



REPORT

P3 Hospitals: The wrong direction

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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.¹

Canadians need access to good public hospitals. In some areas, new public hospitals need to be built while many public hospitals need major renovations.² 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 2001.³

Hospitals that operate as public-private-partnerships (P3s) are a form of private for-profit "care" that erodes Canada's universal health care system.⁴ 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.⁵ Huge P3 profits are related to the overly high cost of private (for-profit) borrowing.⁶ 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.⁷

Health care workers, patients, families and activists in Canada and other countries are lobbying for public, non-profit hospital care.⁸ CUPE, among other unions and organizations from a wide cross-section of Canadian society, are demanding the continuation of public hospitals – not P3 hospitals. In Québec, anti-P3 hospital coalitions involve workers and citizens including students, feminists, environmentalists and construction industry experts.⁹ The Ontario Health Coalition has gathered thousands of signatures in favour of public hospitals.¹⁰ Activists in BC have worked hard to end P3 hospital plans.¹¹ 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.¹²

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.¹³ 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

Introduction

CUPE members support public Medicare. As hospital workers who provide everything from direct care such as nursing and rehabilitation to support services such as food, cleaning and laundry, CUPE members argue against P3 hospitals and for-profit hospital care. P3 hospitals negatively affect CUPE hospital members both as workers and patients.

CUPE represents nearly 200,000 health care workers in Canada – including more than 100,000 hospital workers. CUPE’s entire membership covering such sectors as education, social services, municipal, and airlines equals more than 600,000 members Canada-wide.

This paper examines why governments need to keep choosing public, over P3 hospitals throughout Canada. There are three “building blocks” that make up the best reasons why hospitals need to be public:

***efficient public hospital funding;**

***democratic public hospitals that serve to build Canada; and,**

***high quality public non-profit hospitals are accessible.**

First, the paper explores why P3 hospitals cost more than public hospitals. We advocate that governments should renew hospital infrastructure using partly federal funding and public bonds. Second, the paper shows how P3 hospitals are undemocratic and serve to hurt Canadians. Auditor Generals (AG) should fully investigate all P3 hospitals as such previous examinations have found serious problems including wasted expenditures. Finally, we argue in the paper that hospital quality and access can be far superior within a public hospital system.

P3s are multi-decade contracts for private management of public services or infrastructure. The format usually involves some form of ownership by a private sector consortium. Private companies often **d**esign (D), **b**uild (B), **f**inance (F), **o**perate (O) and **m**aintain (M) the structures. The abbreviation is called DBFOM. P3s can vary from full DBFOM to DBF or BF (where design (D) is often implied). (See Appendix A for examples.) P3s result in higher costs, lower quality and loss of public control. Long term financial obligations of P3s -often 30 years or more - are a form of debt which may be hidden from the public. P3s can also be called AFPs – Alternative Financing Procurement – as in Ontario.¹⁴ In the United Kingdom (UK) the same arrangement is called PFI or Private Financing Initiative.¹⁵

P3 hospital companies charge an annual or monthly fee paid by the government or government agency to cover (often, but not always) the maintenance of the hospital, any support services, and the capital cost - including the cost of borrowing. Sometimes special deals are created

where a P3 hospital may not contract-out some services such as support services or maintenance. However, many P3s contain for-profit support services and other services. Contracts can be as long as 30 years or more.¹⁶

P3s, or PFIs, started in the United Kingdom (UK) in 1992.¹⁷ They also exist in other countries such as Australia. P3 hospitals in Canada started in 1998 in New Brunswick.¹⁸ The first P3 hospital to open in Canada was the Centracare Psychiatric Care Facility in South Bay, a suburb of St. John, New Brunswick in the spring of 1998. The P3 Royal Ottawa Mental Health Centre in Ottawa, Ontario followed on October 27, 2006.¹⁹

There are 18 operating P3 hospitals in Canada and 29 in progress.

Province	Operational P3 Hospitals	Underway/Under construction P3 Hospitals
NB	1	1
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British Columbia	3	5
Canada Totals	18	29

See Appendices A and B at the end of the paper for a full list.

Public hospital advocates, however, are making inroads against P3 hospital development in Canada:

- ․ *The Canadian Council for Public Private Partnerships (CCPPP)* have taken a Québec City hospital – Centre hospitalier universitaire de Québec – and a possible P3 hospital at Sainte-Justine and Jewish General, off their P3 list.²⁰ In August 2010, the Québec government announced that the children’s hospital in Sainte-Justine, Québec, will now be expanded and renovated using traditional methods – “the largest birthing centre in Canada”.²¹ In June 2010, then Health and Social Services Minister Yves Bolduc announced that a new ER department at the Jewish General in Montréal will be built traditionally with new individual rooms to fight infection.²² Also in June 2010, the board

of the CHUQ or Québec City's Hôtel-Dieu hospital voted to use a traditional approach, rather than use a P3 system – although the project may still be turned into a P3.²³

- The P3 at McMaster hospital in Ontario has been deleted from the Ontario governments' P3 web site called *Infrastructure Ontario*.²⁴
- In early 2007, after much lobbying and protest by CUPE Ontario, the Ontario Council of Hospital Unions (OCHU), the Ontario Health Coalition, and others, the Ontario government sent all hospitals a new P3 policy that no longer required the inclusion of most support services in P3 hospital projects.²⁵ Although still problematic because of private financing, the requirement to contract out hard maintenance services (e.g. HVAC services), and other issues, now new P3 hospitals in Ontario usually privatize a much smaller scope of services than the original P3 hospitals. Maintenance, portering, patient food, housekeeping, and other operations typically remain in-house.²⁶ As well, with OCHU's contracting out language, would-be privatizers are required to employ CUPE members under the same terms and conditions as under the central CUPE hospital agreement, further discouraging privatization.
- Also, as a result of lobbying and public pressure, the P3 companies involved with the Osler P3 hospital in Brampton must share 50 per cent of their refinancing financial gains with the public hospital board, according to the P3 contract.²⁷
- In BC, cleaning jobs will now be in-house or public in the Vernon and Kelowna P3 hospitals due to Hospital Employees Union (HEU)/CUPE struggles.²⁸
- The St. Paul's P3 hospital in Vancouver has now been deleted from the P3 website for the BC government – *Partnerships BC*.²⁹
- A large P3 hospital proposed in Comox Valley and Campbell River (Vancouver Island) was stopped largely due to activism by HEU (Hospital Employees Union) and Citizens for Quality Health care.³⁰

In fact, the P3 model is losing some ground around the world:

- For example, by October 2008, Professor Dexter Whitfield, from the *European Services Strategy Unit*, found that the UK had abandoned 8 PFI (or P3) hospitals. The PFI Women's hospital in Sheffield has reverted to public finance.³¹ Southend Hospital NHS Trust dropped their PFI or P3 scheme in favour of public financing at the end of 2007.³² After five years of planning, because of escalating costs, the P3 Royal Brompton Hospital in London, England, was abandoned.³³

- Pierre Beaudoin, chairman and CEO of Bombardier, said in May 2010 that P3 financing was more expensive and that it wasn't a good solution.³⁴

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

Introduction and summary

Public funding is a more efficient way to fund hospitals. P3 hospitals waste money since they cost two to three times the price of public hospitals. P3 hospitals cost so much since they involve private corporations that charge profits. Costs are also higher due to P3 contract negotiation and contract monitoring. Canadian governments should consider tearing up P3 hospital contracts in Canada and create new or renovate existing public hospitals with the help of federal funding and public bonds.

Since P3 hospitals waste valuable health care funding, Canada needs to renew hospitals within the public system

P3 hospitals cost two to three times the price of public hospitals

The overly high cost of P3 hospitals is not affordable for Canada as costs far exceed those of public hospitals.³⁵ Allyson Pollock, a leading health policy researcher from the University of Edinburgh, says that governments spend the equivalent of **two hospitals** to get one P3 hospital.³⁶ Jim and Margaret Cuthbert, well-known Scottish economists, outline that in Scotland, taxpayers get one PFI (or P3) hospital for what **three** public hospitals would have cost.³⁷

In June 2010, the Québec Auditor General (AG) Renaud Lachance released a review of Montréal's University Health Centres explaining that "the capital cost estimates now exceed by at least \$108.4 million the \$5.2 billion announced in March 2004, not counting future estimate revisions...(and) the conventional method is more economical by at least \$10.4 million (for the CRCHUM P3 hospital)" – or the Centre de recherche du Centre hospitalier de l'Université de Montréal.³⁸

In 2008 in Ontario, the Auditor General found that the building of the William Osler P3 hospital in Brampton cost \$194 million more (in 2003 dollars) than it would have as a public hospital.³⁹ Local fundraising in Brampton had to increase to more than \$230 million from an original \$100 million in order to try to cover the difference.⁴⁰

In 2009 in BC, forensic accountants Ron Parks and Rosanne Terhart found that the P3 Diamond Centre in Vancouver's General Hospital total nominal cost (whole life cost including maintenance) could have been \$89 million if it was built publicly. The BC provincial government, however, spent \$203 million – or \$114 million more – on the hospital as a P3.⁴¹ In other words, the P3 hospital in Vancouver was nearly 130 per cent more expensive.

In Québec, the P3 McGill University Health Centre (CUSM) was estimated in April 2006 to cost \$1.482 billion – but increased fifty per cent to at least \$2.225 billion by 2008-2009 according to Québec's Auditor General. The P3 Centre hospitalier de l'Université de Montréal (CHUM) was approved in April 2006 for a budget of 1.386 billion which was increased 81 per cent to 2.515 billion in 2008/2009, if it remains as a P3.⁴² The P3 consortium Axor-Dalkia received **\$5 million as a fee for submitting a bid** for the CRCHUM in Montréal that it later withdrew in March 2010.⁴³

Ontario is also planning many new hospitals or hospital renovations. In 2008 the Ontario Health Coalition calculated that the new P3 hospital cost-per-bed is far higher than that of a public hospital. For instance, the North Bay P3 hospital (Ontario) price-per-bed is just under 1.5 million (\$1,430,412.17). In comparison the new public Peterborough hospital (Ontario) price-per-bed is only about \$400,000 (\$398,785.43).⁴⁴

The Ontario government admitted that the North Bay P3 hospital would be \$160 million more than if they had built the hospital publicly. The Ontario government said that this was justified because of the "risk transfer" they valued at \$230 million.⁴⁵ However, "risk transfer" is very controversial and is often not real. We examine "risk transfer" later in this document.

The P3 Royal Ottawa hospital opened \$29 million *over* the original target budget – at a cost of \$125 million - instead of \$96 million.⁴⁶ The Ontario government will pay for 22 years and eight months. The cost is \$1,090,259 monthly at an interest rate of 6.33 per cent.⁴⁷ In 2005, the Ontario Health Coalition, in a document by economist Hugh Mackenzie, showed that the Royal Ottawa P3 hospital could have been built for \$174 million less through a traditional or conventional public approach.⁴⁸

Appendix A, at the end of the document, shows a Canadian P3 hospital table that includes estimated and actual costs, type of P3, the private consortium name, length of term and construction status.

UK funding wasted on P3 or PFI hospitals has also been substantial. In November 2010, noted PFI academic Allyson Pollock and David Price explained that the National Audit Office (NAO) in the UK identified PFI as a major source of pressure on hospital budgets.⁴⁹ The NAO found that maintenance of the PFI hospitals was more expensive while "catering" was only "slightly" cheaper.⁵⁰ The PFI Royal Infirmary Edinburgh and Hairmyres hospital contracts in Scotland

were found to be **three times** the cost they would have been under public administration.⁵¹ The Centre for International Public Health Policy found that the PFI Worcestershire Acute Hospital in the United Kingdom spent **7 million pounds more** in 2005/06 because they were a PFI.⁵² As of June 2010, there were 76 PFI hospital contracts in the UK totaling about 900 million pounds a year with a capital value of more than 6 billion pounds.⁵³

The English company “Carillion” – part of the William Osler P3 hospital in Brampton Ontario and the Royal Ottawa P3 hospital in Ottawa - financed and built the UK’s Swindon P3 or PFI hospital where cost overruns meant that the hospital cost \$720 million pounds when it’s original estimate was \$330 million pounds.⁵⁴

Why Canada stands to lose \$2.9 billion dollars in health care funding

Independent reviews of existing P3 hospitals have found they cost, on average \$114 million⁵⁵ and \$194 million⁵⁶ more (for BC and Ontario respectively) than if they had been built publicly. If we apply a more conservative number – of \$100 million in higher costs – for the 29 hospitals now in progress in New Brunswick, Québec, Ontario and British Columbia, this means that we will be paying \$2.9 billion more than we would if these hospitals had been financed and built publicly. This will either mean higher costs for the public or cuts to health care budgets, as hospitals cut spending in other areas to pay for the excessive costs of P3 hospitals.

Government “bail-outs” mean wasted public funds

Public funding is also wasted, and governments are made vulnerable, when they need to “bail-out” private consortiums involved in P3s. David Hall, researcher at the *Public Services International Research Unit* (PSIRU), has concerns that these “bail-outs” of P3 projects are making governments very vulnerable.⁵⁷ Some government debt is good, but too much debt can be a bad thing, says Naomi Klein, author of *The Shock Doctrine*. Klein points to Iceland and how government rescuing of corporations have “wiped out” the economy there.⁵⁸ Québec’s Auditor General is also concerned about the future risk to the province if P3s go ahead as planned.⁵⁹

Professor Pierre J. Hamel in the March 2010 study “Un hôpital en partenariat public-privé (PPP): un pari trop risqué » argues that P3s are very risky for hospital construction as P3 companies can go bankrupt. He points to the “largest PPP in the world” – the London underground Metronet - that went bankrupt in 2007 causing the government to “pay for the mess”.⁶⁰

Bankruptcy may be more likely when companies are newly formed for the sole purpose of designing, building, financing and maintaining P3 hospitals. Acces Recherche Montreal LP was created solely by Fiera-Axium Recherche LP and Meridiam Infrastructure to finance the

CRCHUM (P3 research centre at the Centre Hospitalier de l'Université de Montreal) in May of 2010. \$394 million in "senior secure bonds" were introduced into the market at that time.⁶¹

There are several examples of wasted government funding on failed P3 projects. *Partnerships BC* CEO Larry Blain has admitted \$200 million will be saved by publicly financing the province's Port Mann Bridge project instead of using a P3. Unfortunately, the *Macquarie Group* will still benefit from the P3 contracts for advisory services for financing and toll operations on the project.⁶²

Governments have wasted valuable funding on P3 hospitals, as well, through "bail-outs" and uncertainty with private for-profit "partners". The German government had to bail-out *Depfa Bank* and its parent company, *Hypo Real Estate*, who is involved in BC's P3 Royal Jubilee Hospital in Victoria.⁶³ *Depfa Bank* was also involved in BC's P3 Surrey hospital.⁶⁴ The company *Bilfinger Berger* has bailed out *Babcock* as the private equity partner, while the investment bank *Investec*, who is also involved, is in the middle of a multi-million dollar lawsuit concerning alleged illegal share selling.⁶⁵ The companies who own the P3 hospitals in Abbotsford and Leslie and Gordon Diamond in Vancouver, have had three different owners in three years. *John Laing PLC* purchased the P3s in 2007 from the Australian investment bank *Macquarie*, who bought them from the Dutch bank *ABN Amro* in 2005.⁶⁶

Develop the affordable public hospital system that is free from profit

P3 hospitals involve private corporations that charge profits

P3s, and P3 hospitals, waste taxpayers money because of private profits. Profit is money that is taken out of health care funding that should have gone directly into public hospital delivery.

The UK experience with P3 or PFI hospitals have meant huge profits. The first 12 hospital PFI projects in the United Kingdom earned an average return for shareholders (or profits) of 58 percent.⁶⁷ A noteworthy *British Medical Journal* article publicized in 1999 outlined that P3 hospitals in the UK were making profits between 15-25 percent a year.⁶⁸ According to Scottish government officials, a P3 consortium generated 90 million pounds of profits from a hospital that cost 70 million pounds.⁶⁹

Canadian P3 hospital profits are also substantial. The court documents obtained by the *Ontario Health Coalition* show that the P3 Brampton hospital will make roughly \$299 million in dividends (or profits) paid to the equity partners over the life of the contract.⁷⁰

Private borrowing and refinancing costs are too high with P3 hospitals

These huge private sector profits are fueled by the high cost of private borrowing for P3 hospital projects.⁷¹ Ontario 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 since the global financial “meltdown”.⁷² Research fellow at Edinburgh University Mark Hellowell in his August 2009 *Public Finance* paper about PFIs in the UK said that “credit margins – the premiums that banks charge over their own costs of raising capital” had risen to three times more than credit margins in the summer of 2008. Debt is now being spread among many P3 players. The more companies involved the more transaction costs are charged, which increases costs to the taxpayer. There are also fewer banks involved now which creates a type of “monopoly pricing”. For instance, in 2006/07 in the UK and Europe there were more than 50 banks involved in P3 or PFI deals. In August of 2009, there were 15 banks involved in the UK and Europe.⁷³

Refinancing also causes P3 profits to soar. In March 2006, the *British House of Commons Public Accounts Committee* investigated the P3 (PFI) Norfolk and Norwich hospital where the company *Innisfree* was involved. *Innisfree* was bought by *John Laing PLC*, the international company involved in Abbotsford, Vancouver and Victoria BC’s P3 hospitals. The UK committee chair, Edward Leigh, described the P3 or PFI hospital project as “the unacceptable face of capitalism” because of the huge profits being made at taxpayers’ expense - mainly from refinancing.⁷⁴ The refinancing caused profits to increase to more than 60 percent – up from 19 per cent.⁷⁵ Carillion, the company that built and financed Ontario’s Brampton and Royal Ottawa P3 hospitals, made \$45 million pounds in profit from refinancing the Dartford PFI hospital in the UK.⁷⁶ Professor Dexter Whitfield writing about his 2009 book *Global Auction of Public Assets: Public sector alternatives to the infrastructure market and Public Private Partnerships* says that sixty-five PPP projects in the UK alone were sold at a profit of 257 million pounds between approximately 1998 and 2008 and that profits may be higher due to non-disclosure rules!⁷⁷

Larger P3 hospital projects mean larger amounts of private financing with interest rates that are usually higher than those associated with public borrowing. In July 2010, in what the *National Post* calls the largest P3 hospital project in Canada – the P3 company SNC-Lavalin *Innisfree McGill Finance Inc.* (for the McGill P3 hospital in Montréal (MUHC)) – issued \$764 million in 34-year amortizing bonds. This was one of the largest bonds issued for a P3 in Canada and financial analysts said that “the success of this deal” shows that the market can absorb large P3 building paving the way for future large P3 contracts in Canada.⁷⁸ *Acces Recherche Montreal LP* which was created to finance the CRCHUM (P3 research centre at the Centre Hospitalier de l’Université de Montreal) in May of 2010 raised funds through issuing bonds in two “tranches - \$59.3 million of three-year 4.401 per cent debt and \$334.1 million of 32-year **7.067 per cent**

debt” (bold added).⁷⁹ André Noël from La Presse estimated in May 2010 that CRCHUM would cost \$320 million more because the private partner will borrow at 7 per cent instead of at 4.7 per cent which would be the interest rate if the hospital was built within a traditional system with public borrowing.⁸⁰

Unfortunately, workers own pension funds are involved with P3 hospitals. Such as is the case with The Ontario Municipal Employees Retirement System (OMERS) – of which CUPE is a member but does not have full control. The *National Post* reports in December 2010 that pension funds are even more interested in P3 hospitals as builders are “now looking to cash out of completed projects and redeploy their capital into new P3 projects.” The door is now widely open to pension funds, which look to invest in “stable cash flow” to buy P3 hospital debt and take over the long-term service contracts.⁸¹

Risk transfer and private P3 profits

Private P3 hospital companies often argue that governments must pay for the “risk” of any project being transferred to them and that this money should not be counted as profits. This “risk” figure, however, is highly controversial.

The *Supreme Court of Canada*, for example, has ruled that the public sector **cannot transfer** safety risks to for-profit companies. In 1997, it was found that the BC Ministry of Transportation was liable for the public safety of its roads, even though they had hired a private for-profit contractor to repair one particular road - the Sea to Sky highway.⁸²

Lewis Auerbach, former director of audit operations for the federal Auditor General also argues that risk is not ever fully transferred to the private sector in P3 hospital deals.⁸³ A noted Hospital Employees Union (HEU) paper argues that this also applies to hospital infection rates. If infection rates increase in a P3 hospital, the government is still responsible.⁸⁴

Risk transfer, and a related term, “discount rates” are discussed further in “Building Block Two”.

Professor Dexter Whitfield writing about his 2009 book *Global Auction of Public Assets: Public sector alternatives to the infrastructure market and Public Private Partnerships* says that “risk transfer is exaggerated and based on the false assumption that public sector contract management cannot be transformed.”⁸⁵ Public sector building and contract management can be transformed and improved if needed says Professor Whitfield.⁸⁶

Profits are also derived from P3 hospital user fees and tax breaks

P3 hospital user fees also contribute to profits. When profits are involved in hospitals, funds are subtracted from staffing and care delivery.

At the P3 Royal Ottawa Mental Health Centre, a private for-profit clinic called *MindCare Centres*, operates next to public services. A questionable mental health treatment using electricity costs a user fee of \$7,000.⁸⁷

Debatable corporate tax arrangements can also contribute to profits for P3 hospital companies. *Sack, Goldblatt and Mitchell* lawyer Steven Shrybman calls the P3 Brampton contract pertaining to multiple private participants - including builders, pension funds, financiers and service providers - “a huge complex contractual investment edifice” which involves large tax planning schemes.⁸⁸ Professor Dexter Whitfield says that some PPP projects running in the UK are operated from “offshore tax havens”.⁸⁹

Hospital spending is increased due to the extra work of negotiating and monitoring P3 hospital contracts

The extra administration costs due to lengthy contract negotiations and contract monitoring fuels hospital costs with a P3 system. In June 2009, the *Columbia Institute*, a research organization affiliated to the BC labour movement, produced a report that showed that governments hire extra outside contract managers, law and finance consultants to manage P3 contracts – adding additional costs.⁹⁰ In Australia, extra consultancy costs for the P3 Marjorie Jackson-Nelson Hospital are likely more than \$17 million.⁹¹ The Ontario Auditor General found that \$34 million was spent on legal, technical, financial and other advisors between 2000 and 2007 for the P3 Brampton hospital in Ontario because it was a P3.⁹² The *National Post* wrote in December 2010 that the future “continues to look rosy for Canada’s major law firms” since project financing and P3 hospitals “has always been a lucrative area for the profession”.⁹³ The Québec Auditor General found in June 2010 that renegotiating the P3 contracts for Montréal’s University Health centers cost an additional \$108.4 million.⁹⁴

Canadian governments should use federal funding and public bonds to create new, or renovate existing, public hospitals and examine tearing up existing P3 hospital contracts

Canadian governments need to examine tearing up existing P3 hospital contracts

The Canadian federal and provincial governments should consider tearing up existing P3 hospital contracts. P3 hospitals are too costly and fraught with problems. Legal costs of tearing up P3 contracts could be less than allowing the P3 contract to continue. Other countries are considering the same.

Researchers in the UK argue that governments there should look at renegotiating P3 hospitals contracts or “tearing up” P3 or PFI deals. Professor Paul Corrigan, former adviser to two Labour health secretaries and then Prime Minister Tony Blair, says that PFI agreements should simply be torn up. In a July 2010 *British Medical Association* article, Professor Corrigan is quoted as saying that similar agreements are “torn up every day”. Corrigan says if the National Health Services (NHS) and the UK Treasury worked together, the leverage could be used to put “PFI agreements on a different footing”.⁹⁵ The UK National Audit Office (NAO) agrees. The NAO published a report in June of 2010 arguing that the UK government should renegotiate PFI contracts to get better value for money and the Department of Health should consider its negotiating leverage over the market.⁹⁶

CUPE’s sister union in the UK, UNISON, argues that governments should buy P3 infrastructure back from the private sector. This would be a gradual programme, starting with a small number, by “looking at each contract in turn, to see what deal can be struck”.⁹⁷

Canada needs a renewed federal capital investment program

A renewed federal capital infrastructure investment program could help build and renew public hospitals.⁹⁸ The Canadian Centre for Policy Alternatives (CCPA) has called for a federal *Public Assets Fund* that could provide partial funding for public hospitals - up to 25 percent of total costs.⁹⁹ This echoes the *Canadian Healthcare Association* and *Association of Canadian Academic Healthcare Organizations’* call for a national capital infrastructure investment program for healthcare.¹⁰⁰

Whatever you call it, the federal government needs to help pay for public hospital renewal in Canada. The last major influx of federal funding for health infrastructure was in 1966 through the *Health Resources Fund Act* and the *Hospital Construction Grants Program* of 1948.¹⁰¹ This model was created by then Health Minister Paul Martin, Sr., (in 1948) and continued until 1971.

At that time, the federal government provided what was called “fifty-cent dollars” where the provinces matched each federal dollar.¹⁰²

Renewing public hospitals and public bonds

Instead of private financing, governments can issue public bonds for public hospitals. In its 2009 Alternative Federal Budget the CCPA outlined that a public bond, as a secure asset, is a quality investment, so badly needed in an economic downturn or recession. Public bonds are secure and liquid and provide stabilized returns. Bonds can be bought by individual investors and pension funds.¹⁰³ This is different from pension investment in P3 projects, such as the Ontario municipal and school board pension (OMERS) bail-out of the P3 hospital in St. Catharines after the Deutsche Bank withdrew.¹⁰⁴

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

Introduction and summary

Public hospitals allow room for elected officials and their staff to run the hospital system that benefits all Canadians and the Canadian economy. Private P3 hospitals contracts are often secret – hidden away from the “public eye” – further away from public control of day-to-day operations. As a result, even the decision-making process about contracting a P3 consortium can itself be faulty. These decisions have led to P3 hospitals contracts with large foreign-based multinational private consortiums that hurt the Canadian economy. Canada needs Auditor General (AG) investigations of all P3 hospitals to reveal any wrongdoings and/or public waste.

The secrecy of P3 hospital contracts

P3 hospital contracts are usually secret – out of the reach of public scrutiny. In January 2008 the publication *Public Private Finance* UK announced that “the cloud of confidentiality makes it impossible to judge whether the taxpayer is getting a good deal” for P3 contracts.¹⁰⁵ Even the International Monetary Fund (IMF), an international neo-liberal institution, argues that “transparency in PPP finances” is needed.¹⁰⁶

The Ontario Health Coalition went to court to obtain the P3 Brampton hospital contract. They won the right to see the 2000 page contract, but key sections were missing or crossed out. Only one financial number was released for the North Bay Ontario P3 hospital.¹⁰⁷

The process for contracting P3 hospitals is often biased and undemocratic

Because of extreme secrecy, it is very difficult to know the details how P3 hospital contractors are chosen and why. Once AGs investigate, however, false estimations about P3 hospital benefits can be revealed.

Falsely inflated public hospital costs and discount rates

For-profit P3 hospital companies can set “discount rates” falsely high making the public hospital comparator inaccurately seem too expensive. Discount rates are supposed to only represent the appropriate cost of capital. In 2010, Loxley showed that if the P3 analysis (or Value for Money report) is poorly done, the public comparators will always seem to cost more since the supposed risk transfer is great.¹⁰⁸

In June 2010, the Québec Auditor General (AG) Renaud Lachance found that Québec’s P3 agency conducted a biased VfM or Value for Money report (or “value-added analyses”) in favour of the P3 hospital at CRCHUM or Centre de recherche du Centre hospitalier de l’Université de Montréal. The AG found that the maintenance costs of the public sector comparator were unfairly inflated in the case of CRCHUM. The AG said that there should not have been a maintenance deficit of 20 per cent calculated in the first year of use. Also, the AG said that Infrastructure Quebec (IQ) used a “Facility Condition Index” of up to 66 per cent when “experts in this field” consider 15 to 20 per cent already very high for maintenance cost calculations. The discount rate analysis was **not completed** even though IQ said that they had conducted an analysis using a 6.5 per cent discount rate!¹⁰⁹

In November 2009, the Québec Auditor General (AG) Renaud Lachance found that Québec’s P3 agency accepted the discount rate for the P3 McGill University hospital and P3 University of Montreal hospital (CHUM) at eight (8) per cent when the discount rate for other P3 provincial projects was at 6.5 per cent. Québec’s P3 agency overestimated the maintenance costs of the public comparator hospital making the private P3 hospitals falsely seem to be about three times cheaper.¹¹⁰

In Ontario, the AG found that for the P3 hospital in Brampton, the cost estimates for the traditional public procurement approach was inflated by \$634 million over the life of the project. This made the public hospital seem incorrectly much more expensive than the P3.¹¹¹ The Ontario AG described the assessment as wrong since it attributed \$67 million to risk transfer arbitrarily. The P3 cost also didn’t include borrowing costs or consultant fees.¹¹² Previously, Lewis Auerbach (former director of the Office of the Auditor General of Canada) prepared a report for the Ontario Council of Hospital Unions (OCHU), other unions and the

Ontario Health Coalition in 2007 that found that the VfM analysis of the Osler P3 was poorly done since the calculations were inappropriate and unsupported. Auerbach found that the P3 costs were either equal to or higher than the public comparator.¹¹³

In their 2009 study of BC's P3s, forensic auditors Ron Parks and Rosanne Terhart found that the process for assessing P3s was biased in favour of P3s. The value of the supposed "risk transferred" was double-counted – included in the "discount rate" and also given an additional value on its own.¹¹⁴ Also in BC, Simon Fraser university professor and consulting economist Marvin Shaffer found that the methodology BC's P3 agency, *Partnerships BC*, used when choosing public or P3, did not take into account the lower cost of public financing. Shaffer also found that *Partnership BC* over discounted future costs for all P3 projects.¹¹⁵ This echoes what Murray (2006) had found earlier for the Abbotsford P3 hospital in BC. Discount rates of 5 to 7 per cent were used while at that time similar analysis was being performed in the UK with a discount rate of 3.5 per cent. The discount rate was falsely inflated.¹¹⁶

P3 hospitals contracts are too long

The lengthy contracts – that can be 30 years or more – are both undemocratic and tricky. The long contracts often contain extra costs that are moved to the end of the contract. A 30 year contract is undemocratic – much longer than a politician's term. Many politicians are long gone when significant costs take effect, leaving our grandchildren on the hook for our mistakes.¹¹⁷

In 2009 in BC, economist Marvin Shaffer found that the methodology *Partnerships BC* used when choosing public or P3, did not give appropriate consideration to the long-term lease obligations in P3 projects. The P3 projects, then, seemed falsely less expensive.¹¹⁸

P3 hospital contracts not fully assessed

Often there is a lack of independent assessment when P3 contracts are chosen. In 2009 in Québec, the AG (Auditor General) Renaud Lachance found that there was a lack of independent assessment of the McGill University hospital and Montreal University hospital P3s.¹¹⁹

The June 2010 AG report also found that the MUHC or McGill University Health Centre parking lot at Glen Campus did not go through a VfM (Value for Money) comparison. As well, while both hospitals (MUHC and CRCHUM) experienced an extension of the call for proposals from January to March 2010, the "derogations" or changes in the revised P3 proposals (numbering at times up to 325 changes) were not evaluated!¹²⁰

The Ontario AG found in 2008 that the William Osler P3 hospital in Brampton's VfM assessment using a public comparator was completed too late - after a decision was made to build using the P3 method.¹²¹ This also occurred with the Abbotsford P3 hospital in BC where the contract had been signed and the construction had started.¹²²

In fact, value for money tests (VfM) are irrelevant when P3 companies refinance. (See public hospital building block one on refinancing.) Professor Whitfield in his 2009 book about P3 projects explains that "profiteering from the sale of equity makes a mockery of value for money tests".¹²³

Lack of competition in what is suppose to be a "competitive bidding" P3 system

Researcher Stuart Murray in 2006 found that only one company ended up bidding on the Abbotsford P3 hospital contract in BC. This lack of competition may have alone increased the cost.¹²⁴ As of March 2010, there was only one bid left for the CRCHUM P3 hospital in Montréal.¹²⁵ A P3 hospital system with only a few or a single bidder does not leave a lot of room for a full assessment. Professor Hamel wrote that there is little competition with a P3 system.¹²⁶

Government officials can seem too close to P3 hospital consortiums

Companies involved with P3 hospitals and government officials can intertwine involving possible conflict-of-interest. Could it be possible that government officials are promised corporate jobs upon retiring from civil society if certain P3 hospital contracts are made? One example is former BC government staff, Mike Marasco, is now the CEO of *Plenary Health* – a P3 company.¹²⁷ In the UK, there are a number of former government officials that went to work for companies involved with P3 hospitals. The UK's *Guardian* newspaper reported that Simon Stevens, Tony Blair's former health advisor, went to work as the European president of the US company *UnitedHealth*. Patricia Hewitt, the ex-health secretary, earns more than 100,000 pounds as a consultant for a private equity group that bought 25 private hospitals from *Bupa, Alliance Boots and Cinven*. Between July 2009 and 2006, 37 former members of the UK government had gone to private sector jobs within two years of leaving office.¹²⁸

In June 2010, Quebec's AG recommended that "potential conflict-of-interest or undue-advantage situations" be disclosed and documented in relation to the Montreal's University Health Centre's P3 contracts.¹²⁹ In December 2010, the neutrality of the "independent experts" that conducted the analysis for the CHUM was questioned. Both Alain Boisset and Daniel Roth have been consultants for the Québec P3 agency.¹³⁰

P3 hospitals hurt the Canadian economy

The Canadian economy has suffered with the introduction of P3 hospitals. P3 hospitals have hurt local construction industries, including engineers and architects.¹³¹ Hospital workers, often already from vulnerable populations including women migrant workers, have suffered due to P3 hospitals.¹³²

Canada's hospital renewal industry is hurt due to P3s

P3 hospitals are eliminating good jobs in Canada. Large multi-national consortiums design and build P3 hospitals, eliminating Canadian firms. Public hospitals can boost the Canadian economy when Canadian experts are used in the building process and good jobs are kept. Any national public hospital renewal plan should include a "Made in Canada" policy.

The Alberta Construction Association and the *Merit Contractors Association* said in July 2009 that P3s are damaging the local construction industry as there is "too much bundling" of P3 projects which results in "the government not saving the money that it could using traditional procurement financing models" – or public models.¹³³ This message echoes a June 2008 *Business Examiner* article that explained that the "entire construction industry" is "highly aggravated with the deterioration of public procurement policies in general and public private partnerships in particular".

Canadian P3 projects involve foreign players that take over the market. In Victoria, BC, the Royal Jubilee Hospital is being built as a P3 by a Spanish-British consortium.¹³⁴ England's *John Laing plc*, a multi-national company operates BC's Abbotsford P3 hospital.¹³⁵ In Québec, the P3 autoroute 30 went to a Spanish firm and the P3 autoroute 25 bridge went to the Australian financial company *Macquarie Group*.¹³⁶ The multi-national company *Carillion* plans to expand its 10-billion-pound P3 investment programme in Canada over the next five years and recently purchased Canadian construction management group *Vanbots*.¹³⁷

P3 architects in Ontario financially and professionally suffered so much around P3 projects, it was reported in June 2009 that they are *not* covered by their professional liability insurance when working on P3s. The Ontario Association of Architects' (OAA) professional liability insurance subsidiary took "the unusual step of issuing an endorsement restricting coverage on Infrastructure Ontario projects" – the Ontario government branch governing P3 hospitals.¹³⁸

Québec engineers are also worried about P3 hospitals. Zaki Ghavitian, President of the Ordre des ingénieurs du Québec (Québec engineers) fears that the Québec government will try to save on consulting-engineering fees with any potential P3 hospitals, and gouge his industry.¹³⁹

P3s could also prove harmful to First Nations communities. Pro-P3 lawyer Godyne Sibay of McCarthy Tetrault LLP in Toronto argues that First Nations are the next great “potential” in Canada in terms of P3s.¹⁴⁰

Hospital workers laid-off

P3 hospitals are removing good jobs in communities. Allyson Pollock, a leading health policy researcher at the University of Edinburgh, says that “the only way that the companies can get their profits (from P3 hospitals) is by cutting ...hospital staff”.¹⁴¹ Former Ontario CEO Bob Richards of the Brampton hospital (William Osler) said that “every \$1 million paid on debt charges (for a P3) will result in the loss of ten nurses”.¹⁴²

According to the British Medical Association (BMA) in the UK, “lots of money has been taken out of the health service...money that was needed for patient care has been diverted from the frontline, and into the hand of private companies”. The BMA has warned Canada to stop pursuing P3 hospitals.¹⁴³

In BC, P3 hospital work in Vernon and Kelowna meant that HEU maintenance and trades workers lost their jobs¹⁴⁴. In 2006, refinancing at the P3 Norfolk and Norwich Hospital in the UK, likely caused up to 450 staff cuts and reduced services for cardiac patients.¹⁴⁵ The PFI, or P3, Worcestershire Acute Hospitals wanted to cut staff by 675 in order to meet its budget.¹⁴⁶

Professor John Loxley, in the 2010 book “Public Service Private Profits” warns that there is pressure on jobs and wages that accompany P3 hospital deals.¹⁴⁷ Professor Whitfield also warns that P3s reduce employment.¹⁴⁸

Working conditions and wages in hospitals suffer

Fair wages and benefits are important to those who work both inside and on the grounds of hospitals. P3 hospitals usually mean poor wages and benefits. In the PFIs or P3s studied by Professor Dexter Whitfield in the UK in 2008, he found that there was an hourly wage cut for all workers except senior management.¹⁴⁹ Also in the UK, migrant workers at a P3 or PFI hospital take home less than 10 pounds a week.¹⁵⁰

P3 hospitals usually mean most support jobs are privatized or contracted-out. The Brampton, Ontario P3 hospital deal contracts out many support jobs “from patient records to food”.¹⁵¹ This includes food, security, laundry and patient records.¹⁵²

On a positive note, fights from unions and health coalitions have forced governments to limit the amount of contracted out health services in Ontario. In early 2007, the Ontario

government sent all hospitals a new P3 policy that excluded the contracting-out of most support services.¹⁵³ And in BC, through HEU and CUPE's efforts, cleaning won't be privatized in Okanagan hospital P3s which means about 250 good family-supporting jobs are saved.¹⁵⁴

Wages and benefits in BC with for-profit hospital care has meant wages cut almost in half for those who kept their jobs, to a range of about \$9.50 to \$11.50 an hour. Pay equity was lost and benefits were cut altogether or reduced. There were no pensions.¹⁵⁵ In BC, the for-profit hospital workers there faced poor working conditions in 2004-05.¹⁵⁶ Lack of job security and work hour guarantees were prevalent. Workloads became much heavier, with little training, while workers reported that they were asked to "speed-up" and had "no time for care". Workers often felt guilty and put in unpaid overtime to make up any unfinished work. Illness, health and safety violations, injuries and violence were prevalent and as Pat and Hugh Armstrong explain in their 2008 book, *About Canada: Health Care*, for-profit hospital care is still problematic. Health and safety violations have also been reported at the P3 Royal Ottawa hospital.¹⁵⁷

When hospitals are P3, they negatively affect some of the most vulnerable people in our society. 82 per cent of health care and social assistance workers are women, as opposed to 47 per cent women workers in all industries.¹⁵⁸ Many health care workers who work at the bedside and as support workers are immigrants and racialized minorities.¹⁵⁹ In the UK, P3 or PFI workers are also temporary migrant workers.¹⁶⁰ Temporary migrant workers are some of the most marginalized and exploited workers in society, as they often don't have the same rights as other workers in the host country.¹⁶¹

Entire communities suffer when working conditions are poor. "Family stress" was often reported by the for-profit hospital workers in BC as a result of the deteriorating working conditions.¹⁶² Poor hospital working conditions affect the entire economy, including jobs for women in other sectors.¹⁶³ A unionized work force with large bargaining units helps to improve wages, benefits and working conditions.

Canada needs Auditor General (AG) investigations of P3 hospitals

Canada needs a full investigation of current and proposed P3 hospitals. Through the federal Health committee and the federal Auditor General, federal Parliament should fully investigate all P3 hospitals. Many AGs have revealed startling results.

In 2008 the Ontario Auditor General revealed a final construction cost of \$614 million for the P3 Brampton hospital. The AG found that the hospital could have been built publicly for \$194 million less than the P3.¹⁶⁴

Government investigations of P3 hospitals need to be full and complete. In the past, in British Columbia, the Auditor General was only allowed to “review” value for money reports for P3 projects written by Partnerships BC. These reviews were only carried to the level of plausibility, as in it is “plausible” the Olympics will not go over budget. The reviews were also paid for by *Partnerships BC* – the BC government agency promoting P3s. Even the BC Auditor General questioned this process. We need Auditor Generals to audit fully, rather than “review”, P3 schemes. When full audits were completed in Ontario and Quebec, the results were very critical of the P3s studied.¹⁶⁵

Public Hospital Building Block Three: High quality and greater access for patients in a public hospital system

Introduction and summary

Health care quality and accessibility can be better in public hospitals. P3 hospitals are a type of for-profit hospital. Hospital care can suffer in P3 hospitals as it does in entirely for-profit hospitals in the United States. P3 hospitals have cut the total hospital bed count in areas of Canada, decreasing accessibility. P3 hospitals are often too far away for many patients that also decreases accessibility. P3 hospitals usually take longer to build than regular public hospitals.

For-profit care, P3 hospitals and reduced quality of care

Hospital care can suffer in P3 hospitals as it does in for-profit hospitals in the United States. Unhealthy P3 hospitals in Canada may become more and more difficult to convert to public hospitals due to trade agreements. As a type of for-profit hospital, working conditions in P3 hospitals can be poor that negatively affects quality of care.

For-profit hospital care can be very bad for your health

P3 hospitals are a type of for-profit hospital since for-profit companies are involved in aspects of hospital care. For-profit care can be unhealthy. 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. The studies focused on hospitals, nursing homes, HMOs (health maintenance organizations), hospices, dialysis centres and psychiatric hospitals. In another review, out of 500,000 dialysis patients in the U.S., the

patients treated at for-profit centres were more likely to die than those treated in non-profit centres.¹⁶⁶

P3 hospitals can also be unhealthy because of a lack of a “team”. For-profit hospital contractors, involved in P3 hospitals, can interfere with the running of a hospital. Often there is more public control of “clinical” services in P3 hospitals, while support services are more likely to be privatized. Operating difficulties, because of so many different administrations, cause problems.¹⁶⁷

The Ontario Health Coalition argues that a public team approach is needed for hospitals without for-profit contracts or P3 companies.¹⁶⁸ Prominent lawyer Steven Shrybman argued in 2007 that hospital support services and clinical services cannot be kept separate for quality health care. When the public hospital board loses control over for-profit, P3 support services such as portering, food, cleaning, laundry and maintenance, problems arise.¹⁶⁹

P3 hospital companies want to increase the amount of for-profit care

P3 hospitals often involve for-profit support services. There is evidence that companies involved with P3 hospitals, however, want even more for-profit hospital care – beyond any support or other services. Mike Marasco, now with P3 company *Plenary Health*, is pushing for more privatized health care delivery in P3 hospitals. He argues that private delivery will help make P3s more profitable for the companies involved. In “corporate-speak”, Marasco calls it “capturing more health care savings” which really means more savings for the P3 companies and more payouts for governments and taxpayers. He says the next step is to incorporate information technology and medical equipment into the P3 contract.¹⁷⁰

Allyson Pollock, a widely recognized authority on public private partnerships from the University of Edinburgh, thinks that Canada should be smarter and stay away from P3 hospitals. She says P3 hospitals are “the first threat in the privatization of health care, part of a plethora of policies aimed at breaking up the Canadian health care system...We always thought you Canadians were more savvy because you understood that the way to get (fully private hospitals) in, is through the infrastructure.”¹⁷¹

Lawyer Steven Shrybman notes that since governments are “locked” into 25 or 30 year expensive contracts with P3 hospital companies, they may look to other ways to create revenue to pay for P3 company profits. There is pressure for hospitals to offer “extra” services where they charge fees to make up for funding shortfalls. For-profit health care is made more and more possible in these situations.¹⁷²

Trade agreements and P3 hospitals

More P3 hospitals and for-profit care could put Canadian public hospital and health care in jeopardy – especially with internal and international trade agreements – or what should be called “international corporate agreements”. International agreements such as NAFTA or GATS¹⁷³, and more recent internal agreements such as the Trade Investment Labour Mobility Agreement (TILMA), may make it difficult to end P3 contracts if the companies involved with the P3 don’t agree. P3 related companies could sue governments according to these agreements if the P3 companies feel that they have lost money due to any government actions.¹⁷⁴ This gives us all the more reason to tear up P3 hospital contracts while we can.

Good hospital working conditions are needed for quality hospitals

Good working conditions mean working at an appropriate and safe pace, with enough staff so overtime hours are at a minimum. Training is appropriate and workplaces are kept safe in hospitals with good working conditions.

Poor working conditions in hospitals can lead to poor hospital care. When working conditions are poor, staff turnover is high. Quality hospital care means time – a workforce that stays in the workplace long enough to know patients’ needs – otherwise known as “continuity of care”.¹⁷⁵

Poor hospital care can be found in for-profit and P3 hospitals. In BC, hospital cleanliness decreased - including of rooms with antibiotic-resistant infections - under a for-profit hospital company’s sweatshop working conditions.¹⁷⁶

In February 2008, the *Healthcare Commission* in the UK found “soiled commodes, bloodstains on bed rails and thick layers of dust in wards” at the five-year old P3 Princess Royal University Hospital in Orpington, Kent. The P3 hospital contracted out cleaning to *ISS Mediclean* – a member of the P3 consortium - who has a 33-year contract. The PFI hospital was issued an “improvement notice” reserved for the “most serious breaches of the government’s hygiene code” during an unannounced spot check.¹⁷⁷ A July 2009 *Guardian* article in the UK described two for-profit hospital cleaners in Bury St. Edmunds who said that “instead of four cleaners on the ward, they (the employer) said, ‘We’re going to put it down to two people, but you won’t have to Hoover (vacuum)’ – basically, ‘clean less’.¹⁷⁸ Carillion, the P3 company that financed and built both the Royal Ottawa P3 and the Brampton, Ontario P3 hospitals, also financed and built many UK PFI hospitals where their health and safety record is poor. Carillion also pays their many staff low wages in the UK.¹⁷⁹

The staff at the P3 Royal Ottawa Mental Health centre have documented that there are not enough cleaners at the P3 to clean the greater number of washrooms in the new facility and to generally keep the building clean.¹⁸⁰

P3 hospitals can also be unhealthy for both patients and staff due to poor design and construction

Designers and construction experts do not work as teams together with hospital users and workers within a P3 process. Hospital “innovation”, much needed for “green” and safe hospitals, is difficult with P3s.

P3 hospital design flaws are rampant. The P3 Royal Ottawa hospital suffered serious design and construction errors. The P3 facility lacks a proper alarm system and suffers from broken door locks. Washrooms and work areas are inaccessible to electric wheelchairs, while double doors are too heavy and injure patients who are caught in between. The P3 Royal Ottawa also suffers from improper shower heads so patients can no longer shower on their own, unusable grab bars to help patients walk and other design problems.¹⁸¹ Architects and others, including MPs, have found “the design quality of many early PFI projects in the UK to be below par...”.¹⁸² The UK’s Swindon and Dartford PFI hospitals, built by Carillion (who built the Royal Ottawa P3 hospital), suffered poor design.¹⁸³

In a 2006 World Health Organization (WHO) bulletin, P3 hospitals were found to be within budget and on-time, all at the expense of quality. Shoddy construction prevailed.¹⁸⁴

Good hospital building requires teamwork. P3s prevent this type of teamwork. With P3 hospitals, hospital care delivery experts do not consult with designers. Each phase – design, build, finance, maintain or operate (DBFMO) – is compartmentalized. In Québec, the AG found in June 2010 that the complex “governance structure still does not promote, in some cases, the accountability of the UHC (University Health Centres), the executive director and IQ (Infrastructure Quebec).” – meaning that a too-complex governance structure was risky and unaccountable.¹⁸⁵

In Québec, the AG found that the McGill University hospital and the Montreal University hospital and related health departments did not formally approve the P3 hospital contracts.¹⁸⁶ Brian Watkinson, architect and former Executive Director of the *Ontario Association of Architects*, points out that in the U.K., PFI hospitals were designed more in consultation with building maintenance and facilities management than with those who deliver health care.¹⁸⁷ Engineer Kazimir Olechnowicz from the consulting firm *CIMA+*, does not want to be involved with the building of Quebec’s P3 mega-hospital Centre hospitalier de l’Université de Montréal (CHUM), even though his firm created the original design.¹⁸⁸ Olechnowicz says “CHUM is much

too complex a project to be done as a PPP (or P3)."¹⁸⁹ The board at CHUQ or Québec City's Hôtel-Dieu hospital voted down using a P3 structure partly since they felt the project was too complex in June 2010.¹⁹⁰ The vote followed Professor Pierre J. Hamel's 300-page study that argued that hospital building and renovating is too complex for a P3 process.¹⁹¹

Innovative hospital design is difficult with P3 hospitals. An *Ontario Association of Architects'* report said that many architects felt that their "ability to innovate was severely constrained in P3s".¹⁹² Internationally renowned architect Moshe Safdie will not work with P3s even when approached by his hometown Montreal to build the P3 McGill University Health Centre. Once it became a P3, Safdie immediately withdrew citing quality concerns since hospitals, he says, should have "a humane environment". As well, Safdie says with the public hospital process "more scope exists to explore different design visions".¹⁹³

Innovative hospital design is needed so that hospitals may prevent the spread of dangerous infections. In an era of hospital "Superbugs" or Healthcare Acquired Infections (HAI) and infectious diseases such as H1N1 flu (formerly called Swine Flu), it is even more important that new and renewed hospitals be able to be as clean and safe as possible. "The design of the physical environment can have a significant influence on infection prevention and control (IPC)" says Tye S. Farrow and Stephen M. Black in a 2009 *Healthcare Papers* article.¹⁹⁴ The board at CHUQ or Québec City's Hôtel-Dieu hospital voted down using a P3 structure partly since they felt that they would have "increased care needs" in the future.¹⁹⁵

Professor Pierre J. Hamel agrees. His study explains that a leading edge hospital cannot be constrained by a P3 approach and 20 or 30 year contracts. Such contracts inhibit innovation and flexibility. He says it is too difficult and expensive to re-open P3 contracts.¹⁹⁶

P3 processes can even inhibit "green" hospitals. *The Association of Canadian Academic Healthcare Organizations* and the *Canadian Healthcare Association* calls on governments to build and rebuild health care spaces that are "greener".¹⁹⁷ In order for a hospital to be certified as "green", it must pass what is known as LEED certification (Leadership in Energy and Environmental Design). The LEED certification is done by a third party to the building process. There have been P3 contracts that specify a certain level of LEED certification and in fact, some P3 hospitals, such as the P3 Abbotsford Hospital in BC, have a LEED certification level. However, because it is certified by a third party, it is difficult for an architect to guarantee at the onset, a certain level of LEED certification. It is so difficult to guarantee, that the some architect's "errors and omissions insurance" will most likely not protect the architect if she or he is sued related to the "green" level, or LEED standard, of the P3 hospital, says Brian Watkinson in the 2008 *Canadian Architect* article "P3s for You and Me?"¹⁹⁸

The *Columbia Institute* points out that P3s threaten governments' ability to respond to climate change issues since contracts are long and cannot easily be opened.¹⁹⁹ To what extent can P3 hospitals adapt, for instance, to the change to other forms of energy instead of those that are oil-based?

More pure demolition and full construction, without concern for the environment or history, seems to be connected to P3 hospitals. In Québec, the proposed P3 hospital at the University of Montreal (CHUM) was originally supposed to be a combination of new and renewed infrastructure that would renovate Hôpital St. Luc – a green and historical initiative. However, because of P3 contract negotiations, the original public hospital will now be totally demolished – cancelling any historical or environmental efforts.²⁰⁰ Professor Hamel also outlines that P3 companies do not like renovation work that is often more “green”. Hamel argues that there are many “unknowns” with renovation work.²⁰¹

Reduced access for patients to hospital care with a P3 system

P3 hospitals have cut the total hospital bed count in some areas of Canada, decreasing health care accessibility. As well, many P3 hospitals are too far away from many patients. Public hospitals offer more beds and services. See Appendix B at the end of the paper for more information about P3 hospital bed counts.

Fewer beds and P3 hospitals

Although they promise more beds, P3 hospitals usually open with fewer beds than the public hospitals they replace. One example is within the area of Ottawa, Ontario. *The Royal Ottawa Health Care Group* is involved with both the P3 Royal Ottawa Mental Health Centre and the Brockville Mental Health centre.²⁰² 64 transitional treatment beds are scheduled to close in March 2011 at the Brockville Mental Health Centre (BMHC). These include 24 dual diagnosis beds (patients who suffer both from a psychiatric disorder and a developmental problem) and 20 beds each for psychogeriatric and rehabilitation services. This will occur a few years after the opening of the rebuilt P3 Royal Ottawa Mental Health Centre. Services were centralized and supposedly sent to the P3 hospital in Ottawa. However, the Brockville patients are not expected to move to Ottawa, but to find services “in the community” in Brockville. Some nurses in Brockville say “community” services in Brockville are few and it is unlikely these patients will find the care they need.²⁰³

Carillion, the P3 company that financed and built the UK's Swindon and Dartford hospitals (as well as Ontario's Brampton and Royal Ottawa P3 hospitals), opened the new hospitals with inadequate capacity.²⁰⁴

The BC and Ontario Health Coalitions have both shown that P3 hospitals opened in those provinces with fewer beds than the previous public hospitals in the area, even though the general population had increased.²⁰⁵ (See Appendix B)

Ontario's Auditor General (AG) in 2008 found that the William Osler P3 hospital in Brampton opened with only 479 beds in service (608 beds in total) while the original renewed public hospital was to be built with 716 beds.²⁰⁶

The entire health care system feels the affects of P3 hospitals, as services and beds are cut throughout to finance P3 company profits. Professor Whitfield in his 2009 book argues that P3 hospitals mean "increased revenue budget commitments (that) inevitably lead to fewer resources to finance services."²⁰⁷

Inaccessible, centralized P3 hospitals that are too faraway

Access to urgent hospital care is denied when smaller public hospitals close due to P3s. P3 hospitals have opened in Ontario and BC either in urban areas or as a large hospital for an entire region. Smaller and often more rural public hospitals closed either before or at the time of the opening of the new P3. Patients in smaller communities are forced to travel sometimes hours to get to the nearest hospital which is a P3.²⁰⁸

Canadians need accessible public hospitals to keep healthy. Public hospitals should be available in both small and large communities – a pillar of the federal legislation – the *Canada Health Act*. Appendix B includes public hospital closures or scheduled closures.

One example of related public hospital closures is in southern Ontario. The closures of Port Colborne and Fort Erie small hospital units in the Niagara area of Ontario and the opening of the new P3 St. Catharine's hospital in that same area is an example. If these smaller hospitals close entirely, area residents will need to travel, at times, long distances to reach St. Catharine's.²⁰⁹ The new P3 hospital in St. Catharine's is being built in an inaccessible location, full of big box stores, with little bus service, in the northwest part of the city.²¹⁰

In BC, there was a proposal to downgrade two existing smaller local hospitals in Comox Valley and Campbell River (Vancouver Island), and replace it with one large P3 hospital for the whole north island. HEU and the *Citizens for Quality Health care* struggled hard and stopped this large regional P3.²¹¹

The slow P3 hospital process

P3 hospitals take longer to build than regular public hospitals. The *Columbia Institute* has identified that P3 projects often involve a “long, complex and costly procurement process” that is often detrimental to public infrastructure renewal.²¹²

Every day a hospital infrastructure project is late, another month of extra fees are added to the final cost as a result of inflation. Dr. Arthur Porter, from the McGill University Health Centre (MUHC), says that each day the P3 hospital project is late, \$100,000 must be added to the final cost.²¹³ In August 2010, a story in the *Globe and Mail* stated that the MUHC had gone through “more than a decade of delays and false starts”.²¹⁴

In June 2010, the board of Québec City’s Hôtel-Dieu hospital voted to expand the hospital traditionally party because they wanted to speed up the process.²¹⁵

Many other hospitals that are scheduled to be built as P3s, have been delayed. For instance, the P3 hospital at Sault Ste. Marie, Ontario was schedule to open Oct 2010. The opening has now been rescheduled for April 2011, and this is only one of many more examples. For more information see Appendix A at the end of the paper.

Conclusion

This report examines the three main problems with for-profit P3 hospitals: P3 hospital overspending; undemocratic P3 hospitals that hurt the Canadian economy; and, inferior hospital access with a P3 hospital system that also can jeopardize quality of care. It shows that a public hospital system spends less than a for-profit P3 hospital system. Profits, excess administration costs and higher borrowing costs make a P3 hospital system much more expensive for taxpayers. The report shows that P3 hospitals create secret contracts where Canadians are locked in, often for 30 years. For-profit P3 hospitals are removed from democratic, public ownership. P3 hospitals are built using large multinational firms that remove jobs from the local Canadian construction industry. Good public hospital jobs are eliminated for P3 hospital jobs were wages and working conditions are usually poor. With respect to hospital access, the report shows that a P3 hospital system consolidates fewer hospital beds in centralized locations. Smaller, more rural public hospitals often downsize or close when central, larger P3 hospitals are built. Patients and families from small communities in Canada often need to travel lengthy distances to new P3 hospitals, reducing hospital access. For-profit P3 hospitals follow the lead of American for-profit hospitals where care quality can be poor.

The public hospital system in Canada needs to be renewed now. After decades of decreasing public funding, hospital buildings have been allowed to crumble, while technology has developed in leaps and bounds. Changes in population numbers, our aging population and increasing poverty, more stringent infection control and environmental standards, all cry out for public hospital renewal.²¹⁶

The private for-profit health care sector knows Canada needs hospital renewal and wants to benefit from it. They propose for-profit P3 hospitals. Private corporations want to use taxpayer funding to pay for their profits through P3 hospitals. Private for-profit companies want to also profit from more expensive borrowing rates.

For-profit P3 companies hide details from Canadians in contracts that they try to keep secret and away from public scrutiny. They propose 30-year deals where many costs are pushed to the end. The P3 hospital contracts use large multinational construction companies, hurting the local construction industry. Communities, especially small Canadian communities suffer, when good public hospital jobs are replaced with fewer P3 hospital jobs where working conditions can be poor.

Public funding spent on profits for P3 hospital companies, often mean fewer hospital beds available to patients when P3 hospitals open with fewer than promised beds. Rural public hospitals close, reducing access to many patients and families that need urgent care. For-profit P3 hospital care is often questionable, as cleaning is left undone due to fewer cleaners, while profits are placed ahead of quality.

As this paper shows, public hospital renewal in Canada needs to occur through public financing and delivery. The *Canadian Medical Association Journal* published articles in 2008 and again in 2010 outlining that BC, Ontario and Québec “have been quick to jump on the PPP bandwagon in recent years, (when) there’s been little examination of the risks associated with the change”.²¹⁷

Our two recommendations will serve to strengthen Canada through public health care:

- 1) Canadian governments need to examine tearing up existing P3 hospital contracts since the legal costs may be less than continuing with the contract. Governments do need to create new or renovate existing public hospitals. Issuing public bonds for public hospitals can help ease the debt pressure on governments to finance this process. Federal financing, however, needs to be the cornerstone of public hospital renewal.
- 2) Auditor Generals (AG) need to fully investigate all existing and proposed P3 hospitals in Canada. Canadians need to know why and how for-profit P3 hospitals waste funding. They need to know the truth about P3 hospitals.

While the US discusses moves to create a more public and universal health care system²¹⁸, Canada cannot continue to lose public hospital care by building more P3 hospitals or keeping hospitals as P3s. The cost is prohibitive. We also have our health to consider.

Appendix A - P3 Hospital Status

	P3 Hospitals in Canada:	Status		Length of term	Type	Estimated Cost	Actual Cost/Status	For-profit Consortium
Province		Completion Date	Start					
New Brunswick	Centracare Psychiatric Care Facility, South Bay, Saint John	Operational Feb. 28, 1998	RFP issued Feb. 25, 1997	25 Years	DBFM	Unknown	\$6,425,000 ²¹⁹	Cardinal Pomerleau Inc.
	Restigouche Hospital Centre (Campbellton) [mental health]	RFP issued Sept. 14, 2010	Unknown	TBD	DBM	\$85 million ²²⁰	Under construction	<i>Shortlist:</i> Walker Brook Health SNC Lavalin Inc. Plenary Health ²²¹
Québec	Montreal University Hospital Centre (CHUM)	Est. completion date 2018 ²²² RFP now due June 15, 2011, was due March 2010 Infrastructure Quebec (IQ) studying QC government report supporting P3 (Nov 30, 2010) ²²³	RFP issued June 28, 2007	30 Years	DBFM	Now \$2.5 billion, was \$1.4 billion ²²⁴	RFP	<i>Shortlist:</i> Innisfree-Axor-OHL-Dalkia includes Groupe Axor, Cannon & RG Vanderveil and Accès Santé CHUM includes Fiera-Axium, HSIL, Acciona, Parking & Honeywell
	Montreal University Hospital Research Centre (CRCHUM)	Est. construction completion Sept. 30, 2013	RFP issued June 28, 2007	30 Years	DBFM	\$584.1 million ²²⁵	Under construction	Accès Recherche CHUM includes Fiera-Axium, Pomerleau, Parking & Groupe Lemay
	Hotel-Dieu Hospital, Québec City [University of Québec Hospital Centre (CHUQ)] (This hospital may still be built using the traditional public process and is not counted in the total.)	Est. date of completion 2015 ²²⁶	RFEI closed Sept. 23, 2008	TBD	TBD	TBD	Under dispute	TBD
	Sainte-Justine Children’s Hospital (CHUSJ) (Not listed on the PPP Québec web site or CCPPP, Jan. 2011.)	Est. date of completion 2018 ²²⁷	NA	NA	Traditional ²²⁸	Now \$500 mill., was \$353 mill. ²²⁹	Under construction	NA

	P3 Hospitals in Canada:	Status		Length of term	Type	Estimated Cost	Actual Cost/Status	For-profit Consortium
Province		Completion Date	Start					
	Jewish General ER, Montréal (Not listed on CCPPP web site, Jan. 2011)	Announced June 2010 Est. date of completion 2012 ²³⁰	NA	NA	Traditional	\$119.8 mill.	Under construction	NA
Ontario	Royal Ottawa Mental Health Centre	Operational Nov. 8, 2006	Announced in 2001 RFQ issued June 13, 2002	20 Years	DBFOM	\$95 million	\$146 million	The Healthcare Infrastructure Co. of Canada with Adamson, Borealis (OMERS), Carillion, EllisDon, Oxford & Parking
	Brampton Civic Hospital (William Osler)	Operational Oct. 28, 2007	RFEI issued March 15, 2002	25 Years	DBFO	\$350 million, then \$536 million	\$650 million ²³¹	The Healthcare Infrastructure Co. of Canada with Borealis (OMERS), Carillion & EllisDon
	Niagara Health System (St. Catharine's)	Est. construction completion date late 2012	RFQ issued Nov. 14, 2006	30 Years	DBFM	Now \$851.4 million, was \$759 million	Under construction	Plenary Health Niagara with Borealis, Johnson Controls, PCL, Bregman & Silver Thomas
	Bridgepoint Health Centre, Toronto	Est. construction completion date Spring 2013	RFQ issued Nov. 26, 2007	30 Years	DBFM	\$200 million in 2003 ²³²	Under construction	Plenary Group Canada Ltd. Includes Johnson Controls, Innisfree, RBC Capital Markets
	Halton Healthcare Services, Oakville (LEED Silver proposed)	RFP close March 15, 2011	RFQ issued Nov. 26, 2009	TBD	DBFM	TBD	RFP	<i>Shortlist:</i> Hospital Infrastructure Partners Inc. Plenary Health Community Health Consortium includes Sprint-Insight Inc.

	P3 Hospitals in Canada:	Status		Length of term	Type	Estimated Cost	Actual Cost/Status	For-profit Consortium
Province		Completion Date	Start					
	Humber River Regional, Toronto	RFP issued Oct. 26, 2010	RFQ issued May 27, 2010	TBD	DBFM	TBD	RFP	<i>Shortlist:</i> Future Health Consortium includes Honeywell, Canon Plenary Health Care Partnerships includes Johnson Controls, Hewlett-Packard, RBC Capital Markets Hospital Infrastructure Partnerships includes Scotia Capital, Univex Group of Companies
	Centre for Addiction and Mental Health, Toronto	Est. construction completion date 2012	RFQ issued June 27, 2008	TBD	DBFM	TBD	Under construction	Carillion Health Solutions includes Vanbots & Scotia Capital Inc.
	Quinte Health Care, Belleville area	Operational Feb. 1, 2010	RFQ issued March 21, 2006	Un-defined	BF	\$72.2 million	\$99.5 million ²³³	M. Sullivan & Son with Stonebridge Financial Corp.

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	Sudbury Regional Hospital	Operational Nov. 23, 2009	RFQ issued March 21, 2006	Un-defined	BF	\$131.9 million (I.O.)	Un-defined	EllisDon Corp. with RBC Capital Markets
	Trillium, Mississauga (Toronto & Queensway)	Operational May 8, 2009	RFQ issued March 21, 2006	Un-defined	BF	\$104.1 million (I.O.)	\$100 million ²³⁴	EllisDon Corp. with RBC Capital Markets
	Sarnia Bluewater Health	Operational July 29, 2010	RFQ Issued March 21, 2006 20 years of planning ²³⁵	Un-defined	BF	\$214.1 million, was \$135 million in 2006 ²³⁶	\$319 million ²³⁷	EllisDon Corp. with Pacific & Western Bank of Canada
	Hamilton Health Sciences, Hamilton General Hosp.	Substantial completion only spring 2009 (Infrastructure Ontario)	RFQ issued Nov. 3, 2006	Un-defined	BF	\$60.3 million, was estimated at \$44.9 million	TBD	EllisDon Corp. with CIBC World Markets & Pacific & Western Bank of Canada
	Hamilton Hosp.(Juravinski Hosp. & Cancer Centre, formerly Henderson General)	Est. construction completion now Spring 2012, was Summer 2010	RFQ issued Nov. 3, 2006	Un-defined	BF	\$198.1 million	Under construction	EllisDon Corp. with Pacific & Western (P&W) Bank of Canada
	London Health Sciences Centre	Est. completion date early 2011	RFQ issued Nov. 3, 2006	Un-defined	BF	\$211.8 million	Under construction	EllisDon Corp. with P&W Bank of Canada, Bank of Nova Scotia, CIBC World Markets, Manulife, TD Bank
	St. Joseph's, London Phase 1 – Grosvenor Site	Operational March 7, 2009	RFQ issued March 21, 2006	Un-defined	BF	\$32.2 million (St. Joseph's and LHSC at \$340 million plus in 2005) ²³⁸	Un-defined	D. Grant & Sons Ltd. With RBC Capital Markets

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	St. Joseph's, London Phase 2	Under construction Former opening date April 2010	RFQ issued Nov. 3, 2006	Un-defined	BF	\$49.2 million	TBD	EllisDon with Pacific & Western Bank of Canada
	London St. Joseph's - Phase 3	RFP issued Dec. 2010	RFQ issued June 7, 2010	Un-defined	BF	TBD	RFP	<i>Shortlist:</i> EllisDon Corp., Bondfield Construction Co., Grant-Nac Ltd., SNC-Lavalin Construction & McKay Cocker Construction Ltd. (Joint Venture)
	Ottawa Regional Cancer Centre	Est. construction completion date early 2011	RFQ issued Nov. 3, 2006	Un-defined	BF	\$180.6 million	Under construction	PCL with TD Bank
	Rouge Valley Health System/Ajax/Pickering Hospital	Operational Feb. 17, 2011, was Summer 2010	RFQ issued Nov. 3, 2006	Un-defined	BF	\$63,941,270	\$94.5 Million ²³⁹	Aecon Buildings with Stonebridge Financial Corp.
	Runnymede Healthcare Centre, Toronto	Under construction Former opening date Sept. 15, 2010	RFQ issued Nov. 3, 2006	Un-defined	BF	now \$89 mill. from \$63 mill.	TBD	Bondfield with ON Teachers' Pension Plan
	Montfort, Ottawa	Operational June 2010 ²⁴⁰ , from 2009	RFQ issued March 2, 2005	Un-defined	BF	\$188.8 million	\$300 million ²⁴¹	EllisDon with BMO Capital Markets, Caisse central Desjardins & RBC Capital Markets

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	Sunnybrook, Toronto	Operational Sept. 12, 2010	RFP issued Feb. 1, 2001	Un- defined	BF	\$142 million	\$188 million 242	Vanbots with Stonebridge Financial Corp.
	Credit Valley, Mississauga, Phase 2	Substantial completion March 2011	RFQ issued April 4, 2007	Un- defined	BF	\$162.8 million	TBD	Bondfield with National Bank of Canada (financial advisor) & Société Générale (financial arranger)
	Toronto Rehabilitation Institute (University Centre Site)	Est. construction completion date of fall 2011	RFQ issued April 4, 2007	Un- defined	BF	\$112.1 million	Under construc- -tion	Aecon Tri Inc. includes Stonebridge, Manulife, Industrial Alliance & Financial Services, London Life Ins. & The Equitable Life Ins. Co. of Canada
	Lakeridge, Durham (Oshawa)	Est. construction completion now summer 2011, was spring 2011	RFQ issued Oct. 5, 2007	Un- defined	BF	\$91.5 million	Under construc- -tion	Aecon Buildings & Concessions includes Stonebridge, Canada Life Assurance, Industrial Alliance Ins., Manulife & the Equitable Life Insurance Co.

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	Royal Victoria, Barrie	Est. construction completion now Spring 2013 from 2010/2011	RFQ issued Oct. 25, 2007	Un-defined	BF	\$258.5 million	Under construction	Vanbots with Banco Espirito Santo de Investimento SA, National Australia Bank Ltd., Norddeutsche Landesbank Girozentrale, Bank of Montreal, CIT Financial Ltd., National Bank of Canada Inc. & Toronto Dominion Bank
	St. Joseph's, Hamilton. West 5th Campus (LEED silver proposed)	Preferred proponent selected Sept. 27, 2010	RFQ issued March 24, 2009	Un-defined	DBFM	TBD	RFP	Plenary Group/Innisfree with Canon, PCL
								Construction, Honeywell & RBC
	Women's College, Toronto	Est. construction completion date Spring 2016	RFQ issued Oct. 31, 2008	Un-defined	DBFM	TBD	Under construction	Women's College Partnership with Bilfinger Berger, Perkins Eastman Black/IBI, The Walsh Group/Bondfield Const., Black & McDonald/HSG Zander
	North Bay General (LEED certified)	Operational Jan. 30, 2011, was June 18, 2010	RFQ issued Sept. 27, 2005	30 Years	BFM	Now \$551 million, was \$220 million	TBD	Plenary Group, Deutsche Bank, PCL Constructors & Johnson Controls L.P.

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	Sault Area (Sault Ste. Marie)	Operational March 6, 2011 Construction complete Oct. 13, 2010	RFQ issued April 24, 2006	30 Years	DBFM	Now approx. \$988 million (includes more than construction costs. ie. Furniture, etc.), was \$408 million	TBD	Hosp. Infrastructure Partner (HIP) with Carillion Canada, EllisDon, Labourers' Pension Fund of Central & Eastern Canada
	Kingston General Hospital & Cancer Centre of Southeastern Ontario	Est. construction completion date Spring 2012	RFQ issued April 4, 2007	Un-defined	BF	\$142.1 million	Under construction	PCL Constructors Canada with TD Bank
	Mental Health Centre Penetanguishene	Preferred proponent selection Fall 2010	RFQ issued Aug. 17, 2009	TBD	DBFM	TBD	RFP	<i>Shortlist:</i> Carillion includes Siemens Integrated Team Solutions includes EllisDon, Cannon, Honeywell, National Bank of Canada & Univex (Ontario) Plenary Health includes PCL Constructors, Johnson Controls, Innisfree, RBC Capital Markets, Lobo & Vipond

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	Windsor Regional Hospital (Western site)	Est. construction completion date Spring 2012	RFQ issued Oct. 25, 2007	Un-defined	BF	\$91.7 million	Under construction	2205234 ON Inc. with Bondfield, Bank of Montreal, National Bank of Canada, Laurentian Bank of Canada & TD Bank
	St. Joseph's Regional Mental Health (London & St Thomas)	Est. construction completion date December 2014	RFQ issued June 1, 2009	30 years	DBFM	\$830.5 million	Under construction	Integrated Team Solutions includes EllisDon, Fengate/LPF, Honeywell & Scotia Capital Inc.
	University Health Network Redevelopment	Operational Financial close Dec. 8, 1998	RFP issued April 15, 1998	Unknown	F	Unknown	\$349 million (\$281 million private)	Scotia Capital Inc. (private sector bond issue assisted by the ON Financing Authority)
BC	Abbotsford Regional Hospital & Cancer Centre Gold LEEDS certification	Operational August 24, 2008	RFEI issued Jan. 23, 2008 (First proposed in 1988 ²⁴³)	30 Years	DBFMO	\$356 million (from \$211 million in 2001) ²⁴⁴	\$449 million ²⁴⁵	AHA Access Health Abbotsford Ltd. Includes PCL Constructors, Johnson Controls, Sodexo, Intercon Security, Impark
	BC Cancer Agency Centre for the North, Prince George	Est. construction completion date Sept. 2012	RFQ issued July 31, 2008	30 Years	DBFM	\$69.9 million	Under construction	Plenary Group, PCL Constructors, CEI Architecture, Johnson Controls

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	Fort St. John Hospital & Residential Care Project	Est. construction completion date Spring 2012	RFQ May 6, 2008	30 Years	DBFM	\$297.9 million	Under construction	ISL Health with Innisfree, Acciona S.A., Acciona, Stuart Olson, Cannon, Health Care Projects, ACML Management Western Ltd.
	Gordon & Leslie Diamond, Vancouver General (AACC) The Academic Ambulatory Care Centre	Operational Oct. 20, 2006	RFEI issued Oct. 15, 2002 (Plan approved by the City 2001)	30 Years	DBFM	\$95 million	\$203 million ²⁴⁶	Access Health Vancouver with John Laing, PCL Constructors, IBI Group, Henriquez Architects, Brookfield LePage Johnson Controls
	Kelowna & Vernon Hospital Project	Est. construction completion date August 2012	RFQ issued May 7, 2007	30 Years	DBFM	\$432.9 million	Under construction	Infusion Health with Graham Construction, Bilfinger Berger, John Laing, Stantec & Black & McDonald
	Royal Jubilee Hospital, Victoria	Operational March 2011 ²⁴⁷ Construction completed Dec. 31, 2010	RFQ issued May 11, 2007	30 Years	DBFM	\$269 million ²⁴⁸	\$348 million ²⁴⁹	ISL Health with Health Care Projects Canada, Acciona S.A., Lark Group & Innisfree Ltd.
	Surrey Memorial Hospital/Surrey Ambulatory Care Facility/Green Timbers	Est. construction completion date Dec. 31, 2014 Preferred proponent selected Oct. 7, 2010	RFQ issued July 23, 2009	TBD	DBFM	TBD	RFP	Integrated Team Solutions with EllisDon, Fengate, CEI Architecture, Parking Architects, Honeywell

	Proposed and/or Under Construction	Status		Length of term	Type	Estimated Cost	Actual Cost/ Status	For-profit Consortium
Province		Completion Date	Start					
	Surrey Outpatient Hospital	Est. construction completion date April 2011	RFQ issued March 21, 2007	30 years	DBFM	\$239.1 million	Under construction	BCHS Healthcare with Bouygues Bâtiment Int'l, HSBC Infrastructure, Ecovert, Bird Construction, Kasian Architecture & Helios Group
Nova Scotia, PEI and Saskatchewan are on P3 hospital alert!								
Sources:								
CUPE Ontario, June 2009 "Four Privatized P3 Ontario Hospital Projects"								
Infrastructure Ontario								
Partnerships BC								
PPP Council (says ON will pay \$356 million over 20 years for the P3 Royal Ottawa)								
PPP Quebec Auditor General of Québec Canadian Council for Public Private Partnerships (CCPPP)								

NA: Not Applicable

TBD: To Be Determined

All costs are capital (or construction) costs only, unless otherwise specified.

The use of "with" means that all involved companies are listed.

The use of "includes" means that only selected companies are listed.

Appendix B - P3 Hospital in Canada Bed Count, selected

P3 Hospitals in Canada Bed Count, selected				
Province	Proposed and or Under Construction	Estimated Beds	Actual Beds	Notes
New Brunswick	Centracare (psychiatric), South Bay, Saint John	Unknown	50	1500-bed public facility in Lancaster closed after sold to J.D. Irving. ²⁵⁰
Ontario	Royal Ottawa (psychiatric)	284	188	
	Brampton William Osler	608	479	Only 125 new beds while District Health Council advised 930 beds in total (or 451 new beds) due to population increase etc. Peel Memorial public hospital closes. ²⁵¹
	Bluewater Health, Sarnia	TBD	TBD	An area hospital - Charlotte Eleanor Englehart in Petrolia issues a partial closure of ER around the same time of P3 opening. ²⁵²
	Niagara Health System (St. Catharines)	Now 375, was 400	TBD	Reduced services and beds for existing Port Colborne, Fort Erie, Niagara-on-the-lake, Niagara Falls, St. Catharines General & Welland public hospitals. ²⁵³
	Sudbury Regional Hospital	507	429	Two other local public hospitals closed. ²⁵⁴

P3 Hospitals in Canada Bed Count, selected				
	Proposed and or Under Construction	Estimated Beds	Actual Beds	Notes
	Woodstock General	Now 154, was 178	TBD	TBD
	Hamilton Health Sciences, Hamilton General Hosp.	91	TBD	(44 new beds)
BC	Abbotsford	300	261 ²⁵⁵	300 public beds in previous Abbotsford/Mission public hospitals (1991). Population increase in Abbotsford/Mission between 1991 and 2008: 50,000 ²⁵⁶
	Gordon & Leslie Diamond, Vancouver General, AACC (The Academic Ambulatory Care Centre)	60% Faculty of Med. 20% Commercial 20% Mixed Public/Private	Increased ER beds from 22 to 28. ²⁵⁷	
	Royal Jubilee, Victoria	401	416	A very small increase of 15 beds for \$348 million. ²⁵⁸
Sources:				
CUPE Ontario, June 2009 "Four Privatized P3 Ontario Hospital Projects"				
Infrastructure Ontario				
Partnerships BC				
PPP Council				

NA: Not Applicable

TBD: To Be Determined

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Endnotes

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- ³ 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.
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