Fact Sheet

Shared Food Services

"Ready-Prepared" Food Systems in Health Care Facilities
Ready-prepared food production is a food preservation technique. Food production is separated from service by a time buffer.

Food is prepared and cooked using the conventional techniques and then rapidly refrigerated (cook-chill) or frozen (cook-freeze) using specialized equipment. Food is then stored at pre-determined and carefully controlled temperatures in specialized units. Food can be divided into bulk or individual meal portions either before or after refrigeration/ freezing. There are also two options for reheating (also called rethermalization or regeneration): bulk reheating or individual tray reheating.

The cook-freeze method has the highest fixed asset expenses. Cook-freeze requires identical equipment to cook-chill with the addition of a fast-freezing unit. In comparison with conventional hot meal preparation, cook-freeze requires 30 percent greater fixed asset costs and 75 percent more supervision time. Cook-freeze requires more packaging and higher disposal costs. Food costs are slightly lower in cook-freeze than cook-chill since food can be stored for longer periods and used in a subsequent menu cycle.

Freezing guarantees microbiological safety as long as the food is thawed in a cold room and served within 24 hours of thawing. However, freezing does alter the texture and other sensory characteristics of foods. Conventional cooking methods achieve better sensory results than cook-chill or cook-freeze when held hot for 60 minutes or less, but loses this advantage if the food is held 120 minutes or more.

Altogether the costs of moving to ready-prepared food represents a sizeable investment for cash-starved health care institutions. Few have the money to cover the complete capital investment and ongoing operating expenses. This opens the door to greater private sector involvement.

Privatization
Companies that wish to make inroads in the public sector often low-ball initial bids in order to get a foot in the door. Once the service is privatized and the company has a monopoly it can use its leverage to increase charges.

Ensuring that the supplier fulfils the terms of the contract may involve paying for additional supervisory staff to monitor performance, assess standards and handle disputes with contractors. The monitoring of compliance in dietary contracts is of particular importance in health care facilities because of the serious consequences of inadequate hygiene or food quality. Disputes regarding a contractor's performance may involve additional legal fees.

A related problem is that once services are reorganized under corporate control, it is often

complicated and costly for health care facilities to reclaim the service. This is particularly so if in-house kitchens are eliminated.

In many locations in Canada, the population base is small and the private sector is not equipped to supply the variety or volume of pre-cooked food products required by health care facilities. Selection is limited because Canada has few companies in the business of supplying ready-prepared products and those companies offer little menu choice.

Where food services are contracted out to an external commercial operation, there are also losses on public investments. Commercialization of foodservice operations may leave the public with capital assets - such as kitchen facilities, equipment, and storage space - which are no longer required. In this situation, taxpayers pay twice: first for the original capital investment and then for the use of the contractor's facility.

A major player in ready prepared food market in Canada has been Serca Foodservices. Until recently Serca was owned by the Canadian firm Sobey's (which owns food store chains like IGA), but was just sold to Sysco Corp of Huston, Texas. Purportedly, Sysco is North America's largest food marketer and distributor. Sysco, with more than 43,000 employees generated $22.6 billion (US) in revenue for the 2001 calendar year. Serca has operated throughout Canada with about 4,000 employees and a fleet of 500 delivery vehicles. It generated $2.21 in sales revenue for the year ended May 5, 2001.

Broader Social and Economic Costs

Contracting out of food service production can result in the reduction of work in the local area and reduced demand for local area businesses. The local economy may suffer if the service is contracted out to a company which is based elsewhere, or which sources a higher proportion of food and equipment outside the local area.

Typically, the profits of corporate catering firms are not spent in the same communities where they are generated. In contrast, most of the income of public sector workers and small business owners is reinvested in the local economy. As health care facilities are publicly funded institutions, it is entirely legitimate to consider broader policy issues of local economic sustainability.

This has been an explosive issue elsewhere (see the discussion of Winnipeg below) but may be less relevant in Toronto

Food is Central to Health Care

Nutrition is central to the healing process. The nutritional value of food is essential for both the sick and the elderly who rely on health care providers. These groups also face a higher risk of contracting food-borne diseases.

The companies which are lobbying to take over food production for health care facilities - along with the government agents, administrators and planning authorities who support privatization - always draw a line between medical services and the so-called "ancillary" or "hotel" services such as food, laundry and housekeeping. They argue that food is a

support service which is secondary to medical treatment and thus should be supplied by the private sector. In reality, food is a critical element of care.

Proper nutrition is essential for patients recovering from acute illness and injury as well as residents in long-term care facilities. Particular attention must be paid to the taste and sensory appeal of food in health care facilities so that patients and residents develop healthy appetites. Thorough study of different production techniques is necessary to make sure that patients are not put at risk by compromised food quality

Ready-Prepared Food: Impact on Care
Front-line food service staff perform a range of duties which include interaction with patients and consultation with nurses - duties which contribute to the therapeutic process in a health care setting. If most dietary staff are removed to central production facilities, workers who remain will likely have more narrowly defined tasks which do not include the extra care now provided by food service workers to patients and residents.

Menu Limitations
Cook-chill and cook-freeze methods limit menu options because they do not work with all food dishes; for example, steaks, fried food, eggs, and pastries do not adapt well to cook-chill and cook-freeze. Cook-chill works best if food is contained in a sauce; for example, gravy for meat and broth for vegetable dishes. If meals are reheated in trays, however, the broth will sink to the bottom and leave the top of the dish dried out. Reheating in bulk seems to work better.

The Effect on Work Skills
In a conventional food service operation, one of the main requirements of skilled staff is in the choice and preparation of raw food materials. With ready-prepared food, these skilled positions become redundant and much of the preparation work of the conventional kitchen is eliminated. Ready-prepared food shifts the emphasis from a cook's individual skills and creativity to standardized production with less personal influence.

Health and Safety
The repetitious work of rapid assembly production is a health concern for kitchen staff with these responsibilities because it increases the risk of repetitive strain injuries. Another issue is the heavy weight and awkward shape of bulk food packages and rethermalization carts. Injuries caused by slippery floors in the freezer section at the production site are also reported.

The dietary staff at Burnaby Hospital in Vancouver have registered serious health and safety complaints about their cook-chill system. In its first year of operation, the injury rate in the dietary department increased on average 28 percent per month (averaged over the entire year).

It is common for new production methods to be implemented without appropriate consideration of safety measures, especially if staffing levels cut and workloads increased. Without proper planning, working conditions will suffer.

Proper Planning
Long before considering implementation issues, administrators and consultants planning food service reorganization should thoroughly examine various options and facilitate open discussion with community members, workers, and dietary experts. In Britain, health care facilities which achieved overall benefits using new food service methods had completed exhaustive feasibility studies carefully considering the costs, training requirements, technology needs, nutritional quality and related issues. By contrast, unsuccessful facilities relied exclusively on data supplied by consultants and manufacturers and had a narrow focus on cost reduction.

Packaging
In order to protect hygiene and maintain safe temperatures, transportation of food from the central facility to satellite kitchens requires sanitation packaging. Most of this packaging is not reusable and produces considerable garbage.

Maintaining Kitchen Capacity
Health care facilities must maintain kitchen capacity in-house to produce fresh food and to address special health conditions and ethnic diets. In facilities that have long term care beds, kitchens can help make the facility more like home and deal with special occasions. Without kitchens, the facility becomes dependent on the pricing and quality decisions of the contractor supplying the food.

Shared Food Services: Troubled Projects
The evidence so far uncovered with respect to existing shared food service operations in Canada suggest that cost reductions are not easily achieved.

In Ottawa, the Hospital Food Services facility has supplied bulk food for a number of years. However, in an evaluation of food service reorganization options several years ago, the Notre-Dame Hospital in Montreal found that purchasing Ottawa commissary food was more expensive than the hospital's in-house cost. A proposal to extend the Ottawa shared food services (to include a central tray assembly and washing facility) was turned down by participating hospitals because of its "heavy capital requirement with limited payback potential".

Hospitals in Toronto rejected a similar model of shared food services. The nineteen hospitals involved concluded that capital costs would outweigh any benefits. Official correspondence stated that "the most common reason for opting out was that the pay-back was insufficient to warrant the required capital expenditure".

An advanced plan for shared food services in the Quebec health care sector was in the region of Mauricie-Bois-Francs. Following a negative community response to a report which advocated centralizing food services, the regional health board set up a committee with representation from administrators, users, unionized food service staff, and academics with expertise in nutrition and economics. Twelve acute and long-term care facilities were involved. The committee rejected the option of developing a new shared food service facility as unfeasible and exceedingly costly.

Winnipeg

In the mid 1990s, Winnipeg hospitals moved to set up a shared food service for nine hospitals. In 1997 a contract was signed with the private contractor, Aramark: it would design the new Regional Distribution Facility (RDF) and manage production. Service began in September 1998. The RDF received frozen and chilled cooked food from private corporations. Food was thawed and placed on trays at the RDF and it was then transported to the hospitals where it was heated in carts. The dirty trays were sent back to the RDF for cleaning.

Although a major factor behind the move to the new system was the out-of-date kitchens at the two largest hospitals, the new system was unable to provide enough trays of food for all the facilities: as a result the two largest hospitals continued to use their old kitchens and did not actually use the new system.

CUPE and the United Food and Commercial Workers raised concerns about the new food system. The public became incensed with the new system. Instead of producing food in Winnipeg, the private corporations brought much of the food in from other areas – even from outside of the province. There were complaints about food quality. There was particular concern about the quality of food for those in long term care beds, who would have to eat the food for a long time, perhaps the rest of their lives. It was also hard to meet special dietary needs under the new food system. There were also major health and safety issues at the RDF with the tray belt and the dish room. Much of that facility had to be redesigned.

To try to defuse the issue, the Conservative government began to make concessions; severance packages for dietary workers were made the best in the province, it became easier for hospital dietary workers to transfer to the RDF, and new money for training was made available for dietary workers.

This was all to no avail for the Tories. The new food system became a major issue in the provincial election that saws the defeat of the Progressive Conservative government and the election of the New Democrats.

In the fall of 2000, a new report on food services was developed by unions, hospitals, and the new government. It set a new course: work would be brought back in house from the private corporations. A new kitchen would be established at the Health Sciences Centre that would produce much of the food. Instead of producing food in other regions, the jobs would be in the public sector and in Winnipeg. Aramark's contract to manage the RDF would be allowed to expire and management would be brought back to the public sector. Long term care facilities would keep their kitchens; they would be used for special meals (so the residents could have a whole turkey cooked in their kitchen for Thanksgiving or Christmas).

Problems, however, still remain (for example, capital funding for the changes to the Health Sciences Centre has not yet materialized). Still, significant progress was achieved.

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