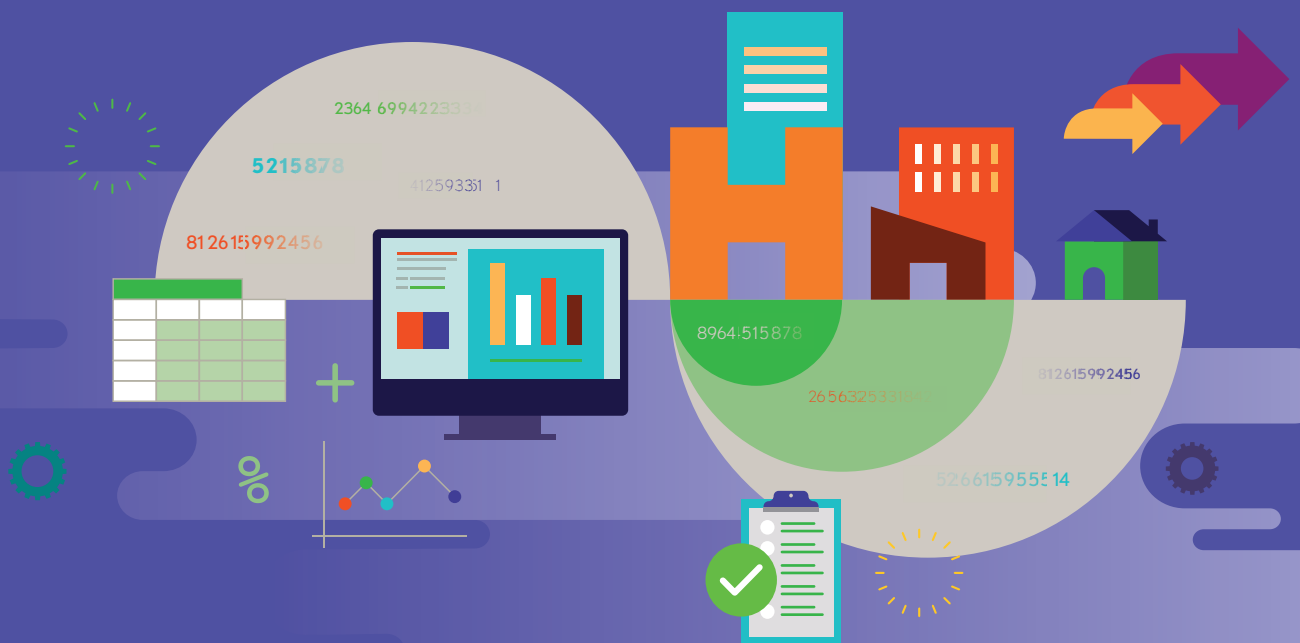


Ontario Hospitals - Leaders in Efficiency

DECEMBER 2019



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.

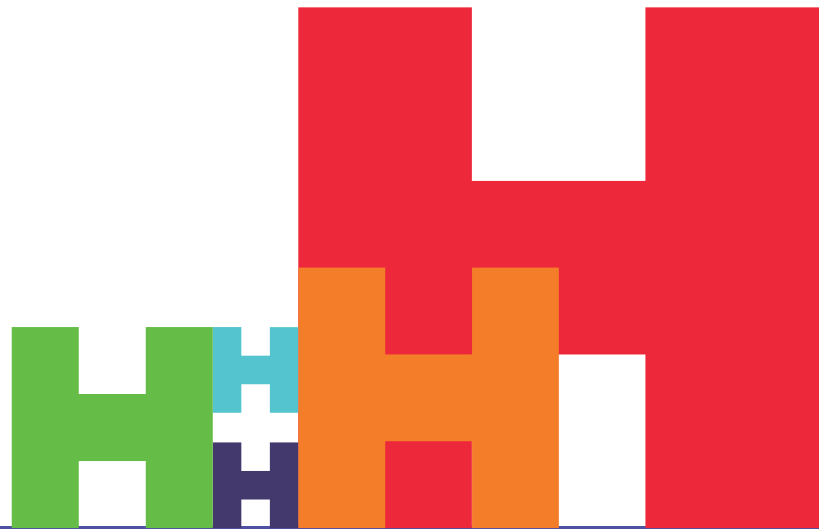


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Hospital Efficiency in Context

Health care reform paired with fiscal restraint presents a challenge

Ontario's health care system has entered a new period of major reform, which will require years to complete. All providers will be impacted as the system continues to change to become more patient-focused, better integrated and even more efficient in serving a growing and aging population. At the same time, Ontario is facing a new cycle of fiscal restraint as the provincial government aims to eliminate the current \$9 billion budget deficit by 2023-24¹. This new budgetary plan falls on the heels of the previous decade of restraint that was sparked by the 2008 financial crisis. Continued financial challenges will potentially be faced across a full range of provincial programs, including the health care sector.

Hospitals have always been at the forefront of efficiency and improvement efforts

With pressure to find short-term financial savings, there will be a heightened interest in focusing on hospitals. This has always been the case. Hospitals comprise the single largest sector within health care, which itself is the largest government budget item. In past decades, during times of fiscal challenge, Ontario hospitals have been at the forefront of efforts to 'bend the cost curve' — efforts that were over and above ongoing work to continuously improve patient care and operational performance. It could be argued that no other public sector — in health care or otherwise — has been more frequently or consistently at the centre of performance improvement work. Ontario hospitals' embrace of the Quality Management movement in combination with funding methods that promote efficiency have been important factors in achievements throughout the years.

Ontario hospitals are the most efficient in Canada

Because of these efforts, several key performance measures show clearly that Ontario hospitals have long been the most efficient in Canada. If Ontario were to fund hospitals at the average rate per capita for all other provinces, it would cost the province an additional \$4 billion². In fact, Ontario's overall health system was recently recognized by the Blue Ribbon Panel on Alberta's Finances³ as a model to emulate due to the significantly lower cost of providing high quality care — owing in large part to the hospital component of health spending.

Despite several years of funding restraint, hospitals continue to uphold and streamline services in every possible way in order to maintain and meet increasing demand for care. Hospitals face daily challenges of crowded emergency departments (EDs), high occupancy and difficulties in discharging Alternate Level of Care (ALC) patients who are waiting for more appropriate services provided in a different setting. These challenges are not surprising given that Ontario (in a tie with Mexico) has the fewest acute care hospital beds per capita in the world that is tracked by the Organization for Economic Co-operation and Development (OECD).

Hospitals are meeting increased demand despite capacity and inflationary cost pressures

In addition to physical capacity limitations, hospitals face cost pressures and constraints over which they have little control. Wage settlements (with labour comprising almost 70% of hospital costs) and other inflationary pressures continue to increase. Hospitals have managed these pressures through responsible collective bargaining both in terms of process and results. Hospitals have developed a province-wide central bargaining process that avoids having to conduct almost 400 separate negotiations, which would otherwise cost hospitals approximately \$33 million. Further, this efficient approach has also resulted in collective bargaining outcomes consistently below broader public sector wage trends.

Despite these moderate labour cost increases, hospitals have found ways to address their collective situation using innovation, new technologies and new ways to deliver care. In addition, and for good reason, hospitals must comply with many regulatory and other responsibilities that span a range from essential health and safety requirements all the way through to a variety of mandatory policies and practices which may no longer hold value.

Further hospital budget tightening will cause significant strain unless overall system capacity is addressed first

Given the current state, the prospect of achieving significant further improvement in the hospital sector without **first addressing** issues outside the sector is slim. While the ALC issue — representing 17% of beds — is an inefficient use of hospitals, it stems from overall health system issues. The lack of alternatives to hospital care for ALC patients — that are less costly and better for patients — has led to severe hospital capacity pressures. Accordingly, attempts to squeeze out any more perceived hospital inefficiencies — **with existing system structure and capacity** — will likely worsen hallway health care. The very real risk is that access to hospital care will become even more difficult and wait times will continue to rise.

Ontario hospitals have been voicing this concern for several years under relatively flat funding increases. (In some years, mid-year funding relief was necessary to support hospitals in meeting unprecedented surges in patient demand.) Hospitals' current pressures and high level of efficiency is the reality and is borne out by the evidence presented below. There is clearly no significant 'low-hanging fruit' to be found in the hospital sector alone. Much greater gains can be realized by addressing system organization and capacity as a whole. In doing so, proper timing and sequencing of events will be critical.

The benefits of structural change will take years to realize

As stated, health care reform is just beginning and will take years. At the same time, as Ontario Health Teams are announced, hospitals will need to be bolstered in order to "protect what matters most." It will be critical to shield hospitals and the broader health system from further financial erosion until key transformative change and potentially new investments have occurred. These changes and investments must have actual realized benefits — in terms of patient outcomes, patient experience, cost-savings (or cost-avoidance) and greater efficiency.

Ontario has been here before. In the early 1990s, a severe economic recession led to a decline in government revenues. For the first time ever, in 1993-94, provincial government expenditure on hospitals declined from the previous year. As cuts continued for several more years, hospitals rose to the challenge. Hospital bed numbers were cut by a third, innovation fostered a switch to more day procedures, lengths of stay were shortened and other general operational efficiencies occurred.

**Ontario's experience
with restructuring and
budget tightening in
the 1990s**

In late 1995, the Ontario government announced the creation of the Health Services Restructuring Commission (HSRC) which would formally reorganize hospitals and services over four years. **At the same time**, a total of \$1.3 billion in hospital funding cuts over three years were announced which represented 5% (\$365 million), 6% (\$435 million) and 7% (\$507 million) each year starting in 1996/97.⁴ Given the efficiencies already achieved, only the first two years of cuts could be made, and the third year was cancelled in order to both protect patient care and maintain hospital financial stability. At the time of the HSRC, there was the ability to consolidate and reduce the number of hospital corporations from 225 to 156. (Presently in 2019 there are 141 hospital corporations led by 126 CEOs.) However, the efficiencies that were sought through mergers and clinical program shifts were not realized until future years. The original restructuring budget of \$450 million was increased to \$880 million by 1997.⁵ A key lesson was that a coordinated strategy for restructuring and cost cutting — as well setting realistic time lines — was essential to system stability and access to care.

**Ontarians need a strong
and stable hospital and
health care system**

In summary, Ontario hospitals are fiscally responsible and have always strived to maintain access to high quality care for the communities they serve. Ontario hospitals lead the country with their long-standing, lean operational performance. However, they are clearly showing the strain of a combination of years of funding restraint, significant demographic growth and a shortage of capacity in other health sectors. Hallway health care and record-high levels of ALC patients and ED wait times are among the most visible signs of a hospital system under severe pressure and are directly experienced by individual patients and their families. The current situation cannot realistically be sustained. As the Ontario government aims to achieve dual goals of deficit elimination by 2023 and initiation of important health system change, it will be critical to ensure that the necessary supports are in place to uphold hospital and health system stability — and ultimately, access to high quality care for Ontarians.

The Evidence

The section that follows offers key evidence of Ontario hospitals' current and past record of high performance as well as that of the pressures that have been 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 \$4 billion**; if funded like Alberta, **\$7.1 billion**.

Ontario hospitals contribute to the:

- **Second-lowest** health care expenditure per capita by a province; and the
- **Lowest** provincial program expenditure per capita by a province



How Ontario Hospitals Have Done This

Continuous improvement has led to Ontario having the:

- **Shortest** average length of stay in acute care hospitals in Canada
- **Lowest** hospitalization rate in Canada

Which results in the:

- **Lowest** number of beds per 1,000 population than any other province or country
- **Lowest** cost of a hospital inpatient stay in Canada

Hospital bed numbers have not changed in two decades although:

- Ontario population has increased 27%
- Population aged 65 and older has increased 75%

Hospitals have achieved these results while:

- **Increasing** volumes year-over-year despite inflation not being fully funded
- **Maintaining** the lowest cost per hospital stay
- **Maintaining** quality over time



System Capacity Issues

Hospitals face **record-setting**:

- Emergency department wait times
- Number of patients waiting in emergency to be admitted
- Number of ALC patients waiting in hospital for more appropriate services

CLINICAL INNOVATION

LEADERS

EVEN IN DIFFICULT TIMES

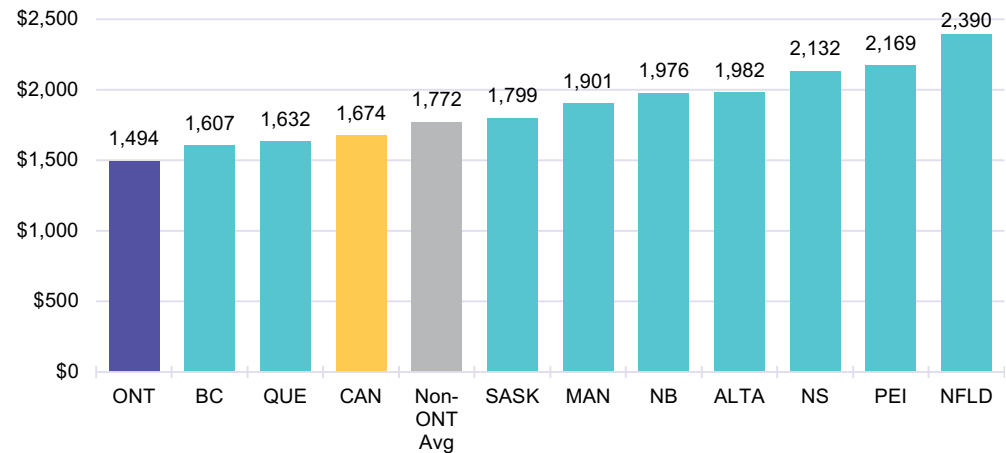
Ontario Government Hospital and Health Spending in Context

Per capita hospital expenditure by provincial governments is lowest in Ontario

Hospital Expenditure

Provincial government expenditure on hospitals is lower in Ontario than in any other province at \$1,494 per capita for 2019. If Ontario were to fund hospitals at the average rate per capita for all other provinces (\$1,772) it would cost the province an additional \$4 billion. This is the Ontario hospital efficiency dividend.

Figure 1a
Hospital Expenditure, \$ per Capita by Provincial Governments, 2019

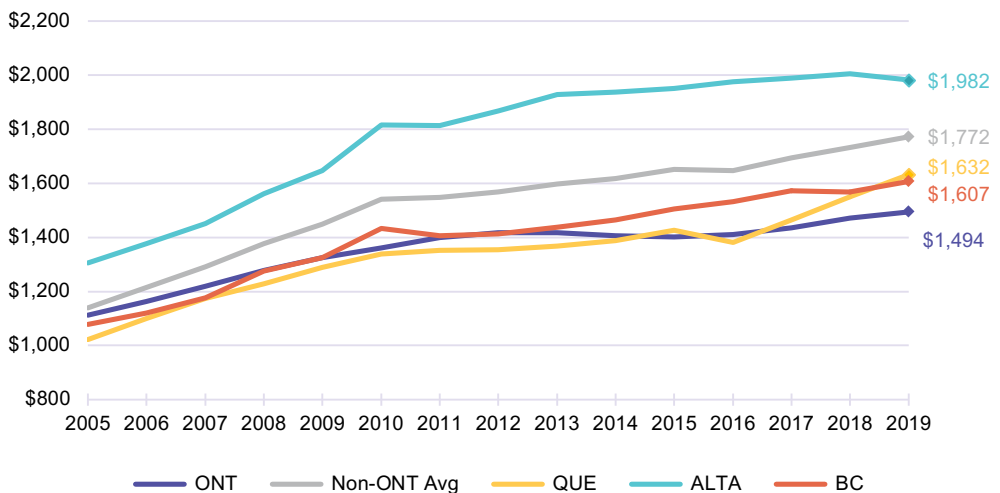


Source: CIHI National Health Expenditure Database, 2019 forecast, Canada includes Territories

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

For many years, Ontario's hospital expenditure has been very low. In comparison, Quebec's ability to keep expenditure low has been attributed to overall lower hourly rates for nurses which are also lower than in Ontario.

Figure 1b
Hospital Expenditure, \$ per Capita by Provincial Governments, 2005-2019
Four Largest Provinces & Non-Ontario Average



Source: CIHI National Health Expenditure Database, 2018 & 19 are forecast

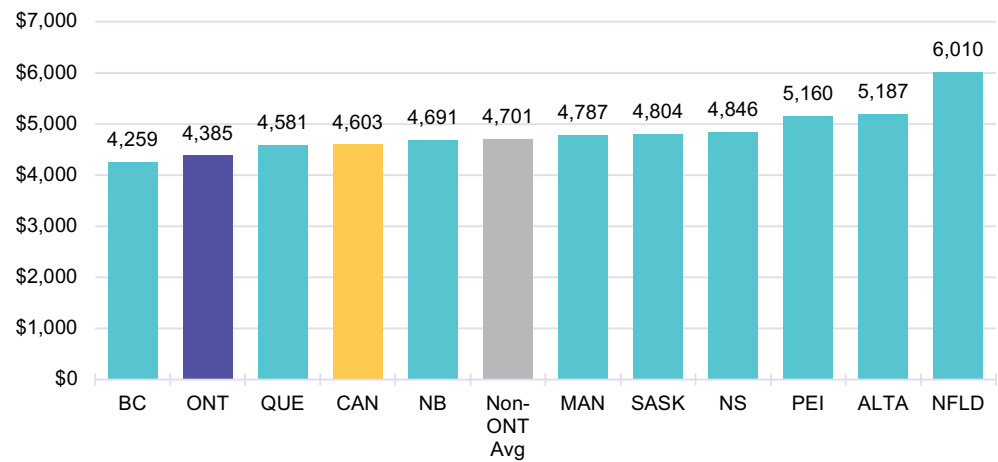
Per capita health care expenditure by provincial governments is second-lowest in Ontario

Health Care Expenditure

Ontario's provincial government total health care expenditure for all sectors combined is the second-lowest of all the provinces at \$4,385 per capita for 2019. If Ontario were to fund health care at the average rate per capita for all other provinces (\$4,701), it would cost the province an additional \$4.6 billion. This is the Ontario health care efficiency dividend.

Sectors include: hospitals, physicians, drugs, public health, other institutions, other professionals, home care, capital, research, health system administration and other.

Figure 2a
Health Care Expenditure, \$ per Capita by Provincial Governments, 2019

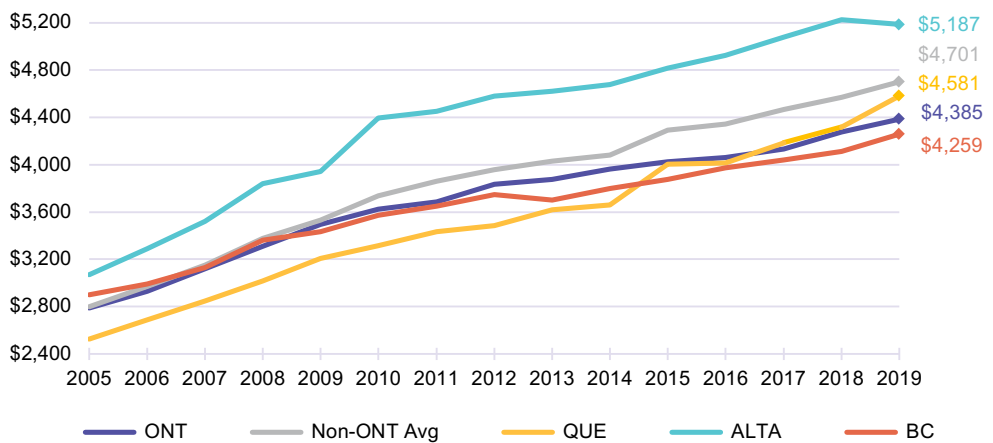


Source: CIHI National Health Expenditure Database, 2019 forecast, Canada includes Territories

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

Ontario has been the second-lowest for total health care expenditure for the past three years and has been below the average for all other provinces since 2005.

Figure 2b
Health Care Expenditure, \$ per Capita by Provincial Governments, 2005-2019
Four Largest Provinces & Non-Ontario Average



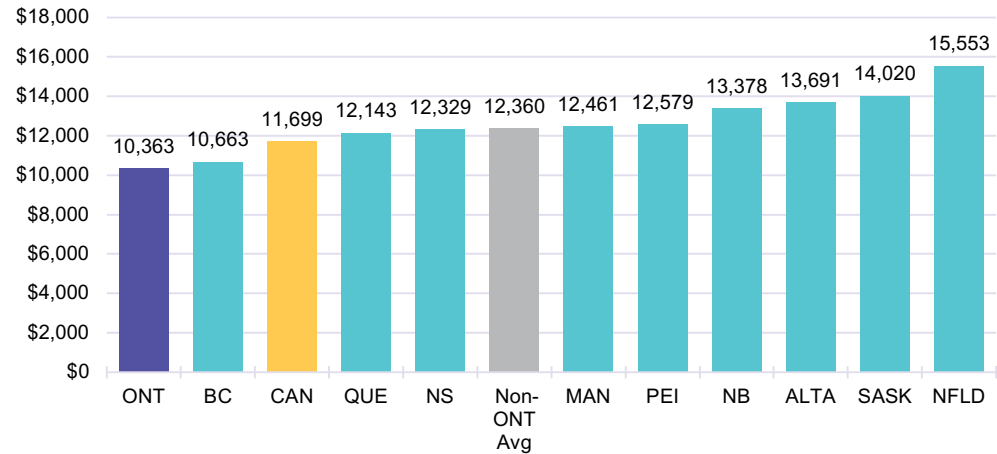
Source: CIHI National Health Expenditure Database, 2018 & 19 are forecast

Per capita provincial government program expenditure is lowest in Ontario

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 \$10,363 per capita for 2017 (latest year available). If Ontario were to fund provincial programs at the average per capita rate for all the other provinces (\$12,360) it would cost the province an additional \$28 billion.

Figure 3a
Provincial Government Program Expenditure, \$ per Capita, 2017

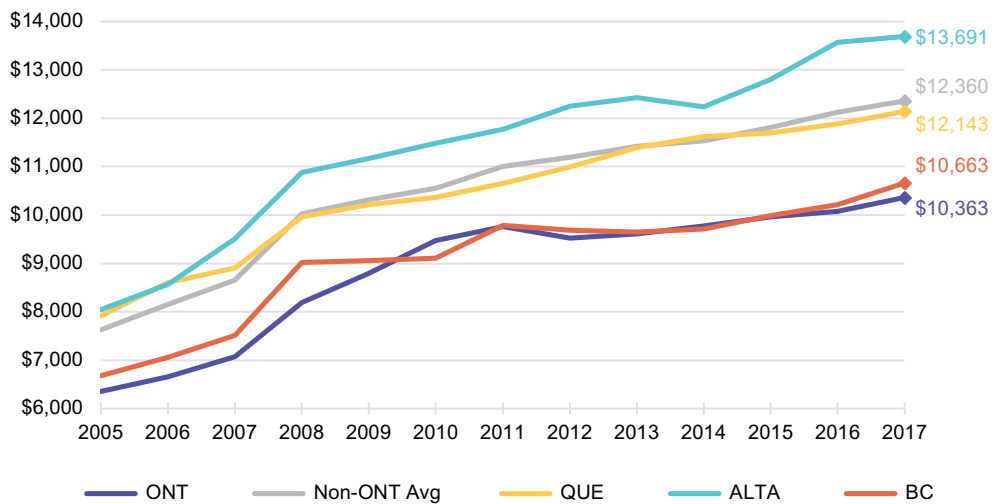


Source: CIHI National Health Expenditure Database, 2017 (latest year available) Canada includes Territories

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

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

Figure 3b
Provincial Government Program Expenditure, \$ per Capita, 2005 to 2017
Four Largest Provinces & Non-Ontario Average



Source: CIHI National Health Expenditure Database, 2017 (latest year available)

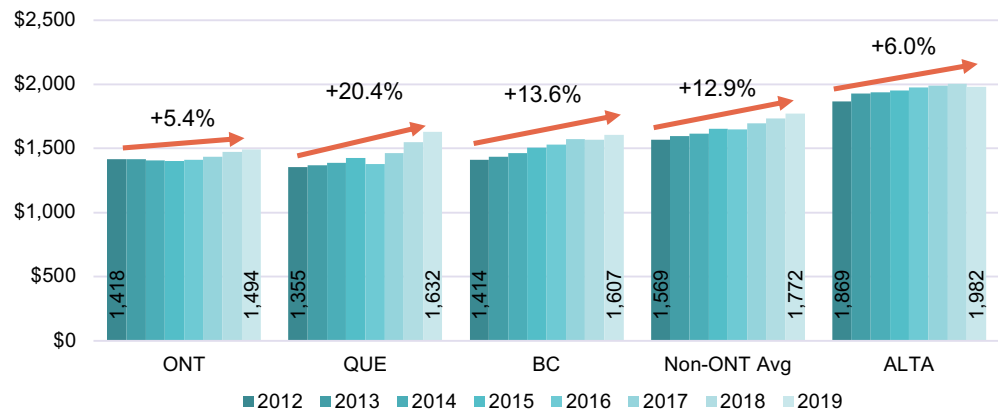
Hospital Funding, Cost Pressures and Hospital Unit Cost

Ontario's constrained hospital funding has been outpaced by inflation and population pressures

A closer review of provincial government hospital funding over recent years reveals hospital financial pressures and lean operations. During a decade of restraint, Ontario hospitals faced four consecutive years of 0% increases in base operating funding from 2012/13 to 2015/16. (Base funding is the main funding envelope supporting basic requirements and excludes specialized programs or specific targeted funding.)

The overall seven-year, per-capita increase in government funding to hospitals between 2012 and 2019 was 5.4%. Within this 5.4% increase, Ontario hospitals absorbed inflationary costs due to labour agreements plus rising costs of supplies, medications and equipment. The per capita calculation does not take into account the impact of population aging which has further increased the pressure on hospitals.

Figure 4
Hospital Expenditure, \$ per Capita – Seven-year Trend, 2012 to 2019
Four Largest Provinces & Non-Ontario Average

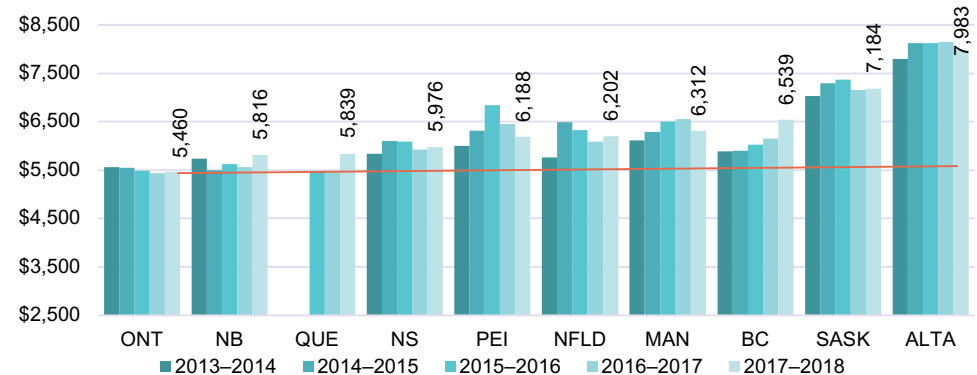


Source: CIHI National Health Expenditure Database, 2018 & 19 are forecast

Ontario has the lowest-cost hospital inpatient stay of all the provinces

Further, in comparison to all other provinces, Ontario has the lowest cost of an inpatient hospital stay, which has been getting lower over the years.

Figure 5
Cost of a Hospital Inpatient Stay in \$, by Province, 2013-14 to 2017-18



Source: CIHI Your Health System - In Depth

Hospital Wage Settlements

Ontario hospitals have taken a responsible approach to compensation

Recent Collective Bargaining Outcomes

The provision of health care is labour-intensive. With approximately 70% of hospital costs attributed to labour, collective bargaining outcomes have a large impact on future hospital cost pressures.

The highly efficient central bargaining process for Ontario hospitals has resulted in recent wage settlements at levels that are below those experienced in the broader public sector.

Figure 6
Recent Collective Bargaining Outcomes (Hospitals) Compared to Relevant Average Outcomes of Other Major Ontario Broader Public Sector (BPS) Employers

Year	Hospital Average	Major BPS Average
2016	1.03%	1.33%
2017	1.40%	1.39%
2018	1.40%	1.85%
2019	1.68%	1.75%
Average over Four Years	1.38%	1.58%

Source: Ontario Hospital Association

Ontario Hospital Bed Capacity and Usage

Ontario hospital bed capacity has not changed over the past two decades although the population has increased 27%

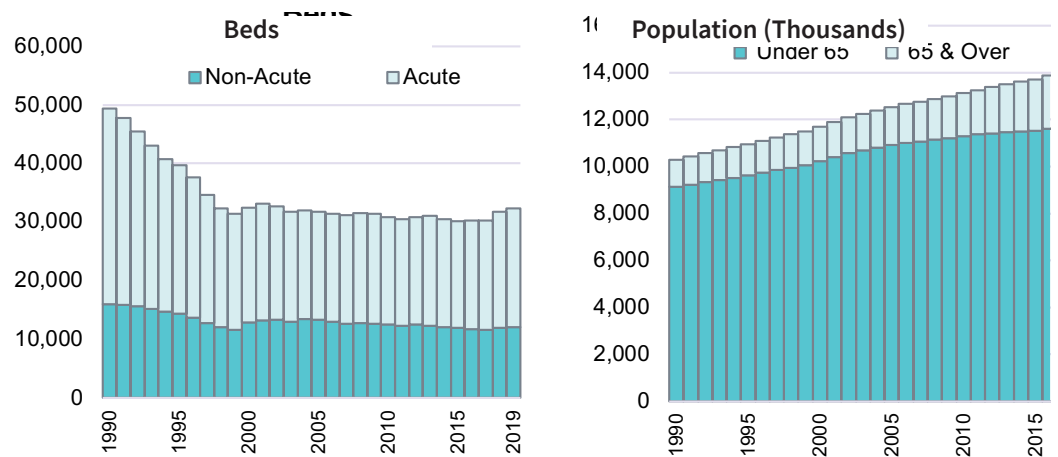
The population aged 65+ has increased 75%

Ontario is tied with Mexico for the lowest number of acute care beds per 1,000 population

Beds vs. Population

An overall per capita bed reduction has been observed worldwide over two decades. In Ontario, beds declined sharply through the 1990s in response to fiscal restraint, hospital restructuring and technological change. Since 1999, overall bed capacity has been virtually constant although the population has increased by 27%. In the past two years, a small increase in beds occurred in order to relieve extreme occupancy pressures. Recently, new strategies to manage tight capacity have been adopted that involve ground-breaking methods to specifically improve patient flow and surgical scheduling processes.

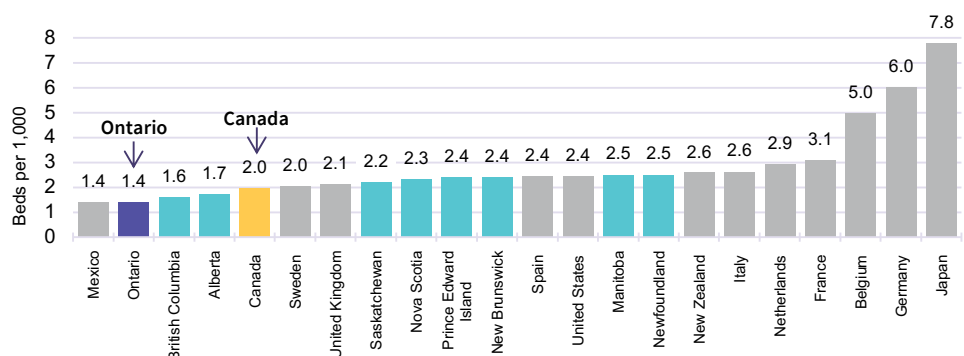
Figure 7
Ontario Hospital Bed Capacity vs. Population, 1990 to 2019



Sources: Ontario Ministry of Health and Long-Term Care Daily Census Data; Statistics Canada Population Data

Ontario has fewer acute hospital beds per 1,000 population than any other province and fewer beds than any other country in the world (tied with Mexico) that is tracked by the Organization for Economic Co-operation and Development (OECD). Ontario has 1.4 acute beds per 1,000 and 2.2 total beds per 1,000.

Figure 8
Acute Hospital Beds per 1,000 Population, 2015, 2016, 2017, 2018
Ontario vs. Other Provinces and Other Countries (Quebec data not available)



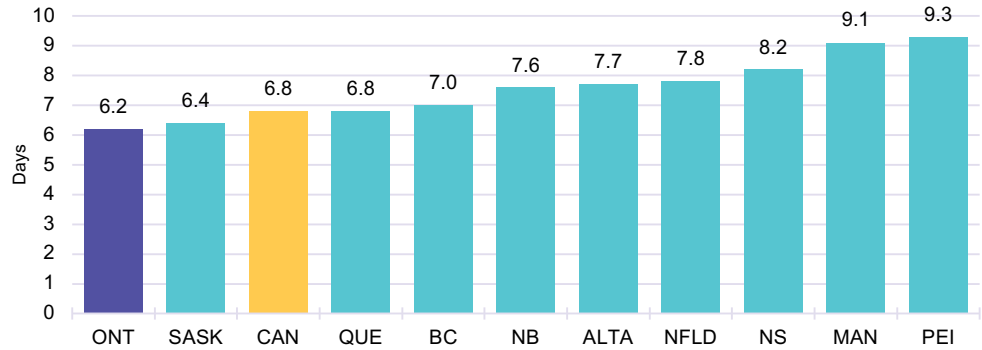
Sources: OECD Health Statistics; CIHI Hospital Beds; Statistics Canada Population Data; Ontario Ministry of Health and Long-Term Care Daily Census Data. Most recent year available for each jurisdiction shown.

How Hospitals have Managed — Shorter Stays, Fewer Hospitalizations

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

Over time, hospitals have accommodated population growth and aging with fewer beds by: working to shorten hospital stays; working to 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.

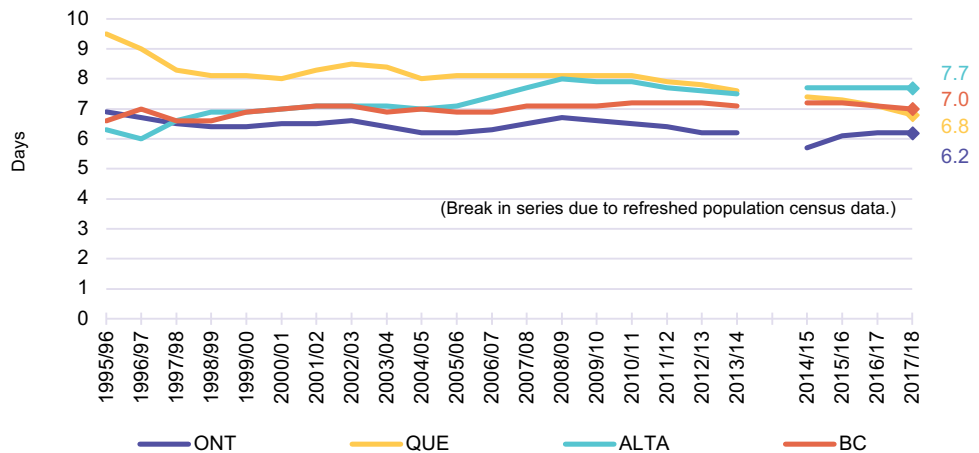
Figure 9a
Inpatient Average Length of Stay in Days, by Province, 2017-18
 Acute Care Hospitals, Age Standardized



Source: CIHI Quick Stats

There are limits to how much and how fast lengths of stay can be reduced. For some types of patients, the average stay may even be longer today than it was in the past (if preventive care or outpatient care is more available, only the most acutely ill will need to be admitted to hospital). Among the four largest provinces, Ontario has had the shortest average length of stay since 1997/98. Compared to all other provinces (not shown), Ontario has had the lowest rate since 2010.

Figure 9b
Inpatient Average Length of Stay in Days, by Province, 1995-96 to 2017-18
 Acute Care Hospitals, Age Standardized, Four Largest Provinces

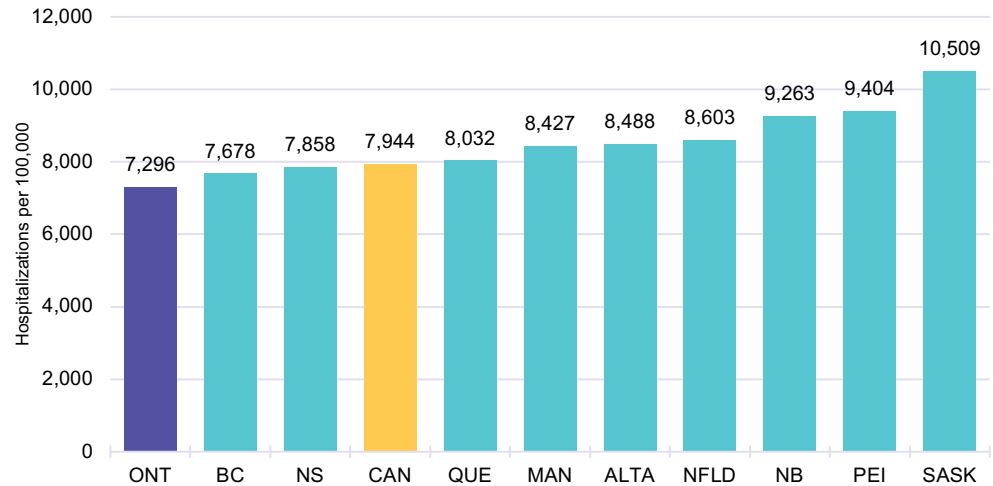


Source: CIHI Quick Stats

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

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

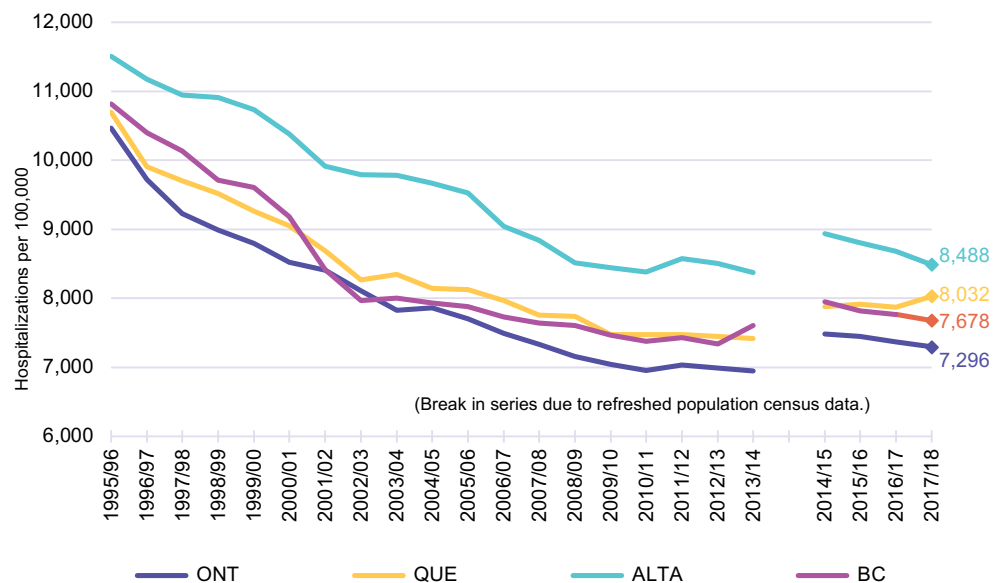
Figure 10a
Inpatient Hospitalization Rate per 100,000, by Province, 2017-18
 Acute Care Hospitals, Age-Sex Standardized



Source: CIHI Quick Stats

The hospitalization rate has been dropping steadily since at least 1995.

Figure 10b
Inpatient Hospitalization Rate per 100,000, by Province, 1995-96 to 2017-18
 Acute Care Hospitals, Age-Sex Standardized, Four Largest Provinces



Source: CIHI Quick Stats

Signs of Capacity Pressure

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

ALC cases are at record highs

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

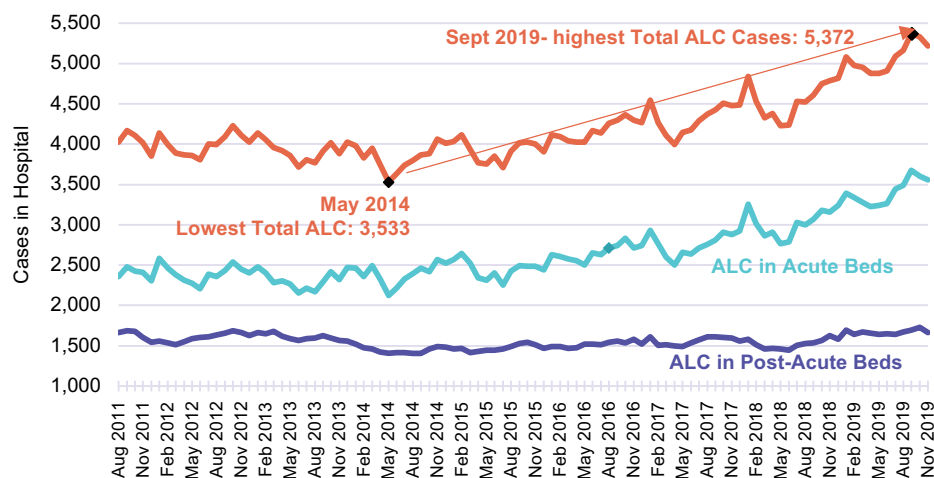
Alternate Level of Care

There are record-high numbers of ALC patients in Ontario hospitals. ALC is a major long-standing issue reflecting sub-optimal care and an inefficient use of hospital resources. The ALC problem reflects a lack of system capacity and lack of access to services outside the hospital.

In September 2019, there were 5,372 ALC patients — accounting for 17% of hospital beds — waiting for a different level of care that was not available when needed. The total number of days of stay in hospital for the patients waiting as of September 2019 was approximately 750,00 days which is a 25% increase from the almost 600,000 days for all ALC patients waiting in September 2018.

A majority of ALC patients are waiting for a place in a long-term care facility while others are waiting for home care services, supervised or assisted living, rehabilitation, palliative care, mental health services or other services. Some ALC patients wait significantly longer for placement in an appropriate care setting due to the nature of their care needs.

Figure 11
Ontario ALC Cases (Total, Acute and Post-Acute), 2011-2019



Source: CCO

With more beds occupied by ALC patients, emergency department (ED) ‘backups’ worsen and become more frequent. Patients waiting in the ED face very long waits to be transferred to an appropriate patient care unit. Due to lack of physical capacity in the ED patients must often wait in a hallway bed or in another ‘unconventional’ location. In some severe cases, bed shortages may lead to cancelled elective surgeries.

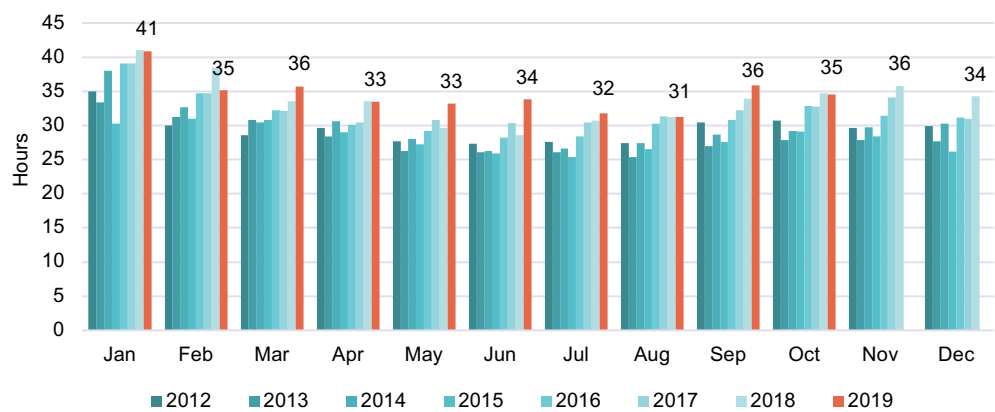
Emergency Department

Long ED wait times are getting even longer. In Ontario in January 2019, 10% of patients waiting to be admitted as an inpatient waited over 41 hours while 90% waited under 41 hours. (This is called the ‘90th percentile’ wait time.) Wait times vary depending on seasonal illness such as the flu. The Canadian Institute for Health Information (CIHI) tracks annual ED wait times (using a comparable measure) for four provinces: Ontario, Alberta, Quebec and B.C. Each province has seen an increase over time. In 2018-19, Ontario’s 90th percentile wait time was 33.3 hours which is higher than Alberta’s (at 27.1 hours) and lower than B.C.’s (at 42.4 hours) and Quebec’s (at 39.9 hours).⁶

Long ED wait times are getting even longer

Figure 12

Ontario ED Wait Times in Hours for Admitted Patients, by Month, 90th percentile (90% of patients waited fewer hours, 10% waited more hours), 2012 to 2019



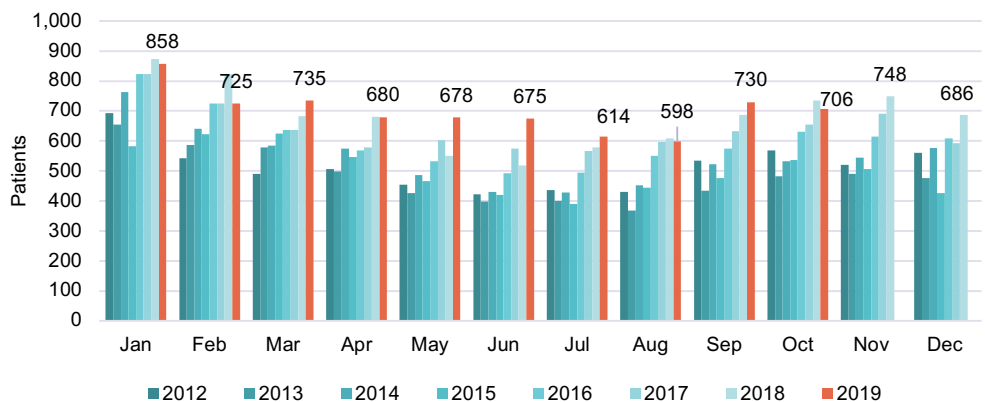
Source: CCO

Over time, there have been increasingly higher numbers of patients waiting at 8 a.m. in the ED for an inpatient bed. This measure reflects the fact that patients are not being ‘cleared out’ of the ED fast enough — due to lack of beds and due to increased ED volumes overall — relating to population growth and aging. The provincial volume of ED patients has been growing at approximately 2.5% annually over the past decade — faster than population growth, to a current level of almost 6 million visits per year.

Ontario EDs are busier than ever with higher numbers of patients waiting for inpatient beds

Figure 13

Ontario Daily Average Number of Patients Waiting for a bed at 8 a.m., 2012 to 2019



Source: CCO

Quality of Care — Broad Measures

Over three broad quality measures, Ontario hospitals' results have been stable over time

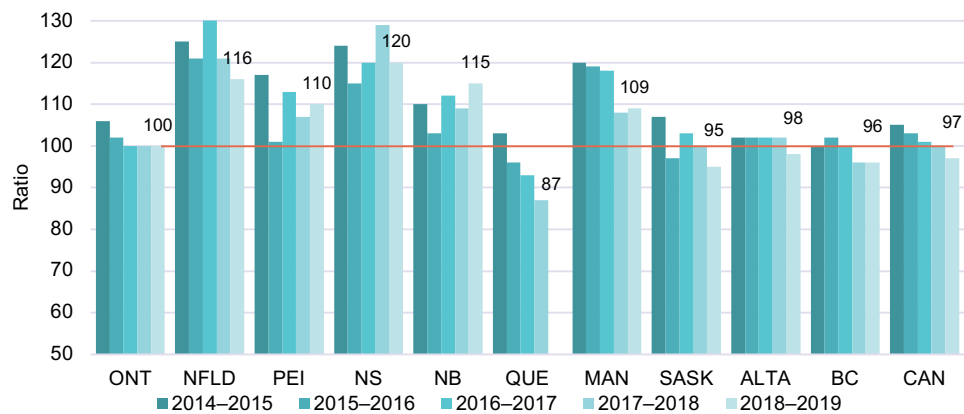
Ontario's HSMR is effectively at the national average and is stable

Ontario's readmission rate is slightly above the national average and has been stable

Hospital Standardized Mortality Ratio (HSMR)

One important hospital quality indicator is the Hospital Standardized Mortality Ratio. 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 (set at 100 in 2017-18). When tracked over time, this measure can indicate whether hospitals have been successful in reducing patient deaths and improving care."⁷⁷ Ontario's Hospital Standardized Mortality Ratio (HSMR) has remained unchanged for three years, and for 2018-19 is effectively at the national average.

Figure 14
Hospital Standardized Mortality Ratio (HSMR), by Province, 2014-15 to 2018-19 (Lower is Better)

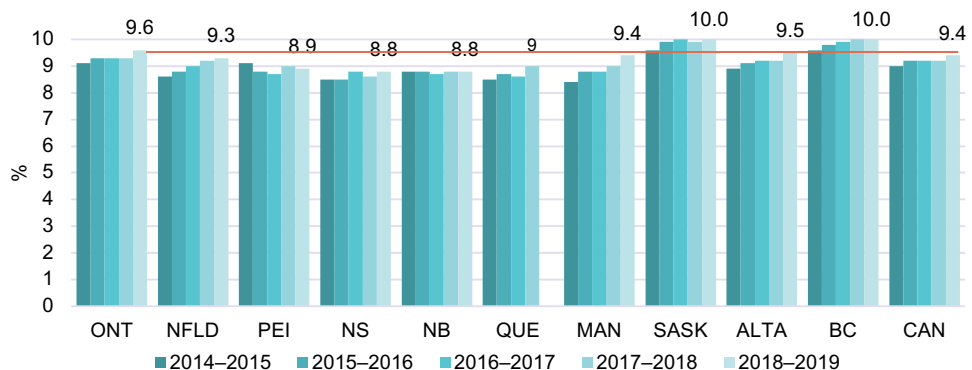


Source: CIHI Your Health System - In Depth

Hospital Readmission Rate

Another key quality indicator is the Hospital Readmission Rate (risk-adjusted to account for the range of severity of illness across patient types). Ontario's rate increased slightly in 2018-19 after holding steady for the previous three years. Ontario's 2018-19 rate is slightly higher than the average rate for Canada.

Figure 15
Percentage of Patients Readmitted within 30 Days, by Province, 2014-15 to 2018-19 (Lower is better)



Source: CIHI Your Health System - In Depth

Timeliness of Hip Fracture Surgery

Patients waiting in the ED are not only waiting to be admitted to an inpatient bed; some are waiting for emergency surgery. One indicator of a system under stress, as well as an indicator of quality of care is the timeliness of hip fracture surgery.

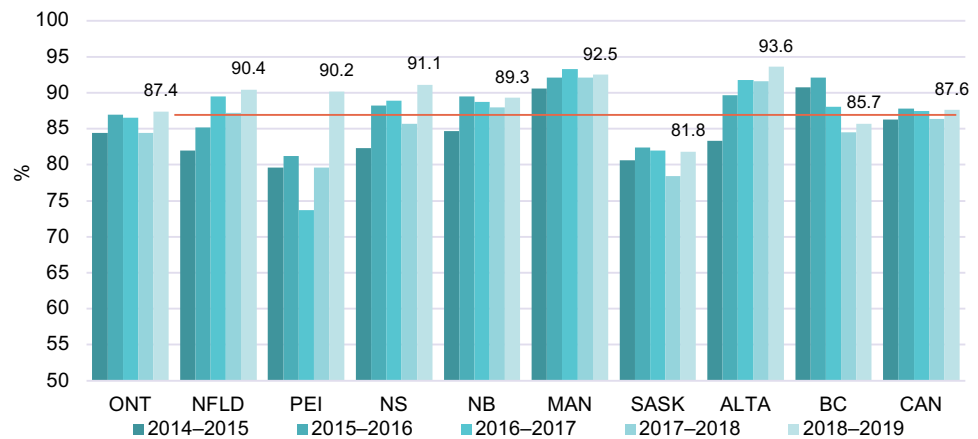
According to the Canadian Medical Association, delays in hip fracture surgery increase a person's risk of death.⁸ This is due to several factors including blood clots (due to being bed-bound) or fasting before surgery (worsened if surgery is canceled and rescheduled.)⁹

A 48-hour benchmark for receiving hip fracture surgery was set by a national committee of Health Ministers in 2005.¹⁰ The percentage of Ontario hip-fracture patients getting surgery within the 48-hour benchmark was 87.4% in 2018-19, which is the same as the average rate for Canada.

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

Ontario is performing at the national average

Figure 16
Percentage of Hip Fracture Surgeries Performed Within 48 Hours, by Province, 2014-15 to 2018-19
(Higher is better)



Quebec data is not available.

Source: CIHI Your Health System - In Depth

Sources and Notes

¹ Ontario Ministry of Finance. 2019 Ontario Economic Outlook and Fiscal Review.

² Ontario Hospital Association calculation using data from Canadian Institute for Health Information (CIHI) National Health Expenditure (NHEX) Database 2019.

Note: CIHI's NHEX database release for 2019 used a revised methodology and new information in compiling health expenditure data. Major differences from past releases which impact OHA's efficiency dividend calculation relate mostly to recategorization of expenditures for Alberta and British Columbia (B.C.). In Alberta, expenditure was reclassified from *hospitals and other institutions* to *public health and other spending*. In B.C., expenditure was reclassified from *hospitals and public health* to *other institutions and other health spending*. *Total health* expenditure was not affected in these provinces. For Quebec, additional expenditures not previously included were added that impacted *total health* expenditure. In Ontario, *hospital* expenditure was not impacted; *total health* expenditure and *other health* expenditure was increased due to inclusion of *home and community care* spending not previously captured (also included for other provinces)

³ Government of Alberta. Report and Recommendations: Blue Ribbon Panel on Alberta's Finances. August 2019. Available: <https://open.alberta.ca/publications/report-and-recommendations-blue-ribbon-panel-on-alberta-s-finances>. Accessed November 2019.

⁴ Ontario Ministry of Finance. 1995 Fiscal and Economic Statement.

⁵ Ontario Ministry of Finance. 1998 Ontario Budget.

⁶ Canadian Institute for Health Information. Your Health System – In Depth. November 2019.

⁷ Canadian Institute for Health Information. Your Health System – In Depth. November 2019.

⁸ CMAJ August 07, 2018 190 (31) E923-E932. Available: <https://www.cmaj.ca/content/190/31/E923>. Accessed November 2019.

⁹ Leung, W. August 6, 2018. Delayed surgery for hip fractures cause of preventable deaths, study finds. Globe and Mail. Available: <https://www.theglobeandmail.com/canada/article-delayed-surgery-for-hip-fractures-cause-of-preventable-deaths-study/>. Accessed November 2019.

¹⁰ Canadian Institute for Health Information. Wait Times for Priority Procedures in Canada, 2019: Technical Notes.

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