The Role of the Private Sector in Canadian Healthcare: Accountability, Strategic Alliances, and Governance

WHITE PAPER - WORKING DRAFT

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Canadian healthcare is very expensive compared to other developed countries. In 2014, total healthcare expenditures were forecast to be $214.9 billion, which is 10.9 percent of GDP, making it the seventh highest among OECD countries (CIHI 2014). In terms of per capita expenditures, based on 2011 data, Canada has the sixth costliest system, 36 percent higher than the OECD average (OECD 2013). Yet, system-wide, Canada's performance compared to OECD countries is relatively mediocre across a wide range of quality measures (CIHI 2014). Indeed, in a recent Commonwealth Fund comparative study of eleven developed countries (2014), Canada ranked second-to-last overall in measures of quality, access, effectiveness, efficiency, and healthiness, ahead only of the United States.

Despite the mismatch between cost and performance, Canadians generally approve of their healthcare system. Canadians favour their system because they believe it is "public," by which is meant that it is universal and has a single government insurance payer. What many do not realize is that 30 percent of the system's expenditures are private, not public. Still, approval is very high. Says Nanos: "There are very few, if any, pillars of Canadian public policy of which Canadians approve as strongly as the principle of universal health care, which has been with us since it was first adopted by the Pearson government in the 1960s" (2009). This view is sustained in a poll commissioned by the *Globe & Mail* in 2012, in which 94 percent of respondents called our universal system "an important source of collective pride."

What lies behind the desire for universality is social justice. The social principles upon which Canadian healthcare is based are grounded in a sense of fairness. These are the principles that are reflected in the Canada Health Act, which declares the primary objective of Canadian healthcare policy to be "to protect, promote and restore the physical and mental well-being of residents of Canada and facilitate reasonable access to health services without financial or other barriers" (Sec. 3). This has been likewise articulated in various national healthcare reviews. For example, in his 2002 report, *Building on Values: The Future of Health Care in Canada*, Romanow says, "Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity" (xvi).

In other words, what Canadians want is a healthcare system that meets certain crucial tests of social justice. The first criterion is financial security for patients and families. Universal government-funded and administered health insurance is seen to protect against financially ruinous hospital and physician costs, which are presumed to be a potential consequence of a private healthcare system. Second, universally available and government insured healthcare benefits need to meet the tests of both "fairness" in the form of universal "access" and "equity" in the availability to everyone of the same level of services. Both access and equity would allegedly be at risk in a private system in which the service model is connected with private profit. A third consideration is "democratic control" in order to meet the responsibility for policy formation and accountability for outputs. Healthcare is seen to be a fundamental good and as such should

be controlled, not by corporations and market forces, but by democratically elected governments.

What does this mean for the role of business in Canadian healthcare? Many proponents of a public system fear that if business plays a significant role in the system of healthcare this will be tantamount to a private sector intrusion into the delivery of a Canadian public good. It would be, as Canadians often say, "like the American system." As such, many people think it would stand in opposition to the principles of social justice.

In this white paper, I will argue that there is much room in Canadian healthcare for the private sector that does not impede the goals of social justice or fairness, namely access and equity. In fact, the reverse is likely true: the involvement of the private sector in the right places in the system can promote access and equity by adding financing, resource capacity, expertise, innovation, institutional learning, and reputation enhancement.

The focus of the discussion will be mainly on the third consideration above, i.e., democratic control of the healthcare system. I want to show that democratic policy making and system oversight are compatible with various forms of partnerships between the public and private sectors. The focus on the issue of system oversight and management is important because considerations one and two above, namely of personal financial security and system fairness (i.e., access and equity), fall within the purview of governments. So long as governments are not abdicating these responsibilities or ceding control of the healthcare system, they are not prevented by the private sector from living up to their responsibility to pursue the objectives of social justice. Instead, the private sector can be a valuable partner in meeting them.

In what follows, I will consider, first, the role that the private sector plays in Canadian healthcare today. Second, different forms of partnership that are applicable to healthcare will be outlined, and I will explain how they can relate to each other. Third, I will propose a collaborative governance model that could provide oversight of public private partnerships that respects and promotes the democratic obligations of governments to exercise oversight in the healthcare system. Fourth, a case will be made for considering strategic alliances as a key form of partnership between the public and private sectors.

THE ROLE OF THE PRIVATE SECTOR IN CANADIAN HEALTHCARE TODAY

Whether making a case to support or to oppose participation by the private sector in Canadian healthcare, it is important to understand what is meant by the attribution of "private," because in healthcare discussions there is ambiguity, both in the meaning of the word, and the circumstances in which it is used. First, consider how the Canadian system is funded. Public funding means coming from a government. For example, insurance coverage for payments to hospitals and physicians is provided by provincial/territorial governments, which in turn fund these payments from general tax revenues and (indirectly) from federal transfer payments. However, when we say that funding is private, such as payments made for prescription drugs, this can mean either funding by private sector corporations who provide insurance, or from the pockets of individuals. Opponents of private sector involvement in healthcare are more likely to be targeting corporations than private individuals, yet both are picked up by the word private.

Second, reference to the private sector can also be taken to be synonymous with "business," but there is also some ambiguity in this. Opponents of business participation in healthcare may be thinking of large corporations, such as multinational pharmaceutical or medical device manufacturers, but not a family-owned neighbourhood pharmacy or a biotech start-up. Both, however, are businesses – and businesses are part of the private sector, but different from individual patients and families who are also private payers for portions of their healthcare.

Third, when private is taken to be a proxy for business, the business being referred to may not pertain to funding but rather to a "business perspective." For instance, business schools teach undergraduate and MBA students the concepts, core principles, subject knowledge, and skills that not only generate competence in dealing with business problems but also a way of looking at problems – from a business perspective. Equally, someone who works in a business, whether in a multinational corporation, start-up venture, or small owner-operator company, is likely to develop a business perspective. This too can be what is meant by private, or by private sector.

Fourth, private sector can refer to "practices" that are commonly associated with what is found in businesses and what business schools research and teach. For example, the boards of directors of many of the large hospitals are structured and function in ways that are based on the theory and practice of corporate governance. Hospitals and other healthcare organizations have widely adopted, or adapted, these practices. Similarly, strategy processes such as the "balanced scorecard approach," which originated in business, are often used in hospitals and other healthcare institutions. Much the same can be said about financial systems, control and reporting, human resource theory, value creation processes such as the "lean" principles and techniques, and so on.

Taking all of this into account, when we talk about the private sector participating in healthcare, we have many possible ways in which that can occur. In the next section, I will be more specific about how much "participation" is in evidence in Canadian healthcare.

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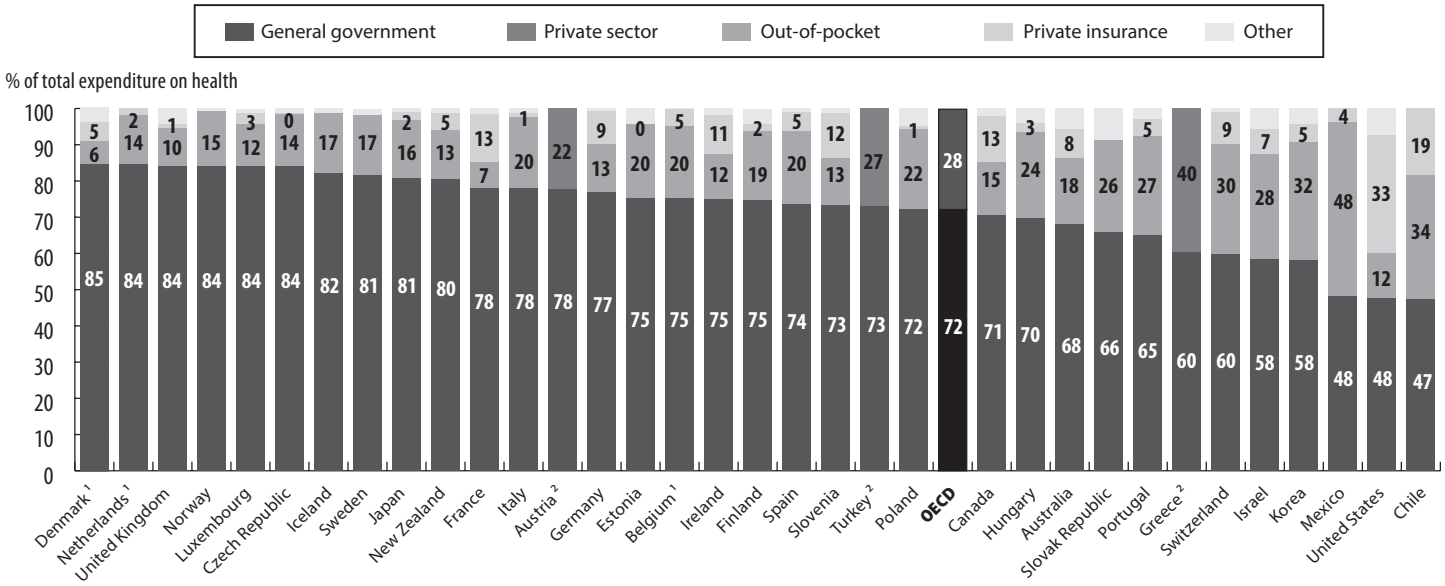
Funding of Healthcare

Think of private participation in healthcare in relation to how the healthcare system is funded. As indicated above, public sector expenditures are goods and services for which a government pays. As well as the operating costs of hospitals and patient visits to physicians, this includes the cost of government health ministries and the funding of capital expenditures in hospitals, clinics, and entities in the other parts of the system. The private sector financing applies mainly to expenditures attributable to private insurance companies and out-of-pocket payments by patients.

Government Funding

A public/private split exists in most countries. Using 2011 data, Table 1 shows the relationship between public and private spending across OECD member countries. Mexico, Chile, and the United States have larger private sector funding percentages than the remainder of the 34 countries. Canada's private sector participation is the 12th highest, slightly higher than the OECD average, and higher as well than 22 other countries.



1. Current expenditure.
2. No breakdown of private financing available for latest year.

Source: Adapted from OECD Health Data 2011

StatLink http://dx.doi.org/10.1787/888932526274

Table 1: Expenditures on health by type of financing, 2009 (or nearest year)

In absolute terms, Canada's private sector expenditures are $60.3 billion (CIHI 2014). By comparison with other developed countries, Canadian private expenditures are sizable. For instance, they are greater than the total public and private healthcare expenditures in both Sweden ($55.6 billion) and Austria ($49.3 billion) (using data from The World Bank 2014). So it is clear that the private sector is currently playing a significant role in Canadian healthcare in funding terms.

Apart from the relative size of the private sector, it is useful to consider the roles that the private sector plays in healthcare delivery in other OECD countries. Canadians often focus on the U.S. because of its size and proximity to Canada, but our comparators should be more broadly based. In the UK, for instance, specialists can practice simultaneously in both state funded and private clinics. The Swedish system is comprised of both public and private hospitals. And the French system is a hybrid.

Healthcare Institutions

Hospitals are Canada's primary institutional service providers. They account for 29.6 percent, or $63.5 billion, of all healthcare expenditures, of which about $2.4 billion is paid by private insurance and out of pocket by households. However, outside of the hospital, the private sector role has been growing either to provide new services or take over some hospital functions. There is private sector ownership of some specialized surgical hospitals (e.g., Shouldice Hospital), and a growing number of private clinics provide diagnostic imaging,

laser eye surgery, optometry, and so on. In other healthcare fields such as dentistry, psychological counselling, chiropractic medicine, naturopathic medicine, and pharmacy (external to the hospital), entities are owned and operated variously by individuals, small practitioner groups, or corporations. Ownership of pharmacies ranges from owner operators, to large corporations, to food chains (e.g., Loblaws), to box stores (e.g., Walmart). Clearly, institutional healthcare delivery is dominated in financial terms by public hospitals, but in the scope of healthcare entities, the private sector is broadly represented and likely increasing.

Product and Service Providers

Ranging from small entrepreneurial entities to large corporations, businesses research, create, design, and manufacture medical technology, devices, and pharmaceuticals. In addition, private sector contractors design, build, finance, maintain, and operate hospitals (see Appendix A); businesses provide services such as maintenance, janitorial, laundry, audit, legal, architectural, and purchasing; and consultants and lawyers provide advice, on everything from policy formation to risk management to organizational restructuring, to government policy makers, regional health authorities and hospital boards, and administrators.

Further, private clinics are increasingly providing diagnostic services such as MRIs. Optometrists/opticians, chiropractors, psychological counsellors, and other health service professionals provide services that lie outside of the Canadian health insurance system. Even physicians, physiotherapists, and pharmacists are for the most part in the private sector. For instance, of Canada's over 16,389 physiotherapists, 40.3 percent are in private professional practice (CIHI 2010). Also, of the 38,737 thousand pharmacists in Canada, 73 percent practice in the community or other non-hospital settings (National Association of Pharmacy Regulatory Authorities 2015). Within the domains of health policy, healthcare services, and healthcare institutional operations, the private sector is well represented. And of course, by private sector, we mean professionals who are practicing privately.

Business Perspectives

In hospitals, clinics, and community care centres, there is an important difference between the "care" of patients and the "operating" aspects of the entities. Consider the very considerable influence of business thinking that exists in the operational side of hospitals and other healthcare institutions. For instance, a hospital CEO's executive team includes not only the chiefs of medicine and nursing, but also the operational executive leads from finance, risk, human resources, information technology and systems, and strategy and communications. The subject knowledge of these operational areas comes directly or is derived from business disciplines (i.e., finance, accounting, organizational behaviour, MIS, and strategy). As well, the management processes employed in the hospital, such as strategic planning, balanced scorecards, lean processes, and so on, have their origins in business thinking and practice.

In addition, the executives, and many of their staff members, are often graduates of business schools or executive training programs, and many have private sector work experience. For example, both the vice president of finance and their reporting line staff may be graduates of commerce or business administration programs who have articled with a public accounting firm while completing the CPA designation. Those persons may have worked in the private industry before later moving into the healthcare sector. Similar cases would be found in MIS and human resources. Indeed, business schools anticipate the need for business-trained hospital and other healthcare leaders. To this end, there are MBA programs at Queen's University, the University of Toronto, York University, McGill University, Western University, and the University of British Columbia that have healthcare management specializations to prepare graduates for such positions.

Business perspectives are in evidence even beyond management. Boards of directors of hospitals (especially in Ontario's 151 hospitals) comprise both internal hospital members (ex officio and appointed) and external elected members. A significant number of the elected members are employed in the private sector, e.g., banks, consulting firms, manufacturing companies, and technology firms, and bring a business perspective to the governance of institutions. Table 2 shows the results of an analysis of external directors' business and academic/professional backgrounds in 17 of Ontario's academic hospitals. From a total of 256 external directors, 70 percent have business experience and 75 percent have either business experience or a business degree/professional designation. In 9 of the 17 hospitals, 80 percent or more of the directors have either business experience or a business degree/professional designation. Clearly, business thinking plays a significant role in hospital governance.

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Selected Academic Hospitals in Ontario (Hospitals with publicly available director bios)	Elected Directors	Ex-Officio/ Appt. Directors	Total Directors	Elected with Business Experience (%)	Elected with Business Degree/ Professional Designation (%)	Elected with Combined Business Experience *and* Business Degree/Prof. Designation	Elected with Business Experience *or* Business Degree/Prof. Designation
Hospital 1	17	6	23	15 (88)	8 (47)	7 (41)	15 (88)
Hospital 2	17	4	21	12 (71)	7 (41)	6 (35)	13 (76)
Hospital 3	16	6	22	8 (50)	5 (31)	4 (25)	9 (56)
Hospital 4	16	4	20	10 (63)	3 (19)	3 (19)	10 (63)
Hospital 5	12	5	17	8 (67)	5 (42)	4 (33)	9 (75)
Hospital 6	15	4	19	9 (60)	7 (47)	7 (47)	9 (60)
Hospital 7	18	6	24	17 (94)	9 (50)	9 (50)	17 (94)
Hospital 8	13	4	17	10 (77)	8 (62)	8 (62)	10 (83)
Hospital 9	11	6	17	3 (27)	4 (36)	3 (27)	4 (36)
Hospital 10	26	6	32	23 (88)	9 (35)	9 (35)	23 (88)
Hospital 11	12	5	17	9 (75)	4 (33)	5 (42)	10 (83)
Hospital 12	15	5	20	6 (40)	3 (20)	2 (13)	7 (47)
Hospital 13	15	3	18	9 (60)	7 (47)	4 (27)	12 (80)
Hospital 14	15	7	22	8 (53)	5 (33)	5 (33)	8 (53)
Hospital 15	7	11	18	7(100)	2 (29)	2 (29)	7 (100)
Hospital 16	15	8	23	13 (87)	5 (33)	5 (33)	13 (87)
Hospital 17	16	9	25	13 (81)	9 (56)	8 (50)	15 (94)
TOTALS	**256**	**99**	**355**	**180 (70)**	**100 (39)**	**91 (36)**	**191 (75)**

Table 2: Business Experience and Education of Elected Directors in Selected Ontario Academic Hospital

In addition, the board's processes, committee structures, self-assessment, and reporting frameworks are derived from private sector theory and practice. Equally, the governance of regional health structures like the Local Health Integration Networks (LHINs) in Ontario, as well as their fundraising foundations, share these private sector characteristics. So private sector thinking, processes, and experience pervade healthcare institutions.

It should be noted that there is controversy in the field of management education regarding the extent to which the emphasis in business schools on profit and competitive advantage develops in students a worldview based on self-interest and lack of appreciation for broader social goals. This may overstate the importance that students attach to finance and strategy courses, and give insufficient recognition to the perceived value of course work in organizational behaviour and corporate social responsibility. But certainly a corporate and commercial way of thinking does affect students, which does reasonably lead to the conclusion that business graduates are in general financially oriented, results focused, and taught to think in terms of rational decision-making frameworks. It is in this way that leaders in healthcare institutions come to adopt a business perspective.

This perspective should not be confused, however, with excessive attention to financial matters at the expense of patient health and safety. To do so would fly in the face of the principle of patient-centredness. Indeed, the restructuring of the NHS England in 2013 was strongly influenced by the results of a national investigative commission that linked unnecessary deaths and very poor patient safety in many hospitals to the over-concern of management and boards with budgetary matters at the expense of patients (Francis 2010).

While the patient care and operational aspects of healthcare institutions are "different," they are not "separate" from one another. Executives and their departments work together as a team in the enterprise of delivering healthcare to patients, families, and communities. Modern healthcare therefore blurs the dividing lines between public and private to deliver institutional healthcare.

Business Practices

Healthcare institutions today are strategic planners. The demands of accountability to governments, agencies, and the public require hospitals and other institutions to plan strategically. They must consider: (a) how they will function strategically in relation to the health system (e.g., LHIN) of which they are a part; (b) how they will be able to partner with community health and social services; (c) how to strategically focus and prioritize their medical services; (d) how to assess financial needs and sources of funding for operational and capital expenditures; (e) how to plan, prioritize, and fund research and teaching (for medical centres); (f) how to allocate health human resources; and address primary care (g) how to establish plans for information and management technology; and (h) how to establish management processes, such as lean operations.

In each of these categories of practice, the theories, core concepts, processes, and practices are derived at least in part from management theory, research, and practice. Of course the implementation is adapted to healthcare, but the conceptual origins are traceable to business.

At the provincial/territorial level, a similar connection to management can be seen. Of course, healthcare policy development is more traditionally the role of governments even if institutional application is business based. But even policy is influenced by business thinking when advisory commissions, councils, and consultations include private sector participants.

To conclude, private sector participation in Canadian healthcare can be thought of in terms of how the system and its components are funded, the infusion of business perspectives into the governance, management, and operations of the healthcare system, and the practices of managing and operating healthcare institutions that are derived or adapted from business. Looking at the delivery of Canadian healthcare today, it is not realistic to question whether business should be present in our "public" system. The question should be, where is the participation of business most likely to contribute to achieving the ideals and strategic objectives of our system?

In order to answer this, we need to understand the ways in which business and government are related to each other in Canadian healthcare. If the healthcare system requires democratic oversight in order to be in accord with social principles such as fairness, access, and equity, then we must understand why business should participate and how business and government relate to each other in ways that make this oversight possible.

Why Should the Private Sector Participate?

The benefits of private sector participation in healthcare should be assessed primarily on the basis of how well it promotes the interests of patients and their families. The overriding commitment should not be to the self-interests of professionals, organizational convenience of providers, pragmatic interests of politicians, or theoretical commitments of ideologues. It was said above that Canadians want healthcare to be guided by the principles of social justice, namely fairness to patients and families in the form of access and equity. So the justification for private sector participation should be assessed on the basis of its contribution to the efficient and effective performance of the system that generates healthcare outcomes to meet the social principles.

While this will be addressed more fully below, it is useful to introduce the key points here. Figure 1 summarizes a "framework" that shows what a collaborative relationship can yield in terms of benefits. The framework sets out two categories of contribution – resources and growth. Within those categories are six types of benefit. Working together toward the potential beneficial outcomes for the healthcare system are efficiency and effectiveness. In turn, these contribute to improved access and equity for patients.

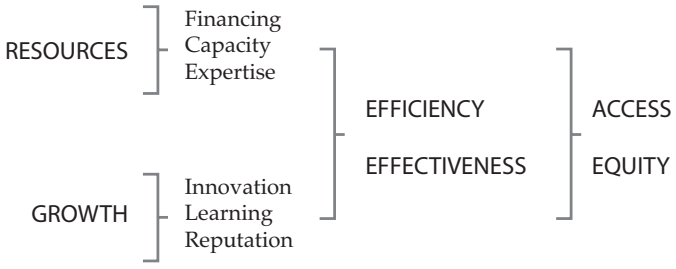

Figure 1: Public and Private Sector Collaboration Framework

The framework categorizes the benefits of public and private entities working together, first, in terms of the resource contributions that derive from private sector strengths, and second, in the growth opportunities for the entity that constitute the relationship between the public and private sector. In more detail, the benefits are as follows.

The first is "financing." The private sector partner may have access to financing for certain projects. If so, this not only adds financial resources to the project, but also it transfers financial risk from the government to the private sector partner. Collateral benefits to the government are both freeing up finances for spending on other programs and removing the need for borrowing. The latter is

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important because adding debt to government balance sheets can affect bond ratings, which in turn can have a negative impact on future borrowing costs.

Second is "capacity." Projects and other joint undertakings have non-financial resource requirements: human resources, technology, plant and equipment, business processes, and so on. Even limitations on time availability can be a capacity constraint. In some cases, a public sector partner may not possess the needed resources; even if they do have the resources, the government may need to deploy them elsewhere. Partnering with the private sector can offer a solution to capacity problems.

"Expertise" is the third enabler that a private partner may be able to contribute. This could be in the form of unique experience in executing tasks required for the project to be successful. Or it could involve proprietary technologies or business processes, which are valuable to the project, rare in terms of availability, and difficult to imitate, or for which there are few viable substitutes.

Fourth is "innovation." Invention and discovery of feasible solutions to problems through new products and services is a strength of the private sector, especially when capacity is combined with expertise. To say that private and public sector entities working together will necessarily innovate is an overstatement. Innovation occurs when the conditions are favourable. However, the potential for innovation should be a consideration when evaluating private sector participation if, based on the best available evidence, innovation has a better chance of occurring if the public and private sectors work together than if they do not.

Fifth is "institutional learning." In the process of working together, public and private sector individuals and institutions can learn much from each other. There is the human dimension of working together in which an individual learns the perspectives of the other as they develop a working rapport. Much was said about the business perspective above; for those whose careers have been in the public sector, the business orientation takes getting used to, and vice versa. In addition, new business processes can be learned – from the balanced scorecard approach to translating strategic objectives into measurable goals with targets, lean value enhancement processes, and so on. Finally, innovations and discoveries can be leveraged, extended, and transferred to other aspects of each partner's business (subject to contractual agreements).

Sixth, "reputational enhancement" is important to the ongoing work of both the public and private partners. For example, a research institute that, because of a private public alliance, has state of the art facilities and technology, combined with a reputation for leading edge research, makes recruitment of new high quality researchers much easier. As well, it improves the chances of success in applications for additional grants and other forms of research funding.

With these points in mind, we turn now to consider what forms participation between the private sector and public sector can take.

RELATIONSHIP BETWEEN PUBLIC AND PRIVATE SECTORS

In this section, I first explore three ways in which the public sector, mainly governments, can relate to the private sector: regulation, ownership/control, and partnerships. Second, I will set out a framework for assessing which forms of relationship are most suited to addressing healthcare issues.

Regulation

Public policy in healthcare is in the purview of governments. The implementation of policy is often delivered or implemented by sub-levels of government or the private sector. In either case, in advancing a policy aim, a government provides a regulatory framework within which the policies must be implemented. For instance, the Canadian government oversees the implementation of the Canada Health Act, and in doing so acts as a regulator for other governments (provincial and territorial) in terms of universal health insurance, and for private sector corporations with respect to pharmaceutical approvals. In turn, provinces and territories regulate medical device approvals.

Regulatory frameworks in healthcare function in much the same way as they do in other areas of public policy. They ensure oversight while recognizing that other entities are better positioned to deliver products and services.

Ownership and Control

Canadians are very familiar with crown corporations such as the Export Development Corporation and Canada Post Corporation. These are not-for-profit corporations, the shares of which are owned by the government, that compete with private sector counterparts. Agencies such as provincial securities commissions, gaming and lottery, and alcohol sales may have different legal structures (depending on the jurisdiction) in not having shares that are owned by the government.

A government may prefer to own rather than regulate in order to implement its policies directly. Sometimes governments change their minds about ownership and divest their corporations. The government of Canada divested itself of both Air Canada and Canadian National Railway. Similarly, the Ontario government announced recently that it intends to sell part of its ownership of Hydro One, its electricity transmission system. Alternatively, governments sometimes transfer

control of entities by means of long-term leases. The Canadian government did this in the 1990s when it leased major airports in Canadian cities to regional airport authorities.

Since governments still retain a public policy interest in many of their divested entities, they can continue their oversight by way of regulation as above. For example, the Ontario government constructed a toll highway (Hwy 407) as a means of achieving a public policy objective, namely relieving traffic congestion on another major highway (Hwy 401) in close proximity. Ontario subsequently sold the toll highway in 1999. Part of the sale involved a regulatory mechanism that tied future toll price increases to mandatory traffic volume targets. There were stiff financial penalties if the higher tolls resulted in reductions in the volume of traffic below a required threshold. As long as the toll road carried the required volume of traffic, it was deemed to be meeting the public policy objective of relieving traffic congestion on the other major highway. The regulatory structure was the government's tool for achieving this.

Regulation is an indirect way for governments to engage with the private sector. Except in cases where regulation is directly tied to a single company, the connection is usually impersonal because it is at an industry level. Ownership by contrast is more direct. But even here, the extent of direct involvement between owner and owned depends on the particular situation. A government can be more or less involved in the oversight and management of the entity it owns.

Assessing whether either regulation or ownership is a desirable form of relationship in promoting public policy or programs by using the private sector requires us to think of the particular situation under consideration in relation to the four tests above: finance, capacity, expertise, and innovation.

Let us compare regulation and ownership with another important form of business and government relationship, namely partnerships.

Types of Partnership

Contracting Out

At one end of the spectrum of partnerships is "contracting out" for goods and services. Governments enter into contracts with businesses to have them perform custodial and cleaning services in government buildings, highway snow removal, road construction, facilities maintenance, supply chain management for procurement, and so on. Hospitals contract out for laboratory services, linens, parking, legal and audit, and other services. The rationale for contracting out is often a matter of cost and expertise: it is less expensive to purchase the service, the service requires competency that does not exist in-house, there is insufficient capacity within the existing in-house resources, or the service required is not a core activity of the organization.

Characteristic of this form of partnership is that the relationship is: (a) established by the government partner; (b) contractually bound; (c) performance-based; (d) limited in scope by the terms of the contract; and (e) time limited. In sum, governments pay for a service to be performed. Once the service has met the completion test established by the contract, the relationship ends, at least until it is renewed or reconstituted by a further contract.

Public Private Partnership

A partnership is created when two or more parties undertake some form of project or activity toward which each makes a contribution to establish the partnership and continue its operation. Contributions can be financial, real property, plant and equipment, expertise, or indeed anything of value that contributes to the venture. Often one partner takes the lead in managing the partnership. A partnership is not a defined legal entity such as a corporation; rather it gains legal status by virtue of legal agreements that the partners enter into between themselves. For example, lawyers and accountants establish partnerships to practice law or accounting together by sharing premises, administration, and business development expenses. Also, mining companies, even competitors, sometimes create a partnership to develop a mine where the cost would otherwise be prohibitive for either partner on its own; rival technology companies will also establish a jointly owned company to develop a new technology or application.

Another common form of partnership of importance to the healthcare discussion is a "public private partnership" ("P3"). This is a joint venture among partners, which, as the name implies, involves a government, either directly through a ministry, agency, or controlled entity, and at least one private sector partner. Each contributes to the establishment of the partnership.

A P3 shares certain features with contracting out, namely that the relationship is government established and led, it is contractual in nature, and it typically has a finite life that is usually coincident with the completion of a project for which the partnership has been formed. What makes it different from contracting out is that the undertaking in which the partners are venturing together is more complex than a simple contract – in some cases because multiple contracts are combined to achieve different but connected objectives.

In Canadian healthcare, a common form of P3s can be observed in hospital infrastructure projects. In a new or redeveloped hospital project, the government (or ministry) engages a partner, or partners, to design, finance, build, operate, or maintain a hospital. The partnership often involves a combination of some or all of these functions. See Appendix A for a chart outlining some of the P3s used for Canadian healthcare projects.

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The rationale for P3s typically focuses on resources and expertise. The resource implications for governments are twofold. The first is financial. In contracting out, a government provides the funding to support the partner's performance of the contract. However, in a P3, the private sector partner often provides the financing for the partnership. Indeed, in all 84 healthcare projects listed in Appendix A, the private sector partner provides financing, in addition to design, build and other functions. This relieves the government of either or both income statement or balance sheet pressure, which is to say that the government is thereby not required to use its own operating or capital funds for the project and it does not need to add debt to its balance sheet through borrowing. The second implication is that governments may not have the resource capacity – e.g., workforce, equipment, technology – to take on a large construction or other project. Since the private sector partners are in business to perform these roles, it makes sense for their resources to be utilized by government.

Expertise is not always present within government, but it can be sourced from the private sector. Project design, construction, and management are the specific expertise of some companies, which can be leveraged by governments through industry partnerships.

What is key for a government in the determination of the viability of a P3 is to ascertain whether it, or potential private sector partner, has the greater expertise in the evaluation of the risks and benefits of a given project, and who is in the best position to manage those risks once identified. Matched with the question of expertise is the matter of resource capability and capacity. Granted, not all projects should be P3s. Each case needs to be evaluated on its own merits. However, where there is a stronger argument for partnering based on resource and expertise considerations, P3s should be seriously considered as an option.

As a further note, we must keep in mind that it is in the nature of "partners" in any undertaking to have aspirations, objectives, and motives that differ from each other. A partnership must accommodate these differences in a way that "corporations" do not. The latter can remove dissonances that inhibit the corporate purpose. They can fire recalcitrant executives, refuse to accept divisional strategies and plans that do not align with the corporate objectives, and harmonize the corporate culture to promote conformity of purpose and perspective. However, partnerships must accommodate differences. Successful partnerships achieve this accommodation whereas unsuccessful partnerships fail and dissolve.

In the realm of healthcare P3s, then, it is to be expected that the private sector partners will have commercial objectives and the government partners will want to achieve public policy ends. Successful P3s are those that accommodate both because doing so allows each partner to achieve outcomes that promote its own objectives, while together partners achieve outcomes that fulfill collective goals. In sum, partners learn to work together, rather than one subsuming the other.

Strategic Alliance

Strategic alliances are a form of joint venture partnership. Often the terminology of joint venture and strategic alliance is used interchangeably. However, strategic alliance as I use the term here refers to a partnership that is more open-ended than a project. Alliance partners have a purpose in going beyond existing projects (Carson 2015a). They come together in order to explore opportunities for the future that are in pursuit of broader strategic goals (Doz and Hamel 1998). The Canadian Partnership Against Cancer is an example of this. It is funded by the federal government to promote cancer control by bringing together cancer experts, charitable organizations, governments, cancer agencies, national health organizations, patients, survivors, and other groups, to implement a Canada-wide cancer control strategy. Its main functions span a continuum encompassing prevention through healthy communities and lifestyle, cancer screening, system performance and quality guidelines, treatment, and follow-up and survivorship (Canadian Partnership Against Cancer 2015).

A project can be a part of such a relationship, but the purpose of the alliance is to pursue business opportunities that go beyond a pre-defined project to include ventures that explore new processes, technologies, or products that may not yet have been identified. An illustration from the technology industry is an alliance that formed in the 1960s between Fuji and Xerox to compete against Canon and Ricoh in the paper copier market. That partnership later grew to include a new partnership that formed between Xerox and Rank Organization and many smaller companies. Collectively they were able to pursue new technological innovations, even though they individually had their separate corporate objectives (Gomez-Casseres 1996).

Some alliances are "pooling" in that they bring together organizations that have similar resources, for example a purchasing alliance that involves a group of hospitals and preferred device suppliers. A "trading" alliance brings together organizations with different resources. An example is the alliance formed in 2011 between General Electric's healthcare unit and M+W Group to produce biopharmaceuticals such as vaccines, insulin, and biosimilars for emerging nations. GE brought its technical expertise to the partnership, and M+W contributed its global engineering, construction, and project management (General Electric Company 2011). Indeed, the Premier healthcare alliance in the U.S. includes 2,300 hundred hospitals and $33 billion in purchases (Zajac et al. 2011).

Figure 2 compares in summary form the three main forms of partnership.

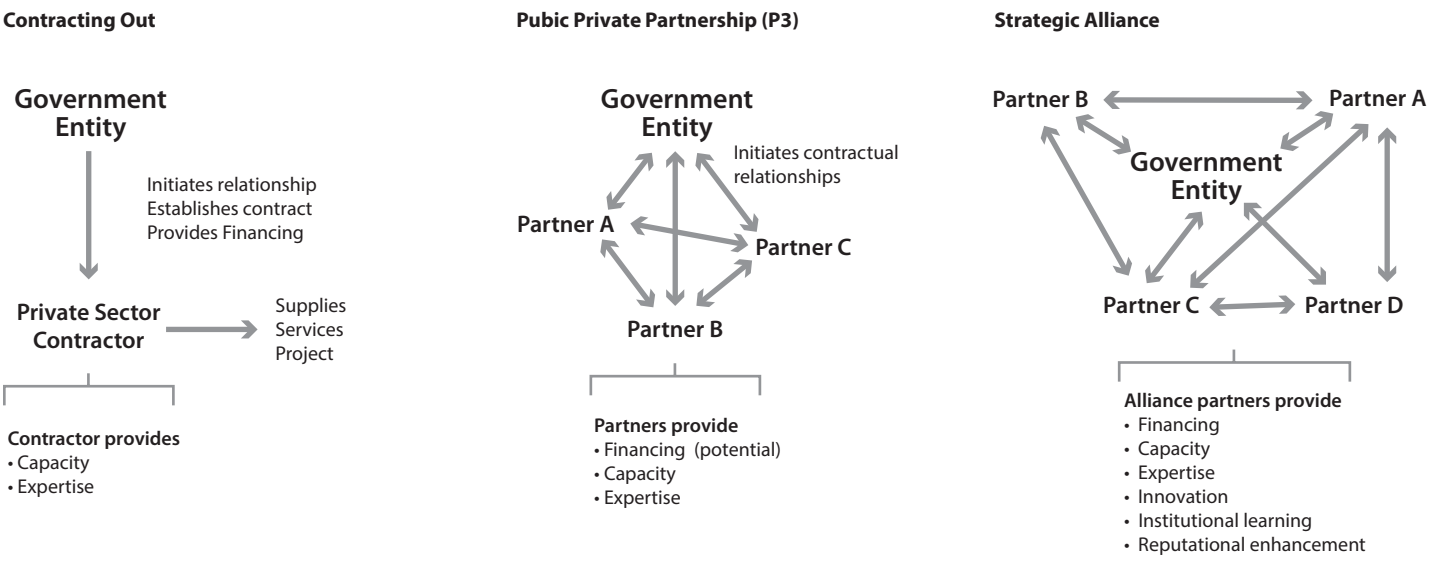

Figure 2: Partnership Form Comparison

The P3s model, which is common in healthcare, especially with respect to infrastructure development, tends to have many of the features of a strategic alliance. Yet the strategic alliance may hold a special promise for Canadian healthcare because it brings partners together around shared strategic priorities. Could governments in Canada feasibly pursue strategic alliances in healthcare with business? The opportunities that could be explored are considerable insofar as the private sector is able to contribute resources and expertise to the alliance. The public sector contributions would include public policy strategic objectives and alliance leadership. Let us consider this more fully.

Public Private Strategic Alliances

There are two important questions to answer: In what parts of the healthcare system would strategic alliances be most appropriate? How should strategic alliances be structured in order to ensure that governments retain their public policy and accountability roles and responsibilities?

There are many places where strategic alliances are appropriate in the healthcare system. For example, in the U.S., General Electric, Siemens, and Philips have developed strategic alliances with academic medical centres, hospital systems, and physician groups. In a Canadian example, a group of hospitals in south eastern Ontario have established a supply chain company to purchase and deliver medical supplies to achieve cost synergies. Further, a possibility exists for a cluster of hospitals to partner with a device manufacturer or technology company to leverage resources and to explore new clinical practice models. Finally, there are possibilities for strategic alliances in which the private sector provides financing and management expertise to build laboratories and the hospitals provide research programs and resources. None of these are radical or untried, but they are not as well developed or far-reaching as they could be.

In short, alliances can form between "suppliers" such as pharmaceutical and biotech firms for drug development and commercialization, or medical device and information technology firms for such things as remote monitors; "suppliers and providers" as in the case of hospital researchers and medical imaging firms; "clusters of providers" such as pharmacies and retail stores; "buyers and providers" such as a manufacturing company establishing on-sight clinics for employees; and "buyers and other buyers" such as a medical device manufacturer, which, as an employer, forms an alliance with a health insurance group (Zajac et al. 2011).

Alliances are not a panacea. Conditions many not conducive to success. The macro environment – political, economic, technological, and social conditions – needs to be supportive of the strategic objectives of the alliance. And the strategic priorities of the partners need to align or success will be difficult to achieve. Further, the alliance partners need to be able to establish a management and governance structure that enables them to work together collaboratively, i.e., that matches their specific behavioural characteristics. Finally, the behavioural complexion of the alliance needs to be compatible with working together. Some partners are better at working cooperatively than others. Indeed, there is a gradation in the degree of cooperativeness: fully cooperative to quasi-cooperative to indifferent to competitive to vengeful (Zajac et al. 2011). At some stage, cooperativeness can fade to the point where the alliance is untenable. Finding and maintaining a collaborative relationship

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is difficult but potentially valuable if it can be sustained. Still, even successful alliances have limitations to their life.

Of course, conflicts of interest and other problems can arise in strategic alliances. However, this does not provide an argument against alliances per se, but rather points to areas where management of the relationship requires attention. As the public and private sectors gain more knowledge of each other's perspectives through the infusion of business thinking in healthcare, and the expansion of private sector service delivery across the continuum of care, the ability to resolve issues and problems increases.

Strategic alliances are a powerful form of partnership, and they can help to promote social justice objectives. This does not mean that all projects and undertakings need to involve this or any other form of business and government partnerships. Rather, it is certain specific undertakings that should be considered, such as projects, strategic research and development, product research and development, service delivery innovations, system integration prototypes and experiments, and so on.

The challenge for a government in a strategic alliance relationship is that it is a "partner" in a strategic venture rather than being in "control" as in a P3. Even though a P3 does not always allow for the immediacy of control that exists in the contracting out relationship, there are, nevertheless, levers of control. These levers are less available in a strategic alliance – a partnership of equals. The question then is, how does government build into the relationship a control feature that allows it to exercise its democratic policy and accountability oversight?

The answer, I suggest in what follows, is at the governance level. I propose a bicameral governance structure in the context of a collaborative governance model.

BICAMERAL COLLABORATIVE GOVERNANCE

Collaborative governance is emerging as a powerful oversight model in multi-stakeholder undertakings, which involve a government and two or more non-government partners. The non-government partners may not include a private sector partner, but for present purposes these collaborations of interest will involve a private sector partner. In a collaborative governance entity the partnership is initiated by the government partner. The government's objective is to create a multiparty entity that will implement a policy or program. While the government is the originator of the collaborative entity, it may or may not be active in its operations. The new Ontario Health Links are an example of such an entity: the government seeks to achieve certain of its local healthcare integration policies through entities that link multiple health providers, such as hospitals, nursing homes, community social services, medical teams, and so on. The governance of such a collaborative entity is a body that is representative of the collaborators. Their relationship to each other may be contractual, but is more likely determined by informal agreements in reference to the government's policies, mandate assignments, and regulations. Typically, collaborative governance functions by discussion and consensus, rather than legal authorities and performance deliverables (Ansell and Gish 2008).

The collaborative governance model has broader application than entities such as Health Links. It could apply to strategic alliances that address major strategic challenges such as health system transformation, in which the collaborators could involve different private sector companies. If so, one of the weaknesses of the collaborative governance model should be easy to see. With such a reliance on discussion and consensus, collaborative governance is most compatible with entities that are closely aligned in terms of overarching objectives, purpose, and values. Corporations have commercial objectives such as growth, profitability, and enhancement of shareholder value. This does not always align with patient-centred and broader social goals. How then could a collaborative governance model effectively address conflicts and contrasting objectives? The answer is that in order for governments to be satisfied that they have a mechanism for asserting some form of control over the entity, something must be added to the governance model.

What is proposed is a bicameral governance structure, which contains a dual oversight component (Carson 2015b). First is the board of directors of the collaborative entity. Call this the Operating Board. The mandate of the Operating Board is to provide oversight of the management and operations of the collaborative. The role of management of the collaborative is to ensure the operation of the collaborative and the achievement of its objectives. The Operating Board oversees management to ensure that it is doing its job. To ensure that clarity exists between the Operating Board and management, there must be an "operating agreement." The day-to-day functioning of management within the terms of the agreement is the responsibility of the Operating Board.

In thinking of strategic alliances, the Operating Board would provide the control feature of management oversight. The ongoing operations of the alliance would be the responsibility of management. The Operating Board would provide the same governance role as any corporate board exercises with respect to management.

The second component of the bicameral structure is what we will call the Policy Council. This is a board comprising the government and private sector representatives, whose role is to ensure that the collaboration is continuing to serve the policy purpose for which it was formed. The Policy Council is the vehicle through which the government is able to ensure that its policy authority and accountability requirements are met. It is not the role of the Policy Council

to concern itself with day-to-day operations, or to intervene in the sphere of the Operating Board's responsibility.

The Canadian Blood Services provides an illustration of the bicameral structure. As an operating entity the corporation and its management are overseen by a board of directors. The board's responsibility is to ensure that management is acting in the best interests of the corporation in accordance with its mandate. In our terminology this is the Operating Board. But the Canadian Blood Services has a second component to its governance structure. The corporation's activities are funded by the provinces (except Quebec), so each province has an interest in ensuring that its objectives are being met overall. The Canadian Blood Services version of what we would call the Policy Council is the entity that reviews the corporation from this overarching point of view. There is a council that is comprised of government officials who review the broad functioning of the corporation in relation to its purpose for being. This is not its operational role. In this way the corporation's bicameral governance structure provides two types of oversight (Sher 2015).

It is important to distinguish between a "bicameral model" and what we might call a "two-level model" in which one board provides oversight to the other. The upper level board is thereby more senior than the lower level board. This is different than in a bicameral structure where the boards have different purposes and roles.

It must be recognized though that the Policy Council has a more senior level standing than the Operating Board, for the Policy Council has the power to end the relationship between the government and its alliance partners. But its senior position does not imply a duty of oversight or a duplication of its role in supervising the senior management of the organization.

Figure 3 summarizes the structural difference between a two-tier governance model and a bicameral model.

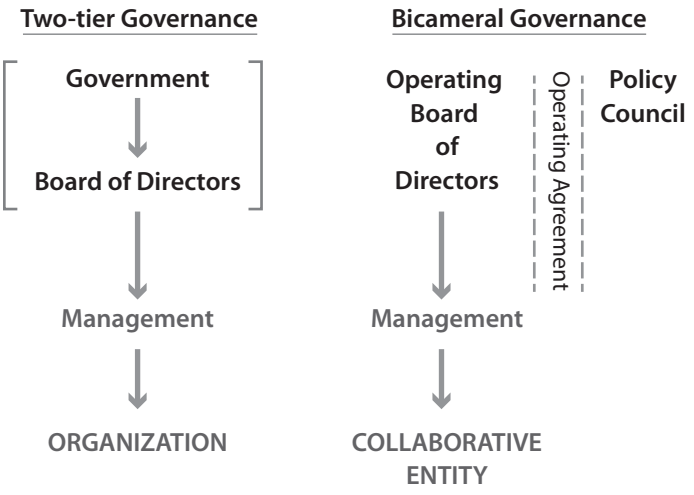

Figure 3: Two-tier and Bicameral Governance

STRATEGIC ALLIANCES IN CANADA

What is being proposed herein is a non-politicized approach to advancing Canadian healthcare in spheres that can best benefit by organizations and individuals from both public and private sectors working together in collaboration. This is not the place to outline in detail where specific opportunities might lie. However, the six-point framework outlined above (i.e., financial, capacity, expertise, innovation, institutional learning, and reputational enhancement) is a useful evaluative tool, both for assessing the viability of an alliance candidate and for seeking out and prioritizing new opportunities.

In these challenging times of resource constraint, many public sector healthcare institutions focus on the first three components of the framework, namely financial, capacity, and expertise, as a way of bolstering what might be absent or in short supply. As an illustration, the Council of Academic Hospitals of Ontario (CAHO) expresses a deep concern about funding for the research enterprise in its 2013–14 Annual Report. Referring to its own study of funding pressures it says:

> These findings by the CAHO community provide the basis for an informed discussion with investment partners in government, industry and the philanthropic community. CAHO will continue to work to develop a model for sustainable, long-term investment in health research…

In this statement, CAHO is recognizing the importance of public private collaboration, but the focus is placed on resource constraint. This is not a criticism of CAHO because this was the purpose of their study. Still, it draws attention to the importance of looking for strategic opportunities beyond the financial aspects.

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The opportunities in Canadian healthcare are numerous and varied. Many involve connecting entrepreneurs or corporations who have developed a new technology with providers and patients. For instance, the Ontario Telemedicine Network is a world leader in telemedicine that links technology, specialists, primary care professionals, and patients. As an example of the available services, a patient in a remote location can send a photograph of a mole on her arm to a dermatologist who then responds with a diagnosis in days, rather than the patient waiting weeks or months for an in-person consultation. Or, a patient wearing a remote monitoring device can be monitored by a practitioner who interprets the data for early intervention at the local level, rather than in the emergency room of a hospital. Alliances such as these achieve not just cost savings, capacity, and expertise, but also innovation, new learning, and reputational enhancement.

Some alliances form because the partners conceive of an innovative solution to a problem coming from an application of an existing technology. In other cases, the alliance partners begin with a problem and together design an original solution that itself can give rise to future applications. Both alliances bring value that goes beyond other forms of partnership with respect to innovation. The latter, though, has the potential to generate more learning and reputation than the former. When thinking of the continuum of partnerships discussed above in relation to Canadian healthcare, all are valuable, but the strategic alliance has the most to offer.

As a summary of partnership structures, Table 3 sets out the considerations for selecting the most appropriate form of partnership for the objectives to be met.

Forms	Contracts	Public Private Partnerships	Strategic Alliances
Roles	• *Services:* Maintenance, professional (accounting, audit, IT) • *Supplies:* Hospital medical, technical, devices, equipment	*Projects:* Hospital, clinical, and other infrastructure design, build, finance, operate, maintain. *Services:* Pooling of resources to achieve shared objectives.	• *Strategic system change processes* • *Research and development* • *Strategic technology transformation:* At either system or institutional levels: strategy, planning, management
Relationship	• Government strategy, management • Government funded	• Government as policy and strategic lead • Private sector responsible for management and execution of project • Funding government or private sector	• Government and private sector as co-leads • Private sector responsible for management and execution of venture • Funding government or private sector
Value Contributions	• Cost saving • Resource efficiency • Expertise availability	• Revenue generation/financing availability, risk reduction • Cost saving • Capacity expansion • Expertise	• Revenue generation, cost saving, risk transfer • Capacity expansion • Expertise • Innovation • Institutional learning • Reputation enhancement
Risk to Democratic Accountability	*Minimal* Government establishes contract details. Service and supply providers tender.	*Medium* Governments are partners. Contracts often contain flexibility for private sector. Potential to extend outside government control.	*High* Governments are equal partners in the venture. Dispute mechanism and exit arrangements are essential for both parties.
Control Feature	Legal contractual control	Partnership influence, legal remedies, cancellation of partnership	BICAMERAL COLLABORATIVE GOVERNANCE

Table 3: Partnership Summary

Choosing the most appropriate form of partnership should be based on a clear understanding of the risks and benefits to be derived. Contracting out for services or supplies is a government-driven relationship that can result in cost savings, capacity enhancement, expertise availability, and reduction of risk by transferring it to a contractor. Alternatively, P3s enable government-led partnerships to provide opportunities of revenue generation or alternative financing availability, resource capacity expansion, expertise availability for each of the partners, and risk reduction or sharing. Further, the strategic alliance provides virtually all of the benefits of a P3, but it adds something very important, namely the capacity of the partners to innovate – to explore new opportunities for research, and system or technology transformation – to learn and grow, and to develop an enhanced reputation for excellence that leads to further opportunities.

CONCLUSION

In the Canadian healthcare system, the public and private sectors have been coming increasingly together in recent years. The private sector is participating ever more broadly as the role of healthcare providers expands outside of hospitals and across the continuum of care. As well, the influence of business theory and practice is found throughout the governance and management of institutional delivery of care. This convergence of purpose and thinking presents valuable opportunities for partnerships and alliances.

Public private partnerships have the potential to contribute much to the development of infrastructure and other capacity in the Canadian healthcare systems. But in pushing the boundaries of partnership structures, strategic alliances have the capability to bring in further resources and expertise to achieve certain public policy objectives. They represent a special type of partnership in which both the government and the private sector partners can have an alignment of strategic objectives and pursue their objectives more successfully by working together rather than apart.

A strategic alliance shares many of the features of a public private partnership, but the essential difference is in the coming together of strategic priorities between the government and the corporation. A public private partnership may be a very effective way of achieving an overall public policy goal, but this is often achieved despite the fact that the private sector party's goals are more commercial than public policy related. Strategic alliances are different than public private partnerships precisely because they represent an opportunity for business and government to come together in a joint undertaking where both have strategic objectives that do in fact align. It is this alignment that creates the exceptionally strong capability of the partners working together – both want substantially the same things because each has found a way to integrate its individual goals with those of the alliance.

However, strategic partners still have their differences. The private sector has commercial goals that it cannot ignore. This leaves government vulnerable to being unable to achieve one of its most important goals, namely responsibility and accountability. The bicameral governance structure provides a mechanism for drawing together both the public and private sector partners in a way that enables both to achieve common strategic objectives while ensuring they meet their obligations to their stakeholders.

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Appendix A: Public Private Partnerships in the Healthcare Sector Across Canada

#	Project Title	Province/Territory	Current Stage	Model
1	Abbotsford Regional Hospital & Cancer Centre	British Columbia	Operational	Design-Build-Finance-Maintain-Operate
2	BC Cancer Agency Centre for the North	British Columbia	Operational	Design-Build-Finance-Maintain
3	BC Children's and BC Women's Redevelopment Project	British Columbia	Under Construction	Design-Build-Finance-Maintain
4	Bluewater Health Sarnia	Ontario	Operational	Build-Finance
5	Brampton Civic Hospital	Ontario	Operational	Design-Build-Finance-Operate
6	Bridgepoint Health	Ontario	Operational	Design-Build-Finance-Maintain
7	Cambridge Memorial Hospital Capital Redevelopment	Ontario	Under Construction	Build-Finance
8	Casey House Facility Replacement Project	Ontario	Under Construction	Build-Finance
9	Centracare Psychiatric Care Facility	New Brunswick	Operational	Design-Build-Finance-Maintain
10	Centre for Addiction and Mental Health Phase 1C Redevelopment Project	Ontario	RFQ	Design-Build-Finance-Maintain
11	Centre for Addiction and Mental Health (CAMH)	Ontario	Operational	Design-Build-Finance-Maintain
12	CHU Sainte-Justine	Quebec	Under Construction	Design-Build-Finance
13	Credit Valley Hospital Phase II Redevelopment	Ontario	Operational	Build-Finance
14	Credit Valley Hospital Priority Areas Redevelopment Phase III	Ontario	Under Construction	Build-Finance
15	Devonshire Care Centre	Alberta	Operational	Design-Build-Finance-Operate
16	Erinoak Kids Centre for Treatment and Development	Ontario	Financial Close	Design-Build-Finance
17	Fort St. John Hospital & Residential Care Project	British Columbia	Operational	Design-Build-Finance-Maintain
18	Gordon & Leslie Diamond Health Care Centre	British Columbia	Operational	Design-Build-Finance-Maintain
19	Halton Healthcare Services (Oakville Hospital)	Ontario	Under Construction	Design-Build-Finance-Maintain
20	Hamilton Health Sciences (Hamilton General Hospital)	Ontario	Operational	Build-Finance
21	Hamilton Health Sciences (Juravinski Hospital and Cancer Centre)	Ontario	Operational	Build-Finance
22	Hamilton Health Sciences McMaster Children's Hospital	Ontario	Under Construction	Design-Build-Finance
23	Haut-Richelieu-Rouville (Montérégie) Long-Term Care Centre (CHSLD)	Quebec	Under Construction	Design-Build-Finance-Maintain-Operate
24	Haute-Yamaska (Montérégie) Long-Term Care Centre (CHSLD)	Quebec	Under Construction	Design-Build-Finance-Maintain-Operate
25	Hawkesbury and District General Hospital Redevelopment	Ontario	Under Construction	Build-Finance
26	Humber River Regional Hospital	Ontario	Under Construction	Design-Build-Finance-Maintain
27	Interior Heart and Surgical Centre Project	British Columbia	Under Construction	Design-Build-Finance-Maintain
28	Jardins-Roussillon (Montérégie) Long-Term Care Centre (CHSLD)	Quebec	Operational	Design-Build-Finance-Maintain-Operate
29	Jim Pattison Outpatient Care and Surgery Centre	British Columbia	Operational	Design-Build-Finance-Maintain
30	Joseph Brant Memorial Hospital Redevelopment Phase 1	Ontario	Financial Close	Design-Build-Finance
31	Kelowna and Vernon Hospitals Project	British Columbia	Operational	Design-Build-Finance-Maintain
32	Kingston General Hospital & Cancer Centre of Southeastern Ontario	Ontario	Operational	Build-Finance
33	Lakeridge Health	Ontario	Operational	Build-Finance
34	Laval Long-Term Care Centre (CHSLD)	Quebec	Operational	Design-Build-Finance-Maintain-Operate
35	London Health Sciences Centre (M2P2)	Ontario	Operational	Build-Finance
36	London Health Sciences Centre (M2P3)	Ontario	Under Construction	Build-Finance
37	MacKenzie Vaughan Hospital	Ontario	Shortlist	Design-Build-Finance-Maintain
38	Markham Stouffville Hospital	Ontario	Operational	Build-Finance
39	McGill University Health Centre (MUHC) Glen Campus	Quebec	Construction Complete	Design-Build-Finance-Maintain
40	Milton District Hospital Redevelopment	Ontario	Financial Close	Design-Build-Finance-Maintain
41	Montfort Hospital	Ontario	Operational	Build-Finance
42	Montreal University Hospital Center (CHUM)	Quebec	Under Construction	Design-Build-Finance-Maintain
43	Montreal University Hospital Research Centre (CRCHUM)	Quebec	Operational	Design-Build-Finance-Maintain
44	Niagara Health System (St. Catharines Hospital)	Ontario	Operational	Design-Build-Finance-Maintain
45	North Bay Regional Health Centre	Ontario	Operational	Build-Finance-Maintain
46	North Island Hospitals Project	British Columbia	Under Construction	Design-Build-Finance-Maintain

#	Project Title	Province/Territory	Current Stage	Model
47	Ottawa Paramedic Service Headquarters	Ontario	Operational	Design-Build-Finance-Maintain
48	Ottawa Regional Cancer Centre (Ottawa Hospital)	Ontario	Operational	Build-Finance
49	Ottawa Regional Cancer Centre (Queensway Carleton Hospital)	Ontario	Operational	Build-Finance
50	Peel Memorial Centre for Integrated Health and Wellness	Ontario	Under Construction	Design-Build-Finance-Maintain
51	Penticton Regional Hospital Patient Care Tower	British Columbia	RFP	Design-Build-Finance-Maintain
52	Phase 1 Patient Tower Project at Etobicoke General Hospital	Ontario	Shortlist	Design-Build-Finance-Maintain
53	Providence Care Hospital	Ontario	Under Construction	Design-Build-Finance-Maintain
54	Public Health Laboratory at MaRS Center Phase 2	Ontario	Under Construction	Build-Finance
55	Quinte Health Care Belleville Site	Ontario	Operational	Build-Finance
56	Restigouche Hospital Centre	New Brunswick	Under Construction	Design-Build-Finance-Maintain
57	Rouge Valley Health System (Ajax-Pickering Hospital)	Ontario	Operational	Build-Finance
58	Royal Jubilee Hospital Patient Care Centre	British Columbia	Operational	Design-Build-Finance-Maintain
59	Royal Ottawa Mental Health Centre	Ontario	Operational	Design-Build-Finance-Maintain-Operate
60	Royal Victoria Hospital (Barrie)	Ontario	Operational	Build-Finance
61	Runnymede Healthcare Centre	Ontario	Operational	Build-Finance
62	Saint-Lambert Long-Term Care Facility (CHSLD)	Quebec	Operational	Design-Build-Finance-Maintain-Operate
63	Saskatchewan Hospital North Battleford - Integrated Correctional Facility	Saskatchewan	RFP	Design-Build-Finance-Maintain
64	Sault Area Hospital	Ontario	Operational	Build-Finance-Maintain
65	St. Joseph's Health Care London (M2P1)	Ontario	Operational	Build-Finance
66	St. Joseph's Health Care London (M2P2)	Ontario	Operational	Build-Finance
67	St. Joseph's Health Care London (M2P3)	Ontario	Under Construction	Build-Finance
68	St. Joseph's Healthcare Hamilton - West 5th Campus	Ontario	Operational	Design-Build-Finance-Maintain
69	St. Joseph's Regional Mental Health Care (London and St. Thomas)	Ontario	Under Construction	Design-Build-Finance-Maintain
70	St. Michael's Hospital Redevelopment Project	Ontario	Financial Close	Design-Build-Finance
71	St. Thomas Elgin General Hospital	Ontario	Shortlist	Build-Finance
72	Stanton Territorial Hospital Renewal Project	Northwest Territories	Shortlist	Design-Build-Finance-Maintain
73	Sudbury Regional Hospital	Ontario	Operational	Build-Finance
74	Sunnybrook Health Sciences Centre	Ontario	Operational	Build-Finance
75	Surrey Memorial Hospital Redevelopment and Expansion: Emergency Department and Critical Care Tower	British Columbia	Operational	Design-Build-Finance-Maintain
76	Swift Current Long Term Care Centre Project	Saskatchewan	Under Construction	Design-Build-Finance-Maintain
77	Toronto Rehabilitation Institute (University Centre site)	Ontario	Operational	Build-Finance
78	Trillium Health Centre	Ontario	Operational	Build-Finance
79	University of Ottawa Heart Institute: Cardiac Life Support Services Redevelopment Project	Ontario	Under Construction	Build-Finance
80	VIHA Residential Care & Assisted Living Capacity Initiative	British Columbia	Operational	Design-Build-Finance-Operate
81	Waypoint Centre for Mental Health Care	Ontario	Operational	Design-Build-Finance-Maintain
82	Windsor Regional Hospital (Western Site)	Ontario	Operational	Build-Finance
83	Women's College Hospital	Ontario	Under Construction	Design-Build-Finance-Maintain
84	Woodstock General Hospital	Ontario	Operational	Build-Finance-Maintain

Source: The Canadian Council for Public and Private Partnerships (Canadian PPP Project Database, 2015), http://projects.pppcouncil.ca/ccppp/src/public/search-project?pageid=3d067bedfe2f4677470dd6ccf64d05ed.

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