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Chairman, The Canadian Council
for Public-Private Partnerships

Speech to

Ontario Hospital Association
Health Achieve 2005
Canadian College of Health Service Executives Luncheon
Metro Toronto Convention Centre
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November 1, 2005

CHECK AGAINST DELIVERY

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Thank you, Bonnie (Adamson), for those kinds words of introduction.

I would also like to thank the board of the Canadian College of Health Service Executives for this opportunity to stand before such a distinguished gathering of Ontario's hospital administrators, trustees and others with a vital interest in the current and future well-being of our health care system.

I am one of those with a vital interest in health policy . . . as a longtime advocate for the mentally ill, and now in my new role as special advisor to the federal health minister on mental health.

But today I speak to you wearing one of my other hats - I will be speaking to you as chairman of The Canadian Council for Public-Private Partnerships.

My theme will, of course, be health care, and hospitals in particular.

First, some history and context . . .

For a dozen years now, the Canadian Council has been working to improve and develop public infrastructure and services by promoting the use of an approach known as public-private partnerships or P3s. (In Ontario a different terminology is used - Alternative Finance and Procurement or AFP's.)

The council is made up of public and private sector members.

We are united in the belief that Canada needs first-class public infrastructure and services to be competitive in a tough global economy.

And that enlisting the private sector as a partner is a feasible option – and at times the best option – for governments to meet current and future infrastructure obligations.

P3s come in many different forms.

Simply put, a public-private partnership is a cooperative venture between the government and the private sector.

It is neither public nor private but rather a combination of the interests and skills of both sectors.

It capitalizes on the special expertise of each partner to meet clearly defined public needs through the appropriate allocation of resources, risks and rewards.

Governments define policy. They identify the assets and services needed to implement that policy.

Then they establish a competitive process to select private sector partners, design contracts and then let the chosen partner get on with the job of providing the asset or service to a specified standard.

Governments retain responsibility for monitoring the contract and enforcing regulations.

On the good ship P3, the government steers and the private sector rows.

There are many benefits to be derived from dividing responsibilities in this way and I'll describe some of them shortly.

First, though, I would like to tell you why the work of The Canadian Council for Public-Private Partnerships has taken on a much greater sense of urgency over the past five years or so.

We are driven by the Infrastructure Deficit.

This is the gap between what has been spent and what should have been spent to maintain public assets.

Exactly what are these assets?

They are the things that underpin not just our economic competitiveness but also the health, safety and living standards of every Canadian.

They are our schools and universities, our roads, bridges and tunnels.

Our airports and transit systems, water treatment plants and distribution systems, wastewater treatment plants, electricity distribution systems and public buildings.

And, yes, our hospitals.

In 1962, 22 out of every 100 public dollars spent in Canada was invested in these public infrastructure assets. By 2002, that had fallen to 12 dollars.

A dramatic drop by any standard. But a drop driven by the immediate pressure on our political leaders to address urgent and obvious needs.

For two decades or so, almost every government in the land focused its attention on slashing deficits, reducing debt and cutting taxes. Public infrastructure was one casualty of that approach.

The bill would eventually come due but it would be someone else's problem.

Well, that bill has now come due -- and it's everybody's problem.

It's also a very large problem. Some estimates put the total figure at \$130 billion, some even higher. One recent estimate suggests that the infrastructure deficit in Ontario alone may be over \$100 Billion.

We learn from professional organizations and local government groups that more than \$16 billion is needed for water treatment and distribution, \$37 billion for wastewater facilities, \$10 billion for roads and bridges, \$8 billion for transit, \$8 billion for Ontario's hospitals alone. . .

And the list goes on.

These are just the amounts needed right now to address past under-investment.

They don't cover future replacement – and half of our civil infrastructure will reach the end of its useful life in the next 25 years.

And they certainly don't cover expansion to meet the demands of a growing population.

Let alone the technological improvements needed to deliver services more efficiently in an increasingly competitive global economy.

At the risk of preaching to the choir, I should point out that the health care sector has not been immune from this national malaise.

Although spending on health care has continued to rise, investments in health care infrastructure – new hospitals, needed extensions to existing hospitals, new hospital equipment – have not kept pace with the needs of a growing and ageing population and with emerging technology for identifying and treating medical issues.

It seems to me that there is a great paradox lurking in our endless national debate over Medicare.

Everyone wants it to be better, but nobody wants it to change.

I understand this completely.

As Canadians, we are justly proud and fiercely protective of a system that many of us see as a defining characteristic of our society.

But we need to be careful that our efforts to preserve this great legacy do not simply become a dogged determination to maintain the status quo.

It will not be news to all of you administrators and trustees who grapple every day with waiting lists, ageing buildings and equipment and growing demand for limited resources. . .

The status quo is not serving us very well at all.

Ontario's health minister George Smitherman recognizes that.

He has declared that Medicare, as currently structured, is economically unsustainable and has announced plans to address that problem but more about that later.

For the past five years Ontario's health care budget has been growing at an average annual rate of 8 percent. It now stands at 32 billion dollars. That's double what it was in 1991. . .

But our population has not doubled. And our population is not twice as healthy.

Can that trend continue indefinitely? Unlikely.

But if it does, and health care costs continue their inexorable climb towards and past 50% of government spending, what will it mean for our schools and universities, our roads and transit systems, our social programs and all the other services that will be squeezed tighter and tighter by the Medicare behemoth. In that context, the current picture is not sustainable.

Health care spending once had to compete for funding with budgetary deficits, and with interest costs on the accumulating public debt. Now it must also compete with other critical spending programs including education, transport, power, the environment and social services.

There is another way to manage the escalating burden of our health care system, but it will mean changing the terms of the discussion.

Here is the health care debate we *should* be having.

Let me pose a key question. Can the private sector participate in health care infrastructure while maintaining the core principles of public Medicare, and perhaps even enhancing public Medicare?

And if so, is the responsible choice to innovate for that purpose, or to refuse to engage in the discussion at all?

First of all, we need to dispense with emotionally charged rhetoric like privatized health care, for-profit health care, two-tier health care, US-style health care.

Those are the distractions from what we can do in Canada without in any way drifting into that unacceptable territory.

Our public Medicare system is too big, too complex and too important to be encapsulated in glib and inflammatory idioms. We need to raise the level of the debate.

And we need to focus on outcomes. Of course, the devil is in the detail and that detail is what pulls us off course from time to time in our effort to get things right.

I don't think we can make much of a breakthrough until we face head-on this issue of public and private. My Council will leave the discussion about how this relates to clinical healthcare services to others better informed than we are.

We do, however, wade with considerable confidence into the area of private involvement in infrastructure and non-clinical service delivery.

So while I will avoid the debate on clinical services, I will say that there is ample international experience to support the idea that a bigger private-sector role in areas like building, finance, construction, maintenance and management can free up funds for crucial clinical services.

As I said, this is the debate we need to have because when we do, something dramatic could occur. Our health care system could improve.

We could reallocate desperately needed resources toward the key clinical care components of the system. That doesn't sound so rash or un-Canadian, does it?

Perhaps we could see something similar to what happened in the United Kingdom, when the Blair government took the bold decision to extend its already comprehensive public-private partnership program to the health care sector.

Now the PFI, for Private Finance Initiative, is responsible for the greatest hospital building program in the history of Britain's National Health Service.

In the last eight and a half years, they have built and opened 24 hospital projects at a cost of more than 2 billion pounds.

Work has started on 12 more (costing 2.5 billion pounds) and there are 44 more schemes, worth a total of 13.5 billion pounds, either in negotiation or given the green light by the Health Department.

That's 80 projects in motion, worth a total of 17.2 billion pounds. In total, more than 100 hospital projects will be completed during the first decade of the program.

All public-private partnerships and by a Labour government based on pragmatic considerations. Not driven by dogma.

And all part of the free, universally available National Health Service.

The fear of many who question a P3 model is that the private sector will influence the delivery of healthcare. I always wonder why people think that could happen in the models of PPP that we have seen emerging here in Canada.

Hotel companies rarely own their hotel buildings. Banks rarely own their main buildings. Is there any suggestion that the managers of those buildings have any influence on the operations of the hotel or the bank?

Earlier, I made reference to the relative advantages of public-private partnerships over traditional procurement models.

One of them, obviously, is the ability to tap into the vast pools of private capital that make possible construction programs like the UK program I have just described.

Opponents of PPP or P3 would say that governments could borrow money more cheaply than the private sector. That is true but only half the story. And I will elaborate on that momentarily.

Another benefit of P3's is risk transfer – risks such as cost overruns.

This allows the private partner to assume the various risks associated with capital projects because it can manage them much better than government.

When government managed projects come in over budget and behind schedule – and let's face it, most of them do – the taxpayer foots the bill.

And this is where you have to look at the issue of the public sector having the ability to borrow more cheaply.

When there is a project capital cost or operating cost

overrun, that affects the cost of capital since more must be borrowed. A 10% overrun in either case typically translates into an increased cost of capital equivalent to about 0.65 of 1% (2/3 of 1%). The involvement of private capital mitigates the likelihood of cost overruns and the higher cost of their capital is typically much less than the consequences on government borrowing of project cost overruns.

I will let you calculate what a 20% or 30% overrun will cost. And that my friends is a very hidden cost.

In P3s, the government agrees to a fixed price and specifies the date it wants the project completed. From that point on, the taxpayers are off the hook and the private partner takes the risk.

If construction costs go over budget, the private partner is obliged to absorb the cost overrun. If the project is not finished by the agreed date, the company pays a penalty for every day it is late and gets no money at all until construction is complete.

The third big advantage of P3s is life-cycle costing.

I'm not revealing a big secret when I tell you that when you are in government, there is never enough money.

So a common public sector approach is to get the project built as cheaply as possible even if that means higher operating costs in the future.

As a further "cost-saving measure", maintenance is deferred or ignored leading to rapid deterioration and much higher repair bills down the line.

There have even been cases where government projects get the go ahead without the maintenance or operating budgets to support them.

P3s are different.

Every P3 proposal comes with a detailed business case that analyses costs over the life of the project.

These include the cost of construction as well as the costs of ongoing operations and maintenance, major upgrades and rehabilitation over time.

This means that at the end of the contract, and let me stress that this maintenance requirement is a contract, the asset reverts to the public sector in good repair.

Are P3s delivering on these lofty promises?

The answer from Britain's independent National Audit Office is an unqualified yes.

In 2003, the NAO conducted a survey of 37 PFI construction projects, including 11 hospitals, and found that the P3 model is performing up to expectations.

On construction costs, 29 of the projects surveyed reported no price overrun.

For the other eight, the cost was only above contract because the government department had required further work that was not in the original specification.

Incidentally, the NAO report noted that historically, almost three-quarters of public sector construction contracts run over budget.

On construction time, 28 P3 projects were delivered on or ahead of time and of the nine that were not, six were delayed by less than two months. Again, this compared more than favorably with historical data showing that some 70 percent of the government's construction projects were delivered late.

If I have spent quite a bit of time talking about what has been achieved in Britain, it is because I firmly believe that we in Canada can do the same.

No. We can do better.

Because we will not make the same mistakes they made in the early wave of PFI hospital projects (and we accept that those "pathfinders" were exactly that, the first projects to test and refine concepts for future project.)

And because we in Canada have all the necessary elements already in place. . .

- A highly professional and motivated public service;

- A capable and experienced private sector looking for infrastructure investment opportunities, eminently capable of implementing these projects (and in many cases, already doing so in the more active and established international markets)

- And large pools of private capital to invest when those opportunities arise.

The only thing that has been missing or inconsistent to date is political will, and even that, it seems is beginning to change.

It's changing because Canadians have wakened to the idea of the infrastructure deficit. They are not satisfied with the job their governments are doing in delivering top-notch public infrastructure and services. And they think it's time to get the private sector involved.

I know this because last year The Canadian Council for Public-Private Partnerships commissioned an independent survey on the issue.

We found that an overwhelming majority of Canadians – more than 8 in 10 – believe the federal, provincial and municipal governments aren't keeping pace with the demand for new or improved public infrastructure and services.

We also found that a smaller but still solid majority – six in 10 – agree that it's time to allow the private sector to deliver these services in partnership with government.

The people in this room will be interested to know that 62% nationwide support private sector involvement in financing and building public hospitals.

When asked about providing non-clinical services in public hospitals, 73 percent believed that a P3 could get the job done. There were some regional variations but, interestingly, support remained strong in the three provinces where debate on public-private partnerships in health care is most advanced.

- British Columbia, which has two P3 hospitals under construction and one on the drawing board.

- Ontario, with two P3 hospitals under way and several more about to enter procurement as AFP (Alternative Financing and Procurement) projects.

- And Quebec where the government says it will be looking to P3 to deliver future major hospital projects.

The results of our 2004 study are in step with findings from a more recent poll commissioned by SES/Osprey Media that questioned 504 Ontarians about their attitude to private sector financing of hospital construction. This poll was conducted in September 2005 and revealed that 52% of those polled strongly or somewhat support such an approach. So it would appear that there is a public appetite to pursue this course.

At The Canadian Council for Public-Private Partnerships we have examined the Canadian projects and also the experience in other countries to try and determine how the P3 idea can be adapted to our unique health care situation.

There are many different ways to structure a P3 but the one that seems to have the most traction in the hospital context is design, build, finance and operate (DBFO) or design build finance and maintain (DBFM).

Most of Britain's PFI hospitals for the National Health Service use the DBFO approach.

And it seems to be the emerging model for Canadian hospitals projects as well.

Here in Ontario, the two P3 hospitals now under construction -- Royal Ottawa and William Osler are DBFOs. The upcoming North Bay Regional Health Centre is a DBFM project under the province's AFP programme.

The Abbotsford hospital and Vancouver ambulatory care projects in BC are variations on the DBFO model.

How does a DBFO work?

In basic terms, the government contracts a private partner to design, build and finance a new hospital facility and to operate selected non-clinical services there for a fixed term, usually 25 to 40 years.

The private partner is usually a consortium that brings together companies with the different skills required for such an undertaking – design, construction and engineering, finance and facilities management.

The hospital pays for the use of the asset by way of a unitary charge (which is similar to a lease payment) and a performance charge (similar to a fee for a management contract).

Each charge can be reduced or waived if the private partner does not achieve performance standards.

And no charge at all is payable until the facility is completed, commissioned and operational.

It remains to be seen if this will be the preferred model in Ontario as the provincial government embarks on its ambitious five billion dollar, five-year health infrastructure program.

We do know that many of the 105 projects being planned will be carried out under the province's Alternative Finance and Procurement initiative. This means that the private sector will, at the very least, be involved in designing, building and financing the hospitals.

A very clear set of policy boundaries has been announced for hospital AFP projects, to clarify that these will be publicly owned and publicly controlled facilities. Hopefully that clarity will allow for a more principled discussion of the approach, without the inflammatory rhetoric we have too often seen in the past.

This is a major step forward, perhaps signaling the overdue end of the tired old Medicare debate and the start of a new discussion about a better way of delivering health care infrastructure in Canada.

- A way that puts the public interest above political posturing and turf wars
- That maintains public control over priorities and standards while giving taxpayers better value for their money
- That restores our health care system to the level that Canadians expect and deserve.

Earlier, I called this debate a paradox - but perhaps it is not so difficult after all.

Perhaps all we really need to do is decide what we want our legacy to be:

- To embrace change that leaves Canada's health care infrastructure stronger than we find it today.

- Or to hold tight to a status quo that virtually guarantees our system's slow demise.

I would like future generations to be able to look back at how we handled the current crisis in Medicare and see that we made the wise choice.

And I hope that you will join me in trying to bring about the changes that will ensure a better health care system for those who come after us.

Thank you