

Strategic Outsourcing by a Regional Health Authority: The Experience of the Vancouver Island Health Authority



PURCHASING

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Introduction

This paper is based on the experience of the Vancouver Island Health Authority's (VIHA's) outsourcing initiatives for select support services as well as residential care and assisted living. I describe the formation and functions of health authorities in British Columbia (BC) in general and VIHA in particular. I also address the initiatives VIHA undertook in support of its strategies and priorities and I include a discussion of results to date.

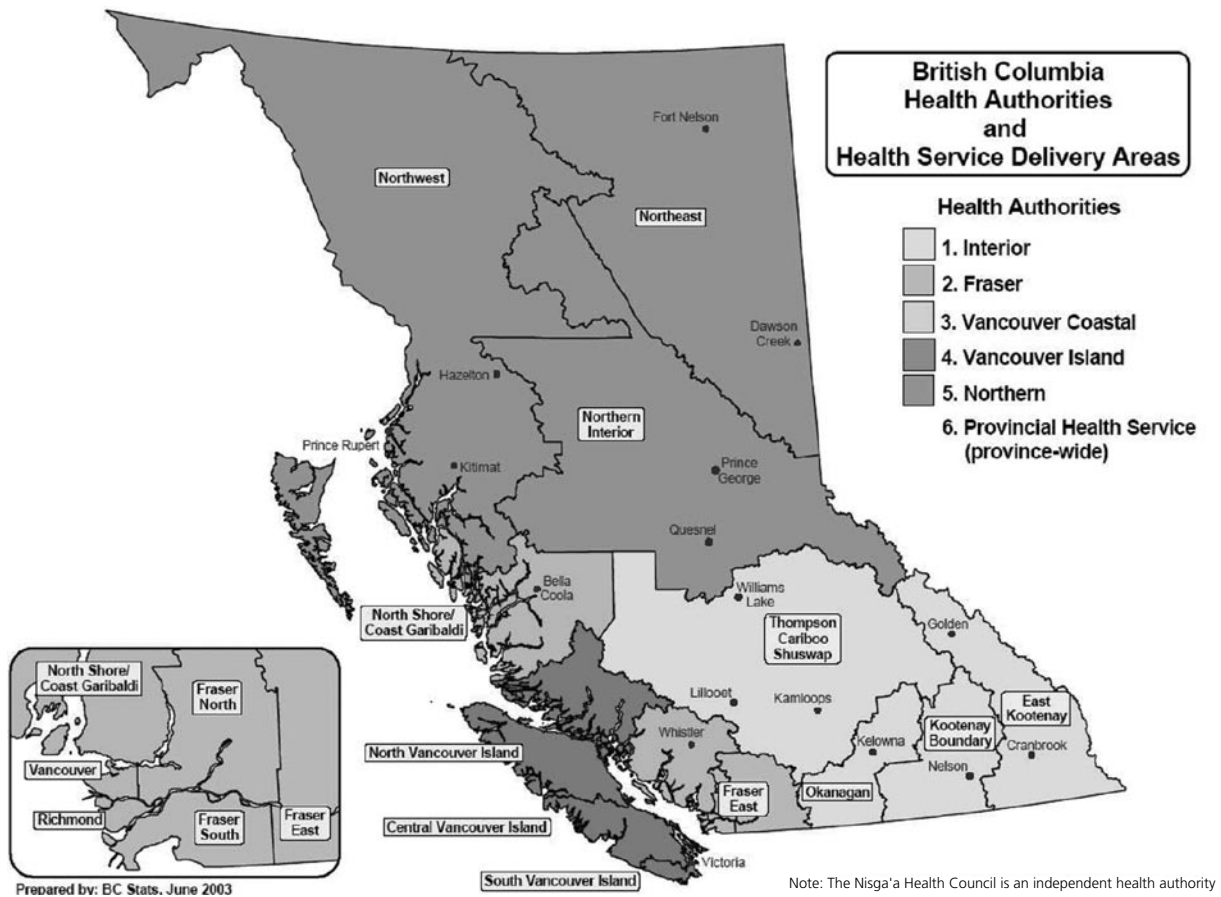
BC's Health Authorities

In December 2001 the BC government merged 52 health organizations to form a

new governance and management structure that involved the creation of five regional health authorities and a province-wide health authority (see Figure 1). These bodies govern, plan and coordinate regional services and participate with the Provincial Health Services Authority, which coordinates and provides programs and specialized services across BC.

The minister of health appoints the health authorities' board members and chairs for two-year terms. The maximum length of time a board member may serve is three two-year terms. Board chairs typically have a strong private sector business background. Performance contracts were created for all six

Figure 1. British Columbia's health authorities and health service delivery areas



health authorities. Fiscal restraint during the first three years of the health authorities' existence (2002–2004) was widespread.

VIHA

VIHA's geographical area covers 56,000 square kilometres and includes Vancouver Island, the Gulf and Discovery Islands and part of the mainland area opposite Northern Vancouver Island (see Figure 2). VIHA serves the health needs of over 730,000 people. It operates a network of hospitals, clinics, centres, health units and long-term care facilities (138 facilities in total). It employs or contracts with 16,000 healthcare professionals, technicians and support staff as well as approximately 1,600 physicians. VIHA's

annual operating budget is over \$1.4 billion and it provides approximately 1,534 acute care beds and 4,900 residential care beds/assisted living units.

VIHA is representative of BC overall. Size-wise – i.e., budget, population and area covered – it is at about the middle of the five regional health authorities, with a balance between major urban and rural/remote components. It is also one of the most self-reliant of the health authorities, with well over 95% of the workload for Vancouver Island residents provided from VIHA facilities.

VIHA's Five-Year Strategic Plan

VIHA's *Five-Year Strategic Plan* provides the overall direction for service delivery to

Figure 2. VIHA's territorial components



the year 2010 (Vancouver Island Health Authority 2006). It articulates the need for enhanced integration, responsiveness and innovation. The plan also identifies priority issues along with challenges associated with population and service delivery growth. Likewise, it sets goals, strategic themes and strategic directions by sector and geographical area. The plan also addresses the following:

- New and innovative service delivery models
- Capacity forecasts
- Alignment with the Ministry of Health's strategic direction
- Recognition of the significant demo-

graphic and health status differences throughout VIHA

- Clinical input and practical experience

Support Service Outsourcing

The fact that each of BC's health authorities must deal with a unique political and financial context has resulted in different outsourcing approaches across the five regional bodies. In addition, agreement between the BC government and healthcare unions has limited the amount of outsourcing permitted. For its part, VIHA has outsourced environmental support services (ESS), food services and a portion of security.¹ Other BC health authorities have outsourced other services, such as laundry.

The following issues influenced VIHA's (and other health authorities') review of the potential to outsource select support services:

- Performance agreements included a 7% decrease in administrative and support costs over three years.
- Existing collective agreements for the major support services union called for wage increases in each of the following three years (8%–10% total).
- A 0% increase to budgets for three years was projected.
- Provincial legislation allowed contracting public health sector support services to the private sector.

There were also multiple risks to consider when contemplating outsourcing. These included, but were not limited to, the following:

- Limited competition
- Organizational disruption
- Organizational culture
- Union response
- Media interest
- Public confidence
- Legal
- Changing political landscape
- Vendor capability

VIHA's key objectives when contemplating outsourcing included the following:

- Reducing support services costs in order to maintain patient/client care services volumes
- Facilitating raising the food-service delivery system to meet the industry's best-practice level
- Acquiring the capital equipment and information technology infrastructure

required to meet industry best practices (historically, support services requests for capital equipment were treated as a lower priority than patient care requests)

- Examining how performance agreement targets could be met
- Maintaining or exceeding current standards of quality and service volume

VIHA was the fourth BC health authority to enter the market, and three international vendors expressed an interest in providing services. This undertaking required the full support of the board of directors and virtually all segments of VIHA.

The environmental support services agreement, which incorporated 80% of VIHA's ESS budget, resulted in the following:

- Annual savings of \$6 million
- Performance standards
- Internal/external audit procedures
- Public reporting of results
- Performance bonuses/penalties
- \$500,000 investment in capital equipment
- \$1 million signing bonus for VIHA

The food service agreement resulted in the following:

- Greater Victoria sites converted >6,000 meals per day projected
- Annual savings of \$2.5 million
- \$5 million capital/information technology (IT) investment
- Performance standards
- Internal/external audit
- Public reporting of audit results
- Performance bonuses/penalties
- \$1 million signing bonus for VIHA

When outsourcing a large and critical component of an organization's infrastruc-

ture, risk mitigation is important. Both the ESS and food service agreements therefore contained the following clauses:

- Recruitment/retention became the sole responsibility of the successful vendor.
- Wage rate increases became the sole responsibility of the successful vendor.
- Significant performance bonds were secured for each contract.
- The contracts are renewable for an additional five years or parts thereof.
- The contents are expandable to other VIHA sites or affiliate organizations.

Results

ESS standards have consistently been met after the first two years of operation (these incorporate infection control standards). Food safety standards are also being met. Food satisfaction ratings, however, remain challenging and require significant investment of time by both the vendor and VIHA. Provincial standards and audit methodology have been developed and adopted by all BC's health authorities for ESS and food services. Standards and audit procedures have been extended to all VIHA facilities regardless of the providers involved. Finally, cost savings are still being realized and have allowed patient/client/resident services to be maintained, thus enabling VIHA to meet its strategic priorities.

Lessons

We learned abundant lessons from undertaking outsourcing of this magnitude:

- A tight request for proposal (RFP) process

and contract provides risk mitigation.

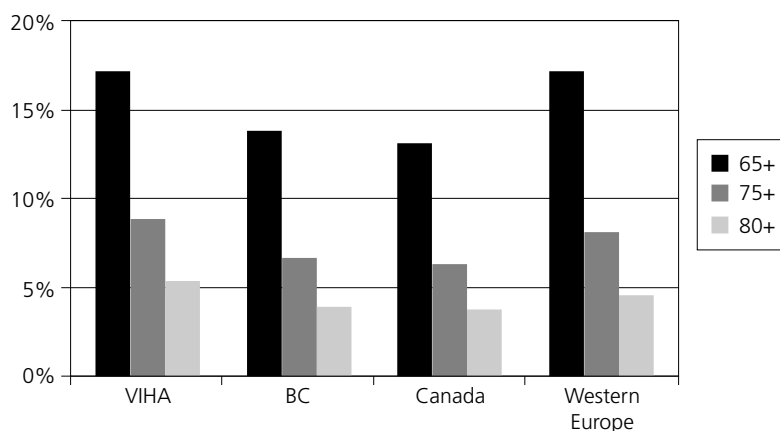
- A changing environment can impact a proponent's success.
- Variables such as low unemployment rates, high cost of living, increased competition in the same wage band, the robustness of union/labour strategy and a changing political landscape all play a role in a private sector vendor's success.

Residential Care and Assisted Living

VIHA's Senior Population

The most notable difference between VIHA and the province's other health authorities is the age of the population we serve, largely because Vancouver Island is a preferred retirement destination. This is one of the most significant challenges we face and will continue

Figure 3. Proportion of seniors in VIHA, BC, Canada and Western Europe



to face for at least the next 20 years. Figure 3 shows that our demographic profile resembles that of Western Europe more than the rest of BC and Canada, as those aged 65 and over make up almost 17% of the total population (compared to 14% in BC and 13% in Canada).

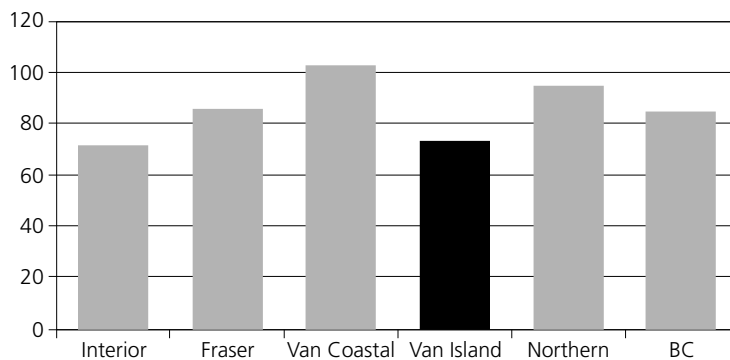
About 8.6% of the VIHA population

is aged 75 and over (compared to 6.4% for BC) and 2.2% of the population is aged 85 and over (compared to 1.6% for BC). Within VIHA, the south area has the greatest proportion of seniors. The largest growth in seniors will, however, occur in VIHA's central area, where a 40% increase (2,119) in residents aged 85 and over is expected by the year 2010.

Outsourcing Residential Care and Assisted Living Services for VIHA's Seniors

Figure 4 shows that VIHA is significantly below the provincial average for home and community beds per 1,000 people aged 75 and over.

Figure 4. Home and community beds per 1,000 people aged 75 and over



The BC government has committed to opening 5,000 additional long-term care beds by the end of 2008. VIHA and BC Housing² have initiated a procurement process to secure 980 residential care beds and assisted living spaces by 2008 and up to 1,230 residential care beds and assisted living spaces by 2010. Partnerships BC³ was engaged to manage the procurement process involved in delivering firm contracts for this capacity.

BC's asset management framework is based on the following principles (Ministry of Finance 2002):

- Value for money
- Sound fiscal and risk management
- Strong accountability in a flexible and streamlined process
- Emphasis on service delivery
- Serving the public interest
- Competition and transparency

Coinciding with these principles, VIHA's key objectives for its residential care and assisted living initiative include the following:

- Deliver on the strategic plan targets for BC and open all units no later than December 2008.
 - Develop communities of care where possible and appropriate.
 - Capture creativity and innovation through the process.
 - Introduce the new Provincial Residential Care Services Operating Agreement.

Time-wise, the competitive selection process was extremely tight: we issued a notice of intent in December 2005 and contracts were signed by May 2006. Our RFPs sought innovations in the area of complex care and

assisted living. Ideally, they were to be set up as communities of care and located in eight different communities on Vancouver Island to meet the demographic needs we identified in our strategic plan. The key terms of the contracts were as follows:

- Project development agreements – terms and conditions:
 - Design requirements
 - Review process
 - Agreed-upon schedule
 - Sanctions if terms and conditions were not met

- Residential care services operating agreements
- Assisted living services operating agreements

We anticipate that all facilities will be open by September 2008. Service providers are responsible for all aspects of financing, including design, development, construction and operational costs. Funding commences

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upon receipt of each provider’s first client and penalties are included for each day a service provider is behind schedule. Service providers are also responsible for all risks associated with construction cost escalation. VIHA and BC Housing have contracted to fund the facilities at the agreed-upon contract prices.

Results

VIHA’s residential care and assisted living initiative has achieved numerous positive results:

- Value for money has been achieved: the successful proponent(s) in all four major geographical areas (eight communities) presented either the lowest bid (3/4) or close to the lowest bid (1/4).

- All contracted proponents’ proposed facilities have been established as communities of care.
- Innovation was sought and provided. Some of the areas of innovation included in the proposals were as follows:
 - Provision of respite or hospice care within the community of care
 - Adult day programs
 - Community outreach
 - Intergenerational programming
 - A community of care model
 - Delivery of a new model of dementia care
 - Therapeutic community bathing programs
 - Delivery of mental health services within specialized areas
 - Design flexibility to allow expansion
 - Design that incorporates a co-located primary health centre

Taken as a whole, the overall development schedule is three months ahead of schedule.

Conclusion

BC’s health environment and structure have changed in the last five years to provide a wide range of health services under large health authorities, and a performance monitoring system is in place to monitor their delivery. VIHA has a well-thought-out strategic plan that captures the demographics and needs of the residents it serves until the year 2010. The two examples given in this paper reveal how VIHA has operationalized strategic levers in order to meet its strategic goals.

Addendum

On July 8, 2007, the Supreme Court of Canada rendered its judgement on the constitutional validity of Bill 29, BC’s Health and Social Services Delivery Improvement Act.

The justices found three sections of Bill 29 to be constitutionally invalid. The decision struck down sections 6.2 (no restrictions on contracting out), 6.4 (no requirement of consultation prior to contracting out) and 9 (layoff and bumping). The judgement overrules previous Supreme Court decisions, which held that collective bargaining was not constitutionally protected. The effect of the decision has been suspended for 12 months to allow the government to address the repercussions of this decision.

The consequences for the province's health authorities and contracted service providers concerning liability and indemnification are undetermined at this time. The Government of British Columbia is currently analyzing the implications of the Supreme Court's verdict.

Endnotes

1 ESS covers housekeeping, linen and laundry distribution, recycling and pest control.

2 The British Columbia Housing Management Commission (BC Housing) was created in 1967 under an Order in Council to fulfill the government's commitment to the development, management and administration of subsidized housing.

3 Partnerships BC is a company responsible for bringing together ministries and the private sector to develop projects through public-private partnerships. Registered under the Business Corporations Act, Partnerships BC is wholly owned by the province of BC and reports to its shareholder, the Ministry of Finance.

References

Ministry of Finance. 2002. *Capital Asset Management Framework*. Victoria: Government of British Columbia. Retrieved April 23, 2007. <<http://www.fin.gov.bc.ca/tbs/camf.htm>>

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