Re-establishing a Federal Role in Hospital Infrastructure Finance

Discussion Paper

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BC Health Coalition
Canadian Health Coalition
Canadian Labour Congress
Canadian Union of Public Employees
Council of Canadians
Friends of Medicare - Alberta
National Union of Public and General Employees
Ontario Health Coalition
Ontario Federation of Labour

Introduction

The need for a better approach to health infrastructure financing

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

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. As the federal government downloaded the responsibility for infrastructure funding onto the provincial and municipal governments, it also reduced transfer payments that would have offset the burden. The ensuing fiscal imbalance has aided in the creation of our infrastructure backlog. The result is a federal government which is running surpluses while provincial and local governments are curtailing services and privatizing infrastructure to hide or defer costs, or to download those costs onto individuals.

The precedent of the National Health Grants could be used to establish a new role for our national government in support of our public health system. The following brief 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.

Part I

Why Not P3s?

The cost for private financing (P3s) is not insubstantial:

- a 1% or more increase in borrowing costs;
- risk premiums in excess of 30%;
- the ceding of management and delivery of all support services to the private consortia at guaranteed rates for long term deals lasting 20 - 40 years;
- the bundling of the service and financing deals making extrication from the contract prohibitively expensive;
- the surrender of public lands for private development - including private health facilities - over the life of the financing deal or longer; 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..[1]

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 to increase their rate of return.

[1]There are a number of sources for these figures. The >1% higher private sector borrowing cost has been evidenced in the Abbottsford, Brampton and Ottawa P3s in Canada and is so widely accepted that no one is disputing this figure. For risk premiums, monitoring costs, and lack of risk transfer see Association of Chartered Certified Accountants, “Evaluating the Operation of PFI in Roads and Hospitals” Research Report No.84, 2004. For the privatization, land deals and service charges see Monbiot, George, “Captive State”; the Direct Lenders Agreements for the William Osler Health Centre in Brampton, the Royal Ottawa Hospital and the Abbottsford Hospital. On high costs and cost overruns see Mehra, Natalie “100 P3s Failed, Flawed and Abandoned”, 2005.

Part II

Paul Martin Sr.'s National Health Grants: Setting the precedent

Federal funding of hospital infrastructure in Canada is not new. In fact, the majority of our current hospital stock was financed through a program of National Health Grants created by Health Minister Paul Martin Sr. in 1948 and continued until 1971.

Paul Martin Sr. saw the creation of public/non-profit hospital infrastructure through the National Health Grants program as a necessary precursor to his goal of establishing a public health insurance program. He believed that investment in public infrastructure would consolidate budding health programs, equalize access to beds and services, and foster the growth of Medicare. In his memoirs he noted:

> *"I proposed subventions to the provinces, which would enable them to improve their health facilities and pave the way for the whole program, including the eventual establishment of health insurance. Immediate action would demonstrate the government's bona fides. Although I did not emphasize it in my talks with [Prime Minister Mackenzie] King, I felt that we had to take immediate action to proceed with some part of the health proposals, and so create a solid foundation for the later implementation of health insurance."* (pp. 45)
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> *"Pressing forward with the grants would strengthen existing preventative and public health services and eventually would lighten the burden on a future health insurance fund by eliminating potential bottlenecks, particularly shortages of hospital beds and personnel.... The grants would correct the unequal distribution of beds across the country, and particularly the dearth of hospitals in rural areas. Because poor facilities discouraged medical personnel from moving willingly to more remote parts, new, strategically placed and up-to-date hospitals would induce practitioners to go where they were needed most....The federal grant was intended as a stimulant to the major responsibility assumed by the provinces and municipalities for building hospitals and for providing medical and health services."* (pp. 47-48).[2]

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.

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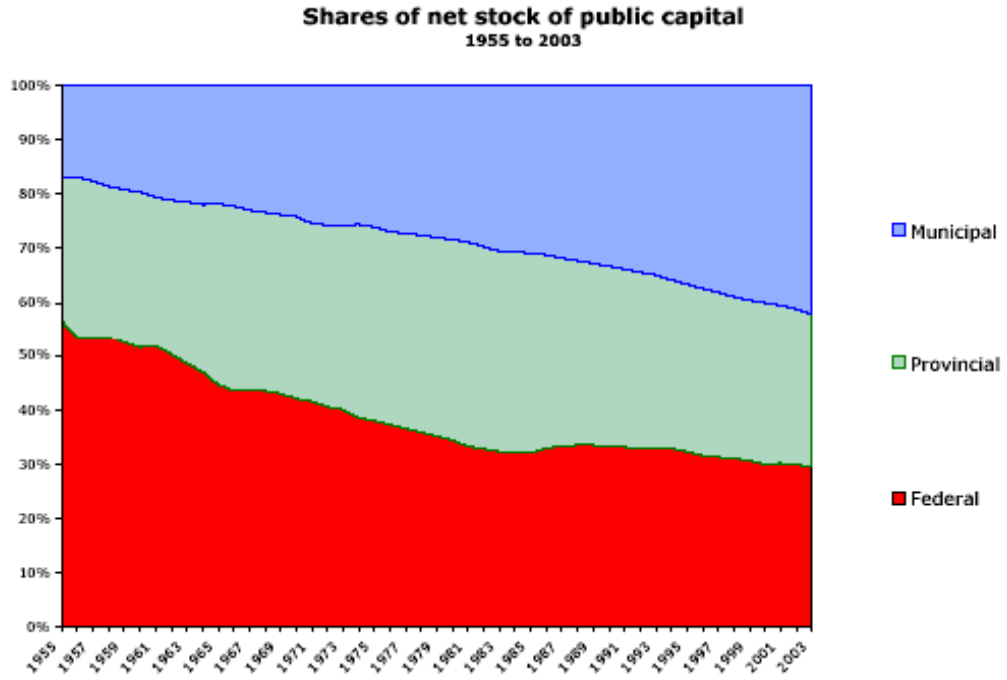
[2]From Paul Martin's autobiography *A Very Public Life*, vol. 2. Paul Martin Sr. was Minister of National Health and Welfare from 1946 until 1957.

Part III

Fiscal imbalance[3]

The federal government whittled down its health care infrastructure funding beginning in the late 1960s, and over time the financial burden shifted to provincial and municipal governments. The data on public capital investment and public sector capital stocks shows clearly the emergence of the fiscal imbalance between levels of government. Chart 1 shows the evolution of the share of the public sector capital stock owned by each of Canada's three orders of government between 1955 and 2003.

The data illustrate the federal government's retreat from a position of leadership in infrastructure. In 1955, the Federal Government owned 57% of the Canadian public capital stock; the provinces owned 26%; local governments 17%. By 2003, the Federal Government owned 30% of the stock; the provinces 29%; and municipalities 41%.



Capital investment showed a similar pattern of downloading. In 1955, the Federal Government accounted for 34% of capital investment; by 2003 it had declined to 22%; the provincial share dropped

[3]This section is paraphrased from Mackenzie, Hugh, *Financing Canada's Hospitals: Public Alternatives to P3s,* October 2004: pgs 6 - 16. All charts are copied from Mackenzie's report from StatsCan data.

from 39% to 26%; the municipal share increased from 27% to 52%.

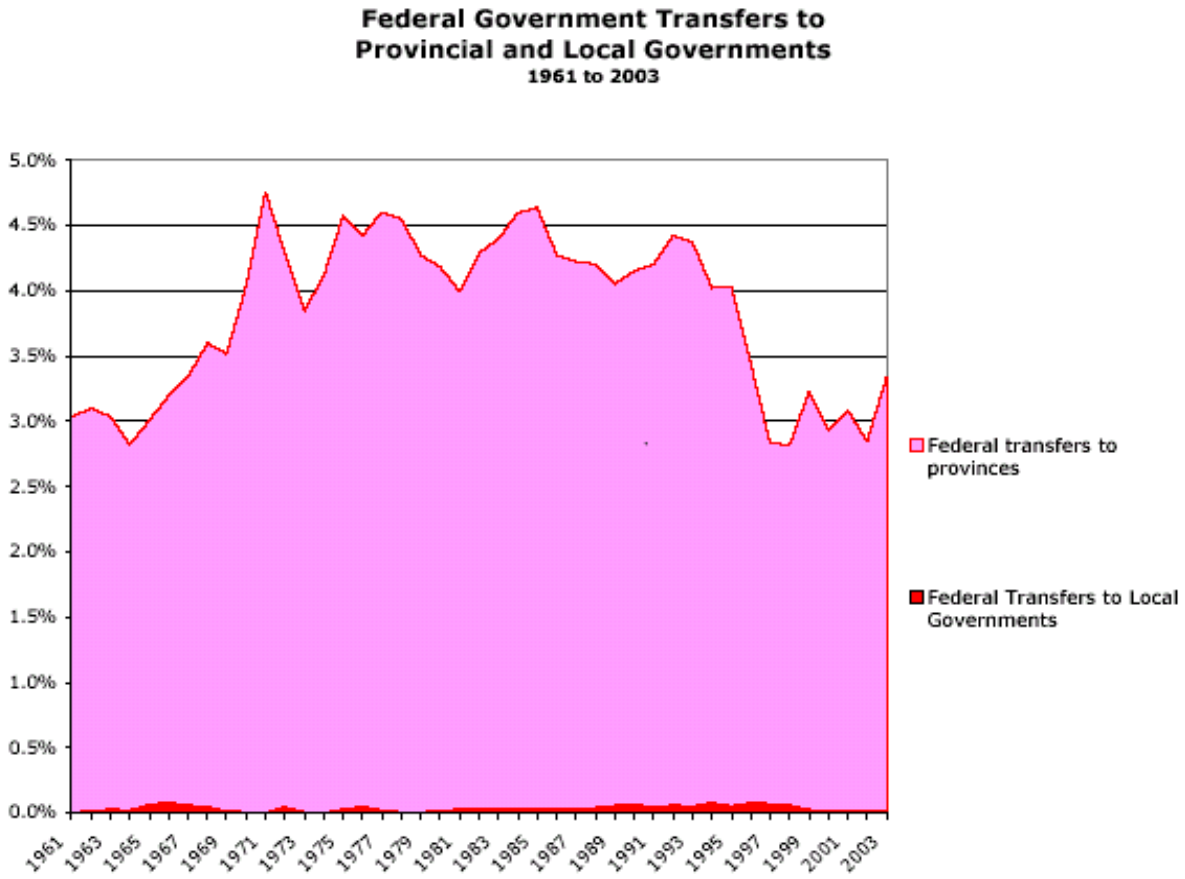
A look at investment net of depreciation is even more revealing. For most of the period since 1975, the Federal Government's investment has hovered around the level required to offset depreciation of its assets. Provincial governments' investment declined steadily until, in the 1990s, their total investment fell below that required to maintain their existing capital base. Over that period, capital responsibilities shifted from the level of government with the largest and most growth-responsive revenue base to the level of government with the smallest and least growth-responsive revenue base.

As a share of GDP, the hospital capital stock expanded rapidly between the mid-1950s and the early 1960s, stabilizing just under 0.40% of GDP in the late 1960s. Since then, except for the recession-related jump in the early 1980s, the hospital capital stock declined steadily as a share of GDP from 1970 to 2000, recovering slightly after 2000. It now stands at about 0.30%. This 0.10% reduction represents approximately $12 billion in hospital capital in current dollars.

Had there been a corresponding increase in transfer payments from the federal government to provincial governments and municipalities and from provincial governments to municipalities, the fiscal imbalance would at least have been offset. Over the nearly 35 years for which consistent data are available, however, that has not been the case.

Federal Government transfer payments to provincial and local governments increased from 3% of GDP at the beginning of the 1960s to a range of 4% to 4.5% during the 1970s and 1980s, and then dropped back to the early 1960s level in the late 1990s.

Local government transfer payment revenue (almost entirely from provincial governments) reached 4.2% of GDP in 1977, from a starting point of 2.1% in 1961. Transfers fluctuated around 4% of GDP, reaching a peak of 4.3% in 1992, and then dropped steadily to 3% by 2000.



The evidence indicates that the shift in responsibility for public capital investment from senior governments to local governments has not been matched by corresponding increases in transfer payments.

Recent Federal Infrastructure Funding

Federal reinvestment in health care infrastructure in recent years has eased the capital crunch, but funding needs to be secure and sustained to allow for long-term planning. The impact of federal funding is underlined in the data on hospital capital investment in the late 1990s. Beginning with the September 2000 Federal-Provincial Health Accord, the Federal Government has undertaken substantial reinvestment in health care, including funding directly targeted to capital investment. Funding specifically directed towards capital investment included $1 billion over two years announced in September 2000 and a further $1.5 billion over three years beginning in 2003-04.

That funding, along with the overall financial relief provided by Federal Canada Health and Social Transfer increases announced at the same time, has had a direct impact on the hospital investment data. The data from the mid-1990s to 2003 shows a decline in investment in the mid-to-late 1990s and a turn-of-the-century rebound.

The weakness of the current federal approach to health infrastructure is that it fails to recognize that funding for hospital capital is an on-going requirement of the health care system. Without exception, the capital commitments of the federal government in the health accords have been funded from year-end budgetary surpluses. These commitments have not been integrated into the government's ongoing health care funding program.

Part IV

Our Proposal

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.