Understanding the Impact of COVID-19 on Ontario Hospital Finances

September 2020

Ontario Hospital Association

This document seeks to enhance the understanding of the context and current state of hospital finances. In the sections that follow, the three inter-related areas of urgent financial need are explained. The OHA welcomes the opportunity to work together with government to further explore, quantify and address the needs of hospitals so that they can continue to meet expectations in delivering high quality services for Ontarians.

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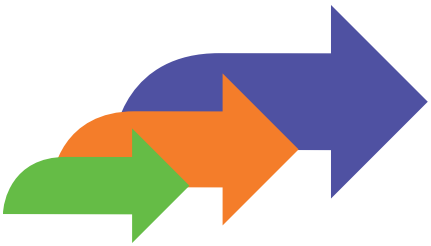

Summary

It goes without saying that the COVID-19 pandemic has generated an unprecedented and profound challenge in the form of a world-wide health and economic crisis. In Ontario, even as wave one subsides and lock-down restrictions are lifted in phases, there should be no illusion about the sizeable effort still needed to guard against and manage the serious, ongoing threat.

For Ontario's hospitals — as well as the broader health system — the front-line pandemic response remains in play at the same time as recovery work proceeds to address other urgent priorities. In the face of great uncertainty, and until an effective vaccine is deployed, hospitals must be constantly vigilant and prepared for the next wave and localized flare-ups. Ontarians are counting on hospitals being able to withstand any difficulty that may be posed by COVID-19 — or any other challenge — without fail. In turn, the ability of hospitals to meet those expectations, within our publicly funded health care system, is heavily reliant on government.

To date, the pandemic has caused tremendous operational and financial stress for hospitals. Up until the pandemic was declared, Ontario's highly efficient yet financially stretched hospitals had been operating at full capacity, dealing with the persistent problem of hallway healthcare[1]. With the onset of the pandemic, at the request of government, hospitals launched a massive and costly wave one response to ensure the provision of essential health services and to keep Ontarians safe.

In a spirit of goodwill and out of a sense of responsibility, hospitals took the lead and became the main backstop in reinforcing the entire health care sector as there were no other options. Not only did hospitals work to uphold their own essential services, they went beyond their traditional roles to provide significant expertise and support to the long-term care and public health sectors. Hospitals are continuing to lead with ongoing responsibilities and dedicated staff in those sectors. It has also recently been recognized that for safety reasons, hospitals are increasingly the focal point to deal with any kind of respiratory illness that previously would have been addressed mainly through primary care.

While hospitals' initial wave one efforts were widely publicized, as months have passed, a great deal of less visible work has continued in the background. Currently, operations remain challenging and clinicians and staff continue to work exceedingly hard. Hospitals are striving to carefully resume postponed surgeries in aid of great numbers of waiting patients and to take up other important work, including research, that had to be suspended. Further, with the ongoing Alternate Level of Care (ALC) problem — made worse by the crisis in long-term care — and the possibility of a second pandemic wave that may coincide with flu season in the fall, hospitals are extremely concerned about capacity.

With the initial pandemic response, the finances of every type of hospital in every community of the province have been impacted. To avert an all-out crisis, hospitals incurred substantial expenses, as would be expected. What may not be well-appreciated is the heavy losses of key revenue streams that are critical in supporting the core work of hospitals. The end result is that in order to maintain operations, hospitals had to and are continuing to deplete already lean cash reserves and incur unsustainably large deficits.

While a full accounting of the financial impact of the first wave response is pending, a recent survey conducted by the Ontario Hospital Association (OHA) provides an early indication. **A preliminary estimate of the combined hospital sector net deficit (shortfall of revenues over expenses) for *April and May 2020 only*, is approximately $500 million. Included in the net deficit is an estimated revenue loss of $320 million.**

As the net deficit has continued to grow in the ensuing months, the most pressing financial issue facing hospitals is that a net deficit of this size will quickly result in cash flow difficulties that are serious enough to prevent them from meeting their financial obligations. This obviously has major implications for service provision and staff retention. Further, it puts at risk the wave one recovery effort — which includes resuming surgical and other

1 The lean operational performance of Ontario's hospitals is documented in *Ontario Hospitals - Leaders in Efficiency*. https://www.oha.com/communications/ontario-hospitals-leaders-in-efficiency

procedures and reducing the massive backlog — as well as essential wave two investments, due to a lack of cash reserves.

The sense of goodwill that was established early in the pandemic is eroding. In turn, this erodes the goodwill between hospitals and their staff and physicians. Currently, months into the pandemic, with a full financial impact of the initial wave one response still pending and unknown future impacts, hospitals are in urgent need of government action to address pressing operational, capacity and financial challenges.

In order to remain financially whole, Ontario hospitals require:

- Immediate and full funding relief for all aspects of the initial wave one pandemic response;
- Funding support for wave one recovery (including surgical backlog), the expected fall capacity pressures and continued support to other sectors if required;
- Funding to support operations in a "new normal" environment which is more costly than Ontario's historically efficient operations.

Recommendations in support of this advice are provided on the following page.

The financial need is substantial, and not just for relief for the pandemic impact. For at least a decade, Ontario's very efficient yet over-stretched hospital system has been striving to keep pace with patient demand, as has been documented in *Ontario Hospitals - Leaders in Efficiency*. Managing under "new normal" conditions with the existing health system configuration and its sub-optimal ways of delivering care is no longer feasible. Ontario hospitals cannot return to a state of 100%-plus occupancy rates and hallway healthcare.

The OHA has been calling for many years, for system reform and effective capacity planning to be able to meet the future needs of our growing and aging population in the most cost-effective manner possible. As the pandemic has so clearly revealed, those future needs, envisioned many years ago, are now present-day needs. Going forward, in addition to providing financial relief to stabilize the hospital system, the OHA strongly believes that now is the time for smart investment to bring about a reformed, modern health system.

Smart investment must yield a better integrated, better coordinated and better planned health system that emphasizes primary care and home and community-based services of all types including for mental health, and that utilizes appropriate virtual care. Integrated health services are critically important in achieving better health outcomes and health system results, including relieving capacity and operational pressure on hospitals.

As well, up-to-date technologies, including systems to support real-time information to plan for and deliver services — that have been slow to appear in the Canadian health sphere due to lack of investment — are also needed. Further, comprehensive health human resource planning will be critical to ensuring the stable and caring healthcare workforce that is necessary to provide safe, high quality care.

The OHA and our hospital members fully recognize the magnitude of the financial challenge that this poses for the Government of Ontario. Because we so strongly believe in the need for reform, and that the current pandemic presents an opportunity for large-scale change, the OHA recommends that the provincial and federal governments work together to form a new fiscal federal agreement in support of health care.

A new agreement would provide Ontario with the ability to support both the immediate hospital and health system challenges, and the investment required to bring about more cost-effective care with higher quality health outcomes. The OHA further believes that this investment would also comprise a significant underpinning to employment support and economic recovery across the province as government seeks solutions to that end. In fact, not having hospitals financially ready for wave two and new normal operations could well lead to further economic shutdowns and cost governments many times the investment being recommended.

List of Recommendations

Recommendation #1

For most hospitals, the financial impact of the initial wave one pandemic response began in March and still continues.

The OHA recommends that government provide hospitals with immediate and full funding relief for all aspects of the initial wave one pandemic response including:

- Incremental expenses;
- Lost revenue;
- Delayed implementation of plans to balance budgets; and
- Capital investments.

Immediate relief will alleviate hospitals' current severe cash flow difficulties.

Recommendation #2

Beyond the need for full reimbursement for the ongoing initial wave one response, additional funding is needed for pandemic costs that will be incurred during the second half of the 2020-21 fiscal year.

The OHA recommends that government ensure flexibility in the Fall 2020 Budget, in the face of great uncertainty, in order to:

- Provide for funding to address the backlog of procedures and services as part of wave one recovery;
- Support hospitals in addressing combined capacity pressures due to wave two for:
  - Ongoing ALC pressures and flu season;
  - Additional expenses related to field hospitals and other physical capacity expansions as hallway healthcare is not an option in this environment;
- Allow for hospitals to continue supporting long-term care providing COVID-19 laboratory testing and operating assessment centres, should government desire.

Hospitals require clarity now regarding the government expectations surrounding each of these items as decisions are already in progress. Further, this recommendation requires an immediate contingency plan to ensure regional service and staffing plans are in place ahead of the surge. The OHA extends an offer to work with government on the contingency plan.

Recommendation #3

The "new normal" operations that hospitals are currently experiencing will continue into the next fiscal year and until an effective vaccine is available and fully deployed.

The OHA recommends that government fully reimburse hospitals for "new normal" operating costs currently and through 2021-22 for:

- Sufficient resources to support the continued protection of staff and patients;
- A level of standby capacity that will ensure effective and safe delivery of care.

This recommendation requires that the OHA, the Ministry of Health and Ontario Health work together to better describe the financial impact of the "new normal" environment.

1. Hospital Wave One Pandemic Response and Financial Impact

Recommendation #1

For most hospitals, the financial impact of the initial wave one pandemic response began in March and still continues.

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Wave One Pandemic Response

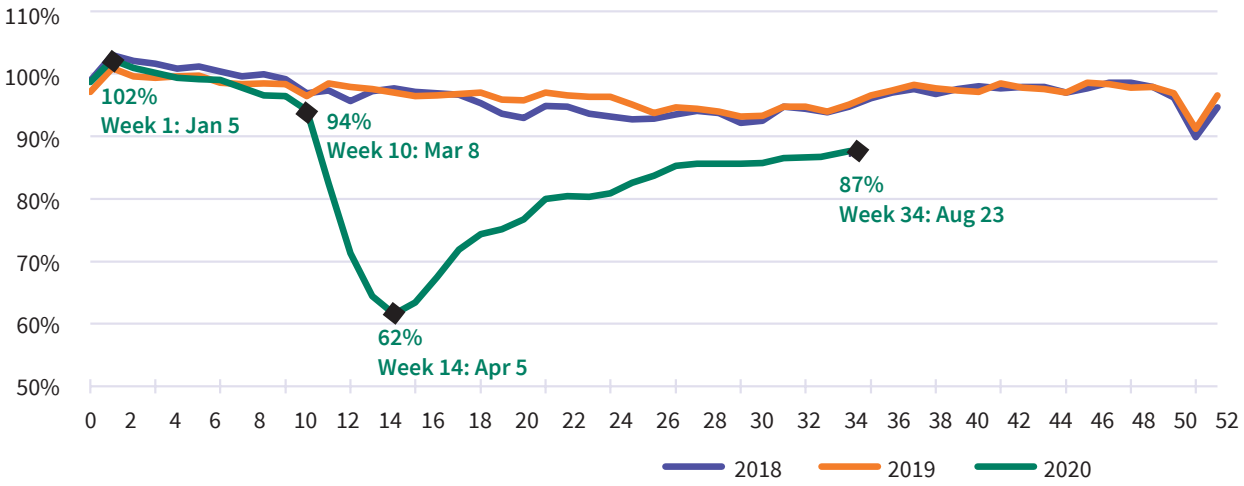
Months before the pandemic was declared by the World Health Organization (WHO) on March 11th and before a provincial emergency was declared on March 17th hospitals were on alert, starting to implement their pandemic plans. At the time of the first Ontario hospital admission for a presumptive case of COVID-19 on January 25th, hospitals were ready to act.

From those early days, hospitals began preparations for a possible overwhelming surge of patients. Together with the provincial and federal governments and with the assistance of private industry, hospitals went to extraordinary lengths to procure essential personal protective equipment (PPE), drugs, ventilators and other capital equipment and supplies in the face of international shortages. Hospitals implemented extensive infection prevention and control protocols and other measures to support physical distancing and safety. Staff were redeployed to areas of high need, additional hiring occurred, and supplementary training took place to enhance clinical and other skill sets.

Hospitals were able to free-up over one third of the provincial bed supply to create critical stand-by capacity. Over 10,000 beds were made available by discharging as many patients as early as possible and by cancelling elective surgeries, as ordered by the province on March 15th. The overall acute care occupancy rate subsequently dropped to 62% by early April. Alternate hospital sites including off-site field hospitals were established which currently remain in use or as standby capacity. Additional spaces were created in hotels, some of which are also currently in operation.

As well, when hospitals were called to assist with the crisis in long-term care, they did not hesitate in assuming operation of several homes and providing direct care to residents of those and other homes. Further, to augment Public Health laboratories, hospitals began using their own laboratories for substantial volumes of COVID-19 tests and have also been operating a number of COVID-19 assessment centres.

Ontario Hospital Acute Care Occupancy Rate - by Week
Seven-Day Provincial Average to Aug 23, 2020



Source: Ministry of Health

Previously, under normal circumstances, many hospitals regularly experienced acute care occupancy rates exceeding 100%. In the first week of January 2020, the provincial average rate was 102%. By clearing over 10,000 beds, including 8,000 acute beds, the rate declined steeply after early March (week 10) to a low of 62% by early April (week 14). By early June (week 23), some hospitals were re-starting elective procedures. On August 23rd, the rate was 87%.

Financial Impact

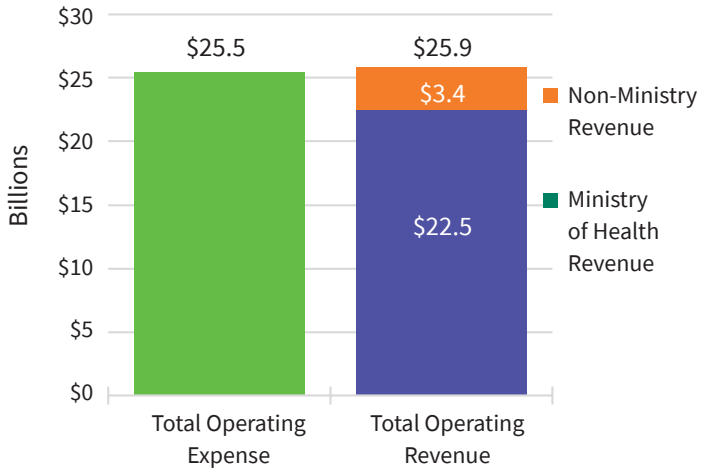
Context

In order to provide some context surrounding the financial impact to date, the size of the hospital system in terms of finances is described as follows: for the 2018-19 fiscal year, hospital operating expense totaled $25.5 billion and operating revenue totaled $25.9 billion.

Of the total operating revenue, approximately $3.4 billion or 13% of revenue came from sources other than the Ministry of Health (deemed "Non-Ministry Revenue").

It is important to note that ALL revenue supports hospital operations. Revenue generated directly by hospitals represents core funding sources and are not discretionary forms of "extra" revenue. Some of this revenue includes preferred accommodation (private/semi-private room differentials), co-payments, out-of-province/country and parking, to name a few.

Ontario Hospital Operating Expense and Revenue in 2018-19



Financial Survey Results and Discussion

The full impact of COVID-19 on hospital finances to date is still to be determined and, currently, the Ministry of Health is assessing expenses related to the first wave pandemic response in detail. (The uncertain financial impact of the wave one recovery process and wave two investment are discussed in Section 2.)

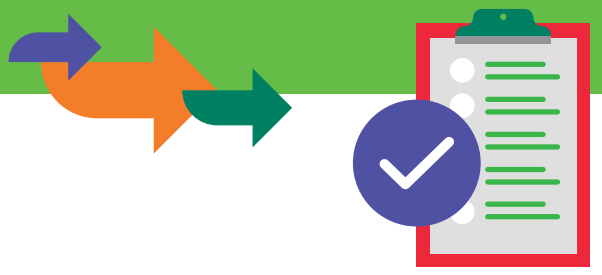
To obtain a preliminary picture, the OHA surveyed hospitals in late June to assess the financial situation in general and revenue losses in particular, for the first two months of the current 2020/21 fiscal year, although it is recognized that hospitals incurred significant expenses and lost revenue in March.

Out of a total of 142 Ontario public hospitals, 120 (85%) responded to the survey. These hospitals represent 98% of the $25.5 billion total operating expense for 2018-19.

The survey results provide a preliminary estimate of a combined hospital sector net deficit (shortfall of revenues over expenses) for *April and May 2020 only*, of approximately $500 Million.

Financial Results:
Combined Hospital Sectors, April and May 2020

Revenue	$ 4,246	Million
Expense	$ 4,794	Million
Net Deficit	**$ (548)**	**Million**



Included in the net deficit is an estimated revenue loss of $320 million for April and May. This includes both Ministry and Non-Ministry revenue losses.

A full listing of revenue losses is available in the Appendix. The following is a selection of the types of revenue losses.

Revenue Losses, April and May 2020: Selected Categories

OHIP/Technical fees	$ 49.7	M
Parking	39	M
Research	32	M
Grants	27	M
Preferred Accommodation	24	M
Inter-Provincial Billing	20	M

For many hospitals, the impact of lost revenue exceeds that of added expense. A large portion of overall revenues are related to the level of patient activity. Specific Ministry of Health revenues that are directly tied to volumes include:

- Quality Based Procedure (QBP) funding;
- Bundled care funding;
- Cancer Care Ontario (CCO) funding;
- Post-Construction Operating Plan (PCOP) funding.

In stabilizing hospital funding, hospitals should be able to keep the full amount of these funding sources. For the purposes of the 2020/21 fiscal year, there should be no reconciliation or claw-back.

Other volume-related funding includes areas such as Inter-Provincial billing (mainly from Quebec) and OHIP/ Technical fees for which hospitals still incurred the labour costs throughout wave one. Hospitals should be reimbursed by government by being allowed to rightfully claim these expenses as incremental COVID-19 costs where appropriate.

In addition, other revenues need to be addressed to keep hospitals financially whole as they all contribute to each hospital's bottom-line. In some cases, parking revenue has had financial conditions placed on it for 10 or 15 years either by banks or the Ministry itself to make available the necessary capital funding. Even losses in hospital retail pharmacies contribute to the overall operations of the hospital as they are now frequented much less.

A common misconception about hospital expenses is that since the provincial acute care occupancy rate dropped to 62%, there would have been a corresponding decrease in expenses. However, total operating expenses are comprised of 70% labour costs and throughout the pandemic hospitals have retained, redeployed and in some cases hired extra staff. Hospitals were anticipating a degree of surge in COVID-19 patients and ventilated patients that did not materialize. Due to hospitals' proactive steps, it was possible to increase critical care bed capacity without implementing all contingency plans.

As well, also due to the need for pandemic preparedness, many hospitals did not implement budget reduction plans for 2020/21. Some of these plans would have necessitated staff reductions through either attrition or layoffs. This would have been clearly counter to the pandemic response and hospitals were advised by government not to take this action. These decisions can rightly be calculated as extra costs as they represent a difference between budgeted and actual expenditures. These missed opportunity savings were captured in the OHA survey as the survey focused on net deficit for April and May.

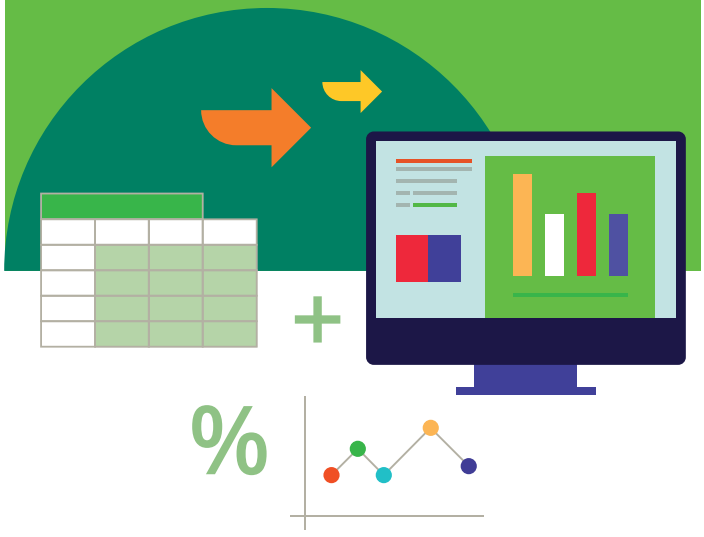
Some examples of capital investments that hospitals had to make to support care have included: ventilators, laboratory equipment and renovations to support COVID-19 testing, capacity expansion, including setting up of field hospitals, and related equipment.

While the survey results are not definitive, they give an indication of the magnitude of the financial impact of COVID-19 on the sector to date.

The approximate $500 million net deficit for only a two-month period at the start of this fiscal year will quickly result in cash flow difficulties that will prevent hospitals from meeting their financial obligations. Cash flow is critically needed to address the backlog of procedures and to invest in contingencies for a second wave.

It is important that hospitals and Ministry officials begin to discuss the full implications of the pandemic on both expenses and revenues in order that hospitals receive timely and sufficient funding relief. This discussion is doubly important given the already high degree of hospital efficiency that existed up until the pandemic.

Further, in full support of Ministry efforts to ensure financial accountability, hospitals welcome any future reconciliation and/or audit process and advise that a balanced approach be taken that fairly considers the overall pandemic context and pre-existing financial positions.



2. Wave One Recovery and Wave Two Investment for Fall Capacity Pressures

Recommendation #2

Beyond the need for full reimbursement for the ongoing initial wave one response, additional funding is needed for pandemic costs that will be incurred during the second half of the 2020-21 fiscal year.

The OHA recommends that government ensure flexibility in the Fall 2020 Budget, in the face of great uncertainty, in order to:

- Provide for funding to address the backlog of procedures and services as part of wave one recovery;
- Support hospitals in addressing combined capacity pressures due to wave two for:
  - Ongoing ALC pressures and flu season;
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- Allow for hospitals to continue supporting long-term care providing COVID-19 laboratory testing and operating assessment centres, should government desire.

Hospitals require clarity now regarding the government expectations surrounding each of these items as decisions are already in progress. Further, this recommendation requires an immediate contingency plan to ensure regional service and staffing plans are in place ahead of the surge. The OHA extends an offer to work with government on the contingency plan.

Wave One Recovery — Resuming Services and Addressing the Backlog

When the pandemic arrived, hospitals shut down all but the most essential services, adding scores of patients to already long wait lists. In addition to cancelling elective procedures, significant numbers of non-emergency diagnostic procedures, outpatient clinics and community-based services were suspended or restricted. Emergency Departments (EDs) continued to operate but saw lower volumes than normal as many people with urgent health conditions stayed away due to fear.

While hospitals still have numbers of confirmed and suspected COVID-19 patients, they are in wave one recovery phase. In early June, after approximately 12 weeks from when elective procedures were ramped-down, hospitals began to carefully resume postponed surgeries.

They are now dealing with additions of new patients plus a substantial backlog of cancelled procedures. The backlog will take many months to clear and patients who wait too long risk seeing their conditions worsen. In addition to the difficulty this poses for patients, this places further demands on hospitals as they see increasing numbers of patients with higher, more intensive needs. Throughout the pandemic, physicians have been in a challenging position of deciding how to prioritize treatment of patients with non-emergency but serious conditions and balancing care for planned and unplanned care.

Addressing the backlog will involve increasing patient volumes well beyond normal levels. To meet the urgent needs of patients, hospitals are considering scheduling extra procedures by way of extended hours and on weekends. This requires additional hospital capacity in terms of operating room time, beds and staffing which would likely involve overtime and premium pay.

While the initial pandemic response was temporarily financed through hospital cash reserves, the recovery process, which includes addressing the very serious surgical backlog and long waiting times for patients, will be hindered without immediate funding relief.

Capacity Situation and Preparing for Wave Two

Hospitals are extremely concerned about the possibility of a second wave occurring in the fall which would coincide with seasonal flu and other illnesses that surge in winter months. As is widely known, the capacity situation in Ontario hospitals has been very tight for many years for several reasons, including:

- High ALC volumes comprising up to 17% of beds;
- Lack of capacity elsewhere in the health system, notably for home care, other community care and long-term care;
- Low numbers of hospital beds per capita that have not kept up with demographic change.

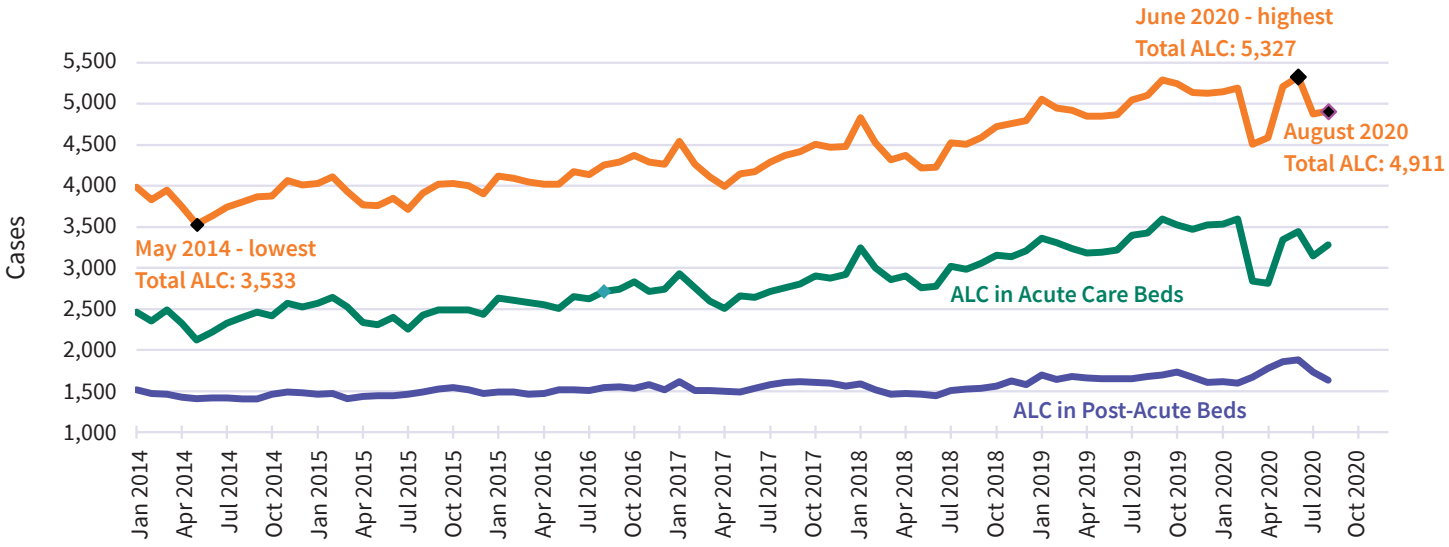
Up until the pandemic, while managing very efficiently, many hospitals regularly experienced occupancy rates well over 100%. High occupancy rates have led to long ED wait times and overcrowding. Each year, seasonal flu and other illness intensifies these problems. With or without a second pandemic wave, the hospital system is heading into very challenging fall and winter seasons if no extra capacity is created. The compound effect of a second wave would put the system into crisis.

Currently, as hospitals work to re-establish elective surgeries and other services, and as ED volumes begin to normalize, occupancy pressures are mounting. As described above, for the province overall, following a sharp decline in occupancy rates, as of late August the acute care occupancy rate was 87%. Several hospitals have rates hovering around the 100% level. This is a problem as hospitals are required to maintain a 10% to 15% standby capacity in order to continue re-establishing elective procedures.

Hospitals face even greater difficulty in discharging ALC patients than normally. Pre-pandemic, approximately 17% of hospital beds were occupied by ALC patients — most of whom were waiting for a long-term care bed, an assisted living bed or home care. Access to long-term care has been reduced dramatically due to the crisis occurring in that sector. Following a drop in ALC cases in March and April 2020, as hospital beds were cleared, ALC cases rose throughout May and June, reaching a historic high of over 5,300. The pandemic impact on home care also contributed to the rising ALC numbers.

Physical distancing is yet another factor impacting both the number of available hospital and long-term care beds.

ALC Cases (Total, Acute and Post-Acute) 2014-2020



Source: CCO

Hospitals are now limiting the use of multi-bed ward rooms to two patients and most long-term care homes are no longer admitting new residents to rooms with more than two beds. These measures removed thousands of beds from the existing physical site capacity in both sectors.

Hospitals must be prepared in order to guard against the risk of a capacity crisis. While there was no choice but to postpone elective surgeries with wave one, it will be very difficult to justify doing so with a second wave. Further, hospitals cannot return to the unsafe practice of hallway healthcare.

In creating extra capacity, hospitals require planning and financial support. This may include rapid construction of additional, temporary infrastructure such as field hospitals, or the use of hotels or empty residential buildings. Further, to the greatest extent possible there should be widespread expansion of home care and community services that promote independent living and continued use of virtual care and enhanced use of community paramedicine.

Continued Support of Other Sectors

Hospitals continue to operate numerous COVID-19 assessment centres across the province. While hospitals have stepped up to provide this important service, dedicated staff have been allocated to these centres and will be needed in their pre-existing roles as the recovery process continues. If government chooses to continue with hospital operation of these centres, which are not core hospital services and are likely more costly than if they were managed outside of the hospital sector, hospitals will require funding support.

Hospital support in the long-term care sector is in a similar situation. Provision of staff and management in individual homes continues and hospitals will be unable to maintain this support without reimbursement.

Further, laboratory support represents another critical contribution of hospital expertise and resources to the overall system-level pandemic response. Hospitals incurred substantial expense with adapting and expanding existing labs as part of the wave one response and will incur ongoing expense if they are to continue.

Hospitals will continue to be the backstop for the system in the event of wave two and demand for hospital services will only increase. For example, normally, primary care providers would be the first line providers to manage respiratory illness. Due to the risk that such an illness might be COVID-19 and the high need for PPE to deal with respiratory problems, it has recently been recognized that hospitals will increasingly become the focal point for care, particularly as "normal" cough and cold illness ramps up with re-opening of child care, schools and post-secondary institutions.

While the initial pandemic response was financed through cash reserves that were drawn down, that option is not available going forward. The lack of cash jeopardizes the process of recovery and investment needed for wave two and continued operations to support other sectors.

The magnitude of additional financial impact that will be incurred in the second half of the 2020-21 fiscal year is uncertain which is why government must create flexibility in the provincial budget.

Opening up the economy means that hospitals need to be prepared for outbreaks and surges. It is less costly by far, to strengthen hospitals with the supports they need than to be forced to close down once again, to guard against hospitals not being able to cope.

Throughout the pandemic hospitals relied heavily on their human resources, to be fully engaged and to go above and beyond. As the fall season approaches, without clarity or a plan, the goodwill that existed originally, is eroding. In facing what they will need to confront in the fall, hospitals and their staff require the assurances that they will have the resources to continue their challenging but necessary work.

The OHA and hospitals are willing to work with government to develop contingency plans to ensure that heading into the fall, access to hospital services can continue to be provided in a safe environment and in a cost-effective way.

3. "New Normal" Operations — Current and Through 2021-22

Recommendation #3

The "new normal" operations that hospitals are currently experiencing will continue into the next fiscal year and until an effective vaccine is available and fully deployed.

The OHA recommends that government fully reimburse hospitals for "new normal" operating costs currently and through 2021-22 for:

- Sufficient resources to support the continued protection of staff and patients;
- A level of standby capacity that will ensure effective and safe delivery of care.

This recommendation requires that the OHA, the Ministry of Health and Ontario Health work together to better describe the financial impact of the "new normal" environment.

Resources to Protect Staff and Patients

While the full financial impact of COVID-19 is uncertain, it is a fact that hospital cost structures have changed. Having worked out some of the complexities of enhancing safety during wave one, hospitals are able to anticipate how things will continue until a vaccine is available and deployed. Providing care under "new normal" conditions is much more difficult, time consuming and expensive. Although hospitals are experiencing these added costs now, they will continue through the next fiscal year at minimum. This requires a re-evaluation of funding levels that hospitals will need, outside of any surge response, that should be considered in preparation for the 2021/22 fiscal year. The fact that hospitals cannot be sustained with the continued expectation of operating at pre-pandemic levels of efficiency should not be overlooked in the face of the high need for immediate funding relief.

As hospitals continue to re-establish elective procedures and other services, higher expenses for equipment and supplies and a range of infection prevention and control measures are to be expected as are price increases if shortages persist. Staffing requirements have also increased and will continue due to the challenging nature of delivering patient care with PPE and added safety protocols. Pre-pandemic, hospital clinicians were already stretched, hurriedly managing high patient volumes on a regular basis. In the time ahead, close consideration should be given to the impact of health human resource issues that may impact well-being and expenses. This includes the potential impact of staff shortages due to increased sick time, family responsibilities and child-care issues related to school or child care closures.

Standby Capacity Costs

As noted in Section 2, hospitals are required to maintain a standby capacity of 10% to 15% in order to re-establish elective procedures. This ensures a ready supply of staffed beds in the event of another surge. As well, the ability to maintain or quickly create a level of standby capacity reflects a higher level of quality and safety that allows for better patient care, helps avoid hallway health care and ensures safer, less congested and less hectic work environments.

Increasing the standby capacity will require higher funding levels. By maintaining a number of open beds for standby purposes, the costs for staff and other normal operating expenses are similar to those when beds are at 100% occupancy. This is mainly because hospital operating

costs are largely fixed costs — due to the mostly 70% compensation costs — and do not fluctuate much when patient volumes are decreased. However, standby capacity means lower patient volumes than with 100% occupancy. Fewer hospital volumes lead to less volume-related revenue. The net effect is a need for greater funding.

Pre-pandemic, Ontario hospitals experienced over a decade of funding restraint, including years of zero-percent base budget increases. This is also documented in *Ontario Hospitals - Leaders in Efficiency*. Near the end of the 2019/20 fiscal year, when the pandemic was declared, many hospitals were on the brink of having to make staff and service cuts while still seeing growing patient demand year after year. To simply maintain existing service levels under ordinary circumstances, hospitals assessed their need for a year-over-year increase of 4.85% or $922 million for the 2020/21 fiscal year, in order to make up for the effect of years of flat funding. Looking ahead to the 2021/2022 fiscal year, with the "new normal" environment, and the current health system configuration, the requirement for higher base budget increases can be expected.

Smart Investment for System Reform

To date, Ontario has not realized the full potential of its health care spending. Up until the pandemic, while operating costs of Ontario hospitals were the lowest in Canada, the fact of very high volumes of ALC patients and continued difficulty in addressing hallway healthcare, indicates a sub-optimal level of performance for the system overall and for patients. Lack of planning in years past, that would have ensured sufficient capacity of the right types of care for all patients has brought Ontario's health care system to its current state.

Ontario has an opportunity to make the necessary reforms to strengthen and modernize the health care system to be able to meet the current and future needs of Ontarians. Smart investment in substantially higher levels of funding in services that prevent or delay the need for hospital care, such as for primary care, and home and community-based care of all types, including mental health services and appropriate virtual care, will help ensure that patients receive more appropriate and less expensive care.

In the current pandemic environment these investments and others to promote better integration are more important than ever. Over a period of time, smart, strategic investment will mitigate the financial impact of the "new normal" environment and other effects of the pandemic on hospital operations, by leading to overall system-level efficiencies.

Under "new normal" conditions resulting in overall higher expenses and a need for a more expensive standby capacity, hospitals will need increased funding to maintain operations.

While hospital funding will require adjustment, the impact can be offset through smart, strategic investment in a range of community-based and better integrated services. The OHA and hospitals are eager to work with government in developing and implementing options for smart investment.

Conclusion

On the heels of many years of tight finances and physical capacity pressures, Ontario hospitals have gone to great lengths to address the numerous and costly challenges posed by the COVID-19 pandemic. To date, the financial impact on hospitals has been severe. In preparation for a potentially very difficult fall/winter season, in the event of a second wave, further expenditures will be necessary to stem a capacity crisis. These and other expenses related to operating under "new normal" conditions are not yet quantifiable and so financial flexibility will be essential. Therefore, the OHA is calling on the provincial government to implement the three recommendations in this report, in order to stabilize the sector and reduce financial uncertainty.

Further, in managing through the difficulties of the pandemic and the continued presence of COVID-19 for the foreseeable future, there are many opportunities to very substantially improve upon the pre-pandemic state of affairs. Now is the time for smart, strategic investment to modernize Ontario's health system to better meet the increasing needs of its population and address long-standing problems of lack of capacity and a sub-optimal health system configuration. A great deal more can be achieved if hospitals and levels of government work together. Therefore, the OHA is calling on the provincial and federal governments to work jointly to form a new fiscal federal agreement in support of health care that would also have an additional benefit of supporting economic recovery.

Appendix

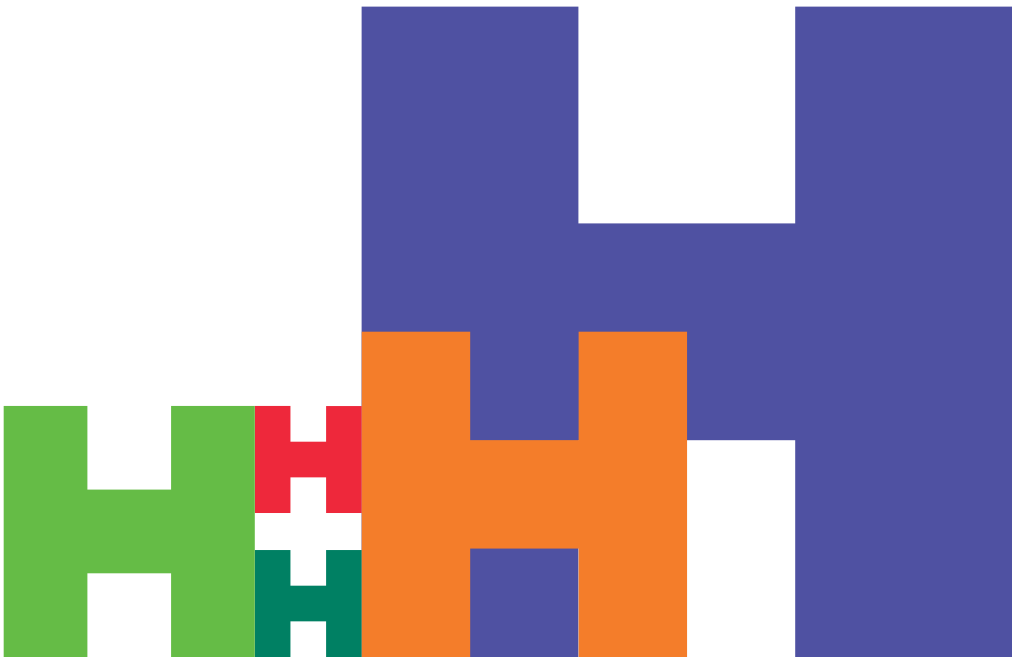
Ontario Hospital Estimated Revenue Losses for April and May 2020

Lost Revenue Category	Amount	% of Total
OHIP/T-fees	49,743,842	16 %
Parking	39,062,471	12 %
Research	31,714,055	10 %
Grants	27,187,520	8 %
Preferred Accommodation	23,681,427	7 %
Inter-provincial Billing	20,265,407	6 %
Other Revenues	12,339,962	4 %
Self-Funded Programs (e.g. audiology clinic)	7,938,003	2 %
Clinics (e.g. Automobile accident assessment clinic)	7,538,892	2 %
Self-Pay (Non-Canadian Resident)	7,152,192	2 %
Bundled Partner Revenue (includes Hip & Knee replacement, etc.)	7,137,192	2 %
WSIB	6,802,485	2 %
Retail Pharmacy	4,694,277	1 %
Donations (e.g. Foundations)	4,269,176	1 %
Cafeteria	2,849,710	1 %
Patient Amenities (WiFi, TV, Phone, etc.) & Equipment (crutches, etc.)	2,304,324	1 %
Federal Government (CAF)	2,081,992	1 %
Leased Space / Rental Revenues (rent relief for physicians)	1,842,464	1 %
Regional Services (e.g. referred in services)	1,732,786	1 %
Uninsured Services (e.g. circumcisions, cosmetic surgeries)	1,653,687	1 %
Gift Shop/Auxiliary	1,586,615	0.5%
Co-Payment (includes CCC/ALC)	1,198,050	0.4%
Ambulance Revenue	1,183,525	0.4%
Other Rentals (e.g. equipment)	825,231	0.3%
Sub-Total	**266,785,283**	**83 %**
Volume-Based Revenues (QBPs, Wait-times and PCOP) reported by only a few hospitals	53,857,647	17 %
Total	**320,642,930**	**100 %**

Substantial portions of Non-Ministry Revenue represent hospital-generated revenue that directly supports hospital services. Many of these sources have been severely impacted by the pandemic.

Much of the revenue sources noted on page 15 are tied directly to patient volumes. As volumes were curtailed during lockdown, specific revenues declined substantially. The largest volume-related impact came from revenues for patient procedures (which were funded through Ministry funding sources) totaling almost $54 million. (These procedures comprise things like elective hip and knee replacements and cataracts).

Revenue loss in areas such as preferred accommodation (private or semi-private rooms); parking or inter-provincial billing for out-of-province patients were to be expected. Hospitals also lost substantial revenue due to loss of OHIP “technical fees” which are provided to cover the cost of diagnostic equipment and maintenance on a volume-related basis. As hospitals were not providing non-urgent diagnostics, these fees were lost; however, related equipment and staffing costs were still incurred.



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