Re-establishing a Federal Role in Hospital Infrastructure Finance

Summary

Across the country, provinces and territories are grappling with the need to redevelop and build new health care infrastructure. Several provinces are turning to private sector financing through Public-Private Partnerships (P3s) or other private financing arrangements. Yet, we have another model of infrastructure financing that can assist provinces and local governments with the infrastructure backlog without the attendant loss of control and high costs.

The higher cost of private (P3) financing is substantial and includes:

- higher borrowing costs;
- risk premiums in excess of 30%;
- ceding of management and delivery of all support services to the private sector for periods lasting 20 - 30 years;
- the surrender of public lands for private development - including private health facilities and the allowance of extra user fees and service charges where possible to provide additional revenue streams from which to take profits for the consortia.

There is little doubt that these expensive and inflexible deals will haunt the health system for the next generation if they proceed, placing competing demands on scarce resources and entrenching a powerful group of for-profit corporations with an interest in two-tier healthcare as a potential additional revenue stream from which to take profits.

Historically, the federal government played a critical role in instigating and supporting the creation of our health care infrastructure through the National Health Grants program. This model was created by then Health Minister Paul Martin, Sr., in 1948 and continued until 1971.

The federal health grants provided matching funds to provincial government grants to build community hospitals. The fifty-cent dollars became very popular with provincial governments. It is estimated that 90% of Canada's hospital stock was created over the course of the program.

The federal government has abdicated its role in infrastructure investment over the last twenty years, while, at the same time, reducing transfer payments to provinces and municipalities. The data show that the level of government with the largest and most growth-responsive revenue base has downloaded its responsibility for investment in public infrastructure to levels of government with the smallest and least growth-responsive revenue bases.

The precedent of the National Health Grants program could be used to establish a new role for our national government in support of the public health system. The discussion paper reviews the precedent, the current fiscal imbalance between levels of government and proposes the re-establishment of a dedicated and stable national infrastructure financing program.

We call on the federal government to:

1. Create and fund a national health care capital investment program, in partnership with the provinces. This new health care capital funding program would be integrated as ongoing core funding. An annual investment rate of 0.4% of GDP - less than the peak in the 1960s but approximately 1/3 higher than the average in the past 20 years - would provide sufficient funding to address current needs and to draw down the backlog of unmet needs.

2. Tie all health care infrastructure funding to public, non-profit ownership, control, management and operation of the facilities, equipment, and services. The current approach to private sector involvement in funding infrastructure through P3s or private finance mechanisms must be abandoned in favour of public financing approaches.

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