THE CANADIAN COUNCIL FOR PUBLIC-PRIVATE PARTNERSHIPS
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FOR-THE-RECORD

Dr. Wilson's prescription

Public health care is about service, not hospital building and maintenance. Let's leave that to the private sector, says former finance minister Michael Wilson

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Canadians can be excused for feeling overwhelmed by the debates on health care. This is not the fault of the Romanow and Kirby reports, for both are well-researched. Rather, the confusion arises out of the interpretations that interest groups attribute to the reports to meet their own particular agenda. Nowhere is that clearer than in the discussion over "public" versus "private" involvement in the health-care system. We can all agree that the existing system needs to be more efficient and effective. There's even agreement that roughly five billion new dollars are required annually to ensure the long-term sustainability of our health-care system. Most important, there is absolute agreement that corrective action must be taken soon.

But where? The Kirby report cites a disturbing statistic: "Between 1982 and 1998, real public per capita spending on new hospital construction declined by 5.3 per cent annually; in dollar terms, investment dropped from $50 to $2 per person over those 16 years." Given current demands on the health-care system and the fact that those demands will only increase as the population ages and grows, those numbers are of serious concern. Somewhere in the debate about "public" versus "private," we must make room for a rational discussion about the role the private sector can play in addressing this problem. Let's start not with clinical services, but the buildings in which those services are provided. Surely our scarce health-care resources are better used providing health care than overseeing construction sites and the heating, ventilation and air-conditioning systems of buildings.

Both Ontario and British Columbia think so. They are investing in four pilot projects to find out whether there's value for the taxpayers' dollars in partnering with industry experts to build and maintain the physical plant of hospitals and to finance the capital costs to do so. In Ontario, Health Minister Tony Clement is asking industry experts to bring forward proposals to finance, build and operate two hospitals: the William Osler Health Care Centre in Brampton and the Royal Ottawa Hospital, a psychiatric hospital. He is not asking these industry experts to provide doctors and nurses, to perform surgeries or to issue prescriptions. He is asking them to provide the money to build the hospitals and to look after the non-clinical aspects of hospital operation after that. The ministry and the two hospitals will detail the specifications that must be met (at a minimum, they'll meet the same standards as though the projects were undertaken conventionally). Mr. Clement is asking whether the private sector can meet these requirements and standards more cost effectively than the public sector. British Columbia has similar projects with the Academic Ambulatory Care Centre at Vancouver General Hospital and the Fraser Valley Health Centre in Abbotsford. Last week, New Brunswick Premier Bernard Lord said he might look at this strategy as well.

Public-private partnerships are a relatively new concept in Canada's health sector, but they're common elsewhere—the United Kingdom is using this approach to modernize its aging hospitals. The British government put the first pilot projects under severe scrutiny and determined that, with a few refinements, the

model was sound. By 2002, 26 hospitals were built or are under construction; another 40 have been approved. Allowing professionals to concentrate on their core businesses is not a new idea; some of Canada's most respected luxury hotels don't own the buildings in which they operate. Rather, through management agreements, they run hotel functions in someone else's facility. Banks, too, have sold much of their downtown real estate to property companies and now lease back the space through long-term arrangements; this lets them focus on banking. The usual model is that public-private partnership hospitals are built and financed by the private sector and leased back to the public sector for a predetermined fee. These private-sector partners are companies, each with a particular skill, that come together in a single company to provide the best hospital facility.

The public sector determines the standards for design and quality of construction. The public sector determines the year-in, year-out commitments to reinvestment in the physical facility. Contracts spell out performance standards and impose severe penalties if performance falls below that. Objections to such public-private partnerships tend to come from public-sector labour unions. They want to protect their jobs, and make the case that the public still has to pay for these public-private partnership hospitals.

We agree: Yes, the $380-million capital costs of the William Osler Health Care Centre or the $90-million costs of the Academic Ambulatory Care Centre have to be paid for. But in partnerships, we, the taxpayers, may pay less. The public benefits in two ways.

When it comes to actual construction costs, publicly managed projects tend to come in late and over their original cost estimates. (When British project development managers compare the costs of building hospitals conventionally against the cost proposed by the private sector, they add 18 per cent to their base estimate—the average cost overrun on conventionally delivered projects as well as their operating costs.) By contrast, public-private partnership hospitals typically come in on schedule and on budget.

Why? Because the private-sector partners pay out of their own pockets if they don't come in on budget; that's a compelling incentive. The partners are also penalized if they fall behind schedule—so opening the new facility on time is really important to them.

The real benefit, however, is in the level of service achieved over time. Unlike conventional hospital projects with their somewhat erratic funding commitments, public-private partnership hospitals commit the private-sector partner to make annual reinvestments to keep the place in good repair. Failure to do so results in penalties or even cancellation of the agreement. This is the public-private model's significant contribution: It brings a level of certainty to the amount and quality of maintenance and improvement that will be made over the long term to our public hospitals. As we've run things in the past, such a commitment can't be guaranteed, because it is subject to the availability of funding.

The public-private partnership model is not about clinical services. It does not, and cannot, impede our access to health-care services or health-care providers. It is very much about getting hospitals built and maintained. In many cases, the choice is not just building hospitals through public-private partnerships or doing so conventionally—it may be not building the hospital at all. Above all, public-private partnerships do not threaten our publicly administered health-care system. Canadians have made it clear over the past year that that is something we all want to protect. Michael Wilson, a former federal finance minister, chairs the Canadian Council for Public-Private Partnerships.

Information on public-private partnerships and hospital development is available on The Canadian Council for Public-Private Partnerships website at: www.pppcouncil.ca.