# MAHC Hospital Capital Taskforce Presentation



**March 1, 2018**

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# Agenda

**Hospital Data & Assertions – Focus on affordability**

**Planning Assumptions Challenges**

**Recommendations**

# Recent Hospital Project Comparisons: Not Equitable or Realistic

- Comparatively, our project costs are much larger - **3x** avg. (after scaling)
- Collingwood project is 45% of our 2-Site project (after scaling). Their new site is only 1.8 km from their original (120 yr. old) site location.
- Most renovate/add-on, not replace/move (consistent with broader industry trends)

| Hospital | Status | Age Yrs | Last known reno's (yrs ago) (5) | Total project ($M) | Gov Share ($M) | Share - scaled ($M) (1) | MAHC 2-site compare | Total project ~ sq ft (4) | Add'n / Reno | km move (2) |
|---|---|---|---|---|---|---|---|---|---|---|
| MAHC 2 site | Stage 1 (proposed) | BB -50 HV - 41 | BB -18,8 HV - 28,13 | $475 | $357 | $357 | 100% | 412,363 | TBD | ? |
| MAHC 1 site | Stage 1 (proposed) | | | $385 | $301 | $301 | 118% | 302,000 | | 20+? |
| Brockville | Contracted | 68+ (3) | 15 | $162 | $144 | $150 | 238% | 38,000 | Y | n/a |
| Collingwood | Stage 1B (Announced) | 90+ (3) | ? | $240 | $200 | $219 | 163% | 246,000 | | 1.8 |
| Burlington | Open Aug '17 | 59 | 22 | $500 | $353 | $144 | 247% | 623,500 | Y | n/a |
| Alliston | Stage 1 (Announced) | 54 (3) | 15 | $136 | $113 | $97 | 368% | 90,000 | Y | n/a |
| St Thomas Elgin | Open Jan '18 | 64 (3) | 20 | $103 | $88 | $71 | 501% | 106,000 | Y | n/a |
| Bowmanville | Stage 1B (Announced) | 67 (3) | 8 | $105 | $80 | $58 | 613% | ? | Y | n/a |
| Avg (non-MAHC) | | | | $208 | $163 | $123 | 290% | 220,700 | | |

Notes: All Data based on public website & media info. Planning projects subject to change

1. Approx scale factor to adjust Gov share ask up or down for comparison purposes (factors include: population growth, hospital scale, age, occupancy)
2. km moved based on ~ distance site(s) moved from current site. For MAHC is set at 50% of distance between current sites
3. Very old site, dates back over 90 yrs,multiple rennovations since then.
4, Project sq. ft. includes both new and revovated areas
5. Not all previous upgrades/timing known; original precapital $ requests, if any, unknown

# Community Growth Rates: Muskoka is below Average

| City | Region & Census Division | Region Population (M) | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2016 | 2041 | 25 | % change | % / Yr | % of Muskoka |
| Bowmanville | Durham | 672 | 933 | 261 | 39% | 1.55% | 217% |
| Burlington | Halton | 569 | 898 | 329 | 58% | 2.31% | 323% |
| Collingwood | Simcoe | 495 | 677 | 182 | 37% | 1.47% | 205% |
| Alliston | Simcoe | 495 | 677 | 182 | 37% | 1.47% | 205% |
| Muskoka | Muskoka | 63 | 74 | 11 | 18% | 0.72% | 100% |
| St Thomas Elgin | Elgin | 92 | 100 | 8 | 9% | 0.37% | 51% |
| Brockville | Leeds & Grenville | 101 | 104 | 3 | 3% | 0.12% | 17% |
| Average of sample 6 | | | | | | 1.22% | 170% |
| Province | | 14,229,546 | 18,221,800 | 3,992,254 | 28% | 1.12% | 157% |

# Muskoka Hospital Age is Average (@ ~45 Yrs): Not End of Life

- Government Hospital Capital spend going forward is ~$2B/Yr (up ~$0.9 B/yr in 2017), yet still looks low to stem overall aging. Model predicts average hospital age is just **maintained** going forward, without inflation, graying, new standards etc.

| Hospital age profile for Ontario's 142 Hospitals | | | | |
|---|---|---|---|---|
| **Age Bracket** | **All Sites (2015) (public funded)** | | **All sites 2028 - @ $2B/yr (1) (2)** | |
| 0 - 10 Years old | 10 | 4% | 39 | 17% |
| 11- 20 Years old | 15 | 6% | 10 | 4% |
| 21- 30 Years old | 29 | 13% | 15 | 7% |
| 31 -40 Years old | 45 | 19% | 29 | 13% |
| 41 -50 Years old (4) | 50 | 22% | 45 | 20% |
| 50 + Years old | 82 | 35% | 90 | 39% |
| **Total** | 231 | 100% | 228 | 100% |
| **Avg age - yrs (2)** | 45 | | 45 | |

Notes: Data Based on 2015 & other AG reports, 2017 Ontario budget & some older budgets, OHA 2017

1. Key assumptions: neutral inflaction factor, 15% new builds, no cost growth due to aging population or new standards
2. Based on $2B capital avg spend/yr commitment, using 15 yrs of ministry data, &

# Very Large Local share request: Not reasonable or affordable

- District and Foundation severely challenged to cover the size of the large local share. For context of how big - example split: 80% District and 20% Foundation split, for the $114M ask, shares would:
  - Total equals entire District yearly Operating Budget & would add ~10% each year to tax payers bills, 150% debt increase. (District plan was to **reduce** the debt over the next decade)
  - Consume foundation donations for 6 years (at current donation levels)
  - Comparison: Total is similar to Burlington Joseph Brant - despite they are 3x our size & growing at 3x our rate
- Meanwhile, our current capital needs sit and $39M, and continue to grow..

| MAHC Model | Local Share ($M) | District Funded ( 80%) (2) | | | | | | fountation funded (20%) (2) | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Share ($M) | Yrly Cost ($M) (1) | Total operating budget ($M) | | Net debt (2017) ($M) | | Share ($M) | Yrly funds ($M) | Yrs to pay |
| 2-Site Model | $114 | $91.3 | $10.0 | $95 | 96% | $63 | 145% | $22.8 | $4.1 | 6 |
| 1-Site Model (excluding site service additional costs) | $84 | $67.0 | $7.3 | $95 | 71% | $63 | 106% | $16.8 | $4.1 | 4 |
| MAHC **current** Capital needs | $39,000,000 | | | | | | | Note: Foundation donaction declines 2015 - 2017: **43%** | | |

Notes: All Data based on public website YE reports and District budget publications
1.Municipal dept servicing @6.5%, assumes no change due to credit rating risks, or larger inflation
2. Split is for illustration purposes only. Needs to be negotiated by both District & foundations

# Planning Assumptions Challenges

- Current operating deficit of ~4% of budget should **not override** all other decision criteria. Funding formula flaw must/will be fixed (Ministry commitment made)
  - This could be fixed for **all** affected midsized hospitals with only ~0.1% increase in HC operating budget
  - Not all decision criteria are of equal importance. Some don't materially change by model. However, others matter much more to the community – e.g. travel time, community economic impact. (Note: Precap planning criteria did not accounted for this adequately)
- No known government requirement for hospitals to attain the latest 'new build standards' in specific timeframes. Why ? Too costly.
  - 2-Site model allows for renovations/additions - a staged rollout, allows adaption to changing standards and future needs/changes, 'Mega-replace' projects do not.
- Site age does not equate to Facility condition (i.e. FCI industry metric)
  - Bracebridge site is ~10 yrs older than Huntsville site, but has a much better FCI score

***Ongoing incremental investments to maintain/upgrade matter***

- Setting the timeframe out 15 – 30 years - What about the next 15 years, do nothing to address the aging?
  - The Ministry's Capital Planning Toolkit states specifically "**5, 10 years out and 20** years out" are to be addressed. (we all know hospital infrastructure must last for many decades into the future)

# Recommendations

- MAHC Consultants – do your job:
  - Research to confirm what the Provincial government has recently funded with scaling, as I have done. Understanding other hospital situations is important.
  - Guidance/recommendations on what funding is **likely** to be received going forward

  (**Note**: my data came from limited research from public websites & media articles only; no access to deep Ministry data, & very limited resources – however**, it is good enough to support the key points**.
- Reality-check - we want fair & reasonable share of limited infrastructure capital, but **we should not ask for way more than we are likely to get - that will only cause more delays**
- Confirm now what local share is actually affordable & acceptable for the community (Foundations & District/Municipalities)
- Move ***faster*** to get into the provincial funding queue ASAP
  - Now end of 2018 submission is expected ? (in year 7, <50% through a Stage 1).

Get projects underway faster, addressing the deepening infrastructure deficit at both our hospitals and move incrementally towards newer hospital standards. **The community can't wait for 15+ years for improvements.**

# The Bottom Line

***The Taskforce should conclude given these realities, and the clear community desire to retain 2 full acute care sites, our best option is to renovate / add on to what we have, affordably, and not build any brand new hospitals***