

**Submission to the Commission**  
*on the*  
**Reform of Ontario's**  
**Public Services**



**Canadian Auto Workers union**  
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# Submission to the Commission on the Reform of Ontario's Public Services

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## 1. Introduction

On behalf of the 145,000 CAW-Canada members residing in Ontario we welcome the opportunity to share our perspective and proposals with the Commission in preparation of your report to the Minister of Finance regarding the reform of public service delivery. While the majority of CAW members in Ontario are employed in the private sector, we also represent some 26,000 public sector workers in the health, post-secondary education, municipal utilities and urban transit sectors providing needed quality service to the public.

Indeed, all CAW members and their families rely on quality public services as part of their broader “social wage” to ensure a meaningful and secure quality of life. Their quality of life does not depend solely on the goods and services they can purchase privately, thanks to their personal incomes. It also depends fundamentally on a strong network of public services, which contribute to the overall well-being of families and communities.

Under fierce public pressure from Canadians, governments had been forced in recent years to gradually re-invest in health care, education, and some other social and public programs (following earlier periods of painful fiscal restraint). But governments placed far more emphasis on tax cuts than on reinvesting in public programs. There is ample fiscal room in Canada for governments to repair the damage to public programs that occurred as a result of spending cuts in the 1990s, and to develop new programs to address the evolving needs of Canadians – in such areas as child care, elder care, pharmacare, and others.

Mr. Drummond's C. D. Howe Benefactors Lecture suggested various options to improve Canada's healthcare system that enjoy broad public support.<sup>1</sup> That report offers practical options for health reform to be

pursued immediately, including: greater emphasis on health promotion; system reorganization and integration with a ‘patient-centric’ focus more responsive to growing chronic care needs; and financing mechanisms for hospitals and physicians that reward quality care, efficiency, and better use of information. Far more controversial and lacking in popular support is the call for ‘experimentation’ with greater competition including private sector delivery of specialized diagnostic and clinical services.

Our submission to the Commission contains the following features. Introductory sections reaffirm the principles of public service delivery, and urge that the long-run effort to reduce the provincial deficit be paired with an expansionary macroeconomic strategy to put Ontarians back to work (thus paying taxes). Then, subsequent sections focus on suggestions for controlling costs associated with the delivery of public services – not by handing over more responsibility and control to private sector agents, but rather by challenging the waste and irrationality associated with many existing forms of private sector participation in public sector delivery. These discussions include sections identifying waste and irrationality associated with private sector procurement, private clinic operation, public-private partnerships in infrastructure construction, and public capital subsidies for long-term care homes. In all of these areas, funding constraints are made worse, not better, by private sector involvement at various stages of the delivery process. Latter sections of our submission consider the broader economic benefits associated with public service delivery in Ontario (including in research and innovation). We conclude with a discussion of ways in which costs could be reduced, and service quality improved, through reforms in existing credentials and

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<sup>1</sup> *Therapy or Surgery? A Prescription for Canada's Health System*, by Don Drummond (Toronto: C.D. Howe Institute, 2011), [http://www.cdhowe.org/pdf/Benefactors\\_Lecture\\_2011.pdf](http://www.cdhowe.org/pdf/Benefactors_Lecture_2011.pdf).

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occupational categorizations in health care. Our analysis emphasizes issues related to health care (since that is where the majority of the CAW's broader public sector members work in Ontario), although many of the principles advanced are also applicable to other public services in our province.

## **2. Reviving the Spirit of Public Service**

In the aftermath of the most calamitous economic and fiscal storm since the Great Depression, it is timely and appropriate to pause to survey the damage. Not unlike the fallout flowing from Hurricane Katrina in the US, we need not only to measure the human and property damage arising from this financial storm, but also to assess existing doctrines, institutions and practices that failed to forecast or adequately respond in such crises.

As the CAW National Executive Board Statement on the Financial Crisis noted in November 2008, this is a time to acknowledge the failures of the free-market business system, especially in the financial sector. This is a time to reject the vision of deregulation, globalization, and corporate dominance that has ruled most of the world for the past quarter century. This is a time to demand accountability: from the business and financial elites, to the men and women whose work determines our real prosperity.

We understand that the Commission is mandated not to recommend increased taxes or further privatization of health care or education. However, the Commission would be complicit by its silence if, given the fiscal straits we find the province in, it were to ignore the continuing fiscal impact of previous measures which cut or eliminated taxes and deepened privatization of our public services and infrastructure.

We are sceptical that simply relying on external private sector experience and motivations in the form of business consultants, public-private partnerships, or further privatization (ASD) of service delivery will successfully create a safe and sustainable path forward towards quality public services. If there are also lessons to be learned from recent troubles at the Ministry of

Health and Long-Term Care (such as the e-health controversies), it is simply that we have had inadequate investment in building the public sector capacity to lead and manage the necessary transformation of health delivery required.

We would offer the Commission a simple hypothesis: the extent to which recent health spending has escalated is directly proportionate to the increasing entanglement of the private sector market in respect of business process outsourcing, information technology, medical devices, biotechnology and pharmaceutical companies as providers and private equity firms, income trusts, investment banks, commercial lenders, law firms, lobbyists and consultants as financiers in the provision of health services.

No effort to achieve a sustainable quality-driven, safe and accessible health system can ignore the pernicious and growing influence of this 'medical-industrial complex'. Having said such, we are not unmindful of the opportunities to consider revenue generation in the form of reduced tax credits/expenditures or new levies to recapture the public subsidy that is directed at this 'medical-industrial complex'.

If there is any urgency to reducing program spending, it ought to take the form of targeted efforts where recent audits and program reviews have identified waste and inefficiency. While we applaud recent initiatives to reduce external consultants by 50%, we need concrete measures and re-investment to repatriate and 'publicize' management and administration in the Ontario public sector from the hands of private sector consultants and advisors.

It is ironic that proponents of innovation and competition applaud greater private sector involvement in public services when public service outsourcing deals with multinational firms Accenture, IBM, Telus and Maximus claimed a Minister in British Columbia – and meanwhile another in Ontario fell under the weight of a \$1-billion IT eHealth scandal. Calls for greater private sector involvement ignore the appalling lack of capacity for effective governance and oversight of these deals, let

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alone the absence of transparency and accountability of such engagement.

Why are current democratically elected governments in Canada apparently incapable of developing their own independent operational policies, and instead repeatedly turn to private sector advisors (with their own vested interests) to tell them how to run public services? Recent examples of external private sector business consultants directing cutbacks in public services raise troubling questions about accountability and democracy – examples such as KPMG (hired by the City of Toronto to provide a citywide service efficiency review), Deloitte Touche (hired by the Federal Government for almost \$20 million to provide private-sector best practices in improving productivity and achieving operational efficiencies), and PriceWaterhouseCoopers (paid a \$2.5-million fee to perform the same work earlier).

All that waste and inefficiency could instead be re-invested in transformative policy changes to revive the ethos, commitment, and effectiveness of public sector management and administration. At a fraction of current program spending on consultants, all levels and jurisdictions of the public sector could contribute to and benefit from a *collaborative learning institute* on public sector efficiency and innovation. This institute could work with existing organizations in a collaborative exercise to provide skills and training as well as higher learning; serving to disseminate knowledge and best practices to inform future public service delivery methods.

We should properly recognize and support our public services and empower both our public servants and the public directly to work to evolve and adapt the delivery of public services to meet our challenges.

### 3. Economic Stagnation and Ontario's Fiscal 'Box'

The recent provincial fiscal update provided by Minister Duncan, reinforced by public comments from Mr. Drummond, has indicated that continuing turmoil in

global financial markets has undermined economic growth projections. Hence, a 'prudent' fiscal plan will take for granted the continuation of disappointing macroeconomic and employment trends over several years to come. This downgrading of economic growth projections, together with the decision to significantly widen the various contingency reserves which explicitly and implicitly 'pad' the budget forecasts, means that the future constraint on program spending in Ontario is even more intense than was communicated to voters during the recent election.

Interestingly, during that campaign all three major parties presented almost identical fiscal plans to the voters. That plan involved balancing the budget by 2017, and required holding total nominal program spending growth to just under 2% per year.<sup>2</sup> That was an austere outlook, which constrained the election platforms of all three parties accordingly. But no Ontario voter could complain that they weren't 'warned' about they were headed for.

Now, however, with the election barely over, the government and Mr. Drummond are significantly ratcheting down the fiscal outlook even below that tight plan. The government now claims that to balance the budget by 2017, nominal program spending growth must be held to just 1% per year. If we allow for slightly faster spending growth in health care (though still well below the combination of inflation and population growth, hence implying reductions in real per capita health budgets), this timetable implies major sustained reductions in program spending on other important priorities. The quality of life experienced by many Ontarians will suffer significantly from several years of sustained reduction in fiscal support from the provincial government.

We do not accept that recent economic developments have genuinely worsened the outlook for provincial finances all that much. Instead, it seems to us that the government is preparing to follow a tried-and-true process of deliberately adopting pessimistic assumptions (explicitly in the economic forecast, and

<sup>2</sup> See Hugh Mackenzie, "Platform Costing and the Politics of Fiscal Policy in Ontario" (Ottawa: Canadian Centre for Policy Alternatives, 2011).

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implicitly embedded within many of the spending ratios and contingency funds) in order to prepare Ontarians for very bad news – only to ‘surprise’ them down the road with the reality that things weren’t that bad after all, and in fact the budget was balanced faster than planned. This tactic (which has been adopted by many other Finance Ministers over the years, most notably by federal Finance Minister Paul Martin in the mid-1990s – for whom Mr. Drummond served at that time as a key advisor) imposes needless dislocation and hardship. If indeed we agree (as all three parties did in the election) that 2017 is an appropriate timetable for eliminating the deficit (and the CAW would support that contention, barring another recession in which case that fiscal timetable must be relaxed again), then we should pursue that target truthfully and transparently – without padding, pessimistic assumptions, and contingency allowances all aimed at justifying spending cuts even deeper than those required to meet the stated timetable.

We note that so far, Ontario has considerably outperformed its own timetable for reducing the deficit which arose in the 2008-09 recession. Year-end deficits for 2009-10 and 2010-11 both came in substantially below their initial and revised forecasts – by over \$5 billion in 2009-10 and over \$7 billion in 2010-11. That represents a total ‘overachievement’ of official targets of over \$12 billion in just two years. It seems clear to us that the ultra-pessimistic tone of remarks from the Finance Minister and Mr. Drummond are motivated by a strategy of establishing the conditions for future ‘overperformance.’ However, the health care and other public services received by Ontarians are too important to be the object of such optics-driven strategies.

On top of this unnecessary and artificial manipulation of the budget forecast itself, we must also highlight our rejection of the notion that the province must accept a very pessimistic economic and employment outlook as given. It is obvious that Ontario’s current fiscal difficulties were caused not by ‘overspending,’ but rather by the unprecedented recession of 2008-09 (which hit Ontario harder than any

other Canadian province), and the subsequent slow and uncertain recovery. After all, Ontario declared a small surplus in 2007-08, before the crisis hit. Our services at that point could be sustainably financed by the taxes we pay. That would continue to be the case, so long as we put Ontario back to work.

In that regard, the task of restoring balance to Ontario’s finances cannot be separated from the task of improving the macroeconomic and labour market context for our public finances. Balancing the budget amidst an economic landscape marked by vast un- and underemployment, excess capacity, and stagnant or falling incomes, will be virtually impossible. Even attempting to do so, given the weakness in the broader environment, can make the economic context even worse (by further weakening demand conditions, employment, and incomes). We would urge the government to complement its fiscal plan with an ambitious, expansionary economic and employment strategy – one that utilizes every policy tool in the box to create jobs, activate idle resources, and generate needed incomes. Among the many social benefits of a jobs strategy for Ontario would be the obvious and direct benefit to provincial finances attained through stronger employment and income performance.

The parameters and mechanisms of such a job strategy are beyond the purview of this brief. We simply note that if no such economic vision is put forward by the government, to supplement the coming austere emphasis on reducing the deficit, then the province will be swimming against a powerful macroeconomic tide. Better to put Ontarians back to work, that way generating the incomes we need to pay down our debts.

## **4. The Perils of Public Sector Procurement**

The recent eHealth fiasco exposed by the Provincial Auditor has tarnished the achievements of the Government’s health reform agenda and devastated the ranks of responsible leadership within the Ministry. By the Ministry’s own self-professed reform metrics of

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'return on investment' and as an informed purchaser of services, the eHealth scandal exposed the failure of uncritical reliance on the private sector. The role of the Ministry of Health is clearly to maximize social benefit whereas private corporations are in business to benefit shareholders by maximizing profit<sup>3</sup>.

Relying on the altruistic instincts of corporations to ensure cost-effective public sector procurement has not been a successful strategy for obvious reasons (something the Pentagon discovered long ago in dealing with military procurement). We commend the Government for the Supply Chain Guidelines announced in 2010 for the Broader Public Sector (BPS) procurement Directive. The province needs to ensure that public dollars for goods and services (including construction, consulting and IT services) are acquired by the public sector through a fair, open and transparent process that ensures value-for-money (VfM) and quality services for Ontario.

These processes are presently fairly developed in the health sector, such as group purchasing organizations such as HealthPRO or Medbuy which combined represent almost \$2 billion in contract purchases in 2010, generating some \$95 million in rebates returned to its BPS partners in 2010. According to an earlier glowing review of the health sector reform launched by the current Government, bulk purchasing resulted in standardized equipment, lower administrative costs, negotiated 'best' price and service packages, and resulting significant savings off the list or retail price for purchase of MRI and CTs<sup>4</sup> (arguably the most expensive capital purchases for individual health providers).

All too frequently, the Provincial Auditor has reported that the Ministry was remiss in analyzing the underlying actual costs of providing laboratory services to utilize in fee negotiations with private laboratory services (2005). Hospitals did not use referral guidelines to ensure

appropriate utilization or clear prioritizing among patients based on needs, as well as being unable to fully utilize the equipment let alone ensure the safety of patients and hospital personnel (2006) in use of diagnostic imaging equipment in hospitals (2006). The complexity of fee-for-service surgeons billing OHIP while hospitals in which such surgeries are performed pay the related non-physician costs at hospital surgical facilities is another identified problem (2008). Also, the assistive devices program (2009) provides another example of how private providers were not subject to the rigour or scrutiny of audit; the Auditor noted the Ministry set or accepted prices significantly higher than fair market value and failed to eliminate ineligible claims, unusual claim patterns, and overpayments, as well as ignoring potential conflict of interest between authorizers and vendors.

The Health Council of Canada more recently in 2010 expressed concerns regarding over-utilization of diagnostic imaging and inappropriate prescribing practices by primary care physicians, as well as low adherence to clinical practice guidelines. This experience strongly recommends greater vigilance, accountability and transparency of health purchasing decisions to ensure the public interest remains central in these transactions.

As well as implementing transparent and appropriate procurement directives and practices, the Government needs to continue to leverage public sector purchasing power in capital equipment, clinical supplies and medical devices procurement. That would not only further reduce transaction costs associated with tendering, it would also leverage volumes to achieve cost discounts. A more active role is also required to ensure procurement is evidence-based and the appropriate value assigned to access and quality, and not merely price.

It should also be acknowledged the public sector procurement objectives are often hostage to other public

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<sup>3</sup> This simple truth is often forgotten in health policy and many thanks to the MacDonald-Laurier Institute publication, "Pills, Patents & Profits: A Primer on Pharmaceutical Policy" by Brian Ferguson of the University of Guelph for re-emphasizing this point.

<sup>4</sup> W. Michael Fenn, "Reinvigorating publicly funded medicare in Ontario: new public policy and public administration techniques", *Canadian Public Administration/ Administration Publique Du Canada*, Vol. 49, No. 4 (Winter/Hiver 2006), pp. 527-547.

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obligations such as provincial trade or industrial strategy or international trade treaties. An example is immediately available in the form of the current Canada-EU trade negotiations which threaten to add \$2.8 billion to our collective national prescription drug bill and effectively swamp the recent laudable provincial initiative to ensure a better public deal for pharmaceuticals.

## 5. The Fallacies of Private Clinic Competition

The research evidence is compelling that medical services are not delivered more efficiently or at lower prices, nor conversely that access, quality or cost are improved, in privately-owned clinics<sup>5</sup>. The debate is thus not whether specialized ‘stand-alone’ clinics indeed provide efficient care, but whether any value reaped in such efficiencies would be extracted by private investors, rather than in some form being repatriated back into the public system for re-investment.

The idea of ‘competition’ is glaringly misplaced as a ‘proposed’ innovation in health care delivery, when collaboration and emulation through ‘best practices’ should be the rule. The anti-competitive 20-year patenting regime for brand name pharmaceuticals would be a far more obvious focus to achieve cost efficiencies in the health sector by promoting “competition.” An analysis of private surgical facilities in Alberta recently concluded:

*The broad conclusion is that, if anything, for-profit hospitals are less cost-efficient than not-for-profit hospitals, and that costs to purchasers are higher.*

Another influential systematic review and meta-analysis of private for-profit ownership of hospitals, in comparison with private not-for-profit ownership, found a higher risk of death for patients<sup>6</sup>. Patient safety should be paramount. In the end, the real fiscal threat to public sector procurement is created by the necessity of purchasing in the market from profit-maximizing firms.

<sup>5</sup> Canadian Health Services Research Foundation, *Mythbusters: Myth: For-profit ownership of facilities would lead to a more efficient healthcare system*, March 2004.

<sup>6</sup> *Canadian Medical Association Journal*, “A systematic review and meta analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals”, P.J. Devereaux, et. al., May 28, 2002 vol. 166 no. 11 1399-1406

## 6. Public-Private Partnerships (P3s)

Infrastructure Ontario has since 2006 relied on Alternative Financing and Procurement (AFP) to unleash substantial public investment in the province’s capital stock and infrastructure amounting to more than \$23 billion. Included in this commitment is some \$5 billion (including the community funding share) up to 2010 for 66 health sector capital infrastructure projects, with almost one-half of health capital projects (principally hospitals, but increasingly including ICT infrastructure) proceeding on an AFP basis.

We understand the present Government devised the AFP approach to address public concern about earlier public-private partnership models regarding ultimate ownership of the capital asset and the private sector “not touching” the patient. However, in view of the financial market collapse and subsequent agenda of fiscal austerity, we recommend that the public interest is best served by a renewed determination to improve value. At a minimum, all existing AFP projects need to be rigorously re-examined (by the Provincial Auditor’s office) to ensure value-for-money (VfM) and public accountability through fair, transparent and efficient processes.

At this time of critical scrutiny of public sector operations in view of the fiscal challenges of reaching a balanced budget, can the Province afford not to re-examine whether such AFP projects are still cost-effective over their remaining 25 to 30-year terms in view of changes to borrowing costs? Are the remaining annual charges to the public sector for such AFP projects warranted in view of the realized borrowing costs and risk transfer, or is re-financing and buying out the private partner more expedient and cost-effective?

Are the concerns and criticisms as well as lessons learned through this extensive public procurement transferable to other projects and forms of infrastructure being readied for Requests for Qualification (RFQ) or

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Requests for Proposals (RFP)? We believe it is an appropriate juncture to move forward and establish a provincial moratorium on new AFP projects, and an immediate audit and review of existing commitments and prospective AFP projects, while strongly encouraging traditional procurement such as Design-Build relying on provincial bond financing.

It is especially timely to ask whether the public sector can continue to rely on ‘partnership’ with the private sector – which is, after all, driven by the goal of revenue or profit maximization for private investors, rather than welfare maximization for the public interest – in a time of fiscal austerity. In 2008, the Auditor General Jim McCarter found in his value-for-money audit that the cost of constructing the new Brampton Civic Hospital “could well have been lower if the government had built the hospital itself”.

According to Andre Picard in the *Globe & Mail*<sup>7</sup>, the Brampton P3 approach cost Ontario taxpayers \$194-million more than a traditionally procured public hospital; and a further \$200 million in interest charges over a 25-year agreement, given the spread between provincial and private borrowing costs. That was an over-spend of \$394 million for a \$614-million hospital, constituting what Picard described as clearly “not capitalism’s shining moment of glory”. While the Brampton Civic was an early P3 project, similar concerns have arisen in other audited P3 or AFP projects.

In a 2004 value-for-money audit by the Auditor General of British Columbia, the Vancouver Coastal Health Authority Ambulatory Care Centre P3 project was found to have been completed at a final capitalized value of \$123 million – 29% greater than the estimated \$95 million capital cost estimated in approving the project as a P3. A lower discount rate was the primary cause – \$17 million – in the increase, compared to \$11 million in changes in design and scope that arose in the 30-year project agreement.

The Quebec auditor general, Renaud Lachance was also sceptical and concluded in 2010 that the largest P3 in Canada – the \$2.6 billion Centre Hospitalier de l’Universite de Montreal (CHUM) project – would cost \$10.4 million more than conventional procurement, rather than saving a reported \$33.8 million.

In jurisdictions where the P3 or Private Finance Initiative (PFI) originated, a fundamental re-examination is taking place as the questionable logic of these complex structured finance projects receives the same scrutiny as some of the other exotic financial instruments that permitted risk to be disguised in inefficient and often destructive ways, such as asset-backed commercial paper (ABCP), credit default swaps (CDS) or collateralized debt obligations (CDO).

The UK House of Commons Committee of Public Accounts has recently released a document entitled “Lessons from PFI and other projects: Forty-fourth Report of Session 2010–12 Report” and concluded:<sup>8</sup>

*Private finance has always been more expensive than government borrowing, but since the financial crisis the difference between the costs has widened significantly. The cost of capital for a typical PFI project is currently over 8% – double the long term government gilt rate of approximately 4%. The difference in finance costs means that PFI projects are significantly more expensive to fund over the life of a project. This represents a significant cost to taxpayers.*

*We have not seen clear evidence of savings and benefits in other areas of PFI projects which are sufficient to offset this significantly higher cost of finance. Evidence we studied suggests that the out-turn costs of construction and service provision are broadly similar between PFI and traditional procured projects, although in some areas PFI seems to perform more poorly. For example we heard that design innovation was worse in PFI projects and we have seen reports which found out that building quality was of a lower standard in PFI*

<sup>7</sup> *In this PPP, taxpayers are the ones who paid*, *Globe & Mail*, February 5, 2009

<sup>8</sup> National Audit Office, *Lessons from PFI and other projects*, April 2011, [http://www.nao.org.uk/publications/1012/lessons\\_from\\_pfi.aspx](http://www.nao.org.uk/publications/1012/lessons_from_pfi.aspx)

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*buildings. PFI is also inherently inflexible, especially for NHS projects. This is in large part due to the financing structure and its costly and complex procurement procedure.*

The Guardian in a recent editorial<sup>9</sup> suggested the acronym 'PFI' would more appropriately be defined as 'Persistence of a Flawed Idea' rather than 'Private Finance Initiative,' and lamented that the NHS faces draconian cuts while private PFI financiers are guaranteed shareholder returns (often diverted to off-shore tax havens, so the Treasury even loses the compensating value of tax collections on those profit flows). The UK House of Commons report was also alive to this issue of 'balance':

*Continuing to use an inefficient funding system such as PFI is likely in many cases to increase the overall burden on taxpayers for the provision of public sector capital projects. If, rather than using PFI, the lower financing costs of government are utilised, we have seen evidence that investment can be increased significantly for the same long term funding costs.*

The report continued to address the interim issue of auditing and re-negotiating these deals to ensure continuing value and fairness for the public sector:

*Given the fiscal challenges faced by government, and the degree to which public expenditure is currently being scrutinised for potential savings, there is pressure on public managers to secure a better deal from existing PFIs. A high profile review of public sector efficiency recommended that the government audit all procurement contracts with a concession value of over £100 million, and explore ways of breaking contracts where these represent poor value for money. At the time of writing, the Treasury was consulting with major DBFO investors on plans to introduce a code of conduct on reducing the costs of existing deals, and individual public authorities are being encouraged to work with investors to identify where and how reductions in their charges might be achieved.*

The UK House of Commons report also contained testimony by David Metter, CEO of Innisfree - the leading infrastructure investment group in the UK in P3 infrastructure projects. He informed the Committee that Innisfree led the P3 consortium at the University of Montreal Hospital project, and that the company raised \$1.3 billion for the project with a credit margin of 310 basis points compared to the pre-2008 debt margins of only 50 basis points. The consortium's secured bonds were rated BBB+ by DBRS and Baa2 by Moody's, compared to the Aa2 rating from Moody's for the CHUM itself. In fact, the members of the P3 consortium only contributed \$180 million worth of their own capital and subordinated loans to the project, thus limiting their own 'skin in the game'.

Innisfree simply provides a channel for institutional investors to invest in public infrastructure projects as a fund manager; investors include leading UK institutional investors and local authority pension funds (which alone currently represent 54% of Innisfree's fund investors). In Metter's testimony to the House of Commons Committee he declared that Innisfree funds typically achieve 8% to 10% yield per annum. Regrettably, transparency of the costs and benefits of AFP projects are obscured by commercial confidentiality as both Infrastructure Ontario and private investors shield themselves from accountability.

The Innisfree/CHUM experience is just another startling example of how the P3 model is increasingly, given the continuing financial tumult, imposing larger and completely unnecessary financing costs on public agencies and taxpayers. A recent comprehensive survey of P3 experiences in the wake of the global financial crisis, and the weakening financial logic and performance of the P3 model, was provided by John Loxley and Salim Loxley.<sup>10</sup> All this evidence should raise enormous concerns about endorsing privatization in general, and the P3 model in particular, as a money-

<sup>9</sup> PFI: Persistence of a Flawed Idea, Guardian.co.uk, August 16, 2010

<sup>10</sup> *Public Service, Private Profits: The Political Economy Of Public-Private Partnerships In Canada*, John Loxley and Salim Loxley (Winnipeg: Fernwood, 2010).

saving ‘reform’ in health care delivery. And we must be especially careful that the current obsession of politicians with reducing short-term deficits does not lead us into ‘shell game’ arrangements which in fact impose a larger long-run burden on government, which is the usual outcome of these initiatives.

In sum, sustainable investment in public infrastructure is vital to provide immediate stimulus to the provincial economy while also enhancing future public sector productivity. Of paramount importance is ensuring accountability and transparency in debt financing while stabilizing public sector finances. The priority of government in the current environment clearly cannot be guaranteeing a rate of return for off-shore private investors, or subsidizing their higher borrowing costs, all in return for arrangements that reflect no significant risk transfer at all.

## 7. Long-Term Care (LTC) Homes Capital Renewal

The capital renewal program in the long-term care home sector illustrates another situation in which programs have out-lived their relevance and purpose. In 1999 the Ministry of Health adopted a policy for funding construction costs of long-term care facilities to provide per diem funding to assist operators in constructing or renovating facilities consistent with the recently adopted Facility Design Manual, 1998. The original long-term care expansion included 20,000 new LTC beds and

another 13,000 renovated beds by 2006 – the largest single expansion of health services in Ontario’s history.

The policy provided a per diem of up to \$10.35 per bed for up to 20 consecutive years to a maximum of \$75,000 per bed in additional funding to support construction loan payments by eligible operators. In the same period, an initial RFP for 6,700 LTC beds was announced with the majority being awarded to major corporate operators such as Extencicare, Leisureworld and Central Care Corporation (now Revera).

The \$10.35 per diem represented a public commitment of \$2.5 billion in capital funding to subsidize construction. For example, a 120 bed LTC facility could receive up to \$9 million in per diem capital funding. This initiative replaced prior capital grant funding for the non-profit municipal and charitable homes for the aged. The program thus constituted an unprecedented public subsidy for the for-profit nursing home sector, which increasingly was being dominated through acquisition by major corporate operators – often with assets held in the form of tax-avoiding real estate investment trusts (REIT).

Whereas the Ministry in 1995 retained a policy of registering a charge against an asset towards which any capital grant was made in order to recover capital grants upon the sale of an asset, no such approach was taken in respect of the \$10.35 per diem. Only in the event that a LTC facility closed did the \$10.35 per diem cease to flow to the operator or its successor.

### Leading LTC sector for-profit corporations in the province of Ontario<sup>11</sup>

Operator	LTC Beds	% of Total	LTC Homes	% of Total
Revera Inc.	7,162	26.5%	64	29.6%
Extencicare Canada Inc.	5,138	19.0%	35	16.2%
Leisureworld	4,314	16.0%	26	12.0%
Chartwell Seniors REIT	3,768	14.0%	28	13.0%
Sub-Total: Corporate Providers	20,382	75.6%	153	70.8%
<b>Total: Major Corporate Providers</b>	<b>26,977</b>	<b>100.0%</b>	<b>216</b>	<b>100.0%</b>

<sup>11</sup>Adapted from Leisureworld Senior Care Corporation Annual Information Form, March 14, 2011 at page 11.

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In consequence the last decade has witnessed unparalleled acquisition and corporate restructuring. Corporations such as Retirement Residence REIT and/or Central Care Corporation variously consolidated the nursing/retirement home market. Similarly, multinational investment fund Macquarie Power Income Fund acquired privately-held Leisureworld with 19 LTC facilities and 3,275 beds for \$528 million in 2005. Approximately 52% of the Leisureworld LTC portfolio consisted of “new” beds entitled to the \$10.35 per diem, which over the remaining 17-year term would provide \$109 million to the new owners.

In 2003, Chartwell Senior Housing REIT completed its IPO, raising \$241.5 million, and commenced operating 7 nursing homes with 813 beds. Only 4 years later, it spent more than that amount in an acquisition, acquiring 8 LTC facilities from Regency Care. With the acquisition, Chartwell also captured the \$10.35 per diem being paid for 1,341 beds (eligible to receive up to \$101.3 million in per diem capital funding) out of the total 1,384 beds acquired. Chartwell also acquired management contracts for 6 other homes for a purchase price of \$262.2 million. Chartwell also purchased Trilogy LTC Residence: a 197 bed home in Scarborough for \$27.7 million (eligible to receive up to \$14.9 million in per diem capital funding). Compare these purchases to the Chateau Gardens acquisition of 6 LTC homes and a retirement home, representing 574 beds for only \$39.1 million (as none of those homes were then eligible for the \$10.35 per diem). Clearly, investors are interested in ‘buying’ the government subsidy, as much as or more than they are interested in acquiring actual LTC beds.

In conjunction with the 2007 announcement of a further 35,000 LTC bed renewal strategy over the next 10 years, the Ministry has revised the per diem capital funding support initiative. The funding subsidy has increased to \$13.30 per diem for a longer term of 25 years (rather than 20), and is now capped at a total eligible expenditure of \$120,000 per bed (rather than \$75,000). We are not aware of any study or analysis that

assessed the merits and shortcomings of the earlier \$10.35 capital funding approach.

More recently, the policy has been revised and scaled based on the size of each LTC home measured by beds (<65; 65-99; and 100+), and the degree of LEED certification attained (Basic, Silver). The program now ranges from a low of \$13.30 for a home with 100+ beds achieving LEED Basic, up to \$15.80 for a small home with less than 65 beds achieving LEED Silver. As most homes require at least 100 beds for economies of scale, the predominant per diem rate would be the \$13.30 or an additional \$1.00 for the LEED Silver certification.

As a result, the public purse is now exposed to an additional \$45,000 per LTC bed in per diem construction costs, with a maximum \$120,000 per bed expenditure. The total amount includes eligible costs for actual construction; furniture and/or equipment; building permit, municipal development charges, architect fees and other eligible professional fees, and related net taxes, and the cost of any items declared eligible by the Minister (pro-rated against the actual eligible costs demonstrated).

The Construction Funding Per Diem is not the only operating funding subsidy being provided operators, even subsequent to acquisition by other corporations. The Ministry also continues to administer Non-Level of Care Funding or supplementary funding streams to qualifying licensees above and beyond the Level of Care Per Diem funding for resident care.

The Ministry also reimburses operators for a proportion (up to 85%) of real property and capital tax paid by privately owned LTC facilities, and subsidizes the payment of taxes incurred by eligible LTC licensees. The benefits of this subsidy simply flow to investors. Again, in a period of austerity the perversity of this approach is glaring. Why does Ontario subsidize multinational corporations (with cash flows measured in the billions in annual revenue) for their municipal property and capital taxes, in addition to more generally continuing to relieve corporations from capital or corporate income taxation?

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Another vehicle for delivering lucrative subsidies to the for-profit LTC sector has been the government's financial support for new information technologies. In tandem with the introduction and implementation of the Resident Assessment Instrument (RAI)-MDS 2.0 tool across the LTC sector, the Ministry provided corporations with further subsidies in one-time funding of \$250 per bed, with a minimum of \$10,000, for the cost of acquiring technology to implement RAI-MDS. Eligible expenditures included hardware and software purchases and administrative and IT support. The Ministry has also committed to annual sustainability funding of \$625 per bed for the first 80 beds; \$500 for the next 48 beds; and \$150 of any additional beds with a minimum of \$40,000. Large LTC homes with more than 256 beds receive a flat rate of \$364 per bed or some \$93,000.

Similarly, in 2008, the Ministry funded \$3 million in Personal Digital Assistants (PDA) to provide 1,390 such devices to nurses to provide point-of-care nursing in the health sector, including homes operated by major corporations such as Extendicare, Leisureworld, Diversicare and Jarlette. More recently, in 2010, the Ministry provided one-time funding of \$18 million to LTC operators for the purchase of eligible equipment (height-adjustable beds) with a minimum of \$15,000 disbursed per home.

The fact that clever financial firms are finding ways to profit from the restructuring of LTC businesses, raises a fundamental issue of accountability of those subsidized businesses to the state which assisted them in the first place. Specifically, why doesn't the policy on recovery of public investment in the event of a disposition or acquisition of a LTC home also apply to the capital funding per diem – just as it would apply to furnishing and equipment? The LTCH Policy regarding Furnishing and Equipment Management<sup>12</sup> stipulates the list and process by which a LTC licensee must provide goods, equipment, supplies and services:

### 3.1 Disposition of Furnishing and Equipment

#### 3.1.1 Conditions

Where the Province of Ontario has contributed to the original purchase price, the following conditions must be met when disposing of furniture and equipment purchased through the Nursing and Personal Care and Program and Support Services envelopes:

- All furnishing and equipment disposed of must be disposed of at fair market value<sup>2</sup>, if fair market value exists;
- The percent share of the Province of Ontario's contribution must be applied to the proceeds and credited to the funding envelope that reflects the disposed asset;
- The relevant amount should be recorded as an Expenditure Recovery in the Annual Report; and
- Where furnishing and equipment are disposed of as a trade-in to purchase similar or like assets, the fair market value should be recorded as the disposition amount.

At the time of the Macquarie acquisition of privately-held Leisureworld, the Leisureworld balance sheet recorded an asset as at December 31, 2003 of \$72.9 million, reflecting the value on an accrual basis of the \$10.35 capital funding per diem. In the same period, property and equipment stood at \$119 million on the balance sheet and interest expenses stood at \$7.5 million on the Statement of Operations. Little surprise that DBRS would indicate in a 2008 release<sup>13</sup> that Leisureworld's credit profile was sound, being "supported by the priority claim over government capital funding, which covers close to 60% of annual debt service".

These amounts pale in comparison to the market value of the assets of Leisureworld and its affiliates which as at January 1, 2010 were appraised by Deloitte & Touche LLP between \$517 and \$539 million in a fair market valuation. When the management-led buy-out occurred in 2010, Leisureworld used proceeds to pay

<sup>12</sup>"LTCH Furnishing and Equipment Management," Ministry of Health and Long Term Care, July 2010, [http://www.health.gov.on.ca/english/public/program/ltc/docs/furnishing\\_equipment\\_policy.pdf](http://www.health.gov.on.ca/english/public/program/ltc/docs/furnishing_equipment_policy.pdf).

<sup>13</sup>"DBRS confirms Leisureworld Senior Care LP at A (high)," Dominion Bond Rating Service, December 20, 2008

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expenses (including underwriting commissions of approximately \$15 million), while the Macquarie Income Fund received net proceeds from the sale of approximately \$55 million after holding the assets for just 5 years.

## **8. Hospital and University-Based Research & Development and Innovation**

It is unfortunately not widely known that our public hospitals constitute a “research powerhouse” in their own right, and contribute significantly and substantially to economic growth, innovation, and productivity in their own regard in Ontario. To support this contention, we examined a unique data set from Re\$earch Infosource Inc. measuring Canada’s top R&D spenders. This organization recently published a list of Canada’s top 40 research hospitals based on total research income.

Total research income for the top 40 Canadian hospitals was \$2.1 billion in fiscal 2010 – an increase of 7.2% over fiscal 2009. Drilling further into this data reveals that the top 15 research hospitals in Ontario (just 37% of the sample of 40 hospitals) gathered up \$1.2 billion, or almost 60% of the total research income received by top hospitals across Canada.

Public universities are another important site of R&D and innovation in Ontario. For example, the top 15 universities in Ontario combined for \$2.5 billion in research income, with the University of Toronto receiving 35% of that amount. A good portion of this university-based research also reflects work related to public service delivery (including health care, education, and others).

Together this amounts to some \$3.7 billion in spending on R&D by premier public institutions in Ontario (including just the top 30 universities and hospitals). It compares to a far more modest \$1.4 billion that the top 15 corporations in Canada in the pharmaceutical and/or biotechnology fields spent in the same period across Canada (not limited to Ontario), including the major brand pharma corporations. As one example, despite the

public image of prolific R&D spending, Merck spent just \$95.4 million in Canada on R&D in this period – less than each of the top 7 universities in Ontario and the top 5 hospitals in Ontario. Here, too, the economic leadership of public institutions (as compared to private corporations) is visible. Rather than seeing these institutions as a “drain” or “burden” on the public purse, and seeking ways to downsize or even privatize them, we should more properly see them as sources of economic opportunity and innovation. We should focus on harnessing more of the economic and fiscal potential of these institutions, rather than downsizing them. Among other benefits, that will help to address the underlying problem of economic stagnation (very slow growth and job-creation) that is the ultimate source of our fiscal constraints in the first place.

Another intriguing element in the Re\$earch Infosource Inc. data is their year-over-year comparison between fiscal year 2009 and 2010. Hospital R&D income grew for the top 15 Ontario hospitals by 6.4%, while the top 15 Ontario universities reported growth of 2.1%. In contrast, the top 15 corporations in pharma and biotech reported a drop in R&D expenditures on average of -2.5%. It appears that retrenchment in already-inadequate R&D spending occurred quite immediately in the private sector in response to deteriorating economic conditions. In contrast, spending on R&D continued to grow in public institutions, particularly in the life sciences in hospitals.

This is a very real illustration of the inherent counter-cyclical benefit of public spending. Not being driven immediately by the cyclical rhythms of the economy, public institutions can provide a strong R&D innovation infrastructure, to the benefit of both the public interest, and for subsequent commercialization by private interests. The evidence is clear that our public hospitals are not only a delivery system for essential medical and nursing care. They are also “research powerhouses” critical to our future prosperity in an innovation-driven economy. Their role strengthens the claim for a fiscal ‘dividend’ from the obvious public

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support provided these industrial sectors in Ontario.

According to the Council of Academic Hospitals of Ontario (CAHO)<sup>14</sup>, an alliance of 25 research-intensive hospitals, Ontario's research hospitals employed 70,000 persons (including 10,000 researchers). Studies indicate an annual return on investment in health research as high as 39%, not to mention other significant returns to our collective health and prosperity. CAHO estimates that the \$850 million spent at these 25 institutions represents 80% of all publicly-conducted health research in Ontario (hence implying that some \$1.1 billion was spent annually on publicly-conducted health research in Ontario).<sup>15</sup> The Ontario Government, according to CAHO data, is the source of only \$226 million in this funding, implying that provincial government funds are directly leveraged by a factor of 4-to-1.

The CAHO report suggests that the provincial government could strengthen the strategy and purpose of these disbursements, in order to enhance both research achievements and subsequent economic spin-off benefits.

## 9. "Innovation" in Health Care and the Misplaced Incentives of Private Health Care

Publicly-funded and publicly-conducted research is simply 'oxygen' to the life sciences industry: the pharmaceutical, medical and assistive devices and biotechnology firms that 'commercialize' the research depend fully on the initial public funding and support for this new knowledge.<sup>16</sup> Ontario's life sciences industry employs more than 40,000 people at 850 companies with revenues topping \$15 billion a year. Our province is home to global titans such as GlaxoSmithKline, Roche,

sanofi pasteur, Johnson & Johnson, GE Medical Systems and Genzyme. Other globally-successful firms such as MDS, Apotex, Biovail and Trudell Medial were born here, again thanks directly to public health research.

The KPMG Competitive Alternatives report consistently finds Canada to offer a lower-cost operating environment for life sciences companies than any other developed OECD country considered in the study.<sup>17</sup> That judgment was true even before recent fiscal enhancements to business, including the elimination of the capital tax on business in Ontario, reductions in the tax rate on corporate income, or the introduction of the value-added HST.

And we feed these life sciences corporations a steady diet of publicly-sponsored basic and allied research; a ready supply of university and college-trained graduates; and tax incentives including tax credits for R&D expenditures (that discount a gross spend of \$100 to only \$37 for start-up firms) that carry back for 3 years or forward for 20 years. And after stumbling upon a 'commercializable' intellectual property generated within these publicly-funded academic health sciences centres, any newly minted entrepreneur can also take advantage of Ontario Tax Exemption for Commercialization (OTEC) refunds for provincial income tax and corporate minimum tax for the first 10 taxation years.

The pharmaceutical industry is a prime example of the thesis that 'innovation' often works at cross-purpose to cost containment. The rate of growth of health care expenditures includes a substantial portion attributable to 'medical technology', defined as the drugs, devices and medical and surgical procedures used in medical care, as well as the broader organizational and support system.<sup>18</sup> The challenge for public policy in the years ahead is to

<sup>14</sup> *Building a Stronger Ontario Through Health Research: Ideas for the 2011 Ontario Election*, April 2011

<sup>15</sup> The CAHO data differs from the Re\$earch Infosource data noted above due to differences in methodology concerning categorization and measurement of R&D funding and expenditure.

<sup>16</sup> *Ontario's Life Sciences Commercialization Strategy: Bringing our Vision to Life*, April 2010.

<sup>17</sup> *Competitive Alternatives 2010* (Toronto: KPMG LLC Canada, 2010), pp. 24-25.

<sup>18</sup> R A Rettig, "Medical innovation duels cost containment," *Health Affairs*, 13, no. 3 (1994): 7-27

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manage the conflict inherent in achieving a goal of moderating the growth of health expenditures, while maintaining a world-class capacity for innovation. At issue is maintaining the rate of innovation, while re-directing it towards cost-reducing, quality-enhancing technological change in the provision of health care in the public interest.

One specific proposal we would offer that could serve to re-capture value from the commercialization of publicly supported R&D would be a ***medical devices levy***. Such a levy was recently included (despite a vociferous industry lobby) in the US Affordable Care Act signed into law in 2010. The amount is based on an excise tax initially set to raise \$40 billion (but reduced to \$20 billion) and set at 2.3% over a decade through a levy on the total revenues of US medical device companies starting in 2013. The idea is to recapture from the medical devices industry, which is characterized by monopoly or near-monopoly pricing practices (given the unique nature of most of the industry's output), a small share of excess revenues to help fund the public health services which are that industry's primary customer. Of course, the scope of such a levy has latitude and could be extended to the total revenues of much of the life sciences and medical technology industries operating and selling their products to Ontario's publicly-funded health sector.

The scope of such a levy would be scalable and directly proportionate to the desired yield. The levy would compel integration between Ontario's research and innovation agenda and its quest for sustainable health care; it could also be targeted to imported goods by the global medical industrial sector (including medical devices, diagnostic imaging, biopharmaceuticals and related fields). Thus the levy would recoup much needed funding for the continued purchase of the products made by these highly profitable firms.

The broader public social goal is to realize a 'wellness dividend' through increased focus and investment in the social determinants of health, as well as greater health awareness and promotion and expansion of evidence-based preventative health measures.

## 10. Scope of Practice and Health Human Resources

Within the context of public funding and public delivery systems in health care, we believe there are many exciting and productive opportunities to enhance the efficiency of service delivery in ways that both improve the quality and accessibility of patient care, and relax the funding constraint facing public services. As our review of the irrationality and waste of so many of the 'private market' solutions that have been proposed for health care and other sectors has convincingly indicated, the private sector is no panacea for funding pressures; to the contrary, private delivery tends to make matters worse. This does not mean that we should give up on prioritizing the search for efficiency and improved delivery within the public system. Instead, we can more effectively concentrate on delivering a better service at a lower cost, rather than wasting energy, attention, and money seeking a private sector solution that simply does not exist. To that end, we recommend the detailed research that has been conducted and published by health innovation experts such as Michael Rachliss.<sup>19</sup>

One promising area of cost-saving, service-enhancing innovation in delivery is the issue of reform in qualification categories and credentialization. For example, in Ontario, nursing is one profession with 2 categories: Registered Nurse (RN), including Nurse Practitioner (NP); and Registered Practical Nurse (RPN). The current entry-to-practice requirement for RNs consists of a 4-year bachelor's degree in Nursing study, whereas RPNs are required to complete a 3-year diploma in Practical Nursing study. Having two such

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<sup>19</sup>See, for example, "Public Health and Primary Health Care Collaboration," prepared for the Canada Health Agency (2010), which lists the efficiencies and fiscal savings available through closer integration of primary care delivery systems with public health planners, available at <http://www.michaelrachliss.com/pubs/Public%20Health%20and%20Primary%20Health%20Care%20English-Version.doc>, or "Public Solutions to Health Care Wait Lists" (Ottawa: Canadian Centre for Policy Alternatives, 2005).

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nursing categories with similar scopes of practice and capable of autonomous practice within the same profession has led to an overlap in roles and lack of clarity regarding role boundaries<sup>20</sup>, and not only between RNs and RPNs.

Significant progress has been made through the HealthForceOntario strategy in establishing innovative health care professional roles in areas of high need, and not only the Nurse Practitioner role. For example, consider RNs performing flexible sigmoidoscopy as independent practitioners or working as RNs Surgical First Assist in collaboration with the surgical team to achieve optimal patient outcomes. Nurse Practitioners (NP) are advanced practice Registered Nurses (RNs) with additional education, training and experience. They possess the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform procedures within their legislated scope of practice as was previously beyond the role of a RN.

In previous decades, an all-RN model of nursing care was promoted on medical-surgical units especially at academic health sciences centres, with RPNs largely relegated to serve as Operating Room (OR) Technicians; or not otherwise enabled and empowered to perform within and to the limit of their professional education and competency in all areas of care. In consequence, more expensive RNs were often the sole and exclusive category of nurse deployed in a labour-intensive context, where labour compensation constituted 60% of total hospital cost.

We acknowledge there is a continuing nursing shortage and in consequence continuing reliance on overtime and agency staffing to populate nurse work schedules. These practices are inappropriate and unsustainable. The excessive overtime worked by many RNs is simply not conducive to quality patient care, let alone to their own health and work-life balance. Overtime costs also obviously contribute to the overall fiscal cost of providing these services.

According to the Ontario Nurses Association website (<http://www.ona.org/faqs.html>), Canadian RNs work almost a quarter-million hours of overtime every week, the equivalent of 7,000 full-time jobs over a year. Further research suggests an almost perfect correlation between sick-time and overtime, and that overtime is highly predictive of increased lost-day injury claim rates among nurses. In effect, the province is gripped in a vicious downward spiral with a nursing shortage and inappropriate and outdated staffing mixes that ignore evolving scopes of practice, and drive costs ever-higher in the health system.

The means to achieve a more virtuous balance are available and much progress has been made in recent years in raising awareness as well as developing and piloting tools such as the RN/RPN Utilization Toolkit – a demonstration project in nursing human resource planning funded through the Nursing Secretariat of the Ministry of Health. This project sought to develop and evaluate a toolkit of instruments and processes to inform decision-making regarding nursing staff mix in adult acute care medical and surgical hospital units. Seven hospital organizations in southern Ontario participated in the project, and three of them subsequently relied on the tools and processes with local modifications.

Use of such evidence-based tools should be mandated in determining the most effective staff mix to ensure safe, quality, and cost-effective patient care. In view of the context of rising demand for health services, cost containment, and shortages of health care workers, all health providers need to continue to explore and refine nursing care delivery models supporting full utilization of skills for all categories of registered and non-registered healthcare personnel. The Commission should recommend health providers accept, implement and evaluate workforce systems utilizing full scope of practice with first priority to nursing, but thereafter among all staff, within a collegial, supportive and collaborative work environment.

<sup>20</sup> “Registered Practical Nurses: An Overview of Education and Practice, A Report to the Implementation Task Force,” Ontario Ministry of Health and Long-Term Care, Health Human Resources Services Number 12, Nursing Health Sciences Research Unit (NHSRU) March 2009.

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## 11. Conclusion

We thank the Commission in advance for their consideration of our opinions and suggestions. We reject the sense of “panic” which has characterized many discussions of Ontario’s fiscal outlook. Before the unemployment and stagnation that resulted from the financial crisis, Ontario’s budget was balanced, and our debt ratio was falling. We can return to that positive state, longer-run trends (such as the ageing population) notwithstanding, so long as we devise and implement strategies that put Ontarians back to work, generating incomes, and paying taxes. We cannot accept a situation of long-lasting stagnation and under-employment as given.

As for working to control the costs of existing public

services, and deliver more value for money to taxpayers and service-users, our review of several topics indicates strongly that the assumption that the “market does it better” is clearly unjustified. In case after case, the distorted incentives, lack of accountability, and inherent irrationality of private-sector procurement contributes to higher costs, not lower costs – from P3 projects which add utterly unnecessary financing costs to public infrastructure, to profit-maximizing innovation in pharmaceutical and medical device industries which take advantage of the public health system’s unthinking willingness to pay. There is plenty of scope, within the important framework of public service delivery, for genuine innovation aimed both at controlling costs and improving service delivery.

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