



Public-Private Partnership (P3) Hospitals

February 2006

THE ISSUE

Faced with the growing need to reinvest in health care infrastructure, provincial governments are increasingly looking to the public-private partnership or P3 model for financing public hospitals and health care facilities. Unlike privatization, which involves the outright sale of government property, or assets to the private sector, P3s allow the private investor to design, build, own, and manage non-clinical services in health care facilities for their long term, public sector tenants.

Letting the private sector raise the money to construct and equip a hospital is attractive to government because such it is able to avoid politically unattractive taxes or deficits. Proponents of P3 arrangements suggest the relationship between the private and public sectors will bring efficiencies, increased productivity, and an entrepreneurial spirit that will generate extra value for taxpayers and shareholder alike.

CONCERNS

- Evidence suggests that in the end the government (the public) ends up paying more – not less. The reason for this is that the cost of borrowing is higher for the private sector – typically .5% to 2.0% higher than governments would pay. Second, the private companies anticipate a profit of at least 5%. Third, there are substantial costs associated with negotiating the deal.
- The Canadian Centre for Policy Alternatives suggests taxpayers will pay a substantial premium for P3 hospital facilities and services that are likely to be 10% more costly than hospitals that are publicly financed, owned and operated.
- Quality – there is concern that the extent and quality of services will decline in P3 hospitals as efforts are made to sustain profit margins in an environment where efficiency gains are limited. A series of 5 articles in the *British Medical Journal* shows that in Britain P3 costs have resulted in fewer hospital beds and poorer service.
- Problems of accountability are inherent in P3 projects where confidentiality is claimed for financial and business records, preventing a proper accounting for public health care spending and frustrating efforts to monitor P3 hospitals for compliance with the principles and objectives of the *Canada Health Act*.
- The risk that by introducing the profit motive to public hospitals, P3s will create a platform for two-tiered service because of the co-mingling in one institution of insured health care services with those provided outside the publicly funded system.

CHAC's PERSPECTIVE

The adoption of the P3 model for public hospitals merits careful assessment. Such an assessment would require cooperation between federal, provincial and territorial governments. An assessment of the feasibility of a public-private partnership should take into account the following criteria:

- Compatibility with the Canada Health Act
- Cost effectiveness
- Efficiency
- Public accountability and transparency
- Clarity of risk liability

Note: In January 2006, the Catholic Health Sponsors of Ontario* approved a statement entitled “**Private Public Partnerships in Healthcare Institutions**” The statement states that there are a number of risks and ethical concerns associated with public-private partnerships. The following text is from the statement.

“The key areas of concern requiring thorough disclosure, discussion and due-diligence by the service provider included:

- PPPs involving direct care of patients by a for-profit partner could jeopardize access to care for some persons and be a disadvantage to the poor based on the profit motive.
- PPPs involving construction could be more costly to the taxpayer and local community over the building’s life-cycle due to the projected mark-up in interest rates during the payback schedule to cover profit.
- Past experience has shown contract service companies have traditionally taken responsibility for hotel costs (housekeeping, dietary, maintenance), resulting in outsourced services and loss of jobs.
- Contract management and building supervision needs written clarification as to who assumes legal risks, oversight of the project, relationship between private partners and the local board, dispute mechanisms, reporting structures and overrun controls. Administrative authority, management of staff, financial cost controls need specific references in the contractual agreement.

The ethical side of Public Private Partnerships requires careful discernment by the institution before entering into any agreement.

- Values must drive the strategic planning and process including: cooperation; transparency; dignity of human work and a healthy workplace, including paying fair wages.
- Clearly define the relationship between mission, values and practice with the distribution of funds.
- Public facilities need to meet the needs of the community.
- Conflict of interest needs discussion and clarity in the agreement as well as monitoring by some oversight body.
- Caution that quality of care is quantified and measured. It should remain the driving force to ensure the end point is at least equal in quality of service to the start of the agreement.
- Contracting-out raises several issues around staffing including wage reduction and subsequent relationship with staff. Guidelines need to be in place for employing and laying off workers, choosing between programs/services, involving people at the provider level in decisions, and giving preferential consideration for the disadvantaged.”

* The Catholic Health Sponsors of Ontario is a Catholic sponsor of 13 health care institutions in Ontario. This statement entitled “Private Public Partnerships in Healthcare Institutions” was approved January 27, 2006.