Getting Past the anti-P3 Dogma

I would like to correct the one-sided story[i] on public-private partnerships (P3s) and their use in Ontario hospitals ("Audit on Royal Ottawa Sought" by Mohammed Adam) published by *The Ottawa Citizen,* January 26, 2009. P3s are relatively new in Canada (compared to the US and the UK) and they provide an opportunity to make use of the best elements of private and public organizations to serve the health needs of Ontarians better. Therefore it was disturbing to see so many misleading statements made in the story and a reliance on "expert' sources who are clearly biased and represent a hyper-ideological and political opposition to P3s under any and all circumstances.

Lewis Auerbach, for instance, is a consultant given to scare mongering. His specialty is auditing not partnerships but he has also produced several reports published by unions across the country about the perils of P3s. In one such report that found cost savings at the Abbotsford hospital P3 in BC, Auerbach but is quoted as saying, "This may not really be a savings overall – it may even be more expensive – but rather a transfer of costs from the P3 parties to patients". He calls white black and plays to the fears of the most vulnerable.

Natalie Mehra is the Director of the Ontario Health Coalition, a thinly veiled arm of provincial labour unions opposed to P3s. It is her claim that "P3s are just another form of privatization" and this is nonsense. P3s exist on a spectrum between full public ownership and full private ownership. P3s exist in the middle of these two extremes because they are "partnerships" and consequently they include aspects of both. They generate both profits and public goods as befitting their hybrid nature and that's why they are called "private-public partnerships".

The *Citizen* article claims P3s are overly secretive. Such a claim is hard to believe when each year my students interview stakeholders on all sides of the P3 equation. The Royal Ottawa Hospital and the William Osler Health Centre have been among them. The people in these institutions have been very generous with their time to help explain their history, their challenges, their responses to those challenges and their future prospects. If my students can do this, then why couldn't the reporter or MPP France Gelinas?

While I wouldn't impugn the reputation of the Ontario Auditor General, but when he says he found evidence hospital construction estimates were inflated for the William Osler Health Centre in Brampton between the 2000 and 2004 in ways not accounted for by higher material prices and inflation, might this be an incomplete cost analysis? He does not apparently factor in changes in market demand during a booming real estate period. The price of real estate and therefore construction moves primarily with market demand and the opportunity cost of not doing something else. Construction costs do not move solely with inflation.

Further, his evidence of poor financial management focuses on hospital costs being more with a P3 than if the Government built it themselves. While this may be true it is an incomplete cost-benefit analysis. Building hospitals with P3s is in some ways like leasing a car only on a grander scale. One of the many benefits of P3s is that citizens get the hospital sooner than if they had to wait until the Province saved enough money to build it on its own. It may have taken a decade for the Province to set aside the $150-200 million to build the Brampton or Ottawa hospitals and then another decade for them to be built. The Auditor General knows better than most that Ontario governments have traditionally been extremely neglectful of contributing to capital budgets. So why did he not assign a value to the 10-20 years of lost health care that would have occurred if the Province had waited to do it themselves? To say that the Royal Ottawa Hospital would have cost millions of dollars less if it would have been built publicly misses the point. The point is whether it would have ever been built at all! This is not a reflection of P3s but of the public choices being made -- increasing taxes, increasing indebtedness (neither of which was politically viable at the time) or using a P3 model.

As far the Royal Ottawa Hospital (ROH) P3 is concerned, the 2001 announcement for the project called for 284 beds at an estimated construction cost of $95 million. When the project went to the RFP stage in 2003 the government itself had reduced the number of beds to 188, increased its capital cost estimate to $100 million and set the construction time estimate to 2 years. Then the project was delayed by almost two years for administrative and political reasons. When the actual deal was struck between The Healthcare Infrastructure Company of Canada (the private consortium) and the Royal Ottawa Health Care Group (the public partner) it was for $142 million and 188 beds. These changes are frequently cited by critics like Mehra and Auerbach as proof the ROH private partners were over time, over budget and under delivering -- despite their being made by the government before a contract was signed. Similar deceptiveness appears in the numbers used at the end of the *Citizen* article. In contrast to the figures published by the *Citizen*, after construction finally began in December 2004, the new facility was completed early and $6 million under budget.

What the article does not say is that the monthly leasing payments are contingent on the ROH partners adhering to strict service standards and if not met those payments may be reduced. Who decides? The public partner. In addition, while it is the practice to let hospitals deteriorate until they need to be abandoned, when the ROH is returned to the public partners in 20 years it must be in essentially new condition. In fact the private partners will leave it in better than new condition having added at their expense all the technology that emerges over the next 20 years.

Is the ROH problem-free? No, but no more than any institution its size. Claiming that the existence of problems is proof P3s don't work is both misleading and disingenuous. If you want to really assess the ROH P3 it may be better to look at how the partners deal with those problems. The ROH stakeholders have invested heavily in good communication and the cultivation of positive healthy relationships to guide and steer the organization towards a shared vision. The hospital staff was fully engaged in designing the facility which they would ultimately use. Regular performance reporting is used and shared equally between the public and private partners. Effective dispute resolution mechanisms are in place. A climate of trust and mutual respect exists that allows the partners to amicably adapt to issues not dealt with in the original contract.

Can they do it better? Probably, yes. And this goes to the point of Professor Angus. We do need to know more about what works and what doesn't in these types of projects so we can learn from them. But we don't need the type of posturing and ideological blather that has so often typified the public debate around P3s.

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[i] Mohammed Adam, "Audit on Royal Ottawa Sought" , *The Ottawa Citizen,* January 26, 2009