Ontario Hospitals - Leaders in Efficiency

Second Edition

August 2024

Ontario Hospital Association

100 Years

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About this Document

This report provides key information and context regarding Ontario hospitals' long track record of efficiency as well as the significant pressures they are facing today.

Through a brief narrative, together with supporting evidence in the form of a series of descriptive charts, the report offers a wider lens view of the hospital sector's past and present state.

Hospital Efficiency in Context

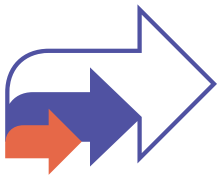
This is the second release of *Ontario Hospitals - Leaders in Efficiency*. First released in December 2019, just prior to the COVID-19 pandemic, this report demonstrates that Ontario hospitals are unquestionably efficient. The sector continues to demonstrate high efficiencies evidenced in the annual "efficiency dividend" results for 2023. In 2023, had Ontario funded hospitals at the average rate per capita for all other provinces, it would have cost the province an additional $3.7 billion.[1] Ontario's efficiency dividend frees up resources for the province to spend on other health and non-health sector priorities.

With a long track record of lean operations, Ontario hospitals have experienced ongoing capacity pressures characterized by frequent bed shortages and hallway health care. The onset of COVID-19 pushed the stress points in hospitals and the health care system to critical levels. This revealed the repercussions of a system highly focused on efficiency but with insufficient planning and resources to ensure surge capacity. With government support, hospitals responded to the crisis, becoming the backstop of the health care system, supporting other sectors such as long-term care, and providing critical services.

Pandemic recovery has not been easy as hospitals have continued to tackle the backlog of care, health human resource (HHR) challenges, labour cost pressures, general price inflation, and higher COVID-19-related operating costs. Compounding these difficulties, in fall 2022, Ontario experienced a significant surge in respiratory illnesses exacerbating HHR challenges and creating further capacity issues – at times even requiring patient transfers between hospitals due to high occupancy. Recovery of the primary care and home care sectors has also been challenged creating greater demand for hospital care. These severe, ongoing pressures highlighted the importance of keeping hospitals financially whole to ensure operational stability, particularly as the continuing impact of COVID-19 on hospitals has now become the new norm.

Today, as the system still struggles to stabilize, Ontario hospitals and health system providers continue to go to extraordinary lengths to maintain access to services for a growing and aging population. The 2023/24 fiscal year brought additional challenges, as hospitals faced tremendous financial

Ontario hospitals' lean operations trace back to over 20 years ago. The then-implemented hospital funding formula successfully controlled costs while promoting fair resource distribution. This approach incentivized hospitals to innovate, leading to more day surgeries, alternative staffing models, and practices reducing admissions. Consequently, Ontario hospitals operate efficiently with fewer beds compared to most other provinces and other developed countries tracked by the Organisation for Economic Co-operation and Development (OECD). This has allowed Ontario hospitals to effectively "bend the cost curve" while maintaining quality. However, throughout this period, while population growth and aging continued, there was a great unmet need for capacity planning at the provincial level. By 2018, hospitals faced severe capacity issues due to systemic shortages, leading to hallway health care and inequitable service access. The allocations provided under the present funding model are insufficient to address modern hospital needs. While hospitals maximized efficiency, this left little room for growth or sudden demand increases, as evidenced during the pandemic.



uncertainty, particularly due to the overturning of Bill 124. In view of such obstacles, the financial and operational outlooks appear uncertain for the 2024/25 fiscal year.

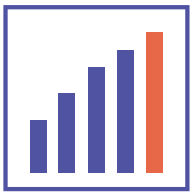
Once again, hospitals are seeing high occupancy rates, record long emergency department (ED) wait times, record high numbers of Alternate Level of Care (ALC) patients and worsening hallway health care. This has occurred even with the government's commitment to make permanent 3,500 beds that were added during the pandemic. On a per capita basis, Ontario still has low numbers of hospital beds, both in comparison to other provinces and other countries. It continues to be the case that the overall health system requires a continual process of capacity planning for beds and spaces, and for essential HHR. This is necessary to ensure an appropriate mix of services across sectors – namely, home and community care, rehabilitation, long-term care and primary care – to help alleviate pressure on hospitals.

The additional funding provided to hospitals throughout the pandemic – and for recent pressures related to increased demand, inflation, Bill 124 impacts and more – has been substantial but critically necessary. In fact, in the five years since 2019, Ontario's population has grown by 10% or approximately 1.4 million. While managing these extraordinary costs, Ontario's hospitals have been fiscally prudent, maintaining their long-standing collective position of having the lowest per capita expenditure by a provincial government.

Most hospital cost pressures are very difficult to control, especially given that almost 70% of expenditure relates to staffing. In response to increases in capacity and demand, hospitals have added 35,000 net new HHR positions, creating unavoidable added expense. Traditionally, hospitals have managed labour cost pressures using finely tuned staffing models to safely respond to patient demands. Current strategies involve maximizing the full scope of regulated health care professionals, introducing teams with a varied skill mix that includes both registered nurses and registered practical nurses, and greater use of nurse practitioners and physician assistants, where possible.

With respect to compensation, hospitals have developed a province-wide central bargaining process that avoids having to conduct almost 400 separate negotiations, also avoiding an additional cost of approximately $33 million. Ontario's highly efficient central bargaining process for hospitals has resulted in wage settlements below those experienced elsewhere in the broader public sector (BPS). The overall hospital bargaining

Bill 124 - *Protecting a Sustainable Public Sector for Future Generations Act, 2019*, imposed temporary wage restraint on health care workers and other public sector employees to a maximum annual increase of 1% for three years. Bill 124 was overturned in November 2022, resulting in renewed labour negotiations that culminated in multiple arbitration decisions providing additional compensation payments to affected staff. An unprecedented and unplanned event, hospitals had to contend with six provincial arbitration decisions over the course of a few months that required that retroactive payments covering two to four years be made over a compressed timeline within the 2023/24 fiscal year. Throughout this process, hospitals were challenged in managing cash flow as they awaited government funding support for these extraordinary expenses. A portion of these reimbursements from government have been made at less than a "dollar-for-dollar" basis with hospitals making up the shortfall, leading to additional financial stress in the face of growing demands. Outstanding reimbursements are still to be calculated for 2024/25.



outcomes for the last 10 years, including those from the Bill 124 reopener arbitration decisions, are lower than the major BPS average by 0.02%.

There are countless instances of hospitals improving and streamlining services. At the macro level, there has been continued consolidation of hospital corporations as well as sharing of senior staff across organizations to achieve greater efficiency. As of 2024, Ontario has 128 hospital CEOs leading 136 hospital corporations – a consistent reduction in corporations from 141 in 2019 and 225 in 1995.

Achieving a lean financial position is not an end in itself. Given the current demographic pressures, without substantial investment in innovation, productivity-improving technology and higher service volumes, quality will begin to suffer and access to care further challenged. Performance measures need to account for factors beyond efficiency and consider the functionality of the overall health system.

While there is room for improvement and a clear need for reinvestment, it should be recognized that Ontario's health system overall is performing well in comparison to other provinces. Out of 37 provincially comparable indicators tracked by the Canadian Institute for Health Information (CIHI) that are designated as "more desirable" (above average performance), same as average or, "less desirable" (below average performance), Ontario performs above average on 16, the same as average on 12 and below average on only nine.[2]

Hospital leaders know they cannot lose ground and are working tirelessly in partnership with other health system partners to transform the health care system, while being highly accountable for their operations. Ongoing collaboration with government to advance and modernize hospitals and the broader system is crucial to meeting Ontario's intense demographic demands and continuing to deliver quality care in a highly efficient manner.

The Evidence

The following sections offer key evidence of Ontario hospitals' current and past record of high-performance, as well as the pressures building over the past few years.

Ontario Hospitals Are Fiscally Responsible

SAVINGS

Ontario hospital budgets reflect the **lowest hospital expenditure per capita by a provincial government**. If Ontario were to fund hospitals at the average rate per capita for all other provinces, it would cost the province an **additional $3.7 billion;** under Alberta's funding model, **$4.5 billion.**

Ontario hospitals contribute to:

- **The lowest** health care expenditure per capita by a province
- **The lowest** provincial program expenditure per capita by a province

HOW ONTARIO HOSPITALS HAVE DONE THIS

CLINICAL INNOVATION

Continuous improvement has led to Ontario having:

- **The lowest** hospitalization rate in Canada
- **The lowest** average length of stay in acute care hospitals in Canada, equal to Quebec

Which results in:

- **The lowest** cost of a hospital inpatient stay in Canada
- **A low rate** of hospital beds per 1,000 population in comparison to most other provinces and other developed countries tracked by Organisation for Economic Co-operation and Development (OECD)

LEADERS

Hospitals have achieved these results while:

- **Maintaining** quality of care over time
- **Ensuring** a responsible approach to compensation

SYSTEM CAPACITY ISSUES

EVEN IN DIFFICULT TIMES

Hospitals face **record setting**:

- Emergency department wait times
- Number of patients waiting in emergency to be admitted
- Number of patients designated as Alternate Level of Care (ALC), waiting in hospital for more appropriate services elsewhere
- Population growth and aging

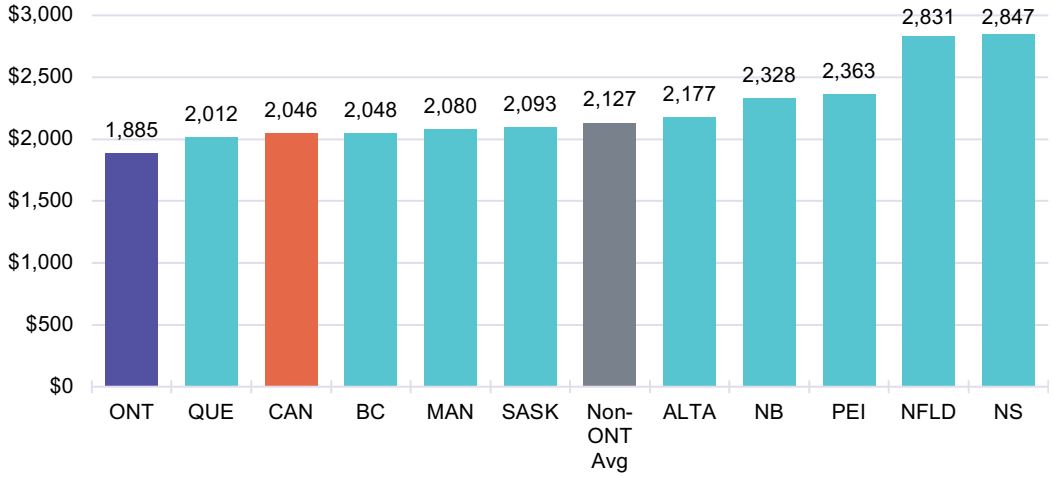
Ontario Government Hospital and Health Spending in Context

Hospital Expenditure

Provincial government expenditure on hospitals is lower in Ontario than in any other province, at $1,885 per capita for 2023. If Ontario were to fund hospitals at the average rate per capita for all other provinces ($2,127), it would cost the province an additional $3.7 billion. This is the Ontario **hospital** efficiency dividend.

Per capita hospital expenditure by provincial governments is lowest in Ontario

Figure 1a
Hospital Expenditure, $ per Capita by Provincial Governments, 2023

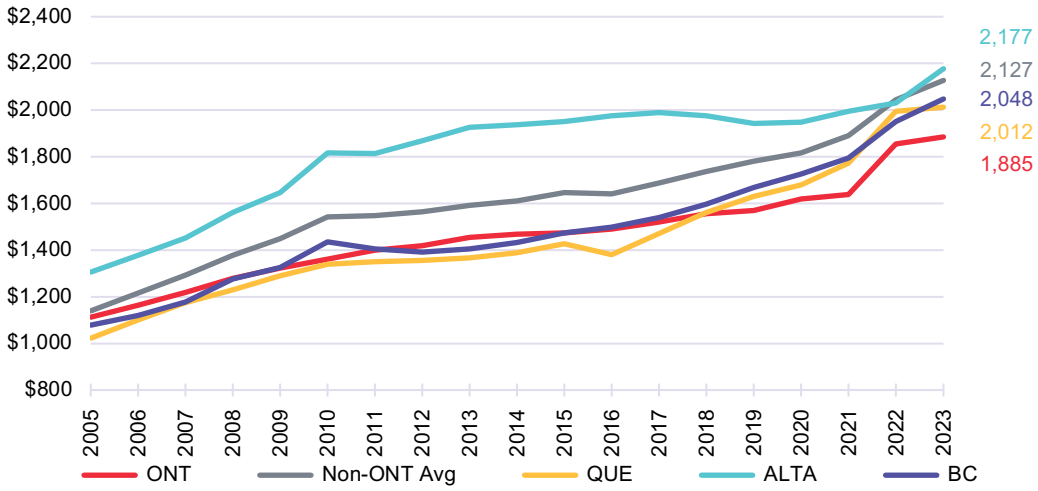


Source: CIHI National Health Expenditure Database, 2023 forecast, Canada includes Territories. Next annual update November 2024.

For the past 18 years, Ontario's hospital expenditure has remained at some of the lowest levels in Canada. Over the last five years, it was consistently lower than the expenditures of the other three largest provinces and the non-Ontario average.

Per capita hospital expenditure in Ontario has been lower than in most other provinces for many years

Figure 1b
Hospital Expenditure, $ per Capita by Provincial Governments, 2005-2023
Four Largest Provinces and Non-Ontario Average



Source: CIHI National Health Expenditure Database, 2022 & 23 are forecast. Next annual update November 2024.

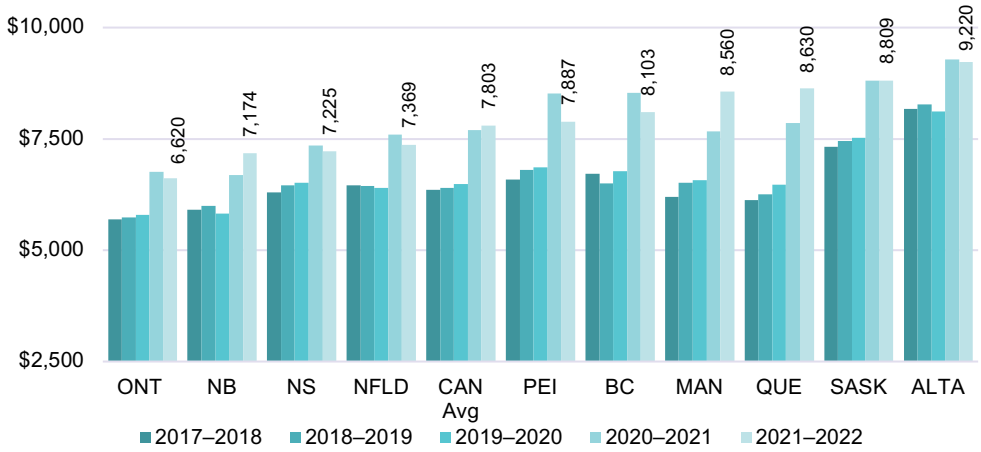
Hospital Unit Cost

Ontario has had the lowest cost of a hospital inpatient stay in four of the last five years. Ontario was 15% lower than the Canadian average in 2021-22 (the most recent year of available data).

In all provinces, hospital unit costs rose significantly during the beginning of the pandemic. Most provinces saw a decline in hospital unit costs from 2020-21 to 2021-22.

Ontario has had the lowest cost of a hospital inpatient stay of all the provinces for several years

Figure 2
Cost of a Hospital Inpatient Stay in $, by Province, 2017-18 to 2021-22



Source: CIHI Your Health System - In Depth. Canada Average includes Northwest Territories and Yukon. Next annual update November 2024.

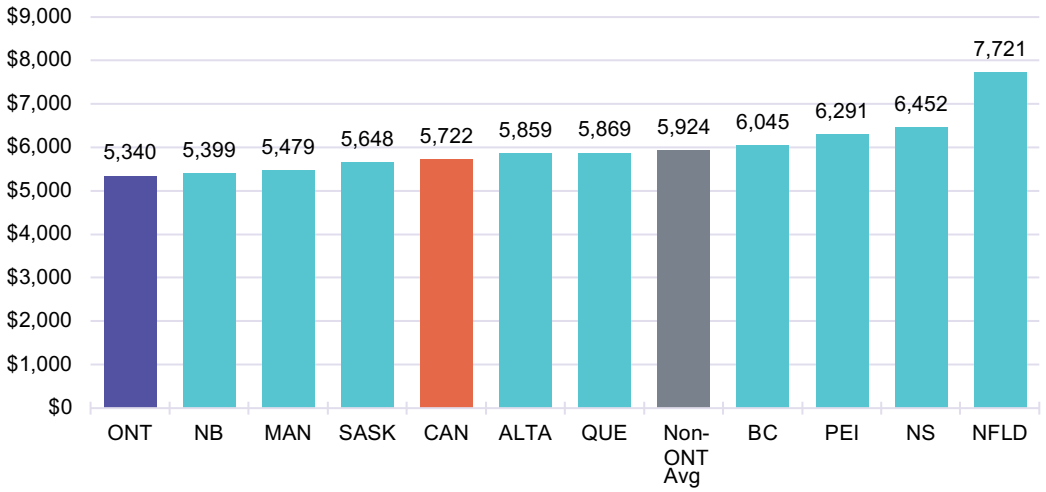
Ontario hospitals have continued maintaining lean operations for many years. During a decade of restraint prior to 2016-17, Ontario hospitals faced four consecutive years of 0% increases in base operating funding – the main funding envelope supporting basic requirements and excluding specialized programs or specific targeted funding – from 2012-13 to 2015-16. As a result, hospitals have absorbed a significant portion of costs related to population growth pressures and annual inflationary costs.

Health Care Expenditure

Ontario's provincial government total health care expenditure for all sectors is the lowest of all the provinces at $5,340 per capita for 2023. If Ontario were to fund health care at the average per capita rate for all the other provinces ($5,924), it would cost the province an additional $8.9 billion. This is the Ontario **health care** efficiency dividend.

Figure 3a
Health Care Expenditure, $ per Capita by Provincial Governments, 2023
All Health Care Sectors* excluding COVID-19 Response Funding

Per capita health care expenditure by provincial governments is lowest in Ontario



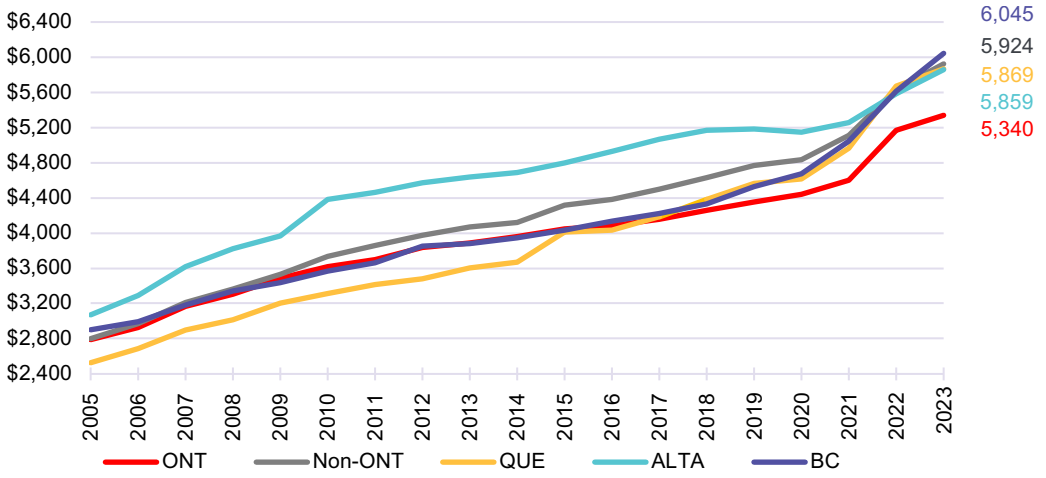
* **Health care sectors include:** hospitals, physicians, drugs, public health, other institutions, other professionals, home and community care, capital, research, health system administration and other. COVID-19 response funding (tracked under "Health Care Expenditures" and not under "Hospital Expenditures") was provided in 2020, 2021 and 2022 and not in 2023. Therefore, figures above reflect the fact that there was no COVID-19 funding in 2023.

Source: CIHI National Health Expenditure Database, 2023 forecast, Canada includes Territories. Next annual update November 2024.

Ontario is the lowest and has been below the average for all other provinces since 2005 for all health sector expenditures.

Figure 3b
Health Care Expenditure, $ per Capita by Provincial Governments, 2005-2023
All Health Care Sectors, excluding COVID-19 Response Funding
Four Largest Provinces and Non-Ontario Average

Per capita health care expenditure in Ontario has been in the lowest range in Canada for many years



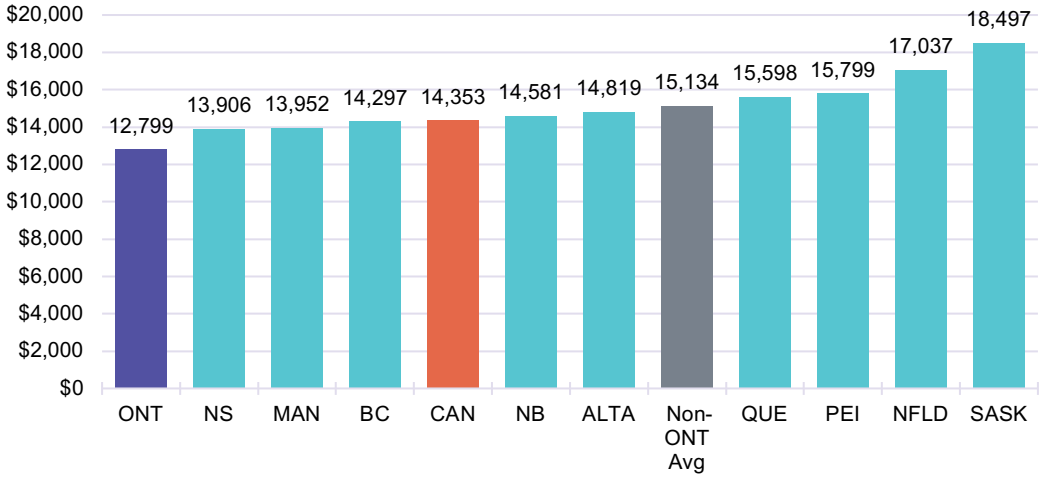
Source: CIHI National Health Expenditure Database, 2022 & 23 are forecast. Next annual update November 2024.

Provincial Government Program Expenditure

Provincial government expenditure for all programs combined (e.g., health, education, transportation, social services, justice and others) is lower in Ontario than in any other province at $12,799 per capita for 2021 (latest year available). If Ontario were to fund provincial programs at the average per capita rate for all the other provinces ($15,134), it would cost the province an additional $34.6 billion.

Per capita provincial government program expenditure is lowest in Ontario

Figure 4a
Provincial Government Program Expenditure, $ per Capita, 2021

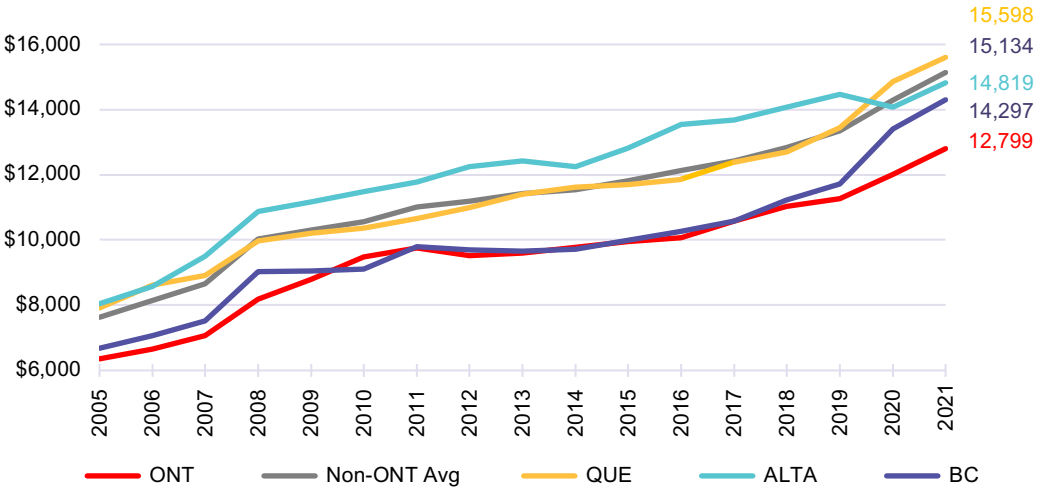


Source: CIHI National Health Expenditure Database, 2021 (latest year available), Canada includes Territories. Next annual update November 2024.

From 2005 to 2021 (latest year available), provincial government expenditure on all programs combined has been the lowest in Ontario in all but two years (including provinces not shown).

Per capita provincial government program expenditure in Ontario has been the lowest in Canada over many years

Figure 4b
Provincial Government Program Expenditure, $ per Capita, 2005 to 2021
Four Largest Provinces and Non-Ontario Average



Source: CIHI National Health Expenditure Database, 2021 (latest year available). Next annual update November 2024.

Hospital Wage Settlements

Recent Collective Bargaining Outcomes

Ontario hospitals have taken a responsible approach to compensation

Health care is a labour-intensive sector. With approximately 70% of hospital costs attributed to HHR, collective bargaining outcomes have a significant impact on future hospital cost pressures.

The highly efficient central bargaining process for Ontario hospitals has resulted in wage settlements below those experienced in the broader public sector (BPS) as is shown in Figure 5.

The overall hospital outcomes for the last 10 years, including those from the Bill 124 reopener arbitration decisions, are lower than the major BPS average by 0.02%.

Figure 5
Trend of Collective Bargaining Outcomes (Hospitals) Compared to Relevant Average Outcomes of Other Major Ontario Broader Public Sector (BPS) Employers

Year	Hospital Average Outcomes	Major BPS Average Outcomes	Hospital vs Major BPS (Negative: hospital outcomes are lower)
2016	1.05%	1.09%	-0.04%
2017	1.05%	1.32%	-0.27%
2018	1.40%	1.85%	-0.45%
2019	1.58%	1.80%	-0.23%
2020	1.68%	1.79%	-0.12%
2021	1.76%	2.48%	-0.71%
2022	4.31%	3.04%	1.27%
2023	3.50%	3.04%	0.46%
2024	3.00%	3.12%	-0.12%
2025	3.00%	2.99%	0.01%
Average/year	2.23%	2.25%	-0.02%

Source: Ontario Hospital Association.

Ontario Hospital Bed Capacity and Usage

Beds vs. Population

Ontario hospital beds have increased in the past several years after almost two decades of virtually no change

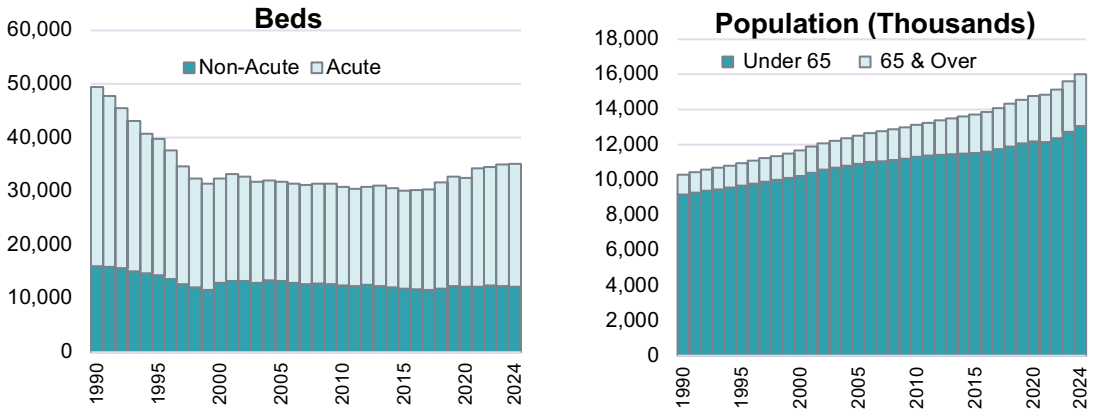
An overall per capita bed reduction occurred worldwide beginning in the early 1990s. In Ontario, bed supply declined sharply in response to fiscal restraint, hospital restructuring and technological change.

From 1999 to 2018, overall bed capacity remained virtually constant while the population increased by 25%. In 2018 and 2019, additional beds were added to relieve extreme occupancy pressures. Additionally, to better manage strained capacity, hospitals were implementing ground-breaking strategies to improve patient flow and surgical scheduling processes.

The pandemic further exacerbated the bed situation. More beds were added to accommodate demand surge and physical distancing protocols. During this period, the government announced the creation of more than 3,500 new hospital beds which have now been made permanent. These beds are essential to managing additional demand due to the high population growth experienced in recent years. Since 2019, Ontario's population has grown by 10% or approximately 1.4 million.

As of March 2024, the total number of hospital beds is approximately 35,000 of which 65% are acute care beds.

Figure 6
Ontario Hospital Bed Capacity vs. Population, 1990 to 2024

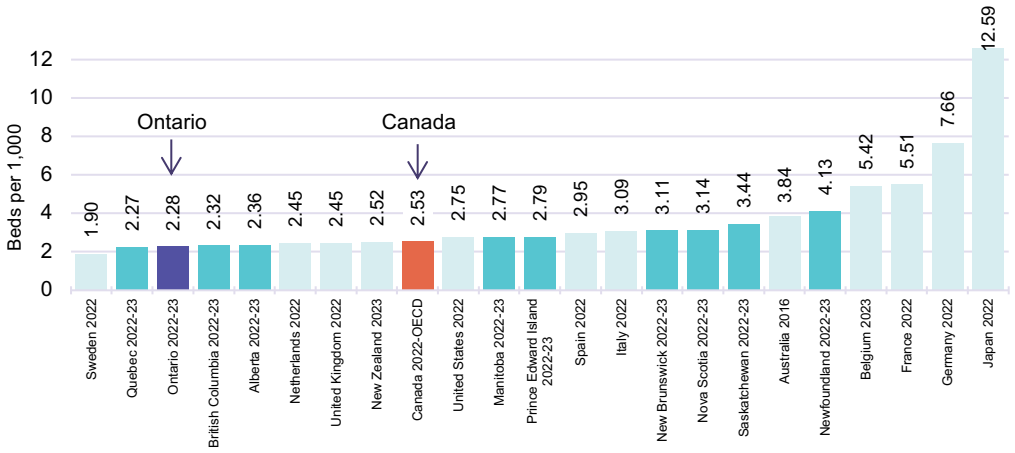


Sources: Ontario Ministry of Health and Ontario Health Bed Data; Statistics Canada Population Data.

Ontario has the second lowest number of total hospital beds (all types) per 1,000 population in Canada, at 2.28. When comparing the province of Ontario with developed countries that are tracked by the OECD, only Sweden has fewer beds.

Ontario continues to have low numbers of total hospital beds per 1,000 population

Figure 7
Total Hospital Beds per 1,000 Population, 2016 to 2022-23
Ontario vs. Other Provinces and Selected Countries



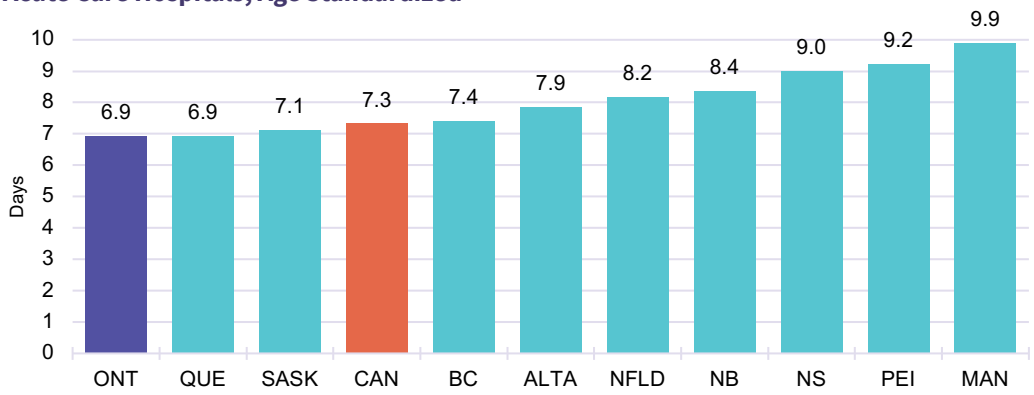
Sources: OECD Health Statistics as of July 2024; CIHI Hospital Beds Staffed and In Operation 2022-23. Beds per 1,000 population calculations made using population data from CIHI National Health Expenditure Database 2022-23 (forecast). Most recent year available for each jurisdiction shown. CIHI notes that bed counts for Saskatchewan hospitals may be overstated due to data quality issues.

How Hospitals Have Managed – Shorter Stays, Fewer Hospitalizations

To accommodate Ontario's growing and aging population while facing a shortage of beds, hospitals continue working to shorten stays, reduce the need for hospitalizations (through greater use of same-day procedures and outpatient services) and a host of other innovative quality and operational improvement efforts.

Figure 8a
Inpatient Average Length of Stay in Days, by Province, 2022-23
Acute Care Hospitals, Age Standardized

Ontario is tied with Quebec for the lowest average length of stay

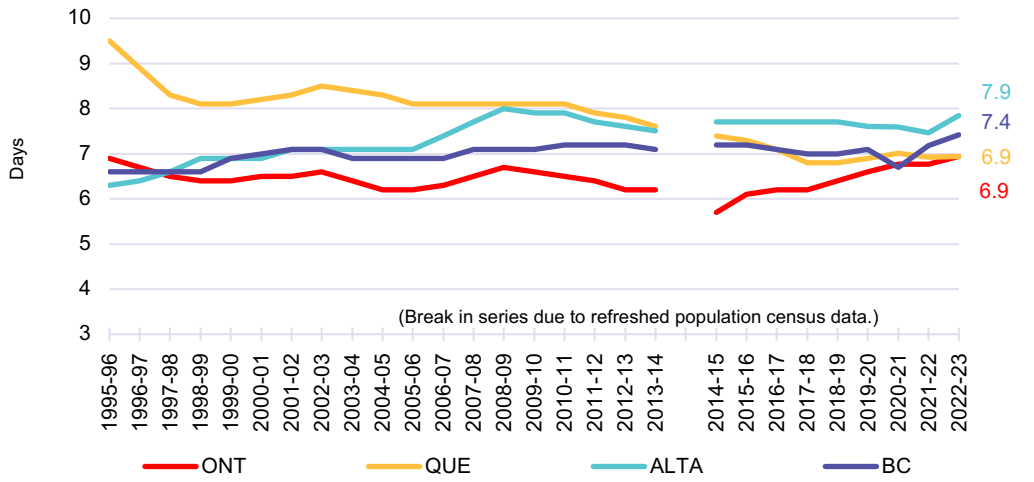


Source: CIHI Hospital Stays in Canada. Next annual update expected November 2024.

There are limits to how much and how fast lengths of stay can be reduced. For some types of patients, the average length of stay (ALOS) may be longer today than in the past. If prevention care or outpatient care is readily available, only the most acutely ill will need hospitalization. Similarly, a shortage of home and community care for those discharged from hospital may contribute to a longer stay. Among the four largest provinces, Ontario had the shortest ALOS in all years but one since 1997-98. Compared to all other provinces (not shown), Ontario has had the lowest rate since 2010-11 apart from 2020-21. To achieve even lower lengths of stay, while avoiding a rise in readmissions, Ontario requires increased coordinated home care, rehabilitation services, long-term care and primary care.

Figure 8b
Inpatient Average Length of Stay in Days, by Province, 1995-96 to 2022-23
Acute Care Hospitals, Age Standardized, Four Largest Provinces

For many years, Ontario acute care hospitals have had the shortest average length of stay

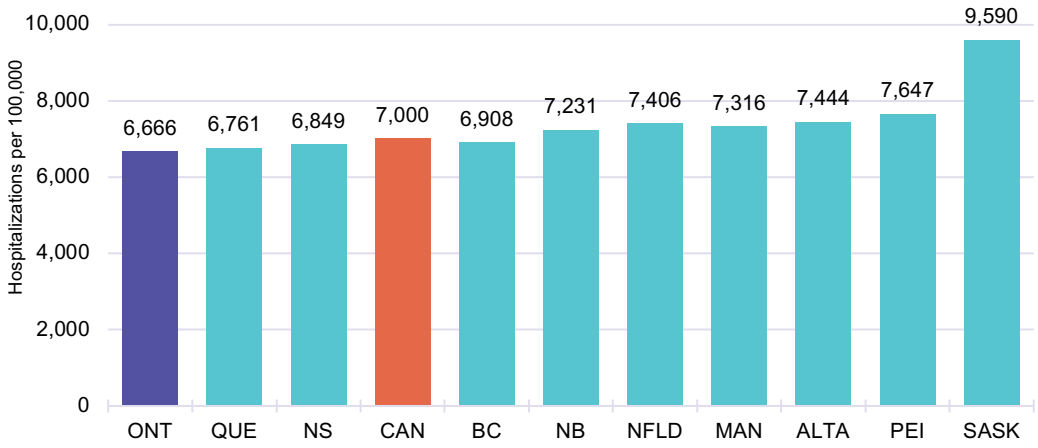


Source: CIHI Hospital Stays in Canada. Next annual update expected November 2024.

Ontario had the lowest hospitalization rate among all provinces almost every year since 1995.

Ontario had the lowest hospitalization rate in all years but one since 1995

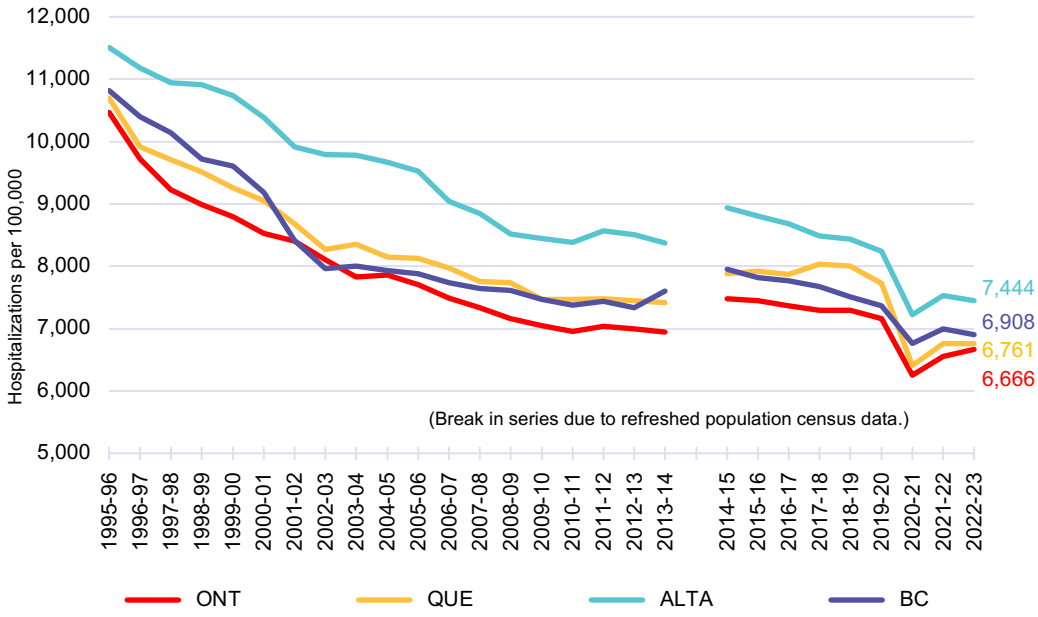
Figure 9a
Inpatient Hospitalization Rate per 100,000, by Province, 2022-23
Acute Care Hospitals, Age-Sex Standardized



Source: CIHI Hospital Stays in Canada. Next annual update expected November 2024.

The hospitalization rate has been dropping steadily since 1995. The rebound in hospitalization rates since the pandemic has not reached pre-pandemic rates. Ontario continues to have the lowest rate of all provinces (not just the four largest) since 2004.

Figure 9b
Inpatient Hospitalization Rate per 100,000, by Province, 1995-96 to 2022-23
Acute Care Hospitals, Age-Sex Standardized, Four Largest Provinces



Source: CIHI Hospital Stays in Canada. Next annual update expected November 2024.

Signs of Capacity Pressure

Alternate Level of Care

As system capacity pressures rise, timely access to care becomes more difficult

ALC is a major, long-standing challenge resulting from a lack of system capacity and access to services outside the hospital. The largest single group of patients designated as ALC are waiting for a place in a long-term care facility, while others are waiting for home and community care support services, supervised or assisted living, rehabilitation, complex continuing care, palliative care, mental health supports or other services.

ALC is linked to increased adverse events such as infections and triggers a ripple effect in the health care system, straining EDs and contributing to long ED waits and surgical delays. When there is a lack of physical space in an ED, patients wait in a hallway bed or in another "unconventional" location. This situation became particularly severe prior to the pandemic. In some instances, bed shortages have led to cancelled elective surgeries.

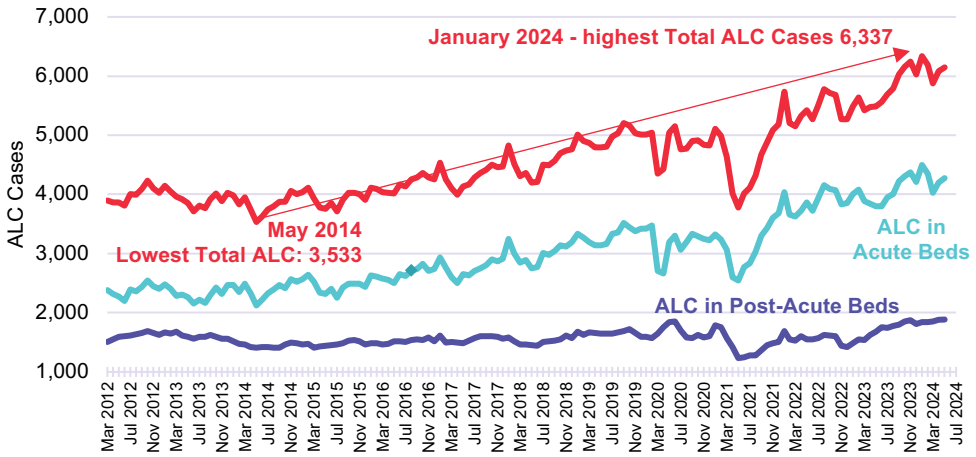
ALC cases reached record highs during January 2024

Throughout the pandemic the need for physical distancing, along with overall health system disruption, reduced the number of available inpatient beds, worsening the ALC situation. In fall 2022, a severe surge of respiratory illness brought a return of hallway health care. In response, additional dedicated ALC beds were opened in reactivation care centres and alternate health facilities which has allowed the ALC count to rise. While this has mitigated the pressure on hospitals, they still must be resourced, and even more patients designated as ALC are waiting for appropriate alternate placement.

In January 2024, the number of ALC patients reached a record high. Since then, ALC volumes have remained consistently higher than previous years.

Figure 10
Ontario ALC Cases (Total, Acute and Post-Acute), Mar 2012-May 2024

High ALC rates have a ripple effect leading to long ED wait times and high numbers of patients in the ED waiting for a regular bed



Source: Ontario Health.

Emergency Department

While Ontario hospitals have reported significantly higher than normal ED wait times for the past few years, hospitals will always be there to care for the communities they serve, no matter the circumstance.

Long ED wait times have been worsening for the past few years

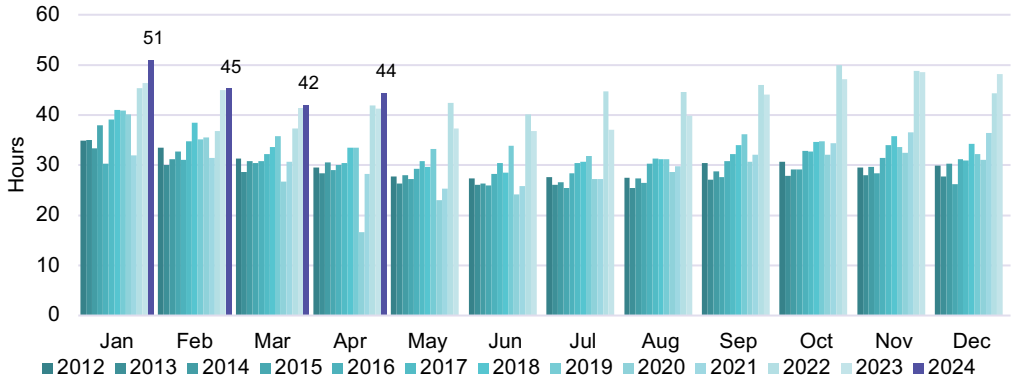
Wait times normally vary due to seasonal illnesses such as the flu. During the pandemic, wait times were impacted with the postponement of scheduled surgical procedures and diagnostics as well as implementation of infection prevention and control protocols.

The steep rise in wait times that occurred in 2022 was attributed to a surge in demand due to respiratory illness and patients who were delayed visiting hospitals due to COVID-19 restrictions creating challenging staffing conditions, compounded by increased sick time and higher staff vacancy rates. Fall 2022 was exceptionally difficult due to the triple threat of COVID-19, influenza and RSV, a virus primarily affecting children.

At the provincial level, key staffing metrics have since improved and the hospital workforce has grown by 35,000 net new positions attributed to concerted hospital efforts as well as supportive government funding and policy initiatives. However, this growth is not even across all parts of the province and service delivery in small, rural and northern hospitals is more sensitive to variances in staffing levels.

The longest ever ED wait times were reached in January 2024, when 10% of patients to be admitted as an inpatient waited over 51 hours, while 90% waited under 51 hours. This is called the "90th percentile" wait time.

Figure 11
Ontario ED Wait Times in Hours for Admitted Patients, by Month, 90th percentile (90% of patients waited fewer hours, 10% waited more hours), Jan 2012 to Apr 2024



Source: Ontario Health.

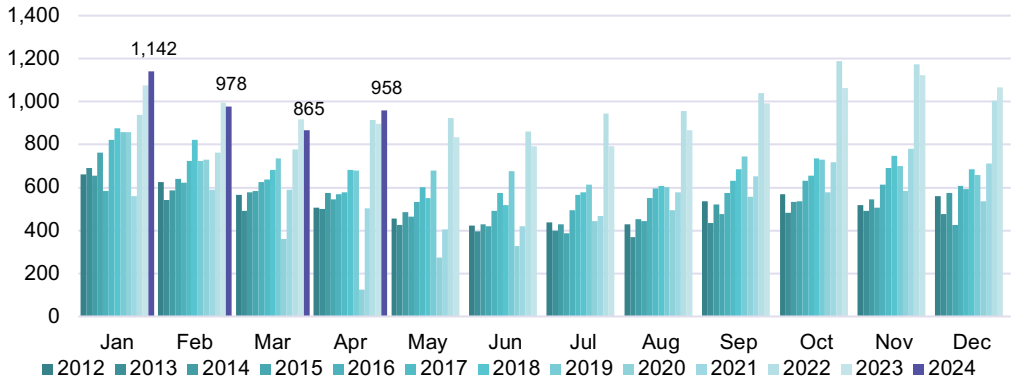
Ontario EDs have become busier, with higher numbers of patients waiting for inpatient beds

While the pandemic led to fewer people coming to the ED, the numbers eventually rebounded. The increasing number of ED patients waiting at 8:00 am for an inpatient bed rose sharply in 2022 and has remained high. This measure reflects the fact that patients are not being cleared out of the ED fast enough due to bed availability and overall increased service demand.

A record high was reached in January 2024 with an average of 1,142 people waiting at 8:00 am for an inpatient bed.

The pandemic saw fewer people seeking care in the ED, but numbers have now far exceeded typical seasonal patterns

Figure 12
Ontario Daily Average Number of Patients Waiting for a Bed at 8:00 am, 2012 to 2024



Source: Ontario Health.

Quality of Care – Broad Measures

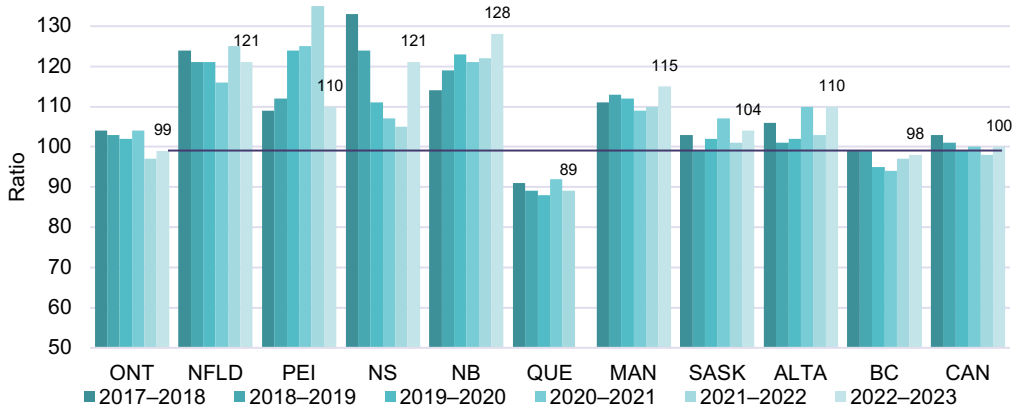
Hospital Standardized Mortality Ratio

Three broad quality measures demonstrate Ontario's performance over the past few years

One important hospital quality indicator is the Hospital Standardized Mortality Ratio (HSMR). CIHI states: "This indicator of health care quality measures whether the number of deaths at a hospital is higher or lower than you would expect, based on the average experience of Canadian hospitals. When tracked over time, this measure can indicate whether hospitals have been successful in reducing patient deaths and improving care."[3] The current indicator calculation includes COVID-19 cases.[4] Ontario's HSMR has been declining (improving) over time and according to CIHI, is the same as the average performance for Canada for 2022-23.

Ontario's HSMR in 2022-23 is the same as Canada's average with a favourable downward trend over several years

Figure 13
Hospital Standardized Mortality Ratio (HSMR), by Province, 2017-18 to 2022-23 (Lower is better)



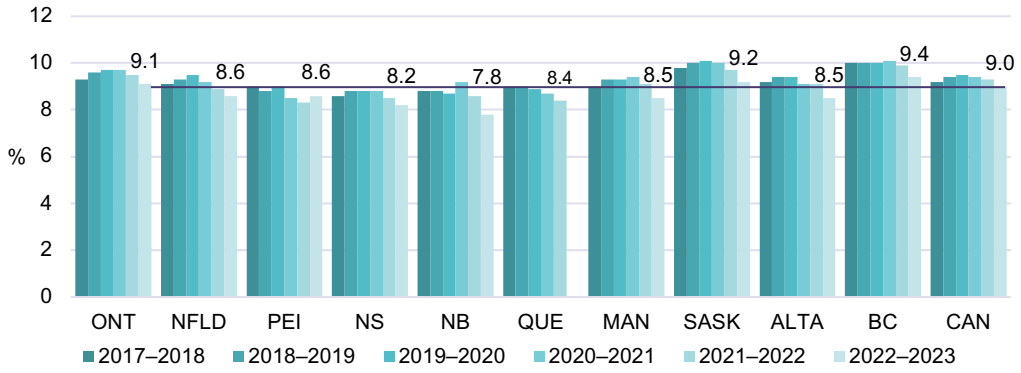
Source: CIHI Your Health System - In Depth. Quebec data are for 2017-18 to 2020-21. Next annual update expected November 2024.

Hospital Readmission Rate

Another key quality indicator is the Hospital Readmission Rate (risk-adjusted to account for the range of severity of illness across acute patient types). Ontario's rate has been declining (improving) since 2020-21 and in 2022-23 is the same as the average performance for Canada in 2022-23, according to CIHI.

Ontario's readmission rate is at the national average and has also been improving in recent years

Figure 14
Percentage of Patients Re-Admitted within 30 Days, by Province, 2017-18 to 2022-23 (Lower is better)



Source: CIHI Your Health System - In Depth. Next annual update expected November 2024.

Timeliness of Hip Fracture Surgery

ED patients are not only waiting for inpatient beds, but some are also waiting for emergency surgery. One indicator of a system under stress and the level of quality of care, is the timeliness of hip fracture surgery.

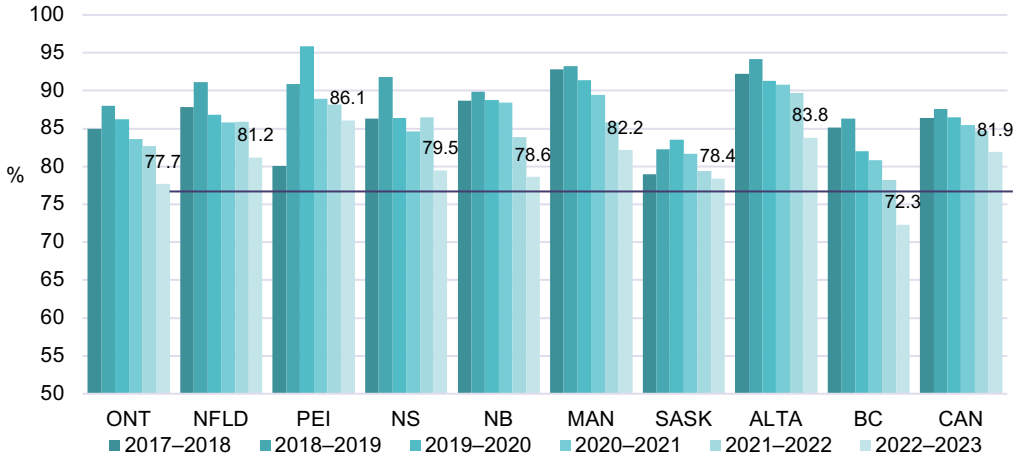
Timely access to emergency hip fracture surgery is a key access and quality indicator

According to the Canadian Medical Association, delays in hip fracture surgery increase a person's risk of death.[5] This is due to several factors including blood clots (due to being bed-bound) or fasting before surgery (worsened if surgery is cancelled and rescheduled).[6]

A 48-hour benchmark for receiving hip fracture surgery was set by a national committee of Health Ministers in 2005.[7] The rate has been declining in recent years across Canada. The percentage of Ontario hip-fracture patients receiving surgery within the 48-hour benchmark was 77.7% in 2022-23. According to CIHI, Ontario's rate is below the average performance for Canada in 2022-23.

Figure 15
Percentage of Hip Fracture Surgeries Performed Within 48-Hours, by Province, 2017-18 to 2022-23
(Higher is better)

Ontario, as well as all other provinces, have seen a worsening of this indicator in recent years which is reflective of hospitals under stress



Quebec data not available.

Source: CIHI Your Health System - In Depth. Next annual update expected November 2024.

Conclusion

The evidence in this report demonstrates how efficient Ontario hospitals have been for many years. Over time, the strain on the sector has left hospitals with no ability to expand to manage surges in demand – be it the increasing needs of the population, or the next pandemic. Additional beds and increased staffing support will help, however, what will shape the health system to meet future needs is further investment in research and innovation to change the way hospitals work. It's a necessary next step to ensure the delivery of efficient, high-quality care to Ontario's growing and aging communities.

Sources and Notes

1 Ontario Hospital Association calculation using data from the Canadian Institute for Health Information (CIHI) National Health Expenditure (NHEX) Database 2023. https://www.cihi.ca/en/national-health-expenditure-trends

2 Canadian Institute for Health Information. (2023). *"Your Health System - In Depth"*. https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/theme/C5001/2/

Note: CIHI's "*Your Health System - In Depth*" website provides 42 health system indicator results for Ontario. For 37 of these indicators, CIHI conducts a statistical assessment to determine whether an indicator is above, below or at the average and has further designated "above" or "below" average as "more desirable" or "less desirable". For the remaining five of the 42 indicators, there is no designation made as to whether the indicator result is "more desirable" or "less desirable".

3 Canadian Institute for Health Information. (2023). *Your Health System*. https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/005/hospital-deaths-hsmr/;mapC1;mapLevel2;/

4 Canadian Institute for Health Information. (2023). *Hospital Standardized Mortality Ratio (HSMR): Frequently asked question*s. https://www.cihi.ca/en/hospital-standardized-mortality-ratio-hsmr-frequently-asked-questions#_faq3

5 Sobolev, B. et al. (2018, August 7). Mortality effects of timing alternatives for hip fracture surgery. *CMAJ* 190 (31) E923-E932. https://www.cmaj.ca/content/190/31/E923

6 Leung, W. (2018, August 6). Delayed surgery for hip fractures cause of preventable deaths, study finds. *Globe and Mail.* https://www.theglobeandmail.com/canada/article-delayed-surgery-for-hip-fractures-cause-of-preventable-deaths-study/

7 Canadian Institute for Health Information. (2019). *Wait Times for Priority Procedures in Canada, 2019: Technical Notes.* https://www.cihi.ca/sites/default/files/document/pdf-hfr-tech-notes-en-web.pdf

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