The Need for Private Funding of Ontario's Hospitals

HILARY SHORT*

With increasing government participation in hospital and health-care financing in Canada, many people have come to believe that public hospitals are owned and operated by government. This general misconception has had a serious side-effect in that people have also come to believe that the hospital is no longer in need of private funds from donations and bequests. On the contrary, hospitals are now urgently in need of private funds – although not for the same reasons as they were before the government entered the health insurance field in 1959. Before OHIP, hospital boards were frequently pre-occupied with finding the money to develop their hospitals, sometimes even to keep them in operation at all. Today the government provides what it considers the necessary operating funds; trustees and administrators face the problem of providing the services the doctors want for their patients, while keeping within a controlled operating budget. There are, however, important ways in which additional funds can be used by the hospital to benefit the community it serves – such funds are needed for capital expenditures, for medical research, to defray operating costs and to maintain or initiate programs not funded under the government program.

In 1959, the Government of Ontario, like other Canadian provinces, joined with the Government of Canada in the provision of a universal hospital care system for the province. Under the agreement made eventually with all the ten provinces, the federal government undertook to pay approximately 50% of the cost of a list of in-hospital basic benefits that were designated as being shareable. Since then, the financing of hospital operating costs has been achieved largely through payment to hospitals through the provincial government for the services provided to insured patients. The actual level of payment for each hospital varies and is based on a global budget approved by the Ministry of Health for the hospital.

Since the late 1960's, the Government of Ontario (incorporating some grant money from Ottawa) has also provided two-thirds of the cost of approved hospital construction projects and will provide the hospital board with a low interest loan to cover as much of the remaining one-third as it cannot raise.

The budget review process has given the government a powerful instrument of control over community hospitals, not just over their size and location, but also over their day-to-day operation, the services and the medical programs they could provide—even how much they could afford to pay their staffs. The Ontario Government has not chosen, however, to use that power to rule over the management of hospitals, but has frequently declared its wish to preserve the tradition of voluntary community involvement in hospital management.

If the government does not run the hospitals, who does? Many members of

**Of the Ontario Hospital Association*

the general public are unaware of who is really entrusted with the operation of the hospitals. The answer is that the legal and moral responsibility for the proper management of a hospital and the quality of care it provides to its patients rests with its board of directors – usually called trustees. (There are more than 4,000 of these trustees in Ontario, all of them serving voluntarily.)

Almost every public hospital in Ontario is a corporation, established by an Act of the Legislature or by letters patent of incorporation. As in any other corporate organization, the hospital is governed by a board of directors. Unlike directors of business corporations, however, hospital trustees do not bear individual liability; the board as a whole is responsible. It must observe the requirements of the Corporations Act for corporations without share capital, and protect and control all of the assets of the corporation – there must be a proper auditing system, adequate insurance and up-to-date by-laws. The board must also be governed in its general conduct of hospital affairs by The Public Hospitals Act of Ontario, its accompanying Hospital Management Regulation (Regulation 729) *and* by the by-laws of the hospital.

In summary, the legal responsibility of the board is to:

1. Manage the affairs of the hospital corporation so as to achieve the basic goal of providing the best hospital service practicable in that community.
2. Appoint a chief executive officer competent to carry out the directives and policies of the board, as well as the requirements of The Public Hospitals Act, the Regulations thereunder and the by-laws.
3. Appoint competent and conscientious medical and dental staff to meet the needs and objectives of the hospital to provide high quality patient care.
4. Establish formal policies as the principles of operation under which the chief executive officer will develop the procedures necessary to meet corporate goals and responsibilities.
5. Delegate responsibility and necessary authority to the chief executive officer for day-to-day functioning and management of the hospital.
6. Require and receive accountability from the chief executive officer and the Medical Advisory Committee, in relation to the delegated authority and in respect of all the legal requirements of hospital operation and management.

Relationship of Board and Chief Executive Officer

The board must appoint a chief officer (most often known as the administrator or executive director) who is responsible to the board for the operation of the hospital according to the Act, the Regulations and the by-laws. It must appoint physicians to the medical staff in accordance with the methods set out in the Act and the by-laws.

The board delegates to the chief executive officer the operational responsibility for implementing the hospital's policies. Establishment of the procedures necessary to implement these policies is the responsibility of the chief executive officer.

In return for delegating the authority for administering the institution according

to the policies it has established, the board expects to receive a regular accounting showing performance in relation to objectives and expectations.

As has already been stated, the hospital board is responsible for appointing physicians to the medical staff in accordance with the methods set out in the Act and the by-laws.

Because trustees must rely mainly on reports of the medical staff to evaluate the standards of medical care in their hospitals, it is essential that they receive data that are complete and intelligible. They look to the administrator to advise them as to the adequacy of information being received and also for advice as to additional reports that would make the picture more complete.

The board has a specific obligation to support the chief executive officer in dealings with the physicians. It must explain to the medical staff the administrator's role, function and scope of responsibility, emphasizing particularly that, as the governing body's chief executive officer, he has the responsibility to ensure that all of the staff, including the medical staff, operate in accordance with the law and the policies established by the board of directors.

Among the administrator's primary functions is the preparation of the hospital's operating budget for board approval. The board is not merely a "rubber-stamp" when it comes to recommendations on policy, for the annual budget is a statement of policy in that it sets out the services the hospital intends to provide for the ensuing year. The board does not concern itself with the fine detail, but it has to satisfy itself as to the justification for increases (or decreases) in staff, services and facilities.

This budget is submitted to the Ministry of Health for ratification. When it is approved, the board checks periodically to see how performance compares with promise.

Within each hospital the trustees are the governors. They govern on behalf not only of their own immediate community, but also of all taxpayers in Ontario, whose government has budgeted $2.06 billion in 1977-78 for the operation of hospitals and other related facilities. This figure does not include capital costs.

Trustees also have other responsibilities. Primary among these are the quality of patient care, and the efficiency with which the hospital resources are being used. The hospital must also concern itself with seeing that the overall health needs of the community are being dealt with effectively and economically. That requires a co-ordinated approach by hospitals, doctors, nursing homes, clinics and other agencies and institutions involved, in order to avoid such problems as duplication, overlapping or gaps in services. The health care field today is undergoing a period of rapid change and development, and a trend which is clearly emerging is that of district and regional organization in which hospitals will no longer function independently, but rather must take their place in the total scene and relate their plans and services accordingly.

As well as reviewing the total health needs, and demands, of the community, today's trustees and administrators find themselves having to rationalize those pressures within the limitations imposed by government.

Government Cutbacks

In 1959, the total gross operating costs of public hospitals in Ontario was $195 million. In 1976 that figure reached $1.79 billion. Another $725 million was spent on personal medical services. Altogether, including the cost of running the provincial mental hospitals and public health services, health cost Ontario $3.4 billion in 1976. Health now outstrips education as the largest sector of provincial government spending and accounts for nearly 30% of the budget. Since 1970, there has been a virtual freeze on hospital expansion and now only exceptional hospital projects are approved. In January 1976, the Ministry of Health began a stepped-up campaign to cut its hospital spending. These measures have included attempts to close nine hospitals, (four of which were subsequently reprieved by the court) and the closure of over 1,000 beds.

Hospitals accepted the need for restraint in government spending while recognizing that a great effort was needed to maintain the same quality of care with fewer dollars at their disposal.

Government cutbacks in hospital spending have forced administrators and hospital boards to review their spending to "trim all the fat" from their budgets. This has resulted in tighter staffing levels and many hospitals have been forced to curtail services and programs, or shelve plans for implementing new ones – this includes community preventive health programs.

For what purposes does the hospital need private funding?

One axiom is that additional income cannot be used by a hospital to embark on new service programs or facilities which would have the result of increasing government's financial liability – unless the Ministry of Health approves. No purpose would be served by donating a complex piece of medical equipment for which the government had not approved the operating costs. However, there are many excellent uses to which donated funds can be put to serve the community.

Firstly, any hospital which is expanding, renovating or making major alterations to existing buildings, must raise one third of the costs of construction from members of the community. The provincial government assumes in The Public Hospitals Act that this will be done by the community, as it undertakes to provide only two-thirds of the funds needed for any capital project. Hospitals also need money for capital equipment. The Ministry allows depreciation on capital equipment, but this does not cover full replacement cost and is not sufficient to upgrade equipment or to purchase equipment made available through advances in technology.

There is also a vital and continuing need for private funding of in-hospital medical research, carried out largely in the teaching hospitals with university affiliation. The primary purpose of the hospital is, of course, the healing of the sick. Nevertheless, the value of medical research to the community cannot be over-estimated.

None of the major developments in health care of the past fifty years would have been possible without research. Diseases such as poliomyelitis, pneumonia,

malaria, diptheria and typhoid have been eliminated from the western world as major health hazards. Insulin, antibiotics, kidney dialysis and organ transplants have all developed from research. Studies are now being made towards finding causes and cures for degenerative diseases – heart problems, cancer, hardening of the arteries – all of which are very costly in terms both of lives and money. It is not widely known that research is funded almost entirely by money from the private sector. The Medical Research Council, a federal agency, which does make research grants, is currently restraining the growth of its program. Provincial aid towards the funding of research has been a very small percentage of the amounts needed, though the promise of future grants from lottery revenues is more encouraging.

Most hospitals involved with research programs have now set up foundations, institutes or endowment funds, as recipients of donations and bequests to be used for research. These foundations are non-profit corporations whose funds and programs are administered by boards of directors separate from those of the hospital itself. Generally there is a research advisory committee which screens applications for funds and makes recommendations to the board. The criteria the board goes by in deciding to allocate funds will, of course, vary according to the philosophy of the hospital, but the hospital will judge the proposal by its potential to improve patient care and advance medical knowledge. Projects considered are usually both basic and clinical medical research, research into developing new techniques, new methods or special equipment leading to improved patient care; research into health care planning and delivery and into methods to improve health care education for health care personnel and the general public.

A donation or bequest to a hospital foundation can be given to be used for a particular project. It is easier, however, if funds are donated for use at the discretion of the foundation's board of directors, since in that way a better balance can be kept in the distribution of funds. Some areas of research have less appeal to the general public, but are nevertheless of great importance and urgently in need of funding.

Not all hospitals are involved in capital projects or medical research. But they also need funds to use in equally important but sometimes less noticeable projects. With government cutbacks, extra funds for the hospital to use for day-to-day operating costs, the in-service education of staff, the purchasing of equipment and furnishings – wheelchairs, hospital beds – help the hospital to maintain the present level of care notwithstanding financial constraints and rising costs.

Additional funds may also be used to finance community-based projects such as preventive mental health programs, birth control clinics, weight control programs and alcohol and drug abuse treatment programs which cannot be funded under conventional operating budgets.

Hospitals have some discretionary income from the additional daily charges for semi-private and private room accommodation over the standard ward rate. Two-thirds of that income, however, is claimed by the government as offset

revenue – in other words, the government reduces its budgetary payments to hospitals by a corresponding amount. Any money which comes to the hospital from grants, bequests and donations remains fully at the hospital's disposal.

We in Canada receive and have come to expect hospital care of a quality that is equalled in few countries of the world. This has come about not only because of the growth of universal health care insurance, but also as a result of the generosity of many thousands of Canadians. With the increasing demands being made on the system and the corresponding rise in costs, the ability of society to provide all but the most necessary services is becoming severely limited. To preserve the excellence of our hospitals, infusions of private funds are, and will be in the forseeable future, of prime importance.