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New transit priorities in Ontario PPP

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Ontario boasts the largest PPP programme in Canada. The province has closed 53 PPPs, about twice those of its Canadian neighbours. Hospitals account for 34 of these 53 projects and another 10 are in procurement.

A decade ago, the provinces hospitals had an average age of 40 years largely greater than their intended lifespans. Ten years ago, Ontarios hospital capital stock was very old and had not received major investments in years, says Bert Clark, chief executive officer of Infrastructure Ontario (IO). This was not due to a lack of desire to invest but because the projects were often late and over-budget as a result of design errors, project management issues and high costs.

The province projected modernisation costs at C$8 billion ($7.7 billion). And domestic construction players lacked sufficient project management and commercial negotiating expertise to use traditional corporate finance. Construction players emerged as the big winners in the first round of projects, along with one financial sponsor. EllisDon won 14 of the contracts, followed by Plenary (five), and Aecon and Bondfield (three each).

The majority (19) of Ontarios closed hospital deals have been build-finance (BF) projects, which allowed IO to access private sector financing and transfer the construction risk to sponsors in exchange for generous completion payments. Several of the hospital projects became BFs because the hospitals had already completed detailed design work, or the projects involved complex renovations of existing facilities. This made it very hard to integrate separate maintenance agreements for facilities such as a ward or a new treatment centre that function as part of an existing hospital, Clark says.

Three of the early hospital PPPs were build-finance-maintain projects, but those did not require attaching new wings to existing facilities. The projects were: the North Bay Regional Health Centre (Plenary, PCL and Johnson Controls), Sault Area Hospital (EllisDon, Fengate and Carillion) and Woodstock (EllisDon, LPF Infrastructure Fund, Honeywell).

Still, these concessions foreshadowed the risk transfer to come. As the programme progressed, design risk was a bigger feature. Three of the subsequent round of hospital procurements used design-build-finance (DBF) contracts for renovations to existing hospitals that did not include maintenance. Some newer concessions include operational risk, which helped some BF constructors expand their expertise and relationships. Plenary and PCL, for instance, are frequent collaborators, as are EllisDon and Fengate, which formed the Integrated Team Solutions (ITS) joint venture. Both pairings have won several DBFM hospitals.

Today, DBF and DBFM constitute separate, but parallel, markets for hospital development. All the building companies go after both types of deals but the investors and management companies have little interest in DBF and much prefer the DBFM model, says George Theodoropoulos, managing director of infrastructure at Fengate in Toronto. There is little long-term capital needed once construction is completed, so the focus is on DBFM.

Managing maintenance

The risk transfer in operations and maintenance has evolved glacially. Some of the risks transferred to private operators on the early contracts, including soft services such as laundry and catering, have been minimised or removed, as others were added.

There was a robust finance and maintenance aspect in the early hospital contracts but, as both the public and private sectors have come to understand and price these risks better, the risk transfer has become more marginal, says Mike Marasco, chief executive officer of Plenary Concessions. Recognising this shift, there are few soft services now included in these contracts.

IO came to realise that these soft services offered merely marginal benefits. There was also the issue that soft services can start to impact on the provision of patient services whether laundry or food and that was something we pledged to keep outside the purview of the private sector, Clark says.

There was also opposition from unions, though that appears to have dissipated. Today, IO-granted DBFM contracts do not include core public services or services that relate to assets, nor do they outsource new services to the private sector.

Some newer concessions transfer other operational risks to the private sector, under design-build-finance-operate-maintain (DBFOM) contracts. Federal, provincial and municipal governments in Canada are still looking to pass along risks that private operators can manage effectively. A Plenary-led consortium, for instance, will assume energy consumption risk for the entire lifecycle of the Humber River hospital project.

Constructors with strong maintenance capabilities have reaped the rewards. The ITS joint venture and Plenary have won five maintenance-linked PPPs each. Carillion and Bilfinger Berger-led groups claimed one each, though Carillion joined the ITS consortium on two DBFM contracts. ITS is preferred bidder for the Providence Care Hospital DBFM, and has been shortlisted (alongside Bilfinger and Plenary groups) for the Peel Memorial Centre. Outside of Ontario, Plenary won the BC Cancer Agency Centre for the North and ITS took the Surrey Memorial Hospital redevelopment and expansion.

But the healthcare sector is slowing. Just four non-Ontario hospitals are out to market: the Hotel-Dieu Hospital in Quebec (BF) and Saskatchewans first healthcare DBFM, a replacement for the Swift Current Care Centre. Partnerships British Columbia has shortlisted bidders on BC Childrens Hospital (Plenary, Balfour Beatty and Graham Design Builders are contenders) and BC Womens Hospital & Health Centre and North Island hospitals (Carillion, Plenary and Balfour Beatty are finalists).

We expect that there may be two or three deals per year in different provinces, Theodoropoulos says. Now their attention is moving to transit projects.

Transit and transport

Transit has moved to the fore in Canadian PPP. Sponsors that have been successful to date hope their experience will transfer to transit, where DBFM contracts will be common. The programmes and the documentation for these new asset classes are quite similar to the hospital projects and these industry players are comfortable with the risk profile and securing financing, says Steven Martin, a partner at Davies Ward Phillips & Vineberg.

Transit projects involve greater amounts of construction risk, though sponsors will mitigate this risk using proven methods. Contractors must post letters of credit (LCs), as hospital sponsors have needed since the 2008 financial crisis. If lenders providing LCs suffer ratings downgrades, project companies or contractors must find replacement banks or post liquid collateral, including cash, Martin notes.

Transit projects are typically vastly more expensive, and rely on significant upfront government contributions. Theodoropoulos suggests that the main difference is that it is easier to find entities than can assume long-term hospital maintenance risk. The government subsidies for construction of transit projects is also very high in Ontario it makes for 85% of total construction costs so that leaves a small amount of capital for operational risks, he says.

Ontario has an aggressive transit and transportation programme that, in terms of dollar value, is the biggest factor driving interest and investment in Ontario. Light-rail transit (LRT) dominates the transit projects. For IO transit projects, we are using availability payments and DBFM and DBF structures, Clark says. The only difference between the healthcare and transit model in risk is the building risk. Hospitals are usually developed on a plot of land with a simple permit system

but building an LRT or motorway through a city requires more intricate planning.

Transport projects on the horizon include the Eglinton Crosstown LRT and Scarborough LRT lines, Highway 407 East Phase 2, and Waterloo LRT in Ontario, and the Edmonton LRT in Alberta. The existing and upcoming Canadian transit projects are all based on availability payments, which is where most of the sponsors expertise is, says Plenarys Marasco. As such, there is a lot of interest from the established players in the transit schemes.

The sponsors that have won healthcare concessions have picked up some transport experience, though usually in different consortium configurations. The Ottawa LRT concession went to a consortium that includes EllisDon. The Waterloo LRT shortlist of three features Plenary, Meridiam, EllisDon and Fengate.

Increased competition

Transit procurements have attracted more bidders than the recent hospital tenders, perhaps because margins are likely to me more attractive than the mature healthcare market. There is a high degree of overlap of PPP bidders across Canada and a high degree of bank and bond support, Clark says. As we move into transit, however, the established domestic players are interested but, because of the scale, we are now seeing more attention from international companies.

While large Canadian transit projects may attract some new sponsors, the bulk of the projects are valued at C$100-750 million, which may favour existing players leaders. The leading developers, contractors and investors are well-established, so I think we will continue to see the same companies chasing the same projects, Theodoropoulos says.

Established sponsors boast strong relationships with local sub-contractors, which have been replicated on multiple PPPs in the country. ITS, for example, has used Cannon Design, Parkin Architects and Architects Tillmann Ruth Mocellin for design and Honeywell and Carillion on facilities management. Plenary often collaborates with HDR Architects, Diamond Schmitt Architects, PCL and Johnson Controls.

Competition has been intense, Marasco says. However, these days, competition is probably most fierce at the stage of teaming for these pursuits, since strong local design/construction and facilities management partners are essential to protect our investment and ensure a successful PPP over the 30-year concession.

Ontario's PPP pipeline by contract structure