CUPE Fact Sheet on For-Profit Hospitals

To date, the Conservative government has announced that for-profit corporations will design, build, finance, own and maintain a new Brampton campus of the William Osler Health Centre and a new Royal Ottawa Hospital. While the government claims (at least for now) that clinical services will not be turned over to for-profit corporations, other services will be. So, at least at this initial stage, CUPE bargaining units will likely be more affected than other hospital bargaining units (such as RN bargaining units).

The government has made clear that it plans more such projects in Ontario.

These initiatives follow on the heels of Alberta's move to allow private hospitals and an initiative to turn a hospital in B.C over to the corporate sector.

These projects are sold as a cost-effective way to deliver health care. Experience elsewhere, however, indicates that such projects lead to increased costs, reduced public accountability, more two-tier health care, fewer hospitals beds, and reduced worker rights. These projects also represent a new level of intrusion into the health care system by for-profit corporations.

Costs Rise

In Prince Edward Island, the government pulled out of its for-profit hospital project after it discovered that it would cost more than if the project was kept public.

Nova Scotia experimented with corporate owned lease-back schools. Again, the provincial government withdrew from these projects after it realized there were no cost savings to be had.

Since the early 1990s, The British government has moved aggressively ahead with such projects projects. The British call them "Private Finance Initiatives" or PFIs. British Medical Journal editorialists have a different name: "perfidious financial idiocy".

Private financing substantially increases hospital costs. For-profit corporations cannot borrow money as cheaply as the public sector. While the British government can borrow at interest rates of 4%, for-profit corporations must spend more on borrowing. (Overestimating the cost of public sector borrowing is one of the main ways the British government tries to show "value for money" for the PFI hospital projects.)

A second factor driving up costs, is that health care funds are diverted to profits: shareholders in British PFI projects can expect returns on their investments of 15-25% per year.

A third factor is the costs of negotiations and consultancy fees. The first 18 PFI hospital projects in Britain spent 53 million pounds (over $110 million) on consultants –the lawyers alone got 24 million pounds. Incredibly, the contract for Coventry's Walsgrave

Hospital was 17,000 pages. Reportedly, the two consortia vying for the deal asked for government cash to pay lawyers to read it all.

It is notable that in Britain PFI hospitals have become notorious for the increased costs of the projects between the time they are first proposed and the time the deal is reached. In Greenwich, costs went from 35 million pounds to 93 million. The first 14 PFI hospitals saw an average increase of 72%.

In light of these factors it is not surprising that while most National Health Service Hospital Trusts spend about 8% of their income on capital, PFI schemes spend between 12% and 16%.

Service Declines

The increased costs of PFI hospitals have been met by bed closures and reductions in service. PFI hospitals have resulted in a 30 per cent reduction in beds. In contrast, at the national level there has been no reduction in the number of acute beds since 1994-5. The Durham PFI hospital (built at a cost of 87 million pounds) was already facing a bed shortage within weeks of opening – in the middle of summer.

The most common way to make up the extra costs of PFI is to reduce the workforce. Every million pounds invested in PFIs eliminates four or five health care jobs – adding up to perhaps more than 25% of the workforce in hospitals and other health care facilities.

Problems with the Facilities

Britain has also seen shoddy construction with PFIs. In the Durham PFI hospital staff complain of the terrible heat that has left patients on the respiratory ward gasping for breath. Building design requires staff to drag fouled linen and waste through wards. The pharmacy has been designed without a waiting area and is squeezed right next to the mortuary, so patients have to contemplate dead bodies going by while waiting for medication. Ambulance bays are so small that a bottleneck is created if four ambulances arrive at the same time.

A key problem with for-profit ownership and design is that the architects often answer to the for-profit corporation, not the hospital and the people who know about health care and who actually work in health care facilities.

Loss of Accountability
When ownership and operation is handed over to for-profit corporations, it becomes unclear just who is in charge of what. The government is responsible for funding, the public hospital for some services and for-profit corporations for other services. Haggling and buck passing are almost assured. Indeed, shortly after opening the Durham PFI hospital in Britain, a dispute arose over whether the hospitals or the corporations were in charge of portering. So a frontline ambulance (the only vehicle covering the whole of Durham at the time) and its crew were taken out of action for 35 minutes to move a patient about 400 yards.

Buck passing may be compounded if (as is often the case) a consortium of corporations wins the contract.

Even when it is clear that a corporation is the responsible party, commercial considerations make corporations reluctant to release information: private corporations like to keep information private. In Britain, secrecy is a key ingredient in the whole PFI process. Once a decision to negotiate has been taken, all of the detailed discussions about the size, shape, cost, and service of the hospital take place behind closed doors.

No Going Back
The decision to hand over hospitals to the private sector cannot easily be reversed**.** The terms of similar lease-back arrangements last as long as 35 years, making the public dependent on the fortunes of the corporate owners for decades. That's a long time to live with a mistake.

There is also the question of the North American Free Trade Agreement (NAFTA). Once hospitals are turned over to for-profits corporations, corporations may claim huge compensation if the service is brought back in house.

Risk
Risk is often said to be transferred to the private sector -- but it often doesn't happen in practice. Risk can only be transferred to a for-profit corporation if the contract indicates that there will be financial penalties if the for-profits fail to meet specific obligations. At the Carlisle PFI hospital in Britain, one of the risks supposedly transferred was targets for clinical cost savings; the cost of the risk was estimated at 5 million pounds. However, in fact, the consortium had no responsibility to ensure that these savings would actually be made and faced no penalty if they were not. The 5 million pound "transfer of risk" was non-existent.

Impact on Staff
In the first few British hospital PFIs, non-clinical staff were routinely "sold on" to private contractors providing support services. But working conditions were only protected for existing staff. A two-tier system was introduced, with new employees working under different conditions.

Following nearly a year of strike action by support staff at Dudley Hospital fighting their compulsory transfer to a private contractor, the British government has announced three "pilot" schemes where support services will be separated from financing the new building. This may allow support workers to remain employees of the hospital, but may also drive the private consortiums to demand higher profits from the remaining tasks turned over to them.

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