

Institutional Health Program— Transfer Payments to Public Hospitals

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The *Public Hospitals Act* provides the legislative authority to regulate and fund the operations of public hospitals in Ontario, while the *Health Insurance Act* defines the medical services to be provided by hospitals. Currently, approximately 80% of the operating costs of public hospitals are funded through transfer payments from the Ministry of Health and Long-Term Care. Each hospital's board of directors is responsible for the delivery of services by the hospital. The Ministry and hospital boards are both responsible for ensuring compliance with legislation and regulations.

In April 1996, the Minister of Health established the Health Services Restructuring Commission (HSRC) under the *Ministry of Health Act* as an independent agency at arms length from the government. The fundamental goal of restructuring is to ensure that appropriate and cost-effective health services are in place to meet the needs of Ontario's growing and aging population.

The Ministry's Institutional Health Program provides funding to public hospitals for the costs of operating their facilities. The Institutional Health Program is administered by the Ministry's Health Care Programs Division, which is responsible for the operational planning, policy development and funding of public hospitals.

In the 1998/99 fiscal year, the Ministry provided approximately \$7.1 billion for the operation of public hospitals as shown in the following table.

Summary of Transfer Payments for the Operation of Public Hospitals

Type of Funding	1997/98 (\$ millions)	1998/99 (\$ millions)
Base Funding	6,509	6,646
Transition Funding	24	251
Growth Funding	47	62
Emergency Ward Funding	0	35
Other Funding	124	83
Total	6,704	* 7,077

* In addition, in 1998/99 the Ministry provided financial assistance to public hospitals to make their computer systems ready for Year 2000.

Source: Ministry of Health and Long-Term Care

In addition to the responsibilities outlined above, the Division facilitates and coordinates the implementation of the recommendations and directions of the HSRC. During the 1998/99 fiscal year, the Ministry provided \$248 million to hospitals for one-time costs incurred in implementing HSRC directions.

The Ministry's Corporate Services Group, through the Health Capital Program, provides financial assistance to hospitals for the cost of approved capital construction. In the 1998/99 fiscal year, the Ministry provided approximately \$52 million in funding for hospital capital construction and \$49 million for HSRC-directed capital projects.

AUDIT OBJECTIVES AND SCOPE

The objectives of our audit of transfer payments to public hospitals were to assess whether the Ministry had adequate procedures in place:

- to ensure that hospitals are funded equitably and in accordance with applicable legislation and ministry policies; and
- to monitor and report on the effective and efficient operation of the public hospital system.

Our audit was performed in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances. Prior to the commencement of our audit, we identified the audit criteria that would be used to address our audit objectives. These were reviewed and agreed to by ministry senior management.

In conducting our audit, we reviewed and analyzed ministry policies and procedures; interviewed ministry and HSRC staff; reviewed relevant reports and literature as well as hospital documentation maintained by the Ministry; and researched the delivery of hospital systems in other jurisdictions.

We also reviewed the relevant work of the Ministry's Internal Audit Branch. However, since the Branch had not performed any recent audits of programs administered by the Health Care Programs Division, we were unable to rely on their work to reduce our audit work. Our audit was substantially completed in May 1999.

OVERALL AUDIT OBSERVATIONS

While the Ministry had adequate procedures to ensure that hospitals were funded in accordance with applicable legislation and ministry policies, there were insufficient procedures to ensure that hospitals were funded equitably. In order to ensure that funding reasonably relates to hospital services provided, the Ministry needed:

- to develop systems to fund hospitals based on the demand for services rather than on historical expenditure patterns;

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- to develop and use appropriate criteria for providing assistance to hospitals experiencing financial difficulties; and
 - to put in place a more rigorous negotiation process to relate operating funds to new approved facilities.

In 1994 we had reported that an appropriate accountability framework would enable ministry management to put policies and procedures in place to hold hospitals accountable for the prudent expenditure of public funds. However, such a framework has still to be developed.

In addition, the Ministry did not have adequate procedures for monitoring and reporting on the effective and efficient operation of the public hospital system. In particular, the Ministry needed:

- to develop a set of indicators to measure and report on the performance of public hospitals in delivering quality services;
- to improve its process for the timely submission, review and approval of hospital operating plans;
- to develop protocols to ensure that patient complaints received by the Ministry are consistently investigated and resolved on a timely basis;
- to evaluate the effectiveness of temporary emergency ward funding and initiatives to reduce overcrowding in hospital emergency rooms; and
- to periodically monitor and assess the effectiveness of the restructuring process.

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DETAILED AUDIT OBSERVATIONS

HOSPITAL FUNDING

ALLOCATION OF OPERATING GRANTS

Hospital operating funds are provided through a base grant and one-time grants allocated for purposes such as transition funding, population growth and specialized treatment programs. Normally, the base grant amount for each hospital is carried forward from one year to the next. However, in the 1996/97 and 1997/98 fiscal years, base grants were reduced by a total of \$365 million and \$435 million respectively. For the 1998/99 fiscal year, base grants totalled approximately \$6.6 billion while total one-time grants to hospitals amounted to \$431 million.

In March each year, hospitals are informed of their operating grant allocation for the upcoming fiscal year. Based on its allocation, each hospital develops an operating plan for ministry approval. Generally, hospitals are allowed to retain their surpluses but are expected to absorb their deficits.

We reviewed the calculation of 1997/98 hospital base and one-time grants for a sample of hospitals and found that the funding was generally determined in accordance with established policies and procedures.

Any funding adjustments were allocated using an Adjustment Factors Funding Formula which is intended to take into account a hospital's cost efficiency. The formula was developed by the Joint Policy and Planning Committee (JPPC), comprising representatives from the Ministry and the Ontario Hospital Association. An efficient hospital is intended to benefit more from this formula than an inefficient one. This formula was used to allocate the reductions in base funding in 1996/97 and 1997/98, and to allocate certain transition funding in 1998/99.

We reviewed the Adjustment Factors Funding Formula, and noted that:

- The formula does not take into account the demand for hospital services and does not measure the appropriateness of current hospital practices. Currently, only certain new one-time funding is allocated by the formula.
- The formula has not established a clear relationship between a hospital's relative cost efficiency and its base grant. As of September 1998, approximately 34% of the hospitals incurring deficits were considered efficient, while 10% reporting surpluses were considered inefficient.
- The formula focuses on acute inpatient care activities and costs, which account for approximately 60% of all hospital expenditures. Activities such as outpatient clinics and emergency care are excluded due to a lack of reliable statistical data.

Recommendation

To better reflect the changing nature of hospital services and to ensure equitable funding to public hospitals, the Ministry should:

- **improve the hospital funding mechanism, taking the demand for services into account; and**
- **expand the funding mechanism to encompass other significant hospital activities such as outpatient clinics and emergency care.**

Ministry Response

The Ministry is reviewing other funding methodologies which are more activity based. The Joint Policy and Planning Committee (JPPC), a partnership between the Ministry and hospitals under the auspices of the Ontario Hospital Association, will be providing ongoing advice to the Ministry on population-based funding for hospitals.

Population-based funding is quickly becoming the preferred funding methodology in both national and international jurisdictions. It is a tool which distributes a predetermined budget to where resources are most needed.

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This method of funding, once initiated, will take into account demand for services, outpatient clinic volume and emergency care volume. The JPPC will be preparing a shared implementation approach to Rates and Volumes Equity (RAVE) funding methodology. The final phase will include acute inpatient and same day surgery portion of hospital funding (60%) with complex continuing care, rehabilitation and emergency services to follow.

TRANSITION FUNDING

In the 1998/99 fiscal year, the Ministry introduced transition funding programs to provide financial assistance to hospitals with short-term financial pressures. Based on its review of the 1998/99 operating plans submitted by hospitals, the Ministry projected that 121 hospitals would incur operating deficits totalling approximately \$236 million, as shown in the following table.

Projected 1998/99 Hospital Deficits

Deficit as a Percentage of Budget	No. of Hospitals	Total Deficit (\$ millions)
0% to 5%	92	79
5% to 10%	20	53
More than 10%	9	104
Total	121	236

Source: Ministry of Health and Long-Term Care projections

Transition funding totalling \$275 million was provided in three distinct phases: \$47 million in April 1998, \$100 million in December 1998 and \$128 million in March 1999. As a result, the Ministry anticipated that most hospitals would report a balanced budget for the fiscal year ended March 31, 1999. We reviewed the allocation of transition funding and noted that:

- The relative cost efficiency of a hospital was not always considered. For example, in the December 1998 phase, while a cost-efficient hospital could receive up to 4.2% of its annual allocation, a cost-inefficient hospital could only receive up to 1.2%. However, for the March 1999 phase, a hospital's relative cost efficiency did not affect the allocation. Eight of the 28 hospitals that received funding were considered cost inefficient by the Ministry. However, all 28 hospitals received 5% of their annual allocation.
- Each phase had different eligibility criteria. For example, while the amount of transition funding a hospital could receive from the December 1998 phase was capped when the hospital's operating position changed to a surplus of 1% of its ministry allocation, no such funding cap was in place for the March 1999 instalment. As a result, 17 of the 28 hospitals that received funding in March 1999 were anticipating operating surpluses ranging from 2% to 6% of their ministry allocation.

Recommendation

To ensure future transition funding is provided in a more equitable manner, the Ministry should review and revise where necessary the criteria for providing assistance to hospitals experiencing financial difficulties.

Ministry Response

The Ministry will continue to develop and refine its approach where funding is provided of a transitional nature. Transitional funding was the first of its kind provided by the Ministry, and the Ministry is now better positioned to propose a consistent approach to meet these funding goals.

GROWTH FUNDING

In 1996/97, the Ministry introduced a program to provide additional funding to hospitals in geographical areas experiencing significant population growth. Between 1996/97 and 1998/99, the Ministry provided a total of \$139 million in growth funding to hospitals based on allocation methods developed by the Joint Policy and Planning Committee (JPPC).

For the 1997/98 fiscal year, the Ministry announced growth funding allocations based on preliminary JPPC growth statistics. When the JPPC revised the calculations, the Ministry decided to fund individual hospitals at the higher of either of the two calculations. This resulted in an additional \$5.6 million in growth funding being provided, including \$2 million that was provided to 19 hospitals that were ineligible for any growth funding.

While the Ministry had advised hospitals that adjustments to reflect actual population growth would be made at the end of the fiscal year, as of March 1999, the adjustment process had not yet been implemented. Since this growth funding has been renewed for two more years, the overpayment could total up to \$16.8 million unless adjustments for actual population growth are made.

Recommendation

The Ministry should refine its funding formula to ensure that financial assistance to hospitals experiencing patient growth is allocated appropriately.

Ministry Response

The Ministry, through its partnership with the Joint Policy and Planning Committee, continues to refine its growth funding methodology.

The original growth funding methodology compared population growth of counties to the provincial average. The consequent population-based expected growth was assigned to hospitals serving areas of high population/aging growth. For the 1999/2000 fiscal year, updated census data and the latest available 1997/98 hospital profiles (weighted cases) were used. There is a potential for the further refinement of growth funding with the implementation of Rates and Volumes Equity funding methodology.

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EMERGENCY WARD FUNDING

In 1997/98, the Ministry began to receive information that emergency departments of hospitals in Metropolitan Toronto and the surrounding area were becoming increasingly crowded, often requiring ambulances to bypass nearby hospitals and take patients to others. The Ministry and the Ontario Hospital Association created a joint working group to address this issue.

In April 1998, the working group released a report containing 25 recommendations to improve the emergency room process in Toronto. The working group found that, on average, patients awaiting admission to inpatient beds used 47% of the emergency department capacity and that patients awaiting transfer to nursing homes or rehabilitation facilities occupied approximately 10% of the available acute care beds. Recommendations from the working group included investing in the creation of temporary long-term care beds in Toronto and interim funding for hospitals that could demonstrate that emergency ward overcrowding led to opening unfunded acute care beds.

Also in April 1998, the Ministry committed \$225 million over two years and created a steering committee to monitor the implementation of the recommendations. We reviewed the status of the Ministry's emergency ward funding initiatives and found that:

- In October 1998, to relieve the pressure on hospital emergency departments, 60 hospitals received funding totalling \$32.8 million to offset the operating costs of unfunded acute care beds, increase emergency staffing and other service enhancements. To ensure funding was used to improve emergency room services, management at each hospital receiving funding had to sign a detailed service agreement. Each hospital was required to collect data to develop benchmarks for improved customer service and submit these data to the Ministry on a monthly basis starting January 1, 1999. To monitor each hospital's progress in meeting the terms and conditions of the agreement, the Ministry developed an audit process.

In March 1999, prior to receiving the required monthly data from the hospitals, the Ministry began allocating the 1999/2000 emergency ward funding of \$40 million for release in April 1999. At the time of our audit, while the Ministry was in the process of collecting the monthly data, it had not developed a process to evaluate the effectiveness of the initial funding in reducing emergency room waiting times or the number of times ambulances had to bypass hospitals.

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- In July 1998, the Ministry released a Request for Qualifications to all Ontario hospitals and long-term care facilities to supply 1,700 temporary long-term care beds to be used by patients awaiting transfer to nursing homes or rehabilitation facilities. The two-year funding made available was \$55 million. The Ministry committed that the beds would be operational by October 1998. As of March 1999, only 962 beds were operational of which 620 were occupied. Ministry funding totalled \$3.3 million. The Ministry attributed the delays to a number of factors, such as a lack of available bed space in the existing hospitals and long-term care facilities.

Considering the number and complexity of the issues relating to emergency ward usage, it is important to evaluate the relative success of ministry funded initiatives. Evaluating the effect on reducing overcrowding in emergency rooms would provide useful information for the Ministry to consider when introducing other related initiatives.

Recommendation

To ensure the efficient and effective use of temporary emergency ward funding, the Ministry should evaluate the effectiveness of all emergency ward funding and initiatives on reducing overcrowding in hospital emergency rooms.

Ministry Response

The 1999/2000 fiscal year funding was allocated based on relative need. Funding criteria included growth in weighted cases admitted through the hospital's emergency department, the hospital's number of Alternative Level of Care days and the hospital's bed occupancy rate. Funding was calculated based on expected direct cost per weighted case. A further study implemented by the Ministry in February 1999 was the issuing of standards for Redirect Consideration/Critical Care Bypass. These standards outline a range of actions hospitals must take before being declared overcrowded.

The Ministry is committed to evaluating temporary emergency ward funding by the end of the 1999/2000 fiscal year.

CAPITAL PROJECT FUNDING

The Ministry provides capital grants to hospitals for the construction and renovation of facilities. Generally, the Ministry funds approximately 50% of the eligible capital and equipment costs of approved capital projects.

Potential construction projects must follow the Ministry's capital planning process, which includes a requirement that projects be tendered. We reviewed a sample of capital project files and found that they were approved according to ministry priorities and within the funding limits set by ministry policy.

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However, we noted that in 1993 the Ministry had approved the construction of a new hospital to serve a rapidly growing population and to provide certain specialized health care services to residents who previously had to travel to larger urban centres. The new hospital, which became operational in 1997, cost approximately \$110 million, of which \$68 million was funded by the Ministry. The Ministry had approved the capital project on condition that the hospital agreed to operate the new facility within its existing funding allocation. The Ministry's annual funding to the hospital remained relatively constant at approximately \$46 million between 1996/97 and 1998/99. During this period the hospital reported to the Ministry that, due to its increasing operating deficit, the extra capacity of the new hospital was not being fully utilized. For example, four of its eight operating rooms were idle and local residents continued to travel to other centres for specialized care. In February 1999, consultants hired by the Ministry reported that a significant deficit does and will continue to exist if the hospital continues to receive its current level of funding.

Recommendation

The Ministry should put in place a more rigorous negotiation process to relate operating funds to new approved facilities.

Ministry Response

The Ministry's capital planning process requires hospitals to address pre-construction operating budgets in the course of planning their projects. Because of the aggressive timeframes set by the Hospital Services Restructuring Commission (HSRC) for implementation of directed projects, the Ministry has allowed hospitals to proceed with project design based on approval of functional programs. The approval to proceed with capital planning does not include ministry commitment to operating funding.

In some instances the Ministry has allowed hospitals to proceed quickly with some components of the overall capital project to ensure that needed preparatory work is complete.

The Ministry is now working to address the pre-construction operating budgets for approved projects that are, or soon will be, under construction. The Ministry has projected the impact of the HSRC directed projects and has incorporated them in the multi-year planning process.

ACCOUNTABILITY FRAMEWORK

The *Public Hospitals Act* provides the Minister with the authority to impose terms and conditions for financial assistance provided to hospitals.

In 1988, Management Board of Cabinet issued a Directive on Transfer Payment Accountability to hold transfer payment recipients accountable for their management of public funds. The Directive prescribed a framework with four key requirements:

- setting expectations;
- contracting for services;
- timely reporting of results achieved; and
- taking corrective action where necessary.

These requirements were reaffirmed in a Directive issued in 1998. Ministries are required to fully comply with this Directive by April 1, 2000. Until then, ministries must comply with it to the extent that it is possible, reasonable and cost effective.

In our 1991 and 1994 *Annual Reports*, we had reported that the Ministry had not fully complied with the original Directive. Agreements with hospitals about the objectives and results to be achieved were not in place. In 1992, the Ministry established a steering committee to review the *Public Hospitals Act* and advise the Minister on the changes needed to effectively respond to future health care needs in Ontario. The committee's recommendations included developing new legislation that clearly defines the responsibilities and accountabilities of the Ministry and hospital boards of directors. However, these recommendations were not implemented.

We were advised that, in response to our previous reports, the Ministry in July 1997 began work on an accountability framework for hospital operations. However, we understand that its implementation was deferred because further study was required.

In 1998, the Ministry retained consultants to assess the effectiveness of the existing hospital operating plan process in addressing accountability. In their report, the consultants noted a lack of mutual understanding about accountability relationships. For example, the consultants noted that while the Ministry believes that hospitals are accountable to it for the expenditure of public funds, hospitals feel they are accountable to their communities and patients and that the Ministry is primarily a payment agency. The consultants recommended that the Ministry:

- implement a process to clearly articulate an accountability framework between the Ministry and the hospitals; and
- redesign hospital operating plans to reflect and support the new framework.

The Ministry accepted the consultants' recommendations and, in January 1999, established a task force to design an accountability framework that clearly delineates the roles and responsibilities of both the Ministry and the hospitals. The task force includes representatives from the Ministry, the Ontario Hospital Association, hospital management and other stakeholder groups. At the end of our audit, the task force had not completed its work.

Recommendation

The Ministry should ensure that an accountability framework that clarifies its expectations of hospitals and their accountability to the Ministry is implemented as soon as possible.

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Ministry Response

The Ministry in partnership with the Ontario Hospital Association is developing an accountability framework. This framework will define roles and responsibilities; outline accountability relationship principles; define reasonable reporting requirements, review and adjustment processes and public disclosure; and recommend an implementation strategy to review existing reporting, review and disclosure mechanisms. New mechanisms will be developed to meet the criteria of the accountability framework.

The accountability framework is expected to be completed in 1999.

PERFORMANCE MEASUREMENT AND REPORTING

Since our 1994 audit, the Ministry has made a number of attempts to develop performance indicators to measure hospital services and outcomes. For example, we were advised that a 1994 project to develop efficiency and performance indicators was discontinued in 1996 because it proved to be too complex and did not use the existing data contained in the Ontario Hospital Reporting System.

In Ontario, the *Ministry of Health Act* requires the Minister to report annually to the Legislature on the affairs of the Ministry. While the Ministry produces an annual business plan, the 1998/99 Business Plan contained only two performance measures for the hospital system:

- readmission rates for the same diagnosis within one week of discharge; and
- percentage of days spent by a patient in an acute care hospital when another type of facility would have been more appropriate.

The Ministry had committed to developing targets for each measure. However, these indicators provide limited information about the performance of the hospital sector. Senior management also informed us that readmission rates were no longer considered a suitable performance measure for the hospital system.

Developing performance indicators was included in the 1998/99 work plans of two ministry working groups. However, as of March 1999, no indicators had been developed to appropriately measure the performance of the public hospital sector.

From a sample of 1998/99 hospital operating plans, we noted that while some hospitals had begun to develop key outcome indicators to monitor and measure their operations, there is no requirement to report these results in annual hospital operating plans. The Ministry has a responsibility to periodically report on the performance of the public hospital system. However, the last ministry-prepared report on the operations of the public hospital sector, *1997/98 Operating Plan Status Report*, was never released.

Recommendation

To better measure and, where necessary, act on the performance of public hospitals, the Ministry should:

- identify a comprehensive set of performance indicators and ensure these indicators are incorporated into hospital operating plans; and
- periodically report on the performance of the public hospital sector in delivering quality services to the public.

Ministry Response

Indicators and areas of comparability are currently being worked on. There are several financial indicators that have been used during the review of operating plans. Data quality indicators will be included with the verification reports which are used to improve the quality of data submitted for the 1998/99 Ontario Hospital Reporting System. The current review of the operating plan requirements for 2000/01 has identified some indicators to be included with the reporting templates.

Input on data quality is being solicited from hospitals to ensure they are useful for developing their operating plans. Additional reports will be developed for all areas with a plan to send out a complete package of reports covering the 1998/99 fiscal year.

The Ministry is presently working to develop a "report card" on hospital performance.

MINISTRY MONITORING

OPERATING PLANS

Hospitals are required to submit various reports to the Ministry, including annual operating plans, quarterly reports and audited financial statements. Hospital operating plans describe and quantify the hospital's programs and services, human resources and financial initiatives. Each operating plan is reviewed by the District Health Council in the context of local, district and regional health needs. The Ministry gives final approval after being satisfied that the funding is used to provide the appropriate services.

In their reports for the second and third quarters of each fiscal year, hospitals are required to outline variances from the operating plan, the reasons for any variances and remedial actions. The Ministry may conduct operational reviews, clinical audits and, in the more serious cases, appoint investigators or supervisors.

The consultants hired by the Ministry to assess the effectiveness of hospital operating plans reported that:

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- Operating plans varied significantly in the quality of supporting information. Some operating plans provided limited documentation to support the hospital directions and expected results.
- There was a lack of consistency in the approach to the reviews of the operating plans, reflecting different personal styles of the Ministry's reviewers.
- A number of hospitals did not receive approval of their operating plans until the end of the third quarter of the applicable fiscal year. Such delays negated much of the value of the planning process.

We reviewed the hospital operating plans and quarterly reports for the 1997/98 and 1998/99 fiscal years and noted that many of the consultants' concerns still existed. Specifically:

- As of March 1999, the Ministry still had not approved the operating plans for 42 out of 180 hospitals for the year then ended. Most of these hospitals had projected significant deficits for the 1998/99 fiscal year.
- Although ministry staff indicated they reviewed the hospital quarterly reports, we could not assess the consistency or quality of the reviews, due to limited documented evidence.

Recommendation

To enhance the hospital operating plan process as an accountability and monitoring tool, the Ministry should:

- **ensure that operating plans are submitted, reviewed and approved on a timely basis; and**
- **develop documentation standards for the review and analysis of quarterly reports.**

Ministry Response

The Ministry is planning to advance the timing of operating plan submissions. This will enable the Ministry to review and approve plans on a more timely basis. However, the timing of funding approval is constrained by government timelines.

The operating plan review process for the 1999/2000 fiscal year has an updated ministry staff review guide. This will enhance the review process. The key issues were to improve the consistency in handling the plans, provide some indicators, provide the trends over three years, and to have guidelines about the time frames and the turnaround time. Ministry staff developed a Review Process and Timelines - Critical Path Flow Chart document along with a Timelines, Completeness & Quality Checklist to improve the accountability from both the hospitals and the Ministry.

The updated staff review guide also provides standards for reviewing the quarterly reports.

The Ministry is also considering having hospitals report, on a quarterly basis, the financial and statistical data recorded in the Management Information System.

MINISTRY BENCHMARKING PROCESS

Benchmarking is a process of identifying and adopting best practices to assist in improving performance. The Ministry's Planning Decision Support Tool (PDST) contains both the raw data and a series of benchmarks for various categories of acute care inpatient activity. These benchmarks highlight areas where there may be opportunities to improve operating efficiencies and effectiveness.

The PDST is intended to assist hospitals in analyzing and reviewing acute care patient services and to assess performance against provincial targets and averages, and benchmark performance levels. The system contains benchmarks that can be summarized in three groups— average length of stay, outpatient surgery and admission rates. We found that:

- The Ministry has not reviewed the ongoing usefulness of the current benchmarks as a measure of hospital operations. For benchmarks to be effective, it is important to periodically review the continued usefulness and applicability of individual benchmarks to the ministry and hospital decision-making process.
- The Ministry expects the individual hospitals to determine their own strategies and implement them in their organizations. However, if information was gathered on best practices, it could be summarized to assist other hospitals.

Recommendation

To ensure the benchmarking process is an effective management tool, the Ministry should:

- **review the usefulness of current benchmarks; and**
- **develop processes to share information on best practices.**

Ministry Response

The redevelopment and refinement of the Planning Decision Support Tool (PDST) is an ongoing process and is constantly being refined which will also improve hospital access to their specific PDST information. The Ministry has recently updated the PDST which will be shared with the hospitals by December 31, 1999.

The government's report card initiative is expected to assist hospitals with sharing information on best practices.

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COMPLAINT PROCESS

Complaints about services or treatments received in a hospital can provide useful information about quality of care. Patients may complain to the hospital, the Ministry or to organizations such as the College of Physicians and Surgeons of Ontario. Generally, a patient would initially contact hospital management.

While the *Public Hospitals Act* does not contain provisions requiring hospitals to respond to complaints by patients, most hospitals have a formal process to deal with patient complaints about the services or treatment received.

Although the Ministry has limited authority to investigate complaints, the *Ministry of Health Act* authorizes the collection of statistics affecting the public. The Ministry does have a responsibility to take corrective action where there is evidence of systemic quality-of-care concerns. Such concerns could result from numerous patient complaints or complaints from professional bodies such as the College of Physicians and Surgeons of Ontario.

In our 1994 audit report we recommended that the Ministry improve its complaint handling process. In 1995, the Joint Policy and Planning Committee surveyed a sample of complainants and made a number of recommendations on improving the Ministry's complaint handling process, including annually evaluating the process and evaluating the feasibility of a single telephone number for registering complaints.

We reviewed the Ministry's process for handling complaints directed to the Ministry and noted that:

- The Ministry has not developed standard processes for individuals with complaints to follow when making complaints.
- Based on our tests, it took the Ministry 40 business days on average to respond to a complaint. The Ministry has not set specific performance levels for responding to a complaint.
- Complaints were rarely followed up to ensure the issue was addressed and any necessary corrective action was taken. The Ministry was formally informed of the hospitals' resolution of the complaints in less than 10% of cases that we reviewed.

Information on complaints received by hospitals could be incorporated into an overall hospital profile or used to corroborate other evidence of service quality deficiencies. However, the Ministry does not have information on the numbers and types of complaints against individual hospitals.

In May 1998, the Ministry approved a plan developed by a task force on improving the complaint process. The task force had made a number of recommendations, including the development of policies and protocols, and a database to track complaints. However, as of April 1999, the recommendations had not been implemented.

Recommendation

The Ministry should develop protocols that ensure that patient complaints to the Ministry are consistently investigated and resolved on a timely basis.

Ministry Response

Hospitals are responsible for the quality of care delivered in their institutions in conjunction with the professional associations.

The Ministry believes that the initial response for complaints made to the Ministry is made in a timely manner. Phone calls are made immediately upon receipt of the complaint, but are not always documented. The Ministry is committed to improving the documentation.

HOSPITAL ACCREDITATION

The Canadian Council on Health Services Accreditation (CCHSA) is an independent organization that administers an accreditation program for health care facilities. The program is based on a comprehensive self-assessment against the CCHSA's national standards and an on-site visit by a team of senior health care professionals from other hospitals. For hospitals, the CCHSA standards and team assessment are designed to address the processes, outcomes and structures relating to the quality of care and services provided. Unlike the United States, where participation is mandatory, the Canadian program is voluntary.

In our 1994 report, we noted that there was no process in place to ensure that all accreditation reports were received, reviewed and followed up by the Ministry. In its response, the Ministry agreed to introduce a monitoring process to ensure that appropriate action is taken by hospitals to address issues identified in the report. During 1997 and 1998, the Ministry did not request hospitals to submit accreditation reports. However, the Ministry is now requiring hospitals to submit the executive summary of their most recent accreditation reports with their 1999/2000 operating plans.

According to the CCHSA, the majority of Ontario acute care hospitals had participated in the accreditation process in 1997 and had received the standard three-year accreditation. However, 10% of the hospitals received a conditional accreditation, which indicates a minimal level of compliance with the CCHSA's standards.

Recommendation

The Ministry should determine whether hospitals are meeting Canadian Council on Health Services Accreditation standards.

Ministry Response

The hospitals are responsible for the quality of care in their institutions and to respond to hospital accreditation issues.

Commencing with the 1999/2000 operating plan submissions, hospitals must include the executive summary report from the Canadian Council of Health Services Accreditation. As part of the review process, the Ministry will also be looking into collecting other information that will help identify hospitals that require further review and follow-up.

HOSPITAL RESTRUCTURING

The Health Services Restructuring Commission (HSRC) has the legislated authority to direct hospitals to undertake restructuring activities and to advise the Minister on restructuring other aspects of Ontario's health services system, such as the reinvestment of savings.

Since its inception in 1996, the HSRC has issued legally binding directions to hospitals to undertake capital projects totalling an estimated \$2.1 billion, and recommended that the Ministry invest \$1.1 billion in community resources such as long-term care facilities and home care. In its restructuring reports, the HSRC estimated that its decisions would generate \$1.1 billion in annual savings to the health system through clinical and administrative efficiencies, rationalization of services and facility closures.

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In February 1999, the government announced that the HSRC's work on hospital restructuring and its authority to issue new directions would end effective March 12, 1999. During its tenure, the HSRC issued final directions to 22 communities affecting 110 hospitals. These directions amalgamated 45 hospitals into 13 and closed 29 hospital sites. Until March 2000, the HSRC will continue to monitor implementation of its existing directions, as well as provide advice to the Ministry on system integration.

As part of the restructuring process, the Ministry provides financial assistance to hospital corporations to assist in implementing the HSRC's directions. The Ministry's share of eligible restructuring costs is 70% for capital and 85% for operating costs. The remaining costs are the responsibility of the hospital or community.

IMPLEMENTATION OF CAPITAL PROJECTS

The HSRC has directed hospitals to undertake a total of 81 capital projects at a total recommended cost of approximately \$2.1 billion. The Ministry's March 1999 HSRC Project Status Report indicated that, based on hospital estimates, these capital projects could cost as much as \$3.9 billion. As shown in the following table, the Ministry's share of total estimated capital costs for hospital restructuring could increase to approximately \$2.7 billion from the \$1.5 billion originally estimated if the Ministry agrees that the additional costs are justified.

Summary of Hospital Capital Costs Resulting from HSRC Directions, May 1999

	HSRC's Original Estimate (\$ billions)	Hospitals' Preliminary Estimate (\$ billions)
Estimated Cost	2.1	3.9
Potential Ministry Share	1.5	2.7
Potential Hospital Share	0.6	1.2

Source: Ministry of Health and Long-Term Care

In discussing the causes and nature of the variations in estimates, we were informed by HSRC staff that the HSRC estimated the capital project cost for only those items directly resulting from its directions. HSRC staff believed that the additional estimated costs were not directly related to its decisions.

According to the Ministry, the projects approved to date are consistent with the HSRC's directions for service and bed requirements. However, where applicable, the funding approved by the Ministry took into account major variances from the HSRC's projected costs. These variances were attributed to factors such as:

- actual renovation costs per square foot being higher than estimated;
- additional square footage being required for displaced programs; and
- additional costs relating to upgrading heating and air conditioning systems.

From our review we noted that there have been significant delays in the approval and implementation of HSRC-directed capital projects. In the Ministry's budget for the 1998/99 fiscal year, \$271 million was allocated for hospital restructuring capital projects. However, actual capital expenditures during the 1998/99 fiscal year for HSRC-directed projects were approximately \$49 million.

According to the Ministry, the delays are due to the amount of time required for the Ministry and hospitals to agree on which components are directly attributable to the HSRC direction and 70% funded by the Ministry, and those components that are necessary to implement the project but are not HSRC-directed, which are funded at 50%.

The HSRC's goal was to complete all restructuring capital projects before its four-year mandate expired in 2000. However, based upon current information, the Ministry estimates that these projects will not be completed until 2003/04.

In March 1999, the Ministry noted the need for streamlining the processes for implementing HSRC directed projects. In March and April 1999, 18 projects received approval, bringing the total number of approved projects to 30. However, the Ministry was still waiting for hospitals to provide detailed plans for the remaining 51 projects.

Recommendation

To ensure the timely completion of capital projects to support the hospital restructuring process, the Ministry should work with the hospitals on streamlining the planning and approval process.

Ministry Response

The Ministry has taken initial steps to streamline the capital approval process. The Ministry commits to a review of the current process during the 1999/2000 fiscal year.

REIMBURSEMENT OF RESTRUCTURING EXPENSES

To assist hospitals with the financial cost of implementing restructuring directions, the Ministry committed \$834 million over a five-year period to reimburse certain operating costs incurred by hospitals. To qualify for reimbursement, the costs incurred must be a direct result of the restructuring activity and not part of the hospital's normal ongoing operations. Eligible

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one-time restructuring expenses include severance costs, employee benefit costs, legal fees, counseling and training costs for terminated employees, and consulting and auditing costs.

Our review of a sample of hospital restructuring operating cost reimbursement claims relating to the 1997/98 fiscal year disclosed the following:

- The review and approval of hospital claims for severance costs and employee benefits, representing 78% of total disbursements to date, were made with little supporting documentation or verification. Claims were approved based on ministry staff's knowledge of the hospitals and the perceived reasonableness of the claim.
- Ministry policy requires that all hospitals must have their restructuring costs audited by their external auditors. However, the Ministry has not reconciled the audited schedules, which are prepared on an accrual basis, with hospital claims for reimbursement, which must be prepared on a cash basis. We were advised that the claims were only used for the Ministry's calculation of cost per weighted case, not for reconciling the amount reimbursed.
- The Ministry reimbursed two hospitals a total of approximately \$100,000 for ineligible employee benefit costs. We were informed that the Ministry was in the process of recovering these overpayments.

Recommendation

The Ministry should ensure that hospital restructuring expenses are reimbursed in a consistent and equitable manner.

Ministry Response

The Ministry will take steps to improve the approval process to enhance the accountability of hospitals for accuracy and reliability of the information submitted for reimbursement of restructuring costs.

Due to the confidential nature of severance payments, hospitals have not been sending the Ministry complete data regarding severance costs. Ministry staff review the claims, are aware of the approximate number of staff terminated and are able to analyze the reasonableness of the claim.

IMPLEMENTATION OF HOSPITAL RESTRUCTURING

The success of hospital restructuring requires careful sequencing of changes. For example, investments in physical facilities and community resources need to be completed before hospitals can realize the savings from clinical and administrative efficiencies. In addition to HSRC directions, a number of hospitals have volunteered to undertake restructuring activities such as program transfers and sharing of administrative resources.

From our review of a sample of restructuring files, we noted that, in general, HSRC directions relating to hospital governance and amalgamations have been implemented as scheduled. However, many hospitals have been unable to realize the anticipated savings. In six

amalgamations, hospitals were combined without the corresponding integration of operations or rationalization of services. In one example, three hospitals were amalgamated to form a new hospital. However, delays in obtaining ministry approval for capital projects resulted in the three sites continuing to operate. The delays were attributed to complications in developing and approving the capital projects. Consequently, the new hospital has been unable to realize the anticipated \$40 million in annual savings.

We also noted that hospital downsizing or program transfers were frequently not accompanied by appropriate funding adjustments to the affected hospital's operating budget. Currently, the Ministry must negotiate any funding changes on an individual basis. This process has hampered restructuring in a number of hospitals. For example:

- In 1998, HSRC directed a hospital to close its 100 chronic care beds by the spring of 2000. However, we noted that the hospital, without obtaining ministry approval, closed all the beds two years early and used the approximately \$10 million in annual savings for other hospital services.
- While a hospital experienced cost increases totalling \$24 million after receiving patients transferred from a second facility, its annual operating budget was only increased by \$6 million. As a result, the recipient facility is projecting a 1998/99 deficit of \$19 million while the transferring facility has a surplus of \$1.1 million.

As noted earlier, the Ministry now estimates that many projects will not be completed until 2003/04. Consequently, the HSRC's term will expire before it can assess the effectiveness of the restructuring process in achieving its financial and operational goals. Experience in other jurisdictions that have undertaken hospital restructuring indicates the importance of evaluating the process both during and following implementation, so that the necessary corrective action can be taken.

Recommendation

To ensure that the benefits from restructuring are realized, the Ministry should:

- **develop a standard process to determine the proper amount of funding required to support program transfers and amalgamations;**
- **develop a mechanism to periodically monitor and assess the impact of restructuring; and**
- **take any necessary corrective action.**

Ministry Response

Significant work has been done on the development of a standard process for funding adjustments for both program transfers and amalgamations. Discussion of the methodology with hospital representatives has led to refinements which will again be reviewed before being finalized. The present methodology is being used on an interim basis.

The methodology does include a provision for monitoring actual volumes compared to the funding adjustment volumes, and readjustment of the funding as needed. The Ministry will also use the report card methodology to review the state of restructuring. As well, since the Ministry will be decentralized, the regional structure will facilitate reviewing the impact on a local level.

If adjustments are needed, discussions with ministry staff will be initiated to resolve the problem with an agreed-to corrective plan.

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