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Why P3s Don't Work, and What Will

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ISBN: 0-88627-337-4

November 2003

CAW 567 OTTAWA

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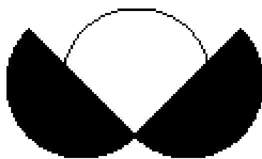
ISBN 0-88627-337-4
$10.00



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FUNDING HOSPITAL INFRASTRUCTURE:

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Introduction and Summary

This report examines the consequences of adopting a "public-private partnership" or "P3" model for providing health care infrastructure and services. It exposes the fallacies of the rationale offered for adopting this approach, and describes the significant cost premium and accountability problems associated with the P3 model.

Given the secrecy that surrounds the two P3 hospital projects that were underway in Ontario, an accurate estimate of their true costs is not possible. But on the basis of the record of other P3s, it is reasonable to expect P3 hospitals to be at least 10% more costly than their public sector equivalents. On this basis alone there is ample justification for the commitment made by Ontario's new government to reject the P3 model for the hospital sector.

But apart from questions of economic efficiency, P3s present serious problems of accountability, some of which have already become apparent during the planning of P3 hospitals in Ontario. Not only does this lack of transparency prevent proper accounting for public health-care spending, but claims of business confidentiality also frustrate efforts to monitor P3 hospitals to determine whether they comply with the requirements and criteria of the *Canada Health Act.*

We also examine the false claim that the privatization of hospital infrastructure is necessary because of present public spending constraints. Under medicare, hospitals and hospital services are paid for from the public purse regardless of their financing and ownership regimes. In our publicly-funded health care system, the question isn't who pays, but how much, and there is simply no justification for paying the additional costs associated with the P3 model.

When properly accounted for, it is clear that public ownership and not-for-profit administration will cost provincial taxpayers less, and result in hospitals that more clearly operate in the interests of patients and in accordance with the requirements and criteria of the *Canada Health Act*. While we acknowledge the fiscal challenges facing the new Government, historically low interest rates make this a particularly opportune time to renew public infrastructure. Our purpose here however, is not to advocate for a particular level of public sector investment but rather to draw attention to the costs and risks associated with the P3 model.

We believe that there is every reason to expect that if P3 hospitals were established in Ontario they would replicate the outcomes of other experiments with this model. These would include a deterioration of hospital services, diminished accountability, an increase in two-tier care, and needless cost. These consequences are likely to discourage confidence in publicly funded health care, and weaken support for the medicare model.

The first priority then is to cancel pending P3 projects. The second is to ensure that all future investment in public hospitals accords with the principles of public ownership and not-for-profit administration.

THE PLAN TO ESTABLISH P3 HOSPITALS IN ONTARIO

For many decades public hospitals in Ontario have been publicly financed, owned and operated. Capital funding for hospital infrastructure was provided by provincial grants, often with substantial contributions by other levels of government, and private charitable donations.

Under the *Public Hospitals Act*, governance of the hospital is vested in the board of a not-for-profit corporation, accountable to the community and subject to extensive regulatory oversight by the Minister of Health. The accountability and not-for-profit character of a public hospital are the key features that distinguish it from a private hospital or independent health facility.

Ontario's Conservative government proposed to change all this by abandoning the public hospital model in favour of P3 privatization schemes. It proposed to establish two P3 hospitals on sites owned by the William Osler and Royal Ottawa Hospitals. Both would be privately financed, owned,[1] and operated. In addition to providing hospital buildings and facilities, these P3 deals would bundle all "non-clinical" services into long-term contracts with for-profit health care companies.

On the eve of the recent election, both of these hospitals signed "framework agreements" with the same consortium of domestic and foreign investors. Neither the provincial government nor the hospitals were willing the disclose the details of these arrangements. It is our understanding that these agreements are contingent upon provincial approvals which

have not yet been granted and which, given the Premier's commitments, will not be forthcoming.

We commend the government for rejecting the P3 model for public hospitals for the financial, policy and practical reasons this report describes. We begin by assessing two of the claims made to justify P3 schemes: first, that government simply can't afford to fund public hospital infrastructure; and second, that privatization of infrastructure and non-clinical services will save money.

FUNDING PUBLIC HEALTH CARE INFRASTRUCTURE

A key justification for adopting the P3 approach is that investment capital is available from private sources that is not available to the province. But this makes no sense, particularly when borrowing costs are at historic lows. In reality, this argument simply reflects a self-imposed constraint by the previous government, since it was effectively committing itself to pay for the new hospitals regardless of how they were financed, owned or operated. The real question isn't whether these costs are ultimately paid for publicly, which they will be, but rather whether, for the same facility, costs will be as low as possible.

In fact the Conservative government's accounting practices constructed a systemic bias against public ownership of health care infrastructure. Under these accounting conventions, P3 hospitals were structured as operating leases, rather than capital expenses, and were accounted for as such in the budget. On the other hand, the full value of a capital grant for hospital construction was reported as an expenditure in the year it was made, subject only to adjustment for depreciation.

Thus, for a P3 hospital, provincial debt would appear to be lower than for the same hospital if publicly financed when, in fact, the reverse would likely be the case. During a period when Enron had made "off-book" balance sheet debt notorious, the Conservative government persisted in using similar accounting practices to obscure the real costs of the P3 schemes it favoured.

P3S, PROFIT AND QUALITY OF SERVICE

The two Ontario hospitals promoting P3 projects have claimed they will achieve significant cost savings. Neither has provided evidence to substantiate these claims, which are contradicted by the reports of Auditors General in other jurisdictions which document that P3 projects often cost substantially more than public sector alternatives. It is unlikely that this would be otherwise given economic realities.

First, the cost of borrowing is significantly higher for the private sector (0.5% to 2%) than for the provincial government unless the latter is willing to guarantee the loan to the private borrower. But if government intervenes to reduce the lender's risk in this manner, it also

negates a key pro- P3 argument that the model offers value for money by transferring risk to the private sector. In current capital markets higher interest rates may increase total project costs by as much as 20% over the life of the project. To some extent this additional cost would be recovered by taxing the profits, but much of this tax revenue would flow to the federal, not provincial government.

Second, private companies must make a profit - a 15 per cent return on capital is not uncommon.

Third, there are substantial transaction costs associated with tendering for and negotiating P3 contracts. The Royal Ottawa Hospital says that it spent $8 million planning and negotiating a P3 deal that has yet to gain formal approval.[2] That is approximately 9% of estimated project costs – far more than typical for hospital procurement. There are also likely to be additional costs for the provincial government as the "third" partner in the P3 scheme.

We have no experience with P3 hospitals in Ontario so projecting their ultimate cost is difficult. All the same, experience with the P3s in other jurisdictions, including those in the health care sector, suggests that they are likely to be at least 10% more costly than public sector alternatives.[3]

In a hospital sector already cut to the bone, the opportunities for offsetting efficiencies are limited. Moreover, lowering labour costs is likely to mean fewer and less qualified staff. Not only does this have obvious and immediate consequences for patient care, but as the recent SARS outbreak vividly illustrates, health care workers and support staff have key roles to play in controlling the spread of disease and infection in the hospital environment.

Given these limitations, unless the province is willing to pay more for the same level of service then something has to give, and that is usually the extent and quality of care. For example, for the Royal Ottawa Hospital, some of the operating cost savings projected by the hospital appear to be the result of reducing the number of hospital beds by 30 per cent. Moreover, neither the hospital nor the government offered any assessment of the ancillary costs of community care for the new outpatient and group home populations that will result from these bed reductions. The experience of P3 hospitals in the UK confirms that substantial reductions in service often occur in the P3 environment.[4]

THE ACCOUNTABILITY DEFICIT

From the outset, efforts by the previous government to establish P3 hospitals proceeded with a remarkable lack of public disclosure and transparency. The Conservatives simply refused to convene any public policy process to support its P3 agenda.

This same secrecy characterized the approach adopted by the hospitals involved in P3 projects. They also refused to disclose more than the most perfunctory details of their plans.

The William Osler Hospital, for example, only revealed the value of the twenty-eight year P3 contract it was negotiating - $1.28 billion - after it had signed a framework agreement with a consortium of domestic and foreign corporations. There has still been no disclosure of the details of this enormous commitment of public funds.

In fact this lack of transparency is typical of P3 projects and continues well beyond the planning phase to obscure day-to-day operations from meaningful public scrutiny. Thus, private companies involved in P3 deals routinely claim commercial confidentiality for financial information and performance data that is necessary to determine whether value-for-money objectives are being achieved. Auditors General have complained about the lack of full access to accounting and other business records that is needed to assess how public funds are being spent in P3 hospitals.

A Platform For Two-Tier Health Care

Lack of transparency is also a problem when it comes to ensuring that a P3 hospital operates in accordance with the requirements and principles of the *Canada Health Act*, most importantly the obligation to provide all insured persons with hospital services on "uniform terms and conditions". (A description of how the *Canada Health Act* applies to public hospitals is attached as an appendix to this report.)

Of particular concern is the co-mingling in one institution of insured health services with those provided outside the publicly funded system, a practice which is permitted in Ontario for a growing list of services, including those which are characterized as "unnecessary" or which are provided to uninsured persons. The problem is that when hospitals are owned and operated by for-profit companies, there is both incentive and opportunity to create a second tier of service for those who can afford it.

In a report concerning the establishment of for-profit hospitals in Alberta, several of Canada's leading health care economists described the problem this way:

> *The private hospital also provides motivation and opportunity to promote additional, uninsured or "not medically necessary" services, which carry substantial profit margins. These services may appear to be merely "offered" to patients, to choose or reject. But they may be packaged with the insured service such that in practice they are not optional. Or the patient who accepts and pays for these "optional" services may be placed on a much shorter queue. ...* [5]

These practices arguably offend both the spirit and the letter of the *Canada Health Act*, but are difficult to police. As the Romanow Commission pointed out, they are also becoming increasingly common as private clinics proliferate:

> *The growth of private advanced diagnostic facilities has permitted individuals to purchase faster service by paying for these services out of their own pocket and using the test results to "jump the queue" back into the public system for treatment.*[6]

Because so much of a P3 hospital's day-to-day operations are shielded from public scrutiny by claims to business confidentiality, they present serious monitoring, enforcement and accountability challenges. To be sure, P3 hospitals are not *de jure* inconsistent with the requirements of the *Canada Health Act*. Rather the problem they pose within the current regulatory framework is to create an institutional environment within which two-tiered services can flourish - and two-tiered care does offend the criteria and requirements of the *Act*.

How Should Public Hospitals be Funded and Accounted For?

The Value of Public Infrastructure

Unfortunately, Canada, as is the case for many countries, suffers from a retreat by the state from its traditional role and functions - including the provision of public infrastructure. From the mid-1970s, as neo-liberal policies and a dedication to "free markets" took hold, government spending was regarded with increasing suspicion. Preoccupation with debt and deficits dominated public policy discussions in Canada and elsewhere since the 1980s.

Reinvestment in public infrastructure is now urgently needed. Typically such investment has been financed by governments borrowing in the bond market. This is healthy socially and certainly is welcome by private capital markets. With interest rates at historic lows, infrastructure financing costs are unlikely to be lower than they are today. In many ways this is an ideal time to rebuild social infrastructure.

It is apparent from this critique of the P3 model that public hospitals should be publicly funded, owned and operated. The public funding model is far cheaper, and not-for-profit ownership and administration is much more transparent and accountable. If the need, means, and model for infrastructure investment are apparent, this leaves only the political problem associated with capital spending during a time of budget deficits.

Getting the Accounting Right

In our view, public sector capital spending should be accounted for on an accrual rather than a cash basis so the costs of acquiring an asset like a public hospital can be spread over its useful life. The virtues of this approach have been acknowledged by the Federal government, which has recently converted to full accrual accounting. While Ontario's Conservative government took some halting steps in this direction, it persisted in the use of accounting methods that favoured off-book financing, negating the entire purpose of accrual accounting.

Decisions about ownership and financing should be objective and transparent - not the result of accounting practices which inherently favour one option over the other. A related accounting issue concerns the need to account for capital and ongoing operating costs separately. P3 projects would have bundled these costs together, frustrating efforts to monitor the use and allocation of public funding.

IN SUM

For the reasons noted, the P3 model for public hospitals is likely to lead to significantly greater costs, diminished accountability, and a deterioration of the quality and extent of universal service. The immediate priority then is to put a halt to present P3 initiatives, and to re-establish these projects within the framework of public funding, governance and operation.

We believe the traditional approach to funding public infrastructure is perfectly sound so long as accounting for such investments is improved. Other public funding modalities have been proposed, such as the establishment of a hospital capital financing authority, or provincial guarantees for bonds issued directly by individual hospitals. These proposals may have some merit but are also likely to present their own challenges and risks.

It is beyond the scope of this report to assess the relative merits of these proposals. It is obvious that the ownership and administration of public hospitals, the bricks and mortar of the health care system, are matters vital to the sustainability of Canada's most important social program – medicare. It is not clear to us that a new approach to funding health care infrastructure is needed, but if new options are to be considered, it would be crucial to encourage broad public participation, discussion and debate of matters so central to the future of public health care.

Of course we are aware of pressures to control public spending, and acknowledge that there is likely to be fierce competition for new operational and capital funding as the neglect of recent years is addressed.

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[1] Both P3 projects were initially described as involving private ownership of the hospitals, see Superbuild and Ministry of Health and Long Term Care Press Release, Dec 7, 2001: ONTARIO INTRODUCES PUBLIC-PRIVATE PARTNERSHIP TO BUILD NEW ROYAL OTTAWA HOSPITAL; and also the National Post for Nov. 8, 2002: *Canada to See First Private Hospital.* It now appears that the framework agreements signed by the hospitals may involve long-term lease arrangements instead of outright ownership, but these details have not been disclosed and are uncertain.

[2] Ottawa Citizen; *Judge rejects bid to block ROH project*, Oct. 2, 2003.

[3] Auerbach, *Public Private Partnerships in Ontario Hospitals*, Dec. 2002; New Brunswick, Office of the Auditor General, 1998 Report, p.191.

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[4] Pollock, Shaoul and Vickers; *Private finance and "value for money" in NHS hospitals: a policy in search of a rationale?*, British Medical Journal, Vol. 324, May 18, 2002; and Gaffney, Pollock, Price and Shaoul, *NHS capital expenditure and the private finance initiative - expansion or contraction*? BMJ 1999, p. 50.
[5] Robert G. Evans, Morris L. Barer, Steven Lewis, Michael Rachlis, Greg L. Stoddart; March, 2000 *Private Highway, One-Way Street: The Deklein and Fall of Canadian Medicare?,* a p. 3.
[6] Canada. Commission on the Future of Health Care in Canada, (R. Romanow, Comm'r.), *Building Values: The Future of Health Care in Canada* (Ottawa: the Commission, 2002) at 8..

APPENDIX "A"

The Status of P3 hospitals under the Canada Health Act.

With the exception of the health care insurance plan of the province, which must be publicly administered on a non-profit basis, the *Canada Health Act* (the *Act*) is silent on whether insured health services are provided on a non-profit or for-profit basis as long as criteria and other requirements of the *Act* are respected. In other words, nothing in the *Act* prohibits the establishment of a P3 hospital[1] as long as it delivers hospital services in accordance with the criteria of universality, comprehensiveness and accessibility, and does not allow user charges or extra-billing.

The five criteria of the *Act* define the essential features of what is often called Canada's "medicare" or "publicly-funded" health care system. What makes the regime "publicly-funded" (in US parlance, the single-payer model) is the prohibition on user charges, extra-billing and private insurance for insured health services - in other words, no private payment for insured health services. What makes it "single-tier" are the criteria of "universality" and "accessibility" which require all insured health services to be provided to all insured persons on "uniform terms and conditions," ie. no special treatment, and no queue jumping.

While nothing in the *Act* speaks explicitly about the ownership of hospitals, the *Act* does explicitly define "insured health services" to include "hospital services" which in turn are defined to include:

> *a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,*
> *(b) nursing service,*
> *(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,*
> *(d) drugs, biologicals and related preparations when administered in the hospital,*
> *(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,*
> *(f) medical and surgical equipment and supplies,*
> *(g) use of radiotherapy facilities,*
> *(h) use of physiotherapy facilities, and*
> *(i) services provided by persons who receive remuneration therefor from the hospital,*[2]

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[1] The *Canada Health Act* sets out the terms and conditions for federal health care funding. Under our constitutional arrangements the delivery of health care services is largely a provincial responsibility. Thus hospitals are approved and licensed under Provincial statutes. As noted the lawfulness of P3 hospitals under Ontario's *Public Hospital Act* has been challenged. But these legal questions are quite distinct from those concerning whether the delivery of services in such hospitals complies with the funding preconditions of the *Canada Health Act*.

[2] Section 2.

The P3 hospital schemes for the Royal Ottawa and William Osler Hospitals proposed to bifurcate responsibility for clinical and non-clinical care (terms which have no defined meaning under either the *Canada Health Act* or the *Public Hospitals Act*), assigning the latter to the private P3 partner. Many of these services, such as meals, laundry, portering, and housekeeping clearly fall under the definition "hospital services". Similarly the P3 deals would privatize the hospital and its facilities, including operating rooms, hospital beds, MRI and CT scans, other diagnostic procedures and equipment, and so on. These facilities are also "hospital services" within the meaning of the *Act,* and obviously essential to delivery of clinical care.

In other words, under these P3 schemes many insured hospital services would be provided by the private P3 partner on a for-profit basis, and must therefore be delivered in accordance with the requirements of the *Act*. But as noted, a P3 hospital creates an environment within which both the incentive and opportunity exist to finesse the constraints of the publicly funded system so that some insured health services can be sold to those who are willing to pay for them – a practice that offends both the letter and the spirit of the *Act*.

Finally it is worth noting that the enforcement of the *Canada Health Act* is notoriously weak, and has been the subject of repeated criticism by Auditors General of Canada. Few complaints are investigated and most remain outstanding for years.[3]

[3] Auditor General of Canada, 2002 Status Report, Chapter Three, *Federal Support of Health Care Delivery*, at para. 3.45.

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