Procurement and Non-Profit Funding Reform Options for Health and Social Services in BC

Health Sciences Association of BC
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INTRODUCTION

The delivery of health care and community social services has perhaps never been under greater strain than it today. Increased demand, combined with decreased workforce capacity have created an emerging crisis.

As we confront the growing crisis in delivering the services all British Columbians depend on, and by looking to best practices elsewhere, we have an opportunity to update and improve our procurement and funding practices here in British Columbia.

RECOMMENDATIONS

HSA strongly recommends recognizing that what works for procurement of capital infrastructure like bridges and subways does not work for procurement of care services for vulnerable citizens and their communities. Current procurement policy in care services requires competitive bidding where it does not make sense, and where it places extraordinary strain on small organizations with unique roles in the community.

This submission explores the origins of current procurement policies in BC, their impact on the delivery of health and social service care, and recommends a range of options to bring our province up to date and in line with leading jurisdictions like Scotland. These recommendations include:

> **Option 1 –** Major legislative and policy overhaul of the Procurement Services Act, Core Policies and Procedures Manual, and Capital Asset Management Framework: use alternatives to competitive tendering/RFP in health and social services (applicable to core provincial government and public bodies, including health authorities).
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> **Option 2** – Major policy changes to the Core Policies and Procedures Manual to overhaul procurement policies and procedures (applicable to core provincial government only).
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> **Option 3** – Minor policy changes to the Core Policies and Procedures Manual to require use of existing alternatives to competitive tendering/RFP in health and social services (applicable to core provincial government only).

BACKGROUND

BC constrained by 2003 Procurement Services Act and Core Policies and Procedures Manual (CPPM)

In October 2021, MCFD announced specific plans to restructure services for children and youth with support needs (CYSN), including for those who are neurodiverse or have disabilities, by moving towards centralized service hubs called Family Connection Centres (FCCs).[1] This policy direction has been influenced by the lack of timely access to CYSN services and internal MCFD pressures to reform procurement practices and contract management. Following a competitive RFP process, in January 2023, one of the FCC contracts was awarded to ARC Programs Ltd. – a for-profit, non-union employer with no experience delivering child development and early intervention services,[2] over Starbright Children's Development Centre, which was the established provider of services in the community for the past 50 years.

This experience is symptomatic of the provincial government's problematic approach to using market-based procurement processes for contracting health and social services. In the late 1990s, the BC provincial government – embracing changes in public administration (under the label "new public management") that were taking hold across high-income countries – began moving to competitive tendering for contracted health and social services, namely in the long-term care sector.[3]

As part of this shift, governments moved away from direct service delivery of health and human services and began contracting out service delivery to non-profit organizations and for-profit corporations. Even as non-profit organizations may have historically received core funding, renewed on an indefinite basis, Canadian provinces have moved away from core funding models that provide sustainable year-over-year funding in favour of time-limited, project-based and contract-based procurement involving competitive tendering (i.e., RFP competitions) where organizations must compete for funding.[4] This has led to growing instability within the non-profit sector and the growth of for-profit service delivery.

A significant moment in British Columbia came in 2003 with the Procurement Services Act, amendments to the Financial Administration Act, and legislative and policy reforms targeting specific sectors, including hospitals and long-term care, which were intended to encourage public-private partnerships and publicly funded, contracted service delivery.[5]

In 2003, the BC Ministry of Finance created the Core Policies and Procedures Manual (CPPM), which forms the policy basis and provides authoritative procedures for financial management and procurement used across ministries, with the statutory authority flowing from the Procurement Services

[1] Ministry of Children and Family Development, "Improved system coming for children and youth with support needs," Government of BC, news release, October 27, 2021, https://news.gov.bc.ca/releases/2021CFD0067-002047.

[2] Government of BC, Operators announced for pilot family connection centres, news release (January 5, 2023).

[3] Andrew Longhurst, Sage Ponder, and Margaret McGregor, "Labour restructuring and nursing home privatization in British Columbia, Canada," in Pat Armstrong and Hugh Armstrong (eds.), *The Privatization of Care: The Case of Nursing Homes*, 2019.

[4] Katherine Scott, *Funding Matters: The Impact of Canada's New Funding Regime on Non-profit and Voluntary Organizations*, Canadian Council on Social Development, 2004.

[5] Andrew Longhurst, Sage Ponder, and Margaret McGregor, "Labour restructuring and nursing home privatization in British Columbia, Canada," in Pat Armstrong and Hugh Armstrong (eds.), *The Privatization of Care: The Case of Nursing Homes*, 2019.

Act.[6] The CPPM must be used across ministries and dictates how government may obtain goods and services. A separate policy manual, the Capital Asset Management Framework (CAMF), sets policy dictating how ministries and all public sector bodies acquire (or dispose of) capital assets, and encourages public-private partnerships and private sector financing via competitive RFP.[7] As researchers and the province's Seniors Advocate have noted, the dominant use since the late 1990s of competitive RFPs – and the lack of public capital funding – in long-term care and assisted living has encouraged the growth of for-profit ownership and provision.[8]

Importantly, the CPPM and CAMF have not been updated since the early 2000s when both were established by the BC Liberal government. CPPM and CAMF language encourages ministries and public sector bodies to use public-private partnerships for asset procurement, and does not differentiate between procurement/funding for health and social services and other goods and services like highways or supplies.

The 2003 CPPM rests on the assumption that public costs can be contained or reduced through competitive (re)tendering and contract consolidation – the same misguided beliefs that led to much more for-profit involvement in seniors' care, contract flipping, and poor working/caring conditions. It is important to remember that under these policies, for-profit long-term care operators cheated taxpayers on half a million care hours they were funded to deliver in one year alone[9] Further, the idea is that RFP processes generate more cost-effective service delivery as providers compete for contracts, and that contract consolidation can reduce, in the case of CYSN services, MCFD's administrative burden, thereby reducing overall costs to government.

These assumptions have not been borne out by experience. Competitive RFP competitions place significant financial and administrative strain on non-profit organizations, which comes at the expense of frontline care. The Family Connection Centre RFP competition added significant internal and external costs for non-profit organizations to prepare complex and lengthy proposals and to incur additional

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[6] BC Ministry of Finance, *Core Policies and Procedures Manual*, https://www2.gov.bc.ca/gov/content/governments/policies-for-government/core-policy.

[7] A separate policy and procedures manual for core provincial government and all public sector agencies, including health authorities covers procurement and disposal of capital assets, the Capital Asset Management Framework, which explicitly encourages public-private partnerships and private financing through competitive tendering, as opposed to traditional and more cost-effective public capital financing. CAMF was also established in 2003 and has not been changed since. https://www2.gov.bc.ca/gov/content/governments/policies-for-government/capital-asset-management-framework-guidelines

[8] C.S. Ponder, Andrew Longhurst, Margaret McGregor, "Contracting-out care: The socio-spatial politics of nursing home care at the intersection of British Columbia's labour, land, and capital markets," *Environment and Planning C: Politics and Space 39(4)*: 800-817, 2020.

Office of the Seniors Advocate, *A Billion Reasons to Care: A Funding Review of Contracted Long-Term Care in BC*, 2020, p. 16.

Andrew Longhurst, *Assisted Living in British Columbia: Trends in access, affordability and ownership*, Canadian Centre for Policy Alternatives, 2019.

[9] Office of the Seniors Advocate, *Billions More Reasons to Care: Contracted Long-Term Care Funding Review Update*, p. 26.

costs for legal support on contract language. Corporations and large organizations are inherently advantaged by a process in which they can more readily call upon these resources.

RFP competitions especially put smaller Indigenous organizations and service providers at a disadvantage, even as these organizations may have the necessary expertise and culturally appropriate approaches to the provision of health and social services. Competitive RFP risks undermining BC's commitment to truth and reconciliation enshrined under the *Declaration on the Rights of Indigenous Peoples Act* and Action Plan, under Goal 4 (Social, Cultural, and Economic Well-being), as Indigenous organizations—typically smaller and with potentially limited expertise with Eurocentric procurement approaches—often do not have resources to make successful bids. Previous and ongoing procurement reform initiatives have somewhat touched on this issue, but the existing Procurement Services Act and CPPM remain barriers.

Previous and ongoing procurement reform initiatives in BC

- In June 2018, the BC government launched the BC Procurement Strategy with a focus on removing barriers for small- and medium-sized enterprises to work with government. This initiative concluded in 2020 with the creation of a procurement concierge, replacement of the BC Bid application, among other adjustments. This initiative did not set out to change the CPPM or introduce any changes in the way that procurement policies and procedures affect contracted health and social services.

- At the same time, the government established the Community Benefits Agreement framework that allows government to use a unionized workforce for major infrastructure projects through the new crown corporation (BCIB).[10] The CBA includes requirements for good wages, apprenticeships, training, prioritization of work and opportunities for local communities, and Indigenous and under-represented groups.

- Formed in May 2019, the Social Services Sector Roundtable, chaired by the Minister of Social Development and Poverty Reduction and comprised of government and non-profit sector senior leadership, has been engaged in discussions about reforming contracting and procurement in the social services sector.

- In 2023, the Ministry of Finance established a Government Transfers Review and, as of September 2023, "extensive feedback has been received to inform policy updates needed to reflect modern values and provide the services that citizens depend upon." A draft policy proposal was forthcoming and to be provided to the Social Services Sector Roundtable.[11]

- Established in 2023, the Social Services Sector Roundtable Contracting Committee identified the need for procurement reform. In late 2023, the Committee's updated Terms of Reference were endorsed and 12 areas of focus were identified. In January and February 2024, the Committee identified four priorities for the year: 1) alignment of stakeholder engagement; 2) opportunities

[10] New framework ties major projects to benefits for workers and communities | BC Gov News

[11] Social Services Sector Roundtable Communique/Minutes, September 27, 2023.

for multi-year terms in contracts; 3) cybersecurity and secure data sharing; 4) timing for contract review and approvals.[12] Working groups are to be established for priority areas 2 and 4.

- There is currently no Ministry of Finance representation on the Contracting Committee, which would be required for discussion and adoption of substantive legislative or policy changes to the Procurement Services Act and Core Policies and Procedures Manual. The social services sector subcommittee members have identified the need for involvement and buy-in from the Ministry of Finance and PSEC.

Progressive procurement and non-profit sector funding reform: the case of Scotland

The Procurement Reform (Scotland) Act 2014 introduced cross-government changes to how the Scottish government and public bodies procure goods and services. Enabled by the legislation, statutory policy guidance outlines requirements and considerations for procuring health and social services for government and public bodies. Notable elements of the Procurement Reform (Scotland) Act 2014 and the statutory guidance are as follows:

- Sustainable procurement duty: In carrying out the procurement, a public body must consider how it can improve the economic, social, and environmental wellbeing of the authority's area; facilitate the involvement of small and medium enterprises and non-profit organizations; and, promote innovation.[13]

- Community benefit requirements: Contractual requirements may be established by the public body to improve the economic, social, or environmental wellbeing of the contracting authority's area.[14]

- Fair Work First requirements: Fair Work First is the Scottish government's policy for driving high quality and fair work across the labour market in Scotland, including appropriate channels for effective voice, such as trade union recognition, investment in workforce development, no inappropriate use of zero-hours contracts, action to tackle the gender pay gap, payment of the real Living Wage, flexible and family friendly working practices for all, and prohibiting the use of "fire and hire" practices (i.e., contract flipping). A public body can exclude a proponent from further consideration where they have failed to confirm in their tender that they will pay staff involved in delivering the contract at least the real Living Wage.

- Special considerations for procurement of health and social care services: Under legislation, a public body may award a contract for a health or social care service without putting it out to tender.[15] Specifically, a public body cannot award a contract on the basis of lowest price only;

[12] Social Sector Contracting Committee Report Out appended to February 29, 2024 Social Services Sector Roundtable Communique/Minutes.
[13] Procurement Reform (Scotland) Act 2014, s. 9.
[14] Ibid., s. 24-26.
[15] Ibid., s. 12-13.

contracts must be awarded on the basis of both quality and price.[16] In evaluating "quality," a public body must consider: the quality of the service; continuity of the service; affordability of the service; availability and comprehensiveness of the service; accessibility of the service; needs of different types of service users; involvement of service users; and, innovation.[17]

Furthermore, the statutory guidance provides helpful language that we suggest could be used in the revised CPPM:

> *As mentioned at section 7.1, buying health or social care services is a complex area and requires special consideration within a contracting authority's overall approach to procurement. This is because the quality or availability of these services can have a significant impact on the quality of life and health of people who might use these services and their carers. In addition, many of these services are becoming increasingly personalised to better match individual needs. For these reasons, these types of services are often purchased differently to other services. That is, a contracting authority has some flexibility to decide how to handle these contracts on a case-by-case basis.*

DISCUSSION

There are a variety of options available to government for progressive procurement reform and sustainable funding for non-profit health and social service providers.

Option 1 – *Major legislative and policy overhaul of the Procurement Services Act, CPPM, and CAMF: use alternatives to competitive tendering/RFP in health and social services (applicable to core provincial government and public bodies, including health authorities)*

The Procurement Services Act, CPPM, and CAMF are overdue for an overhaul. The BC government could repeal and replace or make changes in order to ensure that alternative procurement and funding models are used for contracted health/social services across ministries and public bodies, including health authorities.

The Act would benefit from amending Section 3 of the BC Procurement Services Act, which currently states the following:

> **Best practices**
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> **3** The minister may recommend to government, government organizations and local public bodies
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> (a)practices,
> (b)the form and content of agreements, and
> (c)arrangements
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> that promote fair and open procurement, competition, demand aggregation, value for money, transparency and accountability.

[16] Procurement Reform (Scotland) Act 2014: statutory guidance, May 31, 2022, p. 69

[17] Ibid., p. 68.

The principles of “fair and open procurement, competition, demand aggregation, value for money, transparency and accountability” are not reflective of the special considerations needed in health and social services capital procurement and provision. The principles and social values enshrined in Scottish legislation (as described in the previous section) could be incorporated into an amended BC Procurement Services Act (sustainable, community benefit, special considerations for health/social services, fair work/Living Wage).

Since the CPPM is only intended for use by the provincial public service, there is likely a need for a new policies and procedures manual specifically for health/social services procurement that applies to provincial government and some/all public bodies, including health authorities. Sections 2 and 3 of the BC Procurement Services Act provide the minister with the authority to develop the policies and procedures that public bodies, including health authorities, must follow. The CAMF applies to all public bodies, and so requires changes in order to shift health authorities away from competitive RFPs for capital asset procurement and service provision. For procurement reform to cover seniors’ facility-based care and encourage continued non-profit asset ownership and service delivery, changes must be made to the CAMF.

If the BC government sets as it objective to advance a comprehensive progressive procurement agenda to strengthen the care economy that <u>applies to all public bodies, including health authorities</u>, then Option 1 is preferred.

Option 2 *– Major policy changes to the CPPM to overhaul procurement policies and procedures (applicable to core provincial government only)*

Legislative changes or repeal of the Procurement Services Act, while preferable, are not required to overhaul current procurement policies and procedures of the core provincial public service/ministries. *CPPM Policy Chapter 6: Procurement* could be rewritten to require ministries to use alternatives to competitive tendering/RFPs in the health and social services sectors.

<u>Core funding under agreement is the preferred funding model for health and social services</u> delivered by the non-profit sector as it provides stable, ongoing funding based on agreed upon service delivery expectations and reporting requirements. A community roundtable convened by the BC Health Coalition in 2022 demonstrated cross-sectoral support from the BC Association of Community Health Centres, BC Crisis Lines Network, Federation of Community Social Services, unions and others for an end to competitive tendering in health and social service sectors, and the development of core funding models for non-profits.

However, since service delivery ministries and health authorities have no experience with core funding in the non-profit sector (except for health authority/hospital core funding), this option would be the most difficult to achieve. It would also require changes to the CPPM, meaning involvement by the Ministry of Finance.

Option 3 *– Minor policy changes to the CPPM to require use of existing alternatives to competitive tendering/RFP in health/social services (applicable to core provincial government only)*

Minor changes to the CPPM could require the core provincial public service/ministries to use existing non-RFP procurement mechanisms to fund health and social services. The CPPM only applies to core government, so this option would not apply to other public bodies, including health authorities.

With the existing CPPM, ministries maintain considerable latitude in *determining the specific mechanisms and funding models* it will use to. However, the current CPPM encourages open, competitive tendering. Changes to *Chapter 6: Procurement* could explicitly state that competitive tendering for health and social services is not an appropriate procurement instrument, and that alternatives should be used. The alternatives currently available to government are identified below (followed by a full description in the table below).

- Government transfer payment: Shared cost arrangement
- Government transfer payment: Grant
- Contract: Continuing service agreement (used for contracted long-term care operators)
- Contract: Transfers under agreement (STOB 80 contract)

Funding or procurement model **currently available to government*	**Description**	**Limitations and considerations**
Contract: Transfers under agreement (STOB 80) (current approach)*	Most CDC services are funded through one or more program-specific transfers under agreement (referred to as STOB 80 contracts). CDCs may hold multiple contracts for each of the CYSN programs they deliver, including early intervention therapies, infant development, supported child development and school-aged therapies.	Because these contracts are program-specific, MCFD manages many contracts. Each CDC may hold multiple contracts with specific deliverables and reporting requirements. CDCs do not fund their operations through these contracts alone as they do not cover the full cost of operations or capital costs. Historically, these contracts have been renewed without MCFD putting them out for competitive bid. While far from perfect, many CDCs would prefer maintaining the current approach rather than the use of competitive RFPs and retendering every several years as MCFD is pursuing. BCACDI and CDCs advocated that MCFD increase service levels by increasing funding/contract amounts with existing contract holders, rather than use competitive bids, in order to strengthen the existing CDC sector. MCFD has experience with this form of contracted service delivery.

Contract: Continuing service agreement*	Continuing service agreements (CSAs) are a contract for a specific service between a government entity and a contracted service provider (for-profit or non-profit). CSAs are used in the contracted long-term care sector: health authorities have CSAs with contracted LTC homes for publicly funded beds owned and operated by non-profit and for-profit entities. CSAs recognize that there are benefits to government funders and service providers maintaining a long-term relationship, and provide the service provider with long-term funding certainty.	CSAs have been used in the LTC sector for decades, with contracted service providers providing funded beds to health authorities. CSAs can be modified over time without the need for competitive tendering. Funding for LTC beds is not put out to competitive bid. Similar to CDCs, LTC providers offer specialized services. The BC government has experience with this form of contracting, and there is precedence for its use with organizations that deliver health care services.
Government transfer payment: Shared cost arrangement*	Government transfers include shared cost arrangements that are reimbursement and financing arrangements under contract or formal written agreement to individuals, businesses, or other entities for purposes specified within the agreement. Shared cost arrangements may involve different levels of government that are jointly sharing financial responsibility for specific types of costs related to a project. The funding of expenditures for a project may be shared by the government transfer recipient with other individuals, businesses or other entities. It will involve government transferring resources up front to provide the recipient with advance financing to be able to incur eligible expenditures. Note that the eligible expenditures do not have to be incurred in advance in order to qualify for the government transfer. There is a formal written agreement, legislation and other authorities setting out the terms and stipulations.	According to the CPPM, the selection of a service provider without a competition can only occur where: a. The shared cost arrangement is with another government organization; b. Only one service provider may be qualified or is available to provide the good, service or construction and no reasonable substitution is possible; c. An unforeseeable emergency exists, and the goods, services or construction could not be obtained in time by means of a competitive process; d. A competitive process would interfere with a ministry's ability to maintain security or order or to protect human, animal or plant life or health; e. The acquisition is of a confidential or privileged nature and disclosure through an open bidding process could reasonably be expected to compromise government confidentiality, cause economic disruption or be contrary to the public interest; f. Financial assistance is being provided to a specified target group or population; or g. A competitive selection process is not appropriate.

		The ministry is responsible for documenting why a competitive process was not undertaken. This documentation must be appended to a government transfer file and be available when requested.
Government transfer payment: Grant*	Payment is solely at government's discretion In most cases, recipients have to apply for or meet some eligibility criteria for a grant. Government decides how much, to whom, and when a payment is to be made. Legislative authority and a written agreement (see CPPM 21.3.5.2) are required for authorizing the grant. Eligibility and stipulations are set by government in the agreement that may include performance measures and reporting.	Although not explicitly stated in BC government guidance, we should assume that the Ministry of Finance has the same above requirements for grants as for shared cost arrangements. The Ministry of Finance clearly prefers contracts and competitive tendering (irrespective of how inappropriate it may be). However a directive from Treasury Board or changes to the CPPM could be used to ensure that ministries pursue the use of government transfer payments (grants or shared cost arrangements) to fund CYSN services.
Core funding under agreement (also called global funding or block funding)	Core funding models are intended to support the ongoing operations of health and social service organizations where there is a recognized understanding that the organization provides important program delivery on an indefinite basis. Core funding models typically involve some form of agreement that sets out service delivery expectations and/or staffing levels. Government funders may use funding envelopes which mean that organizations may not move dollars out of that envelope without express permission.	BC could develop a core funding model for contracted health and social services on the core funding used between the Ontario Ministry of Health and the non-profit sector of Community Health Centres. Core funding, with the use of funding envelopes, has enabled the sustainability and growth of the sector regardless of the government in power. It has also provided the flexibility for the organizations to move resources around (with limits) where there is the greatest need – something that CDCs are unable to do with the current STOB 80 contracts. Core funding is the preferred funding model for non-profit organizations, and it provides the greatest workforce stability. Since government has no experience with core funding models beyond hospital/health authority funding, it represents the biggest change in policy and practice within the public service. It would also require policy design and capacity that may not exist within the Ministry of Finance or other service delivery ministries (and without outside expertise).

KEY CONSIDERATIONS

Recognizing the public service's experience rests largely with established procurement practices, and the longer timeline required to overhaul procurement in BC, the existing transfer payment and contract instruments available to government (described above) may be the most practical.

Instrument 1 (government transfer payment: grant or shared cost arrangement) could potentially move the sector away from contracted-based procurement and closer to core funding, but without requiring significant policy work on the part of MCFD or Finance. However, the agreement language contained in any transfer payment agreement is important and should ***not*** be modelled on the Family Connection Centre contract language.

Trade agreements

It is often stated that public bodies must use competitive tendering due to trade agreements. However, health and social services are excluded from domestic and international trade agreements.[18] That said, once a foreign corporation/service provider is awarded a contract, BC becomes much more constrained in its ability to use direct awards or procurement instruments that may treat the foreign entity differently. Hence, there is considerable risk associated with the BC government and health authorities' current procurement approach because it leaves the door open for foreign corporations to become entrenched in BC, and then potentially exploit trade agreements to maintain their permanence.

Ensuring accountability for direct awards, request for expressions of interest, and core funding models

Government always has the option with contracts or grants for *direct awards* where a reasonable case can be made that there are no other experienced or suitable service providers. This is not a difficult case to make regarding health and social services, but some may be concerned about the optics of direct awards considering recent instances of mismanagement in direct awarded contracts for social housing. It is important to note that direct award funding is a long-practiced model that provides full accountability when basic rules for oversight and performance expectations are followed. Direct awards still involve the use of legally binding service agreements with performance and service delivery expectations. Where problems arise with direct awards, the issues are often based on lack of appropriate oversight of contracted providers or a lack of appropriate board governance and oversight of providers' senior executives.

Government and public bodies may also use requests for expressions of interest (RFEOI) to award contracts or grants exclusively for non-profit providers. The Ministry of Mental Health and Addictions, under the leadership of Minister Judy Darcy, initiated grants that provide funding exclusively to non-profits for community mental health services. The Ministry of Mental Health and Addictions has used

[18] Canadian Centre for Policy Alternatives Consortium on Globalization and Health, *Putting Health First: Canadian Health Care Reform, Trade Treaties and Foreign Policy*, Commission on the Future of Health Care in Canada, pp. 6-70; Canada-United States-Mexico Agreement, Chapter 13, Section D: Services; New West Partnership, p. 26.

the Community Action Initiative and CMHA to run grant competitions and award funds. This approach could be replicated more widely.

As well, core funding under agreement (also called global funding), modelled on what is used for Ontario's sector of Community Health Centres, recognizes that in any geographical health and social service area, there are only one or two providers with the appropriate expertise and trust with the population they serve. Core funding involves a legally binding service agreement between the funder and provider and establishes service provision, performance, and quality improvement requirements like any other contract. Core funding is the most significant shift away from "procurement" and "contracting" in favour of sectoral funding. This approach is ideal for Child Development Centres where there are a small number of existing, experienced non-profit providers. The core funding model shares similarities with the *continuous service agreements* that are used for both contracted non-profit and for-profit long-term care operators. Central to any core funding is embedding *quality improvement* through the routine use of meaningful data to improve services and empower organizations and frontline providers to champion improvement.

Capital funding

Health and social services typically require capital assets (the building and physical infrastructure) to provide services. Especially in seniors' care, the CPPM and CAMF have encouraged competitive RFPs in order for health authorities to get the private sector to finance new capital assets and then provide the services. A shift away from competitive tendering and reduced reliance on private sector financing necessarily means that the provincial government must provide predictable and ongoing capital funding for service delivery ministries and health authorities.

Competitive RFPs for long-term care became common in the late 1990s and 2000s because the provincial government did not – and still has not – developed a capital plan which provides predictable capital funding for health authorities and non-profits to finance new assets and meet the growing health and social service needs of the population. In sum, if there is a move away from competitive RFPs, the provincial government must recognize that ongoing and predictable capital funding (through provincial borrowing) must be provided to non-profit organizations and health authorities. Absent this, health authorities are forced to seek private sector financing through RFPs, and negotiate contracts that are more expensive over the long-term (because the private sector's cost of financing is always more expensive than available to government).

Knowledge of the non-profit sector and the importance of relational continuity

A main problem with the current procurement philosophy embedded in the Procurement Services Act, CPPM, and CAMF is that the culture of competitive tendering encourages public servants and health authorities to have little connection with, and knowledge of, non-profit providers and the rich knowledge held by the non-profit sector. The philosophy behind competitive tendering is the misplaced idea that there are many providers within a specific sector, and that competition drives innovation and lower costs to taxpayers. These assumptions are not borne out by evidence or experience in health and human services.

In most communities in health and social services, there are only a few (or one) reputable and experienced provider(s), and their knowledge of the community they serve means that the relational continuity with patients and clients ensures better quality care. In health care, there is a large and growing body of evidence on the importance of *relational continuity* where providers (and provider organizations) develop long-term relationships with the patients/clients they serve while continuously improving care quality through the use of data and patient-reported outcome measures. This results in better health outcomes, reduced emergency and acute care use, and lower costs to the taxpayer. Competitive (re)tendering creates organizational instability, staff turnover, and disrupts relational continuity between patients/clients and carers.

Conclusion

In conclusion, competitive tendering with RFP is a serious threat to the non-profit sector as it both encourages for-profit asset ownership and service provision. While there are existing ways to fund health and social services without significant changes to the current legislative and policy framework controlled by the Ministry of Finance and Treasury Board, we submit that a better policy approach is to revamp the policy to better reflect the nature of health and human service delivery.

Should the BC government wish to strengthen the non-profit sector over the long term, an overhaul of the Procurement Services Act, CPPM, CAMF, and the development of new guidance for procurement and core funding models for non-profit health and social services, would help strengthen and grow the non-profit sector. Major procurement reform would protect publicly funded and publicly delivered services against the growing incursion of for-profit asset ownership and service delivery in health and social services, especially led by the health authorities.