## CAPITAL REGIONAL DISTRICT

## STAFF REPORT TO HEALTH FACILITIES PLANNING COMMITTEE
## WEDNESDAY, NOVEMBER 17, 2004

---

**SUBJECT**

The annual Capital Plan (2005 - 2009 inclusive) for health facilities in the Capital Region.

**BACKGROUND**

The purposes of the Capital Plan are to:

- Describe the content and context of proposed future health facilities capital projects;
- Estimate health facility expenditure for the next five years (2005 - 2009); and,
- Estimate the financial implications for the District including the property tax charge spread over five years.

Last month there was a report on the October 6th Joint Planning meeting between Vancouver Island Regional Hospital Districts and the Vancouver Island Health Authority (VIHA). This included a review of VIHA's 2004-2008 Capital Asset Management Plan (CAMP). This plan will be referred to in this report as will the outcome of the November 3rd VIHA Capital Committee Prioritization Meeting involving all of VIHA's program directors and District staff.

The CRD Five Year Plan is in large part, based on VIHA's plan. It deals with next year's projected capital activity and possible activity over the next four years. While there is reasonable certainty for next year's projections, the following four years are less clear.

Although the CRD plan has an allowance for capital equipment the majority of this report centres on the buildings themselves.

Not unlike the previous two years, projected capital expenditures for 2005 and for the full five years are lower than historic levels and lower than what should be spent.

The low level of capital projects is largely a function of provincial funding cutbacks. As has been mentioned before in 2001, the provincial government terminated its 60% grant for major projects, used for such projects as the Royal Jubilee Hospital Phase 1 redevelopment and the replacement Mount St. Mary residential care facility.

In 2001/2002, the province approved a one-time "restructuring" capital grant program worth $6.8 million which, with the Regional Hospital District 40% matching grant, totaled $11.3 million. The restructuring grants funded projects like the in-patient neurological rehabilitation unit at Victoria General Hospital, involving the consolidation (restructuring) of program services from multiple to single sites.

Some additional provincial capital was directed to long term (residential or complex) care facilities, historically not funded by RHD's or funded at low levels.

Termination of the provincial 60% capital grant for ***Major Projects*** has essentially put them on hold. On November 3rd VIHA met to establish capital project priorities for the coming year. That meeting identified

approximately $144.6 million in unfunded priority major capital projects (excluding residential care). This list of projects differs from the schedule of deferred projects (valued at $ 164.5 Million) obtained from the Capital Asset Management Plan and shown in Appendix F.

A backlog of major projects existed before 2001 but has become larger and more expensive over the last three years.

To date, the provincial position is that it expects Health Authorities to replace 60% grants either through operating fund savings, existing asset leveraging, increased public donations or through partnerships (i.e. private financing). Although there have been small increases in Health Authority funding it has not been sufficient to offset non-discretionary cost increases.

Additional income to fund capital has been minimal and nowhere close to the amount required to fund major projects.

Some smaller projects such as the Saanich Peninsula Hospital Emergency and Palliative Care project proceeded by relying on increased community donations to offset the lost provincial grants.

The shortage of provincial capital funds has also contributed to decisions to renovate rather than replace existing buildings. For example, the first phase renovations currently underway at Lady Minto Hospital will be followed by other phases at a total cost of $7.5 million. According to VIHA, the cost to replace Lady Minto is estimated at $8.6 million. Therefore the cost to renovate the building is the equivalent of approximately 87% of the cost to replace the 47 year old building. In general, older obsolete buildings, particularly highly specialized buildings, are replaced when the cost of renovation exceeds 50% of the cost of replacement.

At this time, the projects identified in Appendix F are unfunded. Even more concerning is the lack of planning for them. These are not discretionary projects and are all likely to proceed within the next ten years. This year witnessed the unsuccessful effort by VIHA to transfer in–patient services from very old buildings to other older occupied buildings on the Royal Jubilee site. This led to acceptance of the inevitability of a new in-patient centre as the only reasonable option. As reported in October, the District's offer to get this project started by approving up to $1.0 million planning funds was denied by VIHA on the basis that VIHA was not ready. It needs to complete its future service delivery and capital investment plans expected in the next fiscal year, May 2005 or thereabouts.

Other supposed funding sources including asset leveraging, untapped donations, consolidation of services and self-financing have not been explained by VIHA but appear to have very modest potential. In the absence of restoring provincial capital grants, the primary source of funding for ***Major Projects*** would appear to be private financing (referred to as partnerships). The province is already moving in this direction with the recent approval of the Vancouver General Hospital Academic Ambulatory Care Centre and the soon-to-be-announced Abbotsford Regional Hospital and Cancer Centre.

Major capital projects are one of three capital project categories contained in the Capital Plan. The categories are summarized as follows:

| | |
|---|---|
| **1. Major Projects** | Projects valued at greater than $1.5 Million related to the modification or expansion of health service/program spaces (program-related) or building system upgrading (non-program-related). |

| | |
|---|---|
| **2. Capital Improvement Projects** | Projects valued between $100,000 and $1.5 Million to refurbish existing facilities or replace building components, improve functionality and upgrade information technology. |
| **3. Minor Capital Improvement Projects** | Projects valued between $5,000 and $100,000 to refurbish or replace building components and minor program-related improvement work. |
| **4. Equipment** | Medical equipment valued at over $100,000. Funding has been a combination of Section 20(3) grant funding and borrowing. |

The District also funds capital work including planning studies and research from Section 20(3), land banking and periodically, off-site services not eligible for provincial funding.

The District has historically funded up to 40% of the cost of ***Major Projects*** and ***Capital Improvement Projects***, smaller percentages for ***Minor Capital Improvement Projects*** (which used to be covered in Ministry operating funding) and ***Equipment***.

Prior to 2004, the District's capital cost sharing was restricted to acute care hospitals and extended care facilities. The 2003 Regional Hospital District Cost Sharing Review enabled the District to cost share a broader range of project types including complex care (including some of the same types of residents as in the obsolete extended care facility category), primary health centres, respite hotels and mental health facilities. As an example the District approved a $1,107,066 contribution to the Aberdeen Seniors Primary Health/Respite Hotel in January this year.

This broader range of eligible projects theoretically allows Regional capital contributions to flow to the highest priority capital which might not always be acute hospitals and extended care. This increasing flexibility does not translate to an automatic increase in the level of RHD contributions. RHD contributions are essentially voluntary and not bound to increase beyond historic funding or projected funding levels associated with the former acute and extended care project eligibility provisions.

The second major category of projects is the *asset refurbishment* projects including ***Minor Capital Improvement Projects*** ($5,000 to $99,999) and ***Capital Improvement Projects*** ($100,000 to $1,499,999). For the last three years the District had an annual global funding amount of $3,000,000 for these types of projects.

Earlier this year VIHA received an external evaluation of all its owned facilities. This report came back with an estimated cost of $194.6 Million to bring existing facilities to standard. The $194.6 million figure was for the entire Island. South Vancouver Island facilities would be estimated at 60% of this cost or approximately $117 million. VIHA subsequently estimated the cost of priority level 1 and 2 projects at $28,043,000 (for the South Island) and included them in the 2004-2008 Capital Asset Management Plan.

The November 3rd Priorities Meeting approved an increase in the combined ***Minor Capital*** and ***Capital Improvement Projects*** from $7.5 Million to $9.5 Million with the Regional Hospital District's requested share increasing by 26.7% from $3,000,000 to $3,800,000. This increase to an annual $9,500,000 expenditure level for asset refurbishments represents 34% of the first two priority levels of work identified in the external review of VIHA facilities (excluding privately owned affiliated facilities) to bring them up to standard. The majority of this high priority work is also therefore unfunded.

This report does not delve into details on the ***Equipment*** side or, the fourth major expense category. From the VIHA Capital Asset Management Plan it is known that 74% of equipment is fully depreciated, the estimated value of equipment expenditures in the Five Year Plan is $138.6 Million and approximately $43.7 Million is unfunded. The District currently funds $2,530,050 per annum to VIHA for ***Equipment*** and this is the value incorporated in our Plan. We expect additional information on the ***Equipment*** side next year.

## THE PLAN SUMMARY

For 2005, the Plan represents a combination of approved and proposed projects. The approved projects consist of work currently in planning and construction. These projects were approved by the Board in 2002-2004. The proposed projects consist of allocations for ***Minor Capital*** and ***Capital Improvement Projects*** ($9.5 Million) and ***Equipment*** ($2.5 Million) and potentially two new VIHA ***Major Capital Projects***.

Assuming that all projects identified in the Capital Plan are approved, with no deletions and no subsequent additions, the five-year cash flow period of 2005 – 2009 involves a total expenditure of $87.3 Million and a Capital Regional Hospital District share of $41.7 Million.

| | | |
|---|---|---|
| Acute Care Hospitals | $25,787,734 | ($10,315,093) |
| Extended Care Facilities | $217,921 | ($87,168) |
| MCI & Capital Improvement Projects (Acute, Extended) | $47,500,000 | ($19,000,000) |
| Complex Care Facilities | 0 | (0) |
| New Health Capital Facilities | $1,129,207 | ($1,129,207) |
| Non-Shareable Projects - Grants | $12,650,250 | ($12,650,250) |
| Less Mount St Mary Revenue | | (-$1,476,893) |
| **TOTAL** | **$87,285,112** | **($41,704,826)** |

## SECTOR BY SECTOR

**Acute Care** (see *Appendix B*)
This sector comprises 30% ($25,787,734) of the Plan with small and medium sized projects at the Royal Jubilee (RJH), Victoria General (VGH), Saanich Peninsula (SPH) and Lady Minto (LMH) hospitals.

**Extended Care** (see *Appendix C*)
This sector comprises less than 1% ($217,921) of the Plan. Projects at these facilities consist of essential, but generally minor work to maintain the function of existing physical plants.

**Minor Capital and Capital Improvement Projects** (see *Appendix A*)
This sector comprises 54% ($47,500,000) of the Plan. These projects encompass essential work needed to maintain the function of existing physical plants and improve the function of departments at acute and extended care facilities. Due to changes in the capital planning cycle, a detailed list of ***Capital Improvement Projects*** will not be available until the VIHA capital planning process has been completed in early 2005.

**Complex Care** (see *Appendix C*)
No activity is forecast for this sector. One of VIHA's strategic priorities is to reconfigure the long term care system by significantly reducing intermediate care facilities and substituting these facilities with assisted living development, upgrading remaining intermediate care facilities to complex care and adding new complex care units. Although we do not have sufficient detail on the entire process it would appear that the replacement assisted living program and the complex care side are significantly under funded.

**New Capital Projects** (see *Appendix C*)
This sector comprises 1% ($1,129,207) of the Plan. As outlined previously, this new sector corresponds with recommendations in the RHD Cost Sharing Review enabling RHD's to cost share in a broader range of health facilities. The above expenditure represents cash flow for the already approved Aberdeen Seniors Primary Health Centre and Respite Hotel project.

**Non-Shareable Projects** (see *Appendix A*)
This sector comprises 15% ($12,650,250) of the Plan. Non-shareable expenditures consist of funding for major equipment. Equipment funding has been continued at the previously agreed annual level of $2,530,050.

## SUMMARY

### I. CONTEXT

The Five Year Health Facilities Capital Plan is based on VIHA's Capital Asset Management Plan. VIHA's Plan identifies approximately $275,260,400 in maintenance/asset refurbishment, program related projects and medical equipment for the South Island of which approximately 53.5% or $147,264,300 is presumed to be funded.

The Plan before Committee is reasonably accurate for 2005 but the remaining four years are unclear. VIHA acknowledges that the Plan is incomplete. VIHA has not completed its health system redesign which involves the development of strategic plans for each of the three Health Service Delivery Areas including the South Island/Capital Region. These strategic plans set priorities for which capital priorities are developed. These plans are not expected to be completed until at least May of next year.

The Capital Plan is also handicapped by the unavailability of funding for ***Major Capital Projects***. From the November 3rd Priorities planning meeting there is approximately $145 Million in unfunded ***Major Projects***. Appendix F shows $165 Million in deferred ***Major Projects*** for a broader scope of projects drawn from the Capital Asset Management Plan. Time did not permit a reconciliation of these two estimates.

While backlogs in ***Major Projects*** commonly occur, they have increased in number and cost under the current government. The major reason is the 2001 termination of provincial capital grants without any reasonable offsetting provincial operating income to allow Health Authorities to secure their own debt financing. There have been operational savings at the Health Authority but they have not generated anywhere close to the amount required to afford these ***Major Projects***. Another concern is that there is no planning underway for projects such as the Royal Jubilee In-Patient Centre. All options to use existing buildings to transfer in-patient functions from dysfunctional, obsolete buildings (which require work to keep them in use) have been tried and rejected leaving a new building as the only reasonable option. Planning will not start until some time next year.

After three years of declining funding for ***Capital Improvement*** and ***Minor Capital Improvement Projects*** and an external review recommending $28,043,000 in high priority corrective work to South Island facilities, the budget for ***Capital Improvement Projects*** is set to increase from $7,500,000 per annum to $9,500,000 per annum with a corresponding increase in District's share from $3,000,000 to $3,800,000 per annum.

The Plan continues to represent what VIHA can afford rather than accurately reflect capital need for the next one and five years.

Projected capital expenditures across all categories will continue at unacceptably low levels. This leads to many things including premature major (and more costly) repairs, buildings not lasting as long as they could, older buildings being redeveloped when they should replaced (e.g. Lady Minto Hospital) and inadequate buildings which compromise resident/patient comfort and safety and efficiency of staff and service capacity. While there is expectation that health facility demand can be reduced, the majority of the deferred projects will proceed. The question of how and when they will be financed is unclear.

While VIHA does its best to maintain its facilities, their capital infrastructure is deteriorating at a rate faster than they can respond given what appears to low maintenance funding. Eventually this will result in increased building systems and/or component failures and the need for unplanned replacement work which usually comes at a higher cost.

The Plan for 2005 – 2009 projects total expenditures of $87,285,112 of which the Regional Hospital District's share is $41,704,826. This is down considerably from the 2002 Plan of $213.5 Million with a Regional Hospital District share of $86.0 Million. Again, this change does not represent any fundamental improvement in the condition, suitability or the capacity of facilities to meet the needs of the population in the Capital Region, but rather the withdrawal of the provincial 60% capital share and the insufficiency of Health Authority operating funding to replace it.

The Plan includes a contingency for two ***Major Projects*** to begin the planning phase of development. These projects are the Victoria General Hospital Emergency Department at $15.0 Million and the final phases of the Royal Jubilee redevelopment at $90.0 Million. This is only a contingency allocation in the event that VIHA decides to move forward with this work in 2005. Currently, there is no indication that VIHA will approve these projects and therefore, they remain on hold.

## II. FINANCIAL IMPLICATIONS

The 2005 CRHD annual debt payment for health facilities in the District is $12,141,620, resulting in a property tax requisition of $75.06 against the 2004 average assessed residential value of $290,237. This represents a decrease of 4% on the 2004 figures of $12,699,360 and $78.50 respectively.

If all projects in the 2005 – 2009 Capital Plan were approved, none deleted and no others subsequently approved, CRHD annual debt payments would be greatest in 2008 at $14,034,066, resulting in a property tax requisition of $86.76 against the 2004 average assessed residential value. This situation is defined by modestly increasing debt being almost offset by reduction in existing debt.

By comparison, the 2002 Plan (the last capital plan with program-related major projects included) anticipated a significant net increase in debt and a peak average household requisition of $104.71 in 2008, $17.95 or 17% higher than the peak in this Plan.

The graph in *Appendix D* depicts the overall debt picture, combining existing and estimated maximum future debt between 2005 - 2009.

*Appendix E* shows the estimated maximum annual debt servicing costs to the CRHD.

*Appendix F* shows the list of deferred major capital projects due to lack of 60% funding.

Notwithstanding the projected $2 Million increase in ***Capital Improvement Projects*** for the Region there remains a very large gap between projected funding levels and the amount reasonably required to maintain, upgrade and replace existing facilities.

While there is a sense of urgency at the Health Authority to make sizeable capital facility investments, the provincial government has not signaled its intent to help the Health Authority. The proposed 2005 budget is approximately at the same level as the last three years. There is some talk of a province wide solution but the province is not consulting with its local government capital funding partner. We would expect that a province wide solution will focus on private financing for which there is no evidence of benefits over traditional public funding.

Under-investing in health facilities is false economy. It costs more in the end to defer maintenance, to under-fund asset refurbishment and to hang on to buildings well beyond their economic life. Health facilities are amongst society's most important physical assets and significantly increased investments need to occur quickly.

## RECOMMENDATION

1. That the Health Facilities Planning Committee receive the annual Capital Plan as information as to the estimated magnitude of future expected health facility capital requirements.
2. That the report be conveyed to the Regional Hospital District Board for information and comment.
3. That the report be conveyed to the Vancouver Island Health Authority.
4. That the report be forwarded to member municipal councils for information.

Jeremy Tate, Director
Health Facilities Planning

Kevin Brewster
Health Facilities Planner

Comments of the Director of Finance:

Comments of the Executive Director: