



FACTS

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Experts Tell Romanow Commission that Public Private Partnerships are not the Answer

May 2002

In February 2002 CUPE arranged a technical briefing on public private partnerships (PPPs) for the Commission on the Future of Health Care in Canada (the “Romanow Commission”). The collective knowledge and experience of Dr. Allyson Pollock, Professor John Loxley and lawyer Steven Shrybman is unparalleled and they did not hesitate to tell the Commission that PPPs do not save money, do not improve service and place Canada’s health system at risk under Canada’s trade agreements. Dr. Pollock outlined the British experience, Professor Loxley detailed his analyses of Canadian PPPs and Steven Shrybman highlighted the implications of PPPs and trade agreements.

Here is what they told the Commission

Dr. Allyson Pollock is Head of the Health Services and Health Policy Research Unit at the School of Public Policy, University College London, and Director of Research and Development at University College Hospitals Trust, in London, U. K. She trained in medicine in Scotland and worked in hospitals in Edinburgh and Leeds before specializing in public health. She is both a physician and an academic.

Allyson Pollock:

The policy of public private partnerships or private finance initiatives (PFIs) as they are called in the UK was a policy dreamed up by the then Conservative government in 1992 to bail out the failing construction industry. However private finance or P3s didn’t really get off the ground until Labour came to power in 1997. This was because new legislation had to be put in place to reassure the private sector that public authorities were not acting *ultra vires*

i.e., outside their legal and statutory powers.

The policy took a while to develop. In fact in 1993 it was apparent at early internal meetings the contracts were to be for much shorter periods of only up to 5 years. Nothing had really been worked out. What happened is rather a dream scenario for the private sector - 30 year contracts of low risk and government guaranteed payments.

I don't know exactly what models are being proposed for the P3s in Canada but given that the same management consultants are advising, designing, evaluating, implementing and promoting the policies in Canada as in the U.K it seems likely there will be a remarkable overlap. The decision to rewrite the federal government's capital investment manual is a significant first step to reforming Canada along the UK lines of PPPs .

Public private partnerships is a policy for the whole of the public sector so it has enormous implications for public life and profound constitutional and democratic implications.

I got involved because of my concerns about the implications of introducing markets into health care, but my Research Unit's analysis extends to London underground, education and other public sector issues.

PPPs are not a neutral financing mechanism. Neither are they a source of new money or investment. Private finance is debt financing. In other words it is a source of borrowing which has to be repaid - either out of the public purse or by giving the private sector a concession to raise user charges as in toll roads. It is not a neutral financing mechanism as we show in detailed studies of the National Health Services (NHS).

In order to understand its impact the analysis requires multidisciplinary input from public health physicians, workers in the service, epidemiologists, accountants, philosophers, and

historians. It is the only way you can actually begin to look at the data within the business cases. However the first obstacle for the public is lack of access to the vital data on the grounds of commercial confidentiality.

In the UK the British Medical Association and UNISON fought very hard for all the business cases and information, to be placed in the public domain. The Health Select Committee also played a key role. It was interesting that the government rather than the private sector hid behind the commercial and confidential rules. The parliamentary select committees have had some success in requiring the data be publicly available and there is an agreed code of practice for release of information in health. Quite a battle had to be fought and won to make the data publicly available and it is largely because of that we have been able to do our analyses.

I don't plan to take you through the detail of all our papers or of the numerous detailed individual and collective case studies using private finance in hospitals. Rather I will use this as an opportunity to make a few points.

The Labour government came to power following a long period of under investment and disinvestment in health care and all public services. However they did not increase public expenditure but kept within the Conservative government's spending plans and pursued a policy of private finance.

Using PFI is more expensive for two reasons - the higher cost of borrowing (government borrowing is always

cheaper) and the financing cost which can add up to 40% of the total costs of schemes. The financing costs are the rolled up interest that accrues by virtue of long repayment periods and borrowing money in advance. That adds a huge burden to the cost of PFI schemes. In addition PFI results in enormous cost escalation

The UK government's sole justification for using private finance rests on claims of value for money (VFM). There is no macroeconomic case for the policy as the Treasury is well in surplus and could have paid for capital investment up front even using borrowing.

So what is this value for money analysis? It is an economic appraisal. VFM is not a cash analysis. In other words, it will not tell the authority what the costs of repayments will be. The VFM analysis applies a discount rate of 6% to a stream of payments. Since discounting automatically refers to payments made into the future rather than payments made up front this favours the use of private finance where payments are spread over 30 years.

The discount rate in the UK is set at 6% which many economists say is too high. But even applying this high discount rate still favours the public sector option and so at this point the argument hinges on risk transfer - the cost of transferring risks to the private sector. In reality the real function of value for money analysis is to disguise the true costs of using private finance

The government cites three reports as showing value for money in PPP's and PFI's These were written by Arthur Anderson and Price Waterhouse

Coopers, management consultant companies which currently design, promote and implement PPP policies in the UK and abroad. However, if you look closely at these three reports, two are simply anecdotal surveys of 100 project managers involved in PPPs who were asked "do you think PFI was a success?" The answer was "yes." Of course the project managers are always going to say "yes." There was no science underpinning the survey.

The other report from Arthur Anderson in conjunction with the LSE Enterprise (not the London School of Economics, but the management consulting arm of the LSE) looked at value for money. We published a critique of that because this report is used by government to support the PFI. The government claims that the report shows that PFIs yield 17% efficiency savings.

However, there are several points to note. Most of the projects did not provide the data to evaluate the claims. We wrote the Treasury to ask for the lists of those projects and they refused to put them out in the public domain. However, using other means we were able to identify some of these projects.

When we looked at the 17% efficiency savings, in more than half the schemes most of the efficiency savings were due to the discount rate. But the rest of the savings were attributed to risk transfer. However, all the risk transfer savings were loaded into three projects. Of the savings that relate to risk transfer some 80% of those savings rest with one project, known as the National Insurance Scheme. This was a big information technology scheme managed by Anderson Consulting

(sister of Arthur Andersen). It was the subject of two or three inquiries by the Public Accounts Committee because it went over time and over budget. Worse still, it is estimated that it cost the government 5 billion pounds in lost revenues because the system lost 5 million tax revenue forms. As well as that the system caused great hardship to the claimants of benefit payments. Thus the real risks passed back to the tax payer, the user and the government. Anderson consulting was paid 3.9 million pounds in compensation – the Treasury minister told the parliamentary Select Committee that they did not want to risk the contract and their relations with the provider.

So after the event, the real risks of project failure were not transferred although the public has been paying for this.

The key to the claim of risk transfer rests with the value for money case. You have to remember that the whole justification for PPP's and PFI's hangs on value for money. The claims of risk transfer are *ex ante*. There have been no *ex poste* evaluations.

The cost of the private sector assuming so-called risk transfer can add up to 70% of the total construction costs. So we are paying the private sector an extra 70% for so-called "taking on risks" which are mainly construction risks. The whole methodology underpinning the calculation of risks it is not at all clear. There is no science behind it. Yet the whole of government policy is hanging on these claims of risk transfer. This is really important because it's the subject of whether a project is off or on sheet balance accounting.

Now coming to the public health concerns. The government can only justify the higher cost of the PFI and PPP's through the value for money analysis. But the real issue for public authorities is how private finance debts are to be repaid. In the UK, National Health Service (NHS) private finance is repaid from the revenue budgets of hospitals. This necessitated a massive change in our accounting systems as for the first time the UK NHS had to pay a charge on capital and this meant creating a stream in the revenue or operating budget to pay for new debt. The idea of course is that the government just pays for a stream of services. It no longer procures assets. So the public authority must identify a stream in the revenue budget to pay for those services.

The repayment of these very expensive PFI's has put the NHS under enormous pressure. A number of subsidies had to be found. The first was land sales. The second was merging hospitals to release more land and buildings for sale. You might say it was sensible rationalization but it inevitably resulted in major service closure and the diversion of income to pay for the new smaller facility. The third was a diversion of capital grants in budgets intended for public facilities into paying off the debts of the new PFI hospitals. Lastly, the treasury also put in a subsidy to facilitate the movement to PFI hospitals.

Even after all these external subsidies - treasury grants, capital grants, land sales and the release of land and buildings from the merger of sites - there was an affordability gap, a gap between what the public sector said it

could afford and what the private sector said was needed. The only way that the extra payments could be managed was by a massive downsizing in service provision. So each area for the PFI hospital has experienced a 30% bed reduction and a 20% - 25% reduction in clinical staff budgets- at a time when it is widely acknowledged there is insufficient capacity in the NHS .

All of these subsidies are set out in the business cases of each PFI hospital. If I put it in perspective, the UK is almost at the bottom of the OECD tables in terms of beds and staff. Here we have a crisis of provision that the PFI is actually perpetuating.

So the use of private finance has enormous implications for the planning process. The public authorities have been told that it's the only game in town. There is no other alternative. So the public authorities are relocating hospitals to out of town sites so they can sell off prime sites in the town areas. That has major consequences for access as does the hospital downsizing, replacing three facilities with one.

The PFI, far from being a neutral financing mechanism, has actually determined the planning process in its own right. And there is no needs based planning. Public health which used to very strong in the UK has been completely marginalized from the planning process. At best the medical director might be on the board of decision-making but he or she isn't allowed to go out to speak to a wider community.

There are also grave issues for accountability of public funds and the

issue of transparency has been raised by parliamentary committees.

But private finance also raises constitutional and democratic issues. PFI contracts provide for 30-year ring fenced guaranteed payments tying up the tax revenues of future generations. Indeed if the private sector walks away the public sector ends up having to pay the banks.

But there are other serious issues. The effect of introducing private finance and resource accounting has been to make health service investment a local responsibility moving away from equity and a national health service. Public authorities including hospitals become responsible for generating their own income and for meeting their own capital investment. It is a race for survival that's very, very competitive. The UK and the NHS are now putting into place embryonic HMO structures that will compound things.

Related to this, the government is now seeking to delimit care. So for the first time in 50 years of the NHS the government has introduced a time limit on NHS care - a maximum 6-week limit. After this time individuals will be reassessed to determine what is medical care and what is personal care that can be charged for. These decisions will be made at the local level so we will be moving into an even greater lottery in terms of equity. These are some of the major risks at the community level.

Last but not least are the political risks because PPPs have resulted in major political costs. The Unions are increasingly concerned with the two-tier

workforce and the contracting out of staff that results. But the private sector have made it very clear that they want to manage not just ancillary staff but also the medical and nursing staff

There is a growing protest from the trade unions and from local community people. There is now no longer a day when there isn't an article on PFI and PPP's in the paper. The public is realizing what the implications are for air traffic control, water, London Underground, British Rail, and schools. Education and schools is the other big area where private finance is being introduced.

Grass roots movements are replacing the vacuum in democracy. An interesting result in the UK general election, was that the independent candidate, a doctor, who stood in Worcester which is middle England – conservative Times-reading middle England – was elected by opposing PFI. He won a landslide majority of 25,000

against the incumbent Labour MP on the cabinet. That got maximum coverage and focused the whole of the public's minds on PFI's and PPP's.

There are enormous political risks in going down this route in terms of public health and access to services because when people register the connections they get very angry - especially in middle England.

The political consequences are not to be under estimated because there will be a mobilization It's like hundreds of forest fires burning slowly against each PFI scheme. They haven't ignited but they will. You can fool the public for quite a long time using technical and arcane jargon but it only takes an Enron for the public to realize the way in which private finance is removing rights and entitlements and the whole thing does begin to come apart.

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John Loxley:

I started doing research on public private partnerships when I was asked to examine a small PPP bridge in Winnipeg (the Charleswood Bridge). The results of that initial analysis were subsequently supported by other analyses of PPPs in various parts of the country. The studies I coordinated include PPP projects for a school in New Brunswick (Evergreen School), schools in Nova Scotia, the

Confederation Bridge between New Brunswick and Prince Edward Island, Halifax harbour project, the Hamilton Wentworth water and sewage project with Philips Environmental Corporation, a central food services facility (Urban Shared Services Corporation), private laboratory services in B.C., reform of the social assistance program in Ontario with Andersen Consulting, and others.

So we had a fair range of different situations for PPPs. It seems to me that PPPs are in fact coming more popular despite a fairly atrocious history in some places. They are being promoted across Canada, in the US and around the world. However, there are some things we learned from these studies - things that the Commission should be keenly interested in.

Much of what we analyzed has to do with the building of capital projects, although I think it's not the only area of conflict.

Much of the emphasis for that is financing pressures on government. Some of these pressures are self-induced through balanced budget legislation and there are a half dozen provinces which now have some sort of balanced budget legislation. Depending on the method of financing that they used previously, and that differs from province to province, if health capital was part of capital spending then there is an incentive to get capital expenditures off the books.

This was the incentive for the bridge in Winnipeg, for the schools in Nova Scotia, and New Brunswick. This was the approach taken initially even on huge projects. The idea is that if you can get the private sector to finance projects then it doesn't show up as debt on the books of the province. Initially that was the way things were done. The private sector would build and then lease the facility back to the government. These leases were considered to be operating costs rather than capital costs. After a while the accountants objected to that and started defining situations in which leases could be off-book or on-book.

What I would argue is that a lease is quite simply debt by any other name. We acknowledge that when we lease cars but we don't seem to acknowledge that when we build and lease back a hospital or a school. The lease payments over a lifetime can be discounted by a cost of capital and a capital value assigned in present value terms, just like debt.

What the accountants have come up with is situations in which these leases can be considered operating leases and therefore only the operating side shows up in the books, or situations in which leases show up as a capital expense, measured as the present value of the lease payments. Some attempts to get around the accounting conventions, as in the Charleswood Bridge case, ended up showing up on the balance sheets as a pretty significant item as a capital lease.

From my point of view, I don't think it matters whether the lease is an operating one or a capital one. What counts is that the lease is a debt and taxpayers are on the hook for that debt. Whether we call it a capital lease or an operating lease, there is a commitment over time that implies a rate of interest and basically the taxpayers are liable.

One other thing I found that was common to all of these programs is that in no case was the prime rate of interest lower than that at which the government could borrow. So on every project, for the sake of getting the borrowing off the books to comply with balanced budget legislation, taxpayers are paying more for capital investment. Every single one!

Theoretically, the rate could be lower but I haven't yet seen this in practice. If this were to happen, it would be a write off of the investment with some tax angle that means that the taxpayer is picking up the bill. Of course, all of this would be hidden in the lease.

What we did very early on, well before this became a public issue, was to lay bare the financing arrangements. It is gratifying to see that, later on, the auditors in New Brunswick, Nova Scotia, and Ontario, actually agreed with our analysis. We feel comfortable about that. This artificial fiscal shortage created by under funding really ends up costing all of us more money.

Sometimes supporters of PPPs will argue that what we say is true but the bridge was completed on time and within specification. Our response is that those approaches to examining the project confuse design-build methods of construction with private financing and ownership. The government doesn't own the bridge, the private sector does. This is a separate question from whether you stay in the conventional way of tendering or you go with the design-build approach. We must separate these out.

Even then, the professional groups raised strong objections to the design-build approach in the case of the Charleswood Bridge because basically the contractors design the things as you build and any cost over runs are their responsibility. But there is an enormous new complex method of getting the tenders on these projects and what happens is that you eliminate the professionals from any kind of independent role. It is the contractor

that is in charge of the quality and time. So the professionals don't like being subordinated to the contractor. But also there are a lot of up front costs and ongoing costs that are incurred by the people preparing the bids and by the city or the province that is doing the evaluations. These costs are never added up in normal evaluations. In the case of the Charleswood Bridge the professionals did add them up and the total was approximately \$1.6 million dollars on an \$11 million project. It's these kind of hidden costs that need to be exposed and taken into account. So the professionals are cooling off on design-build projects.

There are some other things about these PPP projects that are questionable. One is that the contracts are legal documents and there is usually a provision for maintenance. I have never yet seen an independent evaluation of this aspect of the contract. What it does is to commit government money (province, city, hospital or health authority) to help maintain this particular project at a certain level regardless of the availability of fiscal revenues. If you have a bad year and you want to spread the grief around, you can't do that anymore. You have to maintain the project at a given level. It's a contractual obligation. So you are building in fiscal inflexibility.

More importantly I think, the way PPPs are set up there is no real check on whether you are getting done what needs to be done. Normally there is a "ghost" project which is developed first and then you put out the request for proposals and if they come in lower than this "ghost" project that you have put together somehow, then you say you

have saved so much money. And then you make the decision to go ahead with the PPP. What we need to look at is how they put this “ghost” project – a comparator - together in the first place. This varies from project to project.

If you look through the literature of provincial auditor’s reports from New Brunswick and Nova Scotia you find that the people who are promoting PPPs within the government put the comparative case together and they use outrageous assumptions.

The result is, and this is a matter of record, the Auditor General examines the project later and says we have a school that was build according to these specifications and it looked good because your comparator came in several million dollars higher. But you’re not comparing apples to apples or oranges to oranges. So governments are really taken to task on that by auditors.

More disturbing, on bigger projects, government would like to bring in the private sector to do those projects. The result is that we have no check comparable to the Auditor General, on the private sector. That was the case in Halifax Harbour project.

Finally, in PPPs you take government projects, government money, and you take it all out of the public realm and stick it in a legal document and then you say that access to this information is denied because it is subject to commercial and confidential restrictions.

You rarely get to see the request for proposals, the proposals themselves and any planning documents. When you

do push for them, as I have done, some critical stuff is missing. It is often blacked out. In the case of this little bridge (the Charleswood Bridge) for some reason, even though the mayor had promised this information, some material around the maintenance agreement has been blacked out. This has meant that we have not been able to assess whether or not the maintenance agreement is reasonable.

What PPPs do is privatize information that should be in the public realm and that is common to all these PPPS. Occasionally, by some error in judgement on someone’s part you get this information. Usually it is after the event. They are quite interesting documents and if you have a keen eye you can actually see the evolution of the project taking place. But the fact is that they are outside the public realm and we are not able to analyse, assess or comment on things that we should be allowed to comment on. I think that this is a major, major problem with PPPs.

What we tried to do in the case studies is to look at the documents that we could get and we looked at the claims that were being made for each of these projects. We started with what people said they were going to deliver and if they delivered it we said they delivered it. In some cases they did deliver what they claimed to deliver. In some critical areas the delivery was quite efficient. However, on the financing side it was uniformly bad. They make all kinds of outrageous claims about how efficient these projects will be and how good it is for the province from a civic point of view, but uniformly they are costing more money because of the higher cost

of borrowing. We have demonstrated that in case after case.

The rest depends on the specific project. In the case of the private labs it is slightly different because it covers a number of provinces. The private companies promised that they would reduce the cost of testing. When we did the detailed analysis we found that not only was the cost of testing not reduced, but they selectively chose the tests they want to do. They “cherry pick.” They pick the tests that can be done quickly through mass production that are cheap to do, and they avoid the more sophisticated tests that are dumped on the public sector. So the public sector ends losing economies of scale.

There are conflicts of interest galore in the health laboratory sector with a variety of physicians and professionals ordering tests, referring to specific labs, and doing the tests. We can argue that the conflict of interest is fundamental even if they don't own the labs because “fee for service” means there are no restrictions on them or effective limits to increased demands on the system. So lab costs are increasing partly because physicians want to cover their backsides so they order a test, partly because they have a professional link to the labs, and partly because they get paid for the service they prescribe. There is really no check on that.

In the case of the labs this conflict of interest is pretty gross and you find that in other PPP's as well. For example, in the Hamilton-Wentworth – Philips PPP, the senior officials in the Regional government set up this PPP and handed the water and sewage budget over to the private sector. They then promptly handed in their resignations and joined

the private company at higher salaries. This boggles the mind, but it happens. It is crude but it happens. There is clearly a problem of ethics as well as a problem of deliverables.

We do go through a lengthy critique of what was promised in each sector and what was delivered. There are some serious deficiencies. In the case of the labs what happens is that the public sector labs end up with excess capacity. This happens even though they demonstrate that they can produce the services more cheaply – no question about that.

In the case of Hamilton-Wentworth water and sewage, there are other serious issues that relate to health because you have handed over water and sewage to a private company. One of the key arguments that proponents of PPPs make is that risks are shifted to the private sector. They make a lot out of this argument. But in the case of Hamilton-Wentworth there were all kinds of problems with leaks of sewage into the harbour. The Regional government has had to pick up the cost of it. So much for shifting risk to the private sector.

Some may ask ‘why do we have leaks into the harbour now when we never had them before?’ Well, we never had them before because this contract rewards the private sector every time it reduces costs. When costs are reduced it triggers a revenue sharing formula. To save costs they got rid of 40% to 50% of the staff. It's not rocket science. When corporations look at services and ways to reduce costs they either reduce staff or find ways to do it that increase

productivity – better machinery, better technology, better methods, and so on.

In the PPPs that I have looked at the tendency is not to do the latter. The tendency is to get rid of the unions, bring in cheaper labour, and layoff staff beyond a reasonable limit, and simply push the risks back on to the public sector. These actions are quite common in PPPs.

In the case of Hamilton-Wentworth it's been a good deal for the private sector. It's been a nightmare in some respects for the public sector because of these experiences. The staff has borne the brunt of the attack. In fact, it has had the opposite effect to creating a more efficient government. What happens is that as costs go down, for whatever reason, this formula kicks in and the private company picks up the benefit.

The city introduced two cost saving measures that had to do with sludge. It cut back on transportation costs and saved a lot of money. The revenue sharing formula kicked in and the private sector company claimed its share of the cost savings even though they hadn't done anything to deserve the revenue sharing. But they had a legal case to receive the revenues.

In another case study we examined the situation where the government of Ontario asked the private sector, Andersen Consulting, to reform their welfare system. Any savings that were realized were to be shared with Andersen Consulting. A recent Ontario Auditor General's report gave a scathing review of the practices in this project.

The Ontario government paid millions of dollars to Andersen even though it was difficult to document any actual savings. Bills that didn't have to be verified were submitted. There were many questionable practices uncovered in the Auditor's report. They claimed savings in welfare even as unemployment was dropping. No one can determine whether the welfare expenditures are due to anything that Andersen was doing or simply to the fact that unemployment was dropping. No one can determine this. Yet, Andersen was still claiming the benefit.

These agreements have been very loose. They have been extremely favourable to the private sector. In some ways the results can only be explainable by reference to incompetence or something worse.

As you can tell my experience and analysis has made me quite sceptical of PPPs. I have yet to see a PPP project that I can say is a good PPP. My feeling is that we should not encourage this movement. If we want to improve government, then we should improve government. Bringing in an outside consultant is not going to work. It didn't work with Andersen Consulting in Ontario. It didn't work with changes to the Justice Department in New Brunswick.

If there are savings to be had, these should be the result of public policy and improved ways of running government. It should be the result of public discussion and a collective process, not the result of trying to find a quick and easy answer by giving a contract to a private company, especially when the evidence shows that PPPs don't work.

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Steven Shrybman:

I would like to describe the interplay between international trade and health care policy, because I believe that an understanding of this inter-relationship is important to the work of this Commission. I also want to talk about the trade cases that have illustrated how Canada's international trade obligations have already impacted Canada's public health care system in a manner which has increased health care costs.

On the question of privatization, some of the most helpful material can be found in the work that CUPE has been doing to expose the risks associated with public-private partnerships for the delivery of water services, and in what the corporate community has said in response. I will forward the legal opinions I have written on water privatization and trade and the back and forth with the Canadian Council on Public-Private Partnerships.

A comparison of the basic objectives of international trade and health care policies, exposes some fundamental contradictions. Trade liberalization policies promote the agenda of deregulation, privatization and free, or deregulated trade. Canadian health care policy, on the other hand, seeks to exclude market forces so that governments may ensure universal service, provide services through public institutions, and otherwise intervene in

the market place. Indeed, this underlying contradiction is conceded by the federal government, which has

established various reservations and exclusions that are supposed to protect public policy and law in this domain from the influence of international trade disciplines.

While there is some debate about how corrosive the influence of trade rules will be, there is no debate that there is a fundamental need to shelter health care policy and law from the application of these international disciplines. The problem with the safeguards established by Canada, is that they are qualified, ambiguous and very limited in their application. It certainly looks like our health system is more exposed to trade challenges and foreign investor claims than the federal government is conceding.

Most observers who have examined these issues - there is a growing body of academic literature on these subjects - acknowledge that there are serious concerns about the ongoing viability of Canadian health care policies in the free trade context. If these problems are left unresolved, and the status quo of simply trying to hide from them endures, then the resolution of the questions we have asked, will ultimately be provided by international trade and investment dispute panels. That is not an

appropriate way for public policy in any nation to be resolved, especially when the issue is as important as health care.

While these issues remain unaddressed, the progressive development of health policy and law is frustrated because of the uncertainty that now abounds about the extent of the constraints imposed by Canada's international trade obligations. Moreover, we are risking a crisis outcome if an international tribunal concludes that we were wrong to have relied on a reservation that really won't protect our health care system.

Indeed just that type of problem arose when the US challenged Canadian cultural policies in the Split Run Magazine case before the WTO. When Canada didn't jump quickly enough to reform our laws and the WTO ruled in favour of Time Warner, the US threatened to impose \$300 million in retaliatory trade sanctions. These were focused very strategically to include steel exports from Sheila Copp's riding because she was Minister of Culture. That was the environment in which Canada then had to reformulate its cultural policies and get something on the books, quickly – that the US was willing to agree with.

This was a horrendous situation for Canada to find itself in, and one can readily imagine the pressure associated with the threat of trade sanctions. Of course there was absolutely no justification for the \$300 million in retaliatory sanctions because Canada had tried to protect the small market share enjoyed by MacLeans, and a handful of other Canadian Magazines. We are courting just such a crisis, by

leaving Canadian health care policies exposed to a similar outcome, because the federal government is unwilling to acknowledge and take steps to correct the inadequate safeguards now in place to protect our health system from trade disputes and foreign investor claims.

There are now several legal opinions canvassing these issues of which mine is one. Barry Appleton, Prof. Bryan Schwartz, Epps and Flood (University of Toronto Law School) and Gottlieb (a Montreal firm) have also offered their views. These opinions are in general agreement about the contradictions that become apparent when one considers societal goals for public health care, against the commitments the federal government has made under NAFTA and the WTO. Unfortunately, we have heard very little in response to these concerns from the federal government, which chooses to simply dismiss them as unjustified and overblown.

It is fair then to note the federal government's poor track record when it comes to predicting the impact of WTO and NAFTA disciplines. There have now been a number of complaints brought under NAFTA and the WTO by other nations and foreign investors, and Canada has lost every single case decided to this point. While it has tried to characterize some of these defeats as victories - no objective assessment would conclude that Canada has walked away from even one of these disputes, entirely unscathed. On the odd occasion, it may have dodged some of the more lethal bullets but it has always been wounded, and had its public policy options significantly diminished.

These cases involve challenges to the Auto Pact, Canadian cultural policy, supply management for dairy products, our drug patent laws, Canadian industrial and technological support programs for the aerospace industry, and even a challenge to a ban on the use of a neuro-toxic fuel additive.

In fact, the only trade cases Canada has won, involved its challenge to public policies and regulatory initiatives in other countries. One of these cases, Europe's ban on the importation of hormone raised beef, illustrates another way in which the trade and health agendas collide. Many in Europe believe the ban was an important public health measure based on precautionary principle. But precautionary public health protection was not, in the WTO's view, a reason for interfering with trade. Because it refused to back down, Europe is paying \$US113 million dollars in retaliatory trade sanctions each year to the United States, roughly 10% of that to Canada. This is now the price it is paying to preserve a public health measure for which there is very broad public support in Europe.

I don't think anyone can argue that Canada's trade agenda hasn't had an impact on health care and the clearest evidence of that is the area of extended patent protection for brand name drugs under Bill C-91, which eliminated compulsory licensing for generic drugs. We know that this is an area of public health care expenditure that has been increasing through the nineties on both the public and private ledgers.

We've lost two important cases before the WTO involving our patent laws. These cases are illustrative of how trade

will be invoked to punish governments that don't respect the letter of their trade commitments. I mentioned the investor-state that challenged Canada's right to ban a toxic fuel additive - this is the Ethyl case. We know that RJR Reynolds retained Carla Hills, who had been the US trade representative, to threaten Canada with just such a claim, if it proceeded with plans to put cigarettes in plain packaging. RJR Reynold's argued that this would represent expropriation of trademark. Canada backed down, as it did in the Ethyl case, and this type of regulatory chill probably represents the most significant impact that these trade rules are having today - and it is clear that these risks are discouraging a lot of public policy from ever seeing the light of day.

There is an interesting report by Howard Mann of the International Institute for Sustainable Development. He reviews the investor-state claims that have been brought under Chapter 11 of NAFTA. He relates that since the Liberal government was first elected, it has only established two environmental regulations. One was the ban on the use of MMT, the fuel additive, and the other was to ban on PCB exports. Both were challenged under chapter 11 - neither survived.

Let me talk about the state of play of the debate about these issues again. There's now some academic literature on these issues. For example, there is an interesting article by Tracey Epps and Colleen Flood, of the University of Toronto Law School. I believe their work vindicates many of the concerns that we have been raising. They have confirmed the ambiguities associated with current safeguards.

Turning to the question of privatization, the corporate community has now waded into the debate about the impact of international trade rules on P3 relationships. Municipalities are beginning to understand and worry about the fact that by getting into bed with transnational corporations in public private partnership, they are also entering into foreign investment relationships, the full implications of which they don't really understand. The federal government has been telling municipalities not to worry.

But the private sector is saying no such thing, and in fact have encouraged municipalities to comply with Canada's international trade obligations. Instead the private companies are saying: "don't worry because you can contract-out of the risks associated with foreign investor treaties." But I think this is way off base, because about the only thing that is certain about NAFTA and WTO is that governments cannot contract or legislate their way out Canada's international trade obligations. The only way that could be accomplished would be through amending the treaties themselves. This is really not a debatable point.

Let me then say a little more about the role of the private sector and what that means in terms of public-private partnerships for health care services.

Foreign investors bring to such a contractual relationship substantive and procedural rights that simply don't have any analogue in Canadian law. These rights aren't available to Canadian companies operating in the Canadian context.

Under Chapter 11 of the NAFTA these include the right to be treated in accordance with the principle of "national treatment" that guarantees foreign investors the most favourable treatment accorded by governments to any domestic investor. Because there is no distinction drawn between the public and private sector in this regard, this casts into doubt the viability of any Canadian programs, policy, regulation or funding arrangements that favour the public sector.

Foreign investors are also entitled to be free from government regulatory controls called "performance requirements" that have to do with the obligation to source goods and services locally. For example, this might include a requirement that a company use local diagnostic services, or technicians that were licensed in accordance with provincial law.

There is also the right to be treated "in accordance with international law." As the cases unfold, we discover that every investor who has succeeded under NAFTA has succeeded on that ground. There is the right to be free from government action that expropriates or nationalizes a foreign investment, directly or indirectly. Expropriation under NAFTA has now been so broadly defined by the cases that it goes even further than simply entrenching private property rights in our constitution. In fact, expropriation has been so broadly defined that it may include any government action that diminishes the value of an investment.

Take the claim by a US hazardous waste company, Metalclad Inc., against

a small community in Mexico. The municipality said “no” to the hazardous waste company because the particular site they were interested in developing was acquired from a Mexican company that had simply dumped hazardous waste on the site, polluting the local ground water. By saying “no,” the tribunal reasoned it had expropriated the company’s investment, as well as the future profit that would have made had it been able to establish its business. The case was appealed to a Canadian court and was subsequently upheld. Mexico has paid this foreign investor almost \$US16 million in damages.

We know with respect to public services, that at least some transnational corporations understand the value of these new tools. There has now been a complaint brought against Canada by UPS, having to do with Canada Post’s audacity to deliver parcels and courier products as well as the mail. UPS is arguing that by doing so, Canada Post is taking unfair advantage of public infrastructure that has been established at public expense to facilitate mail delivery, but shouldn’t be used for the purposes of allowing Canada Post to compete with UPS in parcel and courier products.

One can see how that same argument might be made about public health care services. A private competitor can now argue that the use of public infrastructure - hospitals and other public facilities - offers public sector service providers an unfair competitive advantage when it comes to competitive areas of service.

We don’t know how this case is going to be resolved. It got underway about a

year and a half ago. UPS is seeking \$200 - \$300 million in damages. We don’t know what influence the case is exerting on the current thinking about public policy and law, and public sector service delivery within the government. Or what trade officials within the Department of Foreign Affairs and International Trade are saying to their colleagues about the implications of the case, and what precisely they should be worrying about. We also don’t know how this case might be influencing government’s thinking about other public services, such as health care.

In the water area there are cases in which the same transnational companies that are bidding on P3 projects in Canada, have actually used this very mechanism to sue governments when privatization deals have gone sour. Those claims relied upon bilateral investment treaties similar to NAFTA. In one case a subsidiary of Vivendi is suing Argentina over a privatization deal for water and sewage services. Their contract with a provincial government in Argentina turned out badly. There were disputes about water quality testing, the company’s right to cut off customers, and provincial rate regulation.

The 112 page contract stipulated that any disputes would be resolved by provincial laws but nevertheless Vivendi invoked the provisions of the international agreement to sue Argentina for \$US 300 million. The case is complicated, and the Tribunal ultimately suggested that Vivendi first take up the claim before the provincial courts and then come back if unsatisfied. Vivendi wasn’t satisfied

with that outcome and has now appealed to have the ruling annulled.

Bechtel has done the same thing in Bolivia. When a privatization deal went sour, the company invoked the provisions of the bilateral investment treaty with the Netherlands.

This is a problem that doesn't exist in Great Britain for the Public Finance Initiatives that Allyson Pollock has described, because efforts to establish these investment rules as a multilateral agreement under the auspices of either the WTO or the OECD, have failed. In fact, efforts to multi-lateralize these commitments have failed largely because people are now beginning to understand how astonishing these new rights and privileges that were given to foreign corporations are, and have rejected the bargain. Meanwhile in North America we are saddled with this regime and Canada seems to be quite committed to it as part and parcel of the Free Trade of the Americas.

So there is real exposure here. These days the companies bidding on public-private partnerships are most often transnational corporations with interests around the world. Typically, this means when negotiating a P3 contract, the resources and expertise of local governments and or hospital boards, are pitted against those of some of the world's largest corporations.

I don't know who is likely to come forward to bid on P3s in the health services area, but for water services the only companies bidding on the privatization initiatives in Halifax and Vancouver were European based transnational corporations. The

particulars of corporate consolidation will of course vary from sector to sector and service to service. There may be Canadian companies capable of bidding on hospital privatization proposals, but these are likely to be swallowed up as global consolidation of the industry continues.

The only realistic assumption to make, is that privatization of health care services will inevitably mean greater participation by foreign corporations in the Canadian market. Those corporations bring to the bargain, the very special rights and remedies provided to foreign investors and service providers, whether these are understood by their public sector partners or not. We are still in the very early stages of understanding what this fully means. It's been easy for the federal government to discount these concerns in the past, but now as the cases arrive and as the academic literature develops, people are beginning to understand that our concerns are very real.

The other problem with privatization in this context is that there are reservations under both the services agreement of the WTO, the General Agreement on Trade and Services (GATS). Similarly, the services and investment provisions of NAFTA are to some extent subject to a reservation for health services. I thought Colleen Flood put it very well when she said Canadian negotiators apparently failed to understand the diverse and mixed character of our health care system when formulating this reservation. Instead, they appear to have reserved health care but only where it is publicly funded and publicly delivered, in an economic context unadulterated by any

competitive element or private sector participation.

Thus, the key safeguard Canada is relying on to shelter the health care system from the full impact of NAFTA investment and services rules, is a reservation under Annex II for social services provided for a public purpose. (There are other limited reservations for subsidies and procurement). But these terms aren't defined by NAFTA so we don't really know what a "social service" delivered for a "public purpose" includes. We do know the United States has said that the participation of a private sector service deliverer on either a profit or not-for-profit basis negates the application of this key reservation.

Colleen Flood thinks that if services are both publicly funded and publicly delivered we are safe, at least from several NAFTA disciplines. She also hopes that even some publicly funded but privately delivered services may fall under this umbrella as well. But the US has been very clear. Once the private sector is involved all bets are off and NAFTA disciplines apply.

So what do we do? Do we pretend that this isn't a problem? This seems to be the federal government's response. Or do we acknowledge that we have a problem and try to address it. We believe that it is important for the Commission to acknowledge that this is a real issue, a real problem that needs to be resolved and not left to the vagaries of international trade dispute resolution.

We have seen state to state complaints with respect to patent issues, but there are diplomatic, strategic and economic

considerations that governments must take in to account before the machinery of international trade dispute resolution is invoked - and, after all, the obligations are reciprocal. There is a limit to how aggressively a government will want certain obligations to be read because they are subject to them as well. When it comes to foreign investors, none of these considerations or constraints apply. When it comes to foreign investors these rules are not reciprocal - they accord only rights, not obligations. The more broadly and aggressively the tribunals read these rules, the better from the perspective of a foreign investor.

There are no strategic or diplomatic costs associated with these claims other than the potential public relations costs. But remember these procedures are very secretive, so public relations costs may not be high. While corporations will incur legal costs, in the general scheme of things those will probably be pretty modest.

The same difficulties arise under the GATS. The GATS applies to all services unless these are delivered in the "exercise of government authority." This is further defined to mean delivered "neither on a commercial basis nor in competition with other service providers." But it would be hard to identify a public health care service that is neither delivered on a commercial basis nor in competition with other service providers. If there is one, it's probably the public insurance regime, because of statutory exclusion of private insurance coverage for insured medical services. But one must be skeptical about this key reservation being given any broader reading than that. Again,

the more private sector participation, the more adulterated any claim to this safeguard will be in any area of health care service delivery.

These are the two major problems that the trade rules introduce to public private partnerships. The risk of foreign investor claims, and the fact that by entering into such arrangements, key safeguards may be negated because they do not apply when services are provided by private companies operating on a commercial basis.

But it might be said that we are already exposed to these risks, because we have a very mixed system, in which there is already a lot of private delivery. I believe this may be true to an extent, which underscores the need to resolve the application of these key safeguards. At the same time we need to be very cautious about creating even more problems for ourselves, by allowing foreign investors to acquire a substantial stake in our market. So as long as there is limited foreign investment in the Canadian health care market, we have less to worry about.

There is one other type of reservation that may turn out to be the more important safeguard for health care services. That is the reservation for all measures of provincial and local governments that were on the books at the time NAFTA was implemented in 1994. These now have the status of non-conforming measures, but endure only so long as they are not reformed in a liberalizing manner.

But an important qualification here, is that both these reservations, and the one for health services, do not apply to

several of NAFTA's most onerous provisions: rules concerning expropriation, and the obligation to treat foreign investors according to international law. In other words, even where they apply, NAFTA reservations only provide limited protection for public policy and law concerning health care.

For example, in an article written by Epps and Flood, they describe a hypothetical case where a government contracts with a US corporation to provide gene therapy because it's innovative and very expensive. But if successful, Canada might then want to make the service universally available and incorporate it into the public system. This may effectively limit the business opportunities the private partner was planning to capitalize on if its pilot project succeeded. There is no reservation under NAFTA that would shelter a government from a claim that the company's investment, including its future potential, had been expropriated in this scenario.

We believe that these issues, and others related to Canada's international trade obligations, must be taken seriously and addressed by the Commission. We also believe the federal government needs to be strongly encouraged to address the problems caused by its failure to provide adequate safeguards to protect our health care system from the application of trade policies that will undermine the founding principles of our public system. Until that protection is assured, we need to be very wary of any initiative that is going to increase private sector participation in our health care system. Of course, there are other reasons for rejecting privatization as the answer to the

question of health care system reform,
but the risks associated with the trade
commitments Canada has made, create
a whole new type of risk, associated
with privatization.