For-profit hospitals a government give-away
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(**Spectator headline:** Ontarians who need to go to hospital put at risk)

If you are not thrilled with the Ontario government's privatizing of hydro, watch out. The Conservative's next privatization plan, targeting the hospital sector, will toss millions of dollars of public money out the window.

In December 2001, Ontario Health Minister Tony Clement announced plans for two new hospitals in Ontario, one at the Brampton campus of the William Osler Health Center and another at the Royal Ottawa Hospital.

The government's announcement told Ontario citizens that the hospitals would be designed, built, financed, owned and operated by the private sector. The hospital board will use public money to lease the hospital from its owners.

The period of the lease? Thirty years or more.

The idea of these public-private partnerships (P3 as they are called) is to help governments raise money to pay for public services, like hospitals, that require massive start-up investment. We'll be able to build more hospitals, advocates argue, if private dollars are available for initial funding.

This argument makes it sound as if private dollars are paying for the hospitals. Indeed, in a letter to the National Post on November 11, Tony Clement wrote of the Osler facility, "It is now and will be a publicly owned hospital in a building built and maintained without taxpayers' money." This statement is outrageously misleading. As I will explain, in the end, it's all public money that pays for the hospitals.

The P3 advocates' second argument is that private sector efficiencies will lead to governments saving money over the life of the hospital.

Finally, P3 hospitals are credited for "transfering risk" to the private

sector.

The way P3 hospitals work, a private consortium borrows large amounts of money to finance building the hospitals. The interest they pay for the huge sums is enormous.

The consortium doesn't go to all this trouble out of sheer generousity. They expect a similar rate of return as for other investments, usually over 5%.

All of these costs are ultimately charged to the publicly funded hospitals. In other words, we all pay, through our tax dollars. And any additional donations you make to your hospital end up, in part, as profits for the investors.

Traditionally, hospitals are funded through government tax dollars, and community fund raising. In that funding approach, there is no cost of borrowing at all. If the government does fund the hospital through deficit spending, they pay a lower interest rate than the private sector.

While new to Ontario, Britain has been experimenting with P3 for a decade. Indeed, Tony Clement visited Britain to check out the P3 scene.

Unfortunately, he missed a key point. P3 hospitals aren't working well in Britain.

In a series of five articles in the British Medical Journal, Professor Allyson Pollock of the London School of Public Policy analysed the British experience with P3 hospitals.

Dr. Pollock's analysis lays bare the accounting hocus-pocus used to justify P3 hospitals. She points out that the high P3 costs rest partly on the fact that private debt always costs more than public debt. In addition, there is the profit margin the private companies demand.

The accounting strategy used to cover up these increased costs places a dollar value on the "risk" transferred from the public to the private sector. For some P3 schemes, this estimate adds up to 50% of total capital costs.

But what actually happens when things go wrong? At one British P3

hospital, equipment was not working properly when the hospital opened. At another, the recovery room is located 80 metres from the operating room. The hospitals received no compensation from the private companies for these mistakes.

And what happens when complete disasters occur? In an Australian P3 scheme, the Victoria government had to buy back LaTrobe hospital from a private company because its losses "meant that it could no longer guarantee the hospital's standard of care."

At Modbury Hospital, another P3 project, the South Australian government was forced to increase its payments or the contractor would have defaulted.

All these exmples show that risk is not really transferred to the private sector. Whether it is hydro or the hospitals, when private provision of necessary public services fails, public money bails out the private sector.

How will our hospitals respond to the increased costs they will have to bear as a result of the P3 scheme? If they follow the British model, they will cut beds, doctors, and nurses. That means more hospital waits, and poorer care.

The only option to service cuts is more public money. At the beginning of November, 2002, debt-ridden Ontario hospitals issued their latest desperation call for $2 billion in additional government funds. Tony Clement delivered $350 million in relief.

What will it be like when hospital boards have to bear the extra burden of covering for-profit companies' financing costs and return on investment?

The groups that benefit from P3 hospitals will be the banks, construction companies and building-management companies that build and maintain the hospitals. The losers will be Ontario taxpayers, and Ontario citizens who require hospital care.