

Four Pillars: Recommendations for Achieving a High Performing Health System



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Introduction

Ontarians love our health care system – and for good reason. Every day, thousands of us are cared for in clinics, offices, hospitals and our homes. And while there is always room for improvement, Ontario’s health care system delivers world-class care quickly, safely, and efficiently.

But our health care system is also under intense pressure. Today, health care spending by the Government of Ontario constitutes more than forty cents of every budgeted dollar, a figure that is expected to grow rapidly in the years ahead. The trajectory of this spending, continued economic distress, and the belt-tightening necessary to eliminate Ontario’s budget deficit by 2017-18 have given new urgency to the long-running debate about how our health care system can be made better and more affordable.

Historically, the intensity of health care reform efforts correlated to the state of the provincial economy. Periods of economic distress sparked wide-ranging reform efforts, whereas renewed economic growth lessened the public’s appetite for difficult decisions.

Efforts like these may have sufficed in yesterday’s context, but today’s economic realities have brought Ontario to a public policy inflection point.

Only by moving ahead with the dramatic, sustained reform of our health care system can we safeguard its future, free up funding to support other important social programs, and re-balance Ontario’s budget. Such reform will require the kind of leadership that only Ontario’s legislators can provide.

We propose dramatic health system reform based on four pillars. The four pillars are:

1. Setting Ambitious Goals
2. Planning Properly
3. Letting Evidence Drive Care Decisions
4. Connecting Care

The chapters that follow explore initiatives that we believe could have the most immediate, positive impact on the quality and affordability of our health care system.

Since 1990, every major Ontario political party has served as government, and we have worked with all of them to strengthen our health care system. We hope that this paper is seen as what it is: an optimistic, non-partisan contribution to the public policy debate, and a promise to work with today's legislators – and tomorrow's – to make our health care system the best in the world.



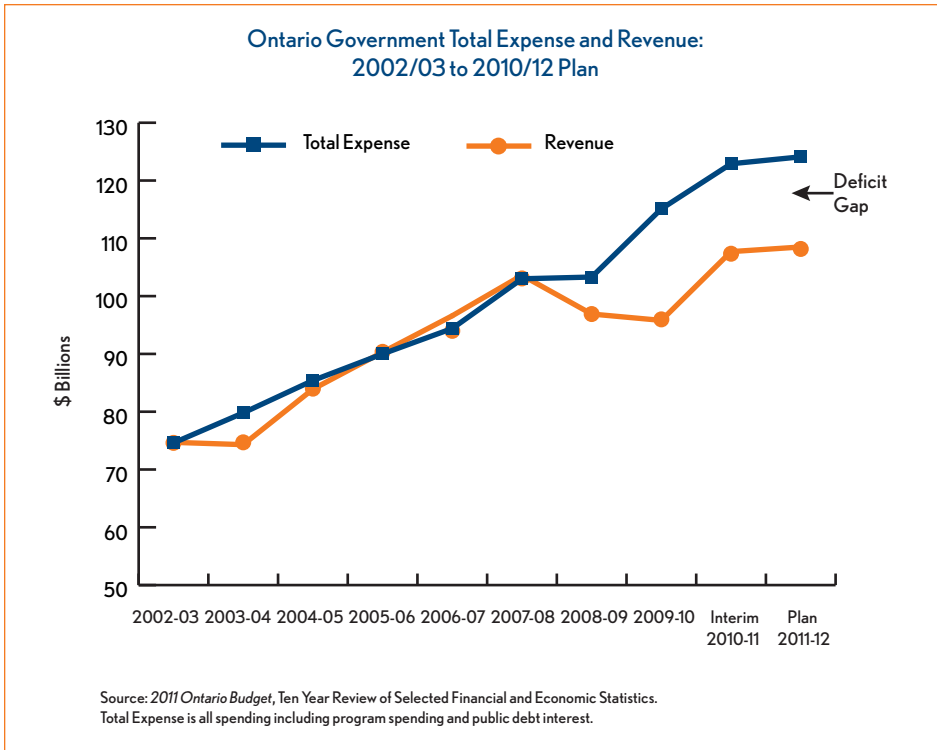
A handwritten signature in black ink, appearing to read "William Botshka".

A handwritten signature in black ink, appearing to read "Peter Johnson".

William Botshka
Chair
Ontario Association of Community
Care Access Centres (OACCAC)

Peter Johnson
Chair
Ontario Hospital Association (OHA)

Setting Ambitious Goals



Big or small, short-term or long-term, goals and goal-setting are the foundation of almost every human activity.

“I want to go there” is an example of a goal, and the process of arriving at it can be applied to any situation. A core question is asked (“Where do you want to go?”), facts are considered, options are weighed, and a decision is made. This basic process informs the actions of individuals, governments, and corporations around the globe each and every day.

That said, setting goals is not always easy, particularly in the context of health care.

Well-developed health system goals share a number of traits. At their best,

they are forward-looking and geared to making a real difference in the quality of care that patients receive. They are challenging, but achievable. And perhaps most importantly, they are easy to understand and measurable.

Goals like these set public expectations and, in doing so, commit government and providers to achieving them.

What makes goal-setting difficult in a health care system with a finite envelope of resources is that it involves making very public choices. Most of the time, setting a goal involves choosing one course of action over another because the resources to do both do not exist. Because individuals and groups often have different perspectives about the optimal direction of the health care system, such choices are inevitably controversial.

This is unfortunate because we have recently seen the powerful, positive effect that goal-setting can have on the delivery of health care here in Ontario.

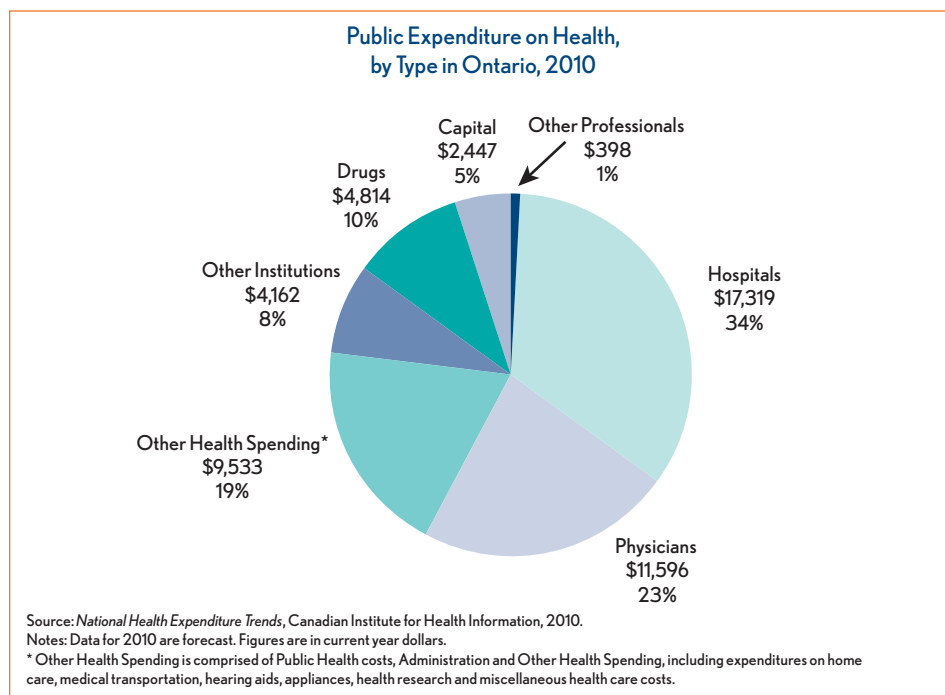
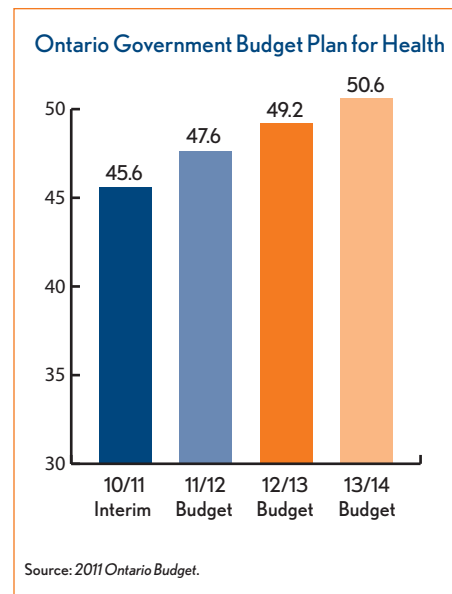
In 2005, the Government of Ontario created the Wait Times Strategy (WTS). The WTS created ambitious goals to reduce the length of time Ontarians wait to receive certain medical services, developed a funding mechanism designed to incentivize providers to meet these goals, and began reporting to the public regularly about the progress being made. Although the creation of the WTS was controversial at the time, we believe it was the right thing to do, and it is now widely seen as a major public policy success.

We believe that goal-setting like this will be even more important for the government, health care providers, and the public as we navigate the current, strained fiscal environment.

Ontario is facing a deficit and debt challenge of historic proportions. Since 2003, public spending has increased annually by an average of 6.5% – more than double the rate of inflation. These increases, combined with a recession-fueled decline in corporate tax revenues, have created a large deficit and a rapidly growing provincial debt.

Public spending on health care – hospitals, community care, long-term care, and physicians – now accounts for more than 40 cents of every budgeted dollar. The government's 2010 *Speech From The Throne* warned that, without serious reform, health care spending will consume 70 cents of every provincial dollar spent by 2022.

The magnitude and trajectory of health care spending means that the success of any plan to eliminate Ontario's deficit, manage its debt, and fund other priorities, depends on successfully bending the health care cost curve.



The challenges facing Ontario's health system aren't limited to funding.

The government's current plan to balance the provincial budget is built on this premise. In the 2010 Budget, the government set a goal of holding annual health sector spending increases to 3% by 2012-13. The government is on track to meet this target and to maintain this rate of growth into 2013-14 after accounting for time-limited investments¹. In an era where annual health system costs increase by more than 2%, funding levels less than this will mean a real reduction in health care spending.

One in ten patients spends more than 8.9 hours waiting in hospital emergency departments². One out of every eleven Ontarians does not have a family physician³. Almost 16% of patients in hospitals are to be transitioned home or to an alternate and more appropriate level of care in their community⁴. And, the impending demographic crunch will mean that thousands of experienced health care professionals will soon be eligible to retire.

Although Ontario has, in some instances, set goals for addressing these challenges, there are often no specific, quantifiable performance targets associated with them.

We believe:

- (1) The Government of Ontario should set and communicate medium-term (5- year) and long-term (10- year) goals with specific, quantifiable performance targets, so that health care providers can effectively contribute to their achievement, and the public can understand where our health system is headed and why.**

¹ 2011 Ontario Budget.

² Ministry of Health and Long-Term Care, Ontario Wait Times, February 2011 data.

³ Statistics Canada, Canadian Community Health Survey, 2010.

⁴ Ontario Hospital Association Alternative Level of Care Survey Results, March 2011.

Planning Properly

You can't reach a goal without a plan. And typically, the bigger the goal, the more important the plan becomes.

Over many governments, health care system planning is not something Ontario has historically done well, and this must change.

In November 2005, Ontario's Ministry of Health and Long-Term Care (MOHLTC) announced that it would develop a 10-year, strategic health system plan. The plan was supposed to provide a long-term vision for the health system, set quality improvement goals and milestones, and guide investment and human resources decisions. Unfortunately, although a draft plan was produced, it was not released.

As a result, a number of local and province-wide initiatives to reduce surgical, diagnostic and emergency room wait times moved forward without this important strategic guidance. Although some of these initiatives saw some success, we believe that more progress would have been made had an overall strategic health system plan tied them together.

Well-developed plans tie goals and performance targets to specific implementation or execution strategies and tactics, timelines, change-management exercises, and funding commitments. They also contain mechanisms to measure and publicly report on progress. As with goal and target setting, sharing details about the plan widely sets public expectations, and commits legislators and providers to achieving them.

We believe:

(2) The Government of Ontario should develop and publish a comprehensive health system strategic plan. This plan should:

- **Feature execution strategies and tactics, timelines, change management exercises, and funding commitment;**
- **Contemplate the appropriate mix of capacities of services our health system needs;**
- **Include quality and efficiency improvement measures, with a focus on using funding incentives to drive positive change;**
- **Be dynamic and evolve as goals are reached and new evidence is gathered and assessed; and,**
- **Include a robust program of community engagement – as the plan is being developed, and as it is being implemented.**

Better planning leads to better outcomes.

Let's build on existing health sector plans.

A number of health sub-sector reports, plans and strategies already exist in Ontario in preliminary form. One example is the recent report of the Ontario Legislative Assembly's Select Committee on Mental Health and Addictions, another is the Government of Ontario's Rural and Northern Health Care Panel.

We believe:

- (3) **The Government of Ontario's health system strategic plan should build on existing research and sub-sector plans in an effort to accelerate the planning process and implementation efforts.**

The strategic health system plan's development process must identify the structural, legislative or regulatory impediments to implementing it, and also plan to eliminate them.

For example, despite the recent introduction of a new organizational structure for Ontario's health system and the introduction of new models of care, new classes of health care provider, and new technology, the legislation that governs hospitals in Ontario – the *Public Hospitals Act* (PHA) – has not been substantially updated in decades. In 2010, the government acknowledged in its *Speech From The Throne* that the PHA should be updated, and committed to doing so. However, work to update the PHA has yet to begin.

We believe:

- (4) **The Government of Ontario should move ahead with its promised review and updating of the *Public Hospitals Act*, and any other relevant legislation and regulations, to ensure that they promote, rather than impede, the implementation of a health system strategic plan.**

No health system strategic plan would be complete without ensuring that we make the best use of the people who provide care.

Health care is a people business. The primary input is skilled health professionals; the primary output is healthier patients.

One of the most important challenges we face is ensuring that our health professionals are trained, deployed, managed and compensated in ways that maximize the quality and efficiency of the patient care they provide. Research suggests that there is a direct link between quality of work life for health professionals and better patient outcomes.

A great deal of progress has been made in this regard over the past ten years. New professions, like Nurse Practitioners and Physician Assistants, have been introduced. The scopes of practice of a wide array of health professionals have been expanded, and we are increasingly offering multi-disciplinary, team-based care options through vehicles like Family Health Teams.

While we have made great strides in terms of scope of practice and new models of care, much more needs to be done to promote and measure the quality of care being provided by health professionals.



We believe:

- (5) The Government of Ontario should facilitate the use of research to determine which staff mixes and models of care work best in different health care settings, from hospitals to home care, and the results should be used to inform the health system strategic plan as it evolves.**

This kind of evidence is key to ensuring that Ontario's valued health professionals are being used most effectively.

Health professionals should be treated equitably.

In its 2010 Budget, the Government of Ontario froze the compensation of non-unionized employees across the Broader Public Service, including those who work for hospitals and Community Care Access Centres (CCACs). Although we understand and share the government's interest in compressing the growth of public sector wages, we are very concerned about the unintended consequences of the freeze.

For example, the freeze has resulted in registered nurses and other in-demand health professionals being paid different rates for doing exactly the same jobs, simply because some are unionized and others are not. In our opinion, this is patently unfair, and is having a very negative impact on the morale of non-union staff. A lack of equity is problematic in any context, but particularly so in Ontario's health system, where organizations have worked hard to recruit and retain talented and motivated staff.

We believe:

(6) The Government of Ontario should implement measures to re-establish compensation equity between union and non-union staff.

Stability and consistency are essential to collective bargaining within our health system. So is expertise. We believe that having a single organization – a registered employers' bargaining agent – bargain collectively on behalf of all health sector organizations would ensure that these essentials are brought to bear on every negotiation, and that efficiencies are maximized.

We believe:

(7) The Government of Ontario should designate a registered employers' bargaining agent for the health system.

Letting Evidence Drive Care Decisions

Patients expect that in a modern health care system, care decisions will be made on the basis of evidence. In Ontario, that would mean patients who have the same conditions would receive similar treatment regardless of where they live. Too often, that does not happen, and patients with the same condition receive very different types of treatment, and can therefore experience very different outcomes.

Our organizations support the use of evidence-based, leading practice models of care, which promote equitable access to care, improve quality, and increase efficiency.

One solution to this problem is to adopt clinical pathways. Clinical pathways are standardized, evidence-based practices that have been used by health care providers around the world to reduce variations in care across health care settings, and to improve patient outcomes and experiences.

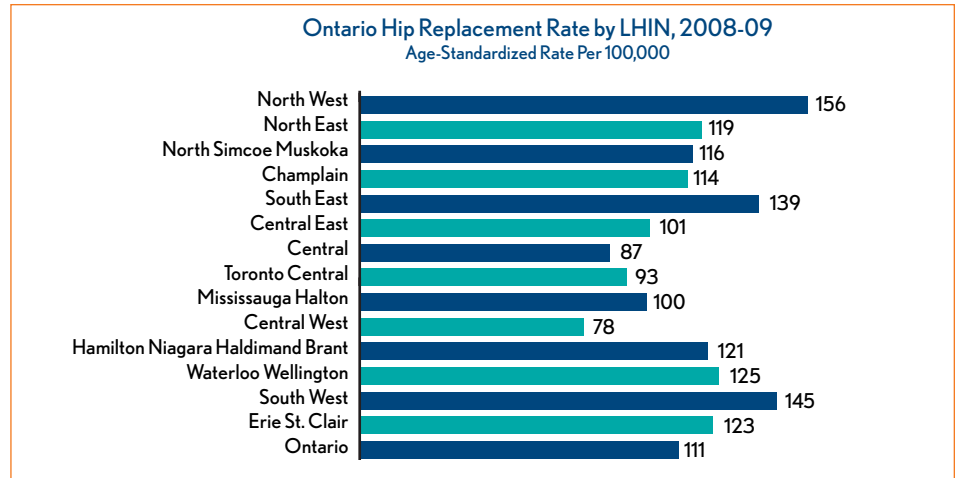
One type of clinical pathway adopted across Ontario involves speedy access to treatment for a particular type of heart attack called a “STEMI” (ST Elevation Myocardial Infarction). Following a 911 call for chest pain, advanced-care paramedics quickly identify a STEMI using an electrocardiogram (ECG) and follow a streamlined process which transports patients directly to the cardiac cath lab (bypassing the ED) for leading-edge, evidence-based treatment. At least 14 Ontario Cardiac Centres have adopted this approach which speeds access to care, saves lives and reduces health system costs.⁵

Ontario’s Cardiac Care Network promotes the use of clinical pathways to improve patient care.



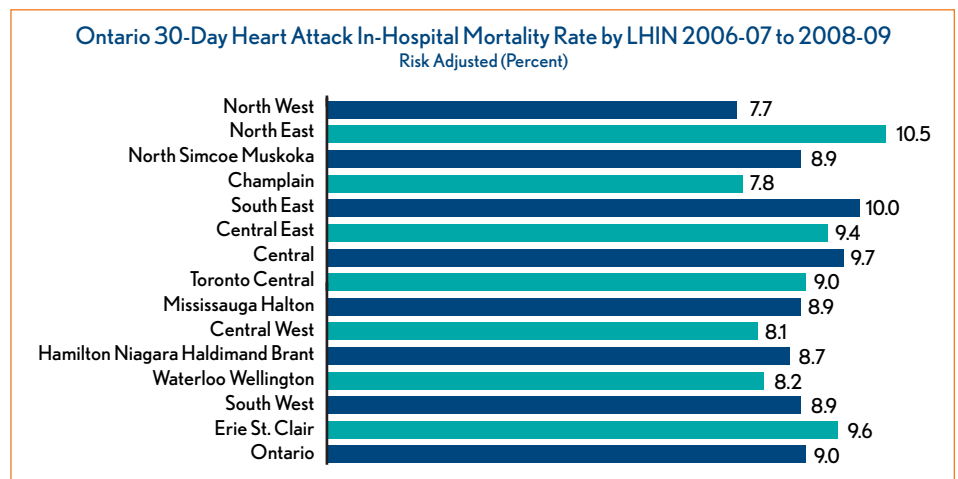
⁵ Cardiac Care Network, *Primary Percutaneous Coronary Intervention, Optimizing Access to Primary PCI for ST Elevation Myocardial Infarction*, 2010

Use of clinical pathways could reduce regional variations in care.

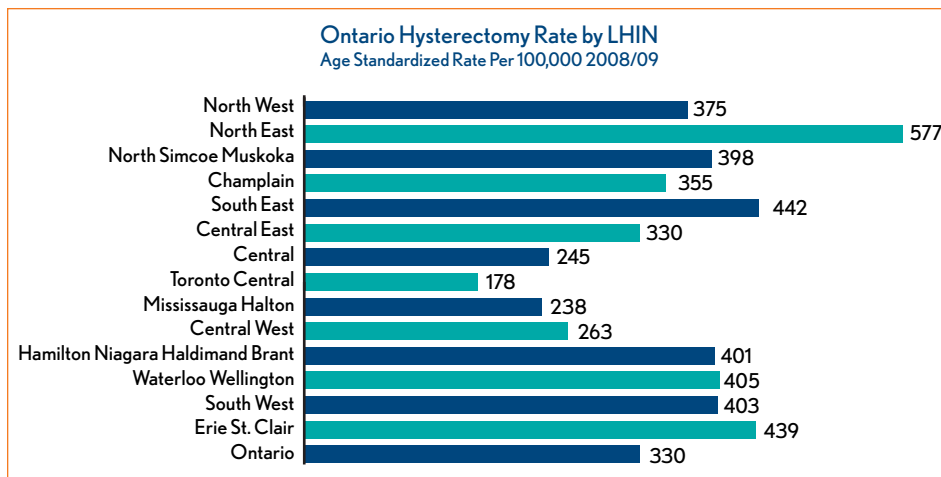


Prepared By: Health Finance and Research Unit, Ontario Hospital Association.
 Source: Health Indicators 2009, Canadian Institute for Health Information/Statistics Canada – Risk-adjusted rate.
 Note: The proportion of people age 20 and older receiving hip replacement surgery varies across the province (when accounting for differences in age structure).
 Age Standardized: Adjusted for differences in age profile between LHINs.

Clinical pathways have been used effectively, but only to a limited extent in Ontario – notably by Cancer Care Ontario (CCO). Prior to CCO developing and implementing standardized protocols for cancer treatment, fragmentation between surgical oncology, medical oncology, and radiation oncology practices contributed to wide, regional variations in outcomes. Today, fragmentation has been replaced by a more cooperative, systematic and cost-effective approach to treating cancer, and outcomes have improved dramatically.



Prepared By: Health Finance and Research Unit, Ontario Hospital Association.
 Source: Health Indicators 2009, Canadian Institute for Health Information/Statistics Canada – Risk-adjusted rate.
 Note: Deaths occurring in hospitals (from all cause) within 30 days of admission to an acute hospital for a heart attack.
 Risk Adjusted: Adjusted for differences between LHINs in factors contributing to the likelihood of this event occurring.



Prepared By: Health Finance and Research Unit, Ontario Hospital Association.
Source: Health Indicators 2009, Canadian Institute for Health Information/Statistics Canada - Risk-adjusted rate.
Age Standardized: Adjusted for differences in age profile between LHINs.



The *Excellent Care for All Act* (ECFAA), proclaimed as law in July 2010, could be a tremendous vehicle for identifying and implementing evidence-based care models in hospitals. Among other things, the ECFAA expanded the role of Health Quality Ontario (HQP) in promoting practices that are supported by the best available scientific evidence. HQO, working with disease-specific Provincial Expert Panels, academics, health care provider organizations, and other experts, should facilitate the creation of clinical pathways and other evidence-based models of care and promote their rapid and wide-spread adoption.

The adoption of clinical pathways and evidence-based practices should occur on an expedited basis in an effort to improve equity and the quality of care, and to drive cost savings.

For example, wound care constitutes a large portion of service authorized in Ontario, as 30% to 50% of service delivery includes acute and chronic wound care. A number of CCACs, including the Central West CCAC, have developed a Wound Care Management Program (WCMP) to assist both service providers and case managers in meeting the complex challenges associated with wound healing. The purpose of the WCMP is to assist service providers and case managers in the accurate identification, comprehensive assessment, and appropriate treatment of wounds. By providing case managers with essential information to ensure quality care for clients with wounds and effective case management services for wound care, the WCMP promotes greater consistency and a higher standard of care to Central West CCAC clients.

Evidence should drive health care decisions.

We believe:

(8) The Government of Ontario should make the widespread adoption of clinical pathways for specific diseases and patient groups like wound care, diabetes, palliative care and mental health a high priority in their health system strategic plan.

We believe that the ECFAA, when combined with changes to current health provider reimbursement models, could be an extremely effective tool in driving evidence-based practice. Although early steps have been taken in this direction, far more must be done.

For example, fifteen years ago, studies showed that doing ECGs and chest x-rays as pre-operative testing a few days prior to cataract surgery had absolutely no clinical value. However, these tests were being done regularly in hospitals until recently.

Although the science underpinning these tests had been updated, there was no single authority driving these validated research findings out to health care providers. This includes the physicians who continued ordering the tests as they had always done, and the hospitals who simply allowed existing practice to continue.

Likewise, there was also a misalignment of incentives. Hospitals collected what are known as technical fees for the tests, so they were incented to have them continue. Physicians collected what are known as professional fees for those tests, so they were also incented to continue.

As of July 1, 2010, the Government of Ontario accepted the research findings and put a stop to this practice by excluding payment for these tests from the OHIP fee schedule.

We believe that this is a powerful example of the challenges in adopting evidence-based practice across Ontario, particularly with respect to ensuring that all incentives in the health care system are aligned with good practice.

This is not an isolated example and, for us, demonstrates why the practice of using evidence to judge a procedure's efficacy and inform funding decisions should be dramatically expanded, even at the risk of causing tension between the funder and the health care provider. During a period of tight budgets, every dollar spent or unspent matters.

We believe:

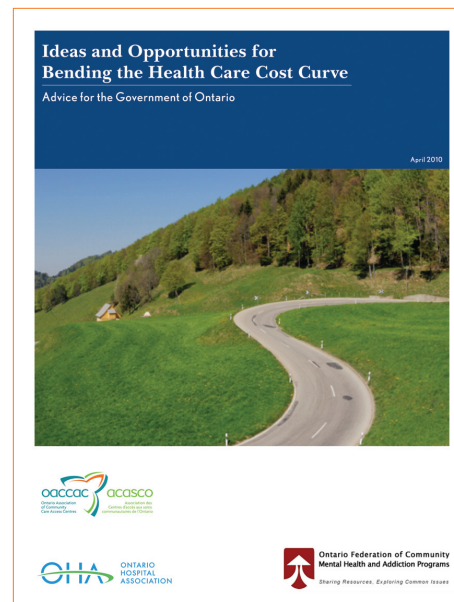
- (9) The Government of Ontario should ensure that it uses all of the available tools, particularly those included in the *Excellent Care for All Act*, to ensure that evidence-based practices are identified and disseminated to health care providers quickly and efficiently, and to incent providers using funding tools to adopt them without delay.

This will improve the quality of patient care and free up precious funding dollars in these tough economic times.

We believe:

- (10) The Government of Ontario should expedite the development of the *Excellent Care for All Act* and associated regulations for application to other key health care providers, in order to facilitate the adoption of care pathways and evidence-based practice and accountability across the continuum of care.

In 2010, our organizations, in partnership with the Ontario Federation of Community Mental Health and Addiction Programs, published a report entitled, “*Ideas and Opportunities for Bending the Health Care Cost Curve*”. This report identifies high-impact ideas that health care providers – with support from the government – could reduce the cost of health care while improving its quality. The strategies identified range from error reduction, to spending on drugs, to ensuring that patients receive care in the most appropriate setting. We believe that this document is a useful starting point for discussions about how evidence-based practice can be deployed broadly across the health system.



Connecting Care

Better integration means a smoother health care journey for patients.

Goal-setting, planning and the application of evidence-based practice achieve maximum impact in systems that are highly integrated.

According to the World Health Organization, “integrated care” is the concept of bringing together the inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. “Integration” is a means to improve services in relation to access, quality, user experience and efficiency.

Patients can derive many benefits from integration. By promoting better coordination among providers, integration can help patients chart a smoother, faster journey through the health care system. Consistent use of standardized, evidence-based leading practices can minimize hospitalizations and costly re-hospitalizations. And by reducing duplication and promoting accountability, it can drive improved efficiency across the health system.

There are many examples of large, highly-integrated health care organizations. One is Kaiser Permanente (KP), one of the largest not-for-profit health providers in the United States. KP has become a leader in patient care, in part, because it is also a leader in physician integration, using financial incentives that are aligned to clinical quality indicators, and the use of health information technology.

The Government of Ontario has taken some steps to facilitate improved integration between some health care providers, specifically, hospitals and CCACs. In 2005, they created Local Health Integration Networks (LHINs), regional planning bodies that now fund hospitals and community health providers and facilitate and approve integration initiatives.

There continues to be much potential in approaches to regionalization that leverage effective health provider governance while also driving toward improved service integration. However, Ontario’s health care system has not yet achieved the kind of organizational and practice integration needed to better address the changing health service needs of Ontarians.

Recently, the government passed legislation that expanded the role of the CCACs to transfer and place patients into the most appropriate health care setting.

Patients who have complex needs and utilize different providers – sometimes at the same time – require smooth handoffs and improved communication between those providers. In Ontario, there is no standardized way that this occurs, but we acknowledge that LHINs and CCACs are working toward this goal. An example of this can be found in the Hamilton Niagara Haldimand Brant LHIN, where palliative care physicians, CCACs, pharmacies, hospitals, community

support services and long-term care homes have created a network to improve the consistency of end-of-life care. However, integration of this kind does not necessarily happen in other parts of Ontario. This could lead – unintentionally – to significantly different quality of care for patients, and different levels of efficiency in delivery.

The ability of individuals to enter the health system at any given point, and then navigate the continuum of care smoothly and efficiently, is one of the hallmarks of a high-performing, patient-focused health system.

Let's reduce duplication and promote accountability.

We believe:

(11) To facilitate care at the right place at the right time, the Government of Ontario should ensure that structures and processes are in place so that patients, especially those with complex care needs, have their care connected across the continuum.

Further, physicians – even those associated with Family Health Teams – operate autonomously from the LHINs, even though they are the primary point of contact for health care for many Ontarians.

Although we believe that some regional variation in the provision of patient services is appropriate, particularly as it relates to differences in both demographics and needs, we also believe that evidence-based approaches should be the norm.

Issues like these would likely have been examined during a legislated review of LHINs that was to have taken place in 2010. However, the government chose to postpone the review until 2012.

We believe:

(12) The planned legislative review of Local Health Integration Networks (LHINs) should be expedited so that the benefits of that review can be made available to the Government of Ontario as soon as possible. The review should consider how to best ensure that patients across Ontario have reasonable access to similar baskets of services, and that consistent approaches are used based upon evidence of success. The review should also examine how physicians can be better integrated with LHINs, CCACs, hospitals and community-based health providers.



Health information technology is a key part of the foundation of highly-integrated health systems. Unfortunately, public perceptions of – and public confidence in – meeting the objective of achieving electronic health records by 2015 has been damaged over the past few years. In this tight budget era, some may feel that spending on front-line patient care today should take precedence over making the enterprise technology investments needed to improve the quality and efficiency of that care tomorrow.

In this context, public understanding of the importance of health information technology, and the support for investments in it, will be more important than ever. We believe that progress on adopting health information technology is too important to delay, even in a challenging financial environment.

We believe:

(13) The Government of Ontario should make a comprehensive health information technology adoption strategy – complete with specific, dedicated, and gated funding – a central part of its health system strategic plan. This plan should set direction and measure progress centrally, but allow for regional execution. Clear, preferred standards for information exchange in order to ensure the interoperability of systems used by health care service providers should be central to this plan.

Integration efforts should not be limited to organizations spread across one geographic area. Indeed, some very important integration initiatives must happen at the organization, or even the patient, unit level. For example, the National Health Service's (NHS) "*Releasing Time To Care*" model has been implemented successfully at a number of Ontario hospitals, including Mississauga's Trillium Health Centre and Sarnia's Bluewater Health. This model encourages staff involvement in process improvement, and has been shown to improve patient care, increase staff engagement and satisfaction, and reduce costs.

While these tools have already been used by some hospitals and other health care provider organizations to good effect, we believe that they should be used across the continuum of care to promote and reinforce a culture of process and quality improvement.

We believe:

(14) The Government of Ontario should promote the adoption of proven process redesign techniques and strategies to improve efficiency and quality outcomes across the health system, and dedicate resources and supports to their implementation.

Ontario's hospitals and health care system continue to manage the challenge posed by large numbers of Alternate Level of Care (ALC) patients. In most cases, ALC patients are people in acute care hospitals who have completed their acute treatment and require a less intensive level of care, but cannot access that care because there is no available space in a rehabilitation or complex continuing care facility, assisted living facility, or at home with community health supports. However, it is important to note that rehabilitation, complex continuing care, and mental health facilities also face significant ALC challenges.

Ontario's health system needs more capacity outside hospitals.

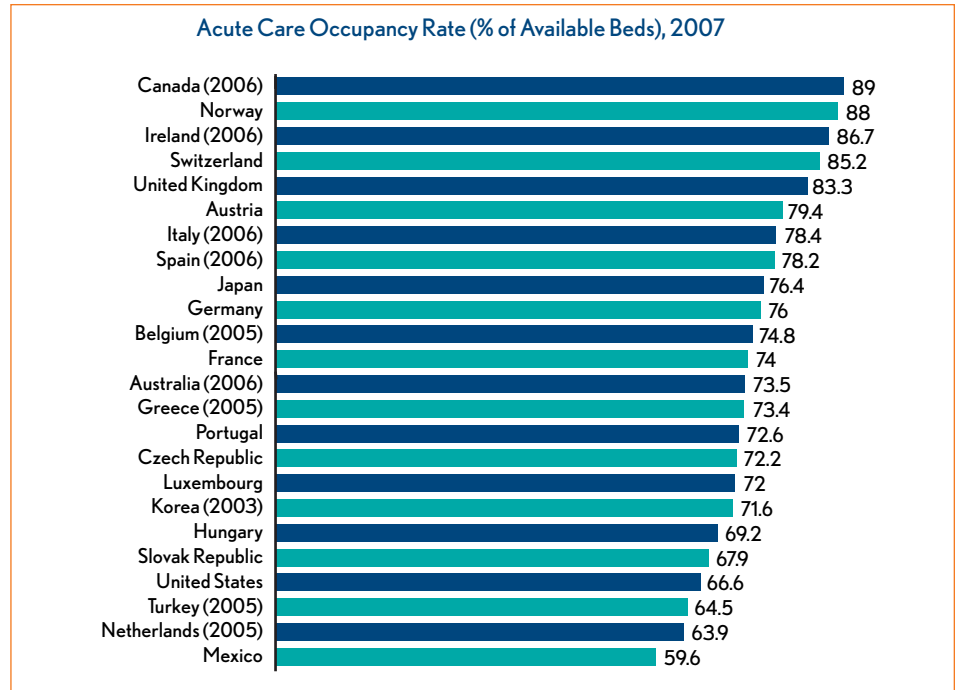
At any given time, approximately 16% of Ontario's hospital beds are occupied by ALC patients. Notwithstanding significant efforts and investments like the government's Aging at Home Strategy, this number has remained stable for almost four years. This suggests that Ontario's health system continues to face a serious capacity challenge, and that the mix of health services needed to make it work smoothly and efficiently for patients is not in place.

This is an urgent issue.

Canada's hospitals have an 89% occupancy rate, (the highest of any Organization for Economic Cooperation and Development (OECD) country – higher than the US (66%), the UK (83.3%), Germany (76%) and France (74%)) and occupancy rates in Ontario are generally thought to be average in Canada. This means that Ontario's hospitals have very little "surge capacity" – the extra space and beds – they'll need if Ontario experiences an increase in demand resulting from seasonal flu, much less a pandemic or a catastrophic event. In fact, this year, the ALC burden on hospitals and its impact on occupancy, combined with the seasonal flu, have caused a significant number of surgeries to be cancelled due to the unavailability of hospital beds.

The inability to move ALC patients efficiently through the health system also results in long waits in hospitals' emergency departments, delays in off-loading ambulances and, in some cases, cancelled or delayed elective surgeries. In fact, the number of patients in emergency departments waiting for an in-patient bed increased by 6% between November 2008 and January 2011.

The government has set a provincial target of reducing the number of ALC patients in acute care beds to approximately 9.6%. However, despite the hard work to date, it seems clear that the health system will only be able to achieve this goal if additional focus is brought to this issue.



Source: Organization for Economic Cooperation and Development, Health Data, 2009
 Note: Data from 2007 unless otherwise noted.

Creating the right mix of capacity is critical to solving this challenge. We believe that a significant increase in capacity in the community sector (e.g., home care, assisted living, etc.) could alleviate a great deal of the pressure on acute care hospitals caused by ALC patients. The 2011 Ontario Budget notes that the government is building on previous investments by increasing funding to the community services sector by approximately 3% per year over the next three years. These investments will go to long-term care homes, home care and other community supports, assisted living services and mental health and addiction services⁶. However, it should not be forgotten that targeted expansions in institutional capacity – particularly in the complex continuing care and rehabilitation sectors – may also be necessary and appropriate.

We believe:

(15) Annual expenditures on the community sector by the Government of Ontario should increase by 3.5% plus inflation (CPI). Enhancing community expenditures in specific targeted areas will facilitate a cost-effective shift of service, resulting in a positive impact on hospital utilization and better care for patients.

⁶ 2011 Ontario Budget.

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