**Windsor Hospial**

**Report of the Executive Committee
April 2008**

Over the past ten (10) years Windsor Regional Hospital has experienced substantial and unprecedented growth physically in facility expansion, staffing increases, program and service creation and expansion.

**Unprecedented Growth over Last 10 Years**
Ten years ago Windsor Regional Hospital’s consolidated operating budget was approximately $90 million dollars. Today it stands at over $270 million dollars. This is a three hundred (300) percent increase. Currently employee wages and benefits make up approximately 66% of the current budget.

**Increase in Demand and Reduction in Supply**
Now that we are completing the Health Services Restructuring Commission’s (HSRC) directions with the commencement of the Western Campus Redevelopment growth related to program expansion has and will continue to stabilize. However, demand for existing services will continue to increase in large part to the influx of the Baby Boomers.

As David Musyj stated in his April Report to the Corporation the first year of the baby boom generation turns 62 this year. The Baby Boomers account for approximately 30% of our population. Also, the average age of the current patient being admitted to Windsor Regional Hospital is 66 years of age. At the same time the supply of healthcare human resources is experiencing the same
phenomenon. The individuals taking care of the patients/clients and residents are getting older. The current average age of a Windsor Regional Hospital employee is 42.03 years. It was closer to 46 years of age only 4 years ago...

**Working Capital Debt and Base Operating Funding**
During this period of substantial growth Windsor Regional Hospital, along with other Hospitals in the Province, had to internally fund a portion of this growth. Early in the history of Windsor Regional it funded the growth with the use of reserve funds (operating surpluses that accumulated in the past). However, for the past 10 years Windsor Regional Hospital has funded a substantial amount of this growth. This has resulted in the Hospital accumulating debt – known as a working capital deficit. Today the working capital deficit stands at $55 million dollars.

Over the next two fiscal years the base funding increases announced by the Ministry of Health and Long Term Care (MoHLTC) for most Hospitals including Windsor Regional Hospital is only 2.25% for 2008/2009 and 1.95% for 2009/2010 fiscal year. Supply costs, energy costs, patient/resident food costs, insurances costs are all increasing at approximately 10-12% per year. Wage and benefit increases, which make up close to 66% of the Hospital’s budget, are also rising at a rate higher than 2%. As a result of the difference between increasing costs and limited base funding adjustments Windsor Regional Hospital is limited in its ability to reinvest in capital purchases or upgrades and strains to achieve a balanced budget – thereby not addressing the working capital debt.
The MoHLTC is aware of Windsor Regional Hospital’s issues. The Board of Directors of Windsor Regional Hospital has spent a considerable amount of time addressing these issues with the Ontario Hospital Association, the Erie St. Clair LHIN and the MoHLTC directly.

**Cost per Weighted Case**
A measure used by the MoHLTC to determine if a Hospital is operating efficiently is a calculation termed Average Cost Per Weighted Case. (CPWC) Case costing has generated considerable interest and enthusiasm. It provides much needed data to inform decision-making at all levels in the hospital. Hospitals have turned to case costing information when faced with important decisions about the types of services to deliver and how to deliver them.

The goal of the costing methodology is to apportion total hospital costs incurred by both the direct patient care and overhead functional centres to individual patients within a given costing period. CPWC is calculated by dividing the net total inpatient cost for a facility by the total weighted cases in that same facility.

Windsor Regional Hospital has been using the case costing data over the past 5-7 years to judge its efficiency. Approximately 5 years ago the Hospital’s actual cost per weighted ($3,700) case was 26% above its Expected Cost per weighted case ($2,930).
Through the use of the Health Care Management (HCM) exercises the Hospital has been able to reduce the difference between its actual cost per weighted case ($4,879) to expected cost per weighted case ($4,411) to 10.6% higher. In addition, as a result of the unprecedented growth the Hospital was able to “spread out” its overhead over more weighted cases. For every 1% drop in its actual cost per weighted case Windsor Regional Hospital would reduce its operating expenses by $950,000.

In addition, each and every acute care bed the Hospital opens (even assuming funding from the Ministry) the Hospital operates that bed at approximately $1,600 per weighted case more than it receives in funding. Similarly for each Complex Continuing Care patient day, it is costing the Hospital $200 per day more than the funding being received. Faced with this higher than expected cost per weighted case calculation it is difficult if not impossible to advocate for additional operating funding for the Hospital. The response is
“reduce your cost per weighted case and you will generate the funds internally”. In addition, one would question “why are we opening more acute care and complex continuing care beds if we cannot afford to do so and each and every new bed adds to the Hospital’s deficit?”

**Is There an Easy Answer?**In order to generate $10 million dollars in cost reductions one might say “easy…eliminate $10 million of current program/services”. That is NOT the answer. That will result in reducing a Hospital’s expenses by $10 million dollars but will not change the Hospital’s actual versus expected cost per weighted case. You will lose the weighted cases. In fact, it would probably increase the difference let alone the impact it would have on patient flow and patient safety.

**Where do we Go from Here?**
Faced with:
1. Fast and Substantial growth;
2. Increasing demands on services which continues to grow;
3. Decreasing supply of healthcare human resources;
4. Debt;
5. Increasing costs;
6. Decreasing base funding levels; and
7. Higher Actual cost per weighted case versus expected cost per weighted case…Where do we go from here?

We need to take a step back. We could use the HCM process again. However, that will only incrementally move the bar.
For the past 10 years we have incrementally increased program budgets by a certain percentage based upon demand and revenues.
This “Incremental Budgeting” technique used budgets prepared using a previous period’s budget or actual performance as a base, with incremental amounts added for the new budget period. The allocation of resources is based upon allocations from the previous period. This approach fails to take into account changing circumstances. Moreover, it encourages “spending up to the budget”
to ensure a reasonable allocation in the next period. It leads to a “spend it or lose it” mentality.

**Zero Based Budgeting Exercise**Zero-Based Budgeting is a technique of planning and decision-making which reverses the working process of traditional budgeting. As stated in traditional incremental budgeting, departmental managers justify only increases over the previous year budget and what has been already spent is automatically sanctioned. No reference is made to the previous level of expenditure. By contrast, in zero based budgeting, every department function is reviewed comprehensively and all expenditures must be approved, rather than only increases. This process requires the budget request justified in complete detail by each program starting from the Zerobase.
The Zero-base is indifferent to whether the total budget is increasing or decreasing. "With zero-based processing one can forget about last year, pretend that the program is brand new,and see if one can provide a detail of expenses for what one would need to fully accomplish the program. This technique will help one to develop a complete picture of what the program actually needs to cost and not just what it has been costing."

In effect we create a clean slate. The analogy we will use is if Windsor Regional Hospital was empty today and we were told we had to start operating it as a Hospital in six months.

**How will You be involved?**
Over the next two weeks you will be receiving Terms of Reference (ToR) for this process. The Board of Directors of the Hospital is expecting all staff (employees and professional staff (medical/dental/midwives) to participate in the Zero Based Budgeting Exercise. In addition to all of you we will be retaining experts in the zero based budgeting exercise to aid all of us through the process. There will also be subject matter experts in Hospital clinical and nonclinical operations involved in this process.  The ToR will set out the process in detail and provide some issues that are “out of scope”. For example, a simple answer may be to roll back wages and benefits by 10%. That is OUT OF SCOPE. That is not how we are going to reduce our actual cost per weighted case. Wages and
benefit levels are where they are at the commencement of this exercise. Windsor Regional Hospital’s Finance/Audit and Resources subcommittee of the Board of Directors chaired by the Randy Morris, Treasurer, will act as the steering committee for this zero
based budgeting process. In addition, while we are proceeding through this process it is inevitable that we will hear about
further funding announcements from the LHIN and the MoHLTC. If we receive more funding that will NOT stop this process. Again, more funding will not result in our CPWC changing.