Issues raised by Public Private Partnerships in Ontario's hospital sector

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This paper was prepared for the Canadian Union of Public Employees. The author was asked to review a number of documents on public private partnerships (P3s) and to provide, if possible, an answer to several questions as they pertain to two already announced P3s in the Ontario hospital sector. The author has reviewed these documents as well as others that support these partnerships, and while he is not in a position to verify the facts underlying each document, including the facts in the reports of various Auditors General, he is of the opinion that the argumentation critiquing P3s in the health sector is sound and that the facts do indeed appear to come from reputable sources. He therefore is, in general, in agreement with the conclusions reached in the documents, and quoted in this paper, except where noted.

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Executive Summary

The Province of Ontario has announced that Cabinet has given approval to proceed with public private partnerships (P3s) that will build and provide all but medical services in two new hospitals in Ontario, the new Royal Ottawa Hospital and the William Osler Health Centre in Brampton. Commitments approaching a half billion dollars have been or will soon be made.

What little information and research there is, suggests that accountability for quality of services and cost containment will be reduced and costs to taxpayers will be higher than they would have been if the hospitals were built in the traditional manner of public tender, private construction, and public ownership and operation.

These are not new issues. The Auditors General of the United Kingdom, New Brunswick, and Ontario have each raised concerns about similar kinds of projects in the health and education sectors, finding that public sector ownership would generally have been more economical. The British and Canadian Auditors General are also concerned about diminished accountability, due to diminished availability of financial, audit, and performance information from the new non-government entities that are formed by these arrangements.

In the case of the Royal Ottawa Hospital, bundled into the financial justifications for private ownership of the facility is a significant reduction in inpatient beds and greater reliance on outpatient group home care. There has been little public discussion about the long-term impact of both of these significant decisions on patients, the community, and on the overall allocation between hospitals and community care facilities of scarce dollars for the health care system.

Why then use these partnerships? The argument made by the hospitals and the province is that without private sector partnerships, the province could not afford to build them. However, Ontario government accounting practices disguise the probable higher cost of these partnerships and bias decision-making against public ownership and in favour of long-term contracts and leases with the private sector. If more appropriate accounting for the investments in these hospitals were used, the decision whether to have public or private ownership would be made on a more even accounting playing field and the result would probably be that provincial debt would likely be increased by a higher amount as a result of private sector ownership of the hospitals than with public ownership. If this is indeed the case, then from a financial perspective alone, the wrong decision has been made.

Given the significant risks of higher costs, diminished accountability and negative financial impacts on the non-hospital sector, a prudent and lower risk course of action would be for the government to reverse its decision to use P3s and to build the hospitals instead on the existing public ownership model.

1. Introduction

1.1 Background

Ontario has decided to build two hospitals in public private partnership (P3): the new Brampton campus of the William Osler Health Centre and a new building for the Royal Ottawa Health Care Group (ROH). The capital costs alone approach a half billion dollars. The major portion, perhaps all, of the cost of the projects - including presumably, capital construction - will come from SuperBuild, the Ontario government's $10 billion program for "leveraging" a "partnership approach" among the province, the broader public sector and the private sector in public infrastructure projects.[1]

Although Cabinet approval of the partnership arrangements for Osler and the Royal Ottawa has been announced in press releases, no government official, provincial politician or hospital has released to the public the P3 proposals or details of the evaluation and analysis of alternatives to P3, if any were performed, to justify the decision to proceed. This despite the criteria and expectations in the *SuperBuild Guide* suggesting that a complete analysis of the pros and cons of public private partnership should be made before the decision to proceed is taken.[2]

This choice is not just an issue of dollars. Some may hope while others may fear that using P3s to finance and operate hospital construction and

1 However the province has not revealed, if it knows, precisely how much it is willing to put in.

2 SuperBuild "is an agency of the Ministry of Finance, [and] is mandated with:

- leading the Government of Ontario's capital-planning and policy-development processes; evaluating and making recommendations to the Cabinet Committee on Privatization and SuperBuild (CCOPS) on infrastructure partnership, privatization and commercialization proposals;
- developing new strategies to strengthen the capacities of the Ontario Government and its BPS partners to attract private-sector financing and support for traditionally public infrastructure;
- and reporting publicly on SuperBuild investment priorities, capital plans and results." (Ontario, SuperBuild Guide, p. 3.)

services is just the first step in achieving a hospital system in which the private sector has a much larger role than at present.

Of the justifications provided by the province a key one is that P3s take advantage of the fact investment capital is available from private sources that is not available from the province. This is a completely self-imposed constraint, however, since the Province is effectively committing itself to constructing a hospital in either case and is obligated to pay for the hospital either way.

Ontario has constructed a systemic bias into decisions about public ownership of these hospitals in three ways. The first is unwillingness to provide funds in the capital budget. The second is the use of accounting practices that make leasing a capital asset from the private sector appear as a lower expense at least in the early years than public sector ownership when in fact it is likely to cost more. The third is the passage of the Balanced Budget Act which requires that Cabinet plan for a balanced budget and provides for salary deductions for Cabinet ministers if proposed expenditures in the budget will increase the provincial debt. However, as discussed on page 35, because of Ontario's accounting practices, the Act actually creates incentives that, while appearing not to increase debt, may do the opposite - and lead to higher costs in the long run for capital projects that are financed through leases, contracts and public private partnerships, rather than through direct provincial ownership.

1.2 Purpose of the paper

It is important for taxpayers to know that all reasonable relevant alternatives have been considered. This includes, at a minimum, whether privately owned hospitals will or will not be more expensive for Ontario taxpayers than had they been built in the conventional manner of calling for tenders for construction, and for the supply of services.

Although there are many possible issues that deserve serious discussion, this paper addresses four questions.

1. Is there sufficient transparency, accountability and public consultation about the health care implications and costs of these P3s?

2. Will P3s in the hospital sector cost taxpayers more or less than provincial ownership of the hospitals? (Is there enough information to answer this important question?)

3. Is the way the provincial government accounts for funding hospitals through public private partnerships (P3s) appropriate both for decision-making (so that the most economical and efficient approaches are taken) and for accountability (so that citizens can see that this indeed is the case)?

4. Given the answers to the first three questions, should the decision to use the public private partnership route to build and finance these hospitals be re-examined?

In answering these questions it is assumed that the Ontario government can be taken at its word, that:

- It wishes to provide Ontarians with the highest possible level of services in the most economic and efficient manner possible.
- It is serious about its written commitment to consult about costs and benefits when transferring public functions to the private sector.

1.3 Chronology

On November 30, 2001, Tony Clement, Minister of Health and Long Term Care and Jim Flaherty, then Minister of Finance and Minister

responsible for SuperBuild, announced that the construction of the new Brampton campus of the William Osler Health Centre would be the first public-private hospital partnership project in Ontario. The government announcement indicated that 70 per cent of the funding would come from the province and the local community would be required, over 25 years, to raise the remaining $105-110 million of the estimated costs of $350-380 million.

The Ministers indicated that a Request for Proposals(RFP) would be issued inviting bids to design, build, finance, own and maintain the new hospital along lines similar to the Private Finance Initiative (PFI)[3] in Great Britain. As Flaherty explained, "We need new ways to invest and modernize Ontario's hospitals at an effective and efficient cost to the taxpayers." Mr. Flaherty did not, however, indicate whether studies had shown that the P3s would be more effective or efficient than public ownership.

A week later the province announced similar plans for ROH. Approval for the new psychiatric hospital, estimated to cost $95 million, apparently followed two years of negotiations between government and the hospital on new programs and funding formulae to meet the hospital's capital needs.

Both announcements took pains to point out that while these new facilities would be privately developed and owned, the funding of the hospital's core activity - clinical services - would remain the responsibility of the Ministry of Health and the hospital boards.

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3 "Since 1992 the British government has favoured paying for capital works in the public service through the private finance initiative (PFI)-that is, through loans raised by the private sector. For hospitals this means that a private sector consortium designs, builds, finances, and operates the hospital. In return the NHS trust pays an annual fee to cover both the capital cost, including the cost of borrowing, and maintenance of the hospital and any non-clinical services provided over the 25-35 year life of the contract. The policy has been controversial because of its high cost and impact on clinical budgets." (Allyson M Pollock, Jean Shaoul, Neil Vickers *Private finance and "value for money" in NHS hospitals: a policy in search of a rationale?* British Medical Journal Volume 324 18 May 2002, P.1205.)

On June 13, 2002, ROH issued a Request for Qualifications (RFQ) as the first stage in identifying a private partner, a key step in the expedited development, construction and property management of the new Royal Ottawa Hospital. The RFQ asks for potential consortia to demonstrate their ability to design, build, finance, own, operate, property manage and maintain the health care facility. On September 19, 2002, three consortia were deemed qualified and invited to respond to a RFP. The Board's objective is to have a completed and operational facility by the year 2004. The new hospital will have 188 beds[4] according to the June 13 press release and the Ontario Hospital Association and 284 beds according to the December 7 press release from the ROH.[5] (The discrepancy may be the province's commitment to 96 beds for long term care "*to be co-located with the new hospital. Additional operating funding is available to assist with construction costs of this facility. Payments from the Government of Ontario will flow once the beds are built and in operation.*"[6]) This compares with the current total of 407 beds[7], of which 207 are at the current hospital and 200 at the Brockville Psychiatric Hospital, which is now part of the ROH.

On May 29, 2002, an RFQ for the private sector to design, build, finance, own, operate, property manage and maintain the new 700 bed William Osler Hospital in Brampton was issued. On July 2, the ceremonial shovel went into the ground to launch the early site preparation works in Brampton.

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4 Ontario Hospital Association, July 4, 2002, Update.

5 Royal Ottawa Hospital, Press Release, Dec. 7, 2001

6 Ibid

7 http://www.rohcg.on.ca

2. Question One:

Is there sufficient transparency, accountability and public consultation about the health care implications and costs of these P3s?

2.1 Criteria and expectations for Public Private Partnerships

SuperBuild suggests that several criteria must be met by these projects. They include, among others:

> *A P3 project must provide a winning business case for the private sector and at the same time, achieve public-sector goals.*
>
> *Risks must be allocated to the appropriate body.*
>
> *The processes used must be open, fair and transparent.*[8]

The Guide unfortunately does not make clear what information the public should have and what it should not and indeed seems to accept that much can and should be kept from disclosure:

> *Confidentiality of information in the process needs to address who is to keep what confidential from whom and in what manner. There may be important reasons to maintain the confidentiality of certain information related to public policy and the protection of proprietary information and intellectual property. However, these reasons must be appropriately counter-balanced against reasons for disclosing information related to the project.* [9]

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8 Ontario, SuperBuild Guide, p. 24.

9 Ibid., p. 21

Others are also thinking about public input and consultation with respect to these decisions, and into subsequent monitoring if the decision to proceed is taken. Ronald Parks and Derek Malcolm, who conducted a review of a British Columbia plan to develop a hospital in Abbotsford as a P3, offer four useful criteria for evaluating these projects:

> *A P3 process should be developed with a view to fair, consistent and equitable evaluation of projects. The literature we reviewed suggests that:*
>
> - *Whatever process is employed, accurate information is critical and needs to be continually refined as new data and direction changes are implemented;*
> - *All the stakeholders should be involved in the process;*
> - *The information gathering should not be compromised either by time or incomplete analysis; and*
> - *Monitoring the process by a suitably qualified independent party is recommended.*[10]

2.2 Auditor General expectations and concerns

All governments at some point or other engage in inefficient and/or uneconomic spending. In itself, this is not cause for alarm, if the mistakes are acknowledged and actions are taken to reduce the incidence and seriousness of these events. What is cause for much greater concern is when governments try to systematically avoid or eviscerate accountability. For this is how the democratic structures of redress can be subverted. Ensuring accountability for public funds is one reason why Auditors General are established in the first place, and why they are so vigilant about threats to accountability.

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10 Ronald H. Parks, Derek Malcolm, "Review of the Initial Evaluation of the Public Private Partnership (P3) for the Fraser Valley Health Centre/Eastern Fraser Valley Cancer Centre", Hospital Employees' Union, 2002. p. 11.

With respect to new kinds of funding arrangements, such as private public partnerships, Denis Desautels, former Auditor General and currently Executive Director of the University of Ottawa's Centre on Governance, has recommended that a framework be in place first. His observations would apply equally well to a provincial government embarking on similar kinds of arrangements.

> *The framework should provide for:*
>
> - *appropriate reporting to Parliament and the public on the extent to which the arrangement has achieved its federal public policy purpose and on the expenditure and investment of federal moneys and the stewardship of federal assets;*
> - *effective accountability mechanisms to ensure that adequate and appropriate evaluation and audit regimes are established;*
> - *adequate transparency of important decisions on the management and operations of the arrangement; and*
> - *protection of the public interest so that delivery of the federal objective adheres to essential and traditional values of public sector administration.*[11]

The basic expectation is that standards of accountability and access to information should not be less because there is a partnership. In this vein, Mr. Desautels has expressed concerns about the diminution of accountability that may occur.

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11 Auditor General of Canada, Report, 1999, Chapter 23, par. 46

> *Beyond the policy issue - namely, whether a proposed new structure is indeed the best option for delivering an activity - is the issue of maintaining accountability. Many of these new organizations involve partnerships that demand more complex arrangements for accountability among partners and back to their respective constituencies.*[12]

He understood that to accomplish this, requires that government make relevant information public. He urged government to "provide for reasonable standards of disclosure in the areas involving a federal public purpose; [and] the standards should reflect public sector standards of access to information."[13]

In view of such recommendations, it is surprising that wide-ranging discussion involving all relevant parties, as to how accountability will be achieved for the P3 arrangements in the health sector has not taken place. This is an issue in Britain as well, not only in the health sector but in education, transport and water.[14] For P3s a key problem is that claims for commercial confidentiality may already be being used as an excuse and smokescreen to avoid accountability for the expenditure of public funds for public purposes.

The Auditors General of Ontario, Nova Scotia, and New Brunswick, as well as auditors in the UK have also expressed various concerns in their reports about specific Public Private Partnerships. To some extent, they have concerns about accounting treatments, but more typically they are concerned about the comparisons that are used to justify the choice of P3s as less expensive than government ownership. In the cases examined, several criticized the assumptions used in these comparisons.

12 Denis Desautels: - *Public Sector Accounting: A Decade of Change* - Speech 4 July 2000, http://www.oag-bvg.gc.ca/domino/other.nsf/html/00cga_e.html

13 Auditor General of Canada. Chapter 23, 1999 Par. 110.

14 Allyson Pollock, Jean Shaoul, David Rowland and Stewart Player, "Public services and the private sector" Catalyst Working Paper, London, 2001, p. 26.

Mr. Desautels, in his 1999 report on infrastructure projects where a partnership model was followed, also found that there were some significant problems with respect to the decisions to undertake the projects. He observed that:

> *In future programs of this type, the government should ensure that project selection criteria are clearly defined, and that persuasive information and analyses are available and have been assessed to support recommendations for project approval.*[15]

There should be appropriate means to address public complaints, and to redress them. This is analogous to the Auditor General's recommendation that government should "establish appropriate mechanisms for redress of citizen complaints."[16] Access to redress should not be less because there is a public private partnership.

Matters do not seem to be improving at either level of government. The Auditor General of Canada wrote a chapter earlier this year underlining her expectations for adequate accountability, criticizing the federal practice of placing billions of dollars in private foundations and other delegated arrangements. Her title conveyed her frustration and central concern - "Placing the Public's Money Beyond Parliament's Reach".[17] This kind of lack of accountability, whether it is the result of creating new institutions or delegating responsibility to private corporations, is most disturbing. As things stand now, it seems like the only time public agencies can gain complete access to and release these records is when the police seize them in criminal investigations.

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15 Auditor General of Canada, Report, 1999, Chapter 17, Par. 50.

16 Auditor General of Canada, Report, 1999. Chapter 23, Par.116.

17 Auditor General of Canada, Report, 2002, Chapter 1.

Access to information is important. It is needed both before and after decisions are taken to proceed. Annual audit is needed to ensure that both financial and performance data is accurate and that value for money is actually being achieved, but the public and Auditors General are not given full access to the private sector accounting records and performance management information needed to assess what has actually happened. In the UK, for example, the National Audit Office has argued that it needs access to private sector accounting records,[18] something it does not now have. Similarly, this author was refused access to documents used to justify the P3 decisions by officials at the Ontario Ministry of Health and the Royal Ottawa Hospital on the grounds of commercial confidentiality.

2.3 Are these reasonable expectations being met for these P3 projects?

The short answer is, to date, no. None of the criteria discussed above appears to have been met with respect to either the Osler or the ROH projects. These are basic requirements for due diligence for assurance that public money is being spent with due regard for economy and efficiency. In sum,

- One can only conclude that there is a paucity of the most basic information required to have an informed public discussion whether to undertake the projects on a P3 basis. Even the province's SuperBuild itself seems to suggest that there should be more public consultation and analysis than there has been to date.

18 Allyson Pollock, Jean Shaoul, David Rowland and Stewart Player, "Public services and the private sector" Catalyst Working Paper, London, 2001, p. 26.

- If the projects go ahead, the Auditor General and the public may not have access to the financial and performance information required to determine whether the facility is being managed with a due regard for economy or efficiency, or with adequate attention to patient and staff needs.

- There is a serious risk that taxpayers will be obligated to pay more money as a result of these P3 arrangements than if the government had adopted normal procurement and contracting processes.

2.3.1 The use of inappropriate comparisons to justify P3s: The Royal Ottawa Hospital

Of great immediate urgency is the fact that the claimed "savings" of a public private partnership over the costs of renovating the ROH does not use relevant comparisons. One relevant comparison would be to compare the full cost of the private sector option of a new building versus the cost of tendering to the private sector for construction and retaining public sector ownership of the new building. It may well be that after allowance is made for the value of "free" land for the private sector contractor, the costs of financing and other matters, public sector ownership and operation of the ROH would actually be lower than private sector ownership. This analysis does not seem to have been done. It should be.

(With respect to the Osler campus, hospital officials have said[19] that the new campus will cost $350-380 million but it is not clear whether this is the anticipated construction cost, the sum of the total amount of the anticipated lease payments or the net present value of the lease payments. There has been no presentation of a comparison with the costs of public ownership.)

19 Brampton Guardian, "Council split about hospital funding", May 8, 2002.

The ROH, in addition to claiming capital savings over the cost of renovation, claims that the P3 will save $4 million annually in operating costs. With the information that has been made public, it is impossible to determine whether this is a meaningful or accurate figure. Certainly, operating savings over the current level of expenditure should be possible, not only because the building will be newer but also because the new building will accommodate fewer in-patients in rooms that are probably smaller than ROH presently has. So it may be possible to show "savings" even if maintenance costs per patient are higher than they are now! The relevant comparison not performed would show whether public operation of the facility would save even more than the $4 million of savings that will be achieved under private operation. This comparison, if it was made, has also not been made public. Again, an inappropriate comparator - this time the cost of operations in the current facility - has been chosen to demonstrate the savings of having private ownership and operation of the facility.

2.4 The answer to Question One

There is insufficient transparency, accountability and public consultation about the health care implications and costs of P3s to build and own hospitals in Ontario. A short list of basic information that deserves public input and discussion includes, but is not limited to, the following:

- Comparisons of the cost and non-cost advantages and disadvantages of relevant alternatives with the use of appropriate comparators
- The RFP (It is essential, for example, to know who will own the hospitals at the end of the lease. None of the public pronouncements to date have dealt with this very important question.)
- The terms of the contract, if one is awarded

And if the project proceeds, one needs also:

- An adequate and appropriate monitoring and audit regime
- Assurance of audit and public access to relevant performance and financial information of the private sector partners

This does not seem like too much to ask, given that the capital costs for both hospitals approach a half billion dollars; and in the case of the ROH, significant reductions of bed populations are planned; even though the full impact of the reduced bed capacity of the ROH on the community infrastructure needed for the increased outpatient and group home population does not seem to have been calculated.

3. Question Two:

How much more will P3s in the hospital sector cost taxpayers than provincial ownership of the hospitals?

What little information and research there is suggests that accountability for quality of services and cost containment will be reduced and costs to taxpayers will be higher than they would have been if the hospitals were built in the traditional manner of public tender, private construction, and public ownership and operation. Due to the many determinants of cost, the precise amounts will vary.

So, the short answer is that it is hard to say, arrived at through an exploration of three main issues:

1. **Sources of higher cost**
   Potential savings from P3s have to overcome a triple hurdle - the higher cost of private borrowing; the need to make a profit and associated other potential operational inefficiencies; and higher procurement costs.
2. **Potential benefits and value for money**
   Most of the potential savings are attributed, either directly or indirectly, to risks transferred from the public sector to the private sector. What is the experience of jurisdictions that have already embarked on transfer of services to private ownership?
3. **Goal congruence and the problem of mixed use and motives**
   Will private sector ownership of hospital infrastructure lead to perverse outcomes with respect to patient care? What are some of the possible impacts on cost and quality of clinical care?

3.1 Issue One - Sources of higher cost

Proponents of P3s identify three cost disadvantages[20] that must be overcome in order to justify proceeding. Research reviewed for this project suggests that these disadvantages are almost never overcome in practice.

3.1.1 Hurdle One: Higher cost of private borrowing

One of the arguments for using private financing is that public funds are not available. This may well be the case, but it is not an inescapable fact. It is a political decision. Governments can decide not to make funds available, or to make them available only for some kinds of projects and not others. In other words the constraints that lead to the choice of private finance are self-imposed. It is a choice especially difficult to comprehend when it leads to higher, rather than lower costs to taxpayers.

It is beyond dispute that when governments decide to undertake a public project for public purposes but choose to have it financed by the private sector, the private sector must borrow money for the same project at a higher cost than the public sector, unless the government in one way or another reduces the risk to the lender to such a degree, either through guarantees or subsidies, that the loan is, in effect, risk free to the lender and completely equivalent to lending directly to the government. Indeed if the lender lends at or very near a risk free rate, this negates the argument that government is getting value for money by transferring risk to the private sector. The market would be saying the opposite - that the risk of default is zero, or nearly so, and that government bears the risk of failure, cost increases and so forth.

20 The Submission of the Canadian Council for Public Private Partnerships to the Commission on the Future of Health Care in Canada, 2002, p. 5.

How high is the private sector financing premium? There are many different estimates for this and in practice it will vary from case to case. One simple approximation is to compare yields on Ontario debt to yield on private debt. In mid-September, the market price for a Toronto Airport Authority bond reflected a yield of about 0.95 per cent more (about 6.7 per cent versus 5.75 per cent for the province) for debt maturing in 25 years. On a $100 million investment, the net present value[21] of 25 $1 million annual additional interest payments discounted at 6 per cent for inflation and other costs is about $12 million, a surmountable hurdle, perhaps, but nevertheless a significantly higher cost. Although the government is technically not borrowing $100 million in this hypothetical example, it is still legally obligated to cover the cost of private sector borrowing, which amounts to the same thing. In the example above, the long-term additional burden is therefore 12 per cent of the value of the project.[22]

A more precise analysis of a public private partnership to build the Evergreen Park School in Moncton has been performed by the Auditor General of New Brunswick. He calculated[23] that the private sector financing premium was only an additional 4 per cent of the total cost of the project but when adjusted for other elements of the project's capital cost, the total capital costs were in total 11 per cent higher. (The project had been justified on the basis of calculations by the NB Department of

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21 In other words, the value today of a $1 million payment to be made 25 years from now is far less than the value of a $1 million payment to be made today - and is even lower, the higher the discount rate. This is why the choice of a discount rate is contentious - the higher it is, the lower the cost differential hurdle that private financing has to overcome. Although at current interest and inflation rates, 6 per cent is high, it is the rate used by the UK government.

22 This estimate excludes taxes, which would tend, all things being equal, to lower the hurdle somewhat, depending on a firm's rate of tax and the proportion of that tax paid to the provincial government. It also excludes additional costs to the government and to the private sector such as bidding and monitoring that would tend to raise the hurdle. Without information on the terms of the contract, costs of monitoring and bidding, and the tax rate of the winning firm, a more precise estimate for these projects is not feasible.

23 New Brunswick, Office of the Auditor General, 1998 Report, p. 191.

Finance showing the private public partnership option was 1 per cent lower for the project as a whole. They computed that although private capital financing costs were 9 per cent higher, operating costs 19 per cent lower would counterbalance them.)

In sum, numbers will vary from project to project but in all cases reviewed for this paper, private financing of capital costs was more expensive. The impacts of this are serious. Unless budgets for public health care expand to pay for these higher costs, the P3 expenditures will have to come out of other areas of health care. In the UK, for example, the government has provided no new net capital for hospitals, so that it has been necessary to opt for private finance initiatives.

> *The private finance initiative has proved to be more expensive than traditional public procurement, with the result that trusts have found that charges paid to the private sector finance a considerably smaller facility than would have been the case had they been paid to the Treasury.*[24]

The result has been hospital closures and major cuts in service.[25]

> *The planning process has essentially been reversed, with services being designed to fit predetermined reductions in capacity... Justifying these reductions, it would seem has become the main planning task.*[26]

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24 Declan Gaffney, Allyson M. Pollock, David Price, Jean Shaoul, "NHS capital expenditure and the private finance initiative - expansion or contraction?" British Medical Journal, 1999, p. 50

25 Ibid. p. 51.

26 Allyson M. Pollock, Mathew G Dunnigan, Declan Gaffney, David Price, Jean Shaoul, "Planning the "new" NHS: downsizing for the 21st century," British Medical Journal, 1999, p. 184.

3.1.2 Hurdle Two - Need for profit

None of the analyses reviewed actually quantified profit expectations. This is not surprising. Typically, contracts do not specify how much profit can be earned - since this would cap the incentive to earn as much as possible while still meeting the terms of the contract. However, it is clear that if costs under public ownership cannot be reduced, either through lower levels of service, job cuts, salary reductions, and/or through more efficient and economic service delivery systems, then the profit requirement will indeed be an additional cost for the project.

This leads to an important question - what proportion of the costs (and putative savings) will be consumed by profit, and what will be the impact of generating the required profits on labour, and on users of the service? As we discuss later, given the lack of goal congruence, contracts will need to specify how service levels are to be maintained and governments will need to expend effort and money to enforce the provisions. In practice, this may be very difficult.

A simple example of how the profit motive could lead to higher overall costs is the Evergreen School in New Brunswick. The NB Auditor General identified a very significant risk - the contract provided "no limit on possible increases" of cleaning and maintenance costs. Indeed clauses like these are a significant risk for all public private partnerships. With a contract that specified no limit to increases for cleaning and maintenance, the contractor would have a legal right to increase charges for these services to ensure that overall, it earned whatever it considered to be a reasonable profit. On the other hand, a private sector provider can legitimately argue that some costs are beyond his or her control. Whether they are or not in any specific case, is another matter.

The Ontario government has recognized that this issue as a problem more generally. Its *SuperBuild Guide* has some excellent practical caveats for those who are contemplating such ventures and concerns itself directly with several good examples of likely goal congruence issues, such as the incentive to reduce maintenance toward the end of a project. As the *Guide* candidly concedes,

> *Ensuring private-sector commitments during ongoing operations is equally challenging. Once the "excitement" of the development phase has passed, the public-sector organization typically views monitoring during ongoing operations as a routine task to be handled by an individual of lower qualifications. As a result, private-sector parties are often able to erode various commitments, particularly with respect to service levels and operations.*[27]

Unfortunately SuperBuild's suggested solution to these "key challenges" is only that "appropriate care must be devoted to ensure that these commitments are fulfilled."[28] The *Guide* does not discuss the public policy mechanisms required for adequate and ongoing monitoring, audit and evaluation. Its caveats to those thinking about undertaking these projects only serve to underscore the need for public knowledge and monitoring of the details of the contract, if the project is, in fact, undertaken and "appropriate care" is required.

The public, at this point in time, has no information about such clauses and their potential significance for either the ROH or the Osler hospital.

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27 Ontario, *SuperBuild Guide*, p. 23

28 Ibid. p. 23

The Evergreen School points to another common example of how a public private partnership can lead to higher costs for the taxpayer in the long run. In this project, the province transferred land at less than market value once lease costs were allowed for.[29] This enhanced the profitability of the project at the expense of reducing the value received by the previous owners of the land, the taxpayers of New Brunswick.

In sum, even if overall project costs are not increased, the profit motive does create pressures that can conflict with the public service goals of the enterprise. We call this the issue of goal congruence and discuss it further below.

3.1.3 Hurdle Three - Higher procurement costs

The bidding process can be very expensive for the companies and the government - and while the winning bidder can eventually recover the costs, other bidders, if there are any, and the government cannot. This creates incentives for bidders to collaborate. As the only legitimate bidder, the consortium is much better able to negotiate terms to its liking and, if projections prove overly optimistic, to renegotiate terms later on. As Professor John Loxley of the University of Manitoba has observed, "It's these kind of hidden costs that need to be exposed and taken into account."[30] As well, consultants have complained about the high "hidden" costs of bidding on P3s, both to the construction industry and the public sector, in terms of preparing and evaluating RFQs and RFPs. Such costs have been estimated at $1.6-million for the Charleswood Bridge in Winnipeg, Manitoba (over 10 per cent of the project cost), with fees to consultants alone being 6.7 times as high as those incurred in a normal design-bid-build project.[31]

29 Salim Loxley, "An Analysis of a Public Private Sector Partnership: The Evergreen Park School, Moncton, NB", March 1999, p. 1.

30 CUPE technical briefing to Romanow Commission. p.8.

31 John Loxley, "Private Development Costly" *Globe and Mail*, June 27, 2000.

3.2 Issue Two - Potential benefits of P3s - Value for money and the issue of risk transfer

Proponents of P3s see many advantages to P3 arrangements. What is suspect about their arguments, coming from a sector where respect for the bottom line is considered primary, is that while the additional costs of P3s discussed above are quantifiable, they contend that quantifying the benefits is more problematic. Indeed, the lobby group for P3s, the Canadian Council for Public-Private Partnerships suggests that the advantage to these partnerships is not "low cost", but rather "value for money", because there needs to be "recognition that not all the potential benefits under a P3 arrangement translate into dollars at the time of bidding."[32] It is not completely clear what is meant by this - but since they do not discuss the *non-quantifiable cost advantages* of public ownership, while claiming them for P3s, there is an asymmetry to their argument that does not do full justice to both sides of the debate.[33]

As we have noted, there is a clear incentive for proponents to choose a high discount rate in order to make their case for long-term savings of leasing over public ownership. While this is an issue to be cognizant of, Allyson Pollock, a British health policy expert who has examined PFIs in the hospital sector, says of the UK choice of 6 per cent "which many economists say is too high," "even applying this high discount rate still favours the public sector option."[34]

32 Canadian Council on Public Private Partnerships, Submission to Romanow Commission, 2002, p. 4.

33 Professor Loxley in looking at Canadian projects, and Allyson Pollock looking at the health sector in the UK, on the other hand, have done careful analysis of many projects and, in so doing, demonstrate, to this author's satisfaction, that the claims for value for money are exaggerated.

34 CUPE technical briefing to Romanow Commission. p. 3.

The argument for the advantages of P3s rests mainly on two other assertions:

1. The first is that since public capital is not available, *private capital can accomplish what public capital cannot.*

   As indicated above, this argument is more than a little disingenuous as the public capital constraint is self-imposed. If the government takes on obligations that are more costly than the option of public ownership, the government is actually increasing - rather than decreasing - the cost to the taxpayer.

2. The second argument is that *significant risks are transferred from the public sector to the private sector.*

   If true, this is an important advantage. Unfortunately this argument makes assumptions that are unlikely to be realized in practice. We address this next.

3.2.1 Risk Transfer - Does the transfer take place or does the taxpaying public still bear most risks?

The theory is that if, for example, costs increase or there is negligence, then the private sector partner bears the risks, not the government. As well, risk sharing creates financial incentives for the private sector partner to achieve savings. This can amount to considerable savings for the taxpayer. In Britain the total savings have been calculated at 17 per cent but Allyson Pollock determined that the contribution of risk transfer to the assertion of 17 per cent savings depends primarily on just one project, the National Insurance Scheme, managed by Andersen Consulting {now Accenture}. As Pollock recounts:

> *It was the subject of two or three inquiries by the Public Accounts Committee because it went over time and over budget. Worse still, it is estimated that it cost the government 5 billion pounds in lost revenues because the system lost 5 million tax revenue forms. As well as that the system caused great hardship to the claimants of benefit payments. Thus the real risks passed back to the taxpayer, the user and the government. Andersen Consulting was paid 3.9 million pounds in compensation - the Treasury minister told the parliamentary Select Committee that they did not want to risk the contract and their relations with the provider.* [35]

Thus contract terms notwithstanding the risk was borne by the taxpayer when things did not go well and the benefits went to the contractor when they did. This is opposite to the direction of risk transfer argued by proponents of P3.

The British experience is eerily similar to the experience reported by the Ontario Auditor General for another private public partnership in which Andersen Consulting was also the primary contractor. This is the now infamous business transformation project in which Andersen was to be paid up to $180 million for helping to achieve savings to the Ontario Works and Ontario Disability Program. At the time of the report, total benefits were $116 million and total costs were $117 million, of which $95.6 million represented payments to Andersen.[36] The auditor identified a number of areas which were excluded from the $180 million cap and where there was no effective limit to what Andersen could charge. In some cases, Andersen hourly rates were several times higher than that paid to civil servants for similar work. Once again, despite claims to the contrary, the project risk was borne mostly by the public sector.

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35 Allyson M. Pollock, Mathew G Dunnigan, Declan Gaffney, David Price, Jean Shaoul, "Planning the "new" NHS: downsizing for the 21st century," British Medical Journal, 1999, p. 185.

36 Office of the Provincial Auditor of Ontario, Special Report on Accountability and Value for Money (2000), p. 264.

Moreover, with payment to Andersen dependent primarily on achieving lower government expenditures by the Ministry of Community and Social Services, the incentive structure rewards initiatives that may also reduce government revenues and increase expenditures to other departments. For example, if wage rates can be cut, this translatesinto lower Ministry expenditures. However lower wages also translates directly into lower income and sales tax receipts for the government. These net deductions from "savings" are not deducted from the "savings" owed Andersen.

The incidents involving Andersen are egregious. While such singular examples do not prove that public private partnerships will *always* cost more than public ownership, they do suggest the risk is high. Indeed, what emerges clearly from these examples, as well as from *all* the others that Pollock and Loxley and their colleagues have examined, is that the structure of these arrangements creates incentives that make it advantageous in one way or another for the contractor to:

- reduce costs, even if this impacts negatively on levels of service; and
- optimize revenues, even if this causes the project ultimately to cost more than it would have with public ownership and normal procurement processes.

In a P3 arrangement, a rational private sector partner will want to accept risk transfers from the public sector in the initial contract and negotiate to receive financial compensation for accepting them but then, if things really go badly, argue for or negotiate alternative arrangements if the risk should ever actually be realized. This may be easier than it sounds. If there is, for instance, an issue of public safety or delivery of an essential service and the government does not have available an alternative service supplier, it will be in a very poor negotiating position to sanction a supplier who demanded additional funds or time or who provided lower than expected levels of service or poorer than agreed upon outcomes. Can the

government afford to put the contractor into bankruptcy? Is it willing to take over the service? Is it able? The cases in the research reviewed suggest that the answer is usually no.

In sum, risk transfer is a way to demonstrate theoretical value for money for public private partnerships. In practice things have not worked out this way in the past and there is good reason to be concerned whether the future will be brighter. Penalty clauses in standard procurement arrangements, with all their limitations, might accomplish just as much, if not more.

3.3 Issue Three: Questionable goal congruence between private and public sectors

By goal congruence we mean alignment of objectives, win-win negotiations and positive sum games. They all amount to the same thing. The very word partnership implies people working toward the same goals. If the public and private sector have aligned goals, then the potential for synergies, including savings, and higher outputs is enhanced and more likely. However, as the evidence reviewed for this paper indicates, the incentive structure for projects reviewed appears to do just the opposite, leading not only to higher costs, but in some instances, also compromising the public service objectives - including quality and level of service - for which the partnership was established in the first place.

Concerns about cost and goal congruence need to be addressed when considering whether to use public private partnerships to construct and operate the Osler hospital in Brampton and the Royal Ottawa. We concentrate on the ROH in this analysis because, while there is a severe dearth of information in the public domain on either project, there is more available on the ROH. Osler probably will have analogous issues.

3.3.1 Does the private sector partner have, as the primary objective, to provide a facility that is optimal for delivering the best possible service, at the lowest possible cost?

In a recent presentation[37], Mr. George Langill, the Executive Director of the ROH, stated that the new ROH will have about half the number of beds which are now in the Brockville and ROH combined. Inpatient costs will drop from 67 per cent to 47 per cent of total operations as outpatient activity increases.[38] As we indicated on page 10, it is reasonable to ask whether the rather modest $4 million in operational savings projected for ROH is dependent on a lower inpatient population, lower allocation of space and other facilities, or will benefit from a greater emphasis on outpatient care paid for from a different budget. The numbers do suggest that ROH anticipates far lower costs per inpatient than is presently the case. However this is all guesswork. The full basis for the P3 assertions and plans should be made public and should be subject to examination and debate.

Mr. Langill noted in the same presentation[39] that facilities for the mentally ill resemble more closely commercial office space, than do the facilities for an acute care general hospital. So it is not surprising that the ROH plans to build its new facility on a section of its property that is much closer to a major thoroughfare in Ottawa, Carling Avenue, near the entrance to the Queensway. This means that in the future, it could conceivably be fairly simple, and perhaps even profitable, to convert the hospital, or some part of it, into usable commercial space. At the point where it becomes more profitable to make this conversion, what will happen to the inpatient

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37 George Langill, Presentation to Canadian College of Health Care Executives, Halifax, May 28, 2002

38 Part one, slide 12 of Langill presentation to CCHCE (http://www.cchse.org/leadership/SpeakerPresentations.htm)

39 Ibid., Part two slide 2.

facilities and services? Will there be appropriate incentives to ensure that the inpatient services remain, or will patients be moved to commercial space in a lower rent part of Ottawa?

In the ROH case, it is also conceivable that the private consortium may include leasing prime commercial real estate in the more immediate future as part of the business plan. Questions immediately arise.: Will the consortium, for example, pay market value or indeed any price at all for the land? Or is this among the reasons that, according to the ROH, there will be more than $20 million in capital savings[40] from the public private partnership, compared to renovation?[41]

It is possible that these decisions are being taken with the interests of some in mind, but not others. For example, who speaks for the patients, both inpatients and outpatients? Who speaks for the staff? Who speaks for those who may require mental health facilities in the future? As things stand now, the extra costs, some of which may not be dollar costs, will not be borne by the contractor but will be borne either by current or future patients and their families and/or the staff.

3.4 The answer to Question Two

According to research and audits of similar projects, the likelihood of incurring higher cost for public private partnerships for these two hospitals is very high, but so far the information that would help to make an informed judgment on either the ROH or Osler has not been released, or publicly discussed.

What is clear is that both the comparisons used to justify the project - the claim that the new hospital will have a lower cost than renovation and

40 Further reasons would include the lower costs of fewer and smaller inpatient rooms in the new hospital over the existing ones at the existing facility.

41 Langill presentation to CCHCE, Part One.

that it will have lower operating costs for the renovation over current operating costs - are each inappropriate for deciding whether to proceed with the new hospital as a public private partnership.

Furthermore, the basis for making even these claims of savings has not been released. This discussion needs to take place so that taxpayers can be assured the province is not undertaking a debt to build these hospitals that is significantly greater than would be the cost of public ownership.

4. Question Three:

Is the way the provincial government accounts for P3s appropriate for decision-making and accountability?

How the costs of new hospitals are accounted for is relevant for both decision-making and accountability. Current practice appears to bias decision-making against public ownership, and to understate the obligations incurred by P3s. As a result, when P3s are used for capital projects instead of public ownership, provincial debt appears lower when in fact it is not.

4.1 Accounting - Why do we need it?

In the private sector, a core reason why accounting practices are supposed to be sufficiently rigorous, relevant, and uniform is so that investors can compare the performance of different companies when making their investment decisions. Another aim is that accounting rules should assist, rather than distort, management decisions about whether to invest, or to trim costs, and so forth. However, as we have seen recently, accountants have worked with management to mislead rather than inform. Enron's use of off balance sheet debt is now famous as one of the most misleading accounting practices. As a result many more people now understand better that accounting rules - and the institutional structures to enforce them - are important.

Accounting is a language, with a vocabulary, rules and syntax. Properly used it can convey truths and useful information and serve as the foundation of the mutual trust needed for enterprises in well functioning societies. Poor accounting rules or improper use of good ones, whether intentional or unintentional, leads to misinformation, mistrust, and their inevitable negative consequences for society as a whole.

4.2 Accounting for capital investments

Public sector accounting has traditionally differed from private sector accounting in several ways. The most notable difference has been the way it treats the entire cost of acquisition of capital assets as an expense in the year(s) of construction through the use of the rules for cash accounting. The private sector has used the rules of full accrual accounting, which instead expenses the costs over the useful life of the asset.

One advantage of accrual accounting is that by spreading expenditures for a capital asset over its useful life, there is not, in terms of reported annual expenses, any more favorable accounting treatment for choosing to lease a capital asset versus direct acquisition. (There may be balance sheet advantages if the lease is considered an operating lease.) Each one is a series of expenses over a period of time. Even with operating leases, the amount of the contracted obligation to pay the lease can be compared with directly acquiring a capital asset, after adjustments are made for risk transferred in the leasing contract. (This requires, of course, that information be made available on the terms and conditions of the lease, which is often not the case with private contracts.)

According to the capital expenditure portion of the Estimates, "The Health Capital Program... includes funding for new construction related to hospital restructuring, as well as public private partnerships."[42] The Estimates thus seem to indicate that only direct government funding related to new construction is in the Budget. What projects are included is not stated. In any case, lease obligations for private sector expenditures and borrowing are not included - even though the Government has contracted to pay them.

42 Ontario, Ministry of Health and Long Term Care, 2002-03 Estimates, p. 20

After the leases are entered into, however, the full amount of the obligations, to the extent that the amounts can "reasonably be determined" - will be included, but only as a footnote to Ontario's financial statements. These obligations will not be broken down by project but rather shown as an aggregate figure for all the province's otherwise unreported financial commitments.

The total value of these commitments grew by about $2 billion dollars from 2001 to 2002 - that is from $12.2 billion in 2001 to $14.2 billion in 2002.[43] This $2 billion dollar increase in the Government's financial obligations, does not, however, appear as an increase to the provincial debt!

4.3 Inappropriate accounting methods can provide misleading information and distort management behavior

To governments that wish to show lower expenditures - and thereby increase their budget surpluses or lower deficits in order to minimize debt - the rules of cash accounting created clear incentives to convert capital expenditures to be reported in just the year(s) of construction into a series of future annual expenditures.

However, in order to accomplish this accounting maneuver the rules required that the government not incur the cost directly but work through an intermediary, normally a private sector partner who would finance and build the asset and lease it back to the government. In other words, accounting conventions created incentives to use financing methods that take public capital expenses and convert them into annual payments to a third party.

43 Ontario, Ministry of Finance, Province of Ontario Annual Financial Statements 2001-2002, Footnote 12, page 55. (http://www.gov.on.ca/FIN/pacc02/english/02_ar.pdf)

This has the virtue of *appearing* to reduce government expenditures and avoid the appearance of deficits. But does it really? We will address this question more fully on page 39-40.

4.4 The rules are changing - How much is accounting practice changing?

In theory the use of leases and other accounting maneuvers should now be diminished because the anachronistic accounting practice of using the rules of cash accounting is about to change, for both the federal and Ontario governments.

The federal government is already converting to full accrual accounting. As the Treasury Board notes:

> *Accrual accounting provides an information tool for managers. It focuses on a wider range of information on which to base decisions and measure program and operational results. By capturing information not previously reported, accrual accounting enhances analytical techniques that will allow a shift in focus from the purchase of inputs to the management of outcomes and results.**

Ontario's 2002-2003 Budget states that, beginning in 2002-3, major tangible assets such as land and buildings will be accounted for on a full accrual basis. However the Estimates reflect a somewhat murkier picture. For example, gross capital expenditures are still reported as an annual expenditure and then an amount of $634 million for "net investment" is subtracted.

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* (http://www.tbs-sct.gc.ca/fin/FIS-SIF/sigs/fis_faq/faq-fis-sif_e.html)

In the private sector the gross investment would appear in the cash flow statement and on the balance sheet, and only the depreciation expense in the income statement. But in the Ontario Budget, the full amount of a direct capital investment, less perhaps a deduction for depreciation, is carried as an expense in the year(s) of construction!

Thus, despite its move to accrual accounting, the Ontario government appears still to use accounting methods that appear biased in favour of financing capital expenses "off the books". This seems to fly in the face of the purpose of full accrual accounting in that it still gives governments that wish to avoid deficits an incentive in favour of choosing public private partnerships over calling for tenders for the private sector to build the asset but for the public sector to finance and own it. The use of such an accounting convention is most unfortunate. Decisions about ownership and financing should be made on intrinsic merits, not as a result of choosing accounting conventions that favour one option over the other.

4.5 Are the commitments to build the new ROH and Osler hospitals anywhere in the 2002-2003 Ontario Budget?

The answer is "probably not", but we don't know for sure. The gross allocation for capital expenditures for health and long term care is just $342 million. This compares with an operating budget in the same sector nearly 75 times higher – $25.45 billion.

Since the government has chosen the leasing route, it appears as if the capital cost of the Brampton and Royal Ottawa hospitals, to which the government has committed itself, does not appear on the government's budget projections.

4.6 Is the budget balanced, if one includes the costs of the private ownership of hospitals?

Notwithstanding the accounting treatment in the Estimates, a cabinet commitment has been made and contracts may soon be signed committing the government to both capital and operating expenditures over a long period of time. This is the sort of planned expenditure that if proper full accrual accounting had been employed, might violate the underlying (and overly simplistic) intent of the Balanced Budget Act not to increase the provincial debt, but equally probably does not technically violate the section that penalizes Ministers if the provincial budget is not balanced.

However, if Ontario employed an accounting methodology for the acquisition and operation of capital assets which treated lease obligations on a level playing field with public ownership, then public ownership of the new hospitals would likely lead to lower provincial expenditures than private ownership, thereby better fulfilling the intent of the Balanced Budget Act.

Had both the ROH and Osler hospital been included in this year's capital budget for health and long term care, it would have had to be at least 50 per cent larger, a very large increase. On the other hand, no matter what the accounting treatment, the relative increase of the P3 costs of these two hospitals will be small relative to the total operating budget.

Even if the extra annual expenses of a P3 for these hospitals were as high as $50 million annually, the increase would be nearly invisible – about 1/5 of 1 per cent. The probable extra costs of the two P3s would be essentially hidden and immaterial in a budget this size.

If and when a contract is actually signed, it will then be added to the liabilities reported in a footnote to the province's accounts. However, as we point out on page 37, the $2 billion increase last year in Ontario's long term liabilities, which may include health care facilities, does not increase the reported provincial debt, even if the contracts are for unwarranted or unnecessarily high levels of expenditures.

4.7 Other accounting issues: Are the P3 hospitals capital or operating leases?

Another significant accounting issue is the allocation of P3 costs in these hospitals between construction and various aspects of administration and maintenance. As things stand now, it appears they may all be bundled together. This confusing lumping together of costs will impede accountability. It is important that decision-makers, including the public, understand and be informed about how these costs are allocated so that if one part of the contract is economical and another is not there is an opportunity to optimize economies and efficiencies.

4.8 Whether capital or operating, debt is debt

Most importantly, and finally, one should not lose sight of the fundamental point that Professor Loxley made to the Romanow commission:

> *I don't think it matters whether the lease is an operating one, or a capital one. What counts is that the lease is a debt, and taxpayers are on the hook for that debt.*[44]

44 CUPE, "Experts tell Romanow Commission that Public Private Partnerships are not the Answer", May 2002, p. 10.

He is right. From the point of view of public disclosure, it is important to know the terms of these leases so that legislatures and the public can assess the full costs of these ventures and can challenge the terms, if appropriate, , whatever accounting treatment the government chooses for them.

It is simply insufficient to lump together billions of dollars of future obligations in a footnote to the government's Annual Financial Report. What is needed is to make these calculations public before the decisions are taken. Earlier disclosure would make it possible to compare P3s with relevant alternatives, such as public ownership, that might well be less costly.

Determining and responsibly challenging the amount of these obligations and their rate of growth is essential. For example, the province plans to move to more community-based mental health care but to date has not allocated the sums required for these new group homes and other facilities. Unless the mental health budget is increased, therefore, there is a serious risk that the obligations to pay for and operate the new smaller ROH will crowd out needed expenditures for other parts of the mental health care system - such as outpatient and community care for the two hundred current hospital residents who will be moved into group homes and the thousands of other potential outpatients. The Osler will presumably have a similar crowding out impact in its area.

Such predetermined and fixed funding demands may have system-wide impacts by establishing prior claims on provincial health spending for decades to come. In Britain, the Private Finance Initiative is doing just this.

As already noted above, with current accounting practices, the ability to hide extra costs of P3s in the operating budget will tend to obscure, especially in the first few years, the amount of these extra costs. This is because at least at first, the lease or amortization charges would be probably not much more than 10 per cent higher annually than the public ownership option.

The problem is that these differences would be multiplied over many years and might increase fairly dramatically. Discussion should therefore focus on whether the total expenditure for private ownership and operation is more economical than the alternative of public ownership, and whether the service is likely to be equal or better.

4.9 The answer to Question Three

The answer to the question thus is: The accounting treatment for P3s in the hospital sector is not appropriate to decision making because:

- the full debt obligations are not known, making comparisons with public sector ownership impossible, and
- both construction and operating expenditures are bundled together in the contract with the private sector partner, making it impossible to determine whether optimal economies are being achieved, or even whether construction costs that should count as capital expenditure are being treated as operational expenditures.

Moreover the absence of details about the contracts, the calculations for the savings and the claim of commercial confidentiality[45] mean that for the foreseeable future citizens may be unable to determine whether the same health outcomes could not have been achieved at less cost to the taxpayer. This is an unacceptable level of accountability for the expenditure of public funds.

45 In a phone conversation, the Executive Director of ROH, September 12, 2002, George Langill, stated that he would not give the author further details on the costs, how savings were calculated, or information about the contracts, because CUPE had put in a grievance, and because of considerations of "commercial confidentiality".

5. Conclusion:

The decision to use the P3 route to build and finance hospitals should be re-examined

The argument made by the hospitals and the province is that without private sector partnerships, the province could not afford to build them. However, Ontario government accounting practices disguise the probable higher cost of P3s and bias the decision-making against public ownership and in favour of long-term contracts and leases with the private sector. If more appropriate accounting for the investments in these hospitals were used, the decision of whether to have public or private ownership would be made on a more even accounting playing field and the result would probably be that provincial debt would likely be increased by a smaller amount as a result.

Given the significant risks of higher costs, diminished accountability and negative financial impacts on the non-hospital sector of using P3s to build, own and operate hospitals in Ontario, and assuming time is of the essence, a prudent and lower risk course of action would be for the government to reverse its decision to use P3s and to build the hospitals instead on the existing public ownership model.

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