

***OHA Position Statement on
Funding and Capacity Planning for
Ontario's Health System and Hospitals***

October 2011

Background

Public sector programs will be strongly impacted by economic factors over the next several years

Ontario's economy will face significant challenges for the foreseeable future. World-wide economic uncertainty and economic downturns among Ontario's major trading partners have led to growing concerns for the outlook for Ontario. Recent private sector forecasts for real growth in Ontario's Gross Domestic Product (GDP) have been revised downward from forecasts earlier in the year.¹ Slower GDP growth impacts government's ability to pay down the deficit and sustain public program expenditures.

The most recent figure for the Ontario provincial deficit is \$14 B for the 2010/11 fiscal year.² The March 2011 Ontario Budget projected the deficit to be eliminated in six years by 2017/18. Over the next five to six years, all publicly funded sectors will be under increasing budget pressures.

In a concentrated effort to spur progress on the deficit, the 2011 Ontario Budget announced the creation of the *Commission on the Reform of Ontario's Public Services*. The Commission's report will inform the 2012 Ontario Budget process with recommendations for improving the efficiency of delivering public sector services including health care.

Health care will experience cuts in real dollar terms

Health care is the largest single budget expense. Annual nominal expenditure increases for health care overall, are planned to hover closely around three percent until 2015/16, according to the 2011 Ontario Budget. In real dollar terms, this represents a *decrease* in funding after accounting for inflation, population growth and other cost-driving factors. In comparison, non-health care sectors including education, justice and children's services among others, face even deeper cuts. There is a risk that the plan for three percent growth in health care may be revised downward depending on economic conditions.

Ontario's Auditor General considers the health care funding outlook to be aggressive

In its *Pre-Election Report on Ontario's Finances*, the Office of the Auditor General reports on its review of government's estimates for "reasonableness" and determines whether government fiscal policy is based on cautious and prudent assumptions. Regarding health spending projections, the report states:

"...The government is projecting that, over the next three years, these costs will grow annually at only half the rate that they have grown in the last eight years....In light of Ontario's growing and aging population, we consider this to be an aggressive rather than a cautious outlook."³

¹ www.scotiacapital.com/English/bns_econ/forecast.pdf
<http://www.rbc.com/economics/market/pdf/provfcst.pdf>
http://www.td.com/document/PDF/economics/qef/prov0911_update.pdf

² Ontario Ministry of Finance, 2010-2011 Public Accounts of Ontario Annual Report and Consolidated Financial Statements, August 2011, p.9.

³ Office of the Auditor General of Ontario, The Auditor General's Review of the 2011 Pre-Election Report on Ontario's Finances, June 2011, p.6.

Ontario's past experience with significant budget cuts

In pursuit of aggressive spending reduction targets, Ontario can draw on its previous experience with large budget cuts and subsequent health services restructuring in the 1990's. In the early to mid-1990's while nominal growth in hospital expenditure had been flat, hospitals had made major efficiency gains through shorter hospital stays and shifts to outpatient surgery and services, enabling large bed and staff reductions.

In the Fall of 1995, government announced two major initiatives affecting health care: large cuts to hospital funding and; the creation of the Health Services Restructuring Commission (HSRC). Budget cuts were to occur over three years. The plan—which was not fully achieved—was to take \$1.3 B out of a \$7.3 B budget: \$365 M in 1996/97; \$435 M in 1997/98 and \$507 M in 1998/99. The establishment of the HSRC was an additional effort to reduce costs and make system improvements.

The sequence of events—with cost cutting occurring prior to restructuring—was problematic. Restructuring required substantial investment and would take time. With the planned three years of budget cuts, hospitals had tight time frames to find efficiencies over and above those achieved in the prior five years. However, the hoped-for efficiencies through mergers and clinical program shifts, as part of restructuring, were not to be realized until future years.

The hospital budget cut intentions were absent of any coordinated strategy to ensure that the cuts could be made without undue disruption and service gaps. After two years of cuts, during which time hospitals found and implemented the last of the major efficiency gains, the only way to implement the plan for year three would have been to directly reduce service volumes which in turn, would impact on patients. The 1998 Ontario Budget announced the cancellation of the third year's cuts and also announced a substantial increase to the restructuring budget:

“Planned reductions in hospital operating funding of \$507 million initially scheduled for 1998-99 will not occur.” (p. 42)

“The 1997 Budget included a provision of \$450 million to support restructuring in the health care system. As a result of additional directions from the Health Services Restructuring Commission (HSRC) and revised information from the hospital sector, this provision has been increased by \$430 million to \$880 million to enable a more efficient and effectively managed health care system to better meet the needs of patients.” (p. 28)

The lack of that essential, coordinated strategy to achieve spending cuts, the insufficient time allowed for capturing proposed savings and the desire to avoid sweeping service reductions meant that budget targets were not achieved. As a result, by the late 1990's many hospitals incurred significant budget deficits which, combined with other factors, was a major cause of hospital working capital deficits that were not addressed. Working capital deficits, which still hamper the hospital system today, have resulted in imperfect "workaround" policy solutions which include government provision of hundreds of millions of dollars in annual cash advances to hospitals to avoid substantial service reductions. The 2011 Ontario Budget commitment to provide hospitals with \$600M to \$800M of working funds relief is now addressing the problem which stemmed from the lack of a realistic cost-

savings plan in the late 1990's—an issue which was compounded over the years by additional deficit-contributing factors.

A further result of the major shifts in funding and services that occurred throughout the 1990's was the shock to the health care labour force. In the absence of a plan, the turbulence of the times negatively impacted both health professionals and employers across the system.

As the HSRC progressed with its work in the latter half of the decade, its decisions were in fact, guided by system-level “capacity planning”. With capacity planning, the HSRC was able to determine a more optimal mix and level of services, both in and out of hospitals for the immediate and future time periods. Planning included the development of benchmark levels for different types of hospital and long-term care beds and community “places” based on population needs and forecasts.

This type of planning, if used today at the system level, would help foster equitable access, ensure provincial standards, facilitate proactive system management and encourage a more cost-effective service mix. Capacity planning is also a necessary tool with which to finally address the root causes of the current but long-standing and avoidable ALC and ED wait times issues. Provincial-level system capacity planning has not been carried out since the HSRC ceased operation in 2000.

For the HSRC, capacity planning also pointed to the need to invest in community services. In the restructuring years that followed the mid-1990's and in a retrospective look at the HSRC in *Riding the Third Rail* it was observed that restructuring—largely of the hospital sector—would have been much more effective if higher levels of investment were made in community services.

“The trend toward outpatient care cannot be optimized without reinvestment in community-based care”⁴

More funding in the community would have reduced pressures on hospitals and provided greater access to care in more appropriate settings.

Ontario's current situation is much more challenging than in the 1990's

There are important similarities between the current situation for health care and that in the 1990's; there are plans for real-dollar cuts to the health budget but no apparent strategy for change that incorporates all sectors of the system that is synchronized with budget financial goals and timelines.

With regard to hospitals specifically, the current situation is much more difficult than in the past.

In the 1990's hospitals were able to find definite, material efficiencies with beds and staffing levels continuing to be reduced throughout the decade. Today however, there is very little room to move. Since 1998 the number of hospital beds (all types) has remained virtually constant at approximately 31,000 but the population has since grown by 1.9 million people or 16%. While outpatient surgeries (which help offset the need for inpatient beds) have increased over time, the per-capita rates have remained steady

⁴ Duncan Sinclair, et al. *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996-2000* (Canada: The Institute for Research on Public Policy, 2005).

over the last seven years.⁵ Hospital bed occupancy rates in Ontario are very high, exceeding 90% for acute care beds in a great many hospitals. An OECD health database of 26 countries shows Canada's acute care bed occupancy rate is 93%. Canada's rate, which is heavily weighted by Ontario, is higher than all other countries in the dataset except Israel.

The ability to reduce beds by reducing the length of a hospital stay is likely at the limit in many organizations. Of all the provinces, Ontario has the second lowest length of stay for acute care (at only 6.9 days) and the lowest age-standardized acute care hospitalization rate at 7,046 per 100,000 people.⁶ The only province with a shorter length of stay is Saskatchewan and that is because, based on their population hospitalization rate, they must be admitting many patients who are treated as outpatients in Ontario. With only 2.3 beds (all types) per 1,000 people in Ontario, the province ranks at the very low end in a comparison with over 30 other countries.⁷ It should also not be forgotten that hospitals now face additional constraints in reducing beds due to obligations to meet service volume targets such as for hip and knee replacements under Ontario's Wait Times Strategy and Canada's Health Accord.

Further, with respect to funding, recent government funding adjustments for hospital base budgets have been lower than in previous years and have also been kept at levels below the inflation rate. Hospital base budget increases for the fiscal years 2009/10 to 2011/12 were 2.1%, 1.5% and 1.5%. Operating costs are already considerably lower than in other provinces. On a per capita basis, provincial government hospital expenditure is lower in Ontario than in every other province except Quebec, which has approximately 30% lower wage rates for nurses. In fact, if Ontario hospitals were funded at the per-capita level of the average of all other provinces, annual expenditure would be \$3.5 B higher than currently.

Hospitals are now in a position in which there is little room to maneuver. While there is always room for improvement at the margins, unless strategic changes are made at the system level, there is very little ability to cut back on capacity in hospitals. The only way to reduce hospital capacity is to keep people out of hospital, which requires investments in the community sectors.

Future funding decisions require a strategic, systems-level approach

While stable access to hospital services has been maintained over the last three fiscal years due to early notification of funding levels and close collaboration of hospitals with LHINs and government, any plans for further reductions to hospital budgets, in real dollar terms, will require strategic, targeted change throughout the system if there is a desire to maintain stability and also to ensure equitable access to services.

⁵ See:

http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Outpatient+Surgical+Cases+per+1000+Population+Ontario

⁶ CIHI, Highlights of 2009–2010 Inpatient Hospitalizations and Emergency Department Visits, May 2011.

⁷ OECD Health Data, 2011 and Ministry of Health and Long-Term Care Daily Census data.

In developing the province's expenditure plan for each of the different sectors within the overall health care budget, it is critical that an approach be taken that considers the system as a whole. The expenditure plan for 2012/13 and beyond must take into account the complex, sensitive linkages and interdependencies in the system that are often not fully appreciated in funding decisions.

For example, the ongoing "Alternate Level of Care" (ALC) problem, in which approximately 4,000 people designated as ALC cannot be discharged from hospital due to a lack of appropriate home care or long-term care, illustrates the close connection between community service levels and the demand for hospital care. In turn, the ALC problem is a contributing factor in the wait times for a range of hospital services including emergency department services with 10% of admitted patients waiting in the emergency department for more than 28 hours. Therefore, funding decisions for each sector should take into account the fact that significant changes in funding levels (real or nominal) in one area of the system tend to "spill over" to affect access to services in other parts of the system, often in unintended, yet predictable ways.

OHA Position on Hospital and Health System Funding in a Period of Restraint

The OHA's vision of achieving a high performing health system reflects our commitment to work collaboratively to accomplish important goals. Despite hospitals currently working at a very high state of occupancy and efficiency, we recognize the challenges posed by the current fiscal environment and the implications for all sectors within the health care system. Given the relative size of health care in the provincial budget, if the Province is to be successful in eliminating the deficit, managing debt and funding a range of priorities, health spending, with hospitals in particular, will be a key area of focus.

Solutions to address health care spending must be ones which bring lasting results and which do not destabilize the system or impede access to needed care. There is a considerable risk, however, that "across-the-board" funding cuts (i.e. funding reductions in every sector or "same percentage" cuts within sectors) may be seen as a straightforward, swift and "fair" solution.

In fact, such an approach, which would ignore the very real complexities of the system, might yield short term savings but would have major consequences that cannot be undone quickly, easily or inexpensively. Long lead-times and transitional costs in either reducing or expanding services in health care's highly labour-intensive environment make this a serious concern.

Instead of across-the-board cuts, more fundamental changes are required that will improve the system's functioning and positively impact on health outcomes and access to care in a cost-effective way. A more workable approach involves making strategic changes in the way services are provided and funded.

With funding reductions (in real dollar terms) for the overall health budget, it is expected that major areas of the system will experience restraint. Even when coupled with the best of plans, staffing levels, wait times and breadth of services will still be impacted.

To enable the proposed funding reductions and to help alleviate service gaps, there will need to be shifts of funding from some areas of the system to allow investments to be made in other key areas. These funding decisions should be strategic and need to be guided by way of a careful, evidence-driven process which will employ capacity planning and other types of tools and evaluations.

As well, still more approaches are needed to help manage the funding cuts, while enabling lasting change. While there are countless strategies available to promote system and organizational efficiencies, the need to move quickly requires a focus on a select number of concrete actions at the provincial level. **To that end, the OHA offers the following recommended actions that will help mitigate the impact of funding cuts on patients and that will help position the system on a course of a more restrained growth in expenditure that can be maintained over time.**

Recommended Actions to Support Hospital and System Stabilization through a Period of Funding Restraint

A number of these actions, which overlap and reinforce each other, have been introduced previously in “*Ideas and Opportunities for Bending the Health Care Cost Curve*”, a joint OHA-OACCAC-OFCMHAP⁸ report. In addition, these actions are consistent with a set of health system reforms proposed by the OHA and the OACCAC in an April 2011 document entitled “*Four Pillars: Recommendations for Achieving a High Performing Health System*”.⁹

It is worth repeating that the “four pillars”—**Setting Ambitious Goals; Planning Properly; Letting Evidence Drive Care Decisions; and Connecting Care**—are strategies that allow high quality, accessible and efficient health care to be compatible with current fiscal realities.

1. Identify and reduce utilization in high-impact, high-cost areas

Provincial efforts to constrain health care spending can be most effective if they are focused on specific high-cost areas in order to achieve targeted results. A vast store of health information is available that can be used to identify high-cost, high-impact areas of spending and utilization, in order to prioritize strategic efforts. Current data reveal that just one percent of Ontario’s population—130,000 people—account for virtually half of the province’s combined hospital and home care costs and that only five percent of the population account for 85% of these costs.¹⁰

A great deal of this public expenditure is concentrated among people who have chronic illnesses which includes not just seniors, but children and other select populations. Seventy percent of Ontarians with a chronic condition have at least two but many people have three or more co-existing conditions.¹¹ Overlapping physical and mental health issues are common. Chronic disease is recognized world-wide as a major health care cost driver and the Ministry of Health and Long-Term

⁸ OACCAC: Ontario Association of Community Care Access Centres. OFCMHAP: Ontario Federation of Community Mental Health and Addiction Programs.

⁹ See <http://www.oha.com/CurrentIssues/Issues/Documents/Four%20Pillars%20-%20FINAL%20FULL.pdf>

¹⁰ Ministry of Health and Long-Term Care, Health-based Allocation Model (HBAM) presentation.

¹¹ Ministry of Health and Long-Term Care. *Preventing and Managing Chronic Disease: Ontario’s Framework*, May 2007. <http://www.health.gov.on.ca/english/providers/program/cdpm/index.html#1>.

Care (MOHLTC) estimates that one third of Ontario’s direct health care costs are due to chronic illness.

Ontario has access to many clinical and policy experts in the field of chronic disease prevention and management—within clinics, hospitals, public health, academic settings and in government policy settings. While a chronic disease management and prevention framework has been developed by the MOHLTC, immediate and focused efforts involving a range of Ontario’s experts need to be directed to spurring implementation of the framework.

Expediting system-wide management efforts for a range of chronic conditions—not just one condition at a time as is the case with diabetes in the province—with the right investments, could result in very large savings. Better management could, at the very least, postpone the need to use high cost services by months or years for individuals. The OHA calculates that \$12 B in annual Ontario health expenditures can be attributed to major chronic illness. At the low-end, if a five percent reduction can be achieved through effective strategies, \$600M could be saved annually. A ten percent reduction would reduce annual expenditures by \$1.2 B. Similarly, by identifying ways to address expenditures for sub-populations of the “one-percent group”, a five percent reduction in expenditure would amount to \$400 M annually; a ten percent reduction would save \$800 M annually.¹²

2. Make targeted, evidence-based investments in key areas through shifts in funding

Targeted investments will be essential in certain areas to enable the system to cope with overall real-dollar funding cuts. In particular, if hospitals are to meet expectations for financial targets without creating further service gaps, a re-profiling of current funding will be required in areas that can help stem the demand for high-cost acute and emergency care. An “investment funding envelope” can be created by shifting a portion of funding from larger sectors and programs that have experienced relatively high growth in expenditures, to two key areas:

- **Community-based services and other identified services and programs** to help to address the Alternate Level of Care (ALC) issue, to enable more people to live at home longer, and to improve and maintain physical function. In addition to essential community supports, including primary care services, this area of investment should include strategic investment in hospital-based complex continuing care and rehabilitation programs and certain long-term care programs, both for restorative and rehabilitative purposes. The recently released “*Walker Report*” which provides comprehensive recommendations involving system re-design should be a foundational work to guide strategic investments in this particular area including for example, geriatric assessment clinics, frail elderly day programs and homemaker services.¹³ Targeted efforts will be

¹² Ontario Hospital Association. *Ideas and Opportunities for Bending the Health Care Cost Curve*, April 2010. [http://www.oha.com/News/MediaCentre/Documents/Bending%20the%20Health%20Care%20Cost%20Curve%20Final%20Report%20-%20April%2013%202010\).pdf](http://www.oha.com/News/MediaCentre/Documents/Bending%20the%20Health%20Care%20Cost%20Curve%20Final%20Report%20-%20April%2013%202010).pdf)

¹³ Dr. David Walker. *Caring for Our Aging Population and Addressing Alternate Level of Care: Report Submitted to the Minister of Health and Long-Term Care*. June 2011. http://www.health.gov.on.ca/en/public/publications/ministry_reports/walker_2011/walker_2011.aspx

further reinforced through effective chronic disease prevention and management investments as discussed above.

- **Mental health and addiction services, both community-based and hospital-based** in order to begin to close long-standing service gaps with more effective and less costly alternatives to the status quo. There has never been a greater appreciation than currently of the need to invest in mental health and addiction services both from the perspective of meeting needs and ensuring equitable access and from the perspective of providing cost-effective care. The gains that have been made in advancing to this level of understanding should not be lost due to the economic environment, which itself contributes to greater need for services.

Within each broad area, specific decisions on where to invest should be based on clear evidence that the investment can provide the intended result—as measured in terms of overall system savings and better patient care. While these decisions are being made, the OHA suggests that in the short term and until a more firm number can be validated, that annual nominal per-capita funding increases for Community Care Access Centres and for the Community Mental Health and Addictions Sector be targeted at 5.5%.¹⁴

This 5.5% in the per capita level exceeds the 2011 Ontario Budget commitment to increase funding for a range of community sectors by approximately three percent (not per capita) in each of the next three years. With regard to CCACs in particular, the Auditor General's Review of pre-election finances noted above, shows that the government's projected annual growth in expenditure in CCACs will be 2.3% for 2011/12 to 2013/14. Given that this sector has the smallest overall budget (about \$2 B) and has an important role in alleviating the demand pressures for hospital care, new investments are clearly needed and these can be made possible through careful shifts in funding.

Further, as these funding shifts occur and as policy decisions are made regarding high-value investments in the system, the way to ensure that a “re-profiled” system can be maintained will be to do the necessary capacity planning as outlined below.

3. Integrate physicians into the structural reform of the system

The organization of primary care and specialty physician services is integral to the operation of the entire system, and meshes with a number of recommended action items here. Following the October provincial election, structural reform of the health system has the opportunity to occur. OHA's official position on structural reform specifically is that: Family Health Teams and other primary care organizations, along with physician specialists and public health be directly integrated and aligned with other parts of the local health care system. There are currently between 2,000 and 3,000 primary care entities in Ontario and there is no transparent accountability for their performance. Also, there are many people who are not “effectively” rostered to primary care organizations.

¹⁴ The 5.5% per capita annual increase would comprise a 3.5% increase plus a percentage increase for annual inflation which is assumed at 2%, as per the Bank of Canada's current target inflation rate.

Consideration of integrating the physician sector on a regional/local basis is key to ensuring alignment of incentives, reducing gaps in care, addressing the needs of high cost and chronic conditions and helping to keep people from needing hospital care. The inclusion of physician services in capacity planning will allow for an even more comprehensive strategy for addressing current and future health care requirements.

4. Initiate provincial-level health care capacity planning

Given a set of strategic policy decisions regarding where investments need to be made and where shifts in funding are required—as per identified goals for improving both health and the operation of the health care system—capacity planning is essential to be able to make informed operating and capital funding decisions.

Capacity planning is a process for determining current and future health service requirements and for making the necessary preparations to be able to meet those requirements. Put simply, capacity planning involves a range of activities such as setting benchmarks for things like the number of hospital beds, long-term care beds, assisted living spaces, home care hours and primary care services—to name but a few requirements—that are necessary to meet the needs of the different populations using these services. Benchmarks should be guided by the best evidence available for determining appropriate utilization levels.

Capacity planning provides key information for proactively managing the system. Which components of the system need more or less funding in the future? What are the health human resource requirements? Are the plans for human resource requirements in line with health system budget forecasts? How can services be organized in such a way to get the best “value for money”? What will be the needed levels of capital investment—for construction costs and equipment purchases—and where should those investments be made or avoided?

Frequently however, “unforeseen” cost pressures arise due to lack of capacity planning at the system level. The result is gaps in service; greater demand for hospital care if appropriate alternatives are not available; and reactive funding decisions when cost and demand pressures become too great.

The current ALC situation, with approximately 4,000 people in hospital beds who would be better served elsewhere, is a symptom of inadequate capacity planning. The OHA estimates that every 10% shift of ALC patients in acute care (who are waiting for long-term care who could be cared for with appropriate home care services) to home care, results in a \$35 M savings.

Provincial-level capacity planning has not been conducted in Ontario since the HSRC ceased operation in 2000. Capacity planning needs to be an on-going process to be able to properly configure the system and to anticipate and proactively address “pressure points” before they become problems.

5. Accelerate the Excellent Care for All Strategy with a focus on improving quality and basing decisions on solid evidence

There are many excellent examples of quality improvement initiatives and evidence-based decision making in our health care system. Such initiatives can save money by identifying practices that are less than optimally effective or that could be provided more efficiently. Further improvements and cost savings can be gained by expanding and accelerating these efforts, particularly by targeting “big ticket items”. One example is the province’s current best practice initiative for total hip and knee replacement which identifies that a patient’s home is almost always the best setting to receive rehabilitation following surgery. This initiative frees up hospital beds and costs much less than the traditional rehabilitation hospital bed model, but will achieve comparable clinical outcomes. The potential exists for diverting approximately 5,000 elective joint replacement cases annually, to a home-based rehab program at a cost differential of \$3,500 per case or \$17.5 M in total¹⁵. Also, by linking this initiative to Ontario’s pending Patient-based Payment funding system, financial incentives and disincentives are created to promote and ensure compliance with best clinical practices.

The Province’s Excellent Care for All Strategy is intended to promote compliance with best clinical practices. The plan is for Health Quality Ontario (HQO) to continually identify these quality clinical pathways and procedures. As HQO begins to take on this mandate, an opportunity exists to do this by leveraging the capacity of one of government’s more recent investments. The Council of Academic Hospitals of Ontario (CAHO) has been funded to establish a program called Adopting Research to Improve Care (ARTIC). This innovative work is aligned with the quality agenda in that its mission is to move research evidence from the “bench to the bedside” to help drive quality and improve patient care across hospitals. ARTIC could be positioned to provide support to HQO to identify clinical practices that should be used throughout Ontario, offering high value in terms of quality and cost savings.

6. Implement Patient Based Payment (PbP) for funding hospitals

Patient-based Payment is an approach to funding providers that is being used increasingly in other countries, primarily for hospital funding. PbP is a method in which funding is allocated in accordance with prices/rates and volumes of services delivered.

PbP can be used to create “built-in” incentives to serve patients in an effective and efficient way. The prices or rates paid for services can be set at a level that enables a provider/hospital to provide those services within certain quality standards, given reasonable costs. PbP creates strong incentives for hospitals to keep actual costs in line with the reimbursed rates and allows hospitals to benchmark their cost profiles with others. PbP is not an open-ended funding method. PbP can be employed in an environment of fixed budgets with pre-set or negotiated volumes.

¹⁵ OHA calculation.

This funding method can be used to incent quality; it can be used to encourage more services of a desired type to be provided and it can use funding to discourage and penalize practices that have been proven, using proper evidence, to have little or no health benefits.

In Ontario, the MOHLTC, the OHA and other groups have collaborated for many years to reach the point where most hospitals could soon begin to be funded on a PbP basis for a broad range of services. PbP is currently being used in Ontario for some specific areas, for example to incent increased provision of “wait times” services. PbP can be combined effectively with accountability agreements that provide for negotiated volumes, which can be further informed through capacity planning.

PbP systems that are aligned across sectors can be even more powerful in driving improvements in quality and efficiency. Care is frequently provided across a continuum that spans more than one sector. Tremendous opportunities exist if all parts of the system are encouraged, by design, through the PbP process, to pull in the same direction. This includes achieving alignment in provincial funding rates for hospitals, physician services, home care, long-term care and others.

Ontario’s continuing effort to implement PbP needs to be expedited. The next step in this important process should be to create a provincial payment commission. A payment commission would be responsible for the critical process of developing and continually revising provincial rates for hospital services (initially) and for other services as work progresses. Establishing a successful PbP funding system in Ontario rests on setting the “right” rates, ensuring that funding directly supports and ensures quality, evidence-based care.

7. Consider options for addressing labour costs

There are limited options available for meeting very ambitious expenditure reduction targets in a compressed period of time, without seriously impacting access to needed care. If services levels are to be maintained under this scenario, consideration will have to be given to finding ways to restrain the growth in the prices paid for labour—the health care system’s major “input”. While the challenges that arise in addressing this option through various means are not underestimated, the area will need to be explored particularly if there is little choice in making rapid and substantial funding cuts.

A number of the fundamental changes listed above will improve the system’s functioning and positively impact on health outcomes and access to care in a cost-effective way going forward, but may take 12 to 24 months until the initial benefits begin to be realized. Although short term labour restraints may not create long term or lasting savings, there are immediate pressures that will not be solely solved by the necessary fundamental changes previously described. Given the very high level of efficiency at which hospitals are currently performing, labour cost restraints will be necessary throughout all health care sectors to minimize impacts on services to patients.

Actions should be taken to make changes to the Hospital Labour Disputes Arbitration Act to further guide arbitrators’ decisions. There should be a designated Employer Bargaining Agency for health services employers to strengthen the bargaining process. The government should also amend the Workplace Safety and Insurance Act to permit hospitals to elect coverage under Schedule II of the Act (i.e. self insurance) to reduce costs and provide an incentive for workplace safety.