of these agents, conduct joint fact finding and consensus building, understand the context in which decisions are made, and effectively arrange and organize joint interactions, one can better understand the resiliency and adaptive capacity of the arrangement and management process.

In order to explore these issues, this study utilized a case study approach with a variety of data sources. This includes, but is not limited to, archival government records including reports from the Auditor General of Ontario concerning the Brampton Civic Hospital conducted in 2008 and 2010, report of debates (Hansard Official Report of Debates) of the Legislative Assembly of

Ontario's Standing Committee on Public Accounts concerning the Auditor's report, government media releases, newspaper reports on the projects, critical reviews of non-public data conducted by lobby groups, journal articles, and the results of eight semi-structured interviews.

While a myriad of data sources could be utilized to piece together a great deal of detail regarding the cases, research interviews provide additional context in addressing the central research questions concerning the structure of relationships throughout the projects, and how public managers sought to leverage relationships and expertise through consultations and smart interventions over the course of the projects. Interviews were conducted with key senior staff and decision-makers in various capacities from the Ministry of Health and Long-Term Care, Ministry of Finance, hospital boards, and the involved private vendors. The subjects interviewed for this research study have first-hand, expert knowledge of these two projects, and their contributions to this research study help to address gaps in knowledge for this project that would not be otherwise available. The interview questions asked as part of this research study have been attached as Appendix D.

4.1 Research Design

This section will address the choice of research design for this project and the data sources utilized, and will reflect on the appropriateness of the design as selected given the subject matter and research question to be addressed.

In regards to the selection of a research method, three conditions exist as defined by Yin (2014) to determine the appropriateness of a particular research approach: the type of research question, the extent of control investigators have over events, and the focus on contemporary or

historical events. Each of these conditions may significantly influence the particular research strategies that may be appropriate in a potential study. According to Yin (2014), case study research is the most appropriate form of research under the following circumstances (p.12):

- “A ‘how’ or ‘why’ question is being asked about
 - a contemporary set of events;
 - over which the researcher has little or no control.”

Yin (2014) states that the most important condition for differentiating between choices among the various research strategies available is to first identify the type of research question being asked. The main thrust of this research project revolves around examining how and why some of Ontario’s earliest forays into public-private partnerships, such as those in Ontario’s health sector, have encountered challenges in their design and implementation. Case studies are noted as particularly useful in establishing operational links that need to be traced over time, such as would be entailed in this project (Yin 2014). Given that the research question to be addressed in this case is a “how” question, in that it looks to examine “how” the procurement process dealt with change and adapted, and “how” the challenges or successes in that regard informed our current approaches to partnerships in this area, either a case study or a history would appear to be the appropriate forms of research.

Further distinctions can be made between varying approaches once it is established that the research question is generally appropriate to the method. The extent of control over behavioural events and temporal considerations also factor into the applicability of a research method. The case study tends to be “preferred in examining contemporary events, but when the relevant behaviors cannot be manipulated” (Yin, 2014, p.8), and when direct observation of the

events being studied or interviews of the persons involved in the events are possible. A case study differs from a historical study due to the ability to draw from a wealth of evidence, including documents, artifacts, interviews, and observations – the latter of which may not be possible for a historical study (Yin, 2014). Given the fact these case studies will be conducted to observe the processes within a number of contemporary cases with considerations for the developments occurring over the course of a partnership, the case study method seems more applicable than other available options.

Additionally, this research project deals with emerging issues that must be studied through varying sources of evidence beyond what may be included in other forms of study. Most of the literature on interpretive case studies notes the ability of the method to tap multiple sources of data through a variety of means (Denzin and Lincoln, 1998; Glesne and Peshkin, 1992; Patton, 1990; Stake, 1995; Yin, 1981). In attempting to gather information surrounding the cases in question for this research project, the case study method will offer a suitably comprehensive view of the cases in question. Identifying a wide scope of influencing factors will be key in determining the potential relationship between complexity and the challenges that have been faced in some of the first and largest partnership projects attempted in Ontario's health care sector.

Case studies are noted as being particularly useful in the study of the knowledge utilization process. One finds this aspect of the method to be particularly synchronous with complexity studies that similarly attempt to study direct and indirect implications deemed too complex or multi-faceted for proper analysis using single factor theories. Examining the knowledge utilization process entails the study of a series of decisions occurring over a protracted period of time not sharply delineated from their particular temporal context, complex

implications that defy reductionist conclusions, significant numbers of relevant participants, and situations that are special in terms of key elements such as agency context or historical moment in time (Yin, 1981).

Given that the case study approach appears suitable to the research to be conducted, the remainder of this section will discuss two of the key approaches to guiding case study methodology as proposed by Robert Stake (1995) and Robert Yin (2014). The methods that they describe, along with other comments on the case study method, will form the foundation of research methodology for this project.

According to Yin (2014), there is no comprehensive or standard research design for case studies at this point. Unlike many other forms of scientific inquiry, common case study designs have yet to emerge. Despite this, Yin (2014) outlines a number of basic research designs for single- and multiple-case studies to be considered, modified, and improved upon while also helping researchers to design rigorous, methodologically sound case studies as part of their research. Case study research varies greatly, and allows for an analysis of a wide variety of subject matter, including individuals, organizations, relationships, programs, or communities. By utilizing a case study method, the researcher engages in a thorough deconstruction and reconstruction of the examined phenomena (Yin, 2014). A case study is also frequently utilized in methods of inquiry that are more practice-oriented, such as public administration (Yin, 2014).

Case studies may also be intrinsic, instrumental, and collective (Stake, 1995). An intrinsic case study would entail the examination of one unique situation, with a significant intrinsic interest on the part of the researcher in the subject and limited transferability beyond the case

study itself. An instrumental case study would entail a study of a particular situation or phenomenon. A collective case study involves the study of multiple cases.

The constructivist paradigm for case study approaches, as defined by Yin (2014) and Stake (1995), is based upon the idea that truth is relative and highly dependent upon the perspective of the observer. Constructivism premises that reality is in many ways a social construct (Searle, 1995). This paradigm does not reject objectivism completely, however. Rather, the subjectivity of human creation of meaning is tempered by a pluralistic viewpoint wherein focus is placed upon “the circular dynamic tension of subject and object” (Miller & Crabtree, 1999, p.10). Case studies provide an opportunity for a researcher to observe and reflect upon the position, context, and perspectives of participants in the study. The views and perspectives espoused by the participants can serve to inform the researcher on their view of reality, and provide insight into various “why” and “how” questions relating to the subject of study (Yin, 2014).

There is evidence to suggest that a constructivist case study approach is compatible with theoretical predispositions informed by complexity theory. A case study would, traditionally, look to bound a case and study specific sets of phenomena within a study (Anderson et al., 2005). One may find this to be at odds with the theoretical predispositions of complexity science, given the assumption of a myriad of environmental influences at or beyond the boundaries of the case of study that could, in a significant way, influence the direction of the phenomena being studied within the research case. However, “[c]omplexity science suggests that important insights can be gleaned by studying the behavior that occurs at and across the boundaries that define the case” (Anderson et al., 2005, p.674). Understanding interdependencies between the case subject and its environment, relationships that extend beyond

the external boundaries of the case, and seeing the broader system of influence can provide insights into how decisions were made, what the influencing factors would have been, and how that influence led to coevolution between the system (case study) and its environment (Anderson et al., 2005). Complexity science leads case studies to include a focus on process as well as events, understanding how an organization learns and collects information, and recognizing both the formal and informal dynamics that would be a part of the decision-making process and shape patterns within the case study subject (Anderson et al., 2005). Finally, attention needs to be given to changes within the environment, and unexpected phenomena or occurrences examined within the case studies. Complexity theory posits that it “might be fruitful to pay greater attention to outliers because they might be a source of new structural arrangements and patterns of behavior” (Anderson et al., 2005, pg. 677).

For the purposes of the case studies of this research, this will entail looking outside of the actual hospital corporations and infrastructure development projects, and understanding the broader context within which they operate. Complexity theory leads this research study towards the examination of the interdependencies and interactions between elements at and beyond the border of the system being studied as a case (McDaniel, 2004), and through research interviews and data collection, this study should advance knowledge relating to the interdependencies and relationships between the two pilot infrastructure development projects and their operating environments. Using the information gained through data collection and synthesis, this research study will provide insights into the history and nature of the projects, how decisions were made, how they interacted with their broader operating environment, and how those interactions defined system properties within the projects themselves. This will include examining the context and need, the broader community, the political environment and how it changed, and the

broader private vendor market. Furthermore, this research project will explain the various power structures, both formal and informal, that would apply to the cases, including the relationship between the hospital corporations, the Ministry of Health and Long-Term Care, and SuperBuild, and how the two pilot projects may have interacted with each other, if at all.

It is the intent of this research project to utilize a multiple-case design, drawing on conclusions from a select group of cases intrinsic to one particular point in time in Ontario. Multiple-case designs are noted as being particularly appropriate when common phenomena are thought to exist in a variety of situations, as may be the case with partnerships in Ontario's hospital sector. The collection of multiple case studies is intended to provide the basis for replicating, confirming, or denying results from other studies (Yin, 2014). A multiple case study allows for analysis both within one setting, or case, as well as across cases. Each of the case studies examined resemble separate "experiments" that are compared to reach a level of analytic generalization. The theory or thesis of the research is used as a template that is compared across the empirical results of each case study (Yin, 2014). By examining multiple cases, the researcher is able to understand similarities and differences between the cases. Multiple case studies "predict similar results (a literal replication)" across the cases studied, or "predict contrasting results but for predictable reasons (a theoretical replication)" (Yin, 2014, p.47).

These case studies are to be performed through a comparative and exploratory case study design involving two cases. The chosen cases are the Brampton Civic Hospital and the Royal Ottawa Hospital; the two first P3 hospitals developed in Ontario. The Brampton Civic Hospital and Royal Ottawa Hospital are apt for comparison, as they were designed and built simultaneously in absentia of the current framework under which P3 arrangements are currently made in the province (Whiteside, 2015). Understanding these two cases can help to shed light on

the experiences that served to inform the current P3 framework in the province. While there are many similarities between the two cases of study and other pilot procurement projects with partnerships, or even with current procurement projects in Ontario, the two particular cases in question are also intrinsic in that they are the only two cases of hospital capital procurement partnerships conducted prior to the establishment of Infrastructure Ontario and the current framework in which such partnership arrangements currently operate.

Gerring (2004) identifies a number of features of case study research from broader literature that help in defining what potential qualities such a study may entail. This includes “(a) that its method is qualitative, small-*N* (Yin 2002); (b) that the research is ethnographic, clinical, participant-observation, or otherwise “in the field” (Yin 2002); (c) that the research is characterized by process-tracing (George and Bennett 2004); (d) that the research investigates the properties of a single case (Campbell and Stanley 1963, 7; Eckstein [1975] 1992); or (e) that the research investigates a single phenomenon, instance, or example (the most common usage)” (p.342). Gerring understands these identified features as particular components of case studies, while each particular instance is seen as insufficient as a stand-alone identifier for case study research. As an alternative, Gerring (2004) proposes a more cohesive definition of case studies, framing this method as “an intensive study of a single unit for the purpose of understanding a larger class of (similar) units” (p.342). He goes on to note that a unit can consist of any conceivable spatially bound phenomenon, observed at a static point in time or over a delimited period of time. This broad definition generally fits the intent of this research project, as the research is focused around a particular unit, that of partnerships in Ontario’s health sector prior to the development of Infrastructure Ontario and the current provincial model for such capital projects, and the purpose is largely that of developing a greater understanding of the mechanics

of these units to determine formative contributing problematic factors, if such exist.

Understanding these formative problems, and examining them in light of the known framework for partnerships in Ontario, will lead to a better understanding of the nature and extent of the challenges that occur in pilot partnership projects of this scale and how we learned from these challenges in the case of Ontario.

The findings produced through interpretive forms of research, such as those within the case studies of this project, are assumed to be incapable of being easily generalized to an overall population in that the subjects of study present within these cases may not be entirely representative of the broader community of public-private partnerships (Stake 1995). While attempts are made through this research process to identify complex issues across case studies, the intent of this research is not to identify general or universal laws pertaining to public-private partnerships. Furthermore, the approach taken is unlikely to produce such results that can be transferred easily to all types of partnerships in all fields (Yin, 2014).

This research project is more interested in documenting a set of particularistic findings that may be common to some types of infrastructure procurement projects that utilize partnerships. Any generalizations across this research project are, at best, rough and based more around similarity. Stake (1990) coined the term naturalistic generalization, referring to a process of providing general conclusions based on similarity. Higher levels of similarity to the agents and circumstances present within this research project point to a greater capacity to synthesize conclusions to additional cases beyond those examined in this study. Therefore, cases beyond this research project with a great deal of similarity to those examined within are likely to be capable of gleaning some general information to better inform later practices and study. As such, the purpose of this research is to gain an increased familiarity with the particular cases of study,

acquiring new insights into the subject to help in the formulation of a more precise problem and develop some hypothesis regarding the subject. This exploratory research provides experience and context that will be helpful in more formulative research for more definite investigation at a later time (Shields and Rangarjan, 2013). Social exploratory research of this kind is generally more concerned with understanding relationships in the setting in question and building additional understanding around the social phenomena being explored without setting any explicit expectations. As such, this research design, as an inductive approach rather than a deductive approach, is not likely to test any theory. Rather, a theory will emerge once the data of the case study is collected and studied. This is common to qualitative research designs, which tend to be less applicable to the theory-testing associated with a deductive approach to research (Rudestam and Newton, 2007).

4.2 Data Construction

Case study research will often utilize multiple data sources. The case study is an intensive study of a specific context or individual. There is no defined way by which case studies are conducted, and it is common for a combination of methods to be utilized (Yin, 2014). This provides not only robust sources of information for the researcher, but also enhances the credibility of the data presented (Yin, 2012). Research from a case study method may incorporate a number of different data collection methods including, for example, “interviews, behavioral observations, participant observation (as in ethnographic research), documentation, and the examination of archival records” (Rudestam and Newton, 2007, p.51).

A significant amount of secondary data is available for both of these cases, for example through data sources such as agreements between public and private partners, where available,

Standing Committee minutes, Auditor General reports on these cases, government announcements, budget documents, and other information originating from the government of Ontario as part of accountability and audit reviews. Furthermore, given the high profile of these particular cases, a great deal of information is available on these cases through articles in newspapers covering the design and rollout of the P3 hospitals, as well as reports from interest groups examining information released through Freedom of Information and Protection of Privacy Act (FIPPA) requests.

Despite the level of information available, there are some rather significant gaps in regards to the available knowledge relating to these cases. In particular, details around the nature and structure of relationships between public and private actors and how this influenced the outcomes of these projects cannot be determined without information beyond what is available in the public record. In light of this, the method for this case study will involve the use of some secondary data to build up the cases of study, and semi-structured interviews for additional primary information that could not be obtained otherwise. In particular, the interviews will help to provide information in regards to the relationship between actors and the adaptability of the relationships and framework for interaction between public and private actors, whether it was a help or a hindrance, and how it did or did not contribute to the challenges experienced over the course of the procurement project. As stated by Rubin and Rubin (1995) regarding interviews as a form of data, “through qualitative interviews you can understand experiences and reconstruct events in which you did not participate” (p.1). Using the secondary data available along with primary data from qualitative research interviews will help to provide a reconstruction of the cases in question with the highest degree of accuracy possible.

Interview data places a particular value on personal language utilized in the interview, interpretation of what is said by interviewees, and context and depth of meaning to the observed interview to gain additional insight into the subject area being studied. Interviews conducted in person, as most were conducted for this study, can often place additional importance on the context of the discussion as adding value to the data (Ritchie and Lewis, 2003). While this may make the data appear contextualized and non-rigorous, there is much literature debating this form of data and its utility in research in the social sciences and otherwise. In a description of interview discourse and the use of qualitative data such as that derived from an interview, Michel Foucault (1978) described qualitative research utilizing interview methods:

“[W]e must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies. It is this distribution that we must reconstruct, with the things said and those concealed, the enunciations required and those forbidden, that it comprises; with the variants and different effects – according to who is speaking, his position of power, the institutional context in which he happens to be situated – that it implies; and with the shifts and reutilizations for contrary objectives that it also include” (p.100).

Any interview method is likely to fall somewhere within a spectrum of methodologies based upon the structuring of the interview. Based on the degree of structuring, research interviews may generally be divided into three categories, including structured interviews, semi-structured interviews, and unstructured interviews (Fontana and Frey, 2005). A highly structured interview would use a set of questions similar to a questionnaire, with a defined set of questions approached in a very similar manner between interview subjects (Cohen et al., 2007). An

unstructured interview, on the other hand, would involve direct interaction between the researcher and the interview subject(s). The unstructured interview method would utilize guiding questions, but would lack a formal structure or protocol, allowing the researcher to move the conversation in any direction of interest that may come up (Research Methods Knowledge Base, 2006).

For the purposes of this study, a semi-structured research interview method has been selected. Semi-structured interview methods are somewhat more flexible than the structured method, allowing for a mix of open-ended and closed-ended questions. Over the course of the interview, the researcher has the opportunity to adjust the sequence of questions or add questions on the basis of participant responses (Zhang and Wildemuth, 2009).

This method of interviewing relies strongly upon the interpersonal skills of the interviewer to establish a relationship and rapport with the interview subject. Any interview method will involve a managed verbal exchange between a researcher and a subject in some form (Ritchie and Lewis, 2003). The effectiveness of an interview method, particularly one that is less structured, will depend upon the ability of the researcher to communicate with their subject and interpret the response (Clough and Nutbrown, 2007). A researcher needs a set of clearly structured questions, and should be able to manage the discussion as necessary, including pausing or probing, and encouraging the subject to talk freely (Ritchie and Lewis, 2003). Thus, strong interpersonal skills are required for success utilizing a semi-structured interview method, with interview subjects disclosing their thoughts or feelings towards the subject matter of the study. Also critical to success of this method is transparency on the part of the researcher in regards to confidentiality, the kinds of questions to be asked, and anonymity. Trust between the researcher and subject are fundamental to open exchanges of information (Newton, 2010).

Research interviews conducted for this study are intended to be more factual in nature, rarely focussing on the opinions or interpretations of the interview subjects and instead seeking additional detail regarding the cases that is not available through the use of secondary data. Much of this will entail discussion of details of structure of relationships between public and private partners, role definition for various actors, and other gaps in knowledge that would not be available but for actual account from individuals involved in the project. For the purposes of this research, context around the interview will include a discussion of the position and function of the individual being interviewed. By understanding the mostly factual information provided by the context of “who is speaking, his position of power, the institutional context in which he happens to be situated” (Foucault, 1978, p.100), and collecting factual context from a number of individuals working on the Brampton Civic Hospital and Royal Ottawa Hospital, some rigor will be added to the interview data collection for this research.

4.3 Analytical Method

The data created throughout the course of this study will be analyzed according to an inductive method of analysis. Inductive analysis, as opposed to deductive analysis, is common to qualitative studies. Inductive analysis is a form of study that “usually is defined as working from the data of specific cases to a more general conclusion” (Schwandt, 2007, p.147). In this sense, an inductive approach to analysis seeks to condense what is often extensive and varied raw data into a summary and synthesis. Inductive analyses will establish links between the objectives of a research study and the summary findings that are derived from data, and then develop a model or theory about the experiences, processes, or underlying structures that emerge in the study of the data (Thomas, 2006). Inductive analysis should advance the understanding of the meaning of

complex data by identifying and categorizing common themes through a process of data reduction (Thomas, 2006).

The SAGE Dictionary of Qualitative Management Research (2008) identifies five key interrelated elements, “some of which are synchronic” (Johnson, 2008, p.113). For the purposes of this study, the elements of the analytical process can be understood as detailed in Figure 2:

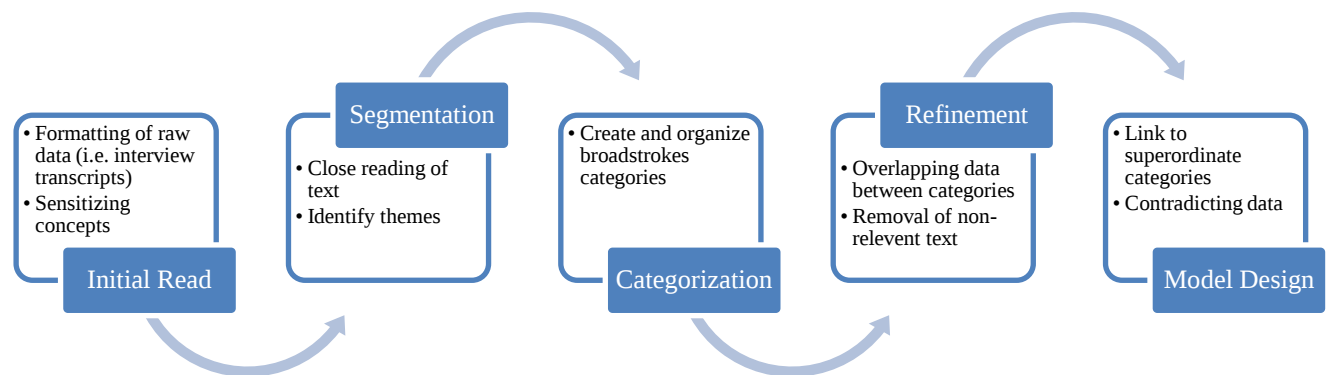


Figure 2: An inductive analytical method for this study⁸

The initial read of the project entails preparation of the raw data files and ‘data cleaning’ (Thomas, 2006). This involves formatting of the data prior to analysis. Also at this stage of induction, the researcher may utilize ‘sensitizing concepts’ to utilize as reference or guidelines, suggesting various directions that the research may take (Johnson, 2008). These ‘sensitizing concepts’ are not fixed indicators, as would be utilized in a deductive approach, but rather “act merely as guides for uncovering empirical variation in the phenomenon of interest” (Johnson, 2008, p.114).

⁸ Adapted from Creswell, 2002, p.266.

Once the text has been prepared and common concepts are understood, the data should be analyzed in a deep reading to gain an appreciation of themes and details within the text (Thomas, 2006). Utilizing the sensitizing concepts, the researcher looks for patterns within the phenomenon of study. The data is reviewed for any deviating instances that might require reconsideration of the themes of the study, ensuring all variances of the phenomenon of study are included (Johnson, 2008).

Categorization entails the development of a number of general categories derived from the aims of the research, with subcategories derived from multiple readings of the raw data (Thomas, 2006). This process may include coding in some instances to elaborate upon what is included in a category or to identify interrelationships for categories (Johnson, 2008); for the purposes of this study, however, it will not. During this process, data collection, analysis, and comparison will occur concurrently in a recursive process towards theory development (Johnson, 2008). Practically speaking, the second and third elements of inductive analysis are likely to occur concurrently (Johnson, 2008).

Once a saturation of data is achieved following a process of constant revision and changing iterations between the collection of data and analysis, data collection is completed and refinement of the data occurs (Johnson, 2008). Data is then segmented into various categories of analysis, and unassigned text that is irrelevant to the research objectives is removed (Thomas, 2006).

Final steps for the induction method include continuing revision, further refining the category system, and including contradictory points of view and new insights gleaned from the data analysis. Text that conveys the core theme or essence of a category is synthesized and

linked under a superordinate category to attest meaning to the data (Thomas, 2006). Analyzing patterns across the data categories can help to present theoretical explanations of variances in the phenomenon of study. Explanations are then presented that fit the data, along with emergent theory that is related to the established knowledge surrounding the phenomenon of study (Johnson, 2008).

4.4 Limitations of the Research Design

A number of limitations must be acknowledged relating to the design of this study overall. In this section, the limitations will be described in detail, along with ways that these particular limitations may be addressed or mitigated, if possible. While some of the limitations of this study have been discussed in part throughout this methodology section, the broader limitations of this study are to be touched on in detail section in relation to three areas of concern:

- Limitations relating to the case study method
- Limitations in data construction
- Limitations relating to case selection

4.4.1 Case Study Method Limitations

As acknowledged earlier, the case study method is commonly criticized for its subjectivity, and lack of precision, objectivity, and rigor (Yin, 2012). Opportunities for subjectivity abound throughout the implementation, presentation, and evaluation of the work performed in case study research. The potential for selection bias in particular represents a risk to the validity of the research as the case study itself is designed with a predetermined outcome

in mind. Selection bias in statistical analysis entails a design that only includes phenomena under investigation “whose dependent variable is above or below an extreme value,” and “an estimate of the regression slope for this truncated sample will be biased toward zero” (George and Bennett, 2004, p.23). The greatest threat from selection bias exists when contradictory cases are ignored, thereby understating or overstating a particular relationship between the independent and dependent variable (George and Bennett, 2004).

Another common issue with case study methods is a lack of focus, as researchers attempt to address an issue that is too broad with more objectives or answers than can reasonably be expected for one study. Yin (2014) and other authors recommend that boundaries are placed on the case to bind it and ensure that the study is of a reasonable scope. Cases may be bound by time and place, activity, definition, and context (Stake, 1995). Boundaries to a study may indicate precisely what will and will not be studied within the scope of the project. Binding a qualitative case study design accomplishes a similar objective to the development of inclusion and exclusion criteria that is found in a quantitative study, while providing some thought towards the breadth and depth of what is to be examined (Rudestam and Newton, 2007).

Finally, case studies tend to suffer from challenges to the generalizability of the research. While the generalizability of this research may not be significant, the work should instead be judged on its validity and reliability. “Rather than transplanting statistical, quantitative notions of generalizability and thus finding qualitative research inadequate, it makes more sense to develop an understanding of generalization that is congruent with the basic characteristics of qualitative inquiry” (Merriam, 1985). The case study method, as will be applied for the purposes of this research study, will focus less on broad applicability and more on exploring a smaller subset of cases in depth with, at most, contingent generalizations (George and McKeown, 1985). As with

most case study researchers, this work does not aspire to be directly representative of a broad set of cases, and is only applicable to a broader population in a contingent manner.

For the purposes of this research, the issue of selection bias is less problematic, as only a number of limited cases exist at all. Viable case studies would be limited to hospitals in Ontario built under the public-private partnership framework in place at a particular point in time. The units of analysis are bounded by the context in which the two cases of study originated. The Brampton Civic Hospital and Royal Ottawa Hospital were part of the ‘first wave’ of Canadian P3 projects, which includes projects reaching financial close between 1990 and 2004 (OECD, 2008; Silversides, 2008). The chosen cases represent the only significant partnership projects in health infrastructure procurement in Ontario of their kind undertaken during this time period. The Brampton Civic Hospital and Royal Ottawa Hospital are uniquely apt for comparison, as they were designed and built simultaneously under a similar conditions (Whiteside, 2015).

The description of case studies in light of their lack of representativeness as provided by George and Bennett (2004) is reflective of the work to be undertaken in this research study, as it is to be “more interested in finding the conditions under which specified outcomes occur, and the mechanisms through which they occur, rather than uncovering the frequency with which those conditions and their outcomes arise” (George and Bennett, 2004, p.31). As with many interpretive approaches, it is then the responsibility of the audience to deem what aspects of the research are transferable to other cases or settings within their own personal experiences (Tripp, 1985). The audience is given the onus to interpret and disseminate the interpretations present within this study based on their reactions to the evidence presented. Transferability of findings depends on the ability of this research project to effectively convey an interpretation of the

agents, processes and context of the selected cases to the audience (Orum, Feagin and Sjoberg, 1991).

4.4.2 Data Limitations

The case studies for this study will utilize multiple forms of data, each with their own particular limitations. Given that semi-structured interviews are to be one of the methods of observation, it should be recognized that there are some limitations with this method of data collection. As stated, the interview method utilized as part of the study has elements of both a semi-structured and unstructured interview method. These forms of methods can provide rich and useful information for exploring a topic broadly, which is appropriate given the objectives of this study. However, in sacrificing structure in the interview method, there can be challenges associated with the data collected in terms of synthesis and analysis. In a less-structured interview method, given the tendency to ask varying questions or exploring topics as they arise, there can be a challenge in drawing conclusions across the interview data set. Each interview will, in essence, have been conducted different from the last, thereby presenting some challenges with synthesis across respondents (Research Methods Knowledge Base, 2006).

The authenticity of information provided in an interview of any kind may be difficult to unequivocally verify. In an interview-based method, there are “no guarantees against the whole or parts of the interview material being fictitious” (Alvesson and Skolberg, 2000, p.262). In regards to the contextual nature and subjectivity of interview methods, Alvesson and Skolberg (2000) state the following:

“How interviewees appear or represent reality in a specific interview situations has less to do with how they, or reality, really are (or how they perceive a reality out there); rather, it

is about the way they temporarily develop a form of subjectivity, and how they represent reality in relation to the local discursive context being created by the interview.” (p.193).

As an additional point of context, this contemporary study involves asking interview subjects questions regarding events that occurred some time ago, in most cases over a decade prior. It may be difficult to gain a completely accurate account of events, given that the details of such may have been distorted over time for the subjects of the interview portion of the study (Alvesson and Skolberg, 2000, p.263).

Understanding and acknowledging the potential issues relating to authenticity and verification can inform the study in many ways. While the lack of verifiable facts in any given interview can be understood as a limitation, the content of the interview itself can be understood within the broader context of the material being studied, as well as in comparison to other interview subjects on the same topic. The motivations or biases of one particular interviewee when compared to those of complimenting interviews can provide a great deal of understanding towards the case itself. Interpretation of interview results will also need to consider the political context of the subject, challenging the perceptions and values of that individual within the context of the study. “Interviewees often frame their accounts in a politically conscious manner” (Alvesson and Skolberg, 2000, p.268) and it is important to acknowledge this, particularly when the interviewees have a stake or vested interest in the subject of the case study.

For that matter, it is expected that interview subjects will, at times, contradict themselves or others. Varying accounts within an interview in relation to stated facts, or amongst a series of interviews, should be understood within the broader context of the subject area, the interview itself, and other collected data. “If on one occasion a person displays a certain attitude and

another a somewhat contradictory one, we cannot simply take this as reflecting what the person in question really thinks, nor can we regard one attitude as the real one and the other as somehow ‘non-genuine’” (Alvesson and Skolberg, 2000, p,205). Rather than accepting one account and dismissing those that are contradictory, the motives, position, and context of the interviews and the subjects should be considered and analyzed to help inform the eventual conclusions made about the case, and acknowledged within the study itself as part of an ongoing dialogue between the researcher and the reader (Alvesson and Skolberg, 2000).

The implication of these particular limitations is that this research study should not rely solely on the interview method for information relating to the examined cases. Rather, the interviews stand as a subjective take on a particular phenomenon of which the researcher has an already advanced understanding in order to assist in informing particular aspects of the pre-established context (Alvesson and Skolberg, 2000). This is aided by the fact that a number of the sources of information to be utilized in these case studies, focused as they are on agreements between public and private sector partners to the purpose of building hospitals, are relatively objective and straightforward with much less room for subjective interpretation. The terms of an agreement for the procurement of services, or the framework for relationships between public and private partners, though perhaps subject to interpretation in application or scope, can be considered factual and valid when supported by the literature. Additionally, the context in which many of these events occurred is historical and irrefutable, thereby framing the context of any particular interviews within that of an established history, many details of which are known and available and considered public knowledge. The interviews themselves can help bring to life the historical account of the cases of study with perspectives and insights beyond what could be found in the literature.

Qualitative data analysis of this kind is to be conducted to the point of reaching saturation. Qualitative data analysis similar to that conducted for this study as noted as having the potential to go on indefinitely, thereby requiring practical and theoretical indications for ending the study (Mason, 2010). To ensure a reasonable end to a study, data is to be collected until it is determined by the researcher that subsequent interviews or data collection would yield diminishing returns, thereby signaling an end to sampling and the interview data collection process. New data collected at this point would only seem to confirm categories, themes, and conclusions that were already reached in earlier interviews (Suter, 2012).

One other limitation of note relates to the number of research interviews conducted for this study, as eight semi-structured research interviews were conducted through the course of this research study. To note, the multiple case study design for this research project focuses on a few critical aspects of two particular projects, with an eye towards interactions and relationships at an executive level. This significantly limits the number of viable research interview subjects for such a study. While a number of key government decision-makers and other agents would have comment on these particular cases (some perhaps in a more general sense than others), it was expected that there would be a limited sample of subjects with in-depth, first-hand knowledge of the management structures and relationships between key actors for these projects. Therefore, an “indefinite” period of data collection was neither plausible nor desirable. For the purposes of this research study, the qualitative research section was understood to be completed when the data collected from key individuals was no longer distinct from prior interviews, and when the subjects with first-hand knowledge critical to this study had already been spoken to. Diminishing returns were experienced in terms of the content provided within the interview context, as similar information was being provided with little additional value added to the discussion of the case.

Yin (2014) stresses the importance of case study researchers utilizing multiple sources of evidence aimed at corroborating findings regarding a phenomenon of interest. In this study, the research interviews conducted, despite their limitations, provide evidence that corroborates, supports, or builds upon evidence provided in other sources of data.

4.4.3 Case Selection Limitations

Finally, while the potential for selection bias has been discussed previously, some additional limitations should be acknowledged relating to the particular case selection for this study and the broader environment in which these two cases exist. The Brampton Civic Hospital and Royal Ottawa Hospital represent part of the ‘first wave’ of Canadian P3 projects. This era of infrastructure projects includes a number of other high profile P3s in Canada including the Confederation Bridge and the Highway 407 ETR. The ‘first wave’ of P3 projects in Canada reached financial close between 1990 and 2004 (OECD, 2008). These cases are unique in that the procurement process for the ‘first wave’ P3s was relatively ad hoc in comparison to later projects. At this time, P3s were a relatively new phenomenon globally, and these projects represented some of the first attempts in Canada to conduct this kind of procurement. Many of the P3 projects undertaken in this era, including the Royal Ottawa Hospital and Brampton Civic Hospital, required that public sector owners (hospitals, cities, or provincial departments) operate as their own P3 procurement authority, in some instances for their first and only time (OECD, 2008; Silversides, 2008).

The procurement environment in Canada generally, and Ontario in particular, since the ‘first wave’ of P3 projects has experienced marked changes. Most projects today are managed or guided through the procurement process by a dedicated agency tasked with oversight of P3

procurements with a standardized process (OECD, 2008). Since the Brampton Civic Hospital and Royal Ottawa Hospital were completed, there have been a number of changes to the way that similar large infrastructure projects are built, financed, and managed in Ontario. These changes to the framework under which public-private partnerships for hospital procurement now operate must be acknowledged as a limitation to this study. The most significant changes include the following:

- The Building a Better Tomorrow framework (2004): this framework stipulates a number of fundamental principles regarding the involvement of the private sector in public infrastructure development, incorporating procurement principles.
- Establishment of Infrastructure Ontario (2005): this Crown agency was incorporated to oversee the delivery of all forms of alternative financing and procurement projects in Ontario.⁹
- ReNew Ontario (2005): a public infrastructure investment plan that ensures projects are to undergo a value-for-money analysis by independent consultants prior to initiation to ensure cost savings versus traditional procurement mechanisms (Hansard Official Report of Debates, 2009).

Many of these changes related to project procurement are aimed at addressing issues similar to those highlighted in the Auditor General's report. Of these, perhaps the most significant change is the establishment of Infrastructure Ontario, which was created subsequent to the start of work on the Brampton Civic Hospital. Infrastructure Ontario is now omnipresent in

⁹ As noted here, Infrastructure Ontario was initially incorporated in 2005. Infrastructure Ontario was subsequently amalgamated with the Ontario Strategic Infrastructure Financing Authority to become the Ontario Infrastructure Projects Corporation (OIPC) through the OPIC Act in 2006. Infrastructure Ontario, in its current form, was established in 2011 through the merger of the Ontario Realty Corporation and OIPC.

major procurement projects in terms of leading and implementing the procurement of the entire project, assisting in the preparation of bid documents, evaluating submissions, negotiating contracts, and managing construction (Infrastructure Ontario, “AFP Project FAQs”). Given the significance of the role that Infrastructure Ontario now has in delivering the province’s more complex infrastructure renewal projects, such as hospitals, it is certain that the approaches to procurement utilized for the Brampton Civic Hospital and the Royal Ottawa Hospital would not be used again for the development of a project of this scale in the province through AFP.

While this limitation may have some consequences for the transferability of the observations produced to other public-private partnerships for hospital procurement following the establishment of the Ontario framework, this research project should still provide some insight into the early stages of infrastructure procurement through public-private partnerships in Ontario. The Brampton Civic Hospital and Royal Ottawa Hospital are the only two major infrastructure projects delivered in Ontario through a public-private partnership prior to the implementation of Infrastructure Ontario, and an examination of these cases will provide some insight into the successes and failures of the early stages of P3 procurement for hospitals in Ontario that would have contributed to the eventual framework under which the province operates today. Overall, the context of public-private partnerships in Ontario continues to change and evolve. The contracts that public and private partners enter into on procurement projects such as this are of a significant length, and remain in place for decades. The environment in which public-private partnerships operate is certain to change over the course of these arrangements. The observations relating to the Brampton Civic Hospital and Royal Ottawa Hospital may be particular to the context in which they were implemented; however, the study of these cases should still reveal some meaningful insights into the nature of public-private

partnerships while also informing the reader regarding this particular time in Ontario infrastructure procurement.

4.5 Case Study Design

The evolution and path of a project or public organization is in many ways determined by its past and predecessors. According to Anderson, et al., (2005) “[i]n complexity theory, this phenomenon is referred to as interdependency of present and past. Thus learning how the system has evolved over time will provide insight into its present patterns of behaviors.” As pilot projects, the Royal Ottawa Hospital and Brampton Civic Hospital P3 projects would have had a formative impact on the values and key aspects of the framework for P3s established in Ontario through agencies such as Infrastructure Ontario. Understanding these two projects, their history, and how the projects evolved can provide insights into how Ontario arrived at the current regime for P3 projects in the province. The multiple case design for this research project is intended to examine Ontario’s first two P3 projects for health infrastructure in detail, with consideration towards understanding the projects as complex, evolving systems. This entails consideration of the various actors at each stage, power structures and relationships, key information inputs, and the evolution of the projects from beginning to end.

In the Auditor General’s 2010 report, the recommendations from the 2008 report are discussed in relation to the changes and systems implemented through Infrastructure Ontario to address some of the issues experienced in the Brampton Civic Hospital in particular. In the 2010 annual report of the Auditor General of Ontario, the report reflected upon the fact that, in regards to P3 projects subsequent to the Brampton Civic Hospital, “there were inevitably lessons to be learned” (p.307). It is the contention of this study that there is much still that can be learned

from these cases in addition to the analysis already conducted by the Auditor General on the Brampton Civic Hospital case. Studies of the Canadian P3 market have indicated that there remains room for improvement in the relational aspects of public-private partnership projects, in how these projects are managed, and in how the partners arrive at agreements through the negotiation process. In examining the P3 community in Canada's largest markets, Ernst & Young noted that "better co-ordination between governments and their private-sector partners, standardized agreements and a predictable flow of projects will help build the expertise needed to create and manage large-scale projects and generate enough business for developers," (as said by Tim Philpotts in the Ottawa Journal, 2006, "P3 market shows promise but needs consistency, planning: report"). This suggests that there may be something to be learned from the examination of the relationships and organizational structures of these formative projects in Ontario; complexity theory offers a lens by which to conduct this examination.

Complexity theory leads the case studies in the subsequent chapter to contain a particular focus on the relationships between actors, interdependencies between actors, and interactions between elements at and beyond the border of the systems being studied (McDaniel, 2004). The analysis in the subsequent chapter, based as it is on a complexity theory model, does not necessarily argue that the agents and organizations should seek a greater degree of interconnectivity. Complexity theory offers a vantage point from which to view interconnected systems, such as the two procurement projects studied here. High levels of interdependence can have both positive and negative impacts on the system of connected agents, and changes between partners can have implications that affect all involved parties. The goal of this research, then, is to understand the associated effects of the actions of actors who would have had a part in these two projects (Mitleton-Kelly, 2003). To this end, the cases of study in Chapter Five will focus on

the various actors engaged at each point in the procurement process, and try to understand the relationships between them. This may entail understanding the actions and responsibilities of the Ministry of Health and Long-Term Care, SuperBuild, the hospital corporations and project teams, private vendors, the broader community, and other agents involved during the various project phases. In examining the actors involved at each stage, the context in which they are operating, and how relationships evolve and change over time, these case studies should shed some additional light onto the evolving formal and informal power structures throughout the projects. In order to better understand the relationships between internal and external actors and the roles that they would have in setting the direction of the projects, this study will also examine the successes as well as the challenges or failures in these two cases in engaging partners or experts in an effective manner, utilizing horizontal steering in the decision-making process, and consulting with stakeholders, partners, or the public (Klijn and Teisman, 2006). The comparative analysis of how this was conducted in a similar or differing manner in these two cases, and the ultimate outcomes of such engagement between partners and stakeholders, should make a contribution to the growing knowledge base pertaining to large-scale hospital infrastructure projects in Ontario specifically, and public-private partnerships for health infrastructure in general.

4.5.1 Study Structure

In the case study for this research project, the research questions (as per Chapter One) are used to structure analysis of the cases and synthesis of the information discovered through the analytical process. The analysis may be understood as the process by which the cases in question are decomposed into individual components. This is subsequently followed by synthesis, to control and correct the results of the analysis as part of the study (Ritchey, 1991). Within-case

analysis will be conducted for each individual phase for both of the projects themselves, followed by cross-case synthesis in relation to the central research questions. The structure of Chapter Five is designed to reflect various phases of project planning for projects of this kind. The various phases of each project are to be structured according to standardized language developed by SuperBuild, the contemporary organization responsible for guidance and coordination of project planning. The functional plan and program for a project represent the foundation of the eventual Request For Proposal (RFP) selection process. It is the interpretation of the functional plan into actual outputs for the development of the project by individual vendors that is utilized for the evaluation of proposals as part of the RFP selection process. As such, the functional plan for the project represents an important first step of the P3 process for projects such as this (Laird and Langill, 2005). The various phases of a project plan as laid out in the SuperBuild guide (2001)¹⁰ will comprise the headings for comparative analysis at varying project phases across the Royal Ottawa and Brampton Civic Hospital projects:

- Scoping the Project
- Selection Process
- Negotiations
- Implementation and Operation

The project phases are largely chronological and sequential for a given project, and as such the analysis and synthesis of these two cases should follow the historical account of these projects over time with consideration towards the research questions at the core of this study. The balance of the subsequent chapter will provide an overview of each of these stages of project planning, as well as an overview of how these phases operated in practice for the Brampton

¹⁰ It should be noted that many aspects of the Brampton Civic Hospital and Royal Ottawa Hospital procurement processes precede or deviate from the SuperBuild partnership guide (2001) structure; these sections are arranged as such for comparative purposes only.

Civic Hospital and Royal Ottawa Hospital. Utilizing complexity theory as a lens of examination for the case studies, each section will provide insights into the history and nature of the projects, how decisions were made, how key actors at each stage interacted with their broader operating environment, and how those interactions defined system properties within the projects themselves (McDaniel, 2004). Each section will include a cross-case synthesis to comparatively examine each of the various phases between projects, considering the similarities and differences between both the approach to each phase of the project, and the eventual impacts of said similarities and differences.

Understanding the governance of these projects through complexity theory will entail examining how the projects evolve and change over time and how the key actors and decision-makers change, as well as the decision-making inputs, information available, and smart interventions through consultations of partners, the public, or stakeholders. Klijn's (2008) perspectives of governance theory posit that it is important to understand the key actors within a system, in addition to understanding their capacity to connect in a meaningful way with other actors, establish patterns and structures of interaction, and conduct these smart interventions to navigate a complex operating environment. A researcher observing the behaviours of actors within a system would look for the capacity of facilitators of interaction to listen, observe, conduct horizon scanning, and make connections with other actors as required through horizontal decision-making processes. Thus, the inputs to be compared across each case will reflect the key objectives at each phase of the planning process. Within each section, consideration will be given to what are the key inputs behind decisions, who was consulted throughout this process, and how the information from consultations has been utilized. Each section will also contain a within-case analysis focused on the experience of each individual hospital corporation.

Figure 3 provides an overview of the structure of the case design, with references to the structured sections of the case studies in Chapter Five:

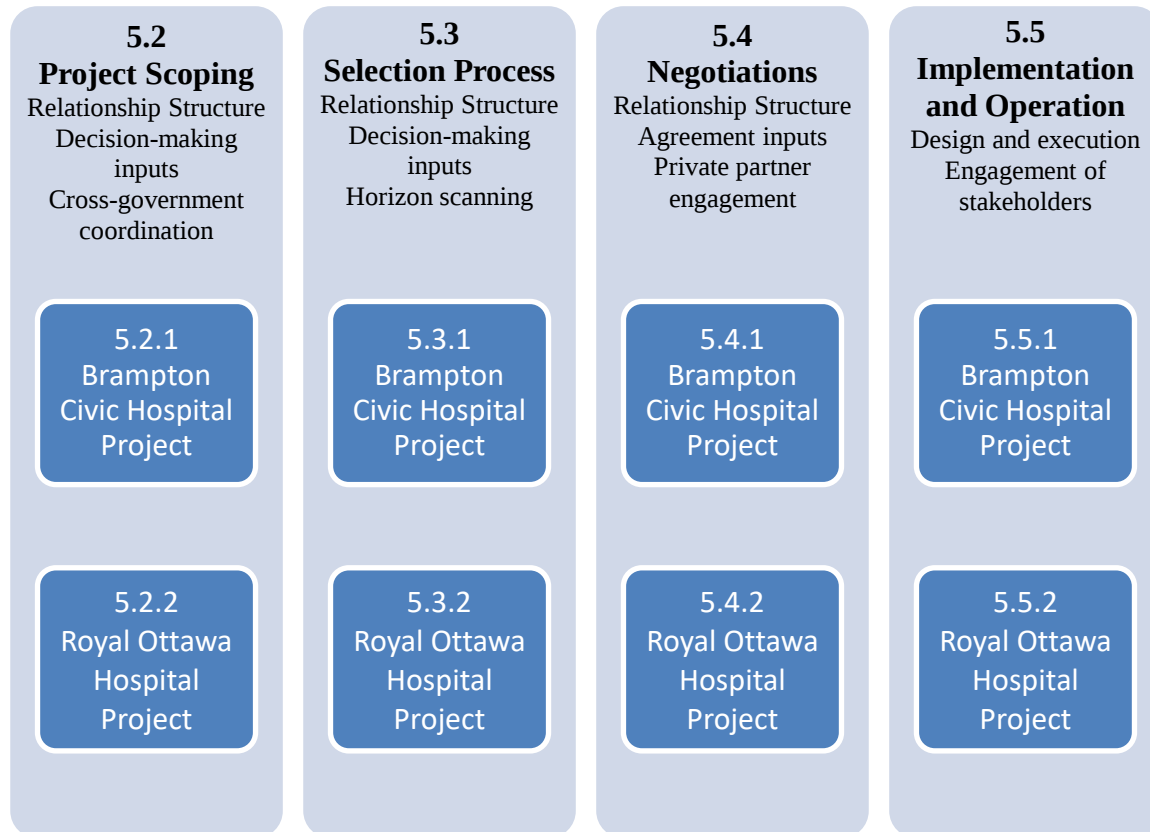


Figure 3: Multiple-case study design

4.5.2 Case Selection

As was discussed in the section 4.4.3 of this chapter, the Brampton Civic Hospital and Royal Ottawa Hospital were chosen as cases of study for this research paper as they were the first hospitals in Ontario built through a public-private procurement process. As a pilot project for partnerships in hospital procurement, these cases present significant lessons from which those interested in this topic can learn. Also, at the time of the hospital's construction, there was very little in terms of mechanisms in place at the provincial level to resolve disputes (Infrastructure

Ontario, 2012). The novelty of P3 arrangements for projects of this kind in Ontario, as well as the sheer magnitude of these projects, meant that the existing policy and decision-making frameworks in Ontario were tested against a new kind of arrangement that had not been seen before (Conference Board of Canada, 2010). As noted in the WOHC response to the Auditor General's report (2010), the Brampton Civic Hospital project in particular faced challenges in multiple areas of project execution, including those relating to equipment, procurement, information technology (IT), local share requirements, and disposition of replaced facilities (Auditor General, 2010). One area that is not touched on, however, is whether there were any significant challenges faced in the relationships and engagement of actors, public and private, as part of the partnership, and what role that may have played in the final outcomes of these projects. Understanding these relational aspects of the project within the broader context of the learning experience that was these two procurement projects in Ontario will provide an enriched understanding of the kinds of challenges and experiences that can be faced in early large-scale health infrastructure procurement management frameworks.

Critically, the case of the Brampton Civic Hospital is a distinctive case that can provide some insight into the problems associated with partnerships in hospital procurement. In the Brampton Civic Hospital case in particular, some lessons may be gleaned from the significant challenges faced by the project, and resultant difficulties that the project faced in delivering on-time or on-budget. As indicated in the Auditor General's Report (2008), the amount of time and cost associated with the design, building, financing and maintenance of the Brampton Civic Hospital was higher than estimated. Findings from a value-for-money report from the Auditor General conducted after the completion of the hospital indicate significant discrepancies between estimated and actual costs, suggesting further insights could be obtained from the study of the

project scoping phase and changes subsequently made in negotiations (Auditor General, 2008). The challenges experienced in this case in particular indicate that additional insights may be warranted in this case to examine the nature of partnerships in the Ontario health sector and establish the potential reasons for challenges experienced within procurement projects.

Finally, as previously stated, since the completion of the Brampton Civic Hospital and the Royal Ottawa Hospital, the Ontario government has created an agency responsible for oversight and project management of partnerships in infrastructure: Infrastructure Ontario. This agency established the *Infrastructure Planning, Financing and Procurement Framework* for Ontario's Public Sector, which lays out fundamental principles of public infrastructure projects (Infrastructure Ontario, 2012). Looking at the challenges faced within these two health infrastructure pilot projects in Ontario should provide an idea as to what lessons were learned over the course of these projects and how any potential failings may have guided the development of frameworks for future projects under Infrastructure Ontario.

4.6 Summary and Conclusion

The purpose of the chapter was to outline the research methods, data construction procedures, and limitations of design of this study. This chapter sets the stage for the research process by examining the approach to data creation and synthesis with an acknowledgement of why that approach suits the subject at hand. The case study approach for this research project is to incorporate a wide variety of data sources publically available and non-public, complimented by data from semi-structured research interviews. The multiple-case design utilized for this study allows some comparison between the first two major P3 hospital infrastructure projects conducted in Ontario, and allows for some consideration into the common management

processes adopted therein. The following chapter will provide an overview of the context and operating environment of both cases as background to the case study, and then will include a study of the Brampton Civic Hospital in detail utilizing the data created and synthesized as indicated in this chapter.

Chapter Five: Multiple Case Study

In his overview of the Brampton Civic Hospital procurement project, provided as part of his testimony to the Legislative Assembly of Ontario before the Standing Committee on Public Accounts regarding the Brampton Civic Hospital (2009), former Deputy Minister of Health Ron Sapsford noted that the “delivery of a project of this size and complexity inevitably poses challenges” (p.284). It is the intent of this chapter to identify and explain the nature and the extent of the complexity and challenges associated with such a project, and provide a detailed multiple-case study examining the management process for the Brampton Civic Hospital and Royal Ottawa Hospital with a particular focus on the relationships between various actors involved in delivering hospital capital procurement projects.

The purpose of this chapter is to compare the cases of the Brampton Civic Hospital and Royal Ottawa Hospital in regards to the management structure of the procurements and the relationship between public and private partners during this process. As stated in the theory section of this dissertation (Chapter Three), a system-level examination of hospital procurement processes in Ontario utilizing complexity theory will involve an examination of the capacity of a system to evolve and interact with a changing operating landscape and interaction with other systems, including mechanisms of horizontal steering and capacity for consultation in the decision-making process (Klijn and Teisman, 2006). Chapters Five and Six will compare the experiences of the Brampton Civic Hospital and Royal Ottawa Hospital projects with a spotlight on how consultations and interactions were structured, how information was gathered, and how the relationship between partners was structured. It will examine the actors involved at each

stage in decision-making, how the project engaged key actors and stakeholders, and how the horizontal steering, or a lack thereof, may have impacted the final outcomes of the project, and what lessons learned in this exercise may inform future frameworks for partnerships in Ontario. Figure 4 provides an overview of the chronology of some key stages of the process undertaken for both projects at a high level, as examined in this chapter:

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Brampton Civic Hospital	Planning begins under HRSC, along with the decision to amalgamate local hospital boards into WOHC				Project specifications and plans are developed, with first capital-cost estimates for the construction of the hospital delivered with the input of a cost consultant	Announcement: Following approval from SuperBuild, on November 2001, both hospitals are announced as P3 hospital projects	Bidding Stages: A four-stage selection process begins with an RFEI in March 2002 with 23 applications submitted, followed in November 2002 by an RFQ and a two-staged RFP, with four invited vendors	Selection: RFP concludes with the selection of the preferred bidder, THICC	Implementation: Following finalization of financial arrangements with the new Liberal government, work began as of November 2004, and was completed July 2007, with the hospital opening October of that year			
Royal Ottawa Hospital		Planning begins under HRSC. Initial directions are for renovation of existing facilities to meet mandate		Moving away from renovation plans proposed under HRSC, new development plans are initiated by ROHCG	Negotiations begin between ROHCG and the Ministry of Health for the development of new facilities		Bidding Stages: A confidential two-stage selection process begins with an RFQ June 2002. In December 2002, an RFP was issued to the three sole applicants from the RFQ. One applicant was subsequently disqualified in the RFP stage	Selection: Largely confidential negotiations follow the completion of the RFP stage. All negotiations concluded in July 2004 and project agreements were signed with the preferred vendor, THICC	Implementation: Work begins in December 2004, after the selected proponent secures financing for the transaction. Work is completed October 2006, six weeks ahead of schedule			

Figure 4: Project Chronology

5.1 Economic, Political, and Institutional Context

The multiple-case study design for this chapter will entail an analysis of the key actors at each phase of the procurement process. This will include an assessment of actors both within the hospital corporations, private vendors, stakeholders, consultants, and community leaders. This

case study will attempt to understand the interactions between actors associated with these projects both internal and external to the hospital corporations, as “[c]omplexity science suggests that important insights can be gleaned by studying the behavior that occurs at and across the boundaries that define the case” (Anderson et al., 2005, p.674). First, however, this section will provide an overview of the broader context in which both the Brampton Civic Hospital and Royal Ottawa hospital procurement projects operated, along with some of the common key public institutions that would have been involved in each case.

Given that both the Brampton Civic Hospital and Royal Ottawa Hospital were announced, designed, and built within a similar timeframe, they also operated within a highly similar environment in regards to the key actors in play in the government of Ontario, and the available vendors in the private market. The ministries, agencies, and public bodies operating in collaboration for the development of public health infrastructure development make-up a broader network of public actors working as a system to deliver on objectives for health-care and health infrastructure in the province. This section will provide an overview of the environment in which both these procurement projects were undertaken, including the key government bodies that would have been involved in each project. Understanding this system and the relationships between these actors is crucial as context to the study of the cases of the Brampton Civic Hospital and Royal Ottawa Hospital.

Two government ministries, the Ministry of Health and Long-Term Care and the Ministry of Infrastructure,¹¹ would have been responsible for the undertaking of major hospital

¹¹ The Ministry of Infrastructure was referred to as the Ministry of Public Infrastructure Renewal from 2005 to 2008. This ministry was merged with the Ministry of Energy in June 2008, creating the Ministry of Energy and Infrastructure; the ministries were re-split in 2010. It will be referred to as the Ministry of Infrastructure for the course of this study.

capital projects such as the Brampton and Ottawa hospitals. The Ministry of Health and Long-Term Care is responsible generally for overseeing the public health system in the province. As part of this, it is responsible for the development, coordination, and maintenance of health services provincially, including maintaining a system of hospitals, long-term care homes, laboratories, ambulance services, and other community services provincially (Standing Committee on Public Accounts, 2009). The Ministry of Infrastructure is responsible for public infrastructure in Ontario, funding capital projects, and drafting the capital budget for the province. Its mandate includes oversight of the delivery of all major capital projects in the province, including courthouses, roads, bridges, water systems, and other public assets such as hospitals. In the case of hospital procurement for the Royal Ottawa Hospital and Brampton Civic Hospital, the Ministry of Infrastructure and Ministry of Health and Long-Term care needed to work collaboratively cross-government in the objective setting, implementation, procurement, and oversight for the construction of the hospitals (Hansard Official Report of Debates, 2009).

One of the main government bodies at the time in relation to this project was Ontario SuperBuild (SuperBuild), the province's predecessor to Infrastructure Ontario. SuperBuild was a crown corporation designed to develop policies and strategies for capital resource infrastructure investment in the province.¹² This included a mandate specific to privatization initiatives and, subsequently, public-private partnerships. The corporation was responsible for the implementation and oversight of policies and strategies relating to P3s in the province (Ontario. O. Reg. 592/99).

¹² Ontario SuperBuild Corporation was established under section 2. O. Reg. 592/99, s. 1 of the Development Corporations Act.

In regards to health infrastructure specifically, SuperBuild sought to build upon the foundations of work laid out by the Health Services Restructuring Commission (HSRC), a prior independent body established in 1996 to expedite reinvestment and restructuring of what was considered to be aging public health infrastructure across the province. The HSRC provided advice to the Ministry of Health and Long-Term Care, particularly in regards to areas of health infrastructure in need of development. SuperBuild would be utilizing much of their input in regards to various health infrastructure projects to be considered over the course of its five year mandate (HSRC, 2000). Unlike the HSRC before it, SuperBuild had a specific mandate for health infrastructure that related to working with the Ministry of Health and Long-Term Care and other health care providers to explore the potential for P3 partnerships for capital projects, and to explore ways to address any barriers provincially to P3 approaches in health infrastructure procurement (Ministry of Finance, 2000).

SuperBuild would have been a key agent in the development of the Brampton Civic Hospital and Royal Ottawa Hospital procurement projects, as they were the main government body responsible for the development of capital programs in the province. As an agency of the Ministry of Finance, SuperBuild was mandated with the following responsibilities (SuperBuild, 2001):

- “leading the Government of Ontario's capital planning and policy-development processes;
- evaluating and making recommendations to the Cabinet Committee on Privatization and SuperBuild (CCOPS) on infrastructure partnership, privatization and commercialization proposals;

- developing new strategies to strengthen the capacities of the Ontario Government and its BPS partners to attract private-sector financing and support for traditionally public infrastructure; and
- reporting publicly on SuperBuild investment priorities, capital plans and results” (p.1).

Much of the procurement management process for the Brampton Civic Hospital and Royal Ottawa Hospital would have been overseen by SuperBuild, and they had a role of connecting various levels of government with other public organizations or private companies to accomplish their mandate as it related to health infrastructure. Internal to Ontario, SuperBuild was also designed to “act as liaison between ministries and agencies of the Government of Ontario with respect to capital programs and share information on capital programs being developed with or implemented by a ministry or agency of the Government of Ontario with other ministries and agencies of the Government of Ontario,” (Ontario. O. Reg. 592/99) and as such would have been a vital player in managing and connecting the various actors involved in the procurement process for both the Royal Ottawa Hospital and Brampton Civic Hospital project. Much of the procurement process and management of these projects, as described below, would have been the responsibility of SuperBuild in conjunction with the particular hospital corporations (Ontario. O. Reg. 592/99).

SuperBuild, in addition to overseeing P3 projects in the province over the course of its mandate, also published guidance materials to assist public sector and non-profit managers and decision-makers in the implementation and management of public-private partnerships. The SuperBuild Guide to Public-Private Partnerships for Infrastructure Projects (2001) outlined the values and general concepts core to the decision to pursue a P3 arrangement, the selection

process, the VFM benchmarks, and more that should underlie P3 procurement projects in Ontario.

As will be described in the subsequent section, the SuperBuild framework represented only a loose and not clearly defined institutional context for the undertaking of the Royal Ottawa Hospital and Brampton Civic Hospital projects. Beyond this, the rules and regulations pertaining to public procurement would have defined the institutional environment in which these two projects were undertaken. It is important to note that a detailed, prescriptive framework did not exist at this time for P3 procurement projects. Many crucial details of the competitive procurement process undertaken for both projects would have been established by the hospital boards themselves; at best, the regulatory environment and oversight of the projects through SuperBuild would be understood as a ‘proto-enabling’ framework for these kinds of procurements (Whiteside, 2015). However, in order to provide as comprehensive of a picture as is possible for the institutional and regulatory environment in which these projects were undertaken, this section will detail some of the key requirements set out for Ontario’s public tendering process.

In Ontario, the *Ministry of Government Services Act* includes requirements that the provincial government operate under the policies and directives established by Management Board of Cabinet (MBC) for all procurements relating to the construction of public infrastructure (Stobo and Leschinsky, 2009). As such, the Brampton Civic Hospital and Royal Ottawa Hospital projects would have been governed under the MBC *Procurement Directive for Goods and Services*, which sets out principles for planning, acquisition and management of goods and services, including infrastructure procurement, for the government of Ontario. These directives

also specify mandatory requirements for adherence to stated principles, as well as responsibilities for organizations involved in procurement.

Procurement directives set out, at a high level, the roles that Deputy heads, Deputy Minister of Ministry of Finance, MBC, the Minister of Labour, and Cabinet would have throughout the procurement process. Requirements within the directives would establish a loose network of responsibilities and accountabilities throughout the procurement process, while not strictly prescribing requirements for how the actors would meet the specific requirements set out by Management Board of Cabinet (MBC Procurement Directive for Goods and Services, 2003). Procurement authority is also clearly established within the directives of Management Board of Cabinet. For an open, competitive process valued at \$20 million or more, as is the case for both projects here, Ministerial approval would be required for the submission, and Treasury Board(TB)/MBC would have final approval over the project (no delegated authority). In these projects, a business case would be submitted by the responsible ministry (Ministry of Health) for review of TB/MBC, under the direction of the Ministry of Finance, Office of the Budget and advisors for Treasury Board (MBC Procurement Directive for Goods and Services, 2003).

The directives also set out requirements for the procurement process itself, establishing requirements for a competitive procurement process, rules around tendering, submissions, retention of expert advice, and record retention, as will be described here. For additional detail regarding how the selection process was conducted in practice for the Royal Ottawa Hospital and Brampton Civic Hospital projects, please refer to Section 5.3 of this chapter.

In terms of set requirements for a competitive process, once a ministry has determined that internal ministry resources, common services or, as may be applicable in some

circumstances, existing competitively established vendor of record arrangements are not appropriate or are insufficient for a project, directives require that ministry undertake a separate competitive process for procurement. The high estimated total contract values for both projects would largely define the rules for procurement that would apply to the governance of both projects. Given that the estimated total contract values for both projects would exceed levels considered acceptable for existing vendor of record arrangements, a competitive process would be required for both projects (MBC Procurement Directive for Goods and Services, 2003).

While not directly prescribing a detailed framework for a competitive procurement process, requirements do state that provisions within the directive pertaining to construction, goods, and services would need to be acquired through “a competitive process that seeks to achieve the best value for the funds expended to meet the specific needs and promotes fair dealings and equitable relationships with the private sector” (MBC Procurement Directive for Goods and Services, 2003, p. 11). Required accountability and reporting are clearly laid out in the directives, and approval level varies dependent upon the total contract value. Given the size of the contracts were greater than \$1 million, approval from Management Board of Cabinet would be required prior to the initiation of the procurement process (MBC Procurement Directive for Goods and Services, 2003).

The requirements set out for the Request For Qualifications [RFQ] process in the procurement directives that would have applied to both projects include clear articulation of all requirements for the projects, full disclosure of evaluation methodology, as well as requirements regarding approvals and details of submission requirements including delivery instructions, timing, pricing basis, closing dates, and other aspects of the submission prior to the posting of the RFQ (MBC Procurement Directive for Goods and Services, 2003). Additionally,

procurements with a potential contract valued at the level of the two proposed hospital projects would normally involve the consideration for a minimum of three submissions, bids, or proposals (MBC Procurement Directive for Goods and Services, 2003).

MBC directives further set out requirements generally for the acquisition of technical and business advice for the assessment of compliance. Ministries are required to obtain legal advice throughout this procurement process; such is particularly important prior to the rejection of a submission, bid, or proposal that does not comply with requirements set out in the related requests for qualifications, tenders or proposals (MBC Procurement Directive for Goods and Services, 2003).

A call for tenders for acquisitions of the level that would have been applicable for the Brampton Civic Hospital and Royal Ottawa Hospital projects would be subject to requirements for open tendering. This includes a notification for the procurement through an electronic tendering system, advertising in a daily newspaper available to potential vendors (the Globe and Mail), and the use of source lists in instances where such lists are fully open to qualified vendors as per Ontario's trade agreements (MBC Procurement Directive for Goods and Services, 2003, p. 11). Requirements are also established in regards to lead times required to allow for vendors to develop proposals; this can be a minimum of 30 days for an alternative service delivery mechanism such as P3s (MBC Procurement Directive for Goods and Services, 2003).

5.1.1 SuperBuild as a 'Proto-Enabling Framework'

In examining the various relationships between actors and structures in the Royal Ottawa Hospital and Brampton Civic Hospital P3 procurement projects, this research study demonstrates the complex and occasionally inchoate process that was implemented for the two first major

forays into P3 procurement for health infrastructure development in Ontario. As is examined in additional detail in section 5.2.3.1, “Structure of Relationships in Project Implementation,” the framework under which these projects operated was still at a highly formative stage. This was characteristic of the ‘first wave’ of Canadian P3 projects, wherein public sector owners operated in the absence of a sophisticated P3 procurement authority (Conference Board of Canada, 2010).

The SuperBuild infrastructure plan, initiated in 1999 under the Harris government, represented the main operating framework for Ontario’s first two public-private partnership hospital procurement projects. The SuperBuild framework may be understood as an ‘enabling field’ for partnerships in this kind in the province, as it exists to facilitate and, almost inarguably, promote the use of P3s in the development of public infrastructure in Ontario. However, at best, this framework would be better described as a ‘proto-enabling field,’ without the level of formal structure that may be expected of a fully-formed ‘enabling field’ (Whiteside, 2015). While this initiative may stand as an initial attempt to institutionalize P3 development in Ontario, the fact remains that there were “few systematized capital planning procedures” (Whiteside, 2015, p. 164) present at this point. The framework for major P3 procurement projects in the province was largely still in development, and SuperBuild and the operating environment under which these two projects would have been developed “lacked the routines necessary to sufficiently transform government operations and normalize P3 use” (Whiteside, 2015, p. 165). Research interview participants corroborated this assessment, noting that, at the time “...there wasn't a template approach as there is now through Infrastructure Ontario” (Participant 3).

As these projects were underway, a more formal framework was implemented in the province. However, given the timing of project scoping and development, both the Brampton Civic Hospital and Royal Ottawa Hospital were largely unaffected by the routines and

institutional support that were brought into effect through the AFP framework under the Liberal government (Whiteside, 2015, p.183). As such, the ‘SuperBuild era’ of hospital infrastructure procurement, which in its entirety captures the two hospitals to be studied as cases in this research, represents a unique period in time given the later establishment of Infrastructure Ontario and AFP frameworks in the province for future procurements. SuperBuild never developed into an institutionalized central government agency for P3s and, unlike what would be expected with Infrastructure Ontario, neither hospital benefited from the assistance of a government agency with specialized expertise in P3 procurement (Whiteside, 2015).

This absence of a specific policy and process relating to P3 procurements was acknowledged as leading to difficulties in the projects, particularly in the development phases, as will be further explored later in this chapter and Chapter Six (Laird and Langill, 2005). These projects were noted for a low level of expertise, routines, and standardization, and authors such as Whiteside (2015) attribute a number of the issues and controversy associated with these projects to the infancy of the framework within which they operated. In contrast to the current AFP framework, wherein aspects of the scope and size of a project precede the decision to use a P3, the steps taken with these two projects suggest a lack of routinization and procedures for the projects, as well as a lack of in-house experience in government (Whiteside, 2015). These projects are also acknowledged as having a “lack of P3 procurement routines and value for money expertise” (Whiteside, 2015, p. 184).

There had been a dearth of hospital construction prior to these projects being undertaken, meaning that the province had not only a lack of familiarity of handling not just a P3 infrastructure project, but hospital procurement in general (Standing Committee of Public Accounts, 2009). This represented a significant challenge that, in both cases, necessitated the

consulting of numerous outside experts. It also necessitated significant involvement on the part of staff from the Ministry of Health and Long-Term Care. Research interview participants echoed the increased role of project teams in project scoping and development in these cases relative to what would exist under the current AFP framework in Ontario.

Such is not to suggest that the procurements occurred within a regulatory vacuum; as described within the previous section, both projects would have been governed within an institutional framework as defined by the rules for procurement set out by MBC. However, within the confines of that framework, the approaches and best practices for P3 procurement in health infrastructure remained poorly defined, and project teams were responsible for designing a procurement process for these projects that would be appropriate to the need and function of the project. Given the concerns around the novel nature of these procurement processes, the Ministry encouraged the hospital early in the RFP process to acquire the services of a process auditor. These were pilot projects, and methods of procurement were evolving and aspects of the project went beyond what could be considered under the current government policies or practices. A process auditor would provide “monitoring of ongoing events [and] a source of advice and counsel to both the hospital and government on a proactive, ongoing basis” (Laird and Langill, 2005, p.74), insuring the integrity of the process.

5.2 Scoping the Project

One of the earliest phases in a major procurement project involves determining the project scope. According to the SuperBuild guide, the overall scope of the project, defined in relation to financial, technical, operational, acceptability, implementation, and timing concerns, should be determined in full at the beginning of the process (SuperBuild, 2001). As it relates to

the two cases in question, an overview will be provided of the project scoping that was undertaken in each case, key actors involved, and relevant inputs into decisions made at this point in the process, including the selection of procurement mechanisms for the projects.

5.2.1 Scoping the Project: Brampton Civic Hospital

The Brampton Civic Hospital is part of the broader WOHC. Located in Brampton, Ontario, the WOHC serves a suburban Toronto satellite population of approximately 1.3 million individuals, as of recent estimates (WOHC, 2013). Given the large and growing nature of the area it serves, the WOHC makes up one of Ontario's largest hospital corporations, serving the areas of Etobicoke and Brampton as well as the surrounding area (Auditor General, 2008).

Brampton is a suburban city in the Greater Toronto Area (GTA), and the seat of Peel Region, with a population that is growing largely due to immigration over the past two decades (Barrows et al., 2012).¹³ Brampton and the surrounding area was recognized at the time as being one of the most rapidly growing regions in Ontario in terms of population, and existing health infrastructure in the region was expected to be stressed significantly by anticipated population growth (Hansard Official Report of Debates, 2009). WOHC had, at the time, projected that from 2000 to 2008 the population of the Brampton area would grow by approximately 15,000 to 20,000 residents annually (Auditor General, 2008). Demographic studies strongly indicated that the city of Brampton required additional bed facilities to meet the anticipated growing demands on the system (Hansard Official Report of Debates, 2009).

Planning began for the Brampton Civic Hospital in the late 1990s under the HSRC. The HSRC was an independent body established by the Ontario Government in 1996. This

¹³ At the 2011 census, Brampton's population was 523,911 (Statistics Canada, 2011).

independent body was tasked with expediting reinvestment and restructuring of aging hospital infrastructure in the province, and provided advice to the Minister of Health on priority-setting to meet issues emerging from historic health infrastructure underinvestment (HSRC, 2000).

The initial decision to build the Brampton Civic Hospital was made in 1996 under the recommendation of the HSRC, as part of the commission's four-year mandate relating to Ontario's hospital infrastructure. Citing the continued growth of the Brampton and Etobicoke areas as driving the need for additional health care facilities, the HSRC recognized in the late 1990s that the residents of the area would require new and expanded hospital facilities to meet growing needs. The proposed project was to be amongst the largest hospital building projects undertaken in Ontario in recent history, with an estimated 1.2 million square feet of new facility construction (Hansard Official Report of Debates, 2009). Part of this project also included the redevelopment of the Peel Memorial Hospital, also under the administration of the WOHC. With the development of new bed facilities at the Peel Memorial Hospital, to be 112 in capacity upon completion, along with that of the Brampton Civic Hospital, WOHC was expected to be able to meet the projected health-care needs of the growing Brampton-area community (Auditor General, 2008).

In order to arrive at an estimate of what the cost of the Brampton Civic Hospital project would be over the duration of design and construction, WOHC engaged the services of a firm of cost consultants. This expert opinion was necessitated largely due to a lack of contemporary comparator cases, as few new hospitals had been constructed in recent years. Resultantly, available data on the costs associated with building new hospitals under a traditional procurement method were lacking (Auditor General, 2008). Cost estimations required the development of a functional program with preliminary estimates of the special requirements for

the hospital and each of its departments, which would then be multiplied by an approximated cost per square foot based on current common pricing. Additional costs including building shell, ancillary services, site development, common grounds, and contingency funding are also factored in to arrive at a total estimated cost for the project. The first estimates provided to WOHC in September 2000 indicated that at a capacity of 716 beds over a 1.275 million square foot area, the hospital would cost the government \$357 million for design and construction (Auerbach, 2007). The range of potential variation for final costs was estimated to be about 7.5%, or \$100 million, greater or less than their initial cost estimate (Auerbach, 2007). The estimated total cost was subsequently updated later that year to reflect new cost drivers identified in the planning process. As of October 2001, the WOHC updated the capital-cost estimate for the new facility to \$381 million (Auditor General, 2008). On November of 2001, the development of 2 new hospitals using the P3 model, the Brampton Civic Hospital and the Royal Ottawa Hospital, were approved (Auditor General, 2008).

Prior to the issuing of the selection process by WOHC, the Ministry of Health and Long-Term Care directed WOHC to commission a VFM assessment of the P3 arrangement. While initial cost estimates were available for review and comparison to private bids for the purposes of a VFM, the Ministry directed WOHC in 2002 to provide a second estimate of what it would cost the government to build the hospital under the traditional procurement system and to conduct a comparison with the costs under a P3 arrangement. WOHC engaged a second cost consultant to come up with this estimate using an approach similar to that of the first estimate (Auditor General, 2008). In January of 2003, a second external consulting firm was contacted to provide an assessment of overall costs for the project (Auditor General, 2008).

The second consulting firm estimated that it would cost the government \$507 million under traditional procurement to design, build, and operate a new 608-bed, 1.2-million-square-foot hospital. With respect to non-clinical costs, such as laundry, housekeeping, food services, and so on, WOHC benchmarked the 2001 cost of having these services provided by WOHC itself and by 10 other hospitals to arrive at an estimate. These estimates formed the basis of the VFM assessment conducted by WOHC. The Ministry hired its own consultants, Deloitte Touche Tohmatsu Limited (Deloitte)¹⁴ to review WOHC's assessment (Auditor General, 2008). The independent assessment undertaken by Deloitte took place during the spring and summer of 2003. This review was intended to lead to a revised VFM, if necessary, followed by a letter of assurance (Auerbach, 2007). As will be discussed in Section 5.2.3.3, many of the VFM considerations for this project occurred quite late in the process, potentially impacting the ability of this information to play a substantial role in the decision-making process for WOHC or the Ministry of Health and Long-Term Care.

5.2.2 Scoping the Project: Royal Ottawa Hospital

The ROHCG operates mental health and addiction programs and services in the Ottawa/Champlain region and much of Eastern Ontario, with a mandate of providing specialized mental health care, advocacy, education and research for the region (ROHCG, "About the Centre"). The Ottawa site of ROHCG currently includes the Royal Ottawa Place, a long-term care facility, and the Royal Ottawa Mental Health Care Centre, formerly known as the Royal Ottawa Hospital (ROHCG, "Our History").¹⁵ The ROHCG also includes the Brockville Mental

¹⁴ Deloitte is a professional services firm that provides audit, tax, consulting, enterprise risk and financial advisory services, and is one of the largest professional services firms worldwide (Deloitte, 2013).

¹⁵ As the Royal Ottawa Mental Health Care Centre was referred to as the Royal Ottawa Hospital for the duration of the design and implementation of the new hospital, it will be referred to as such for the duration of this study.

Health Centre, the University of Ottawa Institute of Mental Health Research, and the Royal Ottawa Foundation for Mental Health (ROHCG, “About the Centre”).

The Royal Ottawa Hospital is one of the oldest hospitals in Ontario,¹⁶ and as of 1961 was designated as the primary care centre in the Champlain region for the treatment of psychiatric disorders and rehabilitation of physical disabilities (ROHCG, “Our History”).

The Royal Ottawa Hospital had previously pioneered the contracting-out of support services in Ontario, entering into agreements with a private partner as recently as 1995 for the delivery of non-clinical services. The Royal Ottawa Hospital had an existing five-year agreement with Brookfield Lepage Johnson Controls as a private partner to manage non-healthcare related services at the hospital (Royal Ottawa Hospital, 2001, “Brand New Royal Ottawa Hospital Approved – Eastern Ontario Applauds Attention to Mental Health”). Former CEO of ROHCG George Langill adopted the term “hotel services” as a means to describe the food, maintenance, and housekeeping services provided as part of hospital operations. Contracting out of these services, Mr. Langill assured, would permit the hospital to focus on the delivery of clinical services while also achieving cost savings through private-sector efficiencies in service delivery (Ontario Public Service Employees Union [OPSEU], 2007).

The Royal Ottawa Hospital was given a new mandate by the Government of Ontario in 1997. According to this mandate, the Royal Ottawa Hospital was now to be the Champlain Health District’s tertiary Academic Mental Health Centre. The mandate for the new hospital

¹⁶ Initially the Lady Grey Hospital, opening in 1910, this hospital began as a sanatorium and specialized hospital for tuberculosis patients. This greatly influenced the architecture of the original building, with many wide windows and large balconies (pictured) (Journey to Nationhood, “Royal Ottawa Hospital – Lady Grey Sanatorium”).

necessitated an evaluation by the HSRC to compare the current facility to the anticipated programs to be delivered (Laird and Langill, 2005).

The initial direction by the HSRC in regards to the mandate for the Royal Ottawa Hospital was to renovate the existing facilities to meet the requirements of the mandate. Following the recommendation of the HSRC, the ROHCG commissioned a separate study to evaluate the capacity of renovations to the current facility to accommodate the new mandate. The ROHCG study determined that the proposed renovations to the old facility were likely to cost more than a new facility, and the ROHCG would not be able to fully meet the new mandate in the current facilities even after renovations had been completed (Whiteside, 2015). The existing facilities, dating back to the early 1900s, were considered inefficient, expensive to operate and repair, and dysfunctional to the effective treatment of those with mental illness. The facilities themselves, and what they would offer upon renovation, was inconsistent with the new mandate for the Royal Ottawa Hospital (Whiteside, 2015). Additionally around this time, the Ministry of Health and Long-Term Care commissioned an operational review of the hospital in response to what was deemed to be a “seriously deteriorating financial position” (HayGroup, 2001, pg. 1) for the hospital. The hospital corporation was demonstrated as experiencing increasing deficits, with projected operating deficits expected to grow in the coming years and a worsening working capital position; recommendations sent a clear message that top-down changes were required for the Royal (HayGroup, 2001).

So, the hospital was faced with an unsustainable financial position, facilities that were inefficient and unsuited to meet the new mandate or the needs of patients, and estimates of up to \$200 million in new capital being required for facility redevelopment (HayGroup, 2001). It was determined that a new site would be less expensive than a redevelopment, but was more onerous

in regards to costs and zoning requirements. Furthermore, a new site required additional financing until the completion of the new facility and disposal of the old one (Laird and Langill, 2005). It was at this point that a P3 approach would have first been considered for the project and discussed, somewhat informally, between government executives and staff at the hospital corporation. Despite suggestions at the time to explore private financing options for the project, it appeared that there was some resistance on the part of senior government executives at the time who would have been uncomfortable with what was perceived as a new approach to financing for health infrastructure (Participant 2).

The election of a new, Conservative government, brought some changes to Queen's Park, including a greater level of comfort with approaches to addressing health infrastructure gaps with use of private finance and management (Participant 2). The subsequent creation of SuperBuild in Ontario, established to foster the development of such public projects through the leveraging of minimal public capital with significant financing and development risk by private partners, would have had significant influence on the decision for the Royal Ottawa Hospital to pursue a P3 as opposed to a traditional capital funding grant for building the new facilities (Whiteside, 2015). P3s were purportedly considered to be the most attractive option due to, in part, attractive borrowing arrangements for the public partners. A P3 arrangement eliminated the need for the Ministry of Health or the Royal Ottawa Hospital to borrow directly for the new hospital developments, instead relying on a private partner to obtain financing for the funds required for construction. The borrowed funds would be bundled-up along with other services into one overarching contract, including the construction of the hospital and delivery of non-clinical services over the 25 year contract (Auerbach, 2007). As is commonly the argument for partnerships of this kind, the transfer of risk, which could be better managed by a private partner,

was a factor in the ultimate decision for developments at the Royal Ottawa Hospital (Laird and Langill, 2005). Furthermore, as previously noted, the Royal Ottawa Hospital had also had some previous success in the outsourcing of facility management services. Nearly a decade earlier the Royal Ottawa Hospital made the decision to outsource facility management and other related services to a private sector partner, with whom they would still have had an agreement at this time (Royal Ottawa Hospital, 2001, “Brand New Royal Ottawa Hospital Approved – Eastern Ontario Applauds Attention to Mental Health”), and significant groundwork had been laid through prior consultations with community and union leaders to understand partnerships with the private sector as a means of managing risk and leveraging private expertise where appropriate (Participant 2). The prior experiences for the hospital corporation in this area, which were noted as being positive by research interview participants, arguably would have eased in any transition towards private financing and facility management operations for healthcare in the region (Participant 2).

It was decided in 2001 that a new facility would be built adjacent to the older, existing facility. The announcement for the new hospital facilities highlighted that the Royal Ottawa Hospital would be the first privately built, operated, and owned hospital in Ontario. The hospital was announced as being developed at an estimated cost of \$95 million, with 284 beds available for occupancy as of May 2004. The existing Royal Ottawa Hospital buildings were to be demolished upon completion of the new facilities (Royal Ottawa Hospital, 2001, “Brand New Royal Ottawa Hospital Approved: Eastern Ontario Applauds Attention to Mental Health”). The decision by ROHCG and the Ministry to conduct a full rebuild of the antiquated Hospital made the project of a considerable scope and size, making it a potentially attractive project for private

vendors with a capacity to undertake design, development, and operation of the new facilities (Laird and Langill, 2005).

As of December 2001, ROHCG received approval from SuperBuild and the Ministry of Health and Long-Term Care to redevelop the Royal Ottawa Hospital utilizing a P3 arrangement (Royal Ottawa Hospital, 2002, “Critical Success Factors for the Re-development of the Royal Ottawa Hospital”). Following the December 2001 announcement that the Royal Ottawa Hospital would be developed as a P3 project, ROHCG had to work to prepare for the selection of a partner in absence of any government policy, proven best practices in Canada, funding methodologies, or work plans (Auerbach, 2007). The P3 approach required ROHCG to conduct a reassessment of current governance and management resources, given the lack of familiarity with the P3 approach for infrastructure prior to this project. This included the recruitment of a project manager to ensure that any required processes were established prior to the beginning of the RFQ and RFP process. Additionally, financial, legal, and design expertise project teams were recruited through a separate RFP process. The use of external experts was extensive, as it was in the Brampton Civic Hospital case, since it allowed those with experience in this area to contribute to the project while ROHCG staff concentrated on the central responsibilities of the hospital corporation (Laird and Langill, 2005).

A long process was subsequently undertaken to demonstrate that the P3 arrangements represented a responsible use of taxpayer funds through a VFM assessment. The VFM for this project was modeled on other examples both locally and internationally, with input provided from government officials based on public procurement experience. External financial consultants familiar with a P3 approach were also consulted (Laird and Langill, 2005). Without any major precedent provincially, the management structure for this project and the VFM was

purportedly to be modeled on the United Kingdom's Private Financing Initiatives (PFI). Positive experiences cited from other jurisdictions such as the United Kingdom helped to provide a supportive background of approaches to partnerships with the private-sector for public infrastructure, and served to inform ROHCG and the ministry through this process (Laird and Langill, 2005).

Part of the VFM for this project entailed determining what risks would be transferred to the private partner. The final estimates provided expected risk of the Royal Ottawa Hospital redevelopment and facility management services under a P3 approach in comparison to a traditional approach, integrating life cycle costs, cost of borrowing, and construction costs into an equation with a net value for both options (Laird and Langill, 2005). The categorization of risk was relatively straightforward, with risks grouped as those that the public partner would be in a better position to manage, including legal or regulatory risks; those that the private partner may be better equipped to manage, including construction timing and schedules; and finally, those that could not be effectively managed by either partner relating to external factors. The external risks, which included energy prices as an example, were to be managed by the public partner. This decision was made largely as the private proponent would be in no better position than the public partner to manage risks relating to external factors, and the transfer of such risk to the private partner would likely result in risk premiums from the private consortium and lenders (Laird and Langill, 2005). As such, as envisioned in the VFM, the main burden of risk from broader operating environment changes, including energy prices, would be borne by the public partner (Laird and Langill, 2005). A number of these risks, including debt financing risks, loss of private equity, and risks associated with fuel or other charges, while set out in the VFM, would

eventually be a subject of debate in later negotiations with the private partner, raising some questions about the function of risk assignment in the grand scheme of the project (Participant 2).

Concurrent with the development of a VFM was the creation of a broad strokes work plan and tentative project budget. As a pilot project for P3s in hospital infrastructure in Ontario, the process adopted for this project would require flexibility and a shared agenda with government, while also considering how this work may inform future projects. According to David Laird and George Langill, at this point in development of the project “it was critical to have established charge out rates for our consultants, clear and understood processes for changing work plans and budgets with clear reporting and accountability frameworks both internal to the hospital and with the government representatives” (p.73). At the conclusion of the VFM, the P3 approach was ultimately perceived as an effective and reasonable mechanism by which to move to an off-balance sheet operating and finance arrangement (Participant 2).

Much like the Brampton Civic Hospital Project, the utilization of a P3 model for the development of these hospitals, at the time of the decision, represented an unprecedented departure from more traditional models of funding and operating public hospitals in Ontario. The Royal Ottawa Hospital P3 development projects, in addition to the Brampton Civic Hospital as previously discussed, represented some of the first forays into major hospital procurement projects in Ontario utilizing this model of financing, building, and operation (Auerbach, 2007). There was some noted unease with the procurement mechanism amongst senior government executives at Queen’s Park, particularly within the Ministry of Health and Long-Term Care (Participant 1), and it was anticipated that significant pressure would be applied by organizations and individuals opposed to private-sector participation in health care in Canada to derail prospective P3 projects in health infrastructure (Participant 6). Resultantly, significant

focus was placed on communications plans early in the project planning stage. Communications were planned for engagement of the community, government, and media that emphasized the need for a new facility and the benefits of the preferred approach (Participant 6). Describing the extent of stakeholder engagement that would have occurred at this point in the project, interviewee 6 indicated that managers of the project had “...identified 85 priority stakeholders and organizations, and we developed an interview guide and a consultation guide. In those, among those 85 organizations, there were mental health agencies, partner agencies or other hospitals, there were the support groups, and neighbourhood associations where a lot of us provided care. The union was huge.” According to interviewee 6, they would have “interviewed 85 of them over the course of three months” (Participant 6). This also included hospital staff, to some degree. While, as previously mentioned, the Royal Ottawa Hospital had some prior experience with outsourcing of facility management services, regular assurances to staff were emphasized throughout the project planning stages for those in directly affected areas of facility management services and union members (Participant 2). These efforts would have been further aided by the fact that these kinds of projects were not entirely new to the region; the city of Ottawa had some experience with P3 or privatization arrangements in the past, and these kinds of projects had also been undertaken federally as well, with various kinds of engagements with the private sector having been undertaken for quite some time for large-scale projects (Participant 2).

5.2.3 Scoping the Project: Cross-Case Analysis

The Royal Ottawa Hospital and Brampton Civic Hospital were significantly different projects in terms of design and function; one interview participant detailed the difference between the two hospitals in terms of requirements, stating that the Royal Ottawa Hospital would not have required operation rooms, and was more akin to a hotel in terms of requirements. The

Brampton Civic Hospital, meanwhile, would have been a far more complicated development project (Participant 6). While the projects had many distinct design features and patient populations, both projects were developed around the same time, involved many of the same agents and organizations, and would have been subject to very similar standards and government mandates. The following section will compare some of the experiences of the Royal Ottawa Hospital and Brampton Civic Hospital in regards to the inception of the projects. This includes an assessment of the selection of a mechanism for procurement in each case, including how this decision was made, who made decisions, who was consulted, and the costing assessment for the projects versus alternative approaches.

5.2.3.1 Structure of Relationships at Project Implementation

Complexity theory understands self-organization and emergence as being an ongoing and dynamic property of organizations. In studying the Brampton Civic Hospital and Royal Ottawa Hospital projects through the lens of complexity theory, informal organization and spontaneously occurring organizational structures, leadership, processes, and events that occur outside of the formal organizational documents and policies become interesting and important (Anderson et al., 2005). The analysis of the cases in this study will provide insights into the structure of relationships at each stage of the projects, considering the key actors involved, how they interacted with one another, who and what information would have been referenced for decisions, and whether coordination and decision-making across the projects was inclusive and horizontal in nature. This involves looking at key inputs and agents not only within the formal structures of the organizations themselves, but also phenomena at or beyond the boundaries of the cases to provide a rich understanding of how these projects were managed (Anderson et al., 2005).

For both the Brampton Civic Hospital and Royal Ottawa Hospital, many of the structure and power relationships at this point were in flux at the project scoping phases, and as such this represents a particularly important stage for the fledgling pilot projects. Given the formative nature of these relationships and evolving role definition for various actors at project scoping, this section will be of significant length comparative to other sections analyzing main actors and relationships. Both hospital corporations were in a similar position at the scoping phase, due in large part to the lack of familiarity to the P3 approach for project procurement. This represented a significant challenge that, in both cases, necessitated the consulting of numerous outside experts. It also necessitated significant involvement on the part of staff from the Ministry of Health and Long-Term Care. In his testimony before the Standing Committee on Public Accounts (2009), former WOHC Supervisor Ken White noted the lack of familiarity of handling not just a P3 infrastructure project, but hospital procurement in general, as being a problem at the onset. He states, “One of the big problems was, there was no construction in health care for many, many years. Hospitals were not equipped with even basic planning skills” (Hansard Official Report of Debates, 2009, p.298). The challenges associated with a lack of familiarity with projects of this kind were echoed for the case of the Royal Ottawa Hospital. Laird and Langill (2005) noted the challenges experienced in the initial stages of this project, finding that “since a P3 approach to hospital facilities had never been done before in Ontario, the absence of policy and process created uncertainty as to how to move the project forward” (p.74). Research interview participants confirmed that as an untested approach with a lack of recent experience in health infrastructure development, there would be challenges relating to structure for the projects and the definition of roles for the actors involved. The projects would have relied on project teams with diverse experience to set parameters during the project scoping phase. One interview

participant pointed out that as “these were the first ever projects undertaken both of their nature and size, and there wasn't a template approach as there is now through Infrastructure Ontario, and so you had very unique teams” (Participant 3).

At the onset of planning for the Royal Ottawa Hospital there existed a great deal of uncertainty around the roles of various government departments and agencies as it related to the project. Ultimately, much of the responsibility for role identification and project scoping fell upon senior Ministry of Health and Long-Term Care staff along with contracted consultants (Laird and Langill, 2005). Oversight of the Brampton Civic Hospital project similarly included a major role for provincial ministries in decision-making at the project onset. There would have been a number of common policy processes applied to each project, leading to some kind of standardization throughout the procurement process. This would have been largely within the purview of the Ministry of Health and Long-Term Care (Participant 5). Both projects would have been required to go through what was considered to be an extensive capital planning process at the Ministry of Health and Long-Term Care. Design requirements would largely be determined by the hospital corporations themselves for each project, with Ministry of Health and Long-Term Care approvals required at various stages (Participant 5). According to one interview participant, the Ministry of Health and Long-Term Care would have allowed the hospitals to manage their own internal processes, while they would be bound to follow set guidelines and protocols at the direction of the Ministry (Participant 4). Research participants emphasized that a great deal of the responsibility for decision-making, role evaluation, and other aspects of the project scoping phase would have fallen upon provincial ministries for these projects, who would consult with the hospital corporations as appropriate.

In his testimony before the Standing Committee on Public Accounts regarding the Brampton Civic Hospital project, Ron Sapsford detailed the role of some of the key actors at the initial phases of the project, stating that “in this particular case, the Ministry of Health and Long-Term Care works closely with its provincial partner, the Ministry of Energy and Infrastructure, in the implementation of capital construction projects” (Hansard Official Report of Debates, 2009, p.283). In both cases, government decision-making on the part of the Ministry of Health and Long-Term care largely determined the pace and direction of the projects overall. Examples from the Royal Ottawa Hospital case point to the fact that this was particularly so in the approvals process, with all authorization of documents, including the RFP, project legal agreements, and funding requiring approval by the Health Minister prior to execution (Laird and Langill, 2005).

The relationship between the Ministry of Health and Long-Term Care and the hospital boards did not seem to exemplify what one would typically consider to be a collaborative, horizontally-managed project structure. Participant 1 noted some challenges in the relationship between the Ministry of Health and Long-Term Care and the hospital corporations that could have impeded the formation of a collaborative relationship between government and the management teams for the projects. Conflict would have arisen at this point in large part around aspects of the functional program and ensuring that the projects themselves remained within what the Ministry of Health and Long-Term Care considered to be a reasonable economic structure (Participant 7). According to one research participant (Participant 1), in the case of the Royal Ottawa Hospital, there “...was an attempt at collaboration...” but ultimately, in terms of the relationship between the hospital board and the ministry, they described the relationship as follows:

“Particularly on the Ministry’s part there was lots of passive aggressive activity. In other words, at the meetings we would agree to a certain situation, and then when it was to be implemented, it went off the table and it wasn’t happening, because I don’t think there was that degree of acceptance. In fact there was almost a sense that before the election that if the bureaucrats waited it out that a new government would come in and blow it all out. So, I think it was an attempt at a collaborative approach, but it ended up being fraught with passive aggressive activity, particularly on the ministry’s part.”

Overall, at the initiation of these projects and throughout the initial planning phases, it appeared that provincial ministries would have been the main drivers for decision-making with input, in most instances, from the hospital board, consultants, and government agencies or commissions. However, in latter stages of the project, the Ministry was not to be a signatory on the eventual project agreements or final arrangements with the private partner (Laird and Langill, 2005), signifying a designed structure wherein there is a more influential role in decision-making for the Ministry of Health and Long-Term Care staff at the project scoping phase than in other phases of the project. SuperBuild, established to foster the development of such public projects through the leveraging of minimal public capital with significant financing and development risk by private partners, would have had significant input into the P3 approach at this stage in planning, with a structured relationship both to the hospital corporations and the Ministry of Health and Long-Term Care (Laird and Langill, 2005). Research interview participants were asked to describe the relationship structure between SuperBuild and other involved parties over the course of the projects. In a general sense, the participants were in agreement that the role SuperBuild would have was not one of collaboration with hospital corporations, or what would be understood as any form of horizontal management, but instead operated as a gatekeeper with a

largely financial role. Participant 7 gave some comments about the relationship that the organization would have with the hospital corporations throughout the procurement projects. According to Participant 7, SuperBuild “...played very much a gatekeeper role, just like the Ministry of Finance. It was an extension of the Ministry of Finance. There were some very smart individuals there that looked at things from very much of a financial perspective, and that only.” In terms of the approach that SuperBuild would take towards projects such as the Brampton Civic Hospital Project or the Royal Ottawa Hospital Project, in their role as a gatekeeper, Participant 7 remarked, “Were they collaborative? I would say no, not at all. They were not collaborative with line ministries. Some individuals were, but largely they were the gate keepers. They had, at that time, no direct interaction with hospitals, nor did they have a particular depth of understanding of healthcare, because their job was to oversee every sector. So, it was a relatively small organization, so it’d be difficult to have that kind of depth. And I would say, they played the role that would be that of today like a management board role.” Overall, SuperBuild would not have had a particularly involved relationship with the hospital corporations. According to Participant 3, “the Ministry of Health during the time of SuperBuild would have very covetously guarded their relationship with the hospitals. They have not yet come to terms with the whole model, and with the fact that SuperBuild was running two transactions to establish a market response for bidders to build new hospitals.” SuperBuild would, however, have a significant advisory role to the Ministry of Health and Long-Term Care at this stage. SuperBuild was structured as an advisory to government in terms of how to establish and scope alternative financial methods and alternative service delivery methods. They would have operated as a ‘brain trust’ to help operating ministries, including health, transportation, infrastructure, or other

ministries looking for solutions to solve some of the broader capital and operational issues facing government at the time (Participant 2).

The hospital boards at WOHC and ROHCG would both have had roles at the project scoping phase, and did have input into some of the decision-making early on in the process, while the overall process and role definition would be driven by provincial ministry staff. According to Saad Raafi, “the hospital board has a say in this transaction both before the RFP and at selection, as well as the Minister of Health, under the Public Hospitals Act, in the first and last instance” (Hansard Official Report of Debates, 2009, p.298). The hospital boards created steering committees relating to proposed infrastructure development, providing leadership at the hospital level in the early decision-making process. In the case of the Royal Ottawa Hospital, a new standing committee of the hospital Board, the Expansion and Redevelopment Committee, was formed. This was a joint management and project steering committee chaired by the CEO of the hospital, George Langill. A project team office was established onsite, as well as documentation clarifying the authorities and accountabilities of the steering team throughout the course of the project (Laird and Langill, 2005).

Other government bodies would have also been consulted at this stage in the process. As previously discussed in this chapter, the HSRC had an influential role at the onset of these projects in identifying the need for health service infrastructure restructuring for both the Champlain Region and Brampton community (Auditor General, 2008; Whiteside, 2015). Additionally, throughout the projects outside consultants would have been contracted through individual RFP processes to provide expert advice on the P3 procurement method, negotiations with a private partner, and other aspects of project development and implementation (Auditor General, 2008; Whiteside, 2015).

Overall, the relationships between SuperBuild, the Ministry of Health and Long-Term Care, and the hospital boards appeared to still be in a very much formative phase as these projects started to get underway. In some ways, there appeared to be tension between the involved parties, as well. Research participants described some interesting dynamics in this relationship that reflect a number of challenges in role definition and relationship management at the onset. Participant 1 provided an overview of the nature of the relationships between some of the more significant actors at this stage, stating the following:

“SuperBuild came on the scene, they had a policy mandate from the government but they didn't have a whole lot of structure and a whole lot of practice in place. Ministry of Health had taken on this capital planning role for years, and were accustomed to a certain responsibility and control, and the first series of meetings with the other two parties, we sort of watched the dynamics between the SuperBuild, who had a mandate that wasn't clearly defined in the context of the ministries, and the Ministry [of Health], who weren't going to give up anything, and so there was a real type of war there and I think in the end of the day, [the hospital boards] ended somewhat being the mediators between the Ministry and SuperBuild, to try to guide this process so that we could get on with the project, but there was a dynamic there initially who is on first, and so that had to get straightened away and I think at the end of the day, certainly throughout our project there was a tension there.”

Other participants described some particularly challenging work that they would have been engaged in with regards to writing policy for SuperBuild at the time. The organization had no in-house experience in projects of this kind, particularly not in major health infrastructure procurement. Those involved described an onerous experience in developing construction

renewal policy with SuperBuild and the Ministry of Health to mitigate all risk to the public healthcare system in these projects (Participant 6).

The management structure for these two projects, and relationships between actors, appeared to be siloed and coordinated, at least at inception, by government ministries. There would have been little interaction between the two hospital boards, and coordination only occurred due to common processes and standards applied to both projects. Evidence seems to suggest that very little cross-project coordination would have occurred between the project teams for the Brampton Civic Hospital and Royal Ottawa Hospital. Research interview subjects were relatively unanimous in indicating that the projects would have operated in a very distinct manner from one another, with very little interaction between the two projects. While noting that these projects would have started before their immediate involvement, Participant 5 indicated that “...these hospitals would have been operated quite separately. Hospital corporations are the owners of hospitals, and so their primary responsibility for building programs lies with the hospitals and its board, and typically in Ontario the management process would be handled quite separately in engaging consultants.” Participant 3 saw the two projects as being mostly distinct, with “dedicated consulting resources, construction managements, architectures, as well as involvement by senior leadership, SuperBuild staff and senior leadership hospitals.” The projects would have “in a sense pretty distinct teams and pretty distinct approaches,” attributed in particular to the fact that the projects were two particularly unique projects in terms of scale and function; one was a mental health facility, whereas the other was to function as an academic health science centre (Participant 3).

As to whether any attempts at coordination between the hospital boards was possible, or even desirable, some interview subjects commented that there did not appear to be much will to

coordinate horizontally between the two projects. There may have been some outreach, and Participant 2 indicated that the Royal Ottawa Hospital had "...tried to create at least an information sharing discussion with William Osler and, to put it bluntly, they didn't want to go there." Interview subjects were in agreement that the management processes for the two projects would have been particularly distinct. Participant 3 noted that "...maybe the CEO's talked, but I wouldn't be surprised if they didn't for whole bunch of obvious reasons. And so, I think that really just reflects the fact that there was no pipeline being developed. These were very bespoke-type solutions and projects." Participant 4 further agreed that the processes would be distinct, stating that any discussions would have been, at most "...some informal talks between the two hospitals corporations." Further describing the management processes, and how they would have been distinct, Participant 4 explained the following: "I know that each had their own teams that were responsible for doing the management processes within each of the two hospitals."

Participant 2 indicated that any similarities between the way that project scoping, engagement of consultants, or other forms of interaction of the sort would have only occurred "[b]y fluke or by coincidence or by normal practices in engineering and retaining consultants, there would be obvious overlaps. I would be surprised if they didn't. Did we do it intentionally? No." They further added that the projects were "...separately contracted along the line" (Participant 2). As previously noted, there were some significant differences between what would be the eventual function of the two hospitals, which may have accounted for the lack of coordination or general information sharing between the two pilot projects. However, the attempts at initiating information sharing discussions suggest that involved actors may have seen some potential value in engagement at this stage.

In summary, this stage of the project appears to be characterized by guarded relationships and silos of interaction between the various public actors that would have been involved at the project scoping phase. The Ministry of Health and Long-Term Care consulted with SuperBuild on the P3 process, and maintained a relatively command-and-control relationship with the hospital corporations. The hospitals themselves would have operated as “almost bespoke-type solutions” (Participant 3) for project design and procurement, operating in a distinct fashion with little coordination horizontally across projects. Evidence does suggest that there were some attempts made at the scoping phase to coordinate and consult beyond expected hierarchical confines to engage in horizontal coordination with actors at or beyond the defined boundaries of the project. The Royal Ottawa Hospital in particular was noted as engaging a wide spectrum of priority stakeholders, organizations, union leaders, and hospital staff as part of stakeholder management and transparency initiatives (Participant 6). These kinds of initiatives did not occur as the result of a mandate or due to the direction of central management; rather, they were a product of self-organization by means of the creation of networks of interaction and engagement to include a wide array of stakeholders both internal and external to the hospital. As will be discussed later in this study, these kinds of engagements did help to add some legitimacy to the decision to pursue what was a new and untested method of health infrastructure development, and can be linked to a positive and ongoing relationship between the public sector actors and broader community.

5.2.3.2 Decision to Adopt a P3 Approach

One of the more critical decisions made during the project scoping phase for both the Brampton Civic Hospital and Royal Ottawa Hospital projects related to whether or not these projects would pursue a traditional procurement method or a P3 method. A number of key inputs would have been a factor in the decision to adopt a P3 approach that would have been common to both cases. In particular, it appears that much of the central leadership on the part of the Ministry of Health and Long-Term Care and SuperBuild explicitly guided or mandated the projects towards the consideration of a P3 approach to procurement; however, evidence suggests that this likely occurred out of necessity as a result of the province's financial realities.

The creation of SuperBuild, a 'proto-enabling' field for the promotion of alternative service delivery, would have had a significant influence on the decision for Royal Ottawa Hospital and Brampton Civic Hospital to pursue a P3 as opposed to a traditional capital funding grant for building the new facilities (Whiteside, 2015). In discussing the decision to adopt a P3 approach for the Royal Ottawa Hospital, Laird and Langill (2005) noted that "with the development of SuperBuild in Ontario, the timing was right to consider this approach in the healthcare arena" (p.71). SuperBuild had a specific mandate for health infrastructure that related to working with the Ministry of Health and Long-Term Care and other health care providers to explore the potential for P3 partnerships for capital projects. In their December 2000 progress report, SuperBuild outlined this approach under the "Encouraging innovation and accountability" subsection of the report, noting that:

"Building on the foundation laid by the Health Services Restructuring Commission (HSRC) and other health care reforms, SuperBuild will encourage even more

innovation in the way hospitals and other health care facilities are planned and built.

We will work with the Ministry of Health and Long-Term Care, hospitals and other health care providers to explore the potential for public-private partnerships for capital projects and to address barriers to this approach” (Ministry of Finance, 2000).

The Auditor General’s 2008 report, as well as subsequent interviews with key actors in follow-up to this report through the Standing Committee on Public Accounts, offered a much simpler explanation as to why the WOHC project ultimately pursued P3s for the development of the Brampton Civic Hospital. According to the 2008 report and accounts by key actors at WOHC, the government at the time directed the WOHC to consider an approach that utilized a public-private partnership prior to conducting any assessments of the merits of this approach, versus traditional design-build-operate methods. This was purportedly as a result of a decision by the government in 2001 that P3s must be considered prior to commitment for funding of new hospitals (Standing Committee on Public Accounts, 2009). This directive was issued vis-a-vis a letter to WOHC in February in 2002 indicating that a P3 model for the project must be utilized, and that other options that deviate from the P3 model could not be considered for the development of the hospital. This letter was cited by Ron Sapsford in his testimony before the Standing Committee on Public Accounts (Hansard Official Report of Debates, 2009), and was also referenced in the Auditor General’s 2008 Report. According to the Auditor General, the decision to utilize a P3 procurement approach was made largely at the behest of the government of the day. According to the Auditor General (2008), the “WOHC did not have the option of choosing which procurement approach to follow. Rather, it was the government of the day that decided to follow the public-private partnership (P3) approach” (p.104).

Research interview subjects offered a different explanation as to the key inputs pertaining to a decision to adopt a P3 approach that seems to reflect some of the more common justifications as to why governments would consider a P3 approach, as demonstrated in the literature; as a means for government to raise capital for infrastructure investment while maintaining some austerity (Vining and Boardman, 2008). Based on the responses provided to questions regarding the decision to adopt a P3, with reference to the directive on the part of the Ministry of Health and Long-Term Care, interview subjects generally pointed to a lack of available capital as being the main impetus for adopting a P3 approach. Participant 3 did not attribute any significant importance to a specific directive from the Ministry of Health and Long-Term Care relating to P3 projects, further stating that “I don't think a directive comes out in any ministry that just wholesale says, you will all do P3s.” Participant 2 acknowledged the possibility of a letter or directive being issued, but stated that regardless of any directive, “...the process was already leaning towards this happening. There was no way the Government of Ontario could afford fixing up the infrastructure for health. I think there is an \$8 or 9 billion shortfall at that time, they had a \$300 million budget as I recall and we evidenced the way to get out of it.” In describing the impetus to adopt a P3 approach for the Royal Ottawa Hospital and Brampton Civic Hospital, Participant 7 agreed that the main justification related to the lack of availability of capital, stating: “...the economic landscape was such that; number one, there wasn't a lot of capital dollars around. And number two; there was a major deed to renew stock in terms of healthcare facilities in Ontario; so clearly, not a political platform.”

5.2.3.3 Value for Money Assessments

One of the (numerous) distinguishing facets of these two pilot P3 hospital projects related to how VFM benchmarks were undertaken. Both projects initially would have used a public

comparator to demonstrate value for the P3 approach for the projects. Eventually, these projects moved away from a public comparator and key decision inputs were increasingly structured on the PFI model from the U.K., which relied upon mandatory value for money assessments as a framework for the justification for using private financing (Participant 3). This would provide critical information for senior staff in government, particularly in the early process wherein the projects would need to seek the approval of Cabinet. As structured for these two projects, neither project would proceed past approvals through Cabinet if it was unable meet the requirements of a very complex VFM benchmark (Participant 7). The VFM processes for these two projects represented the first attempts at such benchmarks in Ontario. As detailed by Participant 7, “we actually designed the process from scratch, you could say, for made in Ontario P3. We did that by reviewing other jurisdictions, most notably the U.K., and then making it appropriate to the Ontario healthcare system.”

Project scoping for both projects was, overall, an extremely extensive process. Government expenditures into the health sector were significant at the time (and continue to be so) with particularly extensive capital planning exercises (Participant 3). According to Participant 7, the decision-making process would have involved consultations and horizon scanning, including “...looking at the U.K., other jurisdictions, how they went about it. And then obviously, the Minister of the day needed to lead that process. There was a lot of consultation and agreement and discussion at the highest levels; so, Cabinet, Management Board or Treasury Board, whatever they’re calling it these days, but also with a constant view to we need to demonstrate these projects are viable for Ontario with a lot of accountability in place.” Resultantly, both projects would have conducted VFM analysis during the course of the project planning stages. In the case of the Brampton Civic Hospital, however, while the Ministry of

Health and Long-Term Care did direct the hospital board to commission a VFM assessment of the P3 arrangement versus traditional procurement methods, evidence suggests that these considerations were not a significant factor in the decision to adopt a P3 arrangement for the project. As context, the VFM represents one of the more significant assessments in the decision to pursue a public-private partnership arrangement such as that of the Brampton Civic Hospital or Royal Ottawa Hospital. A VFM is a comparative analysis of the total project costs expressed in dollars measured at a particular point in time. The difference between the costs for the public sector comparator cost, or in this case traditional procurement method cost, and the adjusted estimate of the anticipated private party bid for the particular project, is referred to as the value for money. Positive VFM analysis for a project such as this would entail a lower total projected cost in dollars for the anticipated private party bid¹⁷ than the public sector comparator (Infrastructure Ontario, 2007). These forms of analysis are common globally, and are an oft used comparator for the cost of pursuing a public-private partnership project versus that of utilizing a more conventional procurement method (UK Treasury, 2006).¹⁸ The VFM is intended to provide a valid comparison of options for decision-makers, clearly demonstrating whether there was any validity in assumptions that a public-private partnership would be better suited to this project than public sector financing and control of non-clinical operations (Auerbach, 2007). According to the best practices of the United Kingdom Treasury in their VFM Guide (2006), value-for-money assessments should take place at the earliest practical stage of the decision-making processes. This allows departments the capacity to pursue alternative routes of procurement in the instance that the P3 approach does not offer the best value for money.

¹⁷ The anticipated private party bid may also be referred to as a 'shadow bid' (Infrastructure Ontario, 2007)

¹⁸ For many jurisdictions including the United Kingdom, best practices for contracts of this size call for the organization to perform a cost/benefit analysis of a range of alternative procurement models, allowing the best value for money option to be selected (UK Treasury, 2006).

According to one interview participant, some of the preliminary risk assessments for the projects would have also been included in the VFM. The risk assumptions detailed within the VFM developed a baseline that, ultimately, public and private partners would have the opportunity to “attack, accept, or reject” during the RFP and negotiations process (Participant 3).

As noted by the Auditor General, this assessment was issued after WOHC had begun work on the functional plan and program for P3 approach to the project, and based on the timing of when the VFM assessment was issued, a VFM was not completed until around the time the first stage of the RFP was issued in November 2002 (Auditor General, 2008). WOHC began the preparation of a VFM benchmark to ensure the validity of the proposed public-private partnership project, and the VFM was to estimate the costs of both infrastructure development for the hospital and costs for the provision of non-clinical operating services. All of these costs would be compared to the same expenditures expected for a conventional, publically-funded model (Auerbach, 2007).

First estimates of what the project would cost under a traditional design-build-operate procurement approach were not provided until after the evaluation of the bidders who had responded to the first stages of the RFP. The Ministry’s initial review of this comparative analysis was not finalized until sometime after that (Auditor General, 2008). WOHC began to update their estimates of a traditional design-build-operate approach in November 2004 as a result of delays in the finalization of the project agreement, after the preferred bidder had been selected and negotiations with the potential private partner mostly concluded (Auditor General, 2008). A final updated review by the Ministry was completed in January 2005. This was two months after WOHC had already executed an agreement with the selected bidder, The Healthcare Infrastructure Company of Canada (THICC). According to the Auditor General

Report (2008), management at WOHC was unaware of the fact that the Ministry had produced an updated report when this fact was brought to their attention.

Both the initial and updated estimates of VFM indicated that a P3 arrangement would provide a better value to WOHC overall and be more favourable than a traditional procurement approach (Auditor General, 2008). According to the Auditor General's report, however, there were limited opportunities by the time WOHC commissioned the VFM assessment for the Ministry for WOHC to consider alternative procurement options or to make any meaningful improvements to the arrangements agreed upon for the development and operations of the hospitals by the private partner (Auditor General, 2008).

The Auditor General report indicated that initial assessments may not have been as robust as is required for a project of this scope, and a number of relevant factors may have been considered too late in the project lifecycle to render any significant changes or improvements in the procurement process (Auditor General, 2010). According to the Auditor General Report (2008), there were a number of concerns relating to the reference point of the WOHC assessment against which the Ministry assessed the reasonableness of bids received. In particular, there was a lack of formal assessment based upon a business-case analysis of the criteria for procurement to ensure value for money for the selected procurement option. Furthermore, the VFM for the project did not include any formal analysis of the likelihood or impact of potential risks, including cost overruns. Risk transferred to the private sector is oft touted as one of the more beneficial aspects of the P3 approach. Identifying potential risks with a project, particularly those that may be taken on by private partners in a P3 arrangement, would have helped to indicate how a P3 arrangement mitigates risk exposure for public sector partners. According to the Auditor General (2008) in the case of the Brampton Civic Hospital, "a proper business-case analysis

would have required much clearer evidence that significant cost overruns were likely if WOHC managed a traditional design-and-build approach” (p.109). Without this information, the VFM assessment, and purported benefits of the P3 arrangement for this project become less clear in review. Additionally, the Ministry did not conduct any formal assessments of cost differentials between public and private financing as part of the VFM exercise. A significant component cost, regardless of the approach taken for a procurement project of this scale, is the cost to finance the project. The Auditor General (2008) noted that the government may have been able to secure a lower financing rate by virtue of the credit rating of the government of Ontario. However, the cost of capital in developed countries can be assumed to be lower, generally, for the public sector. It may be expected that, over the course of the service agreement for this project, efficiencies in operations and maintenance undertaken by the private sector as part of the agreement could offset higher capital costs incurred at the onset, thereby resulting in lower costs overall over the 25-year timeframe for this project (Barrows et al., 2012). Without a formal assessment comparing financing costs between traditional and P3 procurement methods, there was little analysis to indicate whether or not any additional costs associated with private financing would be offset by risk transference to the private sector as part of the arrangement (Auditor General, 2008).

As a final point, in both cases, the VFM results themselves were not published with the RFQ or shared with applicants. Purportedly, the VFM was not published to ensure that cost-effective solutions were proposed, and to prevent vendors from bidding against the published benchmark. However, in practice this resulted in potential applicants not knowing the budget range they were expected to work within for this project, and ran the risk of the submitted proposals exceeding the VFM that had been conducted (Auditor General, 2008; Laird and

Langill, 2005). This characterized the aforementioned guarded relationship that would have existed between public and private partners at the earliest stages of these projects. Information was shared sparingly. In the case of the Royal Ottawa Hospital, as will be discussed, one proponent was eliminated at the RFP stage due to issues with the proposal, further limiting the number of qualified applicants to compete for the project. Dissemination of the VFM and providing clear business requirements to proponents, as well as providing a preliminary submission review process, could have avoided this issue and ensured a more robust and competitive RFP with additional vendors.

5.3 Selection Process

Following the scoping of a project, project teams will establish a strategy for the selection of a private partner. The selection process would be developed and documented for accountability. Often, selection processes may include elements of common organizational procurement policies. However, in the case of a P3 procurement, “the general policies are often inappropriate for a P3 arrangement and, therefore, it may be necessary for the project team to develop tailored process documentation” (SuperBuild, 2001, p.17).

According to the SuperBuild guidance materials, the process framework for a vendor selection for a public-private partnership process will include the stages of the selection process; the process for conduct of bidder briefing sessions; the process for response to questions or issues raised by bidders; security procedures and confidentiality; and conflict of interest policy (SuperBuild, 2001). The following section will detail the process framework for each project, as well as the experience of the hospitals throughout the selection process.

5.3.1 Selection Process: Brampton Civic Hospital

With initial costing estimates completed and project agreement granted, WOHC began what would be a multi-stage RFP process. Following the initial estimates and concurrent with the development secondary cost estimate considerations for the project, a competitive four-stage selection process was initiated in November 2002 to determine a suitable vendor for this project. WOHC retained an accounting firm throughout the RFP to observe the selection process and ensure that WOHC conducted a fair, competitive RFP (Auditor General, 2008). This selection process began with a Request for Expression of Interest (RFEI), wherein companies or consortia interested in applying could indicate as such to WOHC. At the RFEI stage, twenty-three companies/consortia provided an application. This was followed by an RFQ, wherein four parties responded with statements of qualifications (Auditor General, 2008).

Following these preliminary stages, the actual RFP for this project was in two stages. At the Stage 1 RFP, four vendors provided detailed submissions, including bids. Based on scoring, two of these vendors proceeded to the Stage 2 RFP, where they resubmitted their proposal with revisions based on feedback from WOHC. Both a preferred proponent and reserve proponent were selected from the RFP process (Auditor General, 2008). Bids were accepted for a proposed 28-year term agreement. This included 30 months for design and construction, along with a 25-year service period. The bids comprised of cost plus demonstrated capacity of the vendor to deliver on WOHC requirements for design and construction, non-clinical services, and financing costs including interest paid on loans and dividends (Auditor General, 2008).

5.3.2 Selection Process: Royal Ottawa Hospital

The competitive procurement process utilized by ROHCG to select a private partner for the development of the Royal Ottawa Hospital has been described as a “five step” process, as will be elaborated here. However, it is noteworthy that the selection process was undertaken with only two distinct stages, namely an RFQ and RFP (Royal Ottawa Hospital, 2002, “Request for Proposals Issued for the Re-development of the Royal Ottawa Hospital - Milestone Brings New Facility One Giant Step Closer”). As previously noted, the Ministry encouraged the hospital early in the RFP process to acquire the services of a process auditor to ensure the integrity of the vendor selection process. Given that this was a pilot process with evolving methods not necessarily reflected in the current government policies or practices, a process auditor would provide “monitoring of ongoing events [and] a source of advice and counsel to both the hospital and government on a proactive, ongoing basis” (Laird and Langill, 2005, p.74). Research interview participants stressed the focus on communications and outreach planning and strategy early in this process by ROHCG, along with consultations with broad groups of stakeholders in advance. These actions, according to participants, were undertaken in anticipation of opposition from health sector stakeholders and unions, and due to an early legal challenge questioning the authority of government to utilize a P3 approach for the development of a public hospital.

The RFP process for the Royal Ottawa Hospital was similar in many respects to the competitive RFP process for the Brampton Civic Hospital, however lacking the broader RFEI stage and operating under a far more confidential process (Whiteside, 2015). This included an RFQ stage, and an RFP stage. Initially, an RFQ would be utilized to scope potential consortia qualified for the project. On June 13, 2002, the ROHCG issued the RFQ. This first stage entailed soliciting submissions from interested private vendors for the development, construction, and

operations of the Royal Ottawa Hospital. The RFQ required potential applicants to demonstrate their capacity to design, build, finance, operate, manage, and maintain the proposed health care facilities (Auerbach, 2002). Effectively, this stage would provide the ROHCG some idea of the general market readiness for a competitive procurement (Laird and Langill, 2005). It was believed that a minimum of three qualified proponents were required from the RFQ stage in order to ensure a competitive market that could support a P3 project of this kind. If three proponents had not provided responses to the RFQ, ROHCG would have reached out for interviews with parties that had not responded in order to gain additional insight into what aspects of the project led to their decision, and what could be changed to grow their interest in the project (Laird and Langill, 2005).

From the list of RFQ applicants, a list of consortia deemed to be qualified would be invited to the next stage of the process. The selection for qualified vendors was determined by a vote by the hospital Board after reviewing the RFQ submissions (Royal Ottawa Hospital, 2002, “Royal Ottawa Hospital and Three Consortia Move to next Step of Innovative Re-development Project”). As of September 19, 2002, three of the RFQ applicants were deemed qualified by ROHCG and were invited to respond to an RFP as the next stage of the process (Auerbach, 2002). The selected consortia were then invited to develop and submit proposals to meet the specifications for facility development, leasing, operations, and management. These three consortia included Access Health Ontario, THICC, and the Ottawa Healthcare Group (Royal Ottawa Hospital, 2002, “Critical Success Factors for the Re-development of the Royal Ottawa Hospital”).

As of December 13, 2002, ROHCG issued an RFP to the three qualifying consortia. Proposals for the RFP process were submitted prior to an established deadline of February 2003

(Royal Ottawa Hospital, 2002, “Critical Success Factors for the Re-development of the Royal Ottawa Hospital”). At the beginning of the RFP stage, one of the applicants was eliminated as the design submitted for the RFP failed to meet the output specifications set by ROHCG for the project. In their review of this aspect of the RFQ process, David Laird and George Langill (2005) hypothesized that “this issue might have been averted if proponents were afforded the opportunity to submit a preliminary design at the RFQ stage and to receive preliminary feedback before submitting the formal proposal” (75).

The RFP itself was designed to outline details of the actual design of the site that ROHCG intended to buy, set the format and required content for submissions, and detail the evaluation process for transparency (Royal Ottawa Hospital, 2002, “Critical Success Factors for the Re-development of the Royal Ottawa Hospital”). According to the former manager of the Royal Ottawa Hospital, Mr. Graham Bird, the terms and output specifications of the RFP were also designed to prevent escalation of lease costs from rising over the length of the agreement, and ROHCG would be able to “project over the entire length of the partnership what our costs will be, which means we will not be adding extra costs to the taxpayer as time goes on” (Royal Ottawa Hospital, 2002, “Request for Proposals Issued for the Re-development of the Royal Ottawa Hospital - Milestone Brings New Facility One Giant Step Closer”). Proponents were to be rated on their ability to meet a number of criteria as set for the RFP process. The criteria related to the actual outcomes and deliverables expected to be delivered by the proponents for the purposes of design and construction, services, management and governance, and financial management over the course of the project. Based on scoring according to the RFP criteria, a preferred proponent was selected. At the end of the selection process, THICC was selected as the preferred vendor for this project. As noted, this is the same consortium that was selected for the

Brampton Civic Hospital, composed of Carillion Canada, Borealis Infrastructure Management, and EllisDon Corporation (Carillion Canada, “Case Study: Royal Ottawa Hospital”). The second rated proponent, and only other viable proponent in this case, was retained as a backup vendor as contingency should ROHCG be unable to conclude a transaction with the preferred vendor (Royal Ottawa Hospital, 2002, “Critical Success Factors for the Re-development of the Royal Ottawa Hospital”).

5.3.3 Selection Process: Cross-Case Analysis

There were a great deal of similarities between the RFP processes utilized for the Brampton Civic Hospital and Royal Ottawa Hospital projects, owing in no small part to the fact that the two operated under a similar accountability framework for the structure of procurements of this size; this necessitates certain requirements for procurements, as described in Section 5.1 of this chapter, for information dissemination, compliance with trade agreements, and use of electronic tendering systems, as well as a best practice of including a minimum of three vendors for such procurements (MBC Procurement Directive for Goods and Services, 2003). Both projects utilized a multi-stage RFP initiated with an initial RFQ to solicit potential bids from interested vendors.

In both cases, the requirements for the RFP were largely set out during the creation of the function plan and program for the projects. As stated by Saad Raafi, “the project specifications that the hospital is required to have in place are critical up front, because they determine what elements will be required of the bidder, and that goes right into the RFP documents” (Hansard Official Report of Debates, 2009, p.291). According to Laird and Langill (2005), in the Royal Ottawa Hospital project, the functional plan and program for the project similarly represented the

foundation of the eventual RFP. Overall, in each case this phase of the project set a clear understanding to bidding vendors as to what kind of a project they are bidding on, which subsequently “also puts in a very definitive and high set of discipline once the project proponent has been selected, such that the changes in scope have a great deal of significance and are quite limited in the opportunity to change scope” (Hansard Official Report of Debates, 2009, p.291).

The selection processes for the two hospitals differed significantly in terms of the levels of confidentiality for the process overall. WOHC was noted as issuing a much broader RFEI prior to the initiation of the RFQ stage, eliciting responses from a wider selection of potentially interested vendors (Auditor General, 2008). The selection process for the Royal Ottawa Hospital, in comparison, was much more opaque, including only a two-stage RFQ and RFP process with bidding and negotiation kept largely out of the public eye. This, at the time, was justified by the hospital board as a means to ensure a strong competitive process defined by fairness (Whiteside, 2015).

5.3.3.1 Key Actors in the Selection Process

Complex network theory approaches to public governance posit that horizontal orientation and inter-organizational coordination provide a potential approach for public organizations to manage uncertain developments and risk (Wagenaar, 2007). The capacity of a public organization to manage for risk within a complex operating environment is dependent upon its ability to activate agents and utilize the skill and knowledge of these agents and conduct joint fact finding and consensus building through coordinated interactions (Klijn and Teisman, 2006). As this stage in the procurement process would have entailed increasing interactions with private vendors, consultants, and other agents external to government, analysis will focus on the

capacities by which the two projects engaged external agents to provide feedback into the project requirements, and to what degree these engagements would have influenced the final project design.

Project planning documentation and outputs that would enter into the RFP would be determined at this phase of the project largely by the hospital boards. The hospital board would work to develop specific project specifications for the RFP, with final approval of the RFP going before the Minister of Health (Laird and Langill, 2005; Hansard Official Report of Debates, 2009). Unlike in the case of WOHC, wherein the Ministry of Health would continue to have a leading role and significant influence through the selection process, it did appear that ROHCG had a much more involved role in driving the selection process, due in part to their prior experience with contracting out of non-clinical care (Whiteside, 2015).

According to the SuperBuild guide (2001), “given the range of issues that may arise in a complex process, the authors of the process need to possess considerable experience in similar undertakings. The public sector must employ the right mix of internal and external experience” (p.17). As with other stages in the process, external consultants were involved at the selection stage. Unique to this stage of the process, external auditors were retained for this project phase by both hospital corporations to ensure a fair, competitive selection process. Given that much of the process of managing these procurements was not reflected in current government policy or practice, Process Auditors would be required to monitor vendor selection. WOHC retained an accounting firm, tasked with monitoring the selection process and ensuring that “the process was designed and conducted in a manner that was fair to all potential, successful, and unsuccessful respondents. The firm concluded that, despite some variances that it noted, overall the process was fair to all respondents” (Auditor General, 2008, p.116). ROHCG similarly employed a

Process Auditor to ensure integrity of the selection process. According to Laird and Langill (2005), “this proved to be a value added decision, providing not only the effective monitoring of ongoing events but a source of advice and counsel to both the hospital and government on a proactive, ongoing basis” (p.74).

The private sector would have been fairly involved at this stage, included in consultations, and providing input into the projects throughout the procurement phase to varying degrees. Participant 7 indicated that engagement of private partners would have happened extensively in terms of output specifications for both projects. The development of output specifications relies upon input from the users if such specifications are to ultimately be successful (Participant 7). Participant 3 detailed that in regards to consultation at this stage, private partners would have “been given a chance to comment on notional design or general output specification. They would have had input, and notional designs would have been provided, and design would have been rated and evaluated as part of an overall technical and valued of bid.” One research participant described guarded relationships on the part of both parties during the request for information (RFI) stage evolving into a more open series of consultations as the RFP was developed for the projects. Public partners would submit the initial RFI, attempting to gauge costs for the project and providing information general to scope and a number of prescribed elements. The private sector would also have been guarded at this point, reportedly “speaking in tongues” (Participant 3) in initial interactions and during bidders meetings as not to disadvantage their competitive position. Private and public partners would follow this up with confidential meetings wherein more specific requirements and details would be shared. The results of these meetings and discussions would form the eventual development of an RFP, informed through consultations between public and private partners (Participant 3).

This describes the development and evolution of networks of interaction between public and private partners at the earliest stages of the project, wherein additional information is shared by both partners in a gradual fashion as relationships are formed and, ultimately, influences the content and structure of the RFP that is issued. Some participants noted that, in their experience, attempts at engagement at this stage may not have been as successful as they had initially been intended, largely because there were a number of mandatory requirements that would have been required in health care delivery. They did note that there was significant creativity stemming from private sector input in terms of ancillary revenue platforms, as opposed to health infrastructure design (Participant 7).

The Royal Ottawa Hospital group appears to have had some particular success in engaging private partners and capitalizing on the expertise of the private sector in terms of project design and requirements. As stated, the interpretation of the functional plan in both cases led to the actual outputs for the development of the project by individual vendors that are utilized for the evaluation of proposals as part of the RFP process. While the public sector is noted as being good at indicating particular required design features or other conditions, they have struggled in gauging private bidder interests and building capacity for creativity into the vendor bidding process. The SuperBuild guide (2001) notes that “in general, public organizations are quite good at enumerating their own requirements, but quite weak at thinking like a bidder” (SuperBuild, 2001, p.17). The hospital board appeared to have operated under assumptions that working with a private vendor should entail a much less prescriptive approach than would be expected for traditional build-design-operate procurement methods. For the project plan for the Royal Ottawa Hospital, fewer prescriptive specifications were included as to allow for maximum creativity on the part of private partners in the design response. According to Participant 1, “...it

was about 18% or 20% of our specs that were prescriptive, and they were mainly around security issues, the rest were more enabling allowing the private sector to come up with an innovative solution.” As stated, while prescriptive elements remained pertaining to security and safety, overall the project plan differed significantly from what would be expected for a traditional procurement approach. Output specifications for private partners were developed in collaboration with clinical and support teams, whose focus was to envision some of the desired outcomes for the project, rather than specifying particular solutions or dimensions for the new hospital (Participant 1). Participant 6 described consultations and engagements with architecture firms hired as part of what would be the private consortium that would design, build, finance, maintain and operate the building, and also consulting with a compliance architecture firm to ensure that the correct output specifications were included in the functional design for the hospital. These firms would consult with staff extensively and determine critical requirements in terms of space, form, and function, as well as other desired features for the building. These consultants would ultimately be responsible to the public project managers, and would report suggested outputs back for consideration and incorporation into the functional plan (Participant 6).

Participant 2 described a number of different areas of input wherein private partners would have had some input into the functional plan for the Royal Ottawa Hospital, and the general thinking around design. This included separating research and administrative facilities in design due to noted differences in costs related to building codes for different kinds of facilities that may not have initially been recognized by the Ministry of Health and Long-Term Care. Additionally, private vendors would have shared their experiences related to some common issues for mental health units, compliance with the Corporations Tax Act, and other aspects of

output and performance specifications wherein the private sector would have had some level of specialized knowledge to benefit the project (Participant 2).

5.3.3.2 Market Assessments

Given that the P3 process in Ontario was relatively new at the onset of the RFP stage for both the Royal Ottawa Hospital and the Brampton Civic Hospital, some challenges were experienced in relation to market readiness for the projects. Both cases saw only a small selection of bidders at the RFP stage (Whiteside, 2015; Auditor General, 2008), thereby challenging the notion that the AFP procurement process would assist the public partner in securing the lower prices and innovative thinking expected through a market-oriented approach (Murphy, 2008).

In the case of the Brampton Civic Hospital, the lack of formal analysis of market capacity and whether the market itself was competitive enough to support a P3 arrangement was a major concern noted in the Auditor General's 2008 report (Auditor General, 2008). As noted in the recommendations of the Auditor General's 2008 report, at the time when the Brampton Civic Hospital project was undertaken, there appeared to be only a limited number of contractors that were capable of undertaking a large hospital infrastructure project of this kind. Consequently, market readiness appeared to be an issue in this project, as there were a limited number of companies qualified to submit a bid, as reflected in the small number of actual bidders qualified for the Stage 1 RFP (Auditor General, 2008). These observations are conceivably applicable to the Royal Ottawa Hospital case, as well, given that both projects would have drawn from the same pool of potential vendors.

The RFQ, in both cases, appeared to serve as the only major assessment of market readiness for the projects (Auditor General, 2008; Laird and Langill, 2005; Whiteside, 2015). While the RFQ would provide an idea of the full scope of vendors equipped or interested in entering into a partnership of this kind and at this scale, there did not appear to be a broader assessment of market readiness conducted. The RFQ itself appeared to be the main mechanism to test the market readiness for a project such as this, and market readiness was deemed sufficient based on meeting a threshold for the minimum number of applicants at the RFQ stage. As stated by Laird and Langill (2005), “we believed that without a minimum of three qualified proponents we could not depend on a competitive market to keep costs down” (p.75). While three applicants were contacted at this stage, thus meeting the minimum, some contingency mechanisms were considered, as ROHCG “would have considered interviewing parties that had decided not to respond to find out why and what if anything could be changed to increase their interest” (p.75) if the minimum number of qualified applicants had not been met (Laird and Langill, 2005). However, given that one of the applicants was deemed incapable of meeting the demands of the project entering into the RFP stage, it is questionable how competitive the market was for projects of this kind in Ontario, or what benefit could have been derived from the competition of the few applying vendors.

The Auditor General speculates that the bundling of design and construction with non-clinical services in the P3 arrangement for the Brampton Civic Hospital, an observation that would similarly apply to the Royal Ottawa Hospital, may have further limited the market readiness of this particular project (Auditor General, 2008). Major projects of this kind are often highly complex and suffer from significant uncertainty around future usage and future willingness-to-pay or use of facilities. Large public infrastructure projects may be of sufficient

complexity to the point where few alternative private-sector partners are deemed capable of meeting the needs of the public partner. The number of choices in the private market for construction, maintenance, or operation of a facility, let alone a consortium that is capable of accomplishing all required tasks along with financing, can be significantly limited, thereby limiting the benefits achieved from competition that would be expected from a robust private market (Vining and Boardman, 2008).

The Auditor General Report (2008) notes that the lack of a formal market assessment in the Brampton Civic Hospital highlights the “need for a detailed readiness assessment that would identify risks to successful delivery and appropriate mitigation strategies” (p.106). Additional horizon scanning, with a particular focus on the readiness of the private market to deliver a project of this scale, may have been warranted in these cases. The Auditor General (2008) recommended that projects of this kind include a thorough assessment of the private market before any RFP is undertaken. As such, one of the key recommendations from the Auditor General’s 2008 report indicates that “before a decision is made to enter into an AFP arrangement, a comprehensive market assessment should be carried out” (p.120).

Participant 7 offered a contradictory report of the assessments of private market readiness that would have been undertaken in relation to the two P3 projects. In terms of an assessment of how robust the private market was, and whether or not it would be sufficient to support the proposed P3 approaches, they indicated:

“We did that with the help of obviously people outside of government that knew a lot more about the landscape, the market landscape than we did. And there was that assessment, and there was the whole idea of are you going to have the big developers

come to the table and we assess it, that was true. We talked to some equity holder experts and equity holders, ‘is there something that you would be interested in or that you would buy into?’ You know, and we did lot of the ratings as well. It was very clear that this was attractive to the market.”

Interview data suggests that some level of consultation and horizon scanning would have occurred as led by the Ministry of Health and Long-Term Care. Individual market assessments following the development of design and business requirements at the RFP stage on the part of the hospital corporations, however, do not appear to have occurred at all, and they may have relied upon information available from the Ministry assessment. In any case, assessments seemed to indicate that the private market for these kinds of projects was sufficient to support the two pilot P3 projects. Ultimately, however, very few qualified respondents existed at the RFP stage and both projects selected the same private vendor; this appeared to be much less than would be expected of a competitive, robust private market.

5.4 Negotiations

Following the selection of the preferred proponent, negotiations are commenced relating to the various aspects of the agreement to be applied over the term of the partnership. This phase of the project occurred as the planning phases of the project were to be brought to close prior to execution, and entailed reaching agreement between public and private partners that included stipulations regarding service level standards, performance penalties, and other commitments (SuperBuild, 2001).

Negotiations between public and private partners are a critical juncture in the establishment of a public-private partnership, and as such significant attention is paid to the following section in terms of the depth of analysis comparative to other sections. This section will outline the negotiation process in both cases, and then provide analysis as to who was consulted during the negotiations process, how competing interests were managed, as well as consideration for changes in the broader operating context in the province during this time.

5.4.1 Negotiations: Brampton Civic Hospital

Following the review of proposals and selection of a vendor through the competitive RFP selection process concluding in April 2003, WOHC began the negotiation process to produce an agreement with the winning vendor, THICC. This company represented a consortium of three companies responsible for both construction and operations, while WOHC would remain the sole provider of clinical patient care services. Ellis Don was to operate as the construction contractor, whereas Carillion Canada Inc. was to manage non-clinical services upon the opening of the hospital. Borealis Infrastructure Management Inc.¹⁹ represented the final private partner in the THICC consortium (Borealis, 2003). THICC's winning bid indicated that the amount to design and construct the new hospital would be a total of \$427 million (Auditor General, 2008).

Entering into negotiations between the public and private partners, the agreement for the project would relate to the entirety of services to be provided by the private vendor: both the construction of the land and buildings and operational services provided by the private partner (Hansard Official Report of Debates, 2009). The hospital worked with a team of design consultants to craft performance specifications for the project. Much of the functional program

¹⁹ Borealis Infrastructure Management Inc. is an infrastructure management company wholly owned by the Ontario Municipal Employees Retirement System (Borealis, 2003).

and clinical hospital requirements would have been determined between the hospital and the Ministry of Health and Long-Term Care before the RFP was put out to market. Overall, there did not appear to be a great deal of input of the private partner into this process for the Brampton Civic Hospital project. As described by one research interview participant, design requirements were developed as output or performance specifications, falling into three categories: an ‘essential’ category (prescriptive design elements, including mechanical and electrical design features, or room sizes), a ‘required’ category (these allowed the private sector consortium some leeway to come up with two or three equivalent manners in which design intent could be accomplished); and, ‘permissive’ design specifications (very general and allowed the most leeway to the private sector consortium to come up with their own design solution). Most of the ‘permissive’ design specification category would not have any direct impact on the delivery of clinical services, and generally speaking the majority of design requirements for the project were more prescriptive (Participant 8).

With many of the functional requirements for the project already set, the negotiations leading to the agreement between WOHC and THICC would revolve around the development of benchmarks and service standards for the design, building, and financing of a new 608-bed Brampton Civic Hospital over a three year period, as well private sector input into the design of project delivery of a number of non-clinical services upon the completion of the construction project for a 23 year period. This included housekeeping, laundry, patient transport within the hospital, food, security, and maintenance (Auditor General, 2008). The agreement in its entirety was to be for a 25 year period with monthly payments from WOHC over the course of the service period, beginning as of the completion date of construction of the hospital (Auditor General, 2008).

The main agreement, or project agreement, between WOHC and THICC entailed provision of the facility, with a contract for design, building, and maintenance along with ancillary services. It would include an operating budget and structure for payments over the course of the agreement. In addition to this, a number of underlying agreements exist between the various partners involved as part of the overall transaction. This includes a lease between the hospital corporation and THICC as a leaseback to WOHC. According to WOHC supervisor Ken White, structuring the leasing provisions through a leaseback provides THICC with some interest in the facility for which they are a lender and operator, given that they are afforded the ability to levy service fees as required as part of their operations. The leaseback arrangement provides the hospital corporation with the right to occupy the premises short of its own default (Hansard Official Report of Debates, 2009).

According to the negotiated agreement, payment was to be made by the Ministry in an aggregate lump sum payment, referred to as a unitary charge or payment. This payment is calculated in accordance with a 200-page financial model, as referenced in the agreement. There are a number of line items in that model which provide a break-out figure of the multitude of components that comprise the unitary charge. This can include components such as the payment for the construction of the facility within the first three years, financing costs associated with design and construction, and for operational services provided on a day-to-day basis in support of the clinical operations of the Brampton Civic Hospital (Hansard Official Report of Debates, 2009). Negotiated sections of the agreement referring to operational services included detailed provisions for staffing and very specific services, as well as “a whole series of specifications around service levels and ongoing discussion of quality measures and provisions for volumes,” as noted by Ron Sapsford (Hansard Official Report of Debates, 2009, p.285). Many of the

negotiated provisions regarding service standards for the agreement were included in the post-construction operating plan (PCOP). The PCOP was a detailed contractual arrangement with the third party that included specific performance measures and standards related to the agreement for non-clinical service provision. As stated by Ken white, the PCOP includes all incurred incremental costs post-construction, and in doing so “...anticipates standard costs around... increasing patient levels and also includes the details around this arrangement with the third party” (Hansard Official Report of Debates, 2009). Any anticipated standard cost increases due to growing patient levels would be covered by the Ministry of Health as a growing percentage of the global budget (Hansard Official Report of Debates, 2009). This means that the PCOP was designed to change incrementally with anticipated increasing patient levels, wherein if non-clinical service levels increase, then a larger percentage of the overall operating budget would be utilized for non-clinical services (Standing Committee on Public Accounts, 2009).

Following the conclusion of negotiations on the agreement between public and private partners, the WOHC completed a final agreement for the construction of a new Brampton Civic Hospital to function as one of the sites of the William Osler Health Centre under a public-private partnership with THICC. The contract for the design, building, and provision of non-clinical services over a 28 year period for the Brampton Civic Hospital was finalized late 2003. Over the course of negotiations, minor changes to the scope of the project resulted in an increase to the overall budget for the project of \$8 million. In addition to this, WOHC agreed to assume any costs related to the construction of required parking facilities, at an estimated cost of \$32 million, in exchange for any related parking revenue that the private vendor would have received under arrangements as initially indicated in the RFP bid. So, thus, the finalized contract was at a cost of \$467 million for the province for the design and construction of the facilities (Hansard Official

Report of Debates, 2009). Following the completion of the agreement, final approval would be required leading to the execution of the agreement (Auditor General, 2008).

Delays relating to a change in government, negative attention from union and community organizations, and complications relating to the finalization of the agreement resulted in nearly 20 months passing between the selection of a preferred bidder through the RFP process and the end of negotiations and settling upon agreement (Auditor General, 2008). Given the time elapsed, THICC made claims for amendment of the cost of the agreement based upon, among other factors, construction cost escalations, as well as inflation adjustments and extra insurance premiums for non-clinical services. Cost estimates to build the facility were upped by approximately 13% to \$525 million, which included \$67 million in design and construction risks that had initially been indicated by the province as risks to be shifted to the private sector during contract negotiations (Auditor General, 2008). Revisions were made to the project at this point, reducing the initial scope of the project by eliminating an ambulatory care building and relocating those services to another part of the hospital, eliminating an administration building, and reducing the number of parking spaces for the facilities. The actual execution of the agreement between WOHC and THICC occurred as of November 2004, with construction of the new facilities beginning shortly thereafter (Auditor General, 2008).

5.4.2 Negotiations: Royal Ottawa Hospital

Following the selection of the preferred vendor, again THICC, the ROHCG began negotiations for an agreement with THICC for the design, building, financing, operations and property management, and maintenance. Similar to the Brampton Civic Hospital, the agreement negotiations were in regard to details for facility design, construction, project financing, building

maintenance, materials management, food services, and security (Ellis-Don, “The Royal Ottawa Hospital”).

A lifecycle cost approach was taken to the output specifications for the facility over the 23 year agreement period for all involved partners, and it was stipulated that the contract was with one party only. The signing of contract with one consortium is referred to as a “special purpose vehicle,” wherein a special purpose corporation is established by the consortium for all of the facility and services to be provided over the course of the contract, with requirements for construction partners and services partners to cross-guarantee work of the other members of the consortium over the course of the agreement term (Laird and Langill, 2005). All of the parties in the consortium were to be tied together by the agreement, thereby ensuring by design that they seek cost-effective solutions through collaboration or partnership. This approach also purportedly allowed the public partner to obtain financial guarantees for the consortium’s obligations as specified in the agreement over the term and tied the partners together intrinsically for the term of the agreement. For example, “if poor building design resulted in higher energy consumption costs as the building matures, we will still be dealing with the same consortium and will have the building partner’s as well as the services partner’s financial guarantee to draw upon over the entire term” (Laird and Langill, 2005). The agreement stipulated that all design changes not explicitly authorized by the Ministry would be financed by the funds of the hospital. Given that the hospital was required to raise large amounts of their local share of the overall capital cost, approval by the hospital Board of Directors or senior management of the hospital would be required for any design changes initiated by the hospital, adding significant discipline and hierarchical structure to the design signoff phase (Laird and Langill, 2005). The private sector would also have an extensive series of responsibilities pertaining to maintenance and service for

the project, with capital reserves put aside for lifecycle costs pertaining to managing maintenance and whatever other unanticipated consequences may have arisen over the course of the contract. This would have been seen as a major benefit for the public partner due to the lack of available contingency capital that the hospital corporation would have had available (Participant 6).

Performance standards for the private partner included in the agreement were set to a standard similar to that which would be expected if the public sector were to have undertaken this project on its own. The service standards set, as such, are cognizant of the additional costs that would arise from setting higher standards for a private partner. Given that the VFMB had already been completed against public-sector standards, demands for higher standards from the private partner may have invalidated the VFM previously conducted by ROHCG, throwing off cost projections for the project (Laird and Langill, 2005).

Performance penalties were built into the agreement that were designed to be relative to the cost of services for which the penalty was being imposed (Laird and Langill, 2005). The performance penalties in the agreement allowed for time for the private partner to fix any identified problems before actual penalties are imposed. If the problem persisted, the penalties would become progressively costly for the private proponent and could result in the service provider being replaced entirely (Laird and Langill, 2005). The penalties were designed in such a way to avoid excessive punitive measures against the private partner since they could, particularly when combined with higher performance standards, add cost to the project as the proponent adds cost to the hospital to offset potential penalties (Laird and Langill, 2005). If penalties are imposed, debt servicing could be jeopardized. The hospital retained the ability to inform private lenders of issues once they reached a level of seriousness, thereby relying on

those lenders to exert pressure to have issues resolved before it could impact consortium cash flow (Laird and Langill, 2005).

While this does seem to exemplify attempts at a collaborative relationship between the public and private partners, such is not to indicate that there were not challenges in ensuring public and private partners were on the same page. Research participant 2 indicated that coming to such an agreement during this process would have been particularly involved for all parties, describing "...days and days of 15 and 18 hour days locked up in rooms, arguing over every clause." Quite similar to the issues raised during the VFM stage for the Royal Ottawa Hospital project, the main sources of debate between public and private partners during this process appeared to reflect some of the core conflicts as described in literature; conflicts often centered around assumption of risk (Vining and Boardman, 2008). In this case, however, it appeared that the public partner was more intent on ensuring the transfer of risk for items typically borne by the public sector than may have been anticipated (Participant 6).

Negotiations would have centered on issues relating to risks associated with debt financing and responsibility for debt financing, lifecycle management systems, ensuring that private sector equity was not lost, and determining which partner, public or private, would be best equipped to take on risk (Participant 2). Additional risk assumptions that were the subject of debate included performance specifications and assumption of risk for anticipated future costs including changes in costs related to fuel consumption, electricity, maintenance materials, and other items that the private partner would have control over in terms of quantity, but not price. Clauses would also be debated pertaining to changes in commercial tax regimes and assumption of associated costs for either public or private partners (Participant 2). Other major points of contention related to current employees of the hospital, particularly housekeeping, security,

dietary, and other non-clinical staff, and ensuring that these employees would be rehired by the consortium with the same level of employment and seniority as they currently had, that the union would be maintained, and ensuring acceptance of a collective agreement by the private consortium (Participant 6).

Private lenders would have also been engaged in discussions with the hospital corporation around discipline for debt service payments. As a special purpose vehicle with obligations, stiff penalties could jeopardize debt service payments. The hospital structured agreements to allow opportunities for private lenders to exert pressure on the consortium in cases where there were issues with service delivery or otherwise. This represented one particular advantage of using private capital to finance the infrastructure development and service provision, as private lenders could maintain some level of enforcement of agreed-upon standards in lieu of government intervention (Laird and Langill, 2005). Security of cash flow was established through confirmation of provincial government authorization for the transaction, along with guarantors of a Funding Agreement signed with the hospital. The existence of this funding agreement was confirmed to lenders seeking some form of provincial guarantee, however the funding agreement itself was to be confidential and between the Ministry of Health and Long-Term Care and the hospital (Laird and Langill, 2005).

The agreement included facility management services at the Royal Ottawa Hospital. Areas pertaining to operations and equipment at the hospital require careful consideration and expert input to ensure that they meet the needs of the private vendor that will be conducting operations over the course of the agreement. To account for the changing nature of areas of the agreement such as furnishings, equipment, and information technology, a lifecycle costing principle was favored with appropriate allowances set as part of an upfront allowance in the

project agreement. Carillion Canada (Carillion), one of the members of the THICC consortium, was to take over facility management services at the existing Royal Ottawa Hospital site under an early services contract. Service delivery at the new hospital was to begin as of the opening of the new facility. Upon opening, facility management services from the private vendor were guaranteed for the lifecycle of the project (Carillion Canada, “Royal Ottawa Hospital”).

The contract with the private consortium was expected to last for approximately 23 years, largely due to the fact that it would take that long for lenders and equity investors to meet the expected return on capital for the project. Contract termination provisions were critical due to the long nature of the contract. The agreement built in three contract termination scenarios; where the proponent is at fault, where the hospital is at fault, and termination for “force majeure.” The return to the equity participants of THICC varied depending on the termination scenario; however, they would receive recompense for capital expenditures in all scenarios. While this may seem to mitigate risk transfer to the private partner, a touted benefit of a P3 arrangement, exposing private lenders in THICC to capital losses in a situation of default would have reflected much higher interest costs for the project and a greater cost overall (Laird and Langill, 2005).

Towards the final stages of contract negotiations, a provincial election led to the change of a governing party. Amendments were made to the project’s legal agreements to meet the needs of the new government (Laird and Langill, 2005). The project was subsequently reduced in scope relative to beds in operation down to 188 beds, rather than the initially planned 284. Following these amendments, negotiations concluded in July 2004, and the final project agreements were signed with the selected proponent. The construction price was revised, as well as the price of operation of the hospital over the term of the agreement. The total cost over the course of the agreement was to be \$256 million. Of this, the capital cost for the construction and

completion of the facilities was totaled at \$126.8 million, with the remainder of cost considerations relating to on-site services and operations provided upon completion of construction (Royal Ottawa Hospital, 2004, “ROH Signs Deal for New Public Hospital”). The final agreement overall detailed both the capital required for the construction of the facilities, as well as the costs for facility management services over the course of the 20 year and eight month arrangement between public and private partners. Payment would cover the mortgage for the facilities, utility costs, housekeeping, ground maintenance, and other ongoing upkeep. Payment by the public partner was to begin as of occupancy upon the anticipated completion date in late 2006, with all funds flowing from the Ministry of Health and Long-Term Care (Royal Ottawa Hospital, 2004, “ROH Signs Deal for New Public Hospital”). It was at this point that the life-cycle program was also built into the agreement, thereby ensuring that facilities would be kept in ‘like-new’ condition over the course of the agreement through continual maintenance (OPSEU, 2007).

According to the finalized agreement, Carillion, one of the members of the THICC consortium, was to take over facility management services at the existing Royal Ottawa Hospital site on June 1, 2005 under an early services contract. Service delivery at the new hospital was to begin as of the opening of the new facility. Upon opening, facility management services from the private vendor were guaranteed for the lifecycle of the project (Carillion Canada, “Royal Ottawa Hospital”). After the commercial close of the transaction, THICC was given a period of time in order to secure the previously negotiated financing for the transaction as indicated in the project agreement. This process concluded in December 2004 (Laird and Langill, 2005). In September 2005, the hospital announced that the construction of the new Royal Ottawa Hospital was to be

completed as of December 17, 2006 (Royal Ottawa Hospital, 2004, “ROH Signs Deal for New Public Hospital”).

5.4.3 Negotiations: Cross-Case Analysis

The following section will detail and compare some of the experiences at the Brampton Civic Hospital and Royal Ottawa Hospital in establishing an agreement with the private partner. In regards to negotiations, the SuperBuild guide (2001) stresses the maintenance of a competitive process during negotiations, with an even-handed approach to the agreement that involves appropriate consultation with proponents, utilization of the project team to ensure the public sector does not negotiate in ignorance, ensuring commitments made are measurable by some metric of performance, and assessing and addressing the perspective of the proponent. This section will assess the means by which private proponents were consulted during the negotiations process, the performance metrics that resulted from negotiations, and the capacity to utilize the knowledge of agents throughout the negotiations process. Some consideration will also be given to the high transaction costs associated with this stage of the procurement.

The two cases share some particular commonalities in regard to the negotiations process, especially from the standpoint of changes in the broader operating environment, such as shifting political circumstances, which may have impacted both projects during this time. Furthermore, the two cases compare the experiences of varying hospital corporations in dealing with the same private vendor, THICC, and as such many of the actors outside of the staff from the hospital corporation themselves are like to have been involved in both projects. Comparing the experiences of each hospital project and the capacity of public managers to successfully consult and take advantage of the skills of agents involved in the transaction will provide some insight

into the relationship between the public and private sector throughout what was, in both cases, a somewhat challenging negotiations process.

5.4.3.1 Key Actors Involved in Negotiations

The Ministry of Health and Long-Term Care would continue to operate in this stage as the main government approval body, providing authorization to documents including the project legal agreements as well as funding approval at this stage in the project (Laird and Langill, 2005). Final agreements would be reviewed and revised by the Ministry of Health and Long-Term Care, but ultimately in both cases the hospital corporation would be the signatory on the agreement (Laird and Langill, 2005).

Negotiations in both cases would be conducted through interactions between the individual hospital boards, their retained consultants, and representatives of the private consortium; in both cases THICC. A number of consultants were retained by public managers in each case. These consultants would be selected through a competitive process, and would provide advice and the wealth of their experience throughout the negotiations phase. Regardless of the fact that these were pilot projects for the province, the number of consultants retained for a project of this kind are arguably staggering. In the case of the Brampton Civic Hospital, for example, WOHC along with the Ministry are estimated to have engaged with around 60 consultants for legal, technical, and financial advice over the course of the entire project (Auditor General, 2008).

Member companies of the private consortia responsible for service provision would also have a role in the negotiation stage, to varying degrees. Overall, it appears that the only significant expertise of the private partners leveraged at this point for both projects related to

non-healthcare service provision, as opposed to actual design features for the projects.

Interactions with private vendors on the agreements at the negotiation stage were not what would have been considered to be “consultations, in the true sense of the word. But certainly consultants, advisors, and hospital executives went over in detail what they felt they needed in output specifications, design requirements, and to what degree” (Participant 3). However, areas pertaining to operations and equipment at the hospital would still require careful consideration and expert input to ensure that they meet the needs of the private vendor that will be conducting operations over the course of the agreement. As was noted by Carillion and Laird and Langill in their description of the approach to aspects of facility management services included in the agreements with the Royal Ottawa Hospital, to account for the changing nature of areas of the agreement such as furnishings, equipment, and information technology, a lifecycle costing principle was favored with appropriate allowances set as part of an upfront allowance in the project agreement. This approach was similar to ones that had been utilized in partnerships in the United Kingdom, and also was informed by past experience in the contracting out of some operational aspects at the old Royal Ottawa Hospital (Laird and Langill, 2005; Carillion Canada, “Royal Ottawa Hospital”). In addition to operations vendors being an equity investor in the project, Carillion was consulted throughout the negotiation process for the agreement. Carillion had some input into the services outlined with performance measures in the agreement, as well as being included in building management and operations, maintenance of building equipment, architectural elements, and grounds, security, food services, and housekeeping (Carillion Canada, “Royal Ottawa Hospital”). Carillion consulted with an internal integrated project delivery team reviewing the whole life of the project. The team was tasked with reviewing the entire lifecycle of the project and, working with a full-spectrum of vendors, making decisions

regarding the design, construction, and operational life cycle of the hospital. Collaboration with the operations team was crucial to the planning process, particularly regarding the design of kitchen facilities, equipment selection, energy efficiency, operational systems, and the like. The integrated project delivery team included not just the main vendors operating as part of the THICC consortium, but also major subcontractors who had been selected early in the design process, ensuring that major systems including mechanical and electrical systems such as “the building automation system, chillers, and other critical building equipment” were accounted for in review (Carillion Canada, “Royal Ottawa Hospital”).

Overall, the selected private partner for the Brampton Civic Hospital project did not appear to have been allowed significant input into the direction and design of the project. When describing the relationship between public and private partners and the capacity of the public partner to engage the expertise and specialized knowledge of private vendors, one research interview participant remarked that there did not appear to be a great deal of appetite on the part of the public partner to allow significant leeway in design specifications (Participant 8). Design elements tended to be more prescriptive overall. While the RFP for the project and government marketing around the project touted the capacity for private sector innovation as an advantage to the selected procurement approach, ultimately the private partners would not have felt that there was a great deal of room for innovative design creativity for the project (Participant 8). Similar to the Royal Ottawa Hospital project, however, there would be some capacity for innovation in the design of elements of the project not relating directly to healthcare service provision (Participant 8).

It should also be noted that as the projects were being brought to a close an election occurred, replacing the current government with a new Liberal government that had campaigned

against P3 projects, with specific reference to the Royal Ottawa Hospital and Brampton Civic Hospital projects (Block, 2008). Following the elections, much of the work on these projects would be put on hold for a period of several months as considerations on the part of the new Liberal government would need to be addressed prior to bringing the projects to close (Participant 2). During the election, staff at the Royal Ottawa Hospital are described as having worked to build relationships with individuals from different parties, with a particular focus on the Liberal and Conservative parties, who were seen as the only two parties likely to form government at the time. In the case of the Royal Ottawa Hospital, this work appeared to pay dividends in the form of developing a positive relationship with some Liberal Cabinet members (at the time candidates) who would have “championed” the project after the new Liberal government was formed (Participant 1). Participant 6 detailed some of the engagement with key community actors that would have occurred as the projects were on hold to build the case for bringing the project to a close. They described leveraging community and stakeholder resources during this process to meet privately with members of parliament and the Premier in support of the Royal Ottawa Hospital project and mental health needs within the community. Following the outcome of the election, staff from the Royal Ottawa Hospital consulted with what was described as a “Campaign Cabinet”; community leaders from the Ottawa region including past mayors, opinion leaders, and those with influence within the community who would have provided context on the need for health services within the region and would, ultimately, argue to the new government that the project was in the public interest.

5.4.3.2 High Transaction Costs in Negotiations

A significant portion of the final costs of the Brampton Civic Hospital and Royal Ottawa Hospital project were spent solely on planning and negotiation for the project. Research interview participants stressed that the process for these projects was unique at the time, with government agents having little to no experience in partnerships of this nature prior to this. The multi-faceted procurement and negotiation process was untried in Canada, an issue further exacerbated by the fact that the hospital corporation signatories were in deficit as they sought to enter into long-term agreements with their private partner, creating issues as the public partners fought against aspects of “parent guarantees” or long-term commitments (Pigott, 2006).

This ultimately would have led to challenges in the relationships between partners, litigious behaviour, and a lengthy negotiations process. When describing the processes for engaging consultants throughout the projects, Participant 3 indicated that “there was a lot of learning taking place through scoping and a lot of consulting time being used, again, because of the unique nature of those projects and the fact that government had no experience in this prior to that.” While inclusive consultation, horizon-scanning, and engagement of involved actors may assist a project in its ability to effectively manage for complex and evolving relationships (Klijn 2006), one finds that the required contracting of outside expertise on behalf of a public partner with little experience and a weak negotiating position can significantly raise the transaction costs for the project. As will be explored in this section, it appears that there were some instances of such occurring in both projects, potentially leading to high transaction costs associated with bringing the projects ultimately to a close. While the processes may have been untested and new, and that may have offered one explanation for the significant amount of time required to bring the projects to close, as explored in the Analytical Literature Review in Chapter Two, it is

evident that high transaction costs are a common concern with public-private partnership arrangements, particularly under the circumstances common to the Brampton Civic Hospital and Royal Ottawa Hospital projects. Analysis pertaining to the strengths or weaknesses of public-private partnerships in the infrastructure development sector identifies issues of complexity relating to these projects as being a potential inhibitor to the successful undertaking of a health partnership arrangement. It is suggested that “the additional complexity of public-private partnerships makes all but the most straightforward projects just too difficult” (McKee et al., 2006, p.894). A large part of this is the challenge associated with reaching an agreement between public and private partners that contains all of the provisions required to satisfy all involved parties over the course of the project (McKee et al., 2006). According to Vining and Boardman (2008), challenges are like to arise in the negotiations process, particularly for inexperienced public partners. “Governments with weak contracting ability and experience will not have the skill to anticipate these contracting problems and write appropriate contract provisions for them before the contract is finalized” (p.19). Conflicting goals or a divergence in interests between public and private partners may serve to exacerbate the situation. In these circumstances, government negotiations with private partners have been shown to be prone to significant bargaining costs both up front and over the duration of the project (Globerman and Vining, 1996; Brown and Potoski, 2003; Boardman and Hewitt, 2004). High bargaining costs and opportunistic behaviour on the part of any of the parties involved can lead to results such as delay of the start of the project, failure to achieve the goals of the project, or wholesale dissolution of the project (Vining and Boardman 2008). These concerns are echoed in the SuperBuild guide (2001), which outlines a number of concerns regarding a strategy of private-sector bidders “doing what is necessary in order to be selected during the procurement process and then endeavoring to

negotiate their way out of commitments during the negotiations of the final agreement” (p.20). Some private sectors bidders are noted as strategically doing what is necessary to be selected as the preferred proponent during the RFP stage, then subsequently seeking to change the terms of the project during the negotiation phase and prior to the final agreement. According to SuperBuild, “this strategy has proven to be successful in certain instances when a public-sector organization has lost leverage in negotiations because it does not wish to have to reverse an announcement as to the identity of the successful bidder” (SuperBuild, 2001, p.20).

Both projects were noted as arguably having a lack of in-house resource expertise both in regards to project management and negotiation, necessitating the frequent contracting-out of experts and consultants, and resultantly contributing to the overall transaction costs of the projects (Barrows et al., 2012; Ontario Health Coalition, 2008b; Whiteside, 2015). Health capital projects of this kind require some level of expertise and guidance on best practices to pursue in aspects of agreements including the nature of contracts, communications, stakeholder engagement, and dispute resolution (Barrows et al., 2012). While the staff utilized by the hospital board were no doubt competent, lack of in-house expertise would prove to be a challenge in the projects, necessitating extensive contracting out for expert guidance. In his testimony before the Standing Committee on Public Accounts, Saad Raafi defended the level of knowledge at the hospital board level, noting that “some of them are investment bankers. Some of them are corporate bankers. Some of them are heads of construction firms. Some of them are very well-minded individuals from their communities, as we all know” (Hansard Official Report of Debates, 2009, p.297). Despite this level of expertise at the hospital board, a significant number of outside advisors that had worked with involved financiers on other transactions still needed to be retained for both projects. Consultations would have included audit, enterprise risk, financial

advisory, consulting, and tax experts. In general, those experts involved at this stage would have had to forecast for the lifecycle of the projects over the course of the relationship (Participant 3). There were further consultants contracted “who have expertise in Canadian international law regarding deal structuring, transaction and financial advice with respect to credit risk, financial evaluation” (Hansard Official Report of Debates, 2009, p.297).

Vining and Boardman (2008) further explain that transaction costs relating to P3s are anticipated to be high regardless of prior experience, given the relatively complex contracting situations that are involved in these kinds of arrangements. According to their analysis, “contracting costs are likely to be raised when projects exhibit high asset specificity, high complexity/uncertainty and low competitiveness” (p.18). They note that infrastructure projects undertaken by the public sector, including hospitals, roads, schools, and the like usually involve a considerable amount of asset specificity given that the design work for these projects is generally “sunk” and not useable for other projects. The knowledge and expertise gained in the process is of value, but the infrastructure itself has very few other uses as a public good and likely is at cost (negative value) in terms of asset specificity (Vining and Boardman, 2008).

Particular to the Brampton Civic Hospital and Royal Ottawa Hospital projects, however, was a sense of some internal government resistance to embracing privately financed and operated solutions to health infrastructure in the province. Research interview evidence suggests that internal opposition in government to a P3 approach, oppositional behaviour, and excessive requirements around demonstrated value may have contributed in driving up transaction costs for the projects. Research participants had noted that the significant level of consultation required for the projects related to unease with what was a new and untested approach for Ontario. According to participants this, on occasions, would have been reflected in planning sessions and meetings

relating to the selected procurement method for the projects. One research participant described debates between the Ministry of Finance, Superbuild, and the Ontario Financing Authority (OFA) at this point, who were perceived in many ways as opposing a P3 model. Meetings discussing a public comparator for the projects were viewed as confrontational, with representatives from the OFA deliberately “throwing a spanner in the works” (Participant 3), according to one participant, by placing excessive requirements for value obtained from the privately financed and operated approach at nine to fifteen percent greater than the public comparator; an amount that was unlikely to ever be met, and was seen as unreasonable. According to one participant, debates in this regard had the effect of “frustrating the consultants, frustrating the hospitals, and burning money like crazy” (Participant 3). Testimonial from executives and project managers further reflect a situation wherein significant deliberation and consultation would have been undertaken relating to concluding that a P3 approach was appropriate for the project, with admissions that it may have been in excess of what would have normally been required. As indicated by Ron Sapsford, “...there was a great deal of effort—perhaps too much effort, according to the Auditor’s report—about advisers and how much administrative cost went into the analysis of whether the project should proceed on this basis. Some of it, in hindsight, has now been viewed that there are better ways to do it” (Hansard Official Report of Debates, 2009, p.296).

Given the issues relating to public-public resistance to adopting a P3 approach, lack of in-house expertise, and high complexity of the projects that were undertaken, it should come as no surprise that both projects were subject to high levels of cost associated with transactions and negotiations. In the case of the Royal Ottawa Hospital, the overall transaction costs associated with retention of expert advice and negotiations are estimated to have added to the project by

\$8.1 million. This includes the share of costs for lawyers and consultants in putting together the bid, and does not include government costs or additional costs to the hospital. With the final project estimated at \$146 million in costs, this means that approximately 5.5% of the total cost of the project is for consultants and lawyers to accommodate the complex documentation required for a P3 project (Ontario Health Coalition, 2008b). In the case of the Brampton Civic Hospital, given the greater scope of the project overall, total transaction cost expenditure was higher, but was also 5.5% of the overall project costs. The transaction costs associated with the P3 procurement represented a significant cost that was not factored in at any point in estimates or VFM assessments (Auditor General, 2008). WOHC, along with the Ministry, are estimated to have engaged with around 60 consultants for legal, technical, and financial advice over the course of this process at a cost of approximately \$34 million, with the vast majority of those cost relating specifically to the work associated with the new P3 approach (Auditor General, 2010).

Without proper expertise to manage for the noted additional complexity associated with public-private partnership arrangements, it appears that the capacity of a public partner to successfully navigate a new and, for the province, untested method of partnership procurement is significantly limited (McKee, 2006). Consultation and expert input would have been necessary to assist the public partners in managing the inherent and significant complexities of a project of this kind. Such is particularly true in situations without much local precedent or experience, as was the case for the Royal Ottawa Hospital and Brampton Civic Hospital. Managing for the significant complexity of a public-private partnership by “stepping into the complex system and designing governing mechanisms and strategies that are specifically targeted at the situation and characteristics of the process” (Klijn and Teisman, 2006, p.12) and improving the quality of decision-making in this complex process through the facilitation of interactions to listen,

observe, conduct horizon scanning, and make connections with other actors as required may have made these kinds of projects plausible in the first place. However, it must be noted that doing so can significantly raise the transactional cost of the project both in terms of time and investment, as evidenced by the two cases in this study (Barrows et al., 2012; Ontario Health Coalition, 2008b).

5.4.3.3 Performance Standards and Penalties

The complexity of a service agreement can reflect some of the challenges that managing for contingency, change, and risk can pose to a public sector organization entering into an agreement with a private partner. As noted in the previous section, inexperienced partners such as a government with little experience and weaker contracting ability may not have the proper capacity to anticipate contracting issues and write appropriate provisions to mitigate public sector risk (Vining and Boardman, 2008). The previous section noted some of the issues associated with the engagement of expert opinion and the like to manage such complexity; higher transaction costs and additional time to bring to close may be a result. Literature suggests that, in particular, reaching an agreement and subsequent bargaining costs both up front and over the duration of the project are common in government negotiations with private partners (Globerman and Vining, 1996; Brown and Potoski, 2003; Boardman and Hewitt, 2004). The necessities of an agreement, understood as a complex system in and of itself, are like to be unpredictable, and a challenge for a public partner to effectively develop and govern. To what extent can engagement, horizontal decision-making, and smart interventions help to mitigate these issues? Klijn (2008a) posits that top-down management strategies may struggle to have a full appreciation for the complexity of such arrangements. Rather, the ability of actors within the system to connect in a meaningful way and establish patterns of interactions may be a greater

determinant on the capacity of the system, in this case the partnership, to effectively move forward towards shared desired outcomes (Klijn, 2008a). This section will compare the experiences of the Brampton Civic Hospital and Royal Ottawa Hospital in this regard, with a particular eye towards how private partner engagement and relationship building would have had an impact on the eventual direction of the service agreements.

For both projects, initial decisions concerning service standards and performance metrics would have been determined comparative to industry standard or better in most cases. According to Participant 7, “they didn’t get to necessarily negotiate what the performance standard was unless we, as a government or a hospital provider, were unrealistic. But ... there’s lots of industry standards around there and that’s really where I think everyone looked to” (Participant 7). Following initial determinations for levels of service, local considerations, such as enforcement and assumption of risks, would be established through the process of negotiation with the private partner (Participant 7).

The service agreement drafted by the Ministry of Health as part of its partnership with the Brampton Civic Hospital was noted as being quite large, detailed, and complex (Standing Committee on Public Accounts, 2009). As described by Ken White, former hospital supervisor, agreements of these kind can be “...difficult for folks to understand, and it’s even more difficult to figure out what measures you want to use to make sure that you’re getting the level of service that you need” (Hansard Official Report of Debates, 2009, p.292). In the case of the Brampton Civic Hospital, the agreement was a 200-page document that sets the ground rules for the private partners to provide non-clinical services to the hospital. This would include service level standards and benchmarks for service delivery (Hansard Official Report of Debates, 2009). According to Mr. White, each area of service provision to be conducted as part of the agreement,

including those such as housekeeping or laundry services, would require lengthy contractual provisions. These provisions were structured in such a way as to ensure continued value for money over the course of the contract (Standing Committee on Public Accounts, 2009).

For Brampton Civic Hospital, the agreement between WOHC and THICC did contain a number of remedy provisions to protect the hospital from issues relating to delays or other risks during the construction period, and issues with the provision of non-clinical services over the course of the term of the agreement (Auditor General, 2008). In relation to non-clinical services, the project agreement detailed comprehensive service standards that THICC was expected to maintain. WOHC would monitor the private partner in meeting these standards, and necessitated the establishment of a hotline to allow staff at WOHC or patients to report violations of stated service standards. Furthermore, the hospital would conduct regular user satisfaction surveys and encourage the private partner to self-monitor and report service failures, with reports on a monthly basis. WOHC is also granted the capacity to audit the quality assurance and management systems of the private partner on a quarterly basis (Auditor General, 2008). The hospital is, according to the agreement, able to make deductions from monthly payments to THICC based upon any purported failure of the private partner to meet established service standards (Auditor General, 2008). However, there were some concerns around the nature of the contract and its governance, including the mechanisms included for dispute resolution, communications and relationships between actors, and best practice P3 methodologies (Auditor General, 2008). It was noted in the Auditor General's 2008 report that WOHC had yet to establish procedures for monitoring private-partner performance at the Brampton Civic Hospital in regards to non-clinical services provision. The report identifies that the project lacked significant procedures to verify the performance of any contractors and resulting adjustments to

the unitary payment for the project. This is of particular concern given the fact that cost increases relating to operations are paid for by the ministry (Auditor General, 2008). Any cost increases relating to operating costs and meeting service standards for the project are ultimately covered by the Ministry, thereby raising the question of what impetus may exist to keep the operating costs for the hospital down, and whether risk for increasing service costs were to be borne by the Ministry. In response, Mr. White noted that the Ministry was currently working with WOHC on the matter, with the goal of determining how to make aspects of the non-clinical service provision agreement simpler, with clear incentives to reduce costs built into the agreement. (Standing Committee on Public Accounts, 2009). This may represent a significant challenge for procurement projects of this kind. The operating environment may be at a sufficient level of complexity that private sector employees operating under a P3 contract may be difficult to hold to standards of performance and best practices through a contract due to a requirement for detailed provisions laying out how the ministry intends to obtain value for money.

In regards to the Royal Ottawa Hospital, service standards appear to have been created with sufficient flexibility to avoid some of the issues noted in the Brampton Civic Hospital case, particularly given the inputs into the decision regarding how performance measures were set. Part of this may have been attributed to the fact that private partners and their staff had been consulted significantly during the development of performance measures and service standards, as attested to by Participant 2 when asked to describe the nature of the relationship between public and private partners at this stage in the project. ROHCG was careful to avoid setting higher standards of performance for their private partner than those that could be achieved realistically by a public operator for facilities. This entailed avoiding the temptation to set standards for the private partner where no established service standards exist, or to create

standards for the private partner that it potentially could not afford to cover financially. In their study of the Royal Ottawa Hospital, David Laird and George Langill (2005) observed that in the case of performance standards, “if you require higher standards it will cost more and the comparison against the VFMB will not be valid and may result in the project being cancelled, as it may appear that the private sector costs more than the public sector” (p.76). Given that the VFMB had already been completed against public-sector standards, demands for higher standards from the private partner may have invalidated the VFM previously conducted, throwing off cost projections for the project (Participant 2). Performance penalties were built into the agreement that were designed to be relative to the cost of services for which the penalty was being imposed (Laird and Langill, 2005). Some leniency would have been built into the contracts, and Participant 2 described a need for trust between partners in this regard to avoid significant litigious behaviour on the part of either involved party. As a result, the performance penalties in the agreement allowed for time for the private partner to fix any identified problems before actual penalties are imposed (Participant 2). If a problem persists, the penalties become progressively costly for the private proponent and can result in the service provider being replaced entirely (Laird and Langill, 2005). The penalties were designed in such a way to avoid excessive punitive measures against the private partner as such measures can, particularly when combined with higher performance standards, add cost to the project as the proponent adds cost to the hospital to offset potential penalties (Participant 2).

In summary, both projects seemed to grapple with the issue of performance standards during the negotiation phase of the project. Challenges can arise due to public partners increasing requirements in a vacuum, and not necessarily understanding how changes to performance standards and penalties can drive up the cost of a project to an exponential degree (Participant 3).

According to Participant 3, “sometimes the public sector doesn’t know how to properly transfer risk or price it. And so, they ask for the sun, moon and the stars and they get sticker shock.”

However, there do appear to have been some differences in regards to the approach to performance standards between the two projects. This fact was commented upon by research participants during interviews as they examined the nature of consultations and negotiations that would have been involved in the development of performance measures and standards built into the project contracts. The complexity of the performance standards and penalties in the agreement for the Royal Ottawa Hospital seems to have been mitigated through an operating relationship built on trust, rather than pursuing a more prescriptive approach to benchmarks and standards. Participant 1, comparing the Royal Ottawa Hospital project to the Brampton Civic Hospital project in terms of negotiations and the development of performance standards, stated that staff at the Royal “were able to accomplish a lot because the relationships grew in terms of trust, and I can tell you quite explicitly, because we know the team at William Osler, that that wasn't the case, because it got very transactional, their documents, versus [the Royal] which were based more on the trust with basic ground rules.” Participant 2 described this same aspect of the Royal Ottawa Hospital project as follows: “People spent their time trying to do the right thing rather than trying to figure out what clause is not enforced.”

5.4.3.4 Shifting Political Environment

A shifting political environment may have a significant impact on a major infrastructure project. A new government may come to power with a different mandate than the one that preceded it, drastically delaying or altering the direction of a particular project. On projects of this kind, “there are forces beyond the control of a hospital that simply require a renewed focus on what you are trying to achieve and patience in making adjustments to accommodate a

changing landscape” (Laird and Langill, 2005, p.74). This was certainly the case for the two cases of this study.

By virtue of both projects occurring over a similar time period, in the same province, both the Brampton Civic Hospital and Royal Ottawa Hospital experienced a shifting political landscape during the inception, negotiations, and execution of the projects. Given that both of these projects were completed and, from the negotiation process onward, were completed as a partnership project in spite of significant political pressure, it lends credence to the fact that there may have been some resiliency and permanence to the arrangements to the degree that a change in government, let alone a government outwardly hostile to arrangements such as those proposed for these hospitals, did not derail the partnerships. However, changing political environments may still have an impact on projects of this kind, and pose a challenge to public managers already engaged in a procurement process. While the overarching public interest and impetus for a particular project would be less likely to change as a result of a new government, there is reason to believe that the timing of a project in relation to the political climate in which it operates can have a significant influence on any infrastructure project. Shifting political environments have been noted to have an impact on P3 projects that are in progress (Johnston and Gudergan, 2007). The time of implementation as it relates to changing political circumstances can create issues for a project due to the intimate link between government and private partners in P3 arrangements. The project itself may become representative of a particular political agenda, policy goal, or election promise, thereby influencing the direction of the project as well as perceptions of the project overall (Johnston and Gudergan, 2007).

Both projects were initially proposed in the late 1990s under the advisement of the HSRC, an advisory body structured by Premier Bob Rae’s New Democratic Party (NDP),

recognizing the need for a new hospital in the Brampton area and a new tertiary mental health facility in the Champlain region. In 1995, the NDP was replaced by the Progressive Conservative (PC) party under Premier Mike Harris. The decisions to build the hospitals were made after the conclusion of the HSRC under the PC government, with a noted mandate to construct the hospitals utilizing a public-private partnership model. Construction of the hospital finally began under Premier Dalton McGuinty in 2003 after another change in government (Auditor General, 2008).

Given that the projects themselves were not underway with an established management structure during the initial transition between the Rae NDP government and the Harris Conservatives, there are fewer observations that can be made concerning the impact of that particular transition on project direction. During the 2003 election campaign, however, both projects were already at some point of completion with established management structures, ongoing negotiations, and in both cases, completed selection processes (Auditor General, 2008; Laird and Langill, 2005). Critically, on the campaign trail prior to the 2003 election, the province's proposed P3 hospital projects became the subject of debate and attack. On the campaign trail, Liberal candidate Dalton McGuinty pledged to develop the Royal Ottawa Hospital through a more traditional public-sector arrangement, referring to P3s as the "Americanization of health care" (Ottawa Citizen, 2006, "McGuinty a P3 Convert").²⁰ Both the Brampton Civic Hospital and the Royal Ottawa Hospital were condemned by McGuinty as "profit-driven private consortia hospitals" (Yelaja, 2008).

²⁰ Dalton McGuinty would ultimately criticize P3s as being an American solution to Canadian healthcare problems several times over the course of the election. As quoted from September 26, 2003: "I'm calling on Mr. Eves to halt any contract signings when it comes to P3s. I stand against the Americanization of our hospitals" (Block, 2008).

Following the 2003 election, these projects were inherited by the Liberal government that formed under Premier McGuinty; a candidate who had campaigned against P3 hospitals in the province (OPSEU, 2007). At this point, the “old” government had already invested significant time, effort, and money into the two projects, and significant costs were sunk both in terms of those from the Ministry of Health and Long-Term Care, the hospital corporations, and the private partners. Participant 4 expressed that all of these actors, having worked on the development of these projects for some time now, would have been “...worried when they were hearing the Liberal government talk about their views on public private partnership at the time” (Participant 4).

However, when the Liberal government came to power, they ultimately decided to go ahead with both projects, albeit with revisions to the agreements. Recognizing the challenge associated with cancelling the deals, particularly given the need for these hospitals and the fact that cancellation would result in significant penalties to the winning consortium, the new government reviewed the projects and agreements (Laird and Langill, 2005). As noted by Ron Sapsford in regards to the handoff of this project to a new government in the case of the Brampton Civic Hospital:

“There was a very high need to develop a new facility in that part of the province. This had been a long-standing recommendation ... [F]or a new government looking at it, it would be a question of, ‘Do we stop and start over again?’ And when you look at the public interest, there had a been great deal of due diligence—not perfect, and we’ve made some changes, but nevertheless, the overriding consideration, in my view, would be, is there a need to proceed with this project in the interest of health care for the citizens of

Peel and Brampton? My honest belief is that the answer to that question is yes” (Hansard Official Report of Debates, 2009, p.296).

Consequently, the projects were delayed for review pending final approval and altered to meet the mandated requirements of the new government. A number of decisions regarding the projects would have been made at this point that altered the direction of the project, accompanied by revised timelines and cost estimates for the projects. Research interview participants were asked to provide an assessment of what changes, if any, would have actually been put into place following the election, and to describe what the process of negotiations would have looked like. This question was meant to draw out observations relating to the relationships between political actors and the public service, and provide some insight into what happens to established projects transition to a new government. Tensions noted between representative democracy and networked governance systems in the literature point to the difficulty of managing a complex, established collaborative project through classical vertical accountability instruments (Klijn, 2008b). It stands to reason, then, that imposition of new changes at this point in the two hospital procurement projects may have been difficult. This portion of the research study was intended to provide new insight into how changes within the operating environment, in this case the election of a new government, may lead to changes for an already established ongoing project, if at all. Also, considering the significant attention that these projects garnered during the election, any observations relating to how the projects evolved out of the election provide interesting details that should be explored as part of the case studies.

As indicated previously, in the case of the Brampton Civic Hospital, delays largely stemming from the change in government and revisions made to the agreement prior to final Ministry of Health and Long-Term Care approval resulted in a 20 month period passing between

the end of the RFP process and the establishment of a final agreement (Auditor General, 2008). The scope of the Brampton project was noted as changing somewhat following the election. A large part of the agreement for the Brampton Civic Hospital project included services, maintenance, operations, and other on-going considerations that were to be covered by the private partners. Following the election, concerns were raised in negotiations between the new government and the hospital corporation around service standards, human resources, and union considerations that necessitated changes to the agreement. Participant 5 noted some particular controversy surrounding service standards, and in particular, how a hospital with no prior experience in such kinds of service contract arrangements and little knowledge of industry-wide standards would effectively govern and oversee a regime for operations as had been proposed in the Brampton Civic Hospital agreement (Participant 5). Following the period wherein these issues were addressed, given the significant amount of time that had elapsed, THICC wished to increase the cost of their bid to a higher value due to anticipated increases in construction costs. In order to ensure that the project cost did not increase further, the project design was changed. WOHC obtained assurances from the private vendor that these changes would not impact any of the functional requirements of the hospital, and that the VFM would still be comparable to the scope of the initial successful bid (Auerbach, 2007). The project price was subsequently revised to \$525 million with \$67 million in new design and construction risk shifted back to the public sphere. Revisions were also made to the project scope, eliminating an ambulatory care building and relocating those services to another part of the hospital, eliminating an administration building, and reducing the number of parking spaces for the facilities (Auditor General, 2008).

One of the more significant changes for the Royal Ottawa project would have been a renewed focus on public paramountcy for the project. The new government once again had to be

reaffirmed regarding the cost, schedule, and risk transfer advantages associated with the P3 project. Clarifications were also required around ensuring that the projects were consistent with the Canada Health Act. Furthermore, the change between governments led to what several research participants described as a focus on making changes to communicate that the projects were now back within the public sphere. The main function of ensuring public paramountcy for this project, as described by participant 2, was to illustrate that the province of Ontario was in charge of the project, and would be operating the hospital with public employees for the public-private partnership arrangements for the Royal Ottawa Hospital before any final negotiated agreement could be approved by the new government (Participant 2). The ultimate result of this was a capital lease solution, structured more similarly to a mortgage than the initial private construction and operational provisions that had been put forward for these projects (Participant 2). The project was also reduced in scope to a total of 188 beds, and the overall project cost was revised to \$256 million. The final negotiations and revisions under the new government were “a long and challenging process and ensuring that the Board and the project management team were fully committed was critical to achieving close” (p.78). Participant 2 echoed the challenge and frustration that would have occurred at this point in the project when describing shift between governments, stating that “...they moved from an operating lease style to capital lease, which again I don't know what possessed them to do that because they were sitting on a debt level that's off the charts. Then, it set out the rules, and then came all the escorts to those rules and it took us another two years and another ton of lawyers to in fact re-paper the deal to come up with a different colour.” Participant 2 further expressed concerns around changes related to public paramountcy and what function these changes actually would have served. They described the changes to the agreement as serving to do no more than “...tighten up who is in charge; rather

than the notion that we were after, which was ‘how to create a partnership where we are truly equals at the table, and you do it if you’re good at it, and I will do what I am good at, and we will all focus on the patients’” (Participant 2).

The concern of the new government in both cases appears to have been very similar, and a great deal of similarity is noted in the focus on public operations and service provision for the hospitals. Resultantly, the largest changes following the election would be that the operations of the facilities for both projects would in many ways be turned over to the hospitals and the public sector, who would be responsible for maintenance, upkeep, and human resources, as opposed to operations being handled by a private partner under the oversight and enforcement of service standards on the part of a public partner (Participant 5). In both cases, changes were made to the agreements, however neither project was brought back entirely into the public sphere as had been emphasized during the election.²¹ The terminology around these projects also appeared to change, as they were increasingly referred to as Alternative Financing Procurement (AFP) projects; arguably, different than a P3 in the sense that they would remain publically owned. However, “AFPs still look very much like P3s because they will be privately financed, and some will be bundled with lengthy complex service agreements” (Block, 2008, p.2).

Some participants attributed the shift from P3 to AFP as being politically motivated, and concerned primarily with how the projects would be perceived going forward. Participant 7 described the working relationship that the hospital corporations and staff at the Ministry of Health and Long-Term Care would have had with the Premier’s Office at this point, reconciling some of the political concerns surrounding the projects: “We started to talk about it differently.

²¹ As quoted by Dalton McGuinty on May 28, 2003: “We believe in public ownership and public financing. I will take these hospitals and bring them inside the public sector” (Block, 2008).

Instead of P3, or public private partnerships, we started to talk about public accountability and public ownership” (Participant 7). According to Participant 7, the focus on public ownership “was something that gave a person at the time like the George Smitherman, who was very vocal against these kinds of projects due to very true worries that we were able to allay; like, are we laying people off, or we’re doing all this stuff” (Participant 7). The renewed focus on alternative finance procurement “gave him a new set of linguistics, if you will, to talk about it. And the more and more people understood these projects and the more and more they evolved, I think that was how we were successful making that transition” (Participant 7). Participant 4 expressed similar opinions, stating that most of the changes to agreements appeared to be superficial, noting that they “...don’t think those agreements change under the Liberal government, I think just the name changed. Nothing changed in terms of actual results or even the types of agreements that were created” (Participant 4). Participant 4 further detailed that many of the changes that did occur would have had more to do with political perception, as opposed to substantive differences between the original agreements and new agreements emphasizing public ownership: “Because the Liberal government politicked on the basis of they were against the P3s during the election, I think that once they were elected, my perception again is that the Liberal government realized that this was the appropriate way to go for these two hospitals, and I think in order to assuage the public’s perception they changed the name from P3s to alternative finance projects.”

In regards to the Royal Ottawa Hospital project in particular, following the election, there would have been very little that changed in terms of the business case or funding model for the project (Participant 6). A public charter was developed in the case of the Royal Ottawa Hospital; a one page document that affirms the commitment of the hospital corporation towards

maintaining the Royal as a public hospital (Participant 6). This document, however, did not seem to have any major function beyond perceptions of the project. Referencing the public charter, Participant 6 further detailed that they felt that “[i]t’s really important to know that it was a slip of paper that met political needs. There was not any material difference between the original deals and the Liberal deals.”

Some participants expressed that they felt that the reluctance to consider operational service delivery mechanisms for the hospitals reflected a common and fatal flaw in public health infrastructure procurements. One research participant expressed exasperation of the inability of government, in this case the political staff, to appreciate the fact that “capital and operating desperately need to be married” (Participant 8). From their perspective, it was common for government to attempt to “cut ribbons and then try to figure out the rest later” for P3 projects, rather than appreciating the fact that design, construction, and operations have a number fundamentally connected aspects that should be considered if planning is to take into account the full lifecycle of a project. While extensive focus is given to the capital side of planning by government (and how much a project costs up front), ultimately operations and maintenance over the course of the project are a much more significant cost and a longer-term investment.

5.5 Implementation and Operation

Implementation and operation of a project includes the development and construction of the project, ongoing management and operations of the facilities, and the end of term. The agreement set out in the negotiation phase guides the project over development and the lifecycle of the project to the end of term (SuperBuild, 2001). Key to this phase of a procurement project is ensuring that private-sector commitments as laid out in the agreement are met throughout the

term, including monitoring the development and construction commitments (SuperBuild, 2001). This section will analyze the final details regarding the construction of each project, timelines for completion, while also considering some of the challenges experienced thus far throughout the opening of the hospitals and project operations.

5.5.1 Implementation and Operation: Brampton Civic Hospital

Construction of the Brampton Civic Hospital occurred over a three year period between 2004 and 2007. As noted in the Auditor General report, the construction period was not without issue, and projected costs for the project varied throughout the construction period and estimates were frequently on the rise. One particular item of concern that came up over the course of construction was a rise in costs related to facility design to accommodate Information Technology (IT) equipment. Since these costs were not integrated with the initial plans for the site, they were over and above of the initially agreed-to costs for the project. As a result of the required design revisions, \$63 million in additional costs for mechanical and electrical modifications within the new facility were required to accommodate the installation of new medical equipment (Auditor General, 2008). During the three-year period of building construction ending in 2007, the total capital cost for the hospital was \$614 million. Of this, \$467 million was for design and construction costs for the hospital. \$63 million was required for facility modifications to accommodate design changes and equipment installation. \$84 million was for financing costs for the private partner (Auditor General, 2010).

In July of 2007, construction of the hospital was deemed complete. On July 3, transfer of possession for the facilities from THICC to WOHC was marked by a private ceremony on the new hospital grounds (William Osler Health System, 2007, “Brampton Civic Hospital

construction completed”). The Brampton Civic Hospital officially opened several months later in October 2007 with 479 beds in service, with the number of beds increasing to a total of 608 beds over the next few years (Hansard Official Report of Debates, 2009). The planned rollout for increase of bed capacity determined at launch was for 527 beds to be made available as of the 2009-10 fiscal year, 570 beds in 2010-11, and the full capacity of 608 beds by 2011-12. In his testimony to the Standing Committee on Public Accounts, Mr. Ken White indicated that this rollout plan was a result of an anticipated lack of initial demand for health services necessitating the full capacity of the hospital. Furthermore, the hospital lacked a sufficient staffing complement to operate at full capacity as of opening day (Auditor General, 2008). According to Mr. White, “the anticipation that there were going to be 608 beds on day one was an impossibility” (Hansard Official Report of Debates, 2009, p.296).

5.5.2 Implementation and Operation: Royal Ottawa Hospital

The new mental health facility at the Royal Ottawa Hospital was, upon completion, a 2-story building with one lower level, with capacity for 200 bed in-patient care. Additionally, the building featured a 3-story out-patient wing, and a 7-story research and administration tower. The total facility size was over 400,000 square feet of space (Ellis-Don, “The Royal Ottawa Hospital”). This project has been cited as being delivered on time and on budget, opening six weeks before the anticipated completion date and at a cost in line with projections (Murphy, 2008). Interview participants noted that the project “...went from concept to the opening date party in seven years, when the average hospital in Ontario have been 17 years from concept to completion” (Participant 6). The total final cost of the construction phase of the Royal Ottawa Hospital was \$146 million. Of this, \$132 million consisted of senior debt, and \$15 million was of equity. This is based upon the fact that 90% of the funds for construction were borrowed, and

10% was provided by the proponent (Ontario Health Coalition, 2008b). The terms of the leaseback arrangement, similar to the Brampton Civic Hospital, entailed public ownership of the lands with leasing arrangements to the private consortium. Ongoing payments from the ministry were to equal approximately \$1.1 million monthly over a period of 248 months at an interest rate of 6.33% (The Ottawa Citizen, 2009, “Audit on Royal Ottawa Sought”). The total public partner cost for construction, financing, and operations over the course of the 20 year, eight month arrangement between public and private partners was expected to be \$256 million (Royal Ottawa Hospital, 2004, “Construction on New Royal Ottawa Hospital and Research Institute Begins”). At the end of the lease, the Royal Ottawa Hospital is to revert to public ownership (The Ottawa Citizen, 2009, “Audit on Royal Ottawa Sought”).

5.5.3 Implementation and Operation: Cross-Case Analysis

This section will analyze some of the steps taken during the opening of the hospitals and early operations to meet the requirements and specifications of the agreements, as well as any successes or failures in engaging with the local communities in regards to hospital opening and operations. As both projects remain towards the front-end of their lifecycle, this section is not directed at assessing success of these projects in meeting performance obligations or managing operations over the lifecycle of the project. Analysis will detail the challenges in relation to final design specifications for the hospitals, community engagement, and challenges experienced upon the opening of each hospital.

5.5.3.1 Design Specifications

Both projects appeared to experience issues in the construction phase that led to greater cost or additional scrutiny following the opening of the hospitals. Design specifications, particularly in the case of the Brampton Civic Hospital, may not have adequately taken into consideration technical change from the original design parameters to meet the final designs required for a modern hospital. A number of cost overruns were incurred as a result of changes to the design of the facility to accommodate technological enhancements. This may not have been adequately considered at the onset of the project, and the contract for this project may not have provided sufficient flexibility to adapt required design revisions as the technological landscape evolves (Barrows et al., 2012).

In the case of the Brampton Civic Hospital, additional costs were incurred for modifications to facilities to accommodate the installation of medical equipment. A \$63 million cost overrun, or about 13% of the total project cost, was incurred as a result of the planning and installation of medical and IT equipment not being adequately integrated with the construction process for the hospital. The building itself was not suited for the equipment that the doctors wanted to buy (Hansard Official Report of Debates, 2009). In the report, the Auditor noted that some of these costs may have been avoided with sufficient planning for changing technology over the course of the agreement. WOHC acknowledged that part of these costs could have been avoided with additional consideration in the planning stage. The Ministry has indicated that future AFP arrangements would take into account specifications related to equipment installation and changing technology as part of upfront considerations (Standing Committee on Public Accounts, 2009). According to Mr. Sapsford, there was a delay in decision-making concerning the capital equipment. The hospital struggled in making decisions of this kind, according to Mr.

Sapsford, and during construction when final decisions were to be made about equipment, a great deal of renovation was required to accommodate the new equipment (Hansard Official Report of Debates, 2009). These kinds of equipment decisions are now part of up-front considerations for these projects and are adequately incorporated into the agreements made with private vendors (Hansard Official Report of Debates, 2009).

In the case of the Royal Ottawa Hospital, media attention further spotlighted a number of technical, safety, and security concerns at the site upon opening. In particular, a number of issues were noted relating to electronic system design for the facility. This included failures with wireless technology, malfunctions of the phone system and switchboard and jamming magnetic door locks. A number of security concerns were also noted at the site, with a lack of functioning security cameras, security breaches leading to patient escapes, and issues with alarm systems. Furthermore, some concerns relating to health and safety and accessibility were also noted, stemming from design issues for entry and access to water fountains, as well as access to sterilization equipment (The Ottawa Citizen, 2008, “A Royal mess: Can CEO George Weber fix the ROH's growing pains?”). Overall, these changes were relatively minor in scope. Research participants seemed to indicate that large-scale changes, or those on the scale of the changes necessitated at the Brampton Civic Hospital, would not have been possible, regardless. Both public and private partners appeared to have negotiated very little flexibility pertaining to construction timelines and requirements. The hospital corporation had negotiated that change orders would not be brought in, and committed financial liability to the public partner for any change orders over the course of the project. As such, the public partner was committed to the output specifications and design as early as the time when the agreement had been signed between partners (Participant 6).

Smart interventions that capitalize on the specialized knowledge of end users, private partners, and subject-matter experts represent one potential approach to improve upon outcomes relating to project design. Organizations that engage in effective horizontal coordination are seen as being better positioned to act upon the specialized knowledge of a wide range of actors who have a stake in future of the project (Klijn and Teisman, 2006). Klijn and Teisman (2006) posit that outside actors within the environment of a public organization can provide knowledge to help improve outcomes, encourage innovation, and change to adapt to phenomena emerging from the environment that would otherwise be difficult to predict or to plan for. The Ministry has indicated that future AFP arrangements would take into account specifications related to equipment installation and changing technology as part of upfront considerations for such projects (Standing Committee on Public Accounts, 2009). The specialized knowledge of subject-matter experts, such as private vendors, could be utilized to gain additional insight into specifications related to equipment installation and changing technology.

5.5.3.2 Stakeholder Engagement

The means by which cooperation may improve upon the outcomes of a project, as it is understood by governance theory, is the capacity for private agents or others outside the public organization to provide information and context to enhance responsiveness and capitalize on expertise, while the public organizations also engage citizens and service users through a transparent, engaged relationship. This process is a means by which to not only increase effectiveness through smart interventions and improve responsiveness to end user needs, but also to add a sense of enhanced legitimacy to decisions that are made as the public and key stakeholders become active and engaged partners in the project (Klijn and Teisman, 2006). Some of the most marked differences between the Royal Ottawa Hospital and Brampton Civic

Hospital projects relate to the volume and effectiveness of community and stakeholder engagement initiatives. Research interview participants pointed to visible results of the differences in approach to stakeholder engagement between the projects, noting that while media, stakeholder, and public reaction could be described as favorable for the Royal, there were noted difficulties in dealing with the community, press, and local population in the Brampton Civic Hospital procurement project. This seems to speak to the increased sense of legitimacy for decisions that are afforded a cooperative and engaging approach by public managers (Klijn and Teisman, 2006).

In the case of the Brampton Civic Hospital, both issues with adaptation to population growth in the region and outcomes that included a lacking net of new beds in the regional hospital capacity represent a significant failure on this project to achieve its intended goals (Barrows et al., 2012). Additionally, local populations became incensed at the lack of communication between those working on this project and the community, as noted in the closure of the Peel Memorial Hospital and how this issue was handled (City News, 2007, “Thousands Protest Healthcare Issues In Brampton”).

Around the same time as the opening of the Brampton Civic Hospital, the Peel Memorial Hospital was closed. The decision to close the Peel Memorial Hospital was made as a result of limitations in human and financial resources available leading up to the opening of the Brampton Civic Hospital. In the weekend prior to the opening of the Brampton Civic Hospital, records, equipment, patients, and staff were moved in a “flash cut” from the Peel Memorial Hospital to the new Brampton Civic Hospital. A total of 234 patients were transferred to the new facility (CTV News, 2007, “New Brampton hospital brings attention to shortage”). Overall, following the “flash cut,” the broader Brampton community was being serviced by fewer net new beds than

had been originally anticipated, with response from WOHC to concerns raised indicating that new beds would be phased in over several years (Barrows et al., 2012).²²

In December 2007, two patients died at the Brampton Civic Hospital. While the hospital attributed the deaths to medical error in the emergency room, increasing scrutiny was placed upon the role of the private sector at the hospital as a reason for the deaths (Auditor General, 2008). Concerns amongst the Brampton community began to grow as, increasingly, negative media coverage was provided citing anecdotal evidence pointing to long wait times and a lack of sufficient staff in the emergency room. The community concerns peaked in December of 2007, with up to 3,000 community members protesting in the streets of Brampton, demanding action from the government relating to the new hospital and health facilities in the region (City News, 2007, “Thousands Protest Healthcare Issues In Brampton”). Political opposition, including union groups, and community advocacy groups explicitly tied the troubles at the Brampton Civic Hospital to the P3 arrangement for the project.

In the wake of this controversy and community protest, the provincial government appointed a hospital supervisor to the Brampton Civic Hospital, Mr. Ken White.²³ This position includes exclusive rights to excise all the powers of the board and chief executive officer of a hospital (Cherry, 2008). According to Mr. White in his testimony to the Standing Committee on

²² According to the Auditor General’s report, the Peel Memorial Hospital remained closed and continued to provide no clinical services, with only security and engineering staff on hand at the facility to secure and maintain the building and equipment housed therein (Auditor General, 2008). Significant pressure was exerted by the Brampton community in this regard, and petitions lead by the Brampton Board of Trade and other community groups requested a complete renovation and re-opening of the facilities (CTV News, 2007, “New Brampton hospital brings attention to shortage”). A complete redesign of the facility is expected to be completed as of Fall 2016 with the opening of the new Peel Memorial Centre for Integrated Health and Wellness (William Osler Health System, “Build Peel Memorial”).

²³ Ken White was the former CEO of the Mississauga Trillium Health Centre. He had previously been appointed as an investigator for WOHC to guide them through the opening of Brampton Civic Hospital (William Osler Health System, 2008, “Ken White Appointed as Supervisor of WOHC”).

Public Accounts, the appointment of a WOHC supervisor “related to the complexity of finishing a very large construction project and moving into a new facility, while maintaining quality patient services” (Hansard Official Report of Debates, 2009, p.291). A number of hospital operating changes were necessitated due to staff lacking familiarity with the new facility and new technology that differed from the old facilities. Populating the Brampton Civic Hospital with staff from the old facility, beginning clinical services, and designing operational changes to accommodate the new premises were all issues that necessitated the central guidance of a supervisor (Standing Committee on Public Accounts, 2009). Speaking before the Standing Committee on Public Accounts regarding the protests by local community members regarding the quality of services provided at the hospital, Mr. White indicated that the transition made to the Brampton Civic Hospital was dramatic and fraught with internal issues. It was noted that it is necessary to anticipate issues of this kind going forward, as instability in transitions of this kind can jeopardize operational stability and put patient care at risk (Standing Committee on Public Accounts, 2009). Mr. White indicated that the Ministry, with input from WOHC, would continue to work to develop a more consistent approach to change and transition, indicating that he was a member of a “committee ... at the Ministry – I’m on it – that’s looking at how we deal with these transitions” (Hansard Official Report of Debates, 2009, p.296).

In January of 2008, top executives at the Brampton Civic Hospital resigned in the wake of turmoil at the hospital. This included the CEO, CNO, and Executive VP. The complaints further fed the ongoing controversy surrounding the hospital, particularly given the scrutiny by the media and interest groups, with accusations regarding diminished levels of patient care and protests leading up to the resignations (Yelaja, 2008). The project continued to be the subject of

controversy and ire up to and including the release of a report from the Auditor General of Ontario in December 2008 (Talaga, 2008).

In his testimony before the Standing Committee on Public Accounts regarding the Brampton Civic Hospital, Supervisor Ken White noted issues with public expectations for the new hospital versus the final product design (Standing Committee on Public Accounts, 2009). WOHC struggled to engage the community and stakeholders, particularly in relation to the closure of the Peel Memorial Hospital prior to the opening of the Brampton Civic Hospital. It appears that a number of stakeholders drew conclusions relating to the negative nature of the involvement of the private sector in health care as a result of the lack of communication and response (Barrows et al., 2012). The community, as Mr. White indicated, had expectations regarding the hospital location, the closure of the Peel Regional Hospital, and other issues that were not addressed by public outreach (Standing Committee on Public Accounts, 2009).

Public reaction, in many ways, stemmed from the fact that the P3 model was relatively new to Canada at the time, and perhaps not particularly well understood (Barrows et al., 2012). A communications plan may have served as a means to educate the broader public in Ontario, or community in Brampton specifically, on the elements of a P3, including clarifying details about ownership of public assets and service delivery. The community management aspect of the Brampton Civic Hospital in particular has been noted as being poorly done, with little focus on communications or stakeholder engagement for this project (Barrows et al., 2012).

The opening of the Royal Ottawa Hospital was not without some controversy, as well. In particular, some negative attention was paid to the fact that the outcome of the project resulted in a significant reduction in in-patient beds and a higher-than-anticipated reliance on out-patient

group home care services. Overall, 30% of the hospital beds for this project were cut for cost reduction purposes (Auerbach et al., 2003). Additionally, while the project was originally announced as a 284 bed hospital at a cost of \$95 million at the VFM and project scoping stage, it was officially opened on October 27, 2006 with only 188 beds having cost \$146 million. It should be noted that the change in scope and cost of the project occurred prior to final approval and the start of construction, however (Ontario Health Coalition, 2008b).

While the Royal Ottawa Hospital project was not without its issues, there certainly was not the same reaction on the part of the community to the opening of the hospital. Research interview participants noted the difference between the cases, and largely attributed the success of the Royal Ottawa Hospital in this regard to have been a strategy of engagement that included informing the broader community and engaging in community committees (Participant 2). Consultations for the Royal Ottawa Hospital were described as having involved local associations and groups were described in detail by Participant 6:

“...we wanted to make sure we had the neighbours on board. We met with the neighbourhood associations every three months, and there were three involved in the vicinity where the hospital would be built. We’ve essentially made a promise that we would have the exterior of the hospital blend into the design and the feel of the rest of the neighbourhood. We also communicated what the construction schedule would be, and we invited them into some board meetings to get presentations as our Mayor needs, the neighbours need. So we formed a very solid bridge and partnership with the neighbourhood associations that they were brought in as part of the success of the project.”

Participant 2 recalled discussions with members of the media that lauded the work of the Royal Ottawa Hospital for their efforts to engage the community as well as the press. This was even the case for those considered to be ‘hostile’ members of the media, perceived to have an agenda against what would have been spun as the privatization of hospitals. Participant 1 further described an engaged relationship with members of the press, and significant efforts to engage with local media in particular, especially in comparison to the work undertaken in this area by the Brampton project:

“The other thing we did, which William Osler refused to do, was we were very open and transparent with the media and others, and got the media on side locally. We were asked to go to the editorial panels of the Toronto Star, The Globe and Mail, and so on, and we asked Williams Osler to come with us and they refused to go... We were warned not to go to the Toronto Star by various forces. They said, ‘you are just going to get eaten alive,’ but we got a favorable editorial, and the way they said was, ‘this is okay for the Royal Ottawa but may not be okay for anyone else.’ We explained to them why we were doing this and with the rationale and so on in place, they accepted that and they wrote an editorial in our favor.”

The favorability was largely attributed to efforts at broad-based engagement throughout the course of the project. Representatives from the William Osler Hospital Corporation, at this point, were also noted as having refused invitations to participate in editorial panels or attempts at collaborative media engagements that may have been undertaken by the Royal Ottawa Hospital (Participant 1). Similarly, the Royal Ottawa Hospital project was noted for entering into significant negotiations and consultations with their unions prior to the actual P3 arrangements coming into effect. The Brampton Civic Hospital project, meanwhile, was seen as having much

less interaction with labour unions over the course of the project, which interview subjects believed would have had an effect on some of the eventual outcomes (Participant 4). For that matter, union and public interest group opposition to the project was quite significant, with these groups eventually entering into litigation against the Ministry of Health and Long-Term Care in a lawsuit that would remain outstanding through to financial close of the project, creating significant unease for the hospital corporation and private partners (Participant 8).

With regards to the Brampton Civic Hospital project, stakeholders identified a general lack of any kind of formal plans to manage communications and promote transparency between the hospital development project and the broader community (Barrows et al., 2012). It appears that little engagement occurred around the opening of the hospital, particularly in terms of informing the community with respect to the planned closure of the Peel Memorial Hospital. The community appeared unprepared for the outcomes in terms of diminished regional hospital capacity, and “it is apparent that a number of stakeholders took the opportunity derived from this lack of communication to present a negative picture with respect to the involvement of the private sector in healthcare” (Barrows et al., 2012, p.26).

5.6 Summary and Conclusion

This chapter was a multiple case study of the Brampton Civic Hospital and Royal Ottawa Hospital, examining the projects through the lens of complex evolutionary theory to provide insight into the governance of the projects. Particular consideration was given to the kinds of networks of interactions that existed at the project scoping, RFP, negotiations, and implementation stages of the projects. The relationships between the central actors involved in the projects, and how central actors would have changed in their role and relationship over time,

was assessed for each stage of the project. Reflections and observations made within this chapter considered how the structure of interactions would have ultimately shaped the direction of the projects, as well as assessing the ways in which “smart interventions” were conducted to utilize the expertise of actors and stakeholders external to government at critical junctures both to better inform decision-making as well as to add legitimacy to project decisions. Neither project demonstrated, nor was expected to demonstrate, a consistently horizontally managed governance structure. However, key examples cited throughout the chapter note the successes and failures of these projects in engaging with private vendors and stakeholders, activating the expertise of agents through smart interventions, and utilizing inclusive forms of decision-making to assure “buy-in” for the ultimate direction of the project. Overall, the Royal Ottawa Hospital project in particular is noted as having some observable successes in leveraging networks of interaction with private vendors and stakeholders to the benefit of the project. The subsequent chapter will further summarize the findings throughout the comparative case study, highlighting some of the key successes and challenges observed throughout the study of these two projects, among other findings regarding the structure of networked interactions throughout the project.

Chapter Six: Summary of the Analysis and Empirical Findings

Conducting the case studies through the lens of complexity theory, the analysis of the previous chapter was particularly focused on the relationship between actors and how interactions were structured for the Royal Ottawa Hospital and Brampton Civic Hospital partnership projects. Examining the interdependencies between actors, interactions of elements at and beyond the borders of the projects as complex systems, and studying the interconnectivity of the projects was posited to lead towards a greater understanding of how decisions were made and how structures of interaction ultimately shaped the direction of these particular projects (McDaniel, 2004). As stated in the theory section of this research study (Chapter Three), a rich understanding of the interdependence between actors within a system can yield observations around both positive and negative impacts that interdependence and networks of interaction can have, as changes between actors results in co-evolution and change beyond the boundaries of the systems, here understood as two public-private partnership projects (Mitleton-Kelly, 2003).

This chapter summarizes the empirical findings yielded through the study of these two projects from the perspective of complex evolutionary systems theory. These findings relate to how relationships in the projects would have evolved and changed over time (and the impact of such on the projects), the way structures of interactions were shaped between partners, stakeholders, and the project managers, and the various inputs into key decisions-made, with a consideration as to the capacity of the two projects to successfully activate the expertise of partners and stakeholders at critical junctures (Klijn and Teisman, 2006).

This chapter is the product of synthesis of the key themes and conclusions of the previous chapter. Findings are to suggest a response to the central questions of the research through observations made over the course of the case studies and comparative analysis of the projects. As such, the structure of observations and findings within this chapter will directly correlate to the core research questions of the study.

6.1 Who were the key actors involved at each stage of the procurement process?

Complexity theory suggests that the study of interdependencies and interactions among the elements within a system, as well as the study of the unity of the system itself, can provide some critical insights regarding the function of an organization (Anderson, et al., 2005). This particular research question was included to ensure that the study provides insight into the various agents involved at each stage in the process and analyzes the interdependencies between these agents. Empirical findings pertaining to this question related to the key interdependencies and relationships that would have characterized each stage of the process. Focus was given to the delineation of roles between various agents at each stage and understanding power structures, both formal and informal, as well as gaining insight into where cooperation and conflict would have entered into the relationships between agents. The empirical findings pertaining to this research question will detail findings relating to the agents driving design and change at each stage of the projects, observations about the nature of the relationships, and how the patterns of interaction shaped the direction and results for each hospital project.

6.1.1. Significant challenges in role definition and a vertical hierarchy characterized the early stages of these projects

It is not always easy to convert ambition into action in public administration. Plans initially formulated by the government of Ontario for the Brampton Civic Hospital and Royal Ottawa Hospital projects would require cooperation with various actors within the government of Ontario, the hospital boards, local governments, and stakeholders for eventual implementation. The literature available on these two projects helped to define the somewhat inchoate policy processes and institutions for these two projects, while observations from this research study offered new observations pertaining to tensions in the planning stages and struggles with defining roles and power relationships for the projects. Analysis from a complex network perspective, observing as it would the ‘games’ and ‘arenas’ for decision-making in the operational environment and motivations for actors in the projects, should make it possible to picture the complex decision-making environment in which these two projects were formulated, and offer additional perspective into who and what may be connected in the decision-making process (Van Gils and Klijn, 2007). Furthermore, this research study aimed to provide new insight into the conflicts between actors and their values; a constant tension within these projects as these two cases proved to be time-consuming and costly to manage.

Early on in the projects, much of the structure and power relationships between actors would have been in flux, as not only was the P3 procurement process new to the province of Ontario, but also hospital procurement had not been a priority for quite some time for government. Resultantly, hospitals, the Ministry, and other public actors struggled to piece together teams capable of planning to undertake a project of this scale (Hansard Official Report of Debates, 2009). The absence of set policy and processes, along with the ‘proto-enabling’

framework for partnerships existing under SuperBuild, created a great deal of uncertainty in terms of moving projects forward at the onset (Whiteside, 2015). In describing the projects and actors involved at the project scoping phase, research interview participants emphasized the lack of experience and challenges in role definition as defining the early stages of these projects. Ultimately, the provincial ministries had the most experience in capital planning and would have signatory authority at this phase for decisions, and as such would lead in discussions with steering committees created by the hospital boards for decisions relating to procurement methods, project design, VFM, and requirements (Auditor General, 2008; Laird and Langill, 2005). Consultants, government agencies, and commissions would also provide context into these decisions in some capacity (Hansard Official Report of Debates, 2009). SuperBuild would have operated in an advisory function to the Ministry of Health and Long-Term Care at this stage, functioning in what was described by research participants as a gatekeeper capacity.

As will be further detailed in the subsequent section, challenges in political-administrative commitment can lead to the issue of an “unreliable and multi-headed government” (Koppenjan, 2005, p.129), owing in part to the inherent complexity in managing projects with a varying mix of local, regional, or national authorities, each with their own preferences and objectives for the projects. Amidst the environment of a ‘proto-enabling’ framework and loosely defined roles for project partners, research evidence revealed the public partners for these projects as multi-faceted actors with, often, contradicting strategies and goals.

According to interview participants, the early stages of the project were characterized by guarded relationships and, frequently, silos of interaction between the various public actors involved in project scoping. The Ministry of Health and Long-Term Care was described by research participants as being covetous of its relationship with the hospital corporations and its

role in capital planning endeavours. According to one research participant, the “Ministry of Health had taken on this capital planning role for years, and were accustomed to a certain responsibility and control.” Challenges arose in definitions of role and authority as SuperBuild, with a mandate from government and relatively untested structures and networks of interaction, was interjected into the capital planning processes. Research participants recall the hospital boards operating as mediators between the Ministry of Health and Long-Term Care and SuperBuild to ease tension associated with unclear role definitions in the new project relationships.

Relationships between the Ministry of Health and Long-Term Care and the hospital boards were described by research participants as also fraught with passive aggressive activity and resistance to engaging in what would be considered a collaborative, horizontally-managed approach to project design and scoping. There appeared to be a disparity between the functional aspects of the program, as envisioned by the hospital boards, and what the Ministry of Health and Long-Term Care considered to be a reasonable economic structure (Participant 7). This kind of operating environment has been noted as being responsible in other partnerships for issues with late changes to design or policy that can, in some circumstances, drive up costs for projects (Koppenjan, 2005). The subsequent section will summarize the observations made through this study relating to how the issue of lack of experience, conflicting goals, and issues in role definition may have impacted the partnerships in the two cases of study.

6.1.2. Lack of experience and public-public tensions contributed to high transaction costs

Challenges with structure and a lack of experience and knowledge on the part of public sector managers necessitated significant horizon scanning and consultation as these projects were

developed and brought to close. As can be seen in these two cases, the contracting of outside expertise by a public partner with little experience and a weak negotiating position can demonstratively raise the transaction costs for a project. Aforementioned challenges in terms of public sector experience and unclear role definition, as well as hospital boards and the Ministry lacking in-house resource expertise both in regards to project management and negotiation, necessitated the frequent contracting-out of experts and consultants. The multi-faceted procurement and negotiation process that was undertaken for these hospital projects was, at the time, untried in Canada. As a result, consultants were contracted with expertise in areas including audit, enterprise risk, financial advisory, consulting, and tax experts (Participant 3). There were further consultants contracted with expertise in Canadian and international law relating to the structure of deals, financial advice, credit risk, and evaluation (Hansard Official Report of Debates, 2009). Issues with lack of expertise would have been further exacerbated by the financial position of the hospital corporations. Facing significant deficits as they sought to enter into long-term agreements with their private partner, public partners fought against aspects of “parent guarantees” or long-term commitments, lengthening the negotiation and consultation process (Pigott, 2006). All of this resultantly contributed to the overall transaction costs of the projects (Barrows et al., 2012; Ontario Health Coalition, 2008b).

Evidence provided by research subjects in this study indicates that there was a perception amongst those involved in these projects that transaction costs may have been lower were it not for internal opposition to the selected P3 approach. Oppositional behaviour was noted in planning meetings for the projects relating to the procurement method and financing for the projects. In complex network theory literature relating to P3s, this kind of behavior has previously been described as “the issue of the unreliable and multi-headed government”

(Koppenjan, 2005, p.129). This refers to the kind of public-public tensions that can arise in multi-public partner partnership arrangements, wherein decision-making processes struggle against internal public-sector value disagreements (Koppenjan, 2005). Examination of the cases through the lens of complex network theory helped to identify and make clear the source of such tensions within the projects. Examining the relationships between actors involved in these projects helped to draw out some of the values tensions within the decision-making processes and better understand who was involved, and how that could have contributed to additional costs for the projects. According to interview participants, internal government stakeholders including the OFA and Ministry of Health had both been noted as demonstrating some level of opposition to the P3 approach, necessitating significant consultation. Oppositional parties created tensions in meetings between the hospital board, provincial government, and in doing so had the effect of “frustrating the consultants, frustrating the hospitals, and burning money like crazy” (Participant 3). Untenable requirements for P3 comparators and general unease with an untested procurement mechanism drove additional introspection and consultation for the projects. Testimonial from executives and project managers, as well as evidence presented by the Auditor General, support this evidence through acknowledgement that consultation relating specifically to the P3 mechanism may have been in excess of what was required, thus driving the costs for the projects up significantly (Hansard Official Report of Debates, 2009; Auditor General, 2008).

Overall, the Royal Ottawa Hospital incurred transaction costs associated with retention of expert advice and negotiations of as much as \$8.1 million; 5.5% of the total cost of the \$146 million project (Ontario Health Coalition, 2008a). In the case of the Brampton Civic Hospital, given the greater scope of the project overall, transaction costs were appropriately higher, but represented an identical share of the total project budget comparative to the Royal Ottawa

Hospital. In the case of the Brampton Civic Hospital, upwards of WOHC 60 consultants for legal, technical, and financial advice were retained throughout the project, at a cost of approximately \$34 million; this was also 5.5% of the total budget for the \$614 million project. The vast majority of these costs would have related specifically to the work associated with developing and implementing the new P3 procurement approach (Auditor General, 2010).

Certainly, the observations offered by this study are not simply that transaction costs were incurred equally for these projects, nor to merely associate these costs with the untested methods of procurement these projects. Rather, it was the intent of this research to better understand the relationships between actors, in this case internal to the public sector, existing as a complex network itself, and the tensions existing therein. Understanding the public partner as one cohesive unit, as opposed to a network of public actors and institutions, would not sufficiently account for the kinds of public-public value disagreements that can occur in a complex, networked partnership between a private vendor and government. Furthermore, opposition to the utilization of a P3 mechanism may not end upon the finalized decision to pursue a P3, as was observable both in these cases, as well as in other international case studies on partnerships from a complex network theory perspective (Koppenjan, 2005). The research contributions of this study corroborate how these kinds of tensions may arise within a partnership project, and help to contextualize the significant transaction costs associated with these two projects.

6.1.3 Both projects experienced challenges in risk definition and assignment, complicating the negotiations process

Koppenjan (2005), in analyzing a series of transportation infrastructure partnerships in the Netherlands, observed a common pattern of issues for projects wherein hesitant and risk-avoiding behavior for cooperative endeavors in the planning phases resulted in a pattern of stagnating the contract negotiation processes. Aspects of this pattern can similarly be seen playing out within the two cases of this study. Market consultations and assessments conducted for these two projects were seen as similarly disappointing in terms of outcomes. This necessitated what was often unilateral project preparation on the part of the public partner, followed by some particularly challenging contract negotiations. Ultimately, this resulted in challenges in risk management and planning that lengthened and complicated the negotiations process. Research participants in this study provided insight into the knowledge gaps for the public partners as it related to these projects, thereby adding perspective into what is generally acknowledged as challenging and lengthy negotiations processes for the projects.

That these projects had a protracted and often challenging period of negotiation is not in question, nor did it need to be proved through this research as such had been previously established in available literature; however, analysis of the structure of relationships in negotiations helps to identify some of the causal reasons for such being the case. Significant knowledge gaps on the part one or both partners may present challenges that, it has been argued, could be alleviated through a more engaging series of consultations within the relationship, or through effective market consultation on the part of the public partner (Koppenjan, 2005). Contributions from research participants helped to identify some of the gaps in knowledge for the projects, and offered observations of the resultant impact on the projects in negotiations. One

participant noted that there is a common issue of public partners not knowing how to properly assess or price risks for projects involving the private sector, and such would have contributed to any challenges in bringing the projects to close following the negotiations process for the Brampton Civic Hospital and Royal Ottawa Hospital projects. According to this same participant, at the same time, “private partners have no political skill or understanding of relationship management, and may make financially leveraged decisions that may come back to haunt them” (Participant 3). With these two projects in particular, there were noted challenges and deficiencies in defining and assigning risk. According to one participant, “the risk management process was not very well developed” (Participant 3). The projects were described as lacking a defined central repository for risks identified for the project, as a risk register was not developed to detail information on the source, nature treatment option, existing counter-measures, recommended counter-measures and so on for all project risks. Other participants described onerous experiences in developing construction renewal policy with SuperBuild while the projects were underway, appearing to have occurred in an improvisational manner, in order to better mitigate public risk exposure (Participant 6). The lack of internal capacity or an engaged process to address knowledge gaps combined with challenges in market assessment and consultation in the planning process was observed as ultimately leading to challenging negotiations that contributed to delays and rising costs for the projects, as deficiencies relating to risk management and planning were eventually borne out in the negotiations process.

Research participants provided insights into a lengthy and at times challenging negotiation process, with the main sources of conflict centering around risk assumption for anticipated rises in commodity costs, debt financing and responsibility for debt financing, lifecycle management systems, ensuring that private sector equity was not lost, human resources,

potential changes to commercial tax regimes, and generally coming to agreement on which partner, public or private, would be best equipped to take on risk. One participant noted that it was the public partner in these cases that was the more intent of the two partners on ensuring risk transfer for items typically assumed by the public sector, which was seen as protracting the negotiations (Participant 6).

6.2 What were the main considerations and sources of information in the decision-making process at each stage of the procurement process?

This research project was concerned in many ways with understanding the impetus behind key decisions in these two projects and the various inputs that would have been involved in the decision-making process. To this end, the case studies observed how consultations and engagement was conducted, key sources of information, and how relationships and patterns of interaction were structured. Part of this involves understanding the key inputs and sources of information for these projects. This question sought to provide context on how successful the two projects were at scanning their operating environment and what determinants, internal or external to the projects, would have shaped formative decisions throughout the process.

6.2.1 The decision to utilize a P3 procurement method for these projects was largely based on need

The Auditor General's 2008 report made reference to a directive on the part of government indicating that projects would follow a P3 approach, and hospital boards would not have had an option of choosing which procurement approach they would follow for infrastructure development (Auditor General, 2008). Despite this, evidence points to the fact that regardless of any prerogatives relating to partnerships in government, realities of the situation

dictated much of the decision-making as to what procurement method would ultimately be adopted for these projects. In the case of the Royal Ottawa Hospital, the corporation was faced with an unsustainable financial position, facilities that were inefficient and unsuited to meet the new mandate or the needs of patients, and was facing significant capital costs for a facility redevelopment project (HayGroup, 2001). In a general sense, research interview subjects confirmed the veracity of evidence already available pointing to the lack of capital available to the Ontario government at the time and need for solutions to improve health infrastructure in the province as being a common impetus for both projects, and that such would have been a main determinant around the decision to adopt a P3 approach to these projects. As stated by one research participant, "...the economic landscape was such that; number one, there wasn't a lot of capital dollars around. And number two; there was a major need to renew stock in terms of healthcare facilities in Ontario." Research participants expressed opinions indicating that they felt that this approach would have been considered regardless of any government directives relating to consideration of P3 approaches. For example, one participant commented that "...the process was already leaning towards this happening. There was no way the Government of Ontario could afford fixing up the infrastructure for health." Another interviewee (Participant 2) expressed that the projects likely would have required significant additional time to secure financing, should they have considered a publically-funded model.

Overall, observations relating to the operating environment through the inquiry of this study did not serve to reveal divergent observations comparative to available literature on the two projects regarding the context for pursuing a private financing mechanism, instead providing some additional perspective from those close to the projects relating to how such decisions were arrived upon. This, at most, serves to confirm some of assertions of prior analytical literature

pertaining to the projects (Whiteside, 2015). However, the economic climate at the time, capacity of the public partner, and perceptions of public managers pertaining to the use of a private financing mechanism remain important contextual data to consider when analyzing the management and decision-making processes of these two projects.

6.2.2 Value for Money Assessments may not have played a major role in the direction of the two procurements

Evidence suggests that VFM information was conducted too late in some cases to have had a significant impact on the direction of the projects or the decision to pursue a P3 approach (Auditor General, 2008), and the results from the VFM were not shared freely during the RFQ process and would have had little impact on the eventual bids that were received from prospective private partners (Auditor General, 2008; Whiteside, 2015). In the case of the Brampton Civic Hospital, there was a lack of formal assessment based upon a business-case analysis of the criteria for procurement to ensure value for money for the selected procurement option prior to the selection of the P3 approach, and the Auditor General (2008) indicated that insufficient evidence was presented to demonstrate that a traditional design-and-build approach would have been less cost efficient than the selected option. The VFM that was conducted lacked formal assessments of cost differentials between public and private financing, and it was unclear in this document that higher financing costs for the public partner would be offset by costs associated with risk transfer to the private partner (Barrows et al., 2012).

That there were challenges with the VFM and its applicability, for the Brampton Civic Hospital project in particular, was already clearly established in the literature. To a large degree, in the case of the Brampton Civic Hospital, the Auditor General (2008) has discredited the notion

that VFMs conducted for the project could provide any real value. Analysis on the Royal Ottawa Hospital project has similarly found that the justifications for the selected approach presented through the VFM process “bear no correspondence with the reality of [the] project” (Whiteside, 2015, p.173). Research conducted through this study provides additional insight into how Ontario conducted some of its first VFM assessments, and in doing so help to explain why these projects would arrive at VFM that were of less utility than what would be expected of projects of this scale.

Participants described the VFM as existing more of a requirement for approval through Cabinet, as opposed to being a genuinely useful assessment of the value of the P3 approach to procurement for the projects, describing the requirements as a “very complex VFM benchmark” that necessitated “[designing] the process from scratch” (Participant 7). Other participants doubted the usefulness of the Royal Ottawa Hospital’s preliminary assignment of risk between public and private partners in the VFM. One research participant, in describing the negotiations process and deliberations around risk assumptions that were made, noted that the risk assignments indicated within the document only had a small influence over the direction of negotiations by serving as a baseline, and that risk considerations at this stage were poorly developed (Participant 3). Ultimately, moving away from a public comparator, as described by research participants, and modeling key decision inputs on international comparators may have limited the usefulness of the assessment; this corroborates assessments within the literature that poor evidence of public design-build-operate was offered through the VFM (Barrows et al., 2012). Ultimately, the ‘made-in-Ontario’ approaches for VFM developed at the time appeared to have little utility or transferability outside of these two examples.

Characterizing the guarded relationships noted in early stages of the projects, results of the VFMs that had been conducted were not shared with RFQ applicants. While this may have been intended to prevent the setting of a comparator benchmark for RFQ applicants, in practice this resulted in potential applicants not knowing the budget range they were expected to work within for the projects, and ran the risk of the submitted proposals exceeding the VFM that had been conducted (Auditor General, 2008; Laird and Langill, 2005). This appears to be reflective of a conservative approach to information sharing during the RFQ stage. In the case of the Royal Ottawa Hospital, the outcomes of closed lines of communication did appear to be somewhat problematic. One of the proponents that applied was eliminated at the RFP stage due to issues with their proposal, leaving the hospital corporation to select between just two qualified vendors. This was largely due to the fact that the design submitted did not meet the output specifications required by ROHCG. Additional information from the VFM provided to the participants, as well as affording the proponents an opportunity to submit preliminary designs at the RFQ stage with feedback prior to formal proposal submission, may have avoided this issue.

6.2.3 Assessments of the private market did not appear to be robust

Both RFP processes were noted as having conducted private market assessments to demonstrate that the Ontario market of vendors was sufficient to support the procurement. One research participant detailed their experience with private market assessments for the projects, noting that consultations undertaken by the Ministry of Health for the projects would have involved equity holders and experts with ratings for market readiness (Participant 7). The process of assessments was noted as needing improvement. The Auditor General's 2008 report speculated that the bundling of design and construction with operational services for the Brampton Civic Hospital would have limited the number of potential private applicants for the

project (Auditor General, 2008). The report emphasized the need for thorough private market assessments prior to the RFP stage for AFP projects going forward (Auditor General, 2008).

Overall, private market assessments did not ascertain the dearth of potential applicant vendors for these projects. The projects do not appear to have benefited significantly from a competitive private market, both having selected the same vendor through an independent process. There were very few qualified respondents at the RFP stage for both projects, and both projects ultimately selected the same private vendor. Laird and Langill (2005) posited that at least three viable applicants would have been required for the private market to have demonstrated sufficient capacity to support the RFP. While three applicants did apply, in the case of the Royal Ottawa Hospital, only one other rated proponent was considered actually viable for the project. The only alternative proponent was retained as a backup vendor as a contingency should ROHCG be unable to conclude a transaction with the preferred vendor (Royal Ottawa Hospital, 2002, “Critical Success Factors for the Re-development of the Royal Ottawa Hospital”).

6.2.4 Skepticism regarding the impact of politically motivated decisions made following the 2003 election

Following the 2003 election, the two projects were inherited by the Liberal government that formed under Premier Dalton McGuinty. He had notably campaigned against the two projects, and had been elected on a platform to bring these two particular hospital procurement projects back into the public sphere (Block, 2008). When the Liberal government came to power, it decided to go ahead with the projects, albeit with changes to emphasize public paramountcy and, critically, a shift from an operational to a capital lease. This was noted as leading to a 20

month period between the end of the RFP process and the establishment of a final agreement as revisions were made to the agreements to abate the concerns of the new government prior to final Ministry of Health and Long-Term Care approval (Auditor General, 2008). This facet of the two projects, and the resultant outcomes, is interesting as means of demonstrating the kinds of tensions that can emerge between the governance of a complex network, with both vertical and horizontal accountability processes as part of its governance, and the vertical accountability procedures present within a representative democracy. Prior case studies that comment upon the nature of tensions between representative democracy and far more managerial-focused network governance systems have recognized the difficulty in managing complex collaborative processes with classical vertical governance instruments (Klijn, 2008b). It was to this end that this study examined the perception of actors involved in the projects relating to the capacity of the new government to establish meaningful change for the projects through vertical steering on the basis of democratic accountability to promises made during an election campaign. In doing so, it was found that despite a near 20-month delay resulting from the election to ostensibly enforce changes to the projects based on a democratic mandate, evidence from research participants indicated that actual change to the project agreements and ultimate direction were superficial at best.

The evidence provided through this research corroborates observations made in other studies of P3 projects regarding the difficulties democratically elected officials may face when attempting to change the complex, networked, and nigh-established agreements between partners with history and mutual investment (Klijn, 2008b). The concerns of the new government, for both projects, related primarily to a renewed focus for the projects on ensuring public operations, management, and service provisions for the hospitals. Changes to the agreements for the projects

ensured that operations of the facilities for both projects remain within the purview of the hospitals and government, who would maintain public employees for maintenance, upkeep, and human resources, as opposed to operations being handled by a private partner under the oversight and enforcement of service standards on the part of a public partner (Participant 5). Research participants expressed significant skepticism regarding the impact that changes after the election would have had on the project. Many felt that the changes to the project were, overall, politically motivated and concerned more with perception rather than actual function. Moving the projects from an operating lease to a capital lease was described by participants as mostly being due to perception and giving the government of the day a new set of linguistics to describe changes to the project that emphasized public ownership and operations. One participant described the changes as being mostly focused on establishing paramountcy for public management; doing so necessitated revising the agreements to set rules in this regard “...and then came all the escorts to those rules and it took us another two years and another ton of lawyers to in fact re-paper the deal to come up with a different colour” (Participant 2). The time-consuming process of effecting change to the agreements was ultimately viewed as being primarily a communications issue, with little substantive impact on the direction of the projects overall.

6.3 How were key stakeholders and partners engaged throughout the procurement process?

In viewing public sector phenomena through the lens of complexity theory, this research study was interested in the way that agents within the system engaged in smart interventions to achieve desired outcomes (Klijn, 2008a). Complex systems are seen as unpredictable and linear approaches and top-down management strategies may not be able to account for or appreciate the

complexity of the operating environment of a system (Klijn, 2008a). This research question was meant as a means to identify how and why actors within the system would have worked to establish patterns of interactions and meaningful relationships with other agents, leveraging the different capacities of agents as appropriate, and engaging in consensus-building as part of the decision-making process.

6.3.1 Leveraging expert opinion and smart interventions

The public partners in both cases of study were noted as requiring significant consultation over the course of the projects; in some cases, potentially too much expert opinion and input was gathered, particularly around the decision to pursue a P3 approach in the first place (Hansard Official Report of Debates, 2009). As these were pilot projects, the knowledge gap for the public partners was demonstrable for the projects. While some failures have been previously noted relating to knowledge gaps and a lack of consultation to address them, there were a few limited instances noted wherein project managers demonstrated a capacity to leverage key private sector and stakeholder networks to contribute to desirable outcomes for the projects during the selection process and RFP stage.

Research participants detailed the involvement of the private sector during the selection process, and in doing so helped to assess where input at this stage would have had the most significant impact. Early engagement, for example during the RFI stage, presented a significant challenge, and initial interactions appeared to be highly guarded as bidders sought to prevent any impact to their competitive position. In a general sense, it was found that attempts at engagements with private partners throughout the selection process were largely limited by the large number of mandatory requirements that would have been required by the Ministry of

Health in advance of entering the RFP stage. The relationships between public and private partners were seen as evolving towards additional openness and information sharing as the projects moved towards the RFP stage. Opportunities appeared to have been afforded for private partner input into the output specifications of the projects and notional designs as part of the overall technical valuation of the bid. Despite this, interview subjects expressed skepticism about how much impact this would have had into the functional requirements or design of the project, and expressed the view that engagements during this phase may not have been as successful as initially hoped. According to research participants, the area that allowed for the most creativity stemming from input from private partners related to ancillary revenue platforms.

Following the RFP phase, additional opportunities for smart interventions that leverage expertise and networks of interaction appeared to be increasingly common as public and private partners further engaged over the eventual direction of the respective projects; these opportunities were well documented within the literature, and research participants provided complimentary insight into these consultations. In particular, research participants described the role that networks of interaction and trust-based relationships would have had on the development of service standards, performance metrics, and penalties for the Royal Ottawa Hospital project. ROHCG was also successful in leveraging the input of private vendors and those to be involved in service delivery over the course of the agreement. Given the demonstrated issues with project design necessitating major change orders, as was particularly the case for the Brampton Civic Hospital project, this kind of input can be of significant value. Additionally, Carillion, the service delivery firm, was included as an equity investor in the project (Whiteside, 2015), and was consulted throughout the negotiation process for the agreement with some direct input into the services outlined with performance measures in the

agreement, as well as included building management and operations, maintenance of building equipment, architectural elements, and grounds, security, food services, and housekeeping (Carillion Canada, “Royal Ottawa Hospital”). Private partners would have been invited to review the entire lifecycle of the project. In doing so, they engaged private vendor teams consisting of a full-spectrum of vendors, including major subcontractors who had been selected early in the design process. These teams provided feedback regarding the design of kitchen facilities, equipment selection, energy efficiency, and operational systems (Carillion Canada, “Royal Ottawa Hospital”). Finally, engagement with regional stakeholders, community leaders, and interest groups also represents a kind of smart intervention that the Royal Ottawa Hospital project appeared to be comparatively adept at, as described in the subsequent findings section.

6.3.2 Stakeholder engagement and joint-image building

Complex partnership arrangements can involve significant strategic risk. As partners commit themselves to a project or leverage financing for investment to a project, parties open themselves to the potential for capricious behavior or unforeseen circumstances. Joint-image building – the creation of mutual trust and enrichment of project content through facilitated interaction with elements within the environment – can be a mechanism to improve the adaptive capacity of a project and obtain “buy-in” from stakeholders (Koppenjan, 2005). Research conducted in this study found that the Royal Ottawa Hospital had some success in conducting intensive co-operation with a broad network of stakeholders throughout the project. The observations in the case study regarding stakeholder engagement for the Royal Ottawa Hospital project offer new insight into amount of space afforded within the project to conduct joint image building through collaboration and consultation with stakeholders. Through intensive interaction and flexibility, the hospital board appeared to be successful in developing a sense of mutual trust

between actors within the project and stakeholders within the broader operating environment. The interactions described by research participants appeared relatively inclusive, and were conducted at various stages of the project with a myriad of potential stakeholder groups.

The Royal Ottawa Hospital management team was noted as placing a significant focus on communications planning that began early in the project and continued through the duration. Communications were planned for engagement of the community, government, and media that emphasized the need for new mental health facilities in the region and the additional capacity that private financing and operations would afford the project (Participant 6). No mandate or directive prioritized these kinds of engagements; these interactions would have been the product of self-organization on the part of the hospital corporation and their management team to organize networks of interaction with a wide array of stakeholders both internal and external to the public sector. With some experience in prior P3 arrangements, the management team prioritized the development of communications plans early in the project planning stages. According to one research participant, interviews and consultations were developed by the hospital management team identifying up to 85 key stakeholders who were interviewed and consulted over the course of a 3 month period. Engagement would have included mental health and partner agencies, neighbourhood associations, other actors within government, and union representatives. According to another research participant, one key aspect of these engagements would have been to provide regular assurances to staff and union members throughout the project planning stages for those in directly affected areas of facility management services and union members regarding stability of employment and the necessity of P3 arrangements to meet capital requirements for new, improved facilities.

The engagement of stakeholders and community leaders from the Ottawa region appeared to be quite broad, and the Royal Ottawa Hospital was noted as soliciting input from past mayors, opinion leaders, and those with influence within the community who would have provided context on the need for health services within the region. One research participant described how this network of community leaders would not only inform the project, but also would be leveraged as a “Campaign Cabinet” to make the case to the newly elected Liberal government that the project was in the public interest and bring the project to close (Participant 6). As further elaborated in Section 6.4.2, efforts in joint-image building and consultation appeared to have been successful in obtaining additional “buy-in” for the project.

6.4 How did consultations with key stakeholders and partners shape the final project?

Klijn and Teisman (2006) posit that organizations that engage in effective horizontal coordination are better positioned to engage the support and expertise of actors to improve the knowledge, policy, and decision-making of public services. Horizontal decision-making can encourage innovation, change, and adaptation for phenomena emerging within the operating environment of a system that may be otherwise difficult to predict or plan for. This process is also seen as adding a sense of additional legitimacy to decisions, and is associated with improved relationships between public sector actors and the community. Examining the experiences of these projects in creating networks of interaction with stakeholders and communities leads to a number of observations regarding the impact that stakeholder management and leveraging of private sector expertise can have on a P3 procurement project.

6.4.1 *Private partner engagement appeared to have a significant impact on the structure of performance standards and penalties for the Royal Ottawa Hospital project*

The added complexity of working with multiple partners can allow for the development of solutions that may not have been realized without such complexity. Problems of multiple actors, value conflicts, and varying interests are tied, often, to solutions that are themselves complex and inclusive. Increasing complexity, with additional actors and ‘arenas,’ can make it possible (or necessary) to achieve solutions with broad “buy-in” and agreement (Van Gils and Klijn, 2007). Utilizing available literature on the Brampton Civic Hospital case and new insight into the Royal Ottawa Hospital, the case studies for this project contrasted two very different approaches to managing for complex agreements between public and private partners. The observations provided by research participants for the Royal Ottawa Hospital in particular are interesting examples of the kinds of desirable outcomes that may be achieved through interactive decision-making techniques, comparable to those seen in other examples within the literature on partnerships (Koppenjan, 2005).

As previously noted, pricing and planning for risk over the course of the project can be a challenge for public managers. As noted by one research interview participant, “sometimes the public sector doesn’t know how to properly transfer risk or price it. And so, they ask for the sun, moon and the stars and they get sticker shock” (Participant 3). This appeared to be the experience for the Brampton Civic Hospital project; the initial provisions within the agreement for standards and penalties relating to services and operations for the hospital have been described as prescriptive, complex, and transactional, as well as being quite expensive (Standing Committee on Public Accounts, 2009). The agreement consisted of a set of ambitious service standards that would have been difficult to interpret and enforce in practice, all the while driving

up the operating costs of the public partner over the course of the agreement (Auditor General, 2008). Subsequent revisions to the agreement for non-clinical service requirements were required following the actual opening of the hospital, as noted by former hospital supervisor Ken White in his testimony to the Standing Committee on Public Accounts (2009). Work was underway at the time of the hearings to simplify the agreements and build in clear incentives to reduce built-in costs relating to service standards and performance measures (Standing Committee on Public Accounts, 2009).

Service standards and performance metrics for the Royal Ottawa Hospital were noted as being designed with significant contribution from private partners and their staff (Participant 2). Resultantly, the hospital was careful to avoid setting standards for performance for the private partner beyond what could have realistically been achieved within the budgets. Leveraging private sector knowledge in the development of operational standards for the hospital ensured that the public sector avoided setting standards for the private partner where no established service standards exist, and ensured that the public partner was aware of costs and what services would be within their budgets to deliver.

Additionally, performance penalties for these standards were designed in such a way as to avoid significant punitive measures against the private partner that may have subsequently also driven up the operating costs for the project in the long-term, as noted by one research participant. The product of meetings and collaboration between the public and private partners was the development of what was described by one research participant as “basic ground rules” (Participant 2) built on trust between partners. Performance penalties that would ultimately allow the private operations managers time to fix identified problems before penalties were imposed, with progressively punitive measures for persistent issues. This was seen as a means to keep

costs down, avoid litigious behaviour, and foster an environment wherein actors are encouraged towards “...trying to do the right thing, rather than trying to figure out what clause is not enforced” (Participant 2). This seems demonstrative of the idea that inclusive decision-making approaches, particularly in areas where the public partner lacks experience or knowledge, can ensure that decisions around line items such as service standards and performance are well informed, plausible, and effective at achieving the desired result at the desired price (Maguire and McKelvey, 1999).

6.4.2 Effective community and stakeholder engagement added legitimacy to the decisions made around the Royal Ottawa Hospital project

Observations from the research around joint-image building for the cases in this study include new insights pertaining to the capacity of the projects to obtain “buy-in” from key stakeholders. Relationships in a collaborative process are complex, difficult to manage, and success in doing so does not guarantee positive outcomes for the project; interactive governance, including attempts to involve stakeholders in the designing of public policy or projects, does not always foster increased co-operation, nor does not necessarily facilitate better solutions for projects (Klijn, 2008b). However, in these two cases, there were observable differences in terms of both levels of engagement early on in the projects and the perception of the projects overall. Research participants provided new evidence surrounding the attitudes and approaches to engagement for the projects that helps to distinguish the two projects and contextualize some of the acknowledged challenges pertaining to communication planning for the Brampton Civic Hospital project in particular.

The scope of transparency initiatives and media engagement varied for the two hospital corporations. Subsequently, so too did the overall stakeholder, community, and media reaction vary for the projects. The opening of the Brampton Civic Hospital was marked by a hostile relationship with the community culminating in protests of thousands at the hospital, political opposition from union groups and community advocacy associations, negative media attention, and the eventual layoffs of senior hospital staff (City News, 2007, “Thousands Protest Healthcare Issues In Brampton;” Yelaja, 2008; CTV News, 2007, “New Brampton hospital brings attention to shortage;” Barrows et al., 2012). The project continued to be the subject of controversy and ire, eventually leading to inspection and review by the Auditor General of Ontario (Talaga, 2008). Research interview participants attributed the very different reaction to the opening of the Royal Ottawa Hospital to attempts to engage key stakeholders and obtain “buy-in” for the project from a very early stage. As previously noted, the Royal Ottawa Hospital undertook significant engagement activities with stakeholders and the local community in an effort “...to make sure we had the neighbours on board. We met with the neighbourhood associations every three months, and there were three involved in the vicinity where the hospital would be built” (Participant 6). Construction schedules were clearly communicated to the community, members of the public were actively engaged in board meetings, and efforts were undertaken to form a solid bridge and partnership with neighbourhood associations in order to make them an active partner in the success of the hospital project (Participant 6).

According to one interview participant, the Royal Ottawa Hospital made a transparent and open relationship with media and others a priority (Participant 2). Representatives from the William Osler Hospital Corporation, concurrent to this, refused invitations to participate in editorial panels or other media events with Royal Ottawa Hospital staff. Similarly, the Royal

Ottawa Hospital project was noted for entering into significant negotiations and consultations with their unions prior to the actual P3 arrangements coming into effect (Participant 6).

In contrast, the Brampton Civic Hospital project was noted as suffering from significant breakdowns on the communications front, and has been criticized for a lack of formal plans to manage communications and promote transparency with media, labour, and the broader community. Poor communications and stakeholder management around the closure of the Peel Memorial Hospital was seen as exacerbating community concerns with the new hospital development project (CTV News, 2007, “New Brampton hospital brings attention to shortage”). At the opening of the Brampton Civic Hospital, the Brampton community was facing diminished capacity, and the response from the hospital corporation was that additional capacity would be added on a gradual basis over several years (Barrows et al., 2012). WOHC was also described by interview participants as engaging in much less interaction with labour unions over the course of the project (Participant 2), and union and public interest group opposition was noted as significant, culminating in litigation against the Ministry of Health and Long-Term Care in a lawsuit that would hang over the project for the duration prior to financial close (Participant 8). Overall, the lack of communication planning has been perceived to have led to stakeholders drawing overly negative conclusions regarding the nature of private sector involvement in health care.

6.4.3 Additional consultation and smart interventions around technical design specifications could have benefitted the projects

There were similar experiences in the construction phases of the projects leading to higher than anticipated costs for change orders in the projects. Assumption of risk for change

orders in these projects was ultimately to be borne by the public partner, driving up construction costs. In the Brampton Civic Hospital case in particular, significant costs were incurred due to an inability to adequately incorporate the design of technological enhancements required for the facilities (Auditor General, 2008). As noted by one interview participant, there did not appear to be a great deal of comfort on the part of the public partner around allowing a significant amount of design leeway for the private partner. While the RFP for the project, as well as government marketing around the project, touted the capacity for private sector innovation as a benefit of the P3 approach, in the end private partners were noted as not feeling that there was ultimately a great deal of room for innovative design creativity for the project (Participant 8). Furthermore, project parameters lacked flexibility and were difficult to update through change orders to reflect the changing requirements of a modern hospital (Barrows et al., 2012). Speaking before the Standing Committee on Public Accounts regarding the Brampton Civic Hospital project, Ron Sapsford noted significant delays and challenges in decision-making around equipment and design changes. The hospital struggled in making decisions of this kind, according to Mr. Sapsford, and ultimately during construction, a great deal of renovation was required to accommodate the new equipment requirements (Hansard Official Report of Debates, 2009).

Similar issues were experienced in the case of the Royal Ottawa Hospital, however admittedly to a smaller degree. A number of issues were noted relating to electronic system designs for the facility, with failures in wireless technology, communication systems, and security system for the hospital (The Ottawa Citizen, 2008, “A Royal mess: Can CEO George Weber fix the ROH's growing pains?”). Design decisions that account for changing technical requirements for facilities require specialized knowledge that the public partner is unlikely to have. Leveraging expert feedback and input into decisions around facility design, with a

particular focus on some of the more technical networked or electronic systems within the facilities, can help to manage for the changing and ever evolving nature of health, communication, and infrastructure technology.

6.5 Summary and Conclusion

Chapter Five included analysis and synthesis of the data collected for the two case studies. This chapter provided an overview of the observations and empirical findings that emerged from the comparative case study method applied in Chapter Five. The empirical findings were directly correlated to the research questions to be answered over the course of the study (Chapter One), and were the result of analysis and synthesis of the two cases through the lens of complex evolutionary systems theory.

As pilot projects for Ontario, both the Brampton Civic Hospital and Royal Ottawa Hospital projects lacked a great degree of formal structure in their early stages, and interactions between actors at the formative stages of the projects were noted as being fraught with opposition to the P3 approach that had been selected for the projects. This characterizes the kinds of difficulties that can be experienced in large infrastructure pilot projects, and examples of opposition to the selected P3 approach for these projects was noted throughout the various stages of procurement.

These projects spanned a significant period of time, and endured a number of changes to the environment in which they were operating and to the projects overall. The case studies and findings from this chapter explain the changing nature of relationships, shifting roles and

importance for key actors throughout the projects, and the results that these changes and new networks of interaction would have had on the ultimate direction of the projects.

Observations offered through this study as summarized in this chapter reveal some new insights into the challenges in project management, planning, reaching an agreement, and coming to close that were experienced for the Brampton Civic Hospital and Royal Ottawa Hospital P3 projects. In a general sense, both projects were seen as dealing with significant challenges in role definition in early stages, facing internal opposition, and ultimately struggling to effectively utilize a horizontal management approach for most aspects of the project. The implications of such were borne out in a protracted negotiations process that drove up transaction costs. Both projects varied in terms of the inputs into decisions; some, such as the decision to adopt a P3 approach, appeared to occur through edict to meet perceived needs and address issues with lack of capacity. Other decisions or directions for the project were made with the input of stakeholders and actors with a vested interest in the project beyond the hospital corporations. In particular, there were some noted successes in the case of the Royal Ottawa Hospital project in engaging in horizontal steering and activating the specialized knowledge of involved actors over the course of the procurement and construction, and examples point to the impact that these smart interventions would have had both in terms of the agreements between partners as well as adding legitimacy to the decision-making process through engagement of key stakeholders.

Chapter Seven: General Conclusion

This study was an exploratory multi-case study of two of the first P3 projects in health infrastructure undertaken in Ontario. The questions guiding this study explored the capacity of public managers entering into a public-private partnership arrangement to successfully activate agents and utilize the skill and knowledge of these agents, conduct joint fact-finding and consensus-building, and better understand how they have arranged and organized joint interactions between the public and private sector. It is the intent of this final chapter to present a summary of the findings in this study, conclusions, recommendations for future research and study implications.

7.1 Study Summary

The Brampton Civic Hospital and Royal Ottawa Hospital are prominent examples of the ‘first wave’ of P3 projects in Canada. The Brampton Civic Hospital project in particular is an oft studied example that demonstrates the challenges that can be experienced over the course of a large-scale P3 health infrastructure project, having been the subject of scrutiny by media (Picard, 2009; Walkom, 2008; Talaga, 2008; Gilbert, 2009), stakeholders (Auerbach, 2007; Ontario Health Coalition [OHC], 2008; Mehra, 2008), and government auditors (Auditor General, 2008; Auditor General, 2010; Hansard Official Report of Debates, 2009; Standing Committee on Public Accounts, 2009). The Auditor General of Ontario noted challenges for the Brampton project relating to insufficient or poor information, insufficient market assessments, and other challenges that led to cost overruns and delays to the completion date (Auditor General, 2008). The Royal Ottawa Hospital, while perhaps not studied in as much detail as the Brampton case

(there was no subsequent government audit), did seem to demonstrate some notable differences both in terms of the nature of the partnership and the ultimate outcomes of the project. A comparative, multi-case design represented one way to examine the successes and challenges associated with each project, and in doing so expanding the breadth of knowledge of the management structure and relationship between public and private partners in Ontario's first forays into large-scale P3 hospital infrastructure procurement.

Literature on partnerships demonstrates the difference between P3 and other privatization arrangements; P3s are understood as being more akin to a long-term 'marriage' between government and a private partner. This implies an on-going relationship with some level of joint decision-making and shared risk (Globerman and Vining, 1996). At their best, public-private partnerships are cooperative ventures that can utilize the expertise of each individual partner to accomplish a common goal. Partnerships can be one way to leverage private capital and expertise to meet the needs of the public sector in regards to service provision, while also allocating risks, rewards, and responsibilities evenly with a private actor (Kernaghan et al., 2002). In some circumstances, however, the public partner finds itself struggling in achieving expected risk allocation (Bloomfield, 2006), at a disadvantage in negotiation and re-negotiation of the agreement (Vining and Boardman, 2008), facing opportunistic, profit-motivated behaviour on the part of the private partner (Vining et al., 2005), or bearing the burden of high transaction costs (Boardman and Hewitt, 2004). In worst-case scenarios, conflicting goals and a breakdown in the relationship between partners can lead to the dissolution of the partnership through government buy-out, bankruptcy of the private actor, or protracted conflict and litigious behaviour driving costs up for the project, all leading to a partnership breakdown (Vining et al., 2005).

A governance perspective on the management of public institutions links the research questions at the heart of this study to complex adaptive systems theory. The complex arrangements involved in P3 projects can make “all but the most straightforward projects just too difficult” (McKee et al., 2006, p.894); the research questions for this study sought to shed light on the ways that public managers navigate this complex and evolving operating environment. Establishing meaningful connections with partners, activating the expertise and capacity of agents, and establishing patterns and structures of interaction all represent ways by which public managers can navigate a complex operating environment (Klijn, 2008a). Governance perspectives on complexity focus on how government can or should behave as an agent within the scope of complex horizontal governance arrangements (Klijn and Koppenjan, 2012). It is these elements of the theoretical framework for this study that informed the core research questions that were to be addressed through the multiple case study design.

This research study utilized a case study approach with two cases built upon data from archival government records, media releases, newspaper reports, critical reviews of non-public data, journal articles, and the results of eight semi-structured interviews conducted between December 2014 and June 2015. A constructivist design for the case studies allows for reflection upon the position, context, and perspectives of the participants and subjects of the study. Views and perspectives help to inform a broader view of reality and inform the various “why” and “how” research questions at the core of the study (Yin, 2014). As a case study method utilizing complexity theory as a theoretical framework, data collection would be focused on finding and exploring the interdependencies between the case subject and the environment. Relationships and information gathering are at the core of the study, as reflected in the questions asked to research interview participants, and through comparison of the two cases, insights can be provided into

how decisions were made at various stages in the projects, what would have influenced decisions, and how these influences led to co-evolution between the system and its environment (Anderson, et al., 2005). Research in complexity science by means of a case study method should include a focus on processes, and should seek to enrich understanding around how an organization learns and collects information while recognizing both the formal and informal dynamics that would be a part of the decision-making process and shape patterns within the case study subject (Anderson et al., 2005). Inductive analysis of the data collected to this end would then seek to identify and categorize common themes within the cases through a process of data reduction, providing an analysis of the experiences, processes, and structures emerging through the examination of case study data (Thomas, 2006).

This research study contributes a number of observations relating to the Brampton Civic Hospital and Royal Ottawa hospital projects that originate from the application of complex evolutionary systems theory to the case studies. The case studies provided additional insight into the relationships between involved actors and the structure of power relationships throughout the procurement process for each hospital project. In doing so, the case studies identified a number of challenges for the projects arising from a lack of experience with the process, issues in role definition, and public-public tensions existing within a public partner lacking internal consensus. This research also demonstrated the kinds of challenges that may arise when attempting to impose changes on an established or ongoing project through vertical management techniques, as evidenced by the significant delays to the project to enact changes following the 2003 election, with questionable results.

Overall, the projects appeared to struggle to effectively leverage expert knowledge to address knowledge gaps through smart interventions. The public partners in both cases were

challenged by risk assessment and pricing for privately financed projects; these deficiencies were ultimately borne out in the negotiations process, leading to lengthy and challenging negotiations. Additionally, while engagement at the RFP stage for these projects had been intended to allow for expert input into the functional requirements and design of the projects, in practice it was found that areas for substantive input were significantly handcuffed by mandatory health infrastructure requirements set out earlier on in the project. Private partner input into ancillary revenue platforms, however, may have been more substantial.

The most significant area for private sector input was found to be within the development of performance standards and penalties for the Royal Ottawa Hospital project. This had the effective impact of avoiding any significant punitive measures that would have driven up operating costs in the long-term, and ensuring clear communication around expectations for performance. Finally, successes in joint-image building between projects through transparency initiatives and interactive governance varied for the two hospital corporations. There were observable differences in terms of the level of engagement in the projects, as well as the perceptions of the projects overall. The Royal Ottawa Hospital generally appeared more successful in forming a solid connection with stakeholders within the operating environment to obtain “buy-in” for the project, and the outcomes obtained in this regard could represent significant lessons-learned for stakeholder engagement for projects of this kind.

7.2 Reflections on Research Method and Directions for Future Research

It should be recognized that the findings of this research study are not immediately generalizable to P3 projects at large, nor would any observations be directly translatable to even health infrastructure procurements in Ontario or other jurisdictions. As a researcher, there is a clear delineation in a study of this kind between discussing the realities of a case, versus discussing what “ought to be” for practitioners in the field of public administration. In a research study with largely generalizable research findings, this shift is less problematic, as the reader has confidence that the findings would hold true in comparable cases. Any recommendations made as a result of such research would have been based on sufficient observed predictability to provide a basis for decision-making in policy and practice in the field of study (Tripp, 1985). Given the scale and nature of this project, however, this is not possible. As discussed in Chapter Four, any decisions regarding how any findings and conclusions in this study may be applied to the study of P3s and public sector policy are ultimately subject to interpretation by the reader. Inferences as to the nature of these two procurement projects and how lessons learned may inform future policy are based on my own experiences and observations as a researcher and professional in the field of public administration and public management. It is asked that the reader consider whether recommendations and inferences are transferable to their own circumstances as researchers or practitioners in the field of public administration and policy (Orum, Feagin and Sjoberg, 1991).

Overall, projects of this kind, particularly those that include private sector delivery or financing for what would traditionally be public services, would benefit from initiatives to

engage and share information for the purpose of obtaining “buy-in” from both internal and external stakeholders to the project where possible. Research interview subjects regularly described relationships fraught with conflict and resistance to the chosen procurement methods for these projects. This occurred at the earliest stages with opposition from internal stakeholders and partner ministries, and eventually was noted in union and community resistance to private sector involvement in public healthcare provision. The ultimate result of this resistance was higher transaction costs, protracted negotiations, political resistance, and, in the case of the Brampton Civic Hospital project, thousands of members of the community taking to the streets in protest. Much of this would have stemmed with a lack of familiarity of the role that the private partner would play in healthcare delivery. Engaging in outreach, information sharing, and inclusive forms of decision-making could represent one avenue to mitigate some of this resistance while also strengthening the project overall.

Managing complex human environments requires more knowledge and foresight than can be reasonably be expected for a public institution. Practical and inclusive approaches to project management that leverage the interconnected nature of organizations and projects can confer legitimacy to decisions and increase the chances that a public infrastructure project may be responsive to the needs of stakeholders and the community it serves (Maguire and McKelvey, 1999). Early and frequent engagement with clinicians, staff, private vendors, and members of the community, and giving capacity to these stakeholders to influence the direction of project design, can ensure that the final product meets the needs of all involved stakeholders in the project.

In terms of future avenues for study on this subject, the two cases examined in this research study were formative, pilot projects for the province of Ontario in this field. As pointed out by one interview participant, as “these were the first ever projects undertaken both of their

nature and size, and there wasn't a template approach as there is now through Infrastructure Ontario” (Participant 3). The current landscape in Ontario for public-private partnerships is significantly different now, and there have been a number of changes to the way that large infrastructure projects are built, financed, and managed in Ontario since the completion of the Royal Ottawa Hospital and Brampton Civic Hospital projects. The incorporation of Infrastructure Ontario (2005)²⁴, the ReNew Ontario (2005) public infrastructure investment plan, and the principles established in Ontario’s Building a Better Tomorrow Framework (2004) all would have had a significant impact on the way that partnerships for the procurement of health infrastructure development would be undertaken going forward in Ontario. Future research could apply similar theoretical and methodological considerations to compare the capacity for future projects to engage the expertise of consultants, conduct smart interventions, and manage for complexity within the new framework for infrastructure development in the province.

7.3 Concluding Thoughts

It was the intention of this research study to shed some light onto some of the ‘lessons learned’ from two formative P3 projects in Ontario in regards to cooperative decision-making and horizontal steering. The two cases of this study demonstrate the complex and occasionally inchoate process that was implemented for the two first major forays into P3 procurement for health infrastructure development in Ontario.

²⁴ As previously noted, Infrastructure Ontario was initially incorporated in 2005. Infrastructure Ontario was amalgamated with the Ontario Strategic Infrastructure Financing Authority to become the Ontario Infrastructure Projects Corporation (OIPC) through the OPIC Act in 2006. Infrastructure Ontario, in its current form, was established in 2011 through the merger of the Ontario Realty Corporation and OIPC. Additional study in this area could examine the changing function and/or mandate of the organization over time, and what this has meant for the delivery of AFP projects in the province for health infrastructure.

It was suggested through this study that complexity theory offers a conceptual, methodological, and analytical framework through which to understand public institutions, organizations, and projects; to this end, analysis and interpretation of these the Brampton Civic Hospital and Royal Ottawa Hospital projects were developed through a complex evolutionary systems theory lens. To this end, the study examined the key actors, relationships and networks of interaction for the projects, with a particular consideration for the kinds of consultations, engagement, and inclusive forms of decision-making that would have influenced the direction of these projects. The observations drawn from this study demonstrate the kinds of empirical findings that a complex evolutionary systems theory approach to public administration may provide when applied to a case study method, providing comment on the evolving nature of relationships in complex public sector projects and enriching understanding around decision-making at critical junctures.

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Appendix A: Ethics Committee Certificate of Approval

File Number: 11-14-11

Date (mm/dd/yyyy): 12/09/2014



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Christian	Rouillard	Social Sciences / Political Studies	Supervisor
Blair	Parsons	Social Sciences / Political Studies	Student Researcher

File Number: 11-14-11

Type of Project: PhD Thesis

Title: Assessing the Management of Public Private Partnerships in Infrastructure Procurement: A Complex Evolutionary Systems Theory Perspective

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
12/09/2014	12/08/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled “Special Conditions / Comments”.

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the “Modification to research project” form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

[removed]

Riana Marcotte
Protocol Officer for Ethics in Research
For Barbara Graves, Chair of the Social Sciences and Humanities REB

Appendix B: Invitation to Participate in the Study

Subject: Research Participants Required for a Study Assessing the Management of Public Private Partnerships in Infrastructure Procurement

I am writing to recruit research participants for a study investigating the degree to which the government of Ontario was successful in managing a cooperative decision-making process that stressed inclusion and horizontal steering in two formative health infrastructure public-private partnership projects, the Brampton Civic Hospital and the Royal Ottawa Hospital.

If you are interested in contributing your knowledge and experience as an individual involved in either of these projects to improve contemporary understandings of public-private partnerships in infrastructure procurement, then please consider volunteering for this study. If you do so, you will be helping to add a new dimension to the existing research.

I am seeking willing participants previously involved in either project. Your participation will consume approximately 30 minutes to an hour of your time over a single research interview session.

If you are interested in participating or would like to receive more information, please contact me at [removed].

Sincerely,

Blair Parsons, PhD (candidate)

School of Political Studies / Public Administration, Graduate and Postdoctoral Studies

Appendix C: Participant Consent Form

Researcher:

Blair Parsons

Doctoral candidate, University of Ottawa

Phone: [removed]

[removed]

Supervisor:

Christian Rouillard

School of Political Studies

University of Ottawa

[removed]

[removed]

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Blair Parsons as research for the completion of requirements of a doctoral degree at the University of Ottawa, as supervised by Christian Rouillard, Faculty of Social Sciences.

Purpose of the Study: The purpose of the study is to focus on the findings of a multi-case study centered around two public-private partnership projects in Ontario: the Royal Ottawa Hospital and the Brampton Civic Hospital. The study is intended to examine the capacity of public managers entering into a public-private partnership arrangement to successfully activate agents and utilize the skill and knowledge of these agents, conduct joint fact finding and consensus building, and better understand how they have arranged and organized joint interactions between the public and private sector.

Participation: My participation will consist essentially of one audio-recorded research interview ranging between 30-60 minutes, during which I will answer previously disclosed questions regarding one of the cases of this study.

Risks: My participation in this study will entail that I volunteer my own recollection of projects worked on during my professional career. I have received assurance from the researcher that every effort will be made to minimize any risks associated with my participation in this survey by allowing me to decline to answer any questions I am uncomfortable with, and maintaining the confidentiality and anonymity of any statements made throughout the course of the interview.

Benefits: My participation in this study will assist in providing context to the case studies of the Brampton Civic Hospital and Royal Ottawa Hospital, contributing to the advancement of knowledge surrounding the management structures for two formative public-private partnership projects in Ontario.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for context in case study research and that my confidentiality will be protected by ensuring that only the investigator can identify the responses of individual participants, and the

principal researcher will make every effort to prevent anyone outside of the project from connecting individual participants with their responses. Study codes will be utilized for data documents (e.g., interview transcripts) instead of recording identifying information. The principal researcher will keep a separate document that links the study code to participants' identifying information locked in a separate location and restrict access to this document.

Anonymity will be protected by ensuring that participant identities are not linked with individual responses utilized for context in the case studies for this research study. Access to identifiable information will be limited to the principal researcher. Research participant identities will remain anonymous, and conversations will never be individually cited or treated as personal communications for the purposes of this study.

Conservation of data: The data collected, including hard copy notes, tape recordings of interviews, and transcripts, will be kept in a secure manner. Data will be stored in a password-protected USB storage device that only the principal researcher will have access to. Password protected copies of any original data will be kept on a secure computer at University of Ottawa campus for the full period of retention. Data will be conserved for a minimum five year period following the completion of degree requirements for the principal researcher, after which it will be destroyed.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be discarded, along with any reference to any involvement on my part in the study.

Acceptance: I, _____, agree to participate in the above research study conducted by Blair Parsons of the School of Political Studies, University of Ottawa, which research is under the supervision of Christian Rouillard.

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel.: (613) 562-5387

Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Appendix D: Research Interview Guide

1. Both the Royal Ottawa Hospital and Brampton Civic Hospital represented pilot projects, so to speak, for P3 projects in Ontario.
 - a. How distinct and separate were the management processes for these two projects?
 - b. How distinct and separate was the process of engaging consultants and project scoping for each of these projects?
 - c. Was there any interaction between the two hospital corporations?
2. It is indicated in the 2008 Auditor General Report that a letter from the Ministry of Health and Long-Term Care directed the hospital corporations to follow a public-private partnership approach for new projects.
 - a. What kinds of consultations were held prior to the adoption of a P3 approach for these projects?
 - b. What kinds of assessments of market readiness were conducted prior to the adoption of a P3 approach for these projects?
3. Superbuild was designed to “act as liaison between ministries and agencies of the Government of Ontario with respect to capital programs and share information on capital programs being developed with or implemented by a ministry or agency of the Government of Ontario with other ministries and agencies of the Government of Ontario.”
 - a. How did Superbuild accomplish this, in practice?
 - b. How did the Ministry and Superbuild collaborate with the hospital organizations in this process? Was it a more collaborative approach, or a more command and control relationship?
4. The Royal Ottawa Hospital and Brampton Civic Hospital were announced in 2001 under the Conservative government. The procurement processes were already underway, with agreements being reached with private consortia when a new government was elected in 2003 with a new mandate in relation to P3 projects in general, and these two projects in particular.
 - a. How did public sector actors manage for the shifting political environment? What changed or had to be accounted for, if anything?
 - b. How did this shifting political landscape influence the interactions or relationship between the public and private actors?
 - c. To what extent were private partners and stakeholders engaged regarding revisions made to agreements following the election?
5. To what extent were design specifications and requirements for these projects determined in advance?
 - a. What kinds of consultations were held to determine the design requirements for these projects?
 - b. To what extent were private partners given the opportunity to provide creative feedback on the design of the project?

6. At the negotiation stage, the hospital boards and private consortia each may have had their own interests as it relates to the project. In relation to reaching an agreement between partners at this stage of the project, I have two questions:
 - a. How were negotiations managed? How did the public sector partners engage the private sector partners at this point in the project?
 - b. Were there any instances of conflicting interests between the public and private partners in this project? How was this managed?
7. In relation to the conditions for performance for these projects:
 - a. How were performance measures determined for these projects? What was the main source of service standards in the agreement?
 - b. To what extent were the private sector actors included in the development of service standards performance metrics for these hospital projects?