Privatization Watch

Analyzing privatization developments since 1976

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Privatization Watch

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Privatization Briefs

Not Sweden!?

Sweden has long been known for its extensive social welfare programs, but now it's developing a reputation of a different sort—health care privatization. Sweden, or more specifically Stockholm, began experimenting with private sector participation in health services during the early 1990s when waiting lists for care grew longer and longer.

In 1991 the County Council pushed for market-based reforms that transformed Stockholm's health services into a laboratory of privatization experimentation. The County Council introduced competition and private sector participation in hospitals, home care, ambulance services, and other areas of health care.

Lab and X-ray services costs dropped by nearly 50 percent, waiting times for examination and treatment fell 30 percent in one year, and competitive procurement lightened costs by about 10 percent for ambulance service and 40 percent for medical laboratories. After St. Goran's public hospital was leased to a private provider in 1999, costs dropped by 30 percent and the hospital was able to serve 100,000 more patients per year. Local leaders even turned to the privatized hospital for performance benchmarks, which were then used to exert competitive pressure on other public hospitals.

...Not Just Sweden

Australia has also moved toward hospital privatization. State and federal governments have introduced private participation in more than 50 public hospitals, and Mildura hospital has emerged as an impressive success story. The government selected a private operator to design, build, own, and operate a new hospital under a 15-year contract. The contract specifies that the private operator must provide service to all. The contract also includes provisions for third-party performance monitoring and penalties for noncompliance.

The results were encouraging. The new hospital cost 20 percent less to build compared to the public sector. Patient volumes increased, all performance targets have been met, and the provider even made a profit.

The trend toward health care privatization has spread to other unlikely corners, such as Germany and Great Britain, where the National Health Service has turned to the private sector to build and operate new surgery centers.

What are we lashing back at again?

The backlash against private sector offshoring has actually stymied the growth of government sector outsourcing. So says a new report by the market research firm INPUT. In 2004, IT outsourcing by state and local governments barely topped 2003's mark.

The report notes:

Confusion between "outsourcing" and "offshore outsourcing" fueled fierce political debate among the candidates campaigning during this election year.... Although the elections are over and the economy continues to improve, these political debates are expected to have a lasting effect on market growth over the next one to two years.

However, outsourcing is expected to speed up in the long term. "Retiring government employees, as well as archaic government legacy systems, are undeniable factors in the state outsourcing market," said James Krouse, manager of state and local market analysis at INPUT. "The increasing demand for outsourcing in the coming years will be borne out of necessity which politics will be unable to refute."

Convention Center Follies

Can publicly financed convention centers turn any old place in America into a "world class" city? Heywood Sanders is skeptical. The frequent debunker of the case for publicly financed big boxes has just completed a new Brookings Institution report that finds:

- The overall convention marketplace is declining in a manner that suggests that a recovery or turnaround is unlikely to yield much increased business for any given community, contrary to repeated industry projections. This decline began prior to the disruptions of 9-11 and is exacerbated by advances in communications technology. Currently, overall attendance at the 200 largest tradeshow events languishes at 1993 levels.
- Nonetheless, localities, sometimes with state assistance, have continued a type of "arms race" with competing cities to host these events, investing massive amounts of capital in new convention center construction and expansion of existing facilities. Over the past decade alone, public capital spending on convention centers has doubled to $2.4 billion annually, increasing convention space by over 50 percent since 1990. Nationwide, 44 new or expanded convention centers are now in planning or construction.
- Faced with increased competition, many cities spend more money on additional convention amenities, like publicly financed hotels to serve as convention "headquarters." Another competitive response has been to offer deep discounts to tradeshow groups. Despite dedicated taxes to pay off the public bonds issued to build convention centers, many—including Washington, D.C and St. Louis—operate at a loss.

The report is available online: brookings.edu/metro/pubs/20050117_conventioncenters.htm

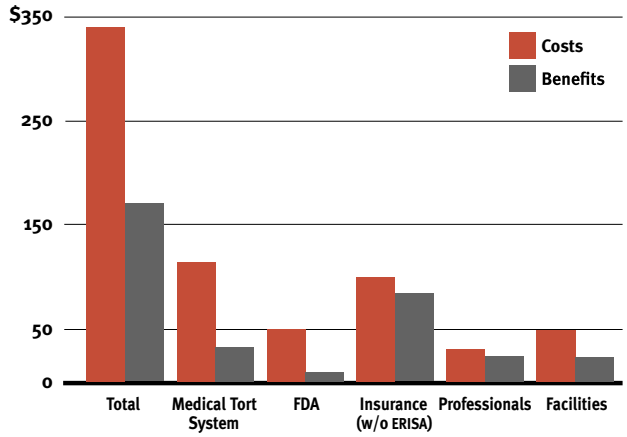
Unhealthy Regulations

Many Americans see government regulation as the only way to ensure high-quality health care and broad access to medical services. It's easy to forget that an excessive regulatory burden can also cost lives by pricing people out of the health care market. According to a recent Cato Institute study by Christopher J. Conover of Duke University, health regulations in the United States neglect that vital injunction: "First, do no harm."

In every area Conover analyzed, he found the costs of regulation outweighed—sometimes dramatically—the benefits, amounting to a net "hidden tax" of some $169 billion annually. But the cost isn't measured only in dollars. Those added costs, Conover estimates, lead to some 22,000 deaths annually, more than the 18,000 attributed to lack of health insurance.

The report is available online: catoinstitute.com/pubs/pas/pa-527es.html ■

Health Regulation Costs and Benefits 2002 (in billions of dollars)



Source: Christopher J. Conover, "Health Care Regulation: A $169 Billion Hidden Tax," Cato Institute Policy Analysis No. 527, October 4, 2004

Private Prisoner Care in Michigan

By Michael D. LaFaive

The state of Michigan has substantial prison-related privatization experience. It has privatized operation of the Lake County-based juvenile correction facility in a contract with GEO Group. Since 1997, it has also competitively contracted for medical services in the remainder of Michigan's correctional system. Indeed, the state's extension of that contract through 2007 suggests that competitive contracting has proved to be a valuable management tool—one that could be employed in all aspects of the prison system.

Michigan's contract for prison medical services is with St. Louis-based Correctional Medical Services Inc. CMS provides medical services to 225,000 local jail inmates and to state and federal prisoners in 27 states. The Michigan Department of Corrections estimates the contract's projected cost over its first six (of 10) years at $347 million.

The state originally hired another vendor in 1997 to provide many of the services now provided by CMS. Early in this contract, however, the state became concerned about the vendor's ability to provide the performance quality it had promised. After some negotiation, the contract was reassigned to CMS in March 1998. In April 2004 the state extended the CMS contract three years, through April 2007.

According to Rich Russell, administrator of the Bureau of Health Care Services for the Michigan Department of Corrections, Michigan has enjoyed both qualitative successes and financial savings as a result of its relationship with CMS and the firm's elaborate system for demonstrating accountability. "We have had a good, cooperative relationship with CMS, and together we look for ways to save money without lowering the quality of care," said Russell.

For instance, CMS has worked with the state to implement an electronic medical record-keeping system, which will be operational soon. Both parties hope that the system will improve efficiency and the flow of information about inmates' medical histories. CMS has also increased staffing levels by adding more physicians and physicians' assistants, and it has helped the state maintain its accreditation with the Joint Commission on Accreditation of Healthcare Organizations, a private, nonprofit outfit that ensures that health facilities maintain acceptable standards of care.

While CMS provides the prison system's medical services, a state chief medical officer and four regional medical officers are the system's gatekeepers, and they determine the level of treatment CMS and its subcontractors should provide to prison patients. If CMS does not think a certain treatment is necessary for an inmate, but the state's regional medical officer does, the dispute is resolved by submitting it to a committee that includes representatives from both the state and CMS.

A summer 2004 telephone survey of state corrections departments by the Mackinac Center for Public Policy found that 32 states contract with private firms for some degree of health services for their prisoners, and that another state, South Carolina, is in the process of doing so. Some states have contracted for health services across their entire prison system, while others target a single prison. Still other states split health delivery contracts by service: One vendor provides physical health services, for instance, while another provides mental health services. Texas has contracts with University of Texas Medical Branch and Texas Tech Health Science Center, both public entities. Contracting solutions are as diverse as the states themselves.

Private firms are trusted with some of the state's most important prison services.

One company, America Service Group Inc. of Tennessee, estimates that the national health market for prison and jail inmates is $7 billion annually. With health care costs and the number of prisoners expected to increase, the country may see more inmate health care privatization by states and counties.

State governments nationwide are trusting some of their most important and expensive prison spending to private firms, and there are bolder steps for Michigan to consider. The Mackinac Center for Public Policy has recommended that the state examine the privatization of its entire system—that is, outsourcing management of its corrections department to a for-profit firm. In 1998, Tennessee almost did so, and savings were then estimated at 22 percent. Similar reductions in Michigan would shave nearly $350 million from the state's general fund appropriation for state prisons, which, given the state's chronic structural deficits, would certainly be a welcome development.

Michael D. LaFaive is Director of Fiscal Policy for the Mackinac Center for Public Policy. This article appeared in Michigan Privatization Report*: mackinac.org/pubs/mpr/* ■

Politics vs. Patient Care: Why public hospitals are turning private

By Francois Melese

The impact of private ownership on performance is neatly illustrated in a retrospective study of 92 expeditions made to the Arctic over the period 1818 to 1909. Most major discoveries were made by privately funded expeditions. Most tragedies (lost ships and lives) occurred on publicly funded expeditions. Why? It turns out that incentives matter.

Private expeditions more clearly aligned the rewards for discoveries. This resulted in systematic differences in the way public and private expeditions were organized. The same is true of most government-funded enterprises.

Take hospitals. Public and private hospitals are organized very differently, and for good reason. One must satisfy a community of stakeholders, the other a community of shareholders. In the former case, a conflicting mix of social, political, and business objectives results in weak incentives to control costs.

Incentives Matter

Public hospitals are expensive, but unfortunately, high cost doesn't buy better care. Instead the cost burden comes from inefficient accounting, restrictive personnel and procurement regulations, a tangled web of bureaucracy, and general lack of accountability.

Consider the case of Natividad, a public hospital owned and operated by Monterey County in California. Most private hospitals don't actually employ physicians. They act as workstations where doctors perform services. After surgery, the surgeon and anesthesiologist each bill the patient, and the hospital bills for services it provides. So doctors that use private hospitals have an incentive to keep track of their patients. Natividad's doctors don't. They're staff. They get a salary regardless of whether or not procedures are recorded. Predictably this contributes to a dismal recording system filled with gaps (unreported procedures and uncollected co-payments), incorrect coding (one out of four bills contains an error), and lack of follow-through (missed billing deadlines).

The best-run hospitals typically collect payments within 50 to 60 days. Natividad's average is around 70 days and has been as high as 133 days.

See HOSPITALS on Page 8

Politics vs. Patient Care in Los Angeles

The *Los Angeles Times* recently completed a five-part series, "The Troubles at King/Drew," which analyzes the county's long-troubled Martin Luther King Jr./Drew Medical Center. The series covers the severity of the hospital's recurring medical lapses, its managerial shortcomings and the political conditions that have thwarted effective reform.

Part 1:
Deep Trouble: A hospital inspired by the civil rights movement fails—sometimes kills—those it was meant to serve.

Part 2
The Myth of Poverty: King/Drew isn't underfunded. It's mismanaged.

Part 3
Unheeded Warnings: How one pathologist got hired and remained on staff despite misdiagnoses and legal woes.

Part 4
Broad Failure: Beyond individual workers' shortcomings, whole departments are in disarray.

Part 5
Timidity at the Top: The county board of supervisors shies away from reform, paralyzed by community protest and racial politics.

Epilogue
Overhaul Urged: The county board must give up its control of King/Drew, experts say. Some also suggest closing for a time to regroup.

Available online: latimes.com/news/local/kingdrew/la-me-kdday1dec05,0,5281026.story

Who's Afraid of Specialty Hospitals?

Commentary by Sean Parnell

Something very odd is happening in the hospital industry. A relatively new kind of hospital, called the specialty hospital, is emerging that seems to be more efficient and produces better health outcomes than existing general hospitals. But instead of welcoming this innovation, policymakers are trying to ban it.

Specialty hospitals are typically smaller than traditional general hospitals and focus on a few specific areas of care such as orthopaedic surgery or heart care. They typically offer a higher level of care than general hospitals because specialization allows them to be more effective and efficient. Specialty hospitals typically have more nurses per patient, lower infection rates, less bureaucracy, and lower costs.

But specialty hospitals are not universally welcomed in the industry. Their competitors—the bigger, more established general hospitals—claim specialty hospitals are "stealing" patients and revenue from them.

In most industries, companies facing competition are expected to improve their service, lower their costs, or go out of business. Instead, general hospitals lobbied Congress to include in the recently passed Medicare reform bill an 18-month ban on the construction of new specialty hospitals. They are now lobbying to make the ban permanent.

One of their arguments is that doctors with an ownership interest in a specialty hospital will send patients there, instead of to a general hospital, in order to generate profits. Two recent studies by the federal government disprove this charge, however, pointing out that most doctors have little or no economic incentive to steer patients to one hospital over another.

To the extent physicians do refer their patients to specialty hospitals, health care experts suggest they do so because they feel better about the quality of care that can be delivered in a facility that specializes in a particular area of care and avoids the bureaucracy that engulfs many general hospitals.

The industry association for general hospitals has also claimed, in a letter to Congress attacking their competitors, that specialty hospitals violate the ethical guidelines of the American Medical Association (AMA). This drew a stinging rebuke from the AMA, which told Congress the general hospitals had distorted its position and that specialty hospitals were fully consistent with its guidelines.

General hospitals also charge their rivals have an unfair

advantage because they don't offer a full range of services, such as mental health or emergency care. But this is not the point of specialization. By not trying to be all things to all people, specialty hospitals can deliver a higher quality of care at lower costs.

It is true that private insurers and government agencies reimburse some procedures at less than they cost to perform, and that specialty hospitals tend to focus on procedures that are not money-losers. Yet the answer to this problem isn't to force specialty hospitals to lose money, too. Instead, general hospitals could stop accepting payments that are below the cost of care—if a general hospital loses money for every privately insured patient it sees in the maternity ward, isn't the real answer for them to stop signing contracts that pay them less than it costs to deliver babies?

In virtually every other sector of the U.S. economy, competition has led to higher quality, lower costs, and innovative services and products. Consumers lose when elected officials give in to the demands of special interests seeking protection from competition. Congress should side with patients and not make the ban on specialty hospitals permanent.

Sean Parnell is Vice President for External Affairs at The Heartland Institute in Chicago. He is the author of a recent three-part series on specialty surgical hospitals in Health Care News. *The series is available here: heartland.org/Article.cfm?artId=16135.* ■

Trade or Aid?
What's the best way to help the world's poor?

Interview By Ted Balaker

The world may never really know how many hundreds of thousands of lives the Asian tsunami claimed. The tragedy spurred a massive relief effort, and it also renewed old debates about how to help the world's poor.

A recent UN report suggested that rich nations should double the amount they currently give to developing nations. The report noted that while the tsunami received great attention, other larger, less publicized tragedies persist. Take for example the scourge of malaria, which the lead author of the UN report calls the "silent tsunami." Each year roughly three million people die of malaria, and most of the dead are African children. Would more aid improve conditions in Africa?

James Shikwati worries that more aid would actually undermine Africa's pursuit of progress. Shikwati is the director of Kenya's Inter-region Economic Network and coordinator of the Africa Resource Bank. He has observed how different approaches to helping Africa's poor have yielded different results. He argues that trade, not aid, is what Africans need more of.

Recently, *PW*'s Ted Balaker interviewed James Shikwati (left).

Do you think wealthy nations should give more aid to poor nations?

Wealthy nations should not give more aid to poor nations without taking an audit of the previous aid initiatives. A lot of what wealthy nations call aid has tended to benefit the wealthy nations in the form of tied aid at the expense of poor nations.

Has foreign aid improved conditions in Africa?

Foreign aid has politicized life in Africa making conditions even worse. Jostling for what politicians call the 'national cake' is a common phenomenon. Instead of Africans solving their own problems, they leave everything to the donors.

Poor nations need to surface their own entrepreneurs in order to solve their problems. Poor nations need to urgently take ownership of the problems afflicting them—what wealthy nations do is take over issues that affect poor nations, leading them to be complacent. Aid is doing more harm to the poor nations in the long run; it encourages corruption both local and international, it kills the private sector, promotes a politically driven private sector, and increases dependency.

What has improved conditions?

Open information flow, open travel, open trade is slowly opening the eyes of Africans to the benefits in a competitive world. Investors' attraction is another aspect that has helped streamline institutions in Africa. Governments are quickly learning that to get local and international investors a good business environment is needed. This is slowly putting Africans on the path of productivity.

What should rich nations do to help the world's poor?

Rich nations, if they want to genuinely assist poor nations, must leave the poor nations alone. They must open up for trade, open up for travel—that is, lift their extreme visa requirements because travel will expose Africans to more productive culture in the rich nations. Former colonial governments must lift their undue influence on their previous African colonies that has hampered efforts to create an African regional market leading to intra-Africa travel restrictions, too. An African regional market will serve as a springboard to enabling Africans to fit competitively in the global market. The rich nations should not interfere with private investors who might choose to invest in Africa; they should not interfere with private initiatives to develop Africa.

The UN reports that so many African children die of malaria because they don't have bed nets to keep mosquitoes out. What should be done about this?

African children and adults alike are perishing because of malaria, however because of aid-driven policies, Africans have been forced to use bed nets even when the evidence indicates that they are failing. This is the best illustration of how donors arm-twist poor nations in order to achieve their own ends.

Wealthy countries should know that poor countries do have solutions to their own problems but they have been suffocated with aid. They need freedom from aid in order to trade.

Foreign aid can come from other governments or from private donations. Do you see any difference in the effectiveness of government aid versus private aid?

Government-to-government aid is the worst culprit in the aid fiasco. It's difficult to monitor what governments do with the aid. In poor nations, it helps subsidize poor policies, encourages corruption and political cronyism, and simply makes leaders lose focus. Private donors have incentives to see it work because it is their own money. It is common knowledge that nobody spends somebody else's money as carefully as he spends his own. ■

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HOSPITALS

While incentive problems conspire to shrink revenues, Natividad is also afflicted with inflated costs. Personnel rules such as fixed salary schedules make it difficult to recruit and retain hard-to-fill positions. So the hospital turns to overtime and temps that cost up to three times as much. Revealing the dismal state of the hospital's cost accounting system, the last CEO complained, "We didn't know how many positions we had." Besides obvious potential for fraud and abuse, sluggishness in adopting new computerized accounting reflects a weakness that partly stems from a tangled bureaucracy. Bureaucracy and red tape slow decisions and inflate costs.

Politics vs. Patient Care

The many stakeholders in public hospitals have a conflicting mix of social, political, and business objectives. It is often unclear who is in charge: the CEO, board of supervisors, trustees, employee unions, doctors, patients, inspectors, or taxpayers. Ideally, the elected county board of supervisors outlines broad health care policy, and approves major expenses and the yearly budget. Together with oversight from appointed trustees, the hospital CEO drafts a budget, and approves expenses and plans that follow the supervisors' guidelines. In reality, unresolved issues of authority and accountability complicate the budget process, interfere with construction and procurement decisions, and slow innovation. A University of Arizona study notes that elected boards are likely to micromanage operations to satisfy political objectives that create inefficiencies and might not always coincide with taking care of the poor.

For instance, in 1993 construction began to replace Natividad's main building at an estimated cost of $75 million. Five years later the project was finally completed, and costs had mushroomed over 50 percent to $116 million. Cost overruns translated into hiring freezes and slowed innovation, restricting investments in new medical equipment and, ironically, in computerized accounting systems.

Faced with shrinking revenues and inflated costs, public hospitals squeeze funding for other programs. This leads to calls for higher taxes, reinforced by threats of cuts in health services. In the case of Natividad, a recent tax measure (Proposition Q) was voted down. Limited in their ability to raise taxes, county governments like Monterey are forced to decide whether they can continue owning and operating a hospital.

Fewer Public Hospitals

- Public Hospitals in 1980: 1,800
- Public Hospitals in 2000: 1,200

Out of 574 hospital conversions studied between 1987 and 1999:

- Government-to–private/nonprofit was the most common kind of conversion (189 hospitals).
- Another 130 hospitals went from nonprofit to for-profit.

Sources: *Governing Magazine*, Urban Institute

The Evolution of Health Care

Although the public hospital has been a fixture of American life for decades, urbanization and ongoing revolutions in health care delivery challenge conventional wisdom that a public hospital is the best way for government to deliver health services. Yet bad news for public hospitals can be good news for patients.

New technologies and drugs have radically reduced the number and length of hospital stays. The result, according to a study by the Urban Institute, was a 14 percent drop in total hospitals in the United States from 1979 to 1998. Over that same period almost one-third of public hospitals were either converted or closed. In California, no new public hospital districts were formed between 1978 and 1998.

Hospital districts were first conceived in the aftermath of WWII when Congress saw a need for rural public hospitals, but rapid urbanization, telemedicine, remote monitoring, and the Internet are revolutionizing rural health markets, and attracting competition from private clinics and hospitals.

A recent study reminds us of the benefits of competition. It turns out that for-profit hospitals have important spillover benefits for medical productivity. They exert a "peer effect" when their not-for-profit counterparts mimic their behavior. Where there are for-profit hospitals, those areas have lower levels of hospital expenditures, but virtually the same patient health care outcomes. [This effect has been noted in other areas, as well. See, for example, "Indirect Competition Reduces Prison Costs," *PW* November 2003: rppi.org/nov03pw.pdf]

The economic argument for government ownership and control usually rests on some perceived market failure. In the case of public hospitals, it is mostly the fear that the poor and under-insured will fall through the cracks. In California,

Privatization Options: Benefits and Obstacles

Options	Benefits	Obstacles
Sell the hospital	■ Increase indigent care ■ Increase primary care ■ Pay off public bonds ■ Reduce hospital liability costs ■ Reduce local tax rate	■ Union opposition ■ Possible community opposition ■ Perceived loss of direct control ■ Perceived reduction in prestige for public officials
Lease the hospital	■ Reduced community opposition ■ Upfront capital infusion ■ More control retained	■ Some union opposition ■ Reduced amount of capital
Form a joint venture	All benefits apply	May require special state legislation
Contract out	Creates competition among providers to serve the uninsured	Union opposition
Outsource non-core functions	Relatively simple to implement	Retains slow government decision structure

counties have a statutory obligation to address the needs of the indigent under Welfare and Institutions Code Section 17000: First and foremost, public hospitals were meant as a safety net for "all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident…[and] not supported…by their relatives or friends [or] by their own means, or by…private institutions."

Modernizing the Safety Net

We can modernize safety nets. Benevolent citizens have learned the hard way that running a hospital is a tough business and more public hospitals are turning private.

Municipalities are refocusing on meeting the needs of the disadvantaged, rather than the business of running a hospital. In California the rush to the exits is reflected in the fact that less than 15 percent of the state's hospitals are public while 85 percent are private. In seven counties, MediCal obligations are now being carried out by a sort of county-operated HMO. For example, in Orange County, Cal Optima contracts with a panel of health care providers—hospitals, pharmacies, physicians, and clinics—who agree to offer discounted services to MediCal enrollees.

Around the country municipalities have demonstrated they can serve indigents more efficiently and effectively by selling their hospital assets. Communities get a cash payment that can be used to retire debt and establish a trust fund for community health care. Since 1994, over 100 charities have emerged from hospital sales.

The county hospital in the Conroe area of Texas was constantly asking for tax increases to serve an ever-growing indigent population. Eventually, the burden grew too heavy and officials decided to focus on meeting the needs of the indigent, not on the business of operating a hospital. After a competitive bidding process, the hospital was sold, and after retiring public bond debt, officials used the residual "profit" to establish a nonprofit foundation to meet ongoing community health needs. Here privatization raised cash, reduced debt, and created a better system for serving indigents. Yet Conroe's approach represents only one of the many privatization options available to policymakers (see above Table).

Privatization can bring the best of both worlds: lower taxes and better services. The time has come for local governments to become selective purchasers of health care for the poorest and sickest among us, and to get out of the business of running hospitals.

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Texas Lands $7.2 Billion Private Toll-Road Investment

By Robert W. Poole, Jr.

In 2001, when Gov. Rick Perry set forth his vision for several thousand miles of brand new infrastructure for Texas, many people were skeptical that any of it would ever come to pass. The plan called for carving out 1200-ft. wide corridors north-south and east-west, avoiding existing metro areas, with space for highways, truck lanes, pipelines, freight and passenger rail, and perhaps electric and telecom utility lines.

People weren't laughing in December, however, when Texas DOT announced the winner of a competition to build the first portion of the first corridor. A team led by Spanish toll road developer/operator Cintra pledged to invest $7.2 billion to build 316 miles of four-lane toll road generally parallel to I-35. Dubbed TTC-35, the overall corridor will run from the Mexican border to the Oklahoma border.

The Cintra team (which includes U.S.-based Zachry Construction and Earth Tech) was selected by the Texas Transportation Commission over two other bidders, in a "best value" competition. Cintra's proposal won because it was judged to maximize private investment, minimize the use of public funds, and accelerate delivery of the roadway. In addition to committing to the $6 billion construction of the new toll road, Cintra will pay a total of $1.2 billion in concession fees to the state, in exchange for the 50-year franchise during which it will operate and maintain the road, collecting tolls to recover its investment. Texas plans to use the $1.2 billion to extend the corridor northwards from Dallas to Oklahoma and southward from San Antonio to the Rio Grande border with Mexico.

Cintra's development plan envisions the initial four lanes as general-purpose toll lanes for cars and trucks. As traffic grows, the roadway will be expanded, ultimately to four truck-only lanes and six car lanes.

The 50-year franchise for the TTC-35 project is the longest such term yet granted for a new toll project in the United States, though such long terms are not uncommon for very large projects overseas. Cintra is part-owner of the 99-year franchise for the Toronto 407ETR toll road, for example.

The TTC-35 bid suggests is that the long-term design/finance/build/own/operate model may be more relevant to the United States than many observers had thought. To the extent that the U.S. highway system is starved for capital, policymakers should pay attention to the prospect of tens of billions in investment capital being available from the global capital markets. ■

Toll Truck Lanes Gaining Momentum

By Robert W. Poole, Jr.

An integral part of the plans for Trans Texas Corridors is that some of the lanes will be truck-only toll lanes. That concept—proposed in a Reason policy study in 2002—is gaining momentum around the country.

One of the most recent developments was the release, in November, of a $500,000 feasibility study of a toll truck road to bypass congested I-5 through Seattle. The 100-mile north-south road, from Chehalis to I-90, is estimated to cost $4.6 billion, which the study estimated could be raised if the road attracted half of the 22,000 trucks using I-5 through Seattle each day, at an average toll of 60 cents/mile. That was the most feasible option from among a number of more grandiose ideas, some of them similar to the Trans-Texas Corridor, evaluated by Wilbur Smith Associates. Strangely, the study did not examine the options of either a higher speed limit or opening the truck road to triple-trailer rigs. Both would make paying tolls more attractive to trucking companies.

The two most advanced toll truck lane proposals are in Los Angeles and Virginia. In the former, the Southern California Association of Governments included in its long-range transportation plan (adopted in April 2004) a $16.5 billion toll truckway linking the ports of Los Angeles and Long Beach with the Inland Empire and Barstow, built along the rights of way of I-710, SR 60, and I-15, a distance of 142 miles. This project's economics are based on allowing the use of double- and triple-trailer rigs, with the potential of 50 to 100 percent greater payload than conventional 18-wheelers. In Virginia, the state DOT is negotiating with its preferred bidder, a consortium called STAR Solutions, to add two toll truck lanes in each direction to all 325 miles of I-81 across Virginia. As currently envisioned, that project would require that all trucks use the new lanes and pay tolls, and it does not envision the use of higher-payload trucks; consequently, the Virginia Trucking Association strongly opposes the plan.

In Georgia, the State Road & Tollway Authority has a feasibility study under way on the potential of truck-only toll (TOT) lanes, in addition to the potential of HOT lanes. Georgia DOT in November received an unsolicited proposal, under the state's public-private partnership law, for the addition of toll lanes to I-75 and I-575 in the Atlanta area. One of the options included in this proposal, from a joint venture

See TRUCK LANES on Page 13

Building for the Future:
Easing California's Transportation Crisis with Tolls and Public Private Partnerships

Read the full study at reason.org/catrans324.pdf

By Robert W. Poole, Jr., Peter Samuel, and Brian F. Chase

California is projected to add 16 million people between 2000 and 2030. In the three largest urban areas, vehicle-miles traveled by individuals will increase by 30 to 50 percent, with truck traffic growing even faster. Congestion on the state's urban freeway systems is bad and will get even worse.

Even before the current transportation funding crisis, available highway financial resources were hard-pressed even to maintain the existing infrastructure, let alone add to its capacity. California must find a better way to finance and deliver highway projects.

Why Business as Usual Will Not Suffice

Of the nearly $400 billion in transportation funds Los Angeles, San Francisco, and San Diego plan to spend by 2030, only a small fraction will be spent to expand the capacity of the highway system. Consequently, congestion will still be a major problem in 2030, even if these three long-range plans can be fully implemented.

And this is the best-case projection by the metropolitan planning organizations (MPOs), assuming that transportation finance in California quickly returns to business-as-usual, from its current dire crisis state. Any number of factors could make the outcome significantly worse.

Learning from Abroad: Lessons from World-Class Cities

Cities like Paris, Toronto and Melbourne have coped with similar pressures of growth versus limited public finances by turning to tolls. Global capital markets are willing to invest billions of dollars in highway transportation projects, if those projects are wanted badly enough that people are willing to pay tolls to use them. A steadily growing stream of toll revenues makes it possible to sell billion-dollar bond issues to amass the capital to build such projects.

Examples of Large-Scale Urban Toll Projects for California

We illustrate the potential of toll-funded mega-projects to address real transportation needs in urban California by means of four case studies. Each is a large-scale project (well over $1 billion) that addresses a specific need, and each could be funded largely or entirely by toll revenues.

The first project is a $2.3 billion tunnel linking Palmdale with Glendale, beneath the Angeles National Forest. With value-priced tolls to keep traffic free-flowing at rush hours, it would cut 45 minutes to an hour off the time between north county and downtown Los Angeles, thereby relieving congestion on SR 14 and I-5. The tunnel would make it far more practical to develop serious airline service at the Palmdale International Airport site.

The second case study is an alternate approach to San Diego's current plan to add $2 billion worth of "managed lanes" to several major freeways. Our plan would build a more ambitious $8 billion, interconnected network of managed lanes. This would give every commuter a form of "congestion insurance" on most of the freeway system, while providing the equivalent of an exclusive, uncongested busway for express bus service.

The third and fourth case studies are of toll truckway systems for greater Los Angeles and the East Bay region of greater San Francisco, respectively. Our Los Angeles proposal would extend a truckway system from the twin ports of Los Angeles and Long Beach through San Bernardino and up I-15 to the California-Nevada line. This $10 billion truckway system would be self-supporting from toll revenues. In the Bay Area, our proposed truckway would link both the Port of Oakland and Silicon Valley with I-5, via I-580. At a cost of $9 billion, it could also be self-supporting from toll revenues.

For all four studies, we modeled the projects as being funded by 40-year, tax-exempt toll revenue bonds.

Dealing with the Risks of Mega-projects

Transportation mega-projects have a well-documented tendency toward cost overruns and traffic shortfalls. Why? Because contractors benefit from decisions to go forward, and can generally get compensated for factors leading to higher costs. And when the project is finished, they can walk away, leaving the government to worry about revenue shortfalls and high maintenance costs.

But the incentives change dramatically when the project is structured as a long-term partnership. Risks—from cost overruns to inadequate traffic and revenues—shift from the taxpayers to the developer/operator. The developer/operator pays far greater attention to controlling costs and to conducting rigorous traffic and revenue studies prior to financing the

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Unions Try to Discredit Education Outsourcing

By Lisa Snell

As the private sector offers services in more segments of the $500 billion K-12 education sector, special interest groups are working to discredit not only private sector involvement in public education, but also the private sector as a whole.

Two recent examples illustrate how teachers unions and other education advocacy groups often present their members with a negatively biased view of the private sector and its involvement in education. This approach leaves educators unexposed to the larger body of evidence that shows competition and privatization have improved service in almost every business sector, including education.

NEA Today: Horror Stories

In the September 2004 issue of *NEA Today*, the monthly organ of the National Education Association, a series of articles collected under the title "Cash Cow" highlights privatization failures and gives union members advice on how to fight privatization initiatives. The report fails to mention the hundreds of case studies showing benefits to children and the public from school privatization.

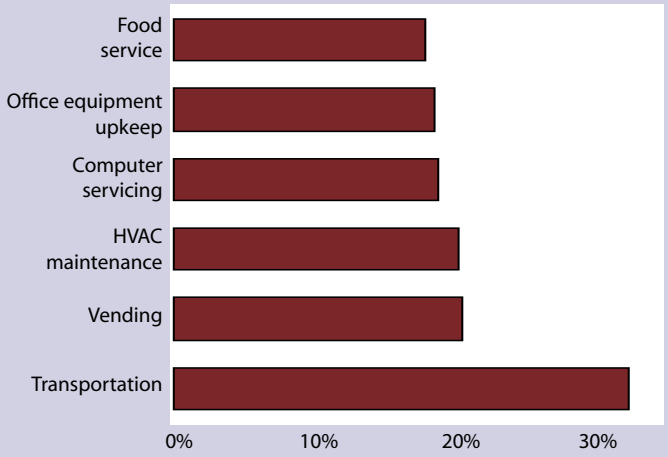
The *NEA Today* series argues that when "private profits outweigh public accountability, educators and kids pay the price." As evidence for the failure of privatization initiatives, the articles offer stock horror stories of privatization missteps and selected studies showing privatization is more expensive than traditional public-sector operation.

The series fails to mention the large body of research that shows substantial cost savings and improvements in service quality from the privatization of school support services.

According to the most recent school privatization survey conducted by *American School & University* magazine, 32 percent of the nation's school districts outsource transportation and about 17 percent outsource food service. Extensive literature reviews of cost savings have found between 20 and 40 percent savings from school outsourcing.

For example, in 2002, the Philadelphia school district faced a $28 million deficit. By turning to privatized transportation, custodial, food service, and other support services, the district saved $29 million over two years and erased its deficit—while running a robust teacher recruitment program and without firing any teachers.

Most Common Contract Services for School Districts



Source: 2001 *American School & University*

Despite its focus on privatization failures, the *NEA Today* series reports that private sector involvement in K-12 education is increasing. The teachers' union portrays the growth of private industry in education as a war between "those of us who believe in free enterprise" but think schools don't fit the for-profit model, and free enterprise firms who want to expand "at any cost." Those firms, according to the article, use "slick marketing" to sell their services but then "cut corners every chance they get" because "[t]hey are not in it for the kids."

NEA Today offers NEA members explicit strategies for fighting off privatization. Ironically, some of the examples given of where privatization was avoided are of workers who became more efficient and delivered better service because of the threat of privatization.

For instance, one of the examples discusses a group of food service workers in Adrian, Michigan who won back their food service operation from Marriott Corp. by offering more nutritious meals, using innovative employee work teams, and turning a "profit" that was put back into the classroom. Missing from the discussion, though, is the conclusion that competition encouraged these public employees to work more efficiently.

As well as strategies to avoid privatization, NEA members are offered several specific strategies to prevent privatization. The most lethal of these is to use the collective bargaining process to legally prohibit the possibility of privatization or outsourcing—i.e., NEA members should agree only to contracts that explicitly prohibit outsourcing. Advice also is provided on organizing a campaign and doing effective community outreach to stop privatization.

Commercialization in Schools

The NEA position on outsourcing was echoed in a September 2004 report on commercialism in education from Arizona State University's Alex Molnar, who negatively portrays private sector involvement in education as exploiting children. Even sponsorships, such as corporate support of the National Merit Scholarship Program, are dismissed as programs that "often serve the donors' commercial purposes."

The report, *Virtually Everywhere: Marketing to Children in America's Schools*, measures what Molnar views as the evils of commercialism in schools by counting the number of media references to private sector involvement in education. Those references include not only privatization but also corporate sponsorships, exclusive licensing agreements, sponsored educational materials, and fundraising.

Molnar reports that media references in five out of eight categories of schoolhouse commercialism increased between July 1, 2003 and June 30, 2004. Overall, he finds media references to commercialism increased 9 percent as compared to the 2002-2003 school year.

Molnar and his Commercialism in Education Research Unit at Arizona State are affiliated with the Campaign for a Commercial-Free Childhood (CCFC), a national coalition of health care professionals, educators, advocacy groups, and concerned parents. CCFC's mission is "countering the harmful effects of marketing to children through action, advocacy, education, research, and collaboration among organizations and individuals who care about children. CCFC supports the rights of children to grow up, and the rights of parents to raise them, without being undermined by rampant consumerism."

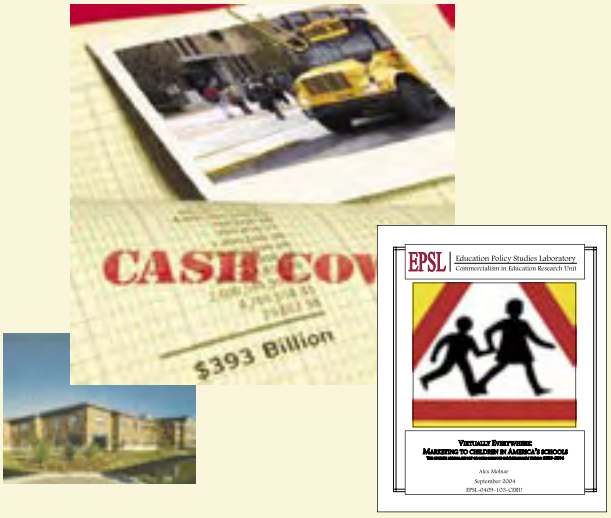
Molnar concludes in his report that commercialism in schools—whether selling junk food, fundraising, or providing sponsorships—undermines the ideal of schools as institutions for preparing the next generation to participate fully in a free and democratic society.

"The more corporate special interests are allowed to influence what schools teach—and by extension, limit what they cannot teach—the less students are seen as active citizens-to-be rather than as passive consumers-to-be-sold, the farther our educational system moves from that ideal," he writes.

Molnar's report offers no evidence of corporations limiting curriculum or blocking participation in the democratic process. His report and the recent *NEA Today* demonstrate the need for a more balanced presentation of private sector involvement in education for the benefit of administrators, teachers, and parents.

This piece was originally published by the Heartland Institute's School Reform News*: heartland.org/Publications.cfm?pblId=6.* ■

For more information ...



- The September 2004 *NEA Today* article series, "Cash Cow," by Kristen Loschert, John O'Neil, and Dave Winans, is available online at www.nea.org/neatoday/0409/coverstory.html.
- The September 2004 report, *Virtually Everywhere: Marketing to Children in America's Public Schools - Seventh Annual Report on Schoolhouse Commercialism Trends: 2003-2004*, by Alex Molnar, Arizona State University, Education Policy Studies Laboratory, Commercialism in Education Research Unit, is available online at www.asu.edu/educ/epsl/CERU/Annual%20reports/EPSL-0409-103-CERU.pdf.
- The 2001 school privatization survey by *American School & University* magazine is available online at images.asumag.com/files/134/109as23.pdf.

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TRUCK LANES

of Bechtel and Kiewit, is TOT lanes.

At the federal level, the surface transportation reauthorization bill passed by the House in 2004 included Rep. Don Young's provision to allocate $1 billion for a pilot program for truck-only lanes on major Interstate routes. That language did not explicitly mention tolls or provisions for higher-payload trucks, however. ■

50th Anniversary of Competition in Federal Government

By Geoffrey F. Segal

On January 15, 1955 Pres. Dwight Eisenhower issued Bureau of the Budget (now the Office of Management and Budget) Bulletin 55-4 to declare that the federal government should rely on the private sector for goods and services. More directly the policy stated, that "(I)t is the policy of the Government of the United States to rely on commercial sources to supply the products and services the government needs. The Government shall not start or carry on any activity to provide a commercial product or service if the product or service can be procured more economically from a commercial source." The directive had one goal: avoid direct competition with the private sector.

This policy has been upheld by every succeeding administration of both parties and is still the foundation to Office of Management and Budget (OMB) Circular A-76, which guides public-private competitions for services. As recently as 1998, President Clinton signed the Federal Activities Inventory Reform (FAIR) Act, which expedited private competitions by categorizing all federal jobs as "inherently governmental" or "commercial." Politicians of both parties expressed support for the concept of government relying on the private sector to carry out certain jobs defined as not "inherently governmental."

Even while this policy has been supported and applied by every administration since, today more than 800,000 federal employees are in jobs that the agencies themselves consider "commercial" in nature—like cutting grass on federal property and writing software—these and countless others are readily available in the private economy.

Upon entering office President Bush initiated an ambitious plan to subject these jobs to competition from the private sector. Competitive sourcing, as Bush's plan is known, may be a slight departure from the intent of the Eisenhower bulletin, but it is still good for taxpayers. In 2003, competitive sourcing saved taxpayers $1.1 billion and initial results from 2004 show even stronger savings. Indeed, the federal government saved an average of $20,000 for each position competed. Given the 800,000 positions, competition could save upwards of $16 billion.

On the 50th anniversary of the policy, it is time to recommit to the 1955 Eisenhower policy. ■

2004 Competitive Sourcing Results

By Geoffrey F. Segal

The U.S. Office of Management and Budget (OMB) released impressive and encouraging results from competitive sourcing initiatives for fiscal year 2004. Agencies completed 217 public-private competitions of "commercial activities" in FY 2004, resulting in net savings, or cost avoidance of approximately $1.24 billion over three to five years.

Agencies also made significant advances in their ability to increase efficiency and cost savings through competition. An average position studied for competition generated savings of approximately $20,000, a 65 percent improvement from the $12,000 savings per position in 2003. Given that the typical government employee receives $80,000 in salary and benefits, competitive sourcing is yielding 25 percent savings—up from 15 percent in 2003. In addition, agencies spent $100 million on conducting the competitions (an additional $36 million was spent on oversight), resulting in over a 12 to 1 return on investment. Over the last two years competitive sourcing has saved more than $2.34 billion.

The typical government employee receives $80,000 in salary and benefits.

Despite the success, during each of the last two appropriations cycles, Congress has attempted to place significant restrictions on competitive sourcing. While largely unsuccessful, Congress has placed restrictions on the resources available to conduct competitive sourcing activities at the Forest Service and the Department of Interior.

In addition, Congress has delayed the Department of Homeland Security's use of competition. ■

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PARTNERSHIPS

project. And because the developer/operator also operates and maintains the project, it does not pay to use cheap construction techniques, for they simply lead to steeper maintenance costs.

Best Practices from Elsewhere

The recent trend in Europe, Australia, and Latin America is to make use of long-term public-private partnership agreements for large toll projects. Typically, the government goes out to bid for a company or consortium to finance, build, operate, and maintain the tolled project for a long enough period to recover its investment (typically 35 to 50 years). The public sector partner often defines the project and does preliminary design, permitting, environmental clearance, and land acquisition. The private sector partner, selected by a competitive process, then finances the project, develops it using the design-build method, and operates it during the agreed-upon franchise term (typically called a "concession" overseas).

The rationale for using such partnerships is twofold. First, having the project developed and operated on a commercial basis tends to de-politicize it, safeguarding it from becoming either a source of jobs or contracts for favored parties or from having its toll revenues diverted. Second, in exchange for the opportunity to make money, the private partner is generally willing to assume significant risks that would otherwise be borne by the taxpayers.

During the past 15 years, nearly two dozen states have passed enabling legislation for public-private partnerships in transportation infrastructure. These policies have allowed fast-growing states like Texas and Virginia to invest billions of dollars into highways.

Potential Legal and Policy Changes

California's one previous attempt to engage the private sector to develop toll roads was flawed. The 1989 AB 680 private toll road law required 100 percent private financing, rather than permitting a mix of public and private support that gives both parties a stake in successful outcomes. It applied only to Caltrans, despite the subsequent devolution of significant transportation authority to regional/local levels of government. And it permitted extremely restrictive non-compete clauses in franchise agreements. Second-generation public-private partnership laws, like those in Texas and Virginia, are far more flexible.

We recommend that California enact a state-of-the-art tolling and public-private partnership law. It would authorize both Caltrans and local/regional levels of government to initiate toll-funded transportation infrastructure projects, and permit them to partner with the private sector to carry out such projects, using both RFPs and procedures for dealing with unsolicited proposals. This would enable California to enter the global capital markets, and allow the state to tap world-class expertise to modernize its vitally important highway system.

The funding and the expertise are out there, and are being used in other countries and other states. The key question is whether California will take advantage of them.

Robert W. Poole, Jr. is Reason's Director of Transportation Studies. Peter Samuel founded and edited Toll Roads Newsletter, *which has now become tollroadsnews.com. Brian F. Chase is an attorney in the San Francisco office of Nossaman, Guthner, Knox & Elliot, LLP.* ■

Who, What, Where

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Conferences

Spring Task Force Summit, American Legislative Exchange Council, Savannah, GA, April 29-30: alec.org

The 2005 National Conference on Performance Measurement and Performance Contracting for Social Services, Performance Institute, Phoenix, AZ, May 5-6: performanceweb.org

Show Me the Measures! Developing and Using Performance Measures in Government, Performance Institute, Arlington, VA, May 12-13: performanceweb.org

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