# P3 Backgrounder #1

## P3 Hospitals in Canada

Public-private partnerships (P3's) are increasingly presented as a solution to funding issues in health care. P3's are relatively new to the health care sector in Canada. However, they are not new to other areas of the Canadian public sector and in other countries – the UK being notable.

### *What is a P3 hospital?*

The hospital is designed, built, owned and operated by the private for-profit corporations. A consortium (group) of for-profit corporations including banks or financiers, architects, property management corporations and private health care service corporations forms and makes a bid to build a new hospital. All of the corporations build their profit margins into the project, including the ongoing privatization of huge parts of the hospital management and services over the life of the deal. The public leases-back the hospital from the consortium over the period of the agreement, which can last 30-60 years (a generation). The costs are paid out of the operating budget of the hospital.

### *Where are the savings?*

The driving force behind politicians and bureaucrat's support for P3's is the desire to avoid borrowing and debt. But, P3's are not a neutral financing mechanism – it is a source of borrowing which has to be repaid – either out of the public purse or by giving the private sector a concession (eg. allowing the company to charge user fees). The Australian experience with P3 hospitals showed that in the long run, P3 hospitals could cost twice as much as publicly financed hospitals.

### *Where is the competition?*

**Private industry is supposed to be more efficient and innovative because it has to be to survive in a competitive marketplace. However, a P3 hospital essentially becomes a monopoly. There is no competitive advantage because the private consortium has an assured contract for 30 or more years.**

**As well, the health ministry has no flexibility. If things change in the community, labour force or health service needs, the health ministry has to renegotiate with the consortium – for any change. In New Brunswick, a P3 school would not unload furniture delivered to the school because this was not in the P3 contract and in the P3 hospital. In Durham, UK ambulance drivers had to move the patients into the wards as the for-profit consortium deemed that portering patients was not its responsibility.**

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## *Where is the accountability?*

With the excuse that they don't want to jeopardize the public sector negotiating position, the government will release little or any financial information about the project and the contracts with the consortium until the deal is completed. That includes what financing guarantees are being made with the consortium or what opportunities the consortia will be given to raise revenues (Eg. using operating rooms and lab equipment for private surgeries, charging user-fees for 'non-medical' services and including boutiques or a hotel as part of the land use). There is little information on how governments will monitor the hospitals to ensure all deals are being kept as contracted.

## *Canadian P3 Hospitals – 15 and counting*

**British Columbia – 2 (under bid)**

- Abbotsford Hospital and Cancer Centre (total proposed cost for capital and services $1.4 billion).
- VGH Ambulatory Care Centre (total proposed cost $91 million).

**Alberta – 1 (proposed)**

- South East Calgary Hospital

**Quebec – 2 (proposed)**

- McGill University Hospital Centre
- University of Montreal Hospital (CHUM)

***New Brunswick – 1 (suggested)***

- Carleton County Hospital

**Newfoundland and Labrador**

- *due to the deficit rhetoric of the Williams government, concerns are that any new infrastructure would be proposed as P3's.*

**Ontario – 10**

***In Negotiations:***

- William Osler Health Centre, Brampton (total proposed cost for capital and services $1.15 billion).
- Royal Ottawa Hospital redevelopment (total proposed cost for capital $125 million, for services, not disclosed)

**Proposed:**

- Centre for Addiction and Mental Health (the Queen Street Psychiatric Hospital, Toronto)
- Bridgepoint Health Centre (Riverdale Hospital)
- Halton Health Care Centre (Oakville)
- Salvation Army Grace Hospital (Toronto)
- Salvation Army Grace Hospital (Markham)
- Uxbridge Hospital
- St. Joseph's Health Care Centre (Hamilton)
- West Lincoln Memorial Hospital (Grimsby)

***The deals have been criticized by:***
***Auditors-general Nova Scotia, New Brunswick; State Auditor of New South Wales (Australia); the UK National Audit Office; Audit Scotland; the UK House of Commons Public Accounts Committee.***

**For More Information: Funding Hospital Infrastructure: Why P3s Don't Work, and What Will** by Lewis Auerbach, Arthur Donner, Douglas D. Peters, Monica Townson, and Armine Yalnizyan. Canadian Centre for Policy Alternatives. See: www.policyalternatives.ca

**For Cash and Future Considerations: Ontario Universities and Public-Private Partnerships** by Heather-Jane Robertson, David McGrane and Erika Shaker.

**Experts tell Romanow P3's are not the answer**. Allyson Pollock. John Loxley. May 2002

# P3 Backgrounder #2

## Public-Private Partnerships – the UK experience

*The Private Finance Initiative (PFI) is the British equivalent of a public-private partnership (P3). The Canadian P3 hospital projects are modeled after the PFI.*

### PFI's: Perfidious Financial Idiocy

**The British Medical Journal says that the acronym PFI (private finance initiative) really stands for "Perfidious Financial Idiocy" as the private hospitals have proved to be costlier and offered shoddier service than their fully public counterparts.**

### Higher costs, cuts in services

**According to author George Monbiot in his book *Captive State: the Corporate Takeover of Britain*, costs for PFI hospitals have been an average of 72% above initial projections and these high costs in infrastructure lead to cuts in clinical budgets. The British Medical Journal reports that, on average, 26% of hospital beds have been cut and staff reduced by 30% (14% doctors, 11% nurses and 38% support staff). New user fees have caused patients to complain that they have to pay for "absolutely everything;" even volunteer services have to pay rent for office space. However, profit margins for the new private owners range from 15-25%.**

### Complicated and expensive deals

Consultants for the first 18 British P3s cost over $110 million alone. The contract for Coventry's Walsgrave Hospital was 17,000 pages long. Britain's auditor-general and deputy controller recently called the accounting systems used to justify these schemes "pseudo-scientific mumbo-jumbo." *The AG said* that no one, not even experts really understand what's going on.

### Land deals are one way the consortium makes a profit.

In Edinburgh, the hospital land was valued at $500 million but was sold by the consortium to a subsidiary for only $25 million to build condominiums valued at more than $700,000 each. The new hospital was built on cheaper land – on an old mine shaft that floods when it rains, forcing hundreds of rats to the surface.

In Coventry, the valuable land that the old public hospital was built on was sold by the consortium and the new hospital built 30 kilometres away from the city centre, inaccessible by public transit and miles away from most resident's homes.

### *Shoddy building and bad design:*

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**Cumberland Infirmary in Carlisle:** Two ceilings collapsed due to cheap plastic joints in piping and other plumbing faults. The sewage system overflowed and dumped sewage into the operating theatre. Because of facility design flaws, soiled laundry must be wheeled through wards that are meant to be sterile. And a glassed-in infirmary with no air conditioning reaches temperatures averaging 30 degrees Celsius in the summer.

**Royal Infirmary of Edinburgh:** Besides the rat problem due to being build on an old mine shaft, the hospital was build without operating theatre lights. The public sector had to negotiate increased payments to get lights installed.

**Durham Hospital:** *A* ceiling caved in and sewage flooded into the pathology department. The pharmacy is beside the mortuary so patients have to watch the bodies going by. The ambulance bay is so small that it gets blocked if four ambulances arrive together. And cold water taps run hot which means no drinking water in some wings.

Carlisle and Whitehaven hospitals: **Government inspectors for the Commission for Health Improvement released a report in July 2003 stating that due to staff shortages, there were reported waits of up to 15 months for scans and cancer treatment. Fire exits were blocked and patient areas were used for storage space. Wards were frequently closed due to infections. Hallways and offices are too small.**

### *For More Information:*

***British Medical Journal* articles on the impact of the Private Finance Initiative** (the British version of P3s):
*Private finance and "value for money" in NHS hospitals: a policy in search of a rationale?* By A. Pollock, J. Shaoul and N. Vickers. (May 18, 2002)
*How private finance is moving primary care into corporate ownership* by A. Pollock and S. Player and S. Godden (April 21, 2001)
*The private finance initiative: The politics of the private finance initiative and the new NHS* by D. Gaffney, A. Pollock, D. Price and J. (July 3, 1999)

**Private Finance Initiative: Analysis**
Series of reports from Britain's *Guardian* newspaper examining that country's version of P3s. See: www.society.guardian.co.uk/privatefinance/

# CANADIAN HEALTH COALITION

*Canadians view medicare as a moral enterprise, not a business venture.*
**– Romanow Report**

Hon. Pierre Pettigrew, PC
Minister of Health
Brooke Claxton Building
Tunney's Pasture
Ottawa, Canada

February 24, 2004

Dear Minister Pettigrew,

**Re: A Moratorium on "Public-Private Partnerships" in Health Care**

I am writing you on behalf of the Canadian Health Coalition on the issue of public-private partnerships (P3s) in health care. Today, across the country, concerned citizens are organizing local media conferences to alert the public to current provincial government plans to privatize hospitals – a core component of our national health care system.

As Canada's federal Health Minister you must not stand idly by as provincial governments threaten the integrity of Medicare by signing contracts with private for-profit hospital consortiums. In light of the gravity of the situation we are requesting that you use the authority of your office to: **1) call for an immediate moratorium on any initiatives to privatize the delivery of health care services including public-private partnerships; and 2) refer the matter to the Health Council of Canada for an evidence-based and transparent examination.**

It is no longer plausible for the federal Minister of Health to claim that ownership of health care delivery does not matter, or that medicare is fully protected from international trade agreements. This denial is no longer plausible in light of the evidence.

The Health Council of Canada should examine all the evidence pertaining to the cost, safety, impact on international trade agreements, and benefits. In particular all proposed contracts should be examined in an open and transparent way, including those with Healthcare Infrastructure Company of Canada, a corporate consortium, which is bidding on contracts to build and own for-profit hospitals in Ontario, British Columbia, Alberta and Québec.

The same private corporations are bidding on contracts across the country. They see the public health system as a potential place to make profits. The group of companies that has won the contracts to build the first two P3s in Ontario – a consortium of companies is

also bidding on the B.C. projects. These corporations vying to take over our hospitals have controversial records in Britain where the most extensive experiment with P3s in the world has been a disaster.

P3s threaten the future of Medicare. They cost much more than public non-profit hospitals. Because the buildings and profit-taking suck up so much money, the clinical side of the hospitals gets cut. In Britain, an average of 30% of staff and 26% of hospital beds have been cut according to the prestigious *British Medical Journal*. These hospitals are not accountable – they answer to shareholders who are looking for profits - not to the public like non-profit hospitals. They suck up so much money that they reduce the scope of services offered under the public health system. They provide both the incentive and the opportunity for for-profit corporations to push service charges, user fees and two tier health care in their endless search for more profits. In other words, the public pays and the private profits. That is not a partnership.

There is no evidence that the people running for-profit hospitals or clinics know anything more about running these facilities better than the people who administer them on a not-for-profit basis. The for-profit consortiums recruit the same managers and administrators. The big difference is that for-profit ownership does not have the same obligations. Their job is to serve the investors in the consortium, not the community.

It is not in the public interest to transform public, not-for-profit, transparent, and accountable health care contracts into private, for-profit, and secret opportunities for corruption and fraud.

In the words of the Romanow Commission's Final report: *"Rather than subsidize private facilities with public dollars, governments should choose to ensure that the public system has sufficient capacity and is universally accessible. In addition, as discussed in Chapter 11('Health Care and Globalization'), any decisions about expanding private for-profit delivery could have implications under international trade agreements that need to be considered in advance."*

In addition, opening up the not-for-profit health care delivery system to private for-profit delivery, including foreign investment, threatens the current protection for Canada's Medicare system in the NAFTA and the GATS. This threat has been documented by the Romanow Commission in its research and final report.

For example, GATS Article 1:3(c) exempts any "service which is supplied neither on a commercial basis nor in competition with one or more service suppliers". How could this provision be applied to situations involving a mix of governmental, private for-profit and private not-for-profit delivery? [Jon R. Johnson, *How Will International Trade Agreements Affect Canadian Health Care?*, Romanow Commission Discussion Paper No. 22, September 2002, p.18].

The Romanow Commission on the Future of Health Care in Canada found no evidence that a greater role for private for-profit health care delivery will deliver better or cheaper,

or improved access. Indeed the expansion of for-profit delivery into Canada's Medicare system has been described as "a perversion of Canadian values". This is because "Canadians view medicare as a moral enterprise, not a business venture". (Romanow Commission, *Building on Values*, p. xx).

We expect a response from you on this urgent matter at your earliest opportunity.

Sincerely yours,

Kathleen Connors, RN
Chairperson
Canadian Health Coalition

cc: Provincial and Territorial Ministers of Health