CUPE RESEARCH

P3 Hospitals: The wrong direction

Executive Summary

CUPE Canadian Union of Public Employees

April 2011

CUPE Research: P3 Hospitals: The wrong direction

April 2011

Executive Summary

Canadians want public health care. They know care should not depend on how wealthy a person is, but rather depend on how much a person *needs* health care, including hospital care. A recent national poll found 89.9 percent of Canadians support or somewhat support universal health care.[i]

Canadians need access to good public hospitals. In some areas, new public hospitals need to be built while many public hospitals need major renovations.[ii] Canada's population is aging and it is also increasing at a steady rate. As of October 1, 2010 the population reached more than 34.2 million up from just over 31 million in December 2001.[iii]

Hospitals that operate as public-private-partnerships (P3s) are a form of private for-profit "care" that erodes Canada's universal health care system.[iv] Profit becomes the focus of the service instead of health care. The first 12 P3 hospital projects in the United Kingdom earned an average return, or profits, of 58 percent.[v] Huge P3 profits are related to the overly high cost of private (for-profit) borrowing.[vi] Economist Hugh Mackenzie in his June 2009 paper "Bad Before, Worse Now" found private borrowing for P3s to be 83 percent more expensive than public sector borrowing.[vii]

Health care workers, patients, families and activists in Canada and other countries are lobbying for public, non-profit hospital care. [viii] CUPE, among other unions and organizations from a wide cross-section of Canadian society, are demanding the continuation of public hospitals – <u>not</u> P3 hospitals. In Québec, anti-P3 hospital coalitions involve workers and citizens including students, feminists, environmentalists and construction industry experts.[ix] The Ontario Health Coalition has gathered thousands of signatures in favour of public hospitals.[x] Activists in BC have worked hard to end P3 hospital plans.[xi] The British Medical Association in the UK has warned Canadian governments to stop pursuing P3 hospitals. P3 hospitals have reduced health care access and quality in the UK.[xii]

This report examines how and why public hospitals are far superior to P3 hospitals. Taxpayer funds are wasted on P3 hospitals, while a lack of transparency and democracy is evident with a P3 hospital system. Hospital renewal through the public sector promotes the Canadian economy. The paper also explores how public hospitals can offer better quality overall than for-profit P3 hospitals.

It is possible for Canadian governments to continue to develop the public hospital system. Governments can issue public bonds in order to finance public hospital renovations and/or building. Canada's Auditor General (AG) should thoroughly investigate all P3 hospitals to fully expose any problems including waste of government funding.

The Canadian Union of Public Employees (CUPE) advocates for public hospitals both as hospital workers and as patients and family members. CUPE represents nearly 200,000 health care workers in Canada – including more than 100,000 hospital workers. Our members provide everything from support services such as food, cleaning and laundry, to direct care such as nursing and rehabilitation. CUPE's entire membership includes such services as education, social services, municipal, and the airline sector. CUPE membership across Canada equals more than 600,000 members making CUPE the largest union in Canada.

What are P3 hospitals and where are they?

Public-private-partnerships (P3s) are a form of privatization. They are not 'partnerships' at all. They result in higher costs, lower quality, loss of public control and less hospital care. If Canada continues to open 29 more hospitals as P3s as planned in Ontario, British Columbia, Québec and New Brunswick, this report shows that we stand to lose about $2.9 billion in valuable government hospital funding to the profits of large multinational consortiums. This figure does not include the funding that continues to be lost from the 18 operating P3 hospitals in Canada in Ontario, British Columbia, Québec and New Brunswick. See Appendix A for the status of P3 hospitals in Canada.

Province	Operational P3 Hospitals	Underway/Under construction P3 Hospitals
NB	1	1
Québec	0	2
Ontario	14	21
British Columbia	3	5
Canada Totals	**18**	**29**

Why choose public hospitals?

The paper is divided into three sections that explain why public hospitals are more beneficial than for-profit P3 hospitals. Each section is called a "public hospital building block" to show how and why the public hospital method is preferred. The first deals with efficient public hospital funding; the second "block" explores the lack of P3 hospital democracy, transparency and nation building; while the third outlines how P3 hospital quality and accessibility can be poor.

Public Hospital Building Block One: **Public hospital funding is more efficient**

P3 hospitals mean profits for multinational corporations and extra administration costs are taken out of taxpayer funding. Public hospitals operate and are financed without profit. Governments in Canada can borrow financing for public renewal at far cheaper rates than through private P3 hospital consortiums. The Canadian federal government should be involved in public hospital renewal. Public hospital bonds could help.

Public Hospital Building Block Two: **Public hospitals are more democratic and serve to build Canada**

Public hospitals are ultimately accountable to elected politicians. If the public hospital system is failing, Canadians can change their government officials through elections. Private P3 hospitals operate undemocratically, often in secret, without full public scrutiny within contracts that can be 30 years or longer. Auditor Generals need to investigate all P3 hospitals in Canada.

Public hospitals require local construction industry workers and hospital staff. Taxpayers' health care funding can go toward providing good public jobs in order to achieve high quality care in public hospitals. P3 hospitals often use large multinational companies that undermine the local construction industry. Money is taken for profits and extra administration costs, away from hospital care with P3 hospitals. Local hospital jobs are often cut as P3 hospitals take more public health care dollars from the area.

Public Hospital Building Block Three: **High quality public non-profit hospitals are accessible**

As P3 hospitals take up much of provincial health care budgets, overall hospital bed count can actually decrease, reducing hospital access. Smaller, more rural public hospitals can close as more regionalized new P3 hospitals are built. With the P3 hospital model, rural patients and families must travel great distances. In some areas, bed-to-population ratios are decreasing, when P3 hospitals are built. P3s also often open too late – long past their original completion date. See Appendix B for selected Canadian P3 hospital bed counts and small community public hospital closures – that also affects hospital jobs.

The P3 hospital model can reduce hospital quality. Private for-profit hospital care in the United States, where it flourishes, has been found to be poor. A review of 20 years worth of data and 149 studies of for-profit and non-profit health care in the U.S., found that the majority of the studies (88) concluded that non-profit health care performed better.[xiii] P3 hospitals are a type of for-profit hospital. Poor care conditions are created as builders and designers do not consult with hospital care staff, while innovations can be difficult. For-profit hospital working conditions are often poor which worsens quality of care especially through high staff turnover. Not enough cleaning staff in P3 hospitals can lead to poorly cleaned hospital areas. Proper cleaning is needed for infection control.

Recommendations

P3 hospitals involve secret contracts that are too long. P3 hospitals waste valuable health care funding and can hurt Canadian patients and society. We need governments at the federal and provincial levels to renew their commitment to universal health care and work toward a fully public hospital system. In particular:

*Canadian governments need to examine tearing up existing P3 hospital contracts that may be less expensive than continuing with the contract. Governments need to create new or renovate existing public hospitals using public funding that includes federal funding and public bonds, and:

*Auditor Generals (AG) should fully investigate all P3 hospitals to allow for full public scrutiny. Previous such AG investigations have found many problems with the P3 hospital system

sl/cope491
April 12, 2011
.

[i] Nanos, Nik. (2009, November.) "Canadians overwhelmingly support universal health care; think Obama is on right track in United States." *Policy Options*. Picard, André. (2009, August 12). "Canadians back `public solutions' to improve care, poll finds." *Globe and Mail.*

[ii] Mackenzie, Hugh. (2004, October). "Financing Canada's Hospitals: Public Alternatives to P3s."

[iii] Statistics Canada web site. (2010, December 22). This is in comparison to December 2001 when the population was 31,021,000 and December 1956 when Canada's population was 16,081,000.

[iv] Pollock, Allyson M., Shaoul, Jean and Neil Vickers. (2002, May 18). "Private finance and "value for money" in NHS hospitals: a policy in search of a rationale?" *British Medical Journal*. 324:1205-1209.; Auerbach, Lewis. Donner, Arthur. Peters, Douglas D., Townson, Monica. And Armine Yalnizyan. (2003, November). "Funding Hospital Infrastructure: Why P3s Don't Work, and What Will." *Canadian Centre for Policy Alternatives.* And Pollack, Allyson. (2008, June 11). "Operating profits: It's a myth that the NHS is unaffordable. In reality it is being destroyed by the rush to market." *The Guardian*.

[v] (2009, July 4). "PFI deals in recession: Singing the blues." *The Economist*. Page 22.

[vi] Hall, David. (2009, January). "A crisis for public-private partnerships (PPPs)?" Public Services International Research Unit (PSIRU), University of Greenwich. London. U.K.; Parks, Ronald H. and Rosanne E. Terhart. (2009, January 5). "Evaluation of Public Private Partnerships: Costing and Evaluation Methodology."; Auditor General of Ontario. (2008). *Annual Report*. Chapter Three.; Mackenzie, Hugh. (2009, June). *Bad Before, Worse Now: The Financial Crisis and the Skyrocketing Costs of Public Private Partnerships (P3s)*.

[vii] Mackenzie, Hugh. (2009, June). *Bad Before, Worse Now: The Financial Crisis and the Skyrocketing Costs of Public Private Partnerships (P3s)*.

[viii] For examples of anti-P3 lobbying results, see page 10-12 of document.

[ix] La Coalition CHU sans PPP. (2009, June 9). "Non aux PPP pour les hôpitaux universitaires!" CNW group, web site. And Marie-Eve Rancourt (2010, November). "Coalition Against User Fees and the Privatization of Public Services."

[x] Mehra, Natalie. (2007, December 10). *The Pulse: Update: Brampton P3 Hospital Target of Massive Community Unrest*. Ontario Health Coalition.

[xi] BC Health Coalition Web site. http://www.bchealthcoalition.ca/content/view/86/30/ (2009, December 11).

[xii] Silversides, Ann. (2008, October). "Public-private partnerships, part 1: the next hospital wave." *Canadian Medical Association Journal*.

[xiii] *Canadian Health Services Research Foundation.* (2004, March). "Myth: For-Profit Ownerships of Facilities Would Lead to a More Efficient Healthcare System." In Armstrong, Pat and Hugh Armstrong. (2008). *About Canada: Health Care*. Fernwood Publishing. Page 123.