



**Build hospitals for people...  
Not for profits!**

Presentation to the  
Select Standing Committee on Health  
by the Hospital Employees' Union

November 8, 2001

There are many issues and challenges facing our public health care system today. These include:

- the impending health service cuts and hospital closures;
- government confusion on health care governance, and the threatened loss of community control and input;
- deteriorating morale among health care workers because of the disrespect your government has shown to this the front line workforce; and
- the threats to Medicare from the delisting of coverage for medical services like eye examinations and the gutting of the Pharmacare program.

Representing 46,000 care providers in every community in B.C., the Hospital Employees' Union has commented, and will continue to comment on these very serious issues, providing creative and effective alternatives that will strengthen and modernize Medicare for British Columbians.

But today, our union would like to focus our submission on your government's proposal to build Canada's first private hospital in Abbotsford. There is no doubt that MSA General Hospital is outdated and urgently needs to be replaced. People in the Fraser Valley—including our members—have worked long and hard to press government to act. They deserve a new public hospital.

And most important, they must have a role in deciding how their new hospital will be built, who will own it, how it will be financed and how to ensure that top quality services are provided.

But until three weeks ago, government and health region officials had been speedily manoeuvring in secret to finalize plans for a private hospital in an effort to prevent any community input into the decision. We're proud of the role that our union has played in blowing the lid off this secret process and opening doors to give the community a voice.

The proposal to follow the private hospital route modelled on the British private finance initiative (PFI) – where the hospital is financed, owned and partly operated by for-profit corporations – is wrong headed, expensive and harmful to patient care.

Let's look at the evidence about the astronomical costs of PFI hospitals in Britain:

- built publicly, the replacement of the Edinburgh Royal Infirmary would have cost 180 million pounds (\$421 million). But the PFI contract guaranteed the corporate owner \$70 million a year for 30 years, for a total replacement cost of \$2.1 billion. Total additional cost \$1.7 billion;
- The \$33 billion in privately financed health care construction projects already signed and underway in Britain will cost government a total of \$225 billion to the end of the agreements;

- real rates of return on investment for corporate owners of hospitals range from 15% to 25% a year.

This submission presents the evidence related to the private hospital route. Our intentions in outlining this research are two fold. Firstly, we want to open up the process and ensure full disclosure so that the public in Abbotsford, and in British Columbia more generally, are aware of what is really at stake. And secondly we want to raise concerns because of the very convincing research evidence indicating that the advisors for the project in Abbotsford, Price Waterhouse Coopers, are themselves participants of many of the PFI hospital disasters in Britain.

After outlining the disastrous consequences of moving down this road in Abbotsford, we will outline an alternative vision of redevelopment at the Abbotsford site based on innovative service delivery within the public system.

## **Background**

On Oct. 23 four days after our union exposed the secret plans to build a private facility in Abbotsford – the Fraser Valley Health Region released a Status Report on the redevelopment of the Abbotsford Hospital. This report points to Britain’s private financing initiative (PFI) as the preferred model for developing new private public partnerships. The selection of Price Waterhouse Coopers as the consultants for this project, confirms this connection with the PFI model. Price Waterhouse Coopers has, over the last several years, been a leading advisor to Britain’s local health authorities (known as National Health Services’ Trusts or the NHS Trust) on the “value for money” of financing the construction of new hospitals through private companies or consortiums.

Under Britain’s private financing model hospital construction and ownership is privatized. The local health authority (i.e. NHS Trust) leases back the hospital from the consortium through the payment of an annual fee over the life of the contract (usually 25-35 years). The annual payment is expected to cover both the lease payment or “rental charges” (i.e. the private sector debt service obligations, the rate of return to equity shareholders, a small building maintenance fee) and a “service fee” to cover health and facilities support services such as cleaning, lighting and laundry.

Because there is now close to a decade of experience with these new arrangements in Britain, there is a growing and impressive body of independent research critically analysing the cost, service delivery, and quality of care implications of the PFI model. This literature and in particular a series of four very credible academic peer reviewed articles published in the British Medical Journal in July of 1999 (see Appendix A for full text of four of the key articles), point to the very considerable problems with PFI in terms of:

- higher costs;
- lower levels of service provision and staffing;
- inferior construction; and
- administrative inefficiencies.

### ***The Higher Costs of Private Financing of Hospital Construction***

In the BMJ articles, authors Declan Gaffney et al., analysed the business plans and contracts between local health authorities and private consortiums in a sample of hospitals involved in the first wave of privately financed hospital construction in Britain. They found that “private financing substantially increased the cost of hospital construction.”<sup>1</sup>

These higher construction costs reflect the lease costs or “rental charges” paid by the NHS Trusts to the consortiums – an annual cost equivalent to 11.2 -18.5% of the construction costs (Table 1) – over the 25 to 30 year life of the contract.

**Table 1: Construction and lease costs (i.e. rental charges)**

<b>NHS Trust</b>	<b>Construction Cost (Lm)</b>	<b>PFI lease cost (Lm)</b>	<b>PFI lease costs as % of construction cost</b>
Calderdale	64.6	8.7	13.5
Carlisle Hospitals	64.7	8.0	12.4
Dartford	94.0	10.5	11.2
Greenwich	84.0	11.0	13.1
North Durham	61.0	7.1	11.6
Wellhouse	54.0	10.0	18.5

Source: BMJ Vol 319, July 10, 1999 (p. 117).

The lease cost fund private sector debt service obligations and returns to equity shareholders. A minor element of the charge also funds maintenance costs over the life of the building.

If the NHS had financed the hospitals themselves, the costs of borrowing would be 3.0-3.5% (i.e. the real annual rate of interest).<sup>2</sup> This means, in effect, that over the 25 to 30 year life of the contract the costs of construction are four or five times what they would be if the hospital had been funded through the traditional forms of public procurement.

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<sup>1</sup>Declan Gaffney et al, “*The Private Finance Initiative PFI in the NHS—is there an economic case?*” British Medical Journal, July 10, 1999, p. 116.

<sup>2</sup>Ibid.

As an example, the replacement of the Edinburgh Royal Infirmary would have cost the government 180 million pounds (C\$421 million). However instead of the government financing it themselves they signed a contract with a private consortium guaranteeing the corporation an annual fee of 30 million pounds for 30 years or 900 million pounds (C\$2.1 billion) in total.<sup>3</sup>

These higher costs reflect the fact that shareholders in private finance initiatives receive real returns of 15-25% a year.<sup>4</sup> On the basis of this analysis the authors of the July 1999 series in the British Medical Journal conclude that:

the private finance initiative, far from being a new source of funding for the NHS infrastructure, is a financing mechanism that greatly increases the cost to the taxpayer of NHS capital development.<sup>5</sup>

Given the actual cost differences between private and public procurement, how was it that the business plans in support of private financing were approved on the basis of demonstrating “value for money”? The authors of the BMJ articles point to two elements of the methodology used in the economic appraisal process for determining “value for money” of private as compared to public financing, that significantly biased the process in favour of the private sector.

Firstly, the economic appraisal process discounted the borrowing costs for the private sector based on the fact that under public procurement all the costs of hospitals are paid in the first few years whereas under the private finance initiative the payments are evenly spread out over 25 to 30 years. The assumption is that money spent now or in the near future carries a higher cost than money spent several years down the road, and therefore the cost for the private sector should be discounted. (It is important to note that in B.C. government borrowing is not paid up front but is financed over a longer term.) The discount rate used in the British private financing schemes is 6%. This is much higher than the equivalent real interest rates that the British government would have paid if they had borrowed the money over the long term.

The authors of the BMJ articles point out that the choice of a higher discount rate (i.e. 6 %) was quite simply a policy decision of Treasury based on “operational considerations” that in the words of the Treasury were “in the high range” and designed “to ensure that there is no inefficient bias against private sector supply.”<sup>6</sup> In other words, the “economic appraisal assumes

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<sup>3</sup> Nick Cohen, “Bevan’s dream is over: Our baby boomer master sneer at public service. The lost must go starting with the NHS, The Observer, July 11, 1999.

<sup>4</sup>Chantrey Vellacott DFK. *Economic Report*. London:Chantrey Vellacott, 1999.

<sup>5</sup>Declan Gaffney et al, “*The Private Finance Initiative* The politics of the private finance initiative and the new NHS, British Medical Journal, July 24, 1999, p. 249.

<sup>6</sup>Declan Gaffney et al., July 10, 1999, page 118.

from the outset what it is held to prove: the economic advantage of private finance.”<sup>7</sup>

The impact of higher and lower discount rates can be illustrated using the Carlisle Hospital’s private financing scheme as an example (Table 2). For the purposes of this submission it is noteworthy that Price Waterhouse Coopers’ were the financial advisors for the Carlisle Hospital’s private financing scheme.

**Table 2: Effect of varying the discount rate on results of economic appraisal in Carlisle hospitals’ private finance initiative**

Discount rate (%)	Public sector option (PSC) (L000s)	Private sector option (PFI) (L000s)	Economic advantage of PFI over PSC (L000s)
6.0	174 337	172 633	1 704
5.5	185 803	186 692	-899
5.0	198 884	202 043	-3 159
4.5	213 900	219 480	-5 580
4.0	231 247	239 388	-8 141
3.0	275 027	288 622	-13 595
0.0	549 882	577 048	-27 166

Source: BMJ Vol 319, July 10, 1999 (p. 118)

The second element of the appraisal process that favours the private sector is the addition of a lump sum “risk adjustment” to reflect the assumed risk transfer from the public to private sector. It is important to note that the 6 % discount “already takes into account an element of risk, as it is set at a level that is deemed by the Treasury to be higher than a risk free interest rate,” and so “the cost of risk is effectively counted twice.”<sup>8</sup>

In reality risk can only be transferred to the private sector through financial penalties imposed on the consortiums if they fail to meet their obligations. As the authors of the BMJ articles point out, this basic principle was consistently overlooked in the economic appraisal process for privately financed hospitals. In effect, there is no risk transfer to the private consortiums.

At Carlisle, one of the risks supposedly transferred was that targets for clinical cost savings would not be met, and the cost of this risk was estimated at five million pounds. The consortium, however, had no responsibility for ensuring that these savings would be made, and faced no penalty if they were not: five million pounds of additional value was

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<sup>7</sup>Ibid.

<sup>8</sup>Ibid.

thus attributed to the private finance initiative on quite spurious grounds.<sup>9</sup>

The best indicator of the limited risk transfer to the consortiums is the interest rates paid by the consortiums to their funders to finance the first wave of private finance initiative schemes. As the authors of the BMJ series point out they paid interest rates of between 4% and 5% which suggests that “in the view of the funders there has been very little risk transfer.”<sup>10</sup> In some cases the consortium managed to remortgage their loans and borrow at even lower rates once the hospital construction phase was complete (i.e. because the risks were even lower) further increasing their shareholder returns.<sup>11</sup>

This analysis outlines only some of the distortions in the costing methodology for the private financing of hospital construction in Britain. It points to the pitfalls of applying a similar approach here in B.C. The negative consequences of this approach become even clearer in the next two sections of the submission. In these sections we examine the reductions in acute care capacity, clinical staffing and support services required to pay for the higher construction costs of privately financed hospitals in Britain.

### **Paying for Private Financing Out of Care: Lessons from British Experience**

In an attempt to answer the concerns that private financing is more expensive than public, Price Waterhouse Coopers points to the “value for money” that the private sector brings through “innovation and commercial freedom to deliver efficiencies.”<sup>12</sup> However a review of the service cuts and quality problems in two of the first privately financed hospitals in Britain -- North Durham and Carlisle (in both cases Price Waterhouse Coopers were the financial advisors for the projects) -- points in the opposite direction (see Appendix B for the full text of the articles on Carlisle and North Durham).

At both North Durham and Carlisle<sup>13</sup> there are significant problems in terms of:

- The physical design of the facility including insufficient room and poor layout in work areas, poor ventilation and no air conditioning in clinical areas;

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<sup>9</sup>Ibid., page 119.

<sup>10</sup>Ibid.

<sup>11</sup>George Monbiot, “Bleeding the hospitals: private companies stand to pocket millions the health service desperately needs” Observer, Tuesday June 5, 2001.

<sup>12</sup>Price Waterhouse Coopers, “UK Healthcare Public Private Partnerships: Investing in Health Care Infrastructure,” April 2001, Overhead Presentation, page 6.

<sup>13</sup>Nick Mathiason, “Bed Crisis – in August?” The Observer, August 27, 2000. Felicity Lawence, “Crisis-hit hospital finds that private financing for NHS comes at a price,” Guardian, July 23, 2001.

- The quality of the construction standards and materials including the use of cheap plastic joints in piping and other plumbing faults which led to sewage system problems and flooding in clinical areas and operating room; and
- Fewer beds available in the privately financed hospital as compared to the public facility it replaced. This resulted in a “crisis” and bed shortages as soon as the new hospitals were opened.

Specifically in terms of North Durham Hospital, it was reported that in addition to the reduction in bed capacity there was a significant reduction in the clinical staff complement and insufficient support staff available to provide the basic care required by patients.<sup>14</sup> And yet despite these reductions in services and sale of property to cover the higher costs of the privately financed construction, the North Durham NHS Trust was unable to meet the financial obligations of the lease arrangement. Additional funding was required. An emergency subsidy was provided from the NHS capital budget, which has the effect of reducing the money available to other hospitals across the country.<sup>15</sup>

The authors of the BMJ series point to similar problems with other privately financed hospitals in Britain. Based on a review of the business plans of 11 privately financed hospital projects, they estimate that on average there will be service reduction of 31 % by 2000-2002 (Table 3), whereas at a national level there were no service reductions since 1994-95.<sup>16</sup>

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<sup>14</sup>Felicity Lawrence, page 6 (see article in Appendix B)

<sup>15</sup>Ibid.

<sup>16</sup>Allyson Pollock et al., “*The Private Finance Initiative Planning the ‘new’ NHS: downsizing for the 21<sup>st</sup> century,*” British Medical Journal, July 17, 1999, page 179.



**Table 3: Changes in bed numbers at NHS trusts under private finance initiative development. Values are average numbers of bed available daily (all specialties).**

Trust	1995-6	1996-7	Planned*
Bromley Hospitals	610	625	507
Calderdale Healthcare	797	772	553
Dartford and Gravesham	524	506	400
North Durham Acute Hospitals	665	597	454
Norfolk and Norwich	1120	1008	809
South Manchester	1342	1238	736
Worcester Royal Infirmary	697	699	390
South Buckinghamshire	745	732	535
Hereford Hospitals	397	384	250
Carlisle	506	507	465
Greenwich	660	566	484
Total	8063	7634	5583
Change (percentage change) from 1995-6	-	429 (-5.2)	2542 (-30.8)

Source: BMJ Vol 319, July 17m 1999 (p, 179).

In some cases the bed numbers for the privately financed initiative are inflated because these include private beds and day use beds in the total

The consequences of reduced bed capacity in privately financed hospitals not only resulted in longer waitlists<sup>17</sup> for acute care services, but also in a reduction in community health services as funding was diverted from the community to pay for the additional cost of private financed acute care services.<sup>18</sup>

Allyson Pollak et al., in the BMJ series, argues that these problems can be attributed to the fact that clinical needs took a back seat to the commercial concerns of the private consortium:

The evidence from the business cases approved by the Department of Health indicates that the 32 hospitals being built under the private finance initiative have been planned not on the basis of health care needs but on the basis of local affordability and cash savings from the revenue budget. The planning process has effectively been reversed, with

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<sup>17</sup>D. Light, "The real ethics of rationing," British Medical Journal, July 12, 1997, pages 112-113.

<sup>18</sup>Allyson Pollack et al., July 17, 1999, page 181.

services being designed to fit predetermined reductions in capacity. The high costs of the private finance initiative entail major reduction in service provision, acute bed capacity and clinical staffing. Justifying these reductions, it would seem, has become the main planning task.<sup>19</sup>

In conclusion it is important to note that there are no examples from Britain where the increased cost of private financing was cancelled out through land sales, the shift to private pay patients or the contracting out of support services.<sup>20</sup>

Given this evidence and your government's determination not to increase health spending, the decision to privately finance the Abbotsford Hospital will inevitably result in any or all of the following:

- reductions in acute bed capacity in Abbotsford and/or the Fraser Valley Health Region;
- reductions in community service capacity in Abbotsford and/or the Fraser Valley Health Region; and
- an increased contribution from the provincial budget for Abbotsford/FVHR which would inevitably reduce access to health services in other regions of the province.

It is important to note that over the last 10 years acute care utilization has been reduced by 40 % (from 1000 days per 1000 population in 1990-91 to 590 days per 1000 population in 1999-2000).<sup>21</sup> In the Fraser Valley Health Region the utilization rates of 564 is already below the provincial average.

In comparison to other provinces, the utilization rates for acute care beds in B.C. are lower than most other provinces, and at the same level as Alberta and Ontario (Table 4). In the last year, most provinces have stopped talking about reduced utilization and instead focussed on the need for additional funding to ensure increased access to both acute and community services.

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<sup>19</sup>Ibid., page 184.

<sup>20</sup>Declan Gaffney, "*The private finance initiative* NHS capital expenditure and the private finance initiative— expansion or contraction," British Medical Journal, July 3, 1999, page 51.

<sup>21</sup>Alan Thompson, MOH, August 2001.

**Table 4: Health Care Services in Provinces and Territories, 1998.**

	<b>Acute Care Hospital Beds (per 1,000 pop.) 1998</b>
Newfoundland	3.3
Prince Edward Island	3.5
Nova Scotia	3.6
New Brunswick	3.9
Quebec	3.7
Ontario	2.2
Manitoba	3.6
Saskatchewan	3.9
Alberta	2.2
British Columbia	2.2
Yukon	1.8
Northwest Territories	3.9
Nunavut	
Canada	

Source: Canadian Institute for Health Information, 2000

This evidence only further reinforces what should already be evident: that B. C.'s health care system can ill afford the reductions in services that would result from the introduction of private financing for hospital construction.

### **The Argument Against the Contracting Out of Support Services**

The other cornerstone of Abbotsford's redevelopment proposal is the contracting out of "non-medical" support services. It is interesting to note that at both Carlisle Hospital and North Durham support services were contracted out as part of the private financing initiative. In both cases, senior administrators and government officials connected with these initiatives have had second thoughts about the wisdom of their decision.

The Medical Director at Carlisle Hospital, Dr. Willie Reid, is very firm in his view that handing over support services like laundry, portering and catering to the consortium was a mistake. "We

ran these services in-house fairly efficiently with staff who were loyal to the Trust,” Reid says.<sup>22</sup> Now these services are contracted with a private company, he says, that “intends to make a profit, while cutting the quality.”<sup>23</sup> Similarly, Frank Dobson, the NHS health secretary, who laid the first stone at North Durham in 1999, now admits that the contracting out of ancillary services was not a positive alternative to public delivery.<sup>24</sup>

In both Canada and the United States there are notably examples of hospitals that have reversed their decision to contract out support services. In 1993, Toronto Hospital, Canada’s largest health care facility, was at the leading edge of strategies to contract out hospital support services.

Much like your government today, the Hospital thought it would strike gold when it contracted out food services, logistics and the management of housekeeping. However, in the last two years all of these services have been returned to the public sector because of quality problems and the hidden costs of contracting out. In the United States the Hospitals and Health Network conducts an annual survey on outsourcing (i.e. contracted out services) in U. S. hospitals. In their 1999 review they note that outsourcing “appears to have peaked.”<sup>25</sup> And as a matter of fact, their 2001 survey points to significant declines in outsourcing over the last two years.<sup>26</sup>

At the end of October the Hospital Employees’ Union released a ground breaking study by a Simon Fraser economist, Marjorie Cohen, on the unique characteristics of health care support work. In that study Cohen found that while support workers may not be in the spotlight, they are a critical part of patient care. She documents the considerable health care specific knowledge, skills and on-the-job experience and training of hospital support staff in housekeeping, trades, food services, laundry and clerical.<sup>27</sup> Cohen argues that “the distinction between ‘caring work’ and the work of support staff is not as clear cut as is often assumed.”<sup>28</sup> Some of her findings include the fact<sup>29</sup> that:

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<sup>22</sup>B. Miller “Grin and bear it. Bringing the first PFI hospital to completion has been a roller coaster ride— and the conflicts may only just be starting.” Health Services Journal, e-gov.uk, 2000, page four of four.

<sup>23</sup>Ibid

<sup>24</sup>Felicity Lawence, July 23, 2001, page seven of seven.

<sup>25</sup>National Health Network, “Outsourcing on the Outs,” Health Forum, October 1999, page 46-52.

<sup>26</sup>National Health Network, “Eleventh Annual Contract Management Survey, 2001.

<sup>27</sup>Marjorie Griffin Cohen, “Do Comparisons Between Hospital Support Workers and Hospitality Workers Make Sense?” Hospital Employees’ Union, October 2001, page 7.

<sup>28</sup>Ibid.

<sup>29</sup>Ibid., pages 7-24.

- Health care housekeeping and cleaning staff are the front line against antibiotic resistant organisms (AROs) and follow special protocols when cleaning around patients infection with organisms such as Methicillin Resistant Staphylococcus Aurous (MRSA) and Vancomycin Resistant Enterococccus (VRE). They also have to have specialized knowledge of different cleaning protocols when working in operating rooms, on burn and dialysis units, in emergency departments and in radiation rooms.
- Hospital laundry workers must be aware of the specialized cleaning requirements for different units of the hospital, for treating heavily stained items and for handling sharps, body parts and fluids and other hazards that could lead to injury or infection.
- Trades workers must be intimately familiar with the complex hospital environment and the implications of the systems they work on for the safety of patients and other health care staff. They require specialized knowledge of hospital layout and design, the procedures for handling hazardous materials and substances and the processes for working on or near medical equipment and in patient areas.
- Food service supervisors must develop specialized meals for patients with dietary restrictions and make sure these meals are delivered to the right patients in a timely manner. In some hospitals and especially in long-term care facilities food service workers are also expected to observe the patients to ensure that they are getting the nutrition they require.

These examples focus on the importance of maintaining support services in-house in order to have an experienced and skilled health support staff with a commitment to the public health system. However, maintaining a close link between caring and support work is essential not only in terms of quality of care, but also in terms of ensuring the cost effective utilization of staffing resources. Many support functions are currently performed by professional and technical staff.<sup>30</sup> The flexibility to shift work from professional and technical back to support staff is particularly important in the current environment given the shortages in so many professional and technical occupations and the new opportunities to improve work processes with the introduction of new technologies. However, this flexibility is lost if support services are contracted out to private companies as part of the 25 to 30 years private financing scheme.

At the North Durham privately financed hospital there is a very graphic example of this rigidity, and the negative consequence in terms of costs and quality of care issues.<sup>31</sup> According to the private consortium now running hospital support services, portering patients around the hospital is not part of its contract. As a consequence one night when a doctor on duty at the hospital needed a patient moved, he was forced to call the one ambulance at the time that was on duty covering the whole Durham city area. This meant the ambulance crew was taken out of action for about 35 minutes to move a patient a mere 400 metres!

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<sup>30</sup>The extent to which non-nursing support functions are preformed by RNs became clear to health care administrators during the nurses' job action in the spring and summer of 2001.

<sup>31</sup>Felicity Lawrence, July 23, 2001, page one of seven.

## **There is a progressive alternative**

Over the last decade there have been numerous provincial and federal government commissions, regional reviews and academic reports on future directions for health care in Canada. Their focus has been on the need to ensure quality and at the same time control costs as we move into the 21<sup>st</sup> century. Without exception these reports point to the benefits of moving to a more seamless system where acute care services are more closely integrated with continuing, community and primary care, and where prevention and early monitoring strategies are more of a priority.<sup>32</sup> It is these themes that should be the guiding threads for the Abbotsford redevelopment: bold reforms within the public system, innovative service delivery models and the integration of acute, continuing and community care.

The improved health outcomes and significant cost savings that can be achieved through prevention and early intervention are illustrated in a recent study on home care in B.C. The study compared the health care costs for home care clients in two regions that cut preventative home care services (i.e. personal care services such as meal preparation and housecleaning) with the costs in two regions that maintained these services.<sup>33</sup> After three years the annual per person costs for all health services averaged \$7,808 for those who still had preventative home support, as compared to \$11,903 in those regions where the services were cut – a difference of over 50%. The differences in costs in the regions that made the cuts were “essentially attributable to a greater use of hospital beds, increased use of homemaker services in the second and third year after the cuts, and increased rates of admission to residential care”<sup>34</sup> As the author of this study points out, “if you squeeze one part of the health system, it results in a bulge in another part of the system.”<sup>35</sup>

Applying this type of thinking to the Abbotsford Hospital redevelopment project, imagine that instead of being a hospital replacement project, this project was seen as an opportunity to bring together community, continuing, primary and acute services in a campus type model on one site with an innovative approach to service delivery and new linkages within and between these services and the community. Imagine also that these innovations were based on specific programs with a proven track record in reducing emergency acute care admissions, enhancing the

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<sup>32</sup>Seaton et al, Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs, Province of British Columbia, Victoria, 1991. Vancouver/ Richmond Health Board, Review of Acute and Rehabilitation Services: Final Report, July 1998. \_\_\_\_\_ Community for Life: Review of Continuing Care Services in British Columbia, October, 1999 (Note: It is not possible to list all of the relevant references These are three of key reports from British Columbia).

<sup>33</sup>Marcus Hollander et al., Final Report: Evaluation of the Maintenance and Preventative Function of Home Care, HomeCare/Pharmaceuticals

<sup>34</sup>Ibid., page iii.

<sup>35</sup>Ibid.

functional independence for clients in the residential and community care, and/or improving the overall health status of specific populations. Two examples of the types of innovation that could be achieved through a campus style model – outreach programs to better manage care for people with chronic ailments and the development of alternatives to acute care services like sub-acute and palliative care and a 24-hour emergency response team – are described below.

There is a growing recognition of the poor quality and high costs of care for people with chronic ailments (i.e. people with high blood pressure, heart disease, asthma, diabetes and depression, etc.). In other jurisdictions improvements in overall health status, and reductions in emergency room admissions and hospital stays have been achieved in programs that focus on early monitoring, outreach and education for people with chronic ailments.<sup>36</sup> The success of these programs depends on better co-ordination between the different sectors of the health system to ensure, for example, that the expertise of hospital-based staff is available to the community, and that a process is in place for identifying people with a chronic ailment so that they can link to the appropriate outreach program/community service. The creation of a campus model for service delivery at the Abbotsford site could facilitate this approach by incorporating outreach programs for people with chronic ailments, community mental health services and specialized home support services on site. This approach to managing the care of people with chronic ailments would help significantly to control costs within the public health system overtime.

The second example focuses on a reconfiguration of services. In 1997 the Ministry of Health conducted a study showing that although many patients in acute care may not match the criteria for acute care, 99% of these patients require some form of care and attention and that this care was simply not available in B.C.<sup>37</sup> A number of recent reviews from the health regions around the province have focussed on the need for these alternate services.<sup>38</sup> They include new specialized residential care services (i.e. palliative and sub-acute care), 24 emergency services in the community to take pressure off hospital emergency departments, and outreach rehabilitation programs in intermediate care and in the community. These services have a proven track record in other jurisdictions, would reduce the pressures on the acute care system, and are less expensive than acute care. Once again they would make sense as part of the campus model of care envisioned in this submission.

This model promises significant gains in terms of improving health outcomes and reducing costs. Strengthening and reforming our public system, and not abandoning it, is the approach that should be followed. Instead of turning to a private financing scheme, your government should be looking at bold reforms within the public system. The campus type model described above is this

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<sup>36</sup> \_\_\_\_\_ Blended Care: Blending the best of institutional and community care, making the most of the health care team, October 1999, pages 7-9.

<sup>37</sup>Advisory Committee on Clinical Resource Management, Acute medical beds: How are they used in British Columbia? Ministry of Health, January 1997, page one.

<sup>38</sup>Vancouver/Richmond Health Board, July 1998, pages 6-8. Review of Continuing Care Services in B.C., October 1999, pages 19-20.

type of bold reform. We urge you to adopt it and work with us, the region and the community to implement it on the Abbotsford site.



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