Paper as follow- up to the private discussion with Justice Campbell

1 The perspective taken in this paper is that the state of Ontario's hospitals is far more precarious than it appears at first glance and that a fundamental change in direction and governance is needed if the system is to be able to respond appropriately to new threats such as SARS and to operate normally.

2 While much of this paper is focused on administrative and clinical issues within the hospital system, it is important to recognize that Ontario's hospitals are struggling with issues related to public expectations, dramatic technological change and very limited political understanding of the problems they face. These would make it very difficult to manage the system even if all the clinical and administrative issues within the hospital system and within each hospital were in order. Three themes stand out from the extensive literature on these subjects: expectations far exceed the public's willingness and ability to pay for them from tax revenue, medical technology is developing at an exponential rate and health portfolios are so large and so complicated that adequately informed political guidance is very difficult and probably impossible during the relatively short time that Ministers stay in the portfolio. For all these reasons, hospital boards and staff are facing extraordinary pressures and deserve understanding. This does not mean that the issues described in this paper shouldn't be addressed because they should. It does mean that we must deal with the sustainability and policy issues facing the Canadian health care system as well if the people who operate the system are to serve the public to their potential.

2 The Ontario Hospital System is a very large insolvency. It developed an overall deficiency in working capital in 1995. Over the years since, it has added between $100 million and $200 million each year to this deficiency that in early 2004 will approach $1.5 billion. Payables are being seriously stretched in most hospitals and many are dependent on month-to-month renewals of bank lines of credit to stay open.

3 The fact that this situation has been evident for so long has had consequences which are well documented. Assets have been eroded, morale was adversely impacted, expenditure on skills was deficient, attention to normal operations was diverted by the ongoing distraction of creditors and systemic problems – that is common problems experienced by most hospitals – received relatively little attention.

5 Some of the most serious consequences of this situation are clinical and because they increase risk, understanding the clinical consequences is vital. First, there has been a general lack of flexibility with very high occupancy rates and little or no resources to invest in the process improvements that are a central part of patient safety. Second, absolutely vital systemic data needed to operate the system is lacking. Data that is lacking includes systemic numbers on referrals among hospitals and the costs of providing specific treatments (i.e. the sum of institutional and professional and technical fees). It will amaze most people that the payments for physicians attached to hospitals are never added to the administrative expenditures for these institutions to get a full understanding

of the costs associated with each hospital and the specific services it provides. The old adage that one can't manage what one doesn't measure is relevant to these two issues.

6 Other less obvious clinical issues are significant as well. Resources have been so stretched that almost every resource decision within the hospital involves winners and losers. Whatever one group "gets" another, which also needs it "loses". This has resulted in a culture which requires extensive internal politics and "change management" to achieve "buy-in" on even the most basic and fundamental of changes, including those related to infection, safety and disease prevention. In these circumstances, one individual is often enough to stop entire organizations from moving forward on needed change. There should be no doubt about the severe impact of this problem when decisions must be taken quickly as in the SARS outbreak.

7 Financial and clinical difficulties have been compounded by many other administrative issues as this situation developed. The system developed by hospitals and the Ministry of Health to manage their relationship is unsophisticated. As noted, there is no systematic data available on referrals of patients within the system so that system capacity can be adequately managed. No serious attention was ever given to alternate configurations for the system, despite evidence that alternatives exist which might serve patients better at lower or equal cost. Some existing mechanisms for co-operation among hospitals are showing signs of strain, such as the collective bargaining arrangements where many hospitals have been paying premiums above agreed rates. There are few standard clinical guidelines in place, aside from the limited requirements of professional colleges. Perhaps most importantly, separation of administrative decisions from clinical decision making, a circumstance very evident in early decision making in relation to SARS, continues with obvious ramifications in any emergency: real doubt about who is in charge and able to make critical decisions quickly.

8 The argument we are making is that the two most risky ways to approach this remarkable set of problems are to do nothing at all about them or to simply continue on the present path of putting in money in incremental steps to buy time.

For the Ontario government, the risks are: becoming hostage to past decision making, being unable to respond as the public would want in emergencies and to continuously have to fund hospitals at the expense of other types of institutions such as universities, community colleges and mass transit systems. The province would also face very serious reputational risk if it ever again became the only North American jurisdiction impacted seriously by a new disease which others who were similarly exposed were able to prevent or control successfully.

For the hospitals, the risks are further erosion of public confidence, accelerating alienation of front line staff, a steadily growing need to ration health services without the legislative mandate to do so and the loss of their ability to plan rationally and therefore to operate effectively.

For the public the risks are fundamental threats to safety and quality, erosion of a strongly valued public service and costs that will ultimately be higher because systemic incremental change has been avoided for so long.

9 Our solution is complex but can be stated easily: if it is a large insolvency, treat it as such and put the whole acute care system into a temporary form of trusteeship so that it can emerge and develop in new directions. Rehabilitation and Complex Continuing Care hospitals should be excluded from these arrangements because their financial positions are relatively much stronger than others.

Normally, rescuing a large organization or a network of organizations facing solvency difficulties involves at least three basic steps, all of which must be taken simultaneously: avoidance of further financial erosion, temporary replacement of existing governance or supervisory arrangements and the injection of the new thinking required to produce a practical and achievable plan to achieve a stable state in the future. We will explore each of these in turn.

10 Short term stabilization of the financial situation involves recognition of the inevitable more than anything else. The only reason banks have financed the working capital deficit of the hospital system is because they have been told by successive Ministers of Health that the government will backstop the hospitals. In effect, this debt, while it is off the government's books, is as much a part of the public debt as is the debt showing on the government's books and it is arguably more honest and more realistic for the government to recognize this and assume it. If it were to do so, the government should also set up a pooled lending arrangement by which any additional funds needed in the short term could go through some systemic review process so that it goes to the hospitals where it is most needed.

11 Capital expenditures could also benefit from a new approach. The government cannot realistically fund more than a small proportion of the $8 billion in capital needs, and the expectations associated with them, now being contemplated by hospitals across Ontario. To fund them, the government would have to allocate all its available capital funding to the hospitals, clearly an impossible strategy. It would make much more sense to fund only those projects that are relatively small, or which are nearing completion, and suspend the others until a full review of the type proposed later can be carried out. It is also imperative that private sector funding for new hospitals be encouraged. The choice before the citizens of Ontario is to accept private funding for new hospitals or to accept that virtually no new hospitals will be built with all the risk to patients – including increased susceptibility to new diseases and infection – such a policy would entail.

12 The temporary suspension of existing governance arrangements is complicated. Such a change is necessary because nearly all of the problems described in the earlier part of this memorandum are systemic problems that have not been sufficiently addressed by managers within the hospital system. However, a temporary suspension of existing governance arrangements would have to be done in a way which avoids

prejudicing some very important functions of hospital boards or their ability to discharge their functions in the medium or long term future.

We suggest the appointment of a new board to serve as a supervisor for the acute care system for a fixed period of a year. We also suggest that the current boards be retained, in an advisory capacity, for that year to continue to attend to critical functions relating to clinical staff and fund raising. We further suggest that the government provide the new board with a list of the systemic issues it wants the board to address on the most urgent basis possible and that the board be provided with the funding necessary to address the tasks entrusted to it in an extraordinarily short time. This situation is a fiscal and operating emergency and it needs to be addressed on that basis if emerging threats such as SARS are to be properly managed and if quality and patient safety are to be safeguarded.

13 The new hospital system board should be asked to deal with the following system issues:

-consolidation of administrative structures in each hospital into common service centers. This consolidation would include supply chain management, human resources services, technology standards and purchasing and the management of real estate assets surplus to present requirements;

-development of a new configuration for the system, which would have hospitals, specialize their services by type of disease (e.g., cancer, orthopedics) or by function (e.g., stabilization and transport for trauma and emergencies) or in some cases by geography;

-adoption of existing clinical standards for the treatment of disease into a series of clinical guidelines which would apply in all parts of the system for most types of illnesses;

-preparation of a hospital system budget funded from existing administration budgets in each hospital that would pay for the preceding initiatives and provide for an administrative home for new activities which are likely to be beyond the capacity of any one hospital. The delivery of hospital services on the Internet is a good example of such an issue;

-development of standardized contractual agreements and templates, drawn from the best of existing practice, which would be used to strengthen hospital relationships with other provider organizations;

-preparation of a series of initiatives to strengthen the hospital-clinician relationship at all levels. These could include standardized alternate payment plans, practice management services provided by hospitals, accelerated adoption of the hospitalist model for physician services and the provision of adequate pension arrangements for physicians associated with hospitals;

-preparation of a systemic capital expenditure plan that would support these systemic arrangements;

-development of a new patient safety initiative which would put patient safety as the highest priority and would draw on the experiences of others, such as NASA in response to the Challenger accident, to avoid repetition of patient safety problems which have recently become very evident.

14 For its part, the government should change its role and change the Public Hospitals Act so that the government becomes a system regulator and a purchaser of services rather than attempting to manage the system through a very large bureaucracy in the Ministry of Health.

At the moment, about 120,000 people are directly employed in Ontario's hospitals and a declining number of Ontario's 26,500 registered physicians, not employed by hospitals, have contractual arrangements with them. In addition, some 50,000 volunteers work in many capacities and at all levels within the system. In short, the combination of size, regulation by professional colleges and very rapid technological change means that the hospital system cannot be managed directly by government and cannot even sustain the detailed supervision by civil servants that is now in place.

In addition to changing its role, the government would need to negotiate with the new hospital system board to put in place specific purchasing arrangements and agreements to support this basic change in the government role. Again, it is vital that the government avoid the temptation of trying to manage the hospital system through the public service. It is also important that the trusteeship not be prolonged beyond a year so that hospital boards do not loose their fundamental role as governors of the system.

15 An important consideration for all involved in arrangements of the type we are proposing is the composition of the interim hospital system board. Several considerations are relevant:

a. the board should not be representative-expertise should be the sole criterion for appointment;
b. it should include people who are not part of the existing health system – new thinking is urgently needed
c. it should include a serious critical mass of physicians and nurses with management training and experience;
d. it should include people from outside Canada, primarily from other single payer systems in the U.K. and Europe;
e. it should have the funding to draw consultants and advisors who are the best anywhere. The Ontario hospital system is world scale in size and it needs a corresponding level of skilled advice if its problems are to be addressed;

f. it should include people from the business world who have skills the system doesn't have – financial, technological and in specialized areas such as real estate management and development.

In short, the SARS outbreak should be seen against a constant background of financial and operating crises and strains which have had a highly detrimental cumulative impact on all who are served by Ontario's hospitals and on all who work in them. More of the same is both unwise and unnecessary. We have had ample warning in recent years that much more than incremental and linear change is required. The SARS outbreak, recent equipment issues and the problems outlined in the hospital review of emergency planning undertaken after the September 11 terrorist attacks should be seen in this light.

The same road that delivered the hospital system to its present troubling state is almost certainly not the road which will take us to a new level of stability and performance. Similarly, society has a moral obligation to the people working at all levels in the system to address the major health policy issues which are a root cause for the serious problems facing front line staff and governors in the hospital system.