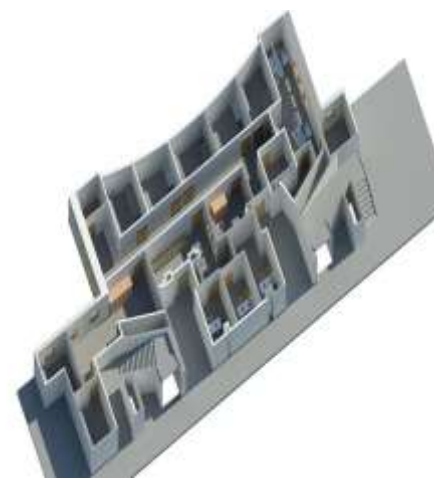


Abstract for Polyclinic and Hospital Construction



This abstract reflects general aspects of Polyclinic and Hospital construction



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The medical care sector has come a long way. Today, there is an expansion of networks and a rapid growth of hospitals and medical care centers with advanced medical equipment and highly qualified staff all over the world. The private sector is expected to play a leading role in medical care sector.

Hospitals will have to meet the high expectations of the public and all stakeholders in an increasingly challenging environment. There are many issues with which hospitals must now contend. These include increasing health care costs that are no longer publicly—or politically – tenable, changing trends in reimbursement for services, demands for transparency of cost and quality data, and workforce shortages. At the same time, the conditions and care needs of hospitalized patients are more complex. The rise in patients with chronic illness, older age adults, and medical interventions and therapies, are already influencing hospitals today and this very trend will grow in the future.

The importance of hospital-based care will not diminish in the future. Changes in the social and economic environments in which hospitals operate, as well as medical and technological progress require hospitals to be equally transformative as the future unfolds. There has been a hospital building boom underway fueled by increasing demand for care services, and increasingly obsolete hospital plants. Though economic conditions are expected to slow its pace, the continuing investment in hospital construction offers the opportunity to refurbish hospitals; its design, culture and practices to better meet the needs of patients and families, and the aspirations of those that provide their care.

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Unless there are principles to guide the development of the hospital of the future, hospitals may simply not be able to surpass the status quo of today.

High health care costs and inadequate access to specialized care are fueling fast growth in medical tourism. Would-be patients in developed countries are traveling thousands of miles –most often to India and Thailand --to receive high-quality care at dramatically lower costs and with no wait. Medical tourism is now a multi-billion-dollar industry. In the past years, a medical tourist was someone seeking services that were not covered by health plans, such as cosmetic surgery. Today, a medical tourist is as likely to be seeking full

or partial joint replacement, cardiac surgery or even stem cell therapy. As a result of revelations concerning patient safety, hospitals have had to look inward at practices, policies and even the cultures and attitudes that are prevalent in their delivery settings. In doing so, there is now renewed emphasis and acceptance that it is the patient who is at the center of care. Not only is the patient the main point, but the patient has the greatest stake in their care and as such, should be respected as an equal partner in their care. The elevation of the patient to partner is not a ceremonial title bestowed for a “feel good” moment, but has significant implications for the quality and safety of patient care.



Today, half of all hospitalized patients have one or more chronic condition, such as diabetes, heart disease and asthma. The prevalence of chronic illness is expected to steadily increase. By 2030, it is estimated that 171 million people will have at least one chronic illness. By this same year, older adults will account for more than 20 percent of the population. While older adults are expected to live

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longer, this will not be without personal health challenges. More than 75 percent of adults over age 65 suffer from at least one chronic condition, and many have multiple conditions. Among current Medicare beneficiaries, 20 percent have five or more chronic conditions. According to the WHO, because of the shortage of health care workers at least 1.3 billion people around the world have no access to basic health care services. In response, the WHO is pressing countries across the globe to address the ethical and financial impacts of worker migration, as well as efforts to retain workers within their country of origin. The practice of health care worker importation and exportation is, of course,

unsustainable. But, it begs the question:

Who will staff the hospital of the future?

Any time an organization embarks on a large project, it can be helpful to reduce that project to small, easy-to-manage parts. With that in mind, most building projects can be organized into six distinct phases:

1. Planning. This includes “blue sky” (“wish list”) considerations, master planning, and predesign efforts.
2. Schematic design. This involves drawing a rough outline of the

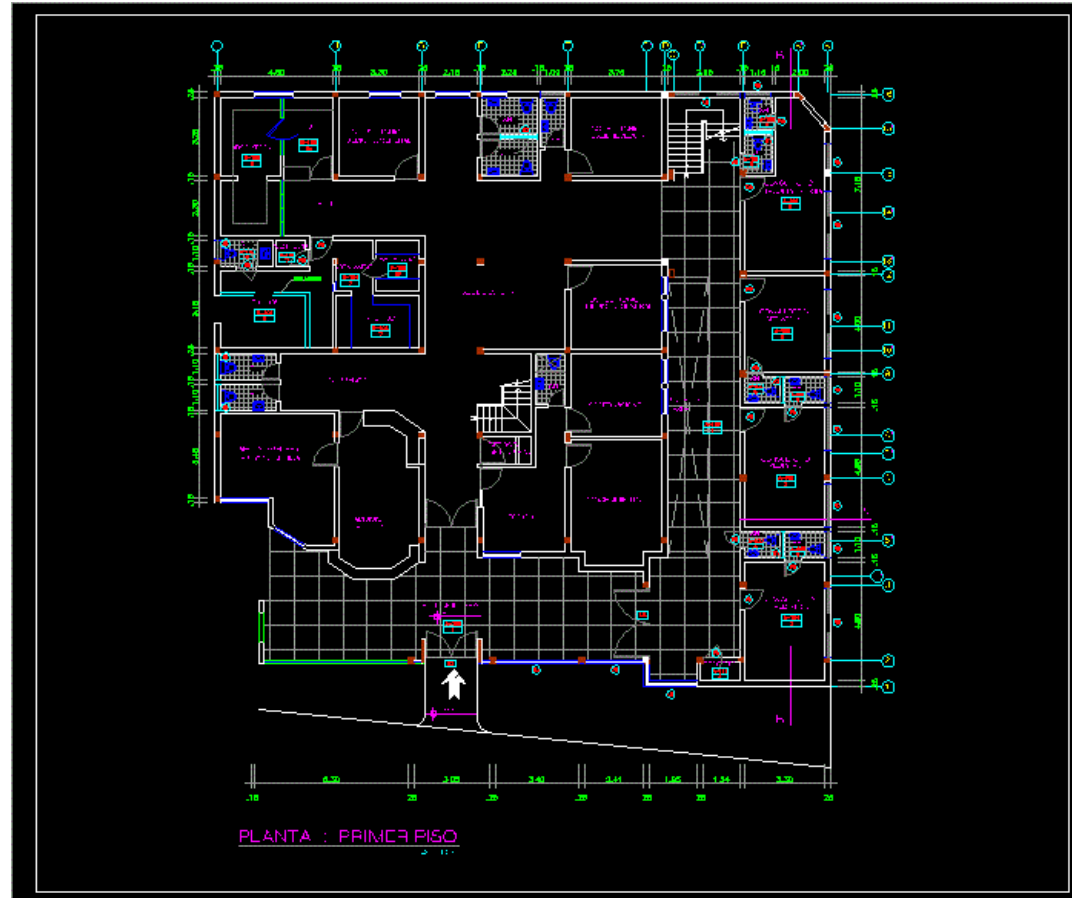
project, including preliminary room layout, structure, and scope.

3. Design and development. This includes adding details to the design, including fixtures, furniture location, and decor.
4. Construction documents. This requires converting all aspects of the design into a template from which contractors can estimate costs, identify issues, and plan construction activities. At this point, organizations will discuss contract conditions — the rights and duties of all participants, including the owner, the contractor, and the architect.
5. Construction. This is the phase in which the building or facility is actually built.

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6. Commissioning. Before taking ownership of a building, project, or renovation, an organization must make sure that all specifications are met and that all systems, components, equipment, and so forth are fully operational. Commissioning encompasses these activities.

Although some of these phases can overlap, they are usually implemented sequentially. The phases provide a framework for the building process; however, some degree of variation is common on almost every building project.



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