Briefing Note
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Financing Canada's Hospitals: Public Alternatives to P3s

At a time when the country was much less wealthy than it is today, Canadians built our hospital capital stock publicly, through matching finances from the federal and provincial governments. In the 1940s, then Health Minister Paul Martin Sr. saw public non-profit hospitals as the necessary foundation upon which a national public health insurance system could be built. His National Health Grants to promote the construction of hospitals across the country worked to accomplish their intended purpose. Far-sighted politicians adopted and continued the program as an essential component of nation-building. This program was so prolific in the subsidization of hospital construction that by 1970, when the program was phased out, almost 90% of Canada's hospital bed capacity had been built (see www.chsrf.ca/final_research/commissioned_research/programs/pdf/hidg/coyte.pdf).

Today, governments are singing from a different songbook. In recent years, a powerful lobby of multinational corporations who stand to benefit from obtaining a substantial rate of return on the finance, commercializing public land and privatizing the services and introducing new paid services in hospitals has emerged. The activities of these corporations, combined with a set of policy choices by governments and agencies, have contrived to drive down public investment in hospital infrastructure and promote privatization through the P3 model.

In the research paper written by economist Hugh Mackenzie, we find that there is an infrastructure backlog which has become more acute through the 1990s. However, the notion that public funding is inadequate to address infrastructure needs is a creation of those interests promoting P3s and does not reflect the fiscal reality or policy options facing our governments. In fact, an investment that is in keeping with historic levels, is sufficient to rebuild and maintain our hospital infrastructure. In addition, the unnecessarily high cost of P3s should be a strong disincentive to politicians planning infrastructure renewal through privatization.

This paper looks at the history of government funding for infrastructure, specifically hospitals, and the genesis of the current infrastructure backlog. It tests the claims of the proponents of P3s against the policy context that has created the backlog and evaluates the economics of P3 hospitals. Far from being the only option, this research finds that there are several policy options much preferable to P3s for hospital infrastructure renewal that maintain public funding, public ownership and control of land, and public delivery of services.

Key Findings:

I. The vested interests promoting P3s for hospital capital misrepresent the facts by

- overstating the crisis in order to create the political will to privatize public hospital services
- mischaracterizing the underlying policy context that has led to government under-investment in hospital capital stock

II. In fact, there has been a shortfall in public capital investment which became more acute through the 1990s. Several key factors have interacted to set a public policy context cool to investment in capital and have produced the decline in public hospital stock relative to the size of the economy:

1) Growing fiscal imbalance between levels of government & withdrawal of the federal government from capital financing:

   From 1955 - 2003 the federal government share of public capital stock decreased from 57% to 30%. In the same time period, their investment in public capital stock dropped from 34% to 22%. Responsibility for renewal of public capital was thus shifted from the level of government with the largest and most flexible revenue base to levels of government with the smallest and least flexible revenue bases.

2) Pre-occupation with short-term balanced budgets:

At the same time as the federal government had decreased its role in capital investment, it reduced transfers to other levels of government. As politicians embraced simplistic notions of superficially balanced budgets and deficit-aversion, capital investment became one of the easiest areas to cut without public outcry. The preoccupation with deficits and tax cuts reduced the planning and investment in the infrastructure for our future, producing short-term budget surpluses or balanced budgets while creating a backlog in needed capital investment.

3) Accounting rule changes:

Despite the fact that such public spending yields long term benefits, accounting measures public infrastructure only in terms of costs. Historically, governments have used a variety of tools to hide the large up-front cost of investment in public infrastructure from the books. Recent accounting rule changes have made this more difficult. Across the country, governments are at different stages of changing accounting rules, some of which contrive to make investment in public infrastructure unpalatable.

III. Despite the fact that the early development of medicare was rife with federal-provincial conflict, inter-provincial squabbles and failed attempts to build national consensus, the federal government was historically able to provide leadership in public finance of hospital infrastructure across the country. The National Health Grants Program which provided matching grants for hospital capital from 1948 – 1969 worked as intended. As a share of GDP, hospital capital stock expanded rapidly between the 1950s and early 1960s. After the program was phased out, from 1970 to 2000, except for the recession-related jump in the early 1980s, capital stock declined steadily. The 1% difference in the size of hospital capital stock represents approximately $12 billion in hospital capital in current dollars. (see charts 4 & 5 in the report)

IV. Even without considering troubling questions about control, ownership, democracy and accountability, P3s are an extremely expensive way for governments to finance public infrastructure. In P3s governments must pay a higher borrowing rate that can add tens or hundreds of millions of dollars to the cost of a project. In addition to the high borrowing rate, the corporations involved in the P3s expect substantial rates of return on their investments, thus driving up costs.

V. In the context of the historic precedent, financial and accounting issues revealed in our research, we have found several general approaches to renewal of hospital infrastructure without the troubling implications and costs of P3s. These options for public investment that would ensure public ownership, control, and the maintenance of public services are not mutually exclusive and could be used by different levels of government or in combination. General approaches include:

: Ensure consistent, reliable and stable capital investment funding from governments
: Develop a new, more transparent approach to accounting for public investment
: Consolidate the operations of transfer payment agencies such as hospitals into the accounts of granting governments and amortize the costs over the economic lifetime of the asset
: Establish public investment financing programs that permit the amortization of government costs
: Guarantee financing by government to ensure most favourable borrowing costs

Specific recommendations for the federal and provincial levels of government are contained in the conclusion of the report. From these, we can see that there are several viable delivery systems that could be used to finance hospital capital publicly, and thereby maintain public control and delivery of hospital services. There are public alternatives to expensive and unaccountable P3 hospitals.