



Health Communiqué

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BPSAA: The Other Shoe Has Dropped

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April 1, 2011 brought the remaining sections of the *Broader Public Sector Accountability Act* (“BPSAA”) dealing with procurement into force. The *Broader Public Sector Procurement Directive* (the “Directive”) issued by the Management Board of Cabinet becomes the procurement marching orders for “hospitals”, among many public sector organizations as of that date.

I. What is BPSAA and What is the Directive?

BPSAA gives Management Board of Cabinet the power to issue directives. Directives don’t have quite the force of a statute, but, as a practical matter, they might as well have.

Under BPSAA, the accountability agreement of every health service provider in the province is amended to include the Directive – and all the compliance and reporting duties that go with it. Measure up – or else!

II. How Did We Get To BPSAA?

The Directive will replace the *Broader Public Sector Supply Chain Guideline, V1.0* (“BPS”) which required certain organizations, within listed ministries, to comply – health being one. The Directive is no surprise; it was put in motion October 20, 2010 when the Auditor General released a report on consultant procurement practices in three Local Health Integration Networks (“LHIN”s) and sixteen hospitals. The Auditor General was not pleased with these practices.

On the same day that the Auditor General revealed his report, the bill that has become BPSAA was introduced into the legislature. Absent an emergency, the legislative history of most statutes can be very slow. BPSAA was debated and passed in less than two months and, on April 1st, the Directive went live.

III. Where Does BPS Fit In?

The Directive is the son of BPS, which it replaces. The family resemblance is striking, including a *Supply Chain Code of Ethics* (the “Code”) and twenty-five *Procurement Policies and Procedures* (“PPP”). So, if you are familiar with BPS, it won’t take long to get comfortable with the next generation.

When replaced, BPS will have been in force for one year, although it was released for review in April of 2009. Over its two year public life, its drafters – persuaded by comments from many procurement fronts – refined and clarified BPS. As a result, the Directive is more compact and more informative about matters such as the intersection of the Directive (and before it BPS) with the Agreement on Internal Trade (“AIT”) and other intra Canada trade agreements. The Directive also seems to give more flexibility to covered organizations, apparently recognizing the pressures they are under and the virtue of customizing a procurement to what is being purchased.

IV. Some Observations on the Directive

(a) AIT

BPS was – it said – “harmonized” with AIT. The trouble was getting a bead on just how “harmonized”.

Many fretted that BPS may have excluded the application of important elements of Part V of AIT – elements that excused healthcare institutions from competitive procurements in certain circumstances. For example, where one healthcare institution was procuring something from another, the competitive procurement rules of AIT would *not* apply.

The reason for the fret was that, if BPS did not include these Part V AIT provisions, then partnering agreements between hospitals, sharing of facilities and a variety of dealings between not for profit organizations would require competitive procurements thus complicating (or even frustrating) clinical initiatives, service transfers and LHIN mandated efficiency measures (shared back office, for example).

The Directive dispelled the doubt around Part V of AIT, declaring:

“Where an exemption, exception or non-application clause exists under AIT or other trade agreement, organizations may apply this clause when conducting a procurement.”

This clarification came with a string – the institution must “...formally establish applicability of this clause...” meaning, take the procurement to the mandated authority levels in the organization, get approval and fully document the circumstances.

(b) Procurement Type

The narrative in BPS – confirmed informally by Ontario Buys – suggested that all competitive procurements over \$100,000 had to create what is known as the “bidding contract”. This procurement device was first recognized in the Supreme Court of Canada in a case called *R. v. Ron Engineering* in 1981. In précis, where an owner issues a request for bids and includes specified closing, irrevocability, bid security and right to impose a contract, the “bidding contract” comes into being between that owner and each proponent who submits a compliant response.

Under the “bidding contract” the duties of the owner are to abide by its process thereby treating all bidders fairly and equally. On the other side of the transaction, the duties of the proponents are to keep their offers open for the period of irrevocability and, if awarded the contract, sign that contract and deliver any stipulated materials (insurance certificates, bonds etc.) required by the contract. If either party breaches the “bidding contract”, it may be liable in damages to the party it wronged.

The notion that BPS required that every procurement create the “bidding contract” was puzzling. This is because the “bidding contract” works poorly in a complex procurement where, for example, different suppliers are proposing different equipment/solutions to meet the needs of the owner. With this type of procurement – where price is often not the determining factor – evaluation is more nuanced and the “bidding contract” tends to restrict the very thing which such processes require – flexibility and discretion.

The Directive recognizes that not all procurements will create the “bidding contract”. The breadth of that recognition can't be known until the Directive has been in place for a time and the actions of hospitals are scrutinized by their LHINs.

V. Where Are We Headed?

The notion of having a consistent way of carrying out procurements, using public money, is a good thing.

From the perspective of the public purse, processes that are “fair, impartial and competitive”, satisfy the stewardship obligations of the spenders of public funds.

For hospitals, the Directive will imbed a process which can be institutionalized and applied and which – when the inevitable bugs are eliminated – will work well. Procurements will be more efficient and “deal flow” will have fewer problems.

From the perspective of vendors, there will be a consistent way of participating in competitive procurements, an assurance of procedural fairness and mechanisms which will help vendors to learn from each procurement and to raise red flags when one is going sideways.

Of course, working through the process will take awhile.

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