Report of the President & CEO to the Board of Directors

Date: February 2012

It is Always Best to Under Promise and Over Deliver

The long awaited Don Drummond report as Chair of the *Commission on the Reform of Ontario's Public Services* (Drummond Report) was released this past month after much anticipation and expectations.

The Province's projected $16 billion deficit, $215 billion debt and its projection to continue to add to this debt until 2017, has made it clear that action must be taken to avoid following the course taken by Greece and Italy just to name a couple of countries that did not address their deficits and debt until it was too late.

With over 300 recommendations – 362 to be exact - the Drummond Report's 542 pages could take decades to implement. It is generally very easy to formulate recommendations. The hard part is developing an implementation plan and actually implementing the recommendations.

However, Drummond makes it clear that "action must begin very soon. The deficit is expected to be $16 billion this year. By 2017–18, it will almost double — and the debt will climb to more than half of gross domestic product — if the status quo is left in place. Decisive, firm and early action is required to get off this slippery, and ultimately destructive, slope. At a time when the news is full of stories of countries around the world that have failed the fiscal test and slid into the ditch, to the enormous detriment of their citizens, Ontario must be different. It must be the best".

In addition, he has made it very clear "that [his] recommendations can deliver the needed degree of spending restraint to balance the budget by 2017–18 *only if all are implemented*. This imposes a discipline of its own. We expect that many of our recommendations will be rejected. We accept that, but each rejected recommendation must be replaced not by a vacuum, but by a better idea — one that delivers a similar fiscal benefit".

Out of the 362 recommendations, 105 of them relate directly to healthcare. Since healthcare consumes 42% of the Provincial budget this should not be surprising.

A lot of the 105 healthcare recommendations have been mentioned in various arenas for that past decade or longer. Changes to physician compensation to a more "salaried" model and away from fee-for service, movement towards electronic health records, movement of certain clinical services from the

hospital to the community that do not need to occur within the hospital and examination of the further consolidation of administration and governance of health care organizations to name a few.

Placing more accountability and responsibility with the LHINs is sensible. However, the previously mandated review of the current level of functioning of the LHINs is well overdue. The last thing we want to do is download a whole bunch of additional responsibility to a body not functioning well and having it sink under its own weight and fail. We do not have time for failure.

An interesting chart in the Drummond report summarizes the Commission's recommendations as they relate to health:

Current System	Reformed System
General Approach	
• Intervention after a problem occurs • Acute care • Hospital-centric • Silos • Resource-intensive minority of patients in regular system • Accept socio-economic weaknesses • Extraordinary interventions at end of life	• Health promotion • Chronic care • Patient-centric • Co-ordination across a continuum of care • Dedicated channels for the resource-intensive minority • Address socio-economic weaknesses • Pre-agreements on end-of-life care
Hospitals	
• Draw patients to hospitals • Historical cost plus inflation financing • Managed through central government • Homogeneous, all trying to offer all services	• Keep patients out of hospitals • Blend of base funding and pay-by-activity • Regional management • Differentiation and specialization along with specialized clinics
Long-Term Care, Community Care and Home Care	
• Not integrated, underfunded and weight on long-term care	• Integrated with weight on home care
Physicians and Other Professionals	
• Not integrated with hospitals and other sectors • Work alone or in groups • Mostly fee-for-service funding • Few standards for medical approaches/conduct of practice • Unclear objectives and weak accountability • Inefficient allocation of responsibilities	• Integrated with primary care being the hub for most patients • Work in clinics • Blend of salary/capitation and fee-for-outcomes • Evidence-based guidelines (through quality councils) • Objectives from regional health authorities and accountability buttressed by electronic records • Allocation in accordance with respective skills and costs; and where feasible shifting services to lower-cost care-providers
Pharmaceuticals	
• Little cost discipline from governments • Cost of plans to private employers driven in good part by employees	• Cost discipline through purchasing power, guidelines for conduct of practice • Greater control exercised by employers

Current System	Reformed System
Service Delivery	
• Mostly public sector	• Blend of public and private sector (within public payer model)
Information Technology	
• Little used by physicians and especially across the system • Information conveyed in doctors' offices	• Extensive use that is key to co-ordination across system and accountability • Information more easily available and conveyed through multiple sources (phone, Internet, etc.)
Medical Schools	
• No attention to system (cost) issues • Little attention to labour supply issues	• Course(s) on system issues • Role in directing physicians to areas of demand (by area of medicine and geographically)
Coverage of Public Payer Model	
• Hybrid with almost 100 per cent primary, less than half of drugs and limited mental health	• Broader coverage widely recommended but not at all clear this will be acted upon

Some of the recommendations applicable to health are well underway. Placing primary health under the LHINs and also moving towards a Health-Based Allocation Model (HBAM) funding model are well underway.

The HBAM model has two main components. The first is a **utilization model** which estimates annual use of health services, taking into account each Ontario resident's clinical, social, and demographic conditions. HBAM's utilization model is based on detailed clinical groups which allow for investigation of access to care by clinical condition. This level of clinical detail did not previously exist and is one of HBAM's major strengths. HBAM's second component is a **cost model**. HBAM determines unit costs for each health service provider. Some provider characteristics, such as teaching activity and having highly specialized clinical programs, justifiably lead to higher unit costs, and therefore these sorts of characteristics are recognized in HBAM.

At the end of the day HBAM is meant to focus on the patient and provide funding for their expected length of stay – not actual length of stay – and require hospitals and caregivers to standardize the delivery of clinical services following clinical best practices.

A healthcare recommendation that, in my opinion, showed a lack of appreciation by Drummond on the current struggles facing hospital utilization was 5-54. It states:

> **Recommendation 5-54:** Given the burden of alternate level of care (ALC) patients on hospital capacity, hospitals must become more effective in optimizing this capacity while applying best practices in planning patient discharges. Further, small hospitals with large ALC populations must

be assessed with a goal of redefining their role in care for the elderly. Again, funding should be aligned appropriately.

In my opinion, this recommendation is far too general and minimizes the amazing efforts hospital staff along with other healthcare partners do to address hospital utilization issues caused by the ALC issues. What the report fails to recognize is the amount of time and resources that is dedicated to this issue that would be better directed toward enhancing patient safety and quality. Instead staff is left to perform a juggling routine on an hourly basis trying to find beds for patients booked for surgery or waiting in the Emergency Department.

Another recommendation that puzzled me was 5-29. It states:

> **Recommendation 5-29:** Support transparency in senior executive and CEO salaries throughout the health care system by publicly posting comprehensive compensation information in a timely fashion.

Since 1996 the *Public Sector Salary Disclosure Act 1996* has required publicly posting any compensation over $100,000 per annum.

In any event, a couple of odd recommendations should not result in throwing the whole report out.

As stated, the easy part was to come up with the recommendations. The harder part will be in the implementation. Considering most of the recommendations have been around for years without being implemented, it is very clear evidence that their implementation will be doubly difficult.

Since Windsor Regional Hospital has been advocating publicly for many of these recommendations, we look forward to being an active partner in their implementation. Windsor Regional Hospital is in a strong clinical and financial position to not only be an active partner but take a leadership role in transforming the healthcare system so it can not only provide outstanding care to today's patients, but also be viable and vibrant for patients of the future.

I will keep everyone up to date on any active implementation of the recommendations from the Drummond Report. Expect over the next couple of months for the various "associations" to lobby/speak for and against many of the recommendations. However, paraphrasing Drummond – we are past talking – it is time for "action" to break out.