Canadian MIS Database

Moving Toward the Reporting of Hospital Financial Performance Indicators

1999–2000 and 2000–2001

Canadian Institute for Health Information
Institut canadien d'information sur la santé

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Executive Summary

The Canadian MIS Database (CMDB) is the national data source for financial and statistical information about hospitals and health regions. The data collected in the CMDB is structured according to the national data standard, *Guidelines for Management Information Systems in Canadian Health Service Organizations* (MIS Guidelines), a standardized framework for collecting and reporting financial and statistical data on the day-to-day operations of health service organizations. These standards have been implemented in most provinces and territories across Canada.[1]

Canadian MIS Database, Moving Toward the Reporting of Hospital Financial Performance Indicators, 1999–2000 and 2000–2001 studies the feasibility of using data from the CMDB in order to report on selected regional level financial performance indicators. Understanding how hospital financial information changes over time is critical to evaluating hospital performance. Currently, indicator results have been calculated for two years at the provincial/territorial level. Fiscal year 2000–2001 represents the first year that regional level results have been produced.

It is important that this report be viewed as a first step in establishing national performance indicators that describe certain components of the Canadian health care system and promote the use of this information for policy development and evaluation. The report also reveals the need for a renewed commitment by ministries and health regions/hospitals to the MIS Guidelines and compliance with national CMDB reporting standards. More than half of the provincial/territorial data submissions to this report have been rated with a warning that data can only be used with major restrictions, and as a result, readers should be cautioned when interpreting the results of this report.

[1] Exceptions in this report include Quebec and Saskatchewan. Saskatchewan implemented the MIS Guidelines beginning April 1,2002. Quebec has implemented provincial reporting standards that are mapped to the MIS Guidelines.

Financial Performance Indicators

The use of financial performance indicators to understand the hospital system in Canada is in its infancy. While several provinces have initiated or carried out performance measurement projects independently, a cohesive national picture is lacking. The aim of this report is to initiate a process to develop a national view of hospital financial performance across provinces and territories. For this report, 11 indicators of financial performance were selected to form this starting point.

At a high level, the selected indicators aim to measure the following concepts: financial viability, liquidity, corporate efficiency, deployment of human resources, capital asset management, and cost of hospital outputs. Indicators are provided at the regional level, but provincial/territorial weighted average values are used for the analysis. The indicators selected for inclusion in this report are:

Indicator	2000–2001 Average	1999–2000 Average	Unit of Analysis[2]
Total Margin	0.8%	1.4%	Legal Entity
Current Ratio	1.04	1.02	Legal Entity
Administrative Expense as a Percentage of Total Expense	8.3%	6.9%	Legal Entity
Information Systems Expense as a Percentage of Total Expense	1.8%	1.8%	Legal Entity
Cost per Weighted Case	$3,001	$3,141	Hospital
Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked Hours	62.0%	61.4%	Hospital
Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case	35.9	38.2	Hospital
Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case	1.1	1.4	Hospital
Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case	2.0	2.3	Hospital
Pharmacy Unit-producing Personnel Worked Hours per Weighted Case	1.9	2.1	Hospital
Average Age of Equipment	9.5	9.7	Legal Entity

[2] Hospitals in Canada operate under a variety of legal organizations. In some provinces hospitals are included under the legal umbrella of a heath authority and in other provinces the hospital itself is the legal entity. For further discussion on unit of analysis see the Methodological Notes.

Conclusions

Decision-makers and health care stakeholders need hospital financial performance measures to assess performance of the system and to ensure its long-term viability. This report contributes to hospital financial performance measurement in Canada by testing the feasibility of calculating system-wide measures of financial performance using data from the Canadian MIS Database. Data quality issues and gaps in the data contained in the CMDB make reporting on these indicators problematic.

In order to produce more meaningful information in the future, it is important that CIHI, hospitals, regions and provincial governments work collaboratively on improving the overall quality of data reported to provincial/territorial databases and to the Canadian MIS Database. In recent years, some data quality improvements have occurred; however, this report reveals that more work is required. The extent of data quality issues varies across provinces and territories.

Recommendations

1. CIHI, the ministries of health, and health regions/hospitals should continue to work collaboratively to improve the quality of the financial and statistical data reported to the Canadian MIS Database by:
   - Requiring the use of the MIS Guidelines as the standard for the collection of data.
   - Submitting standardized financial and non-financial data, according to the CMDB minimum reporting requirements. Where possible, additional detailed data would be desirable to facilitate more detailed analysis.
   - Submitting data by the annual reporting deadline in order to improve the relevance of indicator comparisons.

2. A review should be carried out of the general methodology contained in this report in order to seek improvement, clarity and consistency of reported indicator values.

3. Indicator values at the regional level should continue to be reported on an annual basis.

Acknowledgments

It is only through the contribution of many individuals and organizations that the production of *Canadian MIS Database, Moving Toward the Reporting of Hospital Financial Performance Indicators, 1999–2000 and 2000–2001*, is possible. The Canadian Institute for Health Information (CIHI) expresses its gratitude to the:

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Introduction

Part of the mandate of the Canadian Institute for Health Information (CIHI) is to provide and coordinate the provision of accurate and timely data and information required for effectively managing the Canadian health system. CIHI tracks financial and statistical information about hospitals and health regions in the Canadian MIS Database (CMDB), which provides comparable information across the country that can be used, among other things, to evaluate health care services. The data collected in the CMDB is structured according to the national data standard, *Guidelines for Management Information Systems in Canadian Health Service Organizations* (MIS Guidelines), a standardized framework for collecting and reporting financial and statistical data on the day-to-day operations of health service organizations. These standards have been implemented in most provinces and territories across Canada.[3]

Understanding how hospital financial information changes over time is critical to evaluating hospital performance. *Moving Toward the Reporting of Hospital Financial Performance Indicators,* investigates the feasibility of using data from the CMDB to report on regional level hospital financial performance in 1999–2000 and 2000–2001. CIHI intends to update the information in this report to monitor the ongoing feasibility of using data from the CMDB in the future.

Two advisory groups with members representing primarily provincial and territorial governments guide the MIS Guidelines and the Canadian MIS Database. Membership of the MIS Strategic Steering Committee includes senior financial officers from regional health authorities, provincial and territorial governments; officials from Health Canada; and members from academia. A working group of the Strategic Steering Committee provided guidance and expertise in the identification of the indicators in this report. The indicators were selected from a list of 42 measures drawn from a broad review of research and literature. In June 2001, the Strategic Steering Committee reviewed the list of indicators and assisted in identifying the most relevant ones for national reporting. The criteria used in the selection process were the following:

- Can the indicator be clearly defined?
- Is the purpose of the indicator easily understood?
- Is the indicator a valid measure?
- Is the indicator policy and/or management relevant?
- Is the data required to calculate the indicator readily available and of good quality?

[3] Saskatchewan implemented the MIS Guidelines beginning April 1,2002. Quebec has implemented their own provincial reporting standards; data are mapped to the MIS Guidelines accounts.

The indicators that were deemed to satisfy the above criteria and are included in this report are:

- Total Margin
- Current Ratio
- Administrative Expense as a Percentage of Total Expense
- Information Systems as a Percentage of Total Expense
- Cost per Weighted Case
- Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked Hours
- Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case
- Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case
- Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case
- Pharmacy Unit-producing Personnel Worked Hours per Weighted Case
- Average Age of Equipment

There were other indicators identified by the Strategic Steering Committee for which values could not be calculated. Changes have been made to the MIS Guidelines for 2003 so that these indicators can be reported in future years. These indicators include:

- Average Age of Information Systems Equipment;
- Cost of Equipment Additions for the Year as a Percentage of Total Cost of Property Plant and Equipment; and
- Cost of Information Systems Equipment Additions for the Year as a Percentage of Total Cost of Property Plant and Equipment.

Once the indicators were selected, the MIS Guidelines Technical Working Group—the second of the two advisory groups—provided feedback and suggestions for improvements, which were generally incorporated.

Provincial and territorial data submitted to the CMDB is reviewed for quality using the processes described in the Methodological Notes section of this report. Table 26 lists the data quality assessments that have been assigned to each province and territory by applying CIHI's data quality framework. More than half of the provincial and territorial data submissions have been rated with a warning that data can only be used with major restrictions, and as a result, readers are cautioned when interpreting the results of this report.

Because of this, it is important to note that this report should not be treated as a benchmarking study or a balanced scorecard. Rather, it should be viewed as a first step in establishing national performance indicators that describe certain components of the Canadian health care system and promote the use of this information for policy development and evaluation. The report also reveals the need to improve the quality of

financial and statistical data reported to the CMDB by health service organizations in Canada. It points to the need for an ongoing commitment by ministries of health, health regions, hospitals and functional center managers to consistently apply the MIS Guidelines and to comply with national CMDB minimum reporting standards.

Several organizations, including CIHI, have produced or collaborated on reports that include financial performance indicators that are similar to those found in this report. Examples include reports by provincial ministries of health, *CIHI/Hay Group Benchmarking Comparison of Canadian Hospitals,* and *Hospital Report 2002: Acute Care*.[4] As the specific purpose of each report differs, the methodologies used to calculate similarly named indicators may not be the same from report to report. Readers need to be mindful of the different methodologies when deciding which indicator values best fit their needs. The methodologies used to calculate the indicators in this report are explained in the Methodological Notes section of the report. For additional information please contact CMDB staff at CIHI by phone 613-241-7860, fax 613-241-8120 or e-mail cmdb@cihi.ca.

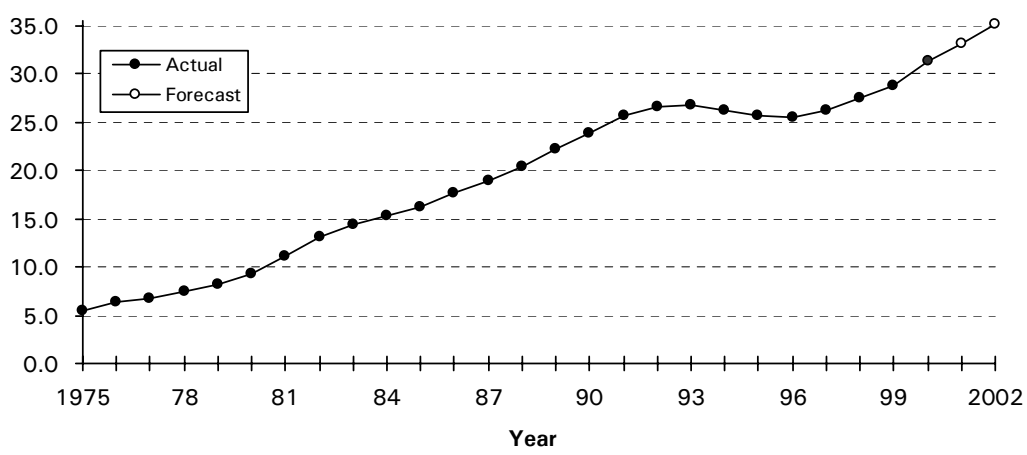
[4] *Hospital Report, Acute Care, 2002* is collaboration between the Ontario Hospital Association, the Ontario Government, the University of Toronto and the Canadian Institute for Health Information.

Section 1: Hospitals in Canada

Total Hospital Expenditure

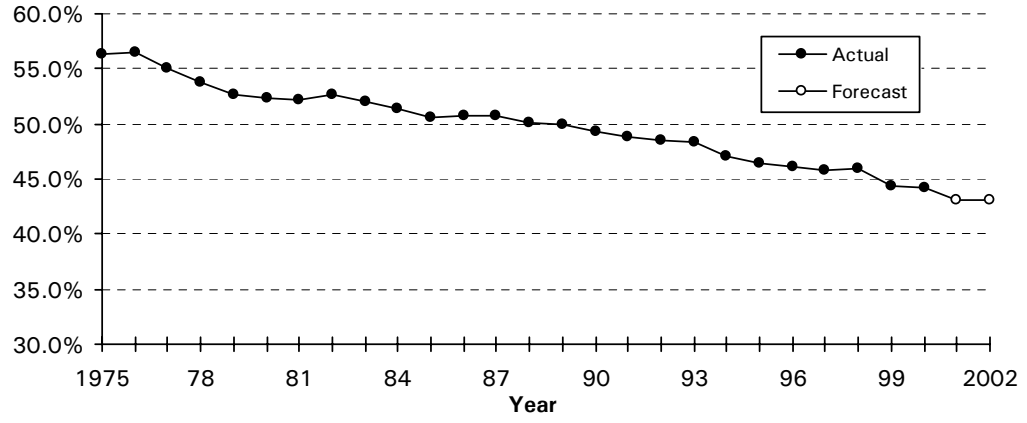
Through the course of the 1990s, Canada's health care system has undergone changes. Figure 1 shows that since 1985 there has been a steady increase in hospital spending, except for a decline in the mid-nineties (1994 to 1996). While the amount of money spent on hospitals tends to increase every year, Figure 2 shows that hospitals' overall share of total provincial government spending on health is declining.

Figure 1—Total Hospital Expenditure, Canada, 1975 to 2002



Source: Canadian Institute for Health Information

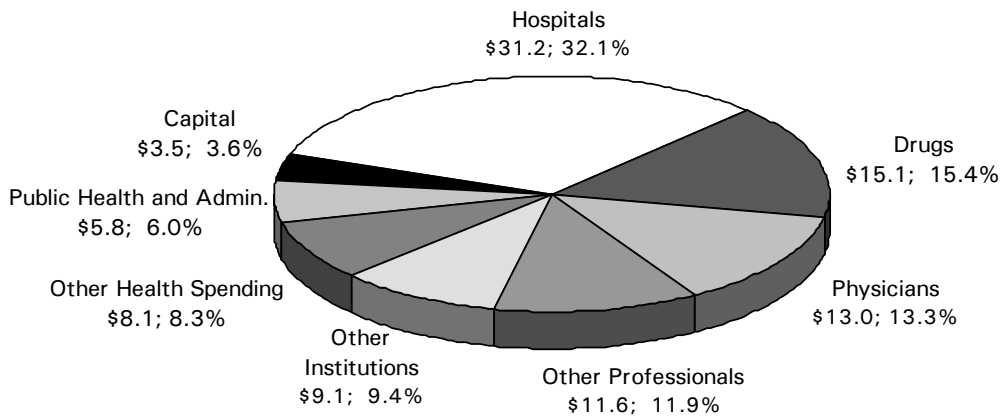
Figure 2—Hospitals' Share of Total Provincial/Territorial Government Health Expenditure, Canada, 1975 to 2002



Source: Canadian Institute for Health Information

Hospitals have traditionally occupied a prominent place in health care provision; however, the past three decades has seen relatively less spending on hospitals. In 1975, hospitals accounted for approximately 56% of provincial government health expenditure. By the end of 2002, this share was approximately 43%, a decline of 13% (see Figure 2). In 2000, Canada spent $31.2 billion on hospitals, accounting for 32.1% of total health expenditure (see Figure 3).

Figure 3—Total Health Expenditure by Use of Funds, Canada, 2000
($' billions)



Source: Canadian Institute for Health Information

Section 2: System Characteristics

Table 1 illustrates how provinces and territories have chosen to organize and manage hospitals.[5]

Hospital services are delivered through a variety of organizational structures. Some hospitals serve small rural communities, while others are much more specialized and may have affiliations with academic institutions. Tables 4 to 6 provide a breakdown of the hospitals in operation between 1995–1996 and 2000–2001.

Almost all hospitals in Canada operate as public not-for-profit entities. Public hospitals can be owned by a voluntary lay group, religious organization, a city, county, municipality or other municipal government, by regional or district authorities or by a branch, division, agency or department of a provincial or territorial government.

There are relatively few private hospitals in Canada. There were 14 privately owned hospitals and 9 federally owned hospitals in 2000–2001. Combined, these 23 hospitals represent only 3% of all Canadian hospitals.

Table 1. Number of Hospital and Regional Organization Structures, by Province and Territory, 2000–2001 and 1999–2000

Province/ Territory	Type of Organization	2000–2001 Organizations	1999–2000 Organizations
N.L.	Regional Health Boards and Corporations	8	8
P.E.I.	Regional Health Authorities	5	5
N.S.	District Health Authorities	10	8
N.B.	Regional Hospital Corporations	8	8
Que.	Boards	18	18
Ont.	Hospitals	188	198
Man.	Regional Health Authorities	12	12
Sask.	District Health Boards	32	32
Alta.	Regional Health Authorities	19	19
B.C.	Regional Health Boards	17	17
	Community Health Councils	34	33
Y.T.	Hospitals	2	2
N.W.T.	Hospitals	5	5
Nun.	Hospitals	1	1

Source: Canadian Institute for Health Information

[5] In January 2000, Nova Scotia replaced its 9 District Health Boards with 4 Regional Health Authorities. Saskatchewan announced plans to replace its 32 District Health Boards with 12 Regional Health Authorities. In December 2001, the British Columbia government replaced its previous regional structure with 5 Regional Health Authorities, 1 Provincial Health Services Authority and 15 Health Service Delivery Areas. Manitoba decreased its regional health authorities from 12 to 11 in July 2002. Alberta reduced the number of its health regions from 17 to 9 effective April 1, 2003.

Hospital Restructuring

The number of facilities that provide hospital care have remained fairly constant however regionalization, hospital mergers and amalgamations brought about by restructuring have in general created fewer, but larger, legal entities that administer Canada's hospital facilities. Table 2 shows that from 1995–1996 to 2000–2001, 169 hospitals previously included in the List of Hospitals were combined into 59 new legal entities due to mergers and amalgamations for a net reduction in the number of hospitals reporting to the CMDB of 110. However, although the number of reporting entities has fallen, most of the 169 predecessor hospital facilities still remain open. Table 3 illustrates the impact in the number of hospital beds over the same period.

Table 2. Changes in the Number of Hospitals in Canada, 1995–1996 to 2000–2001

Fiscal Year	Operating Hospitals	Removed due to Mergers and/or Amalgamations[a]	Added due to Mergers and/or Amalgamations[b]	Net Change due to Mergers and/or Amalgamations[c]	Out of Scope[d]	Closed[e]	Opened[f]
1995–1996	978	-38	12	-26	-45	-26	5
1996–1997	886	-34	15	-19	-20	-8	2
1997–1998	841	-22	9	-13	-3	-10	3
1998–1999	818	-48	17	-31	-3	-5	1
1999–2000	780	-15	4	-11	-3	-4	0
2000–2001	762	-12	2	-10	-6	0	0
Change from 1995–1996 to 2000–2001		**-169**	**59**	**-110**	**-80**	**-53**	**11**

Source: Canadian Institute for Health Information

Notes:

[a] When two or more hospitals merge/amalgamate into one larger hospital, all of the pre-merger/amalgamation legacy hospitals are removed from the CMDB hospital list. This column does not represent hospitals that have been permanently closed.

[b] After a merger/amalgamation the new larger hospital is added to the CMDB list of hospitals.

[c] This represents the reduction in the number of hospitals reporting to the CMDB, not a reduction in the number of facilities that continue to provide hospital services.

[d] Hospitals previously included, and switched to either a nursing station, walk-in or out-patient clinic, retirement/nursing home, ambulatory care unit, home care organization or health services for mandatory correctional services.

[e] This column includes hospitals that have been permanently closed.

[f] The Open column is the number of new hospitals that have been open which are not as a result of a merger/amalgamation.

Table 3. Changes in the Number of Approved Hospital Beds in Canada, 1995–1996 to 2000–2001

Fiscal Year	Operating Beds	Beds Closed During Mergers and/or Amalgamations[a]	Beds Out of Scope[b]	Permanent Bed Closures[c]	Reduction of Beds Staffed and in Operation[d]	Opened[e]
1995–1996	147,071	-2,226	-3,781	-635	-4,931	1,066
1996–1997	136,564	-404	-1,755	-1324	-1,413	1,570
1997–1998	133,238	-1,166	-56	-947	-4,513	616
1998–1999	127,172	-1,347	-1,015	-317	-6,164	34
1999–2000	118,363	-1,032	-404	-230	727	0
2000–2001	117,353	-1,719	-565	-101	0	0
Change from 1995–1996 to 2000–2001		**-7,894**	**-7,576**	**-3,554**	**-16,294**	**3,286**

Source: Canadian Institute for Health Information

Notes:

[a] These bed reductions are the difference between the total beds within the new merged/amalgamated hospital and the sum of the pre-merged/amalgamated legacy hospitals.

[b] Hospital beds previously included, and switched to either a nursing station, walk-in or out-patient clinic, retirement/nursing home, ambulatory care unit, home care organization or health services for mandatory correctional services.

[c] Permanent bed closures usually occur when a hospital has been perminently closed. Permanent bed closures can also be the result of a hospital/provincial/territorial decision to make a permanent reduction in the number of beds in a hospital that continues to opperate.

[d] Hospitals still in operation that have decreased their current number of beds staffed and in operation.

[e] New beds that have been put into service, usually as a result of a new hospital being opened.

Table 4 shows changes in the number of hospitals by type of service from 1995–1996 to 2000–2001. Table 5 shows the number of hospitals in each province and territory from 1995–1996 to 2000–2001, and Table 6 shows the number of approved beds in each province and territory for the same period.

Table 4. Hospitals by Type of Service, 1995–1996 to 2000–2001

Type of Service	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001
General	326	304	286	278	266	260
General with Long-Term Care	457	449	431	420	407	397
Pediatric	8	8	8	8	6	6
Psychiatric—Short-Term	15	14	12	12	11	11
Psychiatric—Long-Term	29	26	26	27	25	23
Other Specialty	24	18	17	16	12	13
Rehabilitation	18	18	17	17	15	15
Extended Care/Chronic	62	46	42	38	37	36
Other	39	3	2	2	1	1
Total	**978**	**886**	**841**	**818**	**780**	**762**

Source: Canadian Institute for Health Information

Table 5. Number of Hospitals, by Province/Territory, 1995–1996 to 2000–2001

Province/ Territory	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001
N.L.	33	33	33	33	32	32
P.E.I.	7	7	7	7	7	7
N.S.	45	35	36	35	35	35
N.B.	31	31	30	30	30	30
Que.	164	142	111	107	99	96
Ont.	255	243	236	222	198	188
Man.	102	81	81	83	83	82
Sask.	84	82	78	76	74	72
Alta.	127	118	117	114	114	113
B.C.	118	104	103	103	100	99
Y.T.	5	4	3	2	2	2
N.W.T.	7	6	6	6	5	5
Nun.	N/A	N/A	N/A	N/A	1	1
Total	**978**	**886**	**841**	**818**	**780**	**762**

Source: Canadian Institute for Health Information

Table 6. Number of Approved Beds, by Province/Territory, 1995–1996 to 2000–2001

Province / Territory	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001
N.L.	2,919	2,582	2,580	2,558	2,451	2,409
P.E.I.	515	515	493	493	494	494
N.S.	4,048	3,350	3,457	3,461	3,461	3,400
N.B.	4,199	4,199	4,199	4,059	4,014	4,014
Que.	46,701	40,592	39,119	39,289	32,036	33,171
Ont.	43,892	41,323	39,797	36,350	35,303	35,268
Man.	5,569	5,154	5,154	5,079	5,086	5,075
Sask.	7,093	6,967	6,764	4,262	4,279	3,919
Alta.	12,413	12,575	12,483	12,435	12,242	11,380
B.C.	19,303	18,909	18,829	18,839	18,616	17,874
Y.T.	126	110	75	59	59	61
N.W.T.	293	288	288	288	288	254
Nun.	N/A	N/A	N/A	N/A	34	34
Total	**147,071**	**136,564**	**133,238**	**127,172**	**118,363**	**117,353**

Source: Canadian Institute for Health Information

Hospital Financial and Statistical Data

Tables 7 through 21 provide an overview of health region/hospital financial and statistical data for fiscal years 1999–2000 and 2000–2001. Tables 7 through 14 show expenses and statistics by province and territory while tables 15 through 21 compare expenses and statistics by peer group.

Table 7. Total Hospital and Health Region Expense Net of Recoveries and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Hospital Expense Net of Recoveries		Number of Hospitals Reporting Expenses and Percentage of Provincial Total Number of Hospitals			
	2000–2001 Dollars	1999–2000 Dollars	2000–2001 Number	2000–2001 Percent	1999–2000 Number	1999–2000 Percent
N.L.	647,097,916	593,594,232	30	94	29	91
P.E.I.	103,380,682	98,148,168	7	100	7	100
N.S.	996,167,336	989,687,573	35	100	35	100
N.B.	885,010,467	852,031,279	30	100	30	100
Que.	6,728,646,935	6,325,895,257	85	89	87	88
Ont.	10,782,930,822	9,831,125,294	166	88	179	90
Man.	1,518,926,035	1,149,226,680	82	100	83	100
Sask.	965,583,087	1,284,309,954	55	75	63	85
Alta.	3,191,364,998	2,754,381,756	105	93	99	87
B.C.	5,573,064,110	4,902,001,652	91	92	89	89
Y.T.	20,708,302	19,552,767	1	50	1	50
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**31,412,880,690**	**28,799,954,612**	**687**	**90**	**702**	**90**

Source: Canadian Institute for Health Information

Note: N/A = data not available

Table 7 illustrates that hospital and health region expenses reported to the Canadian MIS Database rose over a two-year period. Expenses increased from $28.8 billion in 1999–2000 to $31.4 billion in 2000–2001. The number of reporting hospitals in this table and subsequent tables refers to the number of hospitals that have reported financial/statistical data to the CMDB. In 2000–2001, there were 762 hospitals included in the List of Hospitals. Included as well, is the percentage of reporting hospitals to the total number of hospitals in each province.

Of particular note is that the percentage of hospitals reporting in Saskatchewan decreased by 7% since 1999–2000, while hospitals reporting in Alberta increased by 6%.

Internal recoveries have been netted against total expenses in order to eliminate the possibility of double counting expenses within an organization. For example, if an institution records the actual cost of clean linen in the linen functional centre and then allocates these costs to the consuming functional centres, the costs are recorded twice within the organization. Netting the recoveries removes the double counting.

Table 8. Global Funding and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Percentage Global Funding to Total Revenue		Number of Hospitals Reporting Global Funding and Percentage of Provincial Total Number of Hospitals			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Percentage	Percentage	Number	Percent	Number	Percent
N.L.	85.26	86.45	30	94	29	91
P.E.I.	N/A	N/A	N/A	N/A	N/A	N/A
N.S.	81.51	80.90	33	94	28	80
N.B.	80.98	84.55	30	100	30	100
Que.	89.57	90.07	85	89	87	88
Ont.	78.87	78.46	164	87	170	86
Man.	N/A	N/A	N/A	N/A	N/A	N/A
Sask.	87.73	72.54	40	55	46	62
Alta.	85.27	85.20	24	21	18	16
B.C.	82.15	81.46	60	61	56	56
Y.T.	82.91	86.06	1	50	1	50
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**83.09**	**82.72**	**466**	**61**	**464**	**59**

Source: Canadian Institute for Health Information

Note: N/A = data not available

Global funding is revenue arising from the provision of patient services that are the responsibility of the Ministry of Health of the province in which the health service organization is located, as distinct from the Provincial Health Insurance Plan. Revenue from this source will normally be in the form of operating grants.

Table 8 shows the average percentage of hospital revenue that provincial global funding represents of total hospital and health region revenue. The provinces shown as N/A either do not report all of their global funding in the appropriate account as is the case in Manitoba or do not report any global funding as in Prince Edward Island.

Table 9. Long-term Debt and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Long-term Debt		Number of Hospitals Reporting Long-term Debt and Percentage of Provincial Total Number of Hospitals			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Dollars	Dollars	Hospitals	Percent	Hospitals	Percent
N.L.	167,627,159	130,493,203	9	28	10	31
P.E.I.	N/A	N/A	N/A	N/A	N/A	N/A
N.S.	149,081,367	143,817,398	5	14	3	9
N.B.	3,849,836	4,828,138	1	3	1	3
Que.	1,350,719,547	1,362,541,732	77	80	80	81
Ont.	360,792,859	263,502,374	46	24	47	24
Man.	331,452,224	266,128,058	17	21	17	20
Sask.	65,382,664	69,263,348	1	1	3	4
Alta.	15,927,645	20,816,153	2	2	2	2
B.C.	83,150,763	66,162,980	13	13	16	16
Y.T.	N/A	N/A	1	50	1	50
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**2,527,984,064**	**2,327,553,384**	**171**	**22**	**179**	**23**

Source: Canadian Institute for Health Information

Note: N/A = data not available

Table 9 indicates that although only 171 hospitals in Canada reported having any long-term debt, the amount of long-term debt rose from $2,328 million to $2,528 million an increase of $200 million between 1999–2000 and 2000–2001.

Tables 10 through 14 explore levels of activity in hospitals across Canada. Expenses per type of activity provide important direct cost data for policy-makers, and can also promote standards for inter-provincial comparisons. Used in conjunction with population statistics, historical trends can be developed to provide indicators of service recipient growth/decline.

Tables 10, 11 and 12 illustrate some of the concerns related to data quality in the CMDB. Both ambulatory visits and emergency visits appear to have decreased over the past year. However, the number of hospitals reporting these statistics has also decreased indicating that fewer facilities have reported these statistics in 2000–2001. Since the number of facilities in Canada has not decreased materially in 2000–2001 it seems that the reduction in the number of visits reported is not a case of less visits being provided. The data suggests that some facilities that provide emergency and ambulatory care are not reporting their data to the CMDB properly.

Table 10. Ambulatory Care Services Visits and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Ambulatory Care Services Visits		Number of Hospitals Reporting Ambulatory Care Services Visits and Percentage of Provincial Total Number of Hospitals			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Number	Number	Number	Percent	Number	Percent
N.L.	146,316	919,559	6	19	23	72
P.E.I.	N/A	N/A	N/A	N/A	N/A	N/A
N.S.	379,461	1,412,336	10	29	25	71
N.B.	1,380,812	1,285,231	24	80	24	80
Que.	10,101,207	9,595,976	87	91	85	86
Ont.	14,888,715	14,591,604	157	84	170	86
Man.	1,274,541	1,197,301	80	98	80	96
Sask.	391,136	613,663	12	16	42	57
Alta.	4,048,726	3,605,045	99	88	93	82
B.C.	3,051,806	2,827,664	75	76	69	69
Y.T.	N/A	23,016	N/A	N/A	1	50
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**35,662,720**	**36,048,379**	**550**	**72**	**612**	**78**

Source: Canadian Institue for Health Information

Notes:
N/A = data not available

Ambulatory Care Services include Emergency, Day/Night Care, and Specialty/Private Clinics. Specialty/Private Clinic visits have not been shown separately.

Table 10 shows dramatic decreases in ambulatory care services visits for Newfoundland and Labrador, Nova Scotia and Saskatchewan. This decrease is a direct result of hospitals not reporting data to the CMDB that was included in 1999–2000 submissions. Prince Edward Island and the Territories have not included statistical reporting for either 2000–2001 or 1999–2000.

Table 11. Emergency Visits and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Emergency Visits		Number of Hospitals Reporting Emergency Visits and Percentage of Provincial Total Number of Hospitals			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Number	Number	Number	Percent	Number	Percent
N.L.	93,513	345,759	4	13	19	59
P.E.I.	N/A	N/A	N/A	N/A	N/A	N/A
N.S.	258,599	647,620	10	29	24	69
N.B.	816,636	825,621	24	80	23	77
Que.	2,963,593	2,886,687	71	74	72	73
Ont.	5,244,798	5,162,822	136	72	140	71
Man.	668,041	607,897	76	93	77	93
Sask.	247,757	434,905	11	15	37	50
Alta.	1,754,246	1,666,203	97	86	90	79
B.C.	1,554,042	1,476,831	66	67	64	64
Y.K.	N/A	20,236	N/A	N/A	1	50
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**13,601,225**	**14,074,581**	**495**	**65**	**547**	**70**

Source: Canadian Institute for Health Information

Note: N/A = data not available

Table 11 shows that completeness continues to be a data quality issue for the CMDB. Ambulatory care visits shown in Table 10 include Emergency Visits, yet almost every province shows a response rate for Emergency Visits in Table 11 that is lower than the response rates found in Table 10. The reason is that many health regions/hospitals report all ambulatory visits lumped together rather than providing detail by functional centre, as is the CMDB minimum reporting requirement.

Table 12. Day/Night Care Visits and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Day/Night Care Visits		Number of Hospitals Reporting Day/Night Care Visits and Percentage of Provincial Total Number of Hospitals			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Number	Number	Number	Percent	Number	Percent
N.L.	34,992	379,017	2	6	17	53
P.E.I.	N/A	N/A	N/A	N/A	N/A	N/A
N.S.	25,690	119,751	10	29	18	51
N.B.	86,315	45,623	7	23	9	30
Que.	342,942	313,001	61	64	61	62
Ont.	1,858,796	1,724,740	98	52	100	51
Man.	167,243	144,173	17	21	19	23
Sask.	29,444	23,886	5	7	7	9
Alta.	738,782	564,603	39	35	35	31
B.C.	258,483	268,704	38	38	35	35
Y.T.	N/A	N/A	N/A	N/A	N/A	N/A
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**3,542,687**	**3,583,498**	**277**	**36**	**301**	**39**

Source: Canadian Institute for Health Information

Note: N/A = data not available

Table 12 shows data problems that are similar to the concern raised about the counting of Emergency Visits. Day/Night Care Visits are included in the Ambulatory Care Visits count in Table 10 and should be reported under Day/Night Care functional centres. The results here show that this is not happening in all cases. All provinces have encouraged health regions/hospitals to increase the level of surgical cases that are performed in Surgical Daycare rather than admitting these cases as inpatients. The data in Table 12 does not support this because of poor reporting.

Table 13. Number of Inpatient Days and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Inpatient Days		Number of Hospitals Reporting Inpatient Days and Percentage of Provincial Total Number of Hospitals			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Number	Number	Number	Percent	Number	Percent
N.L.	68,724	476,472	8	25	27	84
P.E.I.	N/A	N/A	N/A	N/A	N/A	N/A
N.S.	922,899	1,030,509	24	69	24	69
N.B.	1,038,330	1,052,329	30	100	30	100
Que.	10,215,439	10,218,122	88	92	86	87
Ont.	10,863,068	11,352,660	165	88	179	90
Man.	1,405,437	1,422,800	81	99	81	98
Sask.	935,133	1,084,297	49	67	51	69
Alta.	2,136,617	2,535,086	95	84	91	80
B.C.	5,300,617	5,150,755	84	85	80	80
Y.T.	14,016	13,866	1	50	1	50
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**32,886,264**	**34,323,030**	**624**	**82**	**649**	**83**

Source: Canadian Institute for Health Information

Note: N/A = data not available

Table 13 shows a reduction in Inpatient Days of 4.2% in 2000–2001 compared to the previous year. This is explained in part by a decrease of 3.9% in the number of hospitals who reported this statistic. The number of inpatient admissions in Table 14 also decreased from the previous year. This can be explained in part by the number of hospitals reporting these data, reduction of the number of hospitals as well as a reduction in the number of approved beds.

Table 14. Number of Inpatient Admissions and Number of Hospitals Reporting, by Province/Territory, 2000–2001 and 1999–2000

Province/ Territory	Inpatient Admissions		Number of Hospitals Reporting Inpatient Admissions and Percentage of Provincial Total Number of Hospitals			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Number	Number	Number	Percent	Number	Percent
N.L.	9,371	9,761	8	25	7	22
P.E.I.	N/A	N/A	N/A	N/A	N/A	N/A
N.S.	93,501	107,645	24	69	24	69
N.B.	114,821	119,039	30	100	30	100
Que.	741,775	746,024	87	91	86	87
Ont.	1,166,396	1,172,650	163	87	176	89
Man.	137,496	140,364	80	98	81	98
Sask.	127,873	131,842	50	68	50	68
Alta.	316,522	315,955	102	90	96	84
B.C.	427,963	414,171	84	85	79	79
Y.T.	N/A	N/A	N/A	N/A	N/A	N/A
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A
Nun.	N/A	N/A	N/A	N/A	N/A	N/A
Total	**3,135,718**	**3,157,451**	**628**	**82**	**629**	**81**

Source: Canadian Institute for Health Information

Note: N/A = data not available

While this aggregated view provides a high level perspective of the hospital system, analysis by peer group often demonstrates that the mandate, size and teaching affiliation of hospitals has an impact on the type and cost of services provided.

Tables 15 through 22 present hospital financial and statistical data by hospital peer group. The peer groups are based on the number of hospital beds in community hospitals, except for pediatric and teaching hospitals each of which are shown as a separate peer group. For the purpose of these tables peer groups are:

- Less than 50 beds
- 50 to 99 beds
- 100 to 199 beds
- 200 to 299 beds
- 300 to 399 beds
- 400 beds and over
- Pediatric hospitals
- Teaching hospitals

A teaching hospital is defined as an institution that provides medical education programs, approved by the appropriate authorities, for the major clinical instruction in at least the medical disciplines of internal medicine and general surgery to undergraduate medical students in their final two years. For this report, hospitals that are both pediatric and teaching hospitals are categorized as pediatric.

Table 15 reports Hospital Expense Net of Recoveries, by Peer Group, to be $28.6 billon dollars for 2000–2001. Table 7 reports similar information but includes hospital portion of health region expenses by province for a total of $31.4 billion in 2000–2001. The database contains health region expenses but they are not distributed to individual hospitals, and as a result, health region expenses related to hospitals cannot be reported by peer group. This illustrates one of the data quality issues related to health regions. The MIS Guidelines require that regional expenses be allocated to hospitals within the region before data is submitted to CIHI. If this were the case, Hospital Expenses Net of Recoveries would be the same in both Table 7 and Table 15. Similar problems exist when reporting Revenue and Long-Term Debt.

Hospitals with more than 400 beds and teaching hospitals together account for $17.6 billion (61.5%) of the $28.6 billion of expenses reported to the CMDB in 2000–2001. This is an increase of 12% since 1999–2000 (Table 15). Not only did large hospitals and teaching hospitals report 61.5% of hospital expenses but they also reported 55.5% of all ambulatory care visits (Table 18), 57.4% of inpatient days (Table 21) and 55.0% of inpatient admissions (Table 22) in 2000–2001 as well.

Table 15. Hospital Expenses Net of Recoveries and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Hospital Expense Net of Recoveries		Number of Hospitals Reporting Expenses and Percentage of Total Number of Hospitals in Peer Group			
	2000–2001 Dollars	1999–2000 Dollars	2000–2001 Number	2000–2001 Percent	1999–2000 Number	1999–2000 Percent
Less than 50 beds	1,441,164,214	1,248,079,238	314	88	305	86
50 to 99 beds	1,441,325,166	1,388,003,129	100	90	111	90
100 to 199 beds	2,789,132,024	2,525,216,019	89	86	88	85
200 to 299 beds	2,583,919,781	3,078,841,116	48	84	61	95
300 to 399 beds	1,976,053,439	1,879,567,401	24	100	26	104
400 beds and over	6,280,043,091	5,063,108,709	50	94	47	98
Pediatric Hospitals	772,092,236	796,483,214	5	83	6	100
Teaching Hospitals	11,356,950,034	10,732,030,062	50	96	52	95
Total	**28,640,679,985**	**26,711,328,888**	**680**	**89**	**696**	**89**

Source: Canadian Institute for Health Information

Table 16. Total Revenue and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Total Revenue		Number of Hospitals Reporting Revenue and Percentage of Total of Number of Hospitals in Peer Group			
	2000–2001 Dollars	1999–2000 Dollars	2000–2001 Number	2000–2001 Percent	1999–2000 Number	1999–2000 Percent
Less than 50 beds	923,282,255	869,595,530	314	88	303	86
50 to 99 beds	1,141,625,218	1,120,613,808	99	89	112	90
100 to 199 beds	2,681,105,681	2,323,180,513	89	86	87	84
200 to 299 beds	2,417,995,673	2,926,140,515	48	84	59	92
300 to 399 beds	1,868,107,501	1,867,315,354	24	100	25	100
400 beds and over	5,485,420,584	4,441,413,765	50	94	46	96
Pediatric Hospitals	719,106,939	760,862,689	5	83	6	100
Teaching Hospitals	10,481,737,748	9,460,810,145	50	96	50	91
Total	**25,718,381,599**	**23,769,932,319**	**679**	**89**	**688**	**88**

Source: Canadian Institute for Health Information

Table 17. Long-term Debt and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Long-term Debt		Number of Hospitals Reporting Long-term Debt and Percentage of Total Number of Hospitals in Peer Group			
	2000–2001 Dollars	1999–2000 Dollars	2000–2001 Number	2000–2001 Percent	1999–2000 Number	1999–2000 Percent
Less than 50 beds	38,995,796	30,603,010	18	5	22	6
50 to 99 beds	80,523,544	42,531,318	22	20	19	15
100 to 199 beds	228,910,989	261,124,816	32	31	34	33
200 to 299 beds	306,165,188	282,257,073	27	47	30	47
300 to 399 beds	140,953,229	149,570,325	12	50	12	48
400 beds and over	607,157,885	522,406,234	28	53	28	58
Pediatric Hospitals	25,547,495	30,646,236	2	33	3	50
Teaching Hospitals	664,543,991	673,043,758	22	42	23	42
Total	**2,092,798,117**	**1,992,182,770**	**163**	**21**	**171**	**22**

Source: Canadian Institute for Health Information

Table 18. Ambulatory Care Services Visits and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Ambulatory Care Services Visits		Number of Hospitals Reporting Ambulatory Care Services Visits and Percentage of Total Number of Hospitals in Peer Group			
	2000–2001 Number	1999–2000 Number	2000–2001 Number	2000–2001 Percent	1999–2000 Number	1999–2000 Percent
Less than 50 beds	2,303,796	2,388,158	227	64	253	71
50 to 99 beds	2,510,422	2,593,576	86	77	97	78
100 to 199 beds	3,692,836	4,440,921	77	75	81	78
200 to 299 beds	3,718,940	4,315,345	48	84	58	91
300 to 399 beds	2,779,554	2,571,170	21	88	24	96
400 beds and over	6,804,404	5,658,211	46	87	44	92
Pediatric Hospitals	865,307	1,074,939	4	67	6	100
Teaching Hospitals	12,983,703	13,029,075	40	77	48	87
Total	**35,658,962**	**36,071,395**	**549**	**72**	**611**	**78**

Source: Canadian Institute for Health Information

Note:
Ambulatory Care Services include Emergency, Day/Night Care, and Specialty/Private Clinics. Specialty/Private Clinic visits have not been shown separately.

Table 19. Emergency Visits and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Emergency Visits		Number of Hospitals Reporting Emergency Visits and Percentage of Total Number of Hospitals in Peer Group			
	2000–2001 Number	1999–2000 Number	2000–2001 Number	2000–2001 Percent	1999–2000 Number	1999–2000 Percent
Less than 50 beds	1,837,463	1,798,671	214	60	235	66
50 to 99 beds	1,624,516	1,932,249	76	68	90	73
100 to 199 beds	1,952,860	2,174,070	62	60	68	65
200 to 299 beds	1,579,681	1,876,667	40	70	45	70
300 to 399 beds	1,220,759	1,073,884	20	83	21	84
400 beds and over	2,595,067	2,210,523	40	75	37	77
Pediatric Hospitals	245,407	287,821	4	67	6	100
Teaching Hospitals	2,541,714	2,720,696	38	73	44	80
Total	**13,597,467**	**14,074,581**	**494**	**65**	**546**	**70**

Source: Canadian Institute for Health Information

Table 20. Day/Night Care Visits and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Day/Night Care Visits		Number of Hospitals Reporting Day/Night Care Visits and Percentage of Total Number of Hospitals in Peer Group			
	2000–2001 Number	1999–2000 Number	2000–2001 Number	2000–2001 Percent	1999–2000 Number	1999–2000 Percent
Less than 50 beds	79,663	96,636	52	15	57	16
50 to 99 beds	213,669	131,354	36	32	40	32
100 to 199 beds	219,398	269,456	52	50	54	52
200 to 299 beds	391,451	487,691	39	68	48	75
300 to 399 beds	392,026	313,458	19	79	20	80
400 beds and over	777,587	679,812	37	70	33	69
Pediatric Hospitals	49,179	118,383	4	67	6	100
Teaching Hospitals	1,419,714	1,486,708	38	73	43	78
Total	**3,542,687**	**3,583,498**	**277**	**36**	**301**	**39**

Source: Canadian Institute for Health Information

Table 21. Number of Inpatient Days and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Inpatient Days		Number of Hospitals Reporting Inpatient Days and Percentage of Total Number of Hospitals in Peer Group			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Number	Number	Number	Percent	Number	Percent
Less than 50 beds	1,514,349	1,748,066	278	78	271	77
50 to 99 beds	1,718,803	2,100,050	92	83	107	86
100 to 199 beds	3,590,548	3,601,318	85	83	84	81
200 to 299 beds	4,026,502	5,105,451	49	86	60	94
300 to 399 beds	2,848,269	3,050,483	24	100	25	100
400 beds and over	9,436,367	8,957,469	47	89	45	94
Pediatric Hospitals	294,826	410,171	4	67	6	100
Teaching Hospitals	9,395,624	9,363,888	45	87	51	93
Total	**32,825,288**	**34,336,896**	**624**	**82**	**649**	**83**

Source: Canadian Institute for Health Information

Table 22. Number of Inpatient Admissions and Number of Hospitals Reporting, by Peer Group, 2000–2001 and 1999–2000

Peer Group	Inpatient Admissions		Number of Hospitals Reporting Inpatient Admissions and Percentage of Total Number of Hospitals in Peer Group			
	2000–2001	1999–2000	2000–2001		1999–2000	
	Number	Number	Number	Percent	Number	Percent
Less than 50 beds	196,597	181,747	282	79	268	76
50 to 99 beds	180,617	210,431	92	83	100	81
100 to 199 beds	363,292	371,555	84	82	82	79
200 to 299 beds	350,669	448,810	49	86	58	91
300 to 399 beds	264,801	275,931	24	100	25	100
400 beds and over	705,459	586,388	47	89	44	92
Pediatric Hospitals	49,823	64,520	4	67	5	83
Teaching Hospitals	1,011,546	1,020,983	45	87	47	85
Total	**3,122,804**	**3,160,365**	**627**	**82**	**629**	**81**

Source: Canadian Institute for Health Information

Tables 15 through 22 contain similar response rate issues that were shown in Tables 7 through 14. One of the six pediatric hospitals did not report any data for 2000–2001. Response rates for larger non-teaching hospitals and for teaching hospitals were also lower in 2000–2001 than in 1999–2000.

Section 3: Financial Performance Indicators

System characteristics provide a broad cross-section of descriptive data about the hospital system in 2000–2001. These characteristics outline the basic capacity and outputs of the system and the different methods of organization and delivery of hospital services by provincial and territorial governments. While these data are important to establish context, they do not aid in understanding how well the system is performing. In order to understand this issue, relative measures of performance (such as the indicators listed below) must be examined.

The use of financial performance indicators to understand the hospital system in Canada is in its infancy. While several provinces have initiated or carried out performance measurement projects independently, a cohesive national picture is lacking. The aim of this report is to initiate a process to develop a national view of hospital financial performance across provinces and territories. For this report, 12 indicators of financial performance were selected to form this starting point. Definitions and MIS Guidelines account codes used to produce these indicators are presented in the Methodological Notes section of this report.

From a high level, the selected indicators aim to measure the following concepts: financial viability, liquidity, corporate efficiency, deployment of human resources, capital asset management, and cost of hospital outputs. This section outlines the formula results and interpretation for each indicator. Although indicators are provided in Appendix A at the regional level, the provincial/territorial weighted average values are used for the analytical focus. Calculation of weighted averages is described in detail in the Methodological Notes. In addition, an overall average is also provided. The overall average for each indicator is the weighted average of those provinces reported for the indicator.

The indicators selected for inclusion in this report are:

Indicator	Unit of Analysis[6]
Total Margin	Legal Entity
Current Ratio	Legal Entity
Administrative Expense as a Percentage of Total Expense	Legal Entity
Information Systems Expense as a Percentage of Total Expense	Legal Entity
Cost per Weighted Case	Hospital
Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked Hours	Hospital
Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case	Hospital
Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case	Hospital
Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case	Hospital
Pharmacy Unit-producing Personnel Worked Hours per Weighted Case	Hospital
Average Age of Plant and Building	Legal Entity
Average Age of Equipment	Legal Entity

Indicators for several provinces in 1999–2000 and 2000–2001 are absent for a number of reasons. The Northwest Territories and Nunavut did submit data for fiscal years. Some of the indicators for Prince Edward Island could not be calculated because it did not submit any regional data.

[6] Hospitals in Canada operate under a variety of legal organizations. In some provinces hospitals are included under the legal umbrella of a heath authority and in other provinces the hospital itself is the legal entity. For further discussion on unit of analysis see the Methodological Notes.

Financial Viability—Total Margin

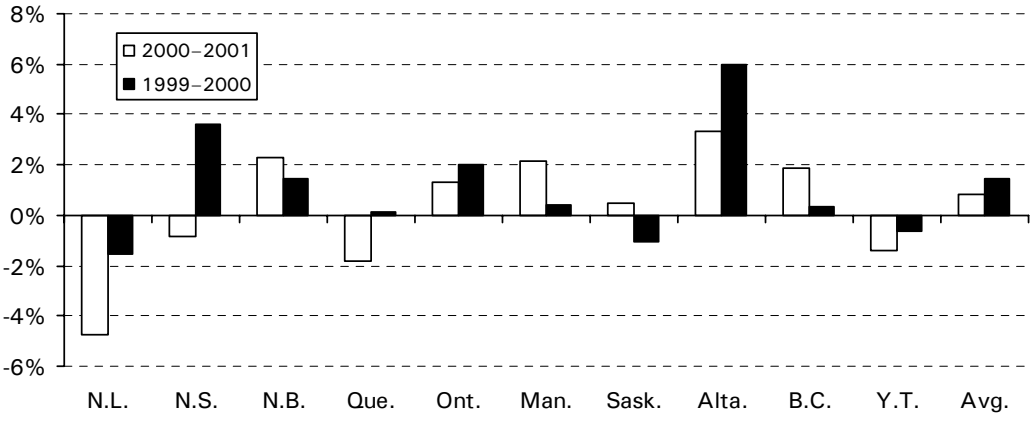
Total Revenues - (Total Expenses - Facility Amortization),
excluding research projects outside of operating fund

Revenues, excluding provincial health insurance plan, grant, donation,
internal recovery and externally-funded research revenues

Total Margin measures the extent to which hospital/health region revenues exceed expenses in a given year. A positive value indicates that revenues exceed expenses and a negative value indicates that expenses exceed revenue.

Of the 170 regions reported in Appendix A, 104 had a Total Margin that was greater than or equal to zero, 46 had a negative Total Margin and 20 regions either did not report the data required to calculate this indicator or had such unusual results that they were considered not reportable. Figure 4 shows the provincial averages for this indicator. The values by province show significant variation ranging from a high of 3.3% in Alberta to a low of –4.8% in Newfoundland and Labrador. In 1999–2000 these same two provinces also represented the high and low values. Alberta's Total Margin was 6.0% and Newfoundland and Labrador's Total Margin was –1.6% in 1999–2000. The negative total margin values for Newfoundland and Labrador indicate that, on average, health regions in that province have experienced expenses in excess of revenues for two straight years.

Figure 4—Total Margin, by Province/Territory,
2000–2001 and 1999–2000



Source: Canadian Institute for Health Information

It can be affected by individual provincial/territorial funding policies, management structure, management decisions and accounting policies. At least two provinces, Ontario and Quebec have included Total Margin as a financial performance indicator in provincial hospital scorecard reports.

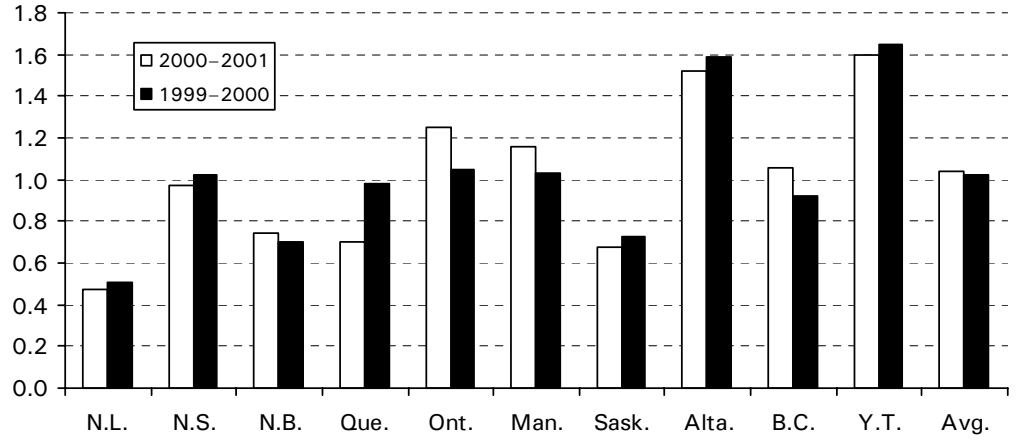
Liquidity—Current Ratio

$$\frac{\textit{Current Assets + debit Current Liability balances excluding deferred revenues}}{\textit{Current Liabilities, excluding deferred revenues + credit Current Assets, except Current Asset contra accounts}}$$

Current Ratio is a measure of how a hospital's or region's current assets and current liabilities are managed. A ratio of one or higher indicates that the organization has enough current assets to pay off its current liabilities over the course of a year. A ratio less than one calls into question the organizations liquidity and can hinder the delivery of quality patient care. Very high values for current ratio could indicate the need for better cash management since a long-term investment of excess cash will normally yield better returns.

The aggregate Current Ratio for the nine provinces and one territory reported in Figure 5 was 1.04 in 2000–2001. This suggests that hospitals in these provinces are being managed in such a way that their current assets are sufficient to liquidate current liabilities within a one-year period. This indicator shows some variability from province to province and region to region within provinces. This suggests that some jurisdictions are facing a liquidity challenge or that the Current Ratio reflects the timing of the receipt of provincial funding.

Figure 5—Current Ratio, by Province/Territory, 2000–2001 and 1999–2000



Source: Canadian Institute for Health Information

The interpretation of this indicator is less straightforward for Canadian hospitals than other industries. Most private sector organizations face substantial variations in their monthly cash flows due to fluctuating demand for their products or services, and other realities of operating in a marketplace. In contrast, hospitals receive a steady stream of global funding from the Ministry of Health; as a result, there is less need for cash; this is reflected in a lower average Current Ratio. Because of this, a Current Ratio of slightly less than one will not necessarily indicate a liquidity problem in the short run. However, it is conceivable that if this continues over a number of years a hospital will be prevented from exercising flexibility in its medium to long-term planning needs.

Corporate Efficiency

Administrative Services Expense as a Percentage of Total Expense

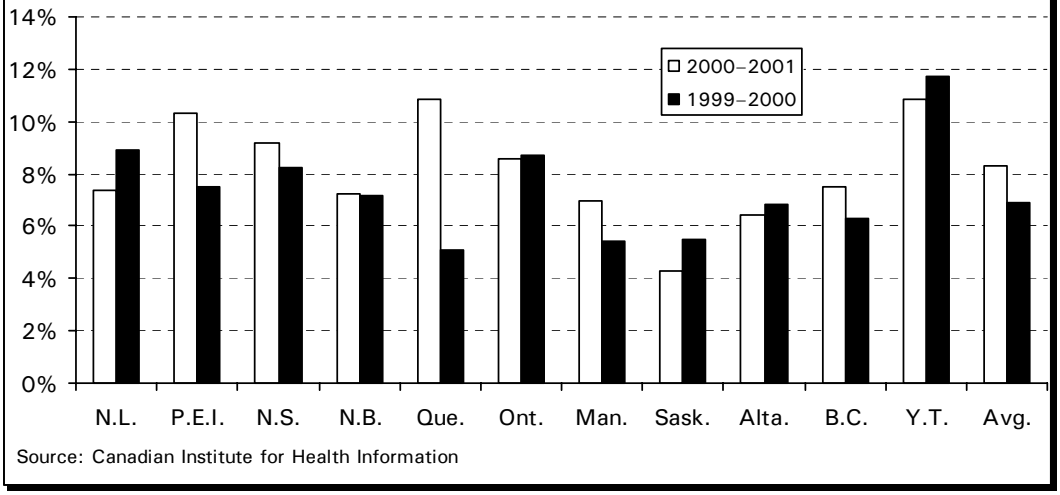
$$\frac{\textit{General Administration, Finance, Human Resources, Systems Support, and Communication Expenses, net of recoveries except cash discounts, and excluding medical compensation and all amortization}}{\textit{Total Expenses, net of recoveries and excluding medical compensation and all amortization}}$$

The percentage of total expense accounted for by administrative services is a measure of corporate efficiency. Administrative Services is defined by the MIS Guidelines to include Administration, Finance, Human Resources, Systems Support (IS) and Communications services.

A lower value indicates that fewer of the organization's resources were consumed through administrative activities so the organization can allocate more resources to areas such as patient care.

For the provinces included in Figure 6, 8.3% of hospital expenditure was for administrative services in 2000–2001 versus 6.9% in 1999–2000.

Figure 6—Administrative Services Expense as a Percentage of Total Expense, by Province/Territory, 2000–2001 and 1999–2000



Source: Canadian Institute for Health Information

Factors that affect spending on administrative services include complexity of care provided by the organization, management practice and structure, and, the size of the organization. Organizations that deliver very complex levels of care and very small organizations tend to spend a higher percentage of total expenses on administrative services.

Table 23. Administrative Services Expense as a Percentage of Total Expense, by Peer Group, 2000–2001

Peer Groups by Total Expense	Avg.	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
$ - - $5,615,000	**12.5**	-	8.3	-	-	-	-	-	4.2	-	12.7
5,615,001 - 9,100,000	**13.5**	-	8.0	-	-	-	-	11.8	8.3	-	9.2
9,100,001 - 14,400,000	**11.3**	-	-	-	-	-	-	-	11.1	-	13.7
14,400,001 - 21,200,000	**9.9**	-	-	-	-	-	-	11.4	3.1	11.0	11.2
21,200,001 - 31,000,000	**10.0**	-	-	-	-	-	-	-	1.9	9.4	7.9
31,000,001 - 44,200,000	**9.2**	-	-	-	7.4	-	-	6.4	2.8	9.8	7.2
44,200,001 - 61,100,000	**9.5**	9.4	-	-	9.2	13.7	-	7.3	5.3	6.0	6.0
61,100,001 - 98,000,000	**8.9**	8.5	10.8	5.5	6.7	12.5	-	6.3	0.5	8.9	-
98,000,001 - 163,000,000	**9.2**	9.1	-	8.0	7.0	11.9	9.4	7.9	-	6.0	10.9
163,000,001 - 1,900,000,000	**7.8**	5.7	-	10.2	7.6	10.8	8.6	6.7	8.7	6.2	7.2

Source: Canadian Institute for Health Information

Table 23 shows Administrative Services Expense as a percentage of Total Expense values for each province grouped by the amount of total expense. The peer groups used in this table are the decile ranking of each organization by total expense (each peer group will contain 10% of the 170 regions listed in Appendix C). The average across the provinces shows a decrease of 4.7 percentage points from the smallest regions (12.5%) to the largest regions (7.8%). The reason for variation among peer groups at the provincial level is less clear.

Note: Caution should be taken when comparing administrative expense indicator values for Quebec with those of other provinces. Quebec does not use the MIS Guidelines to account for hospital expenditures; instead their data is mapped to MIS accounts by CIHI. In some cases the mapping is not precise and some additional expenses that are not normally included as administrative expenses under the MIS Guidelines are included in the Quebec data making Quebec provincial and regional administrative values appear higher than those of other provinces.

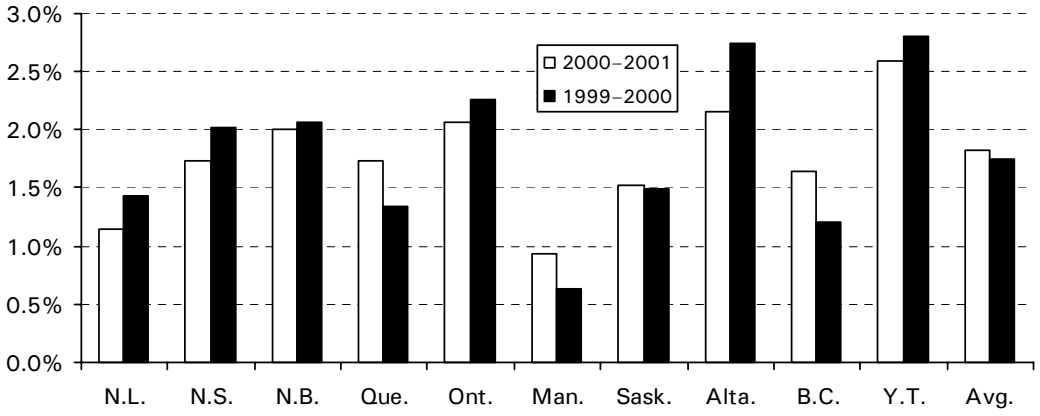
Information Systems Expense as a Percentage of Total Expense

$$\frac{\textit{Systems Support, net of recoveries except cash discounts, and excluding medical compensation and all amortization}}{\textit{Total Expenses, net of recoveries and excluding medical compensation and all amortization}}$$

Another measure of corporate efficiency is the percentage of total expenses that are spent on systems support functional centres. Information technology is fast becoming an integral part of the provision of health care in Canada. Measuring what is currently spent in this area allows stakeholders to make judgments about whether Canada is spending enough to support its information systems infrastructure.

Information Systems Expenses comprised 1.8% of total hospital expenses at the national level in 2000–2001 (variation in the results of this indicator at the provincial level strongly suggests data quality issues in the data being reported to the CMDB).

Figure 7—Information Systems Expense as a Percentage of Total Expense, by Province/Territory, 2000–2001 and 1999–2000



Source: Canadian Institute for Health Information

Changes have been made to the MIS Guidelines for 2003 that will improve the data required to calculate this indicator. These changes will clarify for health regions and hospitals exactly what expenses are defined as information system expenses. The changes include reporting information systems equipment expense in the Systems Support functional centre as well as clearer definitions for other expenses that comprise part of information systems expense.

Cost per Weighted Case

The Cost per Weighted Case (CPWC) indicator provides a measure of the financial cost a facility incurs (on average) for a single inpatient weighted case. It can be used as a standard for comparing facilities on cost efficiency.

$$\frac{\textit{Total Inpatient Costs}}{\textit{Total Inpatient Weighted Cases}}$$

The financial data used to calculate CPWC are from the CMDB. Weighted cases are obtained from the Discharge Abstract Database (DAD),[7] grouped using the 2000 version of CIHI's Case Mix Group (Complexity Overlay)[8] grouping methodology and include inpatient cases only. Surgical day care cases have not been included. The CPWC calculation is performed for facilities that have reported both financial and clinical data.

The cost calculation is based on obtaining the full cost of inpatient services, then dividing by the total weighted cases for each hospital. The total cost of inpatient services includes core acute care expenses, as well as the acute care portion of "shared" expenses such as administration but exclude physicians compensation paid by the health region/hospital and through provincial medical care plans. Costs associated with surgical day care have been removed. In regionalized provinces, adjustments are implemented to determine the acute care portion of expenses reported at the regional level.

Once facility values are calculated, a statistical trim is used to remove outlier values. Remaining facilities are grouped by province to determine a weighted provincial CPWC (Figure 8, Table 24).

Regions in Quebec and Manitoba do not report all cases to the Discharge Abstract Database. As a result, weighted cases are obtained from the Hospital Morbidity Database. Weighted case totals from the Hospital Morbidity Database tend to be slightly higher than weighted case totals obtained from the Discharge Abstract Database. Quebec and Manitoba values for CPWC may be understated relative to the values expressed for the other provinces. It should also be noted that although the Hospital Morbidity Database weighted cases were used in 2000–2001 to calculate some Quebec and Manitoba hospitals' values, they were not used in the calculation of the 1999–2000 values.

[7] The DAD is a national repository of demographic, administrative and clinical data on hospital discharges across Canada. CIHI receives data directly from participating hospitals.

[8] Following extensive consultation with experts in the field, at the time of printing it is believed that the 1999–2000 and 2000–2001 data have not been substantially affected by recent concerns regarding complexity that relate to more current data.

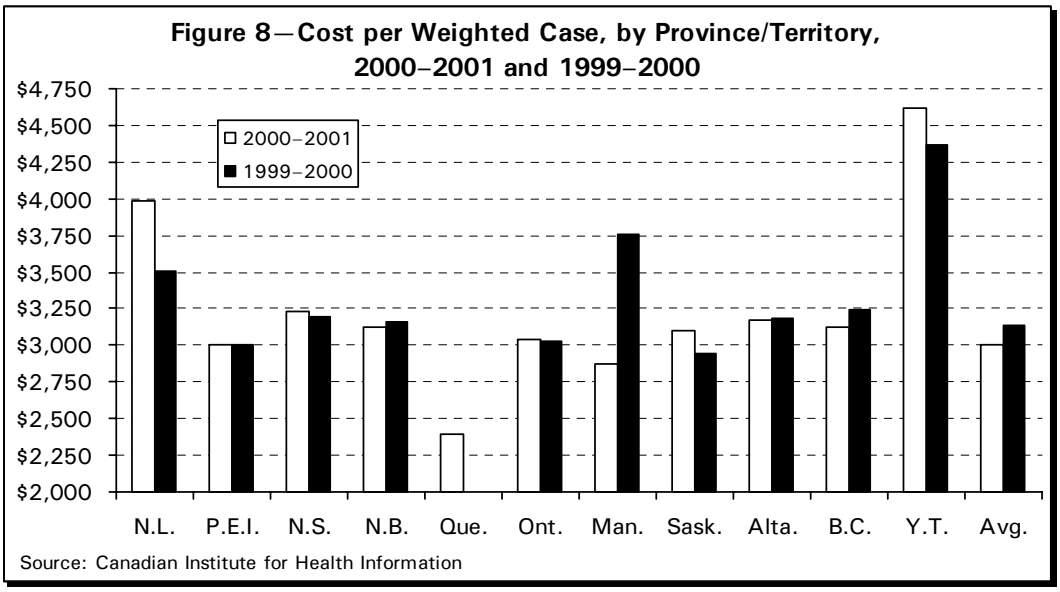


Table 24. Cost per Weighted Case, by Province/Territory, 2000–2001 and 1999–2000

	N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Avg.
2000–2001	3,985	3,003	3,229	3,118	2,395	3,043	2,870	3,096	3,166	3,130	4,616	3,001
1999–2000	3,507	3,000	3,191	3,164	---	3,027	3,762	2,946	3,186	3,249	4,370	3,141

Source: Canadian Institute for Health Information

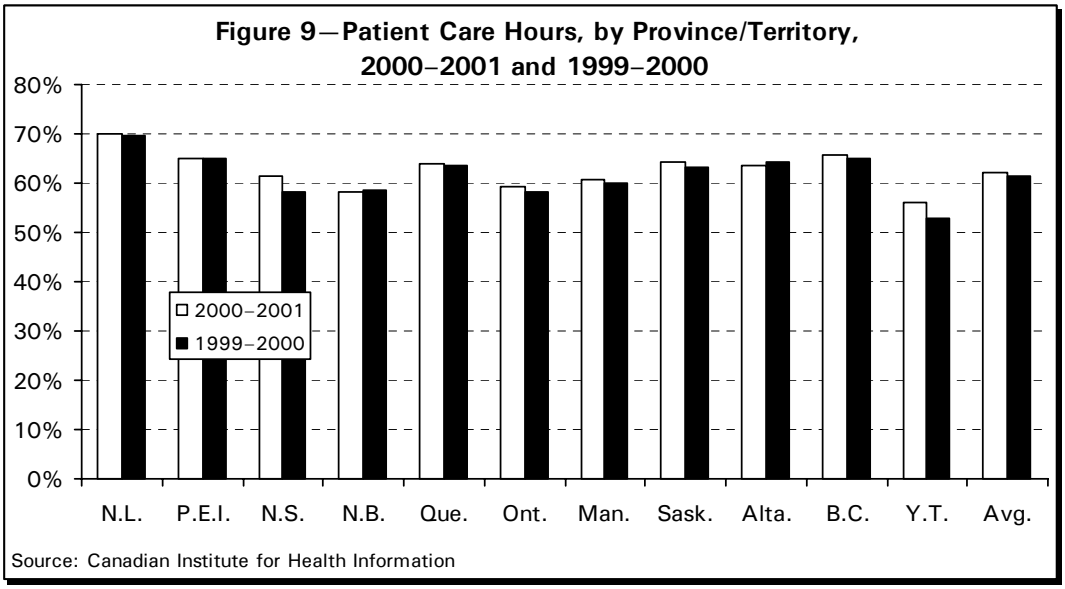
Deployment of Human Resources

Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked Hours (Patient Care Hours)

Inpatient Nursing, Ambulatory Care, and Diagnostic and Therapeutic Services Worked and Purchased Hours

Total Worked Hours, excluding medical personnel hours

The Patient Care Hours indicator is a measure of what percentage of total worked hours are deployed to patient care functional centres. Figure 9 shows that 62.1% of the 771 million worked hours reported by the provinces were available for patient care. Not all hospital staff's worked hours are spent on direct patient care. Some of those worked hours will be spent on other activities such as support and corporate services. A higher indicator value indicates more worked hours are spent on patient care and less are spent on support and corporate services. This indicator, however, should not be interpreted as a measure of the quality of patient care.



Worked Hours per Weighted Case

Worked Hours per Weighted Case provides information about the distribution of human resources to functional centres that provide patient care. To calculate these indicators, worked hours from the CMDB were combined with weighted cases from the CIHI Discharge Abstract Database (DAD).

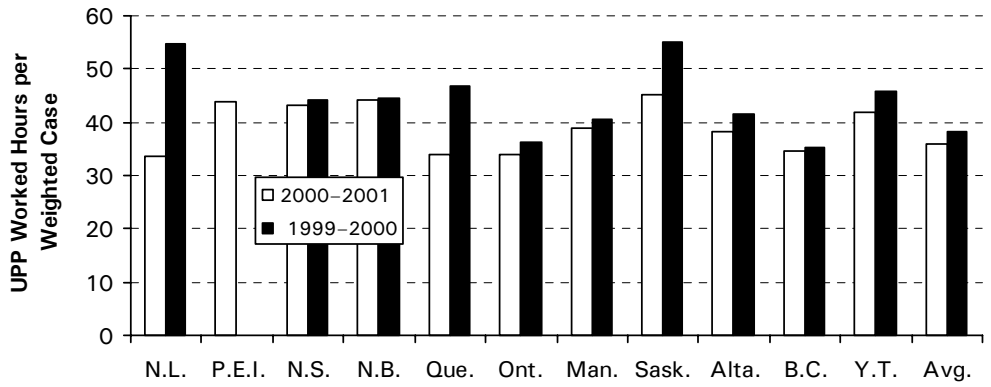
Inpatient Nursing Services Unit-producing Personnel Worked Hours per Weighted Case follows a similar distribution at the provincial level as that reported for Patient Care Hours. Inpatient Nursing Services account for the majority of care provided to patients in Canadian hospitals.

Diagnostic and Therapeutic Services provided to inpatients are represented by Diagnostic Services, Clinical Laboratory, and Pharmacy Unit-producing Personnel Worked Hours per Weighted Case. Worked hours for the diagnostic and therapeutic indicators have been adjusted to reflect inpatient activity determined by workload/activity statistics as outlined in the Cost per Weighted Case formula. These indicators provide some insight into the relative intensity of services that are being provided to inpatients.

Nursing Inpatient Services Unit-producing Personnel Worked and Purchased Hours (excluding Long-term Care)

Total Inpatient Weighted Cases

Figure 10—Nursing Inpatient Services UPP Worked Hours per Weighted Case, by Province/Territory, 2000–2001 and 1999–2000

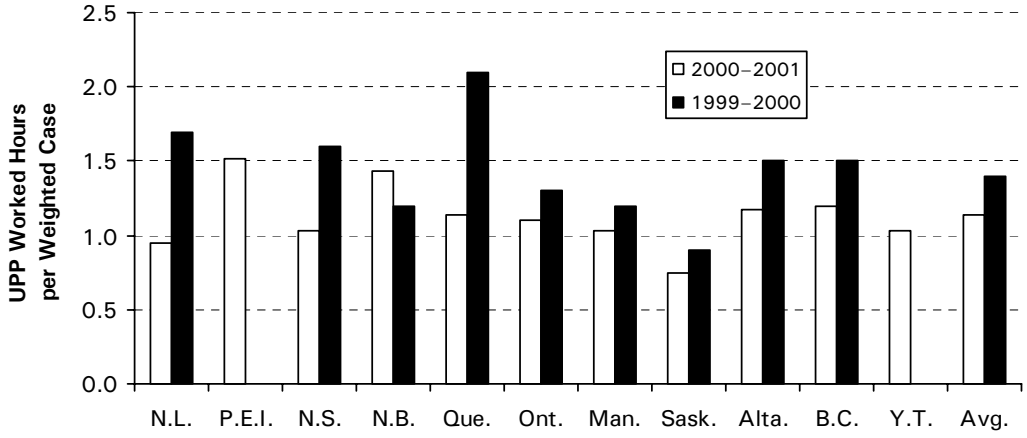


Source: Canadian Institute for Health Information

Diagnostic Services Unit-producing Personnel Worked and Purchased Hours (adjusted for inpatient activity)

Total Inpatient Weighted Cases

Figure 11—Diagnostic Services UPP Worked Hours per Weighted Case, by Province/Territory, 2000–2001 and 1999–2000

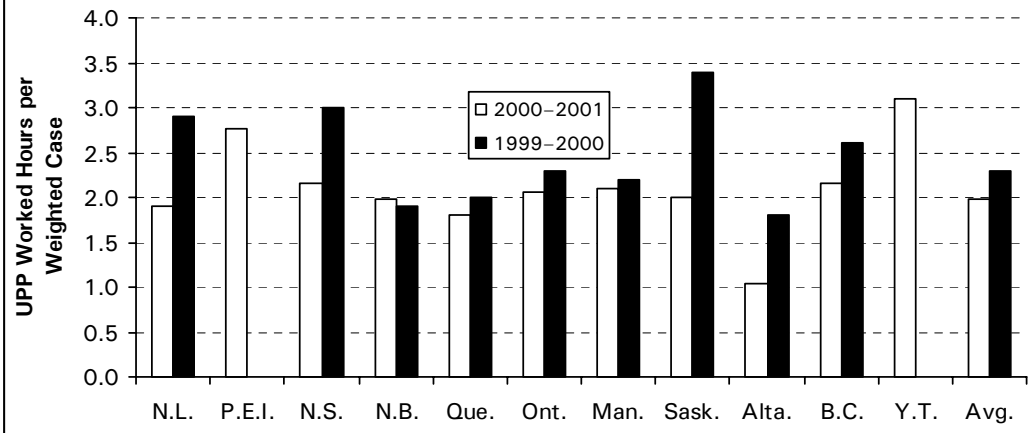


Source: Canadian Institute for Health Information

Laboratory Services Unit-producing Personnel Worked and Purchased Hours (adjusted for inpatient activity)

Total Inpatient Weighted Cases

Figure 12—Clinical Laboratory UPP Worked Hours per Weighted Case, by Province/Territory, 2000—2001 and 1999—2000

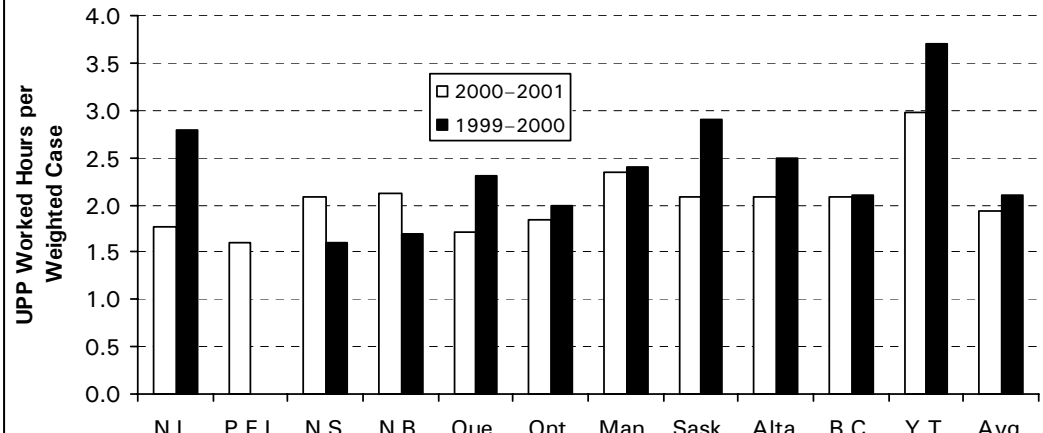


Source: Canadian Institute for Health Information

Pharmacy Unit-producing Personnel Worked and Purchased Hours (Adjusted for inpatient activity)

Total Inpatient Weighted Cases

Figure 13—Pharmacy UPP Worked Hours per Weighted Case, by Province/Territory, 2000–2001 and 1999–2000



Source: Canadian Institute for Health Information

Capital Asset Management

The MIS Guidelines for fiscal year 2000–2001 did not provide the detailed account structure for the collection of data on capital expenditures. However, the MIS Guidelines structure allows for the calculation of average age of plant/buildings and equipment. Based on this age, it is possible to infer whether or not capital assets are being replaced in a timely manner. However, issues with the quality of data and lack of reported data undermine the accuracy and usefulness of these important indicators. The 2003 MIS Guidelines have been enhanced to record data on current purchases of plant, buildings and equipment.

Average Age of Plant and Building

$$\frac{\textit{Accumulated Plant and Building Amortization (Distributed/Undistributed)}}{\textit{Plant and Building Amortization Expense (Distributed/Undistributed)}}$$

The Average Age of Plant and Building was 12.9 years in 2000–2001. This measure is counterintuitive, particularly when many communities have hospitals that are several decades or a century older. This indicator does not only measure the age of a building; rather it also measures the age of land improvements, building service equipment and building improvements that have been undertaken to upgrade the original structure to modern standards. After reviewing the results CIHI, in consultation with the provinces and territories, had strong concerns about this indicator. Consequently this indicator is not being included in the analysis either at the provincial/territorial level or at the regional level.

While hospital buildings may be, on average, older than 12.9 years, the inclusion of Land Improvements (such as parking lots), Building Service Equipment (such as elevators) and Leasehold Improvements as components of Plant and Building keep average age values low. Land improvements, building service equipment and leasehold improvements all have useful lives (between 2 and 25 years) that are less than buildings (40 years).

There are a series of data quality concerns related to this indicator that include the way that some hospitals account for these assets. Hospitals are reporting capital assets on their audited financial statements using Generally Accepted Accounting Principles (GAAP). However, not all hospitals are applying GAAP to the data within their accounting systems, as the MIS Guidelines require. The result is that data reported to CIHI from health regions and hospitals often exclude the appropriate amortization of capital assets needed to properly calculate this indicator. In addition, some hospitals are reporting their capital asset cost and accumulated depreciation as a net book value rather than as separate numbers.

Hospital buildings in Canada are generally amortized over a 40-year useful life but it is not uncommon for a hospital building to still be in use for a much longer period of time, well past the point when the asset has been fully amortized. When this does occur it creates large values that appear in the analysis as an outlier. Even though many Canadian hospital buildings are over 40 years old, most have undergone substantial renovations/restorations that further reduce the average age values. A building may be 100 years old on the outside, but far more modern on the inside.

Until some of these issues have been addressed or resolved, CIHI has chosen not to fully report this indicator at this time.

Average Age of Equipment

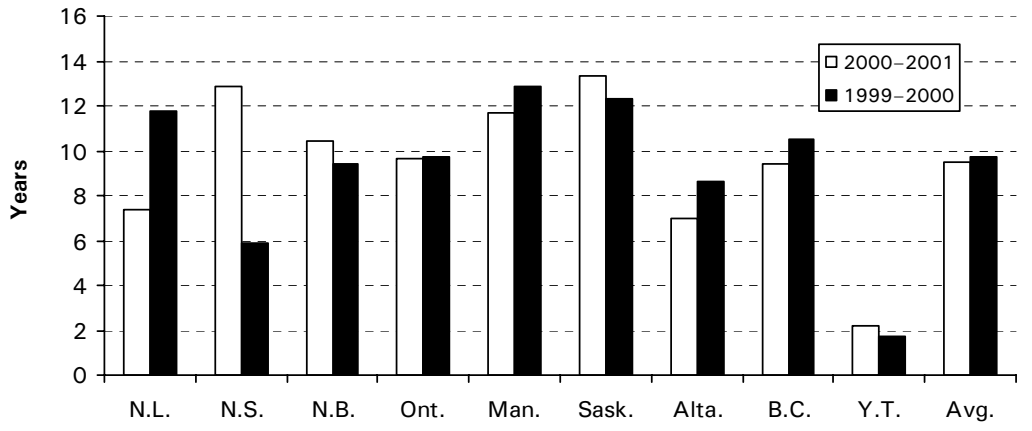
$$\frac{\textit{Accumulated Equipment Amortization (Distributed/Undistributed)}}{\textit{Equipment Amortization Expense (Distributed/Undistributed)}}$$

The Average Age of Equipment indicator is an average that does not reflect the diversity of equipment found in hospitals. Some equipment such as hospital beds are expected to have a useful life of up to 15 years while information systems equipment is expected to have a useful life of less than 5 years. Data quality problems caused by inconsistent application of the MIS Guidelines relating to capital assets limits the usefulness of what should be an important indicator of capital asset management.

Across Canada, the treatment of amortization of equipment does have an effect on the calculation of average age of equipment. Figure 14 shows an average value of 9.5 years. This may suggest a large investment in assets with a long useful life, but could just as easily suggest a need to replace equipment more quickly. Revisions to the 2003 MIS Guidelines will provide more detail in the types of reported equipment and will make this indicator more useful. For instance, data regarding a hospital's investment in information systems technology will be valuable for assessing a hospital's ability to stay current within a health care delivery system reliant in information systems. Beginning in fiscal year 2003–2004, hospitals will be required to report current year purchases of major equipment (excluding information systems equipment) and information systems equipment.

Prince Edward Island is not included in Figure 14 because they do not report regional balance sheets to the CMDB making it impossible to calculate a value for this indicator. Quebec is also not included since it does not report capital assets in its hospitals; all capital assets are considered to be owned by the province.

Figure 14—Average Age of Equipment, by Province/Territory, 2000–2001 and 1999–2000



Source: Canadian Institute for Health Information

Conclusions

Decision-makers and health care stakeholders need hospital financial performance measures to assess performance of the system and to ensure its long-term viability. This report contributes to hospital financial performance measurement in Canada by testing the feasibility of calculating system-wide measures of financial performance using data from the Canadian MIS Database. Data quality issues and gaps in the data contained in the CMDB make reporting on these indicators problematic.

In order to produce more meaningful information in the future, it is important that CIHI, hospitals, regions and provincial governments work collaboratively on improving the overall quality of data reported to provincial/territorial databases and to the Canadian MIS Database. In recent years, some data quality improvements have occurred; however, this report reveals that more work is required. The extent of data quality issues varies across provinces and territories. For some indicators (such as the Average Age of Plant and Buildings), data were suspect in all provinces. For other indicators data issues were specific to one or a few provinces.

In the development of this report, two very important issues regarding data quality emerged:

1. The quality of the data reported to the CMDB by provincial/territorial entities and used in this report is generally insufficient to allow meaningful inter-provincial/territorial comparison of hospital financial performance indicators calculated at a regional level.

2. There are many areas within the CMDB where data quality needs to be improved. CIHI and provincial/territorial reporting entities need to commit to the following:
   - proper recording and reporting of balance sheet related items;
   - submission of statistical data specified by the CMDB minimum reporting standard based on the MIS Guidelines, such as earned hours, workload, visits, attendance days, inpatient days and admissions;
   - allocation of regional shared and centralized services to hospital facilities needs to take place before the data is submitted to CIHI; and
   - application of generally accepted accounting principles to year-end data submissions supplied to CIHI, not just to audited financial statements.

3. CIHI must improve the understanding of the mapping relationships between the provincial charts of accounts and the MIS Guidelines.

There were some indicators identified by the MIS Strategic Steering Committee for which values cannot currently be calculated. Enhancements have been made to the MIS Guidelines for 2003 to specify the data that organizations need to collect so that the indicators can be reported in future years. These indicators include:

- Average Age of Information Systems Equipment;
- Cost of Equipment Additions for the Year as a percentage of Total Cost of Property Plant and Equipment; and
- Cost of Information Systems Equipment Additions for the Year as a percentage of Total Cost of Property Plant and Equipment.

Recommendations

1. CIHI, the ministries of health, and health regions/hospitals should continue to work collaboratively to improve the quality of the financial and statistical data reported to the Canadian MIS Database by:
   - Requiring the use of the MIS Guidelines as the standard for the collection of data.
   - Submitting standardized financial and non-financial data, according to the CMDB minimum reporting requirements. Where possible, additional detailed data would be desirable to facilitate more detailed analysis.
   - Submitting data by the annual reporting deadline in order to improve the relevance of indicator comparisons.

2. A review should be carried out of the general methodology contained in this report in order to seek improvement, clarity and consistency of reported indicator values.

3. Indicator values at the regional level should continue to be reported on an annual basis.

Appendix A

Methodological Notes

Methodological Notes

Introduction

The Canadian MIS Database (CMDB) contains financial and statistical information from hospitals, and limited data from health regions, across Canada. The data are collected according to a standardized framework for collecting and reporting financial and statistical data on the day-to-day operations of health service organizations. The framework is known as the *Guidelines for Management Information Systems in Canadian Health Service Organizations* (MIS Guidelines).

Currently, most information in the CMDB is specific to hospitals. A hospital is broadly defined as an institution where patients are accommodated on the basis of medical need and are provided with continuing medical care and supporting diagnostic and therapeutic services, and which is licensed or approved as a hospital by a provincial government, or is operated by the Government of Canada. This definition includes mental institutions. In provinces and territories where hospitals are part of a regional health authority, regional data is also submitted, providing a complete picture of health services for that region. Statistical data is also collected and includes for example, the number of earned hours, client visits, and beds staffed and in operation. Although the CMDB does not yet request data from all health service organizations such as long-term care facilities, community health centres or home care, the framework is in place to begin collecting this data beginning in April 2004.

In order to ensure the integrity and viability of its databases, the Canadian Institute for Health Information (CIHI) developed a data quality framework to provide all databases and registries with a common comprehensive strategy for evaluating and assessing data quality and identifying priorities for continuous quality improvement. The following information is extracted from the CMDB data quality evaluation and is designed to assist external users of the data to assess its utility. Additional information is available by contacting the CMDB section by phone at 613-241-7860, by fax at 613-241-8120 or by e-mail at cmdb@cihi.ca.

Concepts and Definitions

Mandate/Purpose

The CMDB records financial and statistical information based on a standardized chart of accounts, applying general accounting policies and procedures, workload measurement systems, service activity statistics and indicators that support management decision-making in health service organizations. The information in the CMDB can be used to cost the activities of health service organizations and forms the basis of management reporting including annual general purpose financial statements, financial ratio analysis and operational budgeting.

Population

The database includes financial and statistical information from most hospitals and health regions in Canada.

Variables and Concepts

The variables and concepts used to capture information in the CMDB are based on the *Guidelines for Management Information Systems in Canadian Health Service Organizations* (MIS Guidelines). The MIS Guidelines are a comprehensive set of standards used to report management information that is ultimately submitted to the CMDB and that is related to staffing, costs, workload and provision of services. The MIS Guidelines are designed to apply across the continuum of services, ranging from hospitals to community-based health service organizations, providing a framework to generate, maintain and analyze information required for effective decision-making, and accountability.

The main features of the MIS Guidelines are:

- a chart of accounts—the coding structure for the data that is applicable across different service delivery settings;
- accounting principles and procedures—to ensure consistency with generally accepted accounting principles contained in the Handbook of the Canadian Institute of Chartered Accountants (CICA);
- workload measurement systems—a time tracking management system that provides a standardized method of measuring output; and
- indicators—standardized ratios that demonstrate how the data can be used for planning, control and performance measurement.

Hospitals and health regions are expected to submit MIS Guidelines compliant financial and statistical data relating to hospital services to the CMDB. Health regions also submit other health service activities. All provinces and territories submit hospital data through their respective ministries of health.

The CMDB contains information about the health regions/hospitals that supply data. The information includes a unique institution number, the institution's name, address, type, size and ownership. The CMDB also contains data relating to the financial position (balance sheet) and operations of reporting organizations. Financial and statistical data are recorded by functional centre and by type of expense and revenue source. The functional centres correspond to the core activities carried out in the health service organization and include administrative and support services; ambulatory care services; community and social services; diagnostic and therapeutic services; education; nursing inpatient and resident services; and research. This information is based on the MIS Guidelines reporting standards.

Revenues by source and expenses by type are also recorded in the CMDB. Broad groups of expenses include compensation, supplies and sundries, equipment, referred-out services, and buildings and grounds expenses. The CMDB also records workload information that is used to measure the volume of activity provided by a specific functional centre in terms of a standardized unit of time.

Definitions

Administrative Services—These accounts are established to record expenses, statistics and revenues, if any, of functional centres that generally support administering the health service organization. They include Administration, Finance, Human Resources, Systems Support (IS) and Communications.

Ambulatory Care Services—The Functional Centre Framework Section pertaining to specialized diagnostic, consultative, treatment, and teaching services provided primarily for registered clients and their significant others. Access to these services is generally with a referral from a primary care practitioner or a specialist. These services are generally provided in a hospital setting.

Excludes:

- Services provided to Ambulatory Care patients by personnel who are accountable to and charged to Nursing Inpatient/Resident or Diagnostic and Therapeutic Services; or
- Primary care and supportive services (e.g. Public Health clinics, Home Care programs, Health Promotion/Education) provided to clients of Community and Social Services.

Ambulatory Care Services Visits—(MIS Primary Account 71 3* and MIS Statistical Secondary Accounts 416*, 418*) All visits by, or to service recipients, arranged with or without prior appointment or through a formal scheduling system, to the ambulatory care service functional centre.

Beds Staffed and in Operation—The beds and cribs available and staffed to provide services to inpatient/residents at the required type and level of service, at the beginning of the fiscal year. Includes bassinets set up outside the nursery and used for infants other than newborns

Chart of Accounts—A list of the account numbers and designations in a ledger.

Client—An individual

- who has been officially accepted by a health service organization and receives one or more health services without being admitted as an inpatient or a resident;
- whose person identifiable data is recorded in the registration or information system of the organization and to whom a unique identifier is assigned to record and track services; and
- who is not referred-in from another health service organization. Examples include individuals receiving services in ambulatory clinics, primary care clinics, in their homes, through day/night and outreach programs.

Client Visits—The visits by, or to service recipients, arranged with or without prior appointment or through a formal scheduling system, excluding inpatients and residents.

Community and Social Services—The Functional Centre Framework Section pertaining to the provision of health (e.g. primary care, prevention, wellness, etc.) and social services on an ambulatory/out-reach basis to individuals, groups and/or communities. Access to these services is typically self-determined. These services are considered the first level of contact for individuals, families, and communities with the health system.

Includes:
- Curative, restorative, supportive, disease prevention, and health promotion/ education services.

Excludes:
- Specialty services that are generally provided in an ambulatory care functional centre.

Compensation Expense—Compensation expense is the sum of gross salaries expense, benefit contribution expense, purchased compensation expense, and fee for service expense arising from the remuneration of management and operational support personnel, unit-producing personnel, and medical personnel employed by, or under contract to the health service organization.

Community Health Service Organizations—Organizations primarily engaged in providing health care services directly to clients in the community who do not require inpatient services. This includes organizations specializing in day treatment programs and in the delivery of home care services.

Diagnostic and Therapeutic Services—The Functional Centre Framework Section pertaining to diagnostic and therapeutic services includes professional and technical services which assist in the clinical investigation of the inpatients, residents or clients, either to detect the presence of disease, disability, or injury or to assess the severity of known disease, disability, or injury.

Therapeutic Services include professional and technical services provided to inpatients, residents or clients, which assist in the alleviation or cure of the causes, symptoms and/or sequelae of disease, disability or injury.

Excludes:
- Professional and technical services provided by personnel who are accountable and charged to Nursing Inpatient/Resident Services in the functional centre framework.

Education—The Functional Centre Framework Section pertaining to the provision of in-service education programs to the health service organization's personnel, as well as formal education programs to undergraduate and post-graduate technical, professional and medical students/trainees.

Emergency Visits—(MIS Primary Account 71 3 10* and MIS Statistical Secondary Accounts 416*, 418*) The visits by, or to service recipients, arranged with or without prior appointment or through a formal scheduling system, to the emergency department, excluding client surgical day/night care.

Functional Centre—A subdivision of an organization used in a functional accounting system to record the budget and actual direct expenses; statistics; and/or revenues, if any, which pertain to the function or activity being carried out.

Global Funding—(MIS Financial Secondary Account 11010) The revenue arising from the provision of patient services, which are the responsibility of the Ministry of Health.

Health Service Organization—Health care providers including Community Health Service Organizations, Hospitals, Public Health Organizations, Residential care facilities and Social Service Program Organizations.

Hospital—Hospitals are institutions where patients are accommodated on the basis of medical need and are provided with continuing medical care and supporting diagnostic and therapeutic services. Hospitals are licensed or approved as hospitals by a provincial/ territorial government, or are operated by the Government of Canada and include those providing acute care, extended and chronic care, rehabilitation and convalescent care, psychiatric care, as well as nursing stations or outpost hospitals.

Hospital Expenses Net of Recoveries—(MIS Financial Secondary Accounts 12*, 3*, 4*, 5*, 6*, 7*, 8*, 9*) Expenses incurred by a hospital for compensation, supplies, sundry, equipment, referred-out services and building and grounds less recoveries. Recoveries are the revenue arising from services provided, typically external to the functional centre, and external to the health care health service organization/site, but internal to the legal entity, e.g. a recovery from a related health care health service.

Hospital and Health Region Expenses Net of Recoveries—(MIS Financial Secondary Accounts 12*, 3*, 4*, 5*, 6*, 7*, 8*, 9*) Expenses incurred by hospitals, and health regions, for compensation, supplies, sundry, equipment, referred-out services and building and grounds less recoveries. Recoveries are the revenue arising from services provided, typically external to the functional centre, and external to the health care health service organization/site, but internal to the legal entity, e.g. a recovery from a related health care health service organization.

Inpatient Days—(MIS Statistical Secondary Account 403*) The days during which services are provided to an inpatient, between the census taking hours on successive days. The day of admission is counted as an inpatient day but the day of separation is not an inpatient day. When the service recipient is admitted and separated (discharged or died) on the same day, one inpatient day is counted.

Inpatient Admissions—(MIS Statistical Secondary Account 401*) The official acceptance into the health service organization of an adult/child/newborn/postnatal newborn, who requires medical and/or health services on a time limited basis. The admission procedure involves the assignment of a bed, bassinet or incubator. Admission of a newborn is deemed to occur at the time of birth, or in the case of postnatal newborns, at the time of admission of the mother to the health service organization.

Nursing Inpatient/Resident Services—The Functional Centre Framework Section pertaining to the nursing services provided to inpatients/residents and their significant others to meet their physical and psychosocial needs.

Includes:

- Ambulatory care clients receiving services in inpatient nursing units if separate ambulatory care functional centres have not been established for these services.

- Direct expense data for physicians contracted by the health service organization to provide services within a specific Level 3, 4 or 5 nursing inpatient and resident functional centre.

Public Health Organizations—Organizations that administrate and provide public health programs such as health promotion and protection.

Research—The Functional Centre Framework Section pertaining to formally organized research.

Residential Care Facilities—Health service organizations that are approved, funded or licensed by provincial/territorial departments to provide health care on a continuing basis or to provide shelter for a short period of time to provide a health program or service.

Revenue—(MIS Financial Secondary Account 1*) The gross proceeds from taxes, licenses, duties, user fees, transfer payments and sources other than borrowing.

Social Services Program Organizations—Organizations that administrate and provide programs of a social service nature.

Specialty Day/Night Care Visits—(MIS Primary Account 71 340* and MIS Statistical Secondary Accounts 416*, 418* excluding 4168* and 4188*) The visits by, or to service recipients, arranged with or without prior appointment or through a formal scheduling system, to the specialized day/night care functional centre (registered persons who attend for three to twelve hours on average, typically as the result of a referral from a primary care practitioner), excluding client surgical day/night care.

Total Long-term Debt—(MIS Primary Accounts 5*2, excluding 5*24*) Liabilities of the health service organization's fund that are due more than one year from the balance sheet date, excluding amounts owing by the health service organization on account of bonds issued by it for fund purposes, not due within one year of the balance sheet date.

Unit-producing Personnel (UPP)—Those personnel whose primary function is to carry out activities that directly contribute to the fulfillment of the service mandate. Examples include RNs, RNA', laboratory technologists, accounts payable clerks, pharmacists, housekeepers, home care workers, and public health officers. Excluded are practicing physicians, medical residents, interns and students, and, in most cases, Diagnostic, Therapeutic, Nursing, and Support Services' students.

Worked Hours—Hours spent carrying out the mandate of the functional centre. They include regular scheduled hours, overtime, call back, coffee breaks and worked statutory holiday hours. Worked hours do not include the lunch hour and standby hours.

Workload Measurement System—A tool for measuring the volume of activity provided by a specific functional centre in terms of a standard unit of time.

Major Data Limitations

In 1995, CIHI began collecting financial and statistical data in the CMDB (previously known as the Annual Hospital Survey) for fiscal year 1995–1996. Prior to this time, a similar database was maintained by Statistics Canada. Historical data prior to fiscal year 1995–1996 is not available in the CMDB but can be obtained from Statistics Canada.

For both fiscal years 1995–1996 and 1996–1997 there was a very low response rate for data submissions from the hospitals. As a result, data in these years are incomplete. Subsequent fiscal years have achieved response rates exceeding 90% of all Canadian hospitals. However, not all reporting hospitals provided a complete data set. Generally, the missing data consisted mainly of operating statistics.

Other limitations that affect the comparability of reported data include the extent to which organizations apply the standards as they are described in the MIS Guidelines and the extent to which Generally Accepted Accounting Principles (GAAP) are applied to the data before it is reported to CIHI. For example, Quebec has not implemented the MIS Guidelines hence their data is not submitted in the same format as other provinces.

Major Data Limitations and Estimated Impact or Resolution

As a result of the low response rates for fiscal years 1995–1996 and 1996–1997, data for these years are considered to be incomplete. Users should be cautious when interpreting results from these years or when comparing data from these years to other years.

Data from fiscal years 1997–1998 and subsequent years have higher response rates but not all organizations submitted a complete data set. For example, many organizations chose not to submit operating statistics. As a result data for fiscal years 1997–1998, 1998–1999, 1999–2000 and 2000–2001 should be viewed with care. Users are cautioned when interpreting results from analysis of this data.

Many of the problems caused by limited reporting are overcome through statistical analysis of indicator results. Once this analysis has been completed, organizations with incomplete data can be eliminated from further analysis for specific indicators. As well, organizations with indicator values that fall outside of predetermined upper or lower limits can also be flagged for further analysis or eliminated from results prior to comparative analysis. This process is described under **Methodology for Identification of Outliers.**

Another issue that the CMDB is faced with is the limited extent to which some organizations follow the requirements of the MIS Guidelines. For example, health regions in all provinces other than Ontario and Quebec are not required by the province to allocate regional administrative expenses and expenses for shared services to all of the facilities within the region. Wherever possible, data has been transformed to be in compliance with the MIS Guidelines. Where necessary, regional, centralized and shared services expense have been allocated on a systematic basis by CIHI before data is used to calculate performance indicators.

The province of Quebec has not implemented the MIS Guidelines for hospital reporting. Data reported to CIHI from Quebec is mapped from Quebec's provincial account codes to the MIS Guidelines chart of accounts. In cases where a mapping relationship cannot be established, codes are mapped to a holding account. Holding accounts allow Quebec trial balance data to balance in the database.

Table 25 describes four grades that can be assigned to the quality of CMDB data.

Table 25. CMDB Data Quality Grade Levels

Grade	Name	Explanation
1	**Use without restriction**	
2	**Use with minor restrictions**	These are typically minor issues linked to under-reporting of certain statistical fields, under-reporting of statistics in functional centres or other transaction inconsistencies, inconsistent historical comparisons, some statistics with no expenses, aggregated reporting of certain fields (e.g. compensation), or mid-range provincial/territorial response rates. While users are cautioned to be wary of certain points, the interpretation and utility of the data is not seriously threatened.
3	**Use with major restrictions**	These tend to be more systematic issues that may affect the interpretation and utility of the provincial/territorial data. Examples are large gaps in the data (e.g. missing statistical/expense fields), low provincial/territorial response, many statistics with few or no associated expenses, or data that is grossly inconsistent across time and/or against national averages.
4	**Unusable**	Data with critical errors that prevent the use of the data.

Source: Canadian Institute for Health Information

Table 26 reports the values from Table 25 that were assigned to each jurisdiction based on the CMDB data quality review process for fiscal year 2000–2001. CIHI is currently working with hospitals/health regions and provincial and territorial ministries to improve their data quality.

Table 26. Data Quality Assessment by Province/Territory, 2000–2001

	Minimum Reporting	Transaction Validity	Historical Consistency	Combination Reporting	Relational Validity	Overall Grade
N.L.	3	2	2	---	---	3
P.E.I.	3	2	1	---	---	3
N.S.*	---	---	---	---	---	---
N.B.	2	1	1	1	2	2
Que.**	3	1	1	1	1	3
Ont.	1	1	1	1	1	1
Man.	2	3	1	1	2	3
Sask.	3	3	---	---	---	3
Alta.	2	1	1	1	1	2
B.C.	2	2	1	1	1	2
Y.T.	3	---	---	---	---	3
N.W.T.	---	---	---	---	---	---
Nun.	---	---	---	---	---	---

Source: CIHI Canadian MIS Database

Notes:

* Changes in Nova Scotia's regional structure part way through the year resulted in data quality ratings that are not reportable.

** Based on 1999–2000 data.

Coverage

Canadian MIS Database Frame

Frame refers to a list of entities that should supply data to a database. The CMDB contains financial and statistical data from hospitals across the country. CIHI maintains a list of hospitals reporting to the CMDB. Hospitals are broadly defined as an institution containing at least one over-night acute, rehabilitation or mental health bed. The CMDB does not yet request data from long-term care facilities; community health centres or home care agencies. Most regionalized provinces, however, do submit non-hospital data.

Frame Maintenance

In order to ensure that the CMDB contains up to date information, the provinces and territories are asked twice a year for any changes that impact the CMDB list of hospitals such as bed counts and hospital closures, mergers and amalgamations.

Impact of Frame Maintenance

The documentation process of maintaining the frame includes storing a hard copy of changes submitted by the provinces/territories and documenting the updates in the CMDB. In many cases, hospital lists are updated one or two years prior to the data submission for that year. Consequently, significant effort is made to ensure that data submissions are consistent with the updated hospital structure for a particular entity.

Collection and Non-response

Data Collection

Financial and statistical data from hospitals are collected with the cooperation of provincial and territorial governments that ensure the submission of MIS Guidelines compliant hospital or regional data.

Provinces and territories are given two options for submitting data to CIHI. Data can be submitted using an MS Excel workbook or a text file. Once the data has been submitted, it is run through a series of edit checks. These edits are reviewed and enhanced as necessary. After the data have been entered into the database, indicators are calculated for each institution in order to measure the quality of the reported data.

Data Quality Control

Once the data have been assembled for a province, all records are processed using a web-based application and established edits are applied. Using these edits, an exception report is produced and sent to each provincial/territorial ministry of health. It is the foundation for the provincial/territorial data quality report. This report outlines the major data quality issues for each province/territory in an effort to help improve reporting practices.

Analysts at CIHI create a Data Quality Report that identifies anomalies in the data through analytical review of hospital financial and statistical data. This review employs approximately 400 calculations, including regional indicators, provincial/territorial comparisons and comparisons to the last three years of data for each supplier. To facilitate and encourage data quality, officials in the appropriate provincial/territorial ministry of health also review the Data Quality Reports.

Response

Response rates of data submissions to the CMDB have been steadily increasing since 1995 when the database was transferred from Statistics Canada. Table 27 shows that 93% of all hospitals in the CMDB list of hospitals responded to our call for 2000–2001 data. These hospitals represent 96% of all hospital beds. In contrast, only 51% of hospitals representing 56% of hospitals responded to the call for 1995–1996 data.

Table 27. CMDB Response Rates, 1995–1996 to 2000–2001

Fiscal Year	Response Rate Based on Hospitals	Response Rate Based on Beds
2000–2001	93%	96%
1999–2000	90%	95%
1998–1999	88%	93%
1997–1998	85%	90%
1996–1997	54%	57%
1995–1996	51%	56%

Source: Canadian Institute for Health Information

Observing simple response bias also assesses data quality. This statistic determines whether or not an event had been observed or reported properly. In the CMDB this might include, for example, reporting inpatient visits and inpatient days outside of inpatient nursing functional centres or when credit and debit values are reversed. A related statistic is correlated response variance which occurs when data is consistently incorrectly observed, recorded and reported, for example, when data elements are collected only by select provinces. It is difficult to determine whether any regional differences are due to differences in data collection, software or variations in coding practice or hospital policy.

Adjustment for Non-response

While response rates based entirely on the CMDB frame are high, simple response bias and correlated response variance are evident because not all respondents report values for the entire minimum data set. Non-responding hospitals were reported to the appropriate ministry in the provincial/territorial data quality report. To date, no steps have been taken to impute or otherwise adjust for unreported data. As a result, values for some financial performance indicators may not be able to be calculated or used for health regions/hospitals that do not report an entire data set.

Major Changes

There have been no major changes to the data collection tools, standards or data providers (provinces/territories) since the inception of the CMDB in 1995.

Revision History

The fiscal year 2000–2001 data used in this publication were current as of March 31, 2003.

Major Revisions

Although data from previous years have not been reported there have been revisions to the fiscal year 1999–2000 data. Most of the changes represent minor corrections. Five provinces resubmitted their entire data file in order to reflect changes and corrections that resulted from provincial/territorial data quality reviews.

Comparability

Geography

Facility postal codes are collected from all respondents. Information about hospitals can be compared by postal code if the postal code contains more than five hospitals. Generally, the smallest geographic area would be by health region. Regions in provinces other than Ontario and Quebec are defined as health regions. In Ontario, the Statistics Canada grouping by District Health Council was used to approximate regions.

Facility

Facility-level information from the CMDB can be compared to information from the Discharge Abstract Database (DAD). Even though hospitals may report to the DAD using multiple facility codes, these facility codes can be mapped to only one accounting entity reporting to the CMDB.

Time

All provinces and territories submit data on a fiscal year that covers April 1 through March 31 of the following year.

Person

Information in the Canadian MIS Database is collected at the organization level. It is not possible to derive information about persons from the CMDB, nor track them across time.

General Methods

The following is intended as a general overview of the methods applied to calculate the Performance Indicators in this report. More detailed information can be obtained by contacting the Canadian MIS Database section by phone (613) 241-7860, by fax (613) 241-8120 or by e-mail at cmdb@cihi.ca.

Unit of Analysis

Hospitals in Canada operate under a variety of legal organizations. In some provinces hospitals are included under the legal umbrella of a heath authority and in other provinces the hospital itself is the legal entity. Indicators calculated using the legal entity as the unit of analysis include Total Margin, Current Ratio, Administrative Support Expense as a percentage of Total Expense, Information Systems Expense as a percentage of Total Expense, Average Age of Plant and Building, and Average Age of Equipment. Indicators that are calculated using individual hospitals, regardless of the legal entity, are UPP Worked Hours for Patient Care Functional Centres as a percentage of Total Worked Hours, Cost per Weighted Case, Nursing Inpatient Services UPP Worked Hours per Weighted Case, Diagnostic Services UPP Worked Hours per Weighted Case, Clinical Laboratory UPP Worked Hours per Weighted Case, and Pharmacy UPP Worked Hours per Weighted Case.

Appendix B

Performance Indicator Methodology

Performance Indicator Methodology

1. **Total Margin:** This indicator measures financial viability. It is strongly influenced by positive financial outcomes on a yearly basis.

$$\frac{\textit{Total Revenues—(Total Expenses - Facility Amortization), excluding research outside of operating fund}}{\textit{Revenues, excluding provincial health insurance plan, grant, donation, internal recovery and externally-funded research revenues}}$$

MIS account codes used in the numerator include all fund types, excluding primary accounts 7* 7 in funds 3-9, secondary financial accounts 1 *, 3 *-9 * excluding 9 50 20, 9 50 40, 9 50 60.

MIS account codes used in the denominator include all fund types, excluding primary accounts 72 *, 82 * and 7* 7 in funds 3-9, secondary financial accounts 1*, excluding 1 10 15, 1 4*, 1 5*, 1 22.

2. **Current Ratio**: This indicator of an organization's liquidity measures how current assets and liabilities are managed. The organization's inability to meet short-term obligations can hinder the delivery of quality health care services.

$$\frac{\textit{Current Assets + debit Current Liability balances excluding deferred revenues}}{\textit{Current Liabilities, excluding deferred revenues + credit Current Assets, except Current Asset contra accounts}}$$

MIS account codes used in the numerator include primary account 1* + debit balances in primary account 4* excluding 4* 8.

MIS account codes used in the denominator include: Primary account 4* excluding 4* 8 + credit balances in primary account 1* except 1* 4.

Note: To be consistent with financial statement reporting data are adjusted for amounts not re-allocated on the trial balance (e.g. only a net credit position across current cash accounts would be added to the denominator).

3. **Administrative Services Expense as a Percentage of Total Expense:** Administrative Expense is a measure of an organization's efficiency.

$$\frac{\textit{General Administration, Finance, Human Resources, Systems Support, and Communication Expenses, net of recoveries except cash discounts, and excluding medical compensation and all amortization}}{\textit{Total Expenses, net of recoveries and excluding medical compensation and all amortization}}$$

MIS account codes used in the numerator include primary accounts 7* 1 10, 7* 1 15, 7* 1 20, 7* 1 25, 7* 1 30, secondary financial accounts 1 20, 1 21, 1 22, 3 *-9* , excluding 1 20 90, 3 90, 7 50, 7 51, 9 50, 9 51.

MIS account codes used in the denominator include secondary financial accounts 1 20, 1 21, 1 22, 3 *-9 * excluding 3 90, 7 50, 7 51, 9 50, 9 51.

4. **Information Systems Expense as a Percentage of Total Expense:** This is an indicator that examines the expenditures on information services.

$$\frac{\textit{Systems Support, net of recoveries except cash discounts, and excluding medical compensation and all amortization}}{\textit{Total Expenses, net of recoveries and excluding medical compensation and all amortization}}$$

MIS account codes used in the numerator include primary accounts 7*125, secondary financial accounts 1 20, 1 21, 1 22, 3 *-9 *, excluding 1 20 90, 3 90, 7 50, 7 51, 9 50, 9 51.

MIS account codes used in the denominator include secondary financial accounts 1 20, 1 21, 1 22, 3 *-9 * excluding 3 90, 7 50, 7 51, 9 50, 9 51.

5. **Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percent of Total Worked Hours:** This indicator measures human resources.

$$\frac{\textit{Inpatient Nursing, Ambulatory Care, and Diagnostic and Therapeutic Services Worked and Purchased Hours}}{\textit{Total Worked Hours, excluding medical personnel hours}}$$

MIS account codes used in the numerator includes primary accounts 7* 2, 7* 3, 7* 4, secondary statistical accounts 3 50 10, 3 5 090.

MIS account codes used in the denominator include all fund types excluding primary account 7* 5, statistical secondary accounts 3 10 10, 3 10 90, 3 50 10, 3 50 90.

6. **Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case:** This indicator measures the number of nursing inpatient services worked hours that are required to produce a weighted case.

$$\frac{\textit{Inpatient Nursing Services Worked and Purchased Hours (excluding Long-term Care)}}{\textit{Total Inpatient Weighted Cases}}$$

MIS account codes used in the numerator include primary account 7* 2 (excluding 71 2 95), secondary statistical accounts 3 50 10 and 3 50 90.

The denominator includes Total Inpatient Weighted Cases (obtained from the Discharge Abstract Database, excluding Day Surgery).

7. **Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case:** This indicator measures the number of Clinical Laboratory worked hours that are required to produce a weighted case.

$$\frac{\textit{Laboratory Services Worked and Purchased Hours (adjusted for inpatient activity)}}{\textit{Total Inpatient Weighted Cases}}$$

MIS account codes used in the numerator includes primary account 71 4 10, secondary statistical accounts 3 50 10 and 3 50 90. The numerator is adjusted for the proportion of inpatient activity determined by workload/activity statistics as it is outlined in the Cost per Weighted Case methodology below.

The denominator includes total Inpatient Weighted Cases (obtained from the Discharge Abstract Database, excluding Day Surgery).

8. **Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case:** This indicator measures the number of Diagnostic Services worked hours that are required to produce a weighted case.

$$\frac{\textit{Diagnostic Services Worked and Purchased Hours (adjusted for inpatient activity)}}{\textit{Total Inpatient Weighted Cases}}$$

MIS account codes used in the numerator include primary accounts 71 4 15, 71 4 20, 71 4 25, 71 4 30, secondary statistical accounts 3 50 10 and 3 50 90. The numerator is adjusted for the proportion of inpatient activity determined by workload/activity statistics as it is outlined in the Cost per Weighted Case methodology below.

The denominator includes total Inpatient Weighted Cases (obtained from the Discharge Abstract Database, excluding Day Surgery).

9. **Pharmacy Unit-producing Personnel Worked Hours per Weighted Case:** This indicator measures the number of worked hours required from Pharmacy to produce a weighted case.

$$\frac{\textit{Pharmacy Worked and Purchased Hours (adjusted for inpatient activity)}}{\textit{Total Inpatient Weighted Cases}}$$

MIS account codes used in the numerator includes primary account 71 4 40, secondary statistical accounts 3 50 10 and 3 50 90. The numerator is adjusted for the proportion of inpatient activity determined by workload/activity statistics as it is outlined in the Cost Per Weighted Case methodology below.

The denominator includes: Total Inpatient Weighted Cases (obtained from the Discharge Abstract Database, excluding Day Surgery).

10. **Average Age of Plant and Buildings:** This is a measure of capital that examines the relationship between yearly plant and building amortization expense to the total of accumulated amortization for plant and building assets.

$$\frac{\textit{Accumulated Plant and Building Amortization (Distributed/Undistributed)}}{\textit{Plant and Building Amortization Expense (Distributed/Undistributed)}}$$

MIS account codes used in the numerator includes primary accounts 3* 8 21, 3* 8 26, 3* 8 31, 3* 8 36, 3* 8 41, 3* 8 46, 3* 8 66.

MIS account codes used in the denominator include primary accounts 7* and 8*, secondary financial accounts 9 50 20, 9 50 40, and 9 50 60.

11. **Average Age of Equipment:** This is a measure of capital that examines the relationship between yearly equipment amortization expense to the total of accumulated amortization for equipment assets.

$$\frac{\textit{Accumulated Equipment Amortization (Distributed/Undistributed)}}{\textit{Equipment Amortization Expense (Distributed/Undistributed)}}$$

MIS account codes used in the numerator includes primary accounts 3* 8 51, 3* 8 56.

MIS account codes used in the denominator include primary accounts 7* and 8*, secondary financial accounts 9 50 80 and 7 50.

Cost per Weighted Case Methodology

The following outlines CIHI's methodology for calculating the Cost per Weighted Case (CPWC). The financial data used is from 2000–2001 data submitted to CIHI's Canadian MIS Database. Weighted cases are obtained from the Discharge Abstract Database and the Hospital Morbidity Database grouped using the 2000 version of CIHI's Case Mix Group (Complexity Overlay) grouping methodology **(Day Surgery Cases are excluded)**. The CPWC calculation is performed for facilities that have reported both financial and clinical data.

Cost Distribution Logic

The cost calculation is based upon obtaining the full cost of inpatient services, then dividing by the total weighted cases for each hospital. The full cost of inpatient services includes expenses associated with health regions, such as diagnostic/laboratory services and/or administration/support expenses.

Recoveries Netted, Expenses Removed

The first step in the calculation is to net recoveries and remove the designated expenses. The secondary codes associated with these exclusions/netting are:

Recoveries

Secondary Description	Secondary Code
Recoveries	1 2*

Expenses

Secondary Description	Secondary Code
Undistributed Amortization—Grounds, Buildings and Building Service Equipment	9 50 20, 9 50 40, 9 50 60[9]
Interest on Long-Term Liabilities	9 55
Compensation—Medical Personnel	3 90
Termination Benefits	3 ** 85

[9] Undistributed amortization is occasionally reported at the roll-up level (eg. 9 50 00), making it impossible to know the portion applicable to equipment. Nationally, 70% of the undistributed amortization reported applies to buildings, grounds and service equipment. Accordingly, 70% of the dollars reported under 9 50 00 are removed to obtain the equipment portion.

Functional Centre Exclusions[10]

Primary Description	Primary Code	Secondary Code
Long-Term/Chronic Care	71 2 95	ALL
Community	71 5	ALL
Research	71 7	ALL
Education	71 8 (except 71 8 40)	ALL
Undistributed	71 9	ALL

Allocation Methodology—Diagnostic/Therapeutic Services (D&T)[11]
The preferred method for allocating Diagnostic and Therapeutic Services (D&T) expenses to inpatient services is via workload measurement data. To do this, first all D&T accounts are rolled up to level 3 functional centres. From there, all service recipient activity workload is used to derive an inpatient/client[12] ratio. **Note:** Non-service recipient activity workload is excluded, but the expenses associated with non-service recipient activity are allocated using the inpatient/client ratio. Therefore the following formula is used to obtain the inpatient workload ratio:

$$\frac{\textit{Inpatient Workload}}{\textit{Client} + \textit{Inpatient Workload}}$$

Where workload is not reported, procedures (for Laboratory and Diagnostic Imaging, including respiratory therapy) or attendance days (for therapies) are used to distribute costs. In the absence of these statistics, visits are used.

Allocations for Accounts with No Workload or Activity Statistics
A national workload average, by level 3 account, is used to make allocations in functional centres where expenses are reported without corresponding workload/activity or statistics. Where no statistics are reported at all, a national average for each level 3 functional centre is used. In rare instances where workload is nationally absent for a given level 3 functional centre, a generic average produced from workload across all functional centres is used. For a complete listing of the account codes for activity/workload statistics please refer to chapter 2.4 of the MIS Guidelines.

[10] The expenses in these functional centres are not excluded until all allocations have been made.
[11] Where health regions report D&T costs within the corporate entity (e.g. not within stand-alone D&T centres), these costs are distributed, by proportion of expense, to inpatient and client frameworks.
[12] Client refers to a patient seen by a hospital on an outpatient basis as well as patients and organizations receiving services in a community and social service setting.

Operating Room/Post-anesthetic Recovery Room—*Primary Accounts, 71 2 60, 71 2 65, 71 2 62 (OR/PARR Combined)*
Many hospitals use their main inpatient operating suite to treat both inpatient and client surgical visits. Ideally, nursing workload should be used to break out the inpatient/client split in these functional centres. Lack of reporting of nursing workload prohibits this. Instead, surgical visits are used:

Surgical Visits

Secondary Description	Secondary Code
Surgical Visits—Inpatient	4 37 10
Surgical Visits—Client	4 37 70, 4 37 80

An additional step is required to recognize the difference in resource intensity between a "typical" inpatient and client surgical visit. To accomplish this, inpatient visits are weighted 3 to every 1 client visit.

Where surgical visits are not reported expenses are attributed to inpatient services.

Allocation for Regional Expenses
Additional allocations must be made to hospitals that are under the control of health regions. In order to do this, first the portion of regional expenses that are attributable to the hospitals in each region must be separated from the portion attributable to non-hospitals. This hospital/non-hospital ratio is obtained through the use of the non-hospital information supplied to CIHI by the provinces—in Newfoundland, Nova Scotia, Manitoba, Alberta, and British Columbia transaction data for facility based non-hospitals are used.

Once the hospital portion of regional expenses is obtained, they are allocated based on the proportion of each hospital's total expense to the total hospital expense for that region. Regional expenses are rolled up to Level 2 functional centre reporting and are added to the level 2 categories[13] in each hospital.

Where health regions operate stand-alone Diagnostic and Therapeutic units, the expenses from these sites are considered to be the same type of regional expenses as corporate administration or laundry. Unless workload data are provided that allow for the direct allocation to specific sites, D&T expenses will be broken down into inpatient/client groups, adjusted to the proportion of hospital expenses (if not in the hospital sector) and distributed to individual hospital sites.

Allocating Administration/Support, and Accounting Centre Expenses
The final steps to achieving the full cost of inpatient services for each facility is accomplished by using a step-down allocation approach. This is a sequenced allocation for each functional centre.

[13] Long-term/Chronic Care accounts are not rolled up to level 2 so they can absorb allocated expenses from other functional centres (e.g. Diagnostic and Therapeutic, Administration/Support etc.).

Accounting Centres
In many cases, hospitals report recoveries and expenses pertaining to patient care in the Accounting Centres. If any (net) expenses or recoveries remain in the Accounting Centres they must be distributed. A ratio is calculated based on the total facility cost across each Level 2 functional centre, excluding the Accounting Centres. The following formula is used:

$$\frac{F/C_n \text{ Costs}}{\text{Total Costs } (71\ 1 + 71\ 2_{+D\&T} + 71\ 3_{+D\&T} + 71\ 2\ 95 + 71\ 5 + 71\ 6 + 71\ 7 + 71\ 8 + 71\ 8\ 40 + 71\ 9)}$$

Where – F/Cn is each of the functional centres identified in the denominator.
– D&T is the portion of D&T costs associated with either inpatient/client services.

Administration and Support Services
Administration and Support Services are allocated using following formula, where administration/support services are excluded from the denominator:

$$\frac{F/C_n \text{ Costs}}{\text{Total Costs } (71\ 2_{+D\&T} + 71\ 3_{+D\&T} + 71\ 2\ 95 + 71\ 5 + 71\ 6 + 71\ 7 + 71\ 8 + 71\ 8\ 40 + 71\ 9)}$$

Once administration is allocated In-service education is allocated, by proportion of expense, to inpatient and client frameworks:

$$\frac{F/C_n \text{ Costs}}{\text{Total Costs } (71\ 2_{+D\&T+71\ 4\ 40+} 71\ 3_{+D\&T+71\ 8\ 40} + 71\ 2\ 95 + 71\ 5 + 71\ 6 + 71\ 7 + 71\ 8 + 71\ 9)}$$

Recovery Revenue
With the exception of Accounting Centres, net revenues are not distributed. Outside of the Accounting Centres, allocations are restricted *to a minimum value of zero—no negative allocations are made at the framework level.*

Performance Indicator Weighted Average Methodology

All of the indicators reported in *Canadian MIS Database, Moving Toward the Reporting of Hospital Financial Performance Indicators, 1999–2000 and 2000–2001* are weighted averages. Weighting is applied by calculating the indicator value based on the sum of all the numerators divided by the sum of all the denominators.

Provincial indicator values are calculated as the sum of all provincial organizations' numerators divided by the sum of all provincial organizations' denominators. National indicator values are calculated as the sum of all organizations' numerators divided by the sum of all organizations' denominators.

Validation of Indicator Results Methodology

After all of the indicator values were calculated for this document, a validation report was created for every region and, in the case of Ontario and Quebec, for every hospital. The validation reports, along with a covering letter and a fax-back form, were sent to the CEO of each organization. These reports contained the organization's numerator, denominator and calculated value for each indicator, along with a complete indicator methodology. In all, 326 indicator validation reports were sent out.

The instructions contained in the validation report asked each organization to confirm that the values in the report were correct. If they were not, the organization was required to send a detailed account-by-account request to have their data changed. Change requests that did not include an entry to change the database were not considered valid requests. In order to ensure that the changes were valid, a CMDB Senior Analyst contacted all organizations that requested changes. Each request for change was sent to the respective provincial ministry of health for approval. Any change that was not accepted by the provincial ministry was not implemented in the CMDB. This was a very important data quality measure that ensured that the CMDB and provincial MIS databases contained the same data.

The indicator results of 93% of the organizations included in this report were positively confirmed. Of the 326 validation reports sent, 183 fax-back forms were returned. CIHI attempted to contact the remaining 143 organizations by telephone in order to obtain verbal confirmation of results. After several attempts, we were unable to contact or confirm the results of all but 14 out of the 326 organizations that were sent validation reports.

Not all organizations agreed with their indicator values at first. Many did not understand how to apply the methodology since the MIS Guidelines account numbers used were different from their provincial chart of accounts. The process also provided a great deal of valuable information and suggestions that will be useful in improving the validation process for next year's report and include:

- changes in the indicator methodology that will make the indicators more relevant and easier to understand. Some organizations agreed with the calculated values but had issues with the underlying methodology;
- additional text describing the indicators;
- sending validation reports to CFO's rather than CEO's; and
- mapping the indicator methodology to the provincial charts of accounts.

A CMDB Senior Analyst contacted all of the organizations that had questions, disagreed with any value or did not understand any part of the indicator methodology. All questions regarding indicator values were resolved for the purposes of this report.

Methodology for the Identification of Outliers

An outlier is defined as an indicator value that is greater than or less than a pre-determined range of acceptable indicator values. For this report, the range of acceptable values will be:

I.5 times the inter-quartile range (IQR), calculated as follows:

1st quartile (25th percentile) minus 1.5 * IQR **to** 3rd quartile (75th percentile) plus 1.5 * IQR.

Any indicator that falls outside this acceptable range is carefully reviewed. Unless there is a compelling reason for retaining the value, it is removed or "trimmed" from further analysis.

Trim Rules for National and Provincial Averages
For all provincial and national averages that are published throughout the report:

- for Hospital-Specific Indicators (i.e. Patient Care Hours, Weighted Cases Indicators) - Hospital values will be trimmed out if beyond the range of acceptable values; and
- for Regional-Specific Indicators (i.e. Current Ratio, Total Margin, Administrative Expenses etc.) - Regional values (including the aggregate regional values in Ontario and Quebec) will be trimmed out if beyond the range of acceptable values.

Trim Rules for Regional Indicator Values
For all regional averages that will be published in the appendix:

- for Hospital-Specific Indicators (i.e. Patient Care Hours, Weighted Cases Indicators) - Hospital values will be trimmed out if beyond the range of acceptable values; and
- for Regional-Specific Indicators (i.e. Current Ratio, Total Margin, Administrative Expenses etc.) - Regional values (including the aggregate regional values in Ontario and Quebec) will be trimmed out if beyond the range of acceptable values.

Decile Ranking of Regional Indicators

Regional decile ranking was determined by listing the values for all 165 regions in order from the least favorable result to the most favorable result. The first ten percent (least favorable) of the regional values receive a decile rank of 1, the second ten percent receive a decile ranking of 2 and so on to the final ten percent (most favorable) that have a decile ranking of 10.

Appendix C

Regional Indicator Values by Province/Territory

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Table C1.1 Part 1

Hospital Financial Performance Indicators, 2000—2001, Atlantic Provinces

Province/Territory	Total Margin		Current Ratio		Administrative Services Expense as a Percentage of Total Expense *		Information Systems Expense as a Percentage of Total Expense		Cost per Weighted Case	
	%	Decile	Ratio	Decile	%	Decile	%	Decile	$	Decile
Newfoundland and Labrador, by Regional Health Board										
Avalon Health Care Institutions Board	-6.7	1	0.3	1	10.2	3	0.7	3	4,813	1
Central East Health Care Institutions Board	**	**	0.2	1	8.6	5	1.6	6	3,750	2
Central West Health Board	-1.5	2	0.4	1	8.5	5	1.0	3	3,819	1
Health Care Corporation of St. John's	-3.7	1	0.4	1	5.7	8	1.2	4	3,964	1
Peninsulas Health Care Corporation	-8.0	1	0.9	4	9.2	4	1.8	7	3,740	2
Western Health Care Corporation	-7.8	1	0.4	1	9.1	4	0.8	3	4,130	1
Provincial Average	**-4.8**		**0.5**		**7.4**		**1.1**		**3,985**	
Prince Edward Island, by Regional Health Authority										
East Prince Health Region	**	**	---	---	**	**	---	---	2,660	8
Eastern Kings Health Region	**	**	---	---	12.4	1	---	---	3,338	3
Queens Health Region	**	**	---	---	10.8	3	---	---	3,212	4
Southern Kings Health Region	**	**	---	---	5.3	9	---	---	2,058	9
West Prince Health Region	**	**	---	---	8.0	5	---	---	3,174	4
Provincial Average	---		---		**10.3**		---		**3,003**	
Nova Scotia, by District Health Board										
Central Regional Health Board	-3.4	1	---	---	11.3	2	2.5	10	3,565	2
Eastern Regional Health Board	-2.1	2	0.7	2	7.2	7	0.6	2	2,489	8
Izaak W. Killam Hospital for Children	1.0	5	1.2	6	9.6	4	2.0	8	4,263	1
Northern Regional Health Board	7.5	10	1.6	8	5.5	9	0.5	2	2,721	7
Western Regional Health Board	1.9	6	1.0	5	6.8	7	1.4	6	3,042	5
Provincial Average	**-0.9**		**1.0**		**9.2**		**1.7**		**3,229**	
New Brunswick, by Regional Hospital Corporation										
Region 1 (Beausejour) Hospital Corporation	6.2	9	0.5	2	5.7	8	1.8	8	3,010	5
Region 1 (Southeast) Hospital Corporation	-0.1	4	0.4	1	7.4	7	**	**	3,327	3
Region 2 Hospital Corporation	-2.0	2	1.0	5	7.6	6	2.6	10	3,281	3
Region 3 Hospital Corporation	3.4	8	0.6	2	6.6	8	1.6	6	2,600	8
Region 4 Hospital Corporation	4.4	8	0.8	3	9.2	4	2.2	9	3,266	3
Region 5 Hospital Corporation	5.1	9	1.2	6	7.8	6	1.0	4	3,637	2
Region 6 Hospital Corporation	4.4	8	0.4	1	7.1	7	2.0	8	3,186	4
Region 7 Hospital Corporation	6.5	10	0.9	4	7.4	6	1.9	8	2,999	5
Provincial Average	**2.3**		**0.7**		**7.2**		**2.0**		**3,118**	

* Administrative Expense includes: Administration, Finance, Human Resources, Communications and Systems Support Functional Centres.
"**" = Value was outside of reportable range. See Methodology for Identification of Outliers in Methodological Notes.
"---" = Not applicable or not reportable

Table C1.1 Part 2

Hospital Financial Performance Indicators, 2000–2001, Atlantic Provinces

Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked		Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case		Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case		Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case		Pharmacy Unit-producing Personnel Worked Hours per Weighted Case		Average Age of Equipment	
%	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Years	Decile
---	---	---	---	---	---	---	---	---	---	11.9	3
57.3	3	45.6	2	0.6	8	1.8	7	1.8	6	10.6	5
---	---	---	---	---	---	---	---	---	---	---	---
73.2	10	30.0	9	1.0	4	1.9	6	1.6	8	---	---
61.4	5	49.5	2	0.6	8	2.1	5	3.2	1	0.7	10
---	---	---	---	---	---	---	---	---	---	11.0	4
69.9		**33.6**		**1.0**		**1.9**		**1.8**		**7.4**	
69.5	9	45.4	3	1.5	2	2.3	4	1.8	6	---	---
51.4	1	49.3	2	1.3	3	---	---	1.3	9	---	---
64.7	7	44.2	3	1.6	1	3.2	1	1.7	7	---	---
61.4	5	37.0	5	1.6	1	---	---	0.6	10	---	---
62.4	6	39.9	4	1.0	5	1.2	9	1.2	10	---	---
65.0		**43.9**		**1.5**		**2.8**		**1.6**		---	
63.3	6	39.8	4	1.2	3	2.7	2	2.6	2	---	---
64.8	7	43.3	3	0.9	5	1.6	8	1.3	9	14.6	2
49.0	1	52.6	2	0.7	8	2.8	2	2.3	3	---	---
69.5	9	53.0	2	1.7	1	1.9	5	2.1	4	---	---
56.0	2	41.6	4	0.9	5	1.2	9	1.5	9	11.7	4
61.5		**43.3**		**1.0**		**2.2**		**2.1**		**12.9**	
56.2	2	39.9	4	0.9	6	2.3	4	2.6	2	10.0	5
59.8	4	46.9	2	1.7	1	2.3	4	2.8	2	6.7	8
61.3	5	44.1	3	1.6	1	2.4	3	1.6	7	11.6	4
56.6	2	39.1	5	1.1	4	1.3	9	1.6	8	13.5	2
58.4	3	53.2	1	1.7	1	1.9	5	2.9	1	13.1	2
60.5	4	53.5	1	1.1	4	2.4	3	2.9	1	12.7	3
55.7	2	45.3	3	1.8	1	1.8	7	2.3	3	9.5	6
48.9	1	43.1	3	1.1	4	1.0	10	1.1	10	9.6	6
58.2		**44.2**		**1.4**		**2.0**		**2.1**		**10.4**	

Table C1.2 Part 1

Hospital Financial Performance Indicators, 2000–2001, Quebec, Ontario and Manitoba

Province/Territory	Total Margin		Current Ratio		Administrative Services Expense as a Percentage of Total Expense *		Information Systems Expense as a Percentage of Total Expense		Cost per Weighted Case	
	%	Decile	Ratio	Decile	%	Decile	%	Decile	$	Decile
Quebec, by Hospital Region										
Bas Saint Laurent (01)	0.0	4	0.7	3	13.5	1	1.4	6	2,853	6
Saguenay-Lac Saint Jean (02)	-0.3	3	0.7	2	11.0	3	1.4	6	3,013	5
Capital National (03)	-3.8	1	0.5	2	9.8	3	1.6	7	2,518	8
Mauricie (04)	-0.2	3	0.5	2	11.8	2	1.3	5	2,015	10
Estrie (05)	-0.4	3	0.7	2	9.1	4	1.5	6	---	---
Montréal (06)	-2.4	2	0.8	3	10.5	3	2.1	9	2,451	9
Outaouais (07)	-2.7	2	0.8	4	13.5	1	1.4	6	3,093	4
Abitibi-Témiscamingue (08)	-0.7	3	0.7	3	12.1	2	1.4	5	2,873	6
Côte-Nord (09)	0.0	4	0.8	3	13.1	1	1.4	6	---	---
Nord du Quebec (10)	---	---	---	---	---	---	---	---	---	---
Gaspésie-Îles-De-La-Madeleine (11)	-1.7	2	0.7	2	14.1	1	1.2	4	3,343	3
Chaudière-Appalaches (12)	0.2	4	0.7	2	11.2	2	1.5	6	2,730	7
Laval (13)	1.0	5	0.9	4	9.1	4	1.0	3	1,994	10
Lanaudière (14)	0.0	4	0.6	2	10.5	3	1.5	6	1,910	10
Laurentides (15)	-0.2	4	0.8	3	11.4	2	1.3	5	2,024	10
Montérégie (16)	-1.3	3	0.8	3	11.7	2	1.7	7	2,466	8
Centre-Du-Québec (17)	**	**	0.2	1	11.6	2	0.9	3	**	**
Région 18	-2.2	2	0.8	3	16.1	1	1.0	3	---	---
Provincial Average	**-1.8**		**0.7**		**10.9**		**1.7**		**2,395**	
Ontario, by District Health Council										
Algoma, Cochrane, Manitoulin and Sudbury	-0.2	3	1.8	9	7.8	6	1.9	8	3,266	3
Champlain	-1.6	2	1.0	4	9.0	5	2.9	10	3,071	4
Durham, Haliburton, Kawartha and Pine Ridge	-0.1	4	1.5	8	8.0	5	1.3	5	2,853	6
Essex, Kent and Lambton	-0.4	3	1.0	5	7.8	6	1.8	7	3,094	4
Grand River	1.7	6	2.0	9	9.9	3	2.2	9	2,408	9
Grey Bruce Huron-Perth	-0.9	3	2.3	10	9.1	4	1.4	6	2,825	6
Halton-Peel	2.1	7	**	**	7.6	6	1.8	7	2,779	7
Hamilton-Wentworth	0.2	4	0.9	4	8.4	5	2.8	10	2,952	6
Muskoka, Nipissing, Parry Sound & Timiskaming	0.7	5	**	**	9.3	4	1.5	6	3,089	4
Niagara	-0.8	3	0.9	4	8.9	5	2.2	9	2,682	7
Northwestern Ontario	2.4	7	1.6	8	6.9	7	1.2	4	2,775	7
Quinte Kingston Rideau	-0.2	3	1.2	6	8.7	5	2.1	9	3,032	5
Simcoe-York	5.3	9	2.0	10	8.2	5	1.8	8	2,701	7
Thames Valley	3.2	7	1.1	5	7.2	7	1.8	7	3,581	2
Toronto	1.9	6	1.2	6	9.2	4	2.1	9	3,167	4
Waterloo Region-Wellington-Dufferin	5.7	9	2.1	10	9.4	4	1.8	8	2,758	7
Provincial Average	**1.3**		**1.2**		**8.6**		**2.1**		**3,043**	
Manitoba, by Regional Health Authority										
Brandon Regional Health Authority	0.5	5	1.3	7	5.6	8	1.2	5	2,589	8
Burntwood Regional Health Authority	-1.4	2	0.8	3	7.2	7	0.6	2	4,424	1
Central Regional Health Authority	1.3	5	1.7	9	8.4	5	0.5	2	2,551	8
Churchill Regional Health Authority	1.1	5	1.4	7	11.8	2	1.2	4	2,569	8
Interlake Regional Health Authority	5.2	9	1.6	8	5.7	8	0.2	1	2,497	8
Marquette Regional Health Authority	1.7	6	1.1	6	7.9	6	0.1	1	2,339	9
Norman Regional Health Authority	-5.1	1	0.7	3	7.5	6	0.7	2	2,195	9
North Eastman Health Association	0.0	4	1.6	8	11.4	2	0.6	2	1,952	10
Parkland Regional Health Authority	2.1	6	1.3	7	7.1	7	0.3	1	2,671	8
South Eastman Health/Sante Sud-Est Inc.	-4.5	1	1.0	5	4.6	9	0.0	1	1,807	10
South Westman Regional Health Authority	2.1	6	1.5	8	8.6	5	0.4	1	2,979	6
Winnipeg Regional Health Authority	3.0	7	1.1	6	6.7	8	1.3	5	3,034	5
Provincial Average	**2.2**		**1.2**		**6.9**		**0.9**		**2,870**	

* Administrative Expense includes: Administration, Finance, Human Resources, Communications and Systems Support Functional Centres. In Quebec, Finance also includes part of Materials Management.

"**" = Value was outside of reportable range. See Methodology for Identification of Outliers in Methodological Notes

"---" = Not applicable or not reportable

Table C1.2 Part 2

Hospital Financial Performance Indicators, 2000-2001, Quebec, Ontario and Manitoba

Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked		Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case		Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case		Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case		Pharmacy Unit-producing Personnel Worked Hours per Weighted Case		Average Age of Equipment	
%	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Years	Decile
66.4	8	33.6	7	1.2	3	2.5	3	3.0	1	---	---
66.6	8	42.2	3	0.7	7	1.7	8	2.1	4	---	---
61.5	5	32.4	8	0.7	7	2.8	2	3.3	1	---	---
67.4	8	29.4	10	0.8	7	1.5	8	1.5	9	---	---
61.7	5	---	---	---	---	---	---	---	---	---	---
61.0	5	34.4	7	1.3	2	1.8	6	1.6	7	---	---
67.5	9	48.8	2	0.5	9	1.2	9	2.3	3	---	---
63.8	6	36.7	6	1.0	4	2.4	3	1.9	6	---	---
65.8	8	---	---	---	---	---	---	---	---	---	---
---	---	---	---	---	---	---	---	---	---	---	---
62.5	6	37.7	5	1.2	3	2.1	5	2.2	3	---	---
68.7	9	37.9	5	1.1	3	2.3	3	2.0	4	---	---
70.6	10	29.8	9	0.9	5	1.5	8	1.8	7	---	---
69.3	9	30.5	9	0.8	6	1.3	9	1.6	8	---	---
70.1	9	31.7	9	1.3	2	1.9	6	1.2	9	---	---
69.5	9	33.9	7	0.9	5	1.8	7	2.0	4	---	---
62.0	5	36.3	6	0.9	6	3.7	1	**	0	---	---
64.6	7	---	---	---	---	---	---	---	---	---	---
63.9		**34.0**		**1.1**		**1.8**		**1.7**		---	
58.3	3	33.5	7	1.4	2	2.4	3	2.3	3	9.9	6
58.0	3	34.8	6	0.9	6	1.7	7	1.8	6	14.5	2
61.6	5	33.3	7	1.0	4	2.2	4	2.0	5	11.4	4
59.8	4	34.3	7	1.3	2	2.6	2	1.9	6	11.4	4
58.7	3	28.1	10	0.8	6	1.9	6	1.3	9	7.9	7
59.0	3	34.0	7	1.0	4	1.7	7	1.7	7	7.0	8
63.6	6	31.9	8	0.9	5	2.2	4	1.9	5	7.3	8
56.6	2	31.6	9	1.1	3	1.9	6	1.7	7	13.1	3
56.3	2	35.5	6	1.0	4	1.8	6	2.1	4	10.4	5
58.1	3	32.8	8	0.8	6	1.8	6	1.4	9	10.5	5
55.3	2	31.9	8	0.9	5	2.0	5	1.3	9	9.4	6
57.9	3	32.6	8	0.9	6	2.2	4	1.8	6	9.6	6
63.4	6	33.5	7	0.9	5	1.7	7	1.6	8	6.8	8
59.0	3	37.1	5	1.5	2	2.3	4	2.1	4	9.4	6
59.8	4	35.0	6	1.3	3	2.1	5	1.9	5	8.8	7
57.8	3	31.2	9	0.9	5	2.0	5	1.8	6	10.2	5
59.2		**33.9**		**1.1**		**2.1**		**1.9**		**9.6**	
60.6	4	33.5	7	0.8	6	---	---	1.6	8	9.3	7
68.9	9	61.8	1	0.6	8	1.7	7	1.9	6	8.2	7
---	---	---	---	---	---	---	---	---	---	7.7	8
---	---	---	---	---	---	---	---	---	---	7.3	8
---	---	---	---	---	---	---	---	---	---	8.9	7
---	---	---	---	---	---	---	---	---	---	16.8	1
---	---	---	---	---	---	---	---	---	---	9.9	6
---	---	---	---	---	---	---	---	---	---	16.2	1
---	---	---	---	---	---	---	---	---	---	13.7	2
---	---	---	---	---	---	---	---	---	---	9.9	5
---	---	---	---	---	---	---	---	---	---	12.2	3
60.5	4	39.1	4	1.1	4	2.1	5	2.4	2	13.4	2
60.7		**38.9**		**1.0**		**2.1**		**2.3**		**11.7**	

Table C1.3 Part 1

Hospital Financial Performance Indicators, 2000–2001, Saskatchewan and Alberta

Province/Territory	Total Margin		Current Ratio		Administrative Services Expense as a Percentage of Total Expense *		Information Systems Expense as a Percentage of Total Expense		Cost per Weighted Case	
	%	Decile	Ratio	Decile	%	Decile	%	Decile	$	Decile
Saskatchewan, by District Health Board										
Assiniboine Valley Health District	-1.5	2	0.7	3	1.4	10	---	---	1,566	10
Battlefords Health District	-2.9	2	0.8	3	1.8	10	---	---	3,253	4
Central Plains Health District	**	**	2.3	10	4.8	9	---	---	1,898	10
East Central Health District	3.3	7	0.3	1	2.5	10	0.3	1	3,202	4
Greenhead Health District	3.9	8	0.6	2	**	**	---	---	---	---
Living Sky Health District	-5.8	1	0.5	1	5.1	9	---	---	3,108	4
Mamawetan Churchill District Health Board	-6.8	1	1.0	5	5.1	9	---	---	**	**
Moose Jaw-Thunder Creek Health District	1.5	6	2.1	10	5.3	9	0.5	2	3,026	5
Moose Mountain Health District	**	**	---	---	2.7	10	---	---	2,674	7
North Central District Health Board	**	**	1.6	8	7.7	6	---	---	4,005	1
North East District Health Board	4.0	8	**	**	12.7	1	---	---	1,013	10
North Valley Health District	2.0	6	0.6	2	9.0	4	---	---	2,346	9
Northwest Health District Board	-3.0	1	**	**	5.0	9	---	---	2,165	9
Parkland District Health Board	9.9	10	1.0	5	1.4	10	---	---	1,632	10
Pasquia Health District	-1.9	2	**	**	1.2	10	---	---	3,680	2
Pipestone Health District	0.1	4	1.0	5	1.7	10	---	---	2,170	9
Prairie West Health District	0.0	4	1.4	8	1.1	10	---	---	2,112	9
Prince Albert Health District	0.7	5	---	---	0.5	10	---	---	3,351	3
Regina Health District	1.8	6	0.3	1	5.4	9	1.6	7	3,131	4
Rolling Hills District Health Board	-1.6	2	---	---	1.5	10	---	---	1,751	10
Saskatoon Health District	0.0	4	0.8	3	5.2	9	1.7	7	3,429	3
South Central District Health Board	-1.0	3	---	---	2.1	10	---	---	3,577	2
South County District Health Board	-1.4	2	0.9	4	1.7	10	---	---	1,603	10
South East District Health Board	**	**	0.7	3	**	**	0.1	1	3,021	5
Southwest District Health Board	-3.2	1	2.7	10	7.2	7	---	---	3,199	4
Swift Current Health District	-0.6	3	1.2	6	3.7	10	---	---	2,333	9
Twin Rivers Health District	-6.4	1	**	**	3.5	10	---	---	1,942	10
Provincial Average	**0.5**		**0.7**		**4.3**		**1.5**		**3,096**	
Alberta, by Regional Health Authority										
Alberta Cancer Board	7.4	10	1.4	7	5.3	9	2.7	10	3,616	2
Alberta Mental Health Board	2.9	7	1.9	9	8.3	5	2.1	9	---	---
Aspen Regional Health Authority	3.3	8	1.9	9	7.3	7	1.1	4	2,351	9
Calgary Regional Health Authority	1.6	6	1.5	8	6.5	8	2.7	10	3,455	3
Capital Health Authority	2.7	7	1.4	7	5.3	9	2.0	8	3,354	3
Chinook Regional Health Authority	5.8	9	1.6	8	6.4	8	1.7	7	2,424	9
Crossroads Regional Health Authority	7.3	10	1.3	7	8.1	5	**	**	2,745	7
David Thompson Regional Health Auth	5.3	9	2.1	10	6.8	7	1.8	8	2,698	7
East Central Regional Health Author	6.1	9	1.7	9	6.0	8	1.3	5	2,830	6
Headwaters Health Authority	8.5	10	2.0	10	7.4	7	2.4	10	2,894	6
Health Authority 5	7.2	10	1.6	9	5.3	9	1.2	4	2,816	6
Lakeland Regional Health Authority	5.3	9	1.2	6	5.8	8	1.3	5	2,401	9
Mistahia Regional Health Authority	7.6	10	1.2	6	11.2	2	2.4	9	2,886	6
Northern Lights Regional Health Authority	5.3	9	1.4	8	12.1	2	2.6	10	3,382	3
North-Western Regional Health Authority	4.7	9	2.4	10	11.0	3	2.0	8	3,605	2
Palliser Health Authority	3.8	8	1.4	7	7.2	7	2.5	10	2,650	8
Peace Regional Health Authority	-7.3	1	1.3	7	9.4	4	2.6	10	**	**
WestView Regional Health Authority	1.9	6	1.6	8	6.7	8	1.7	7	2,898	6
Provincial Average	**3.3**		**1.5**		**6.4**		**2.2**		**3,166**	

* Administrative Expense includes: Administration, Finance, Human Resources, Communications and Systems Support Functional Centres.
"***" = Value was outside of reportable range. See Methodology for Identification of Outliers in Methodological Notes
"---" = Not applicable or not reportable

Table C1.3 Part 2

Hospital Financial Performance Indicators, 2000–2001, Saskatchewan and Alberta

Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked		Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case		Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case		Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case		Pharmacy Unit-producing Personnel Worked Hours per Weighted Case		Average Age of Equipment	
%	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Years	Decile
65.6	8	31.3	9	0.2	10	1.6	8	0.6	10	---	---
---	---	---	---	---	---	---	---	---	---	9.5	6
**	**	34.4	7	0.7	8	3.0	2	---	---	---	---
66.2	8	64.0	1	0.9	5	0.5	10	3.9	1	**	**
---	---	---	---	---	---	---	---	---	---	---	---
54.9	1	52.6	2	0.7	7	0.6	10	---	---	---	---
---	---	---	---	---	---	---	---	---	---	---	---
63.6	6	42.6	3	0.8	6	2.8	2	1.7	7	10.6	5
---	---	---	---	---	---	---	---	---	---	---	---
56.4	2	49.7	2	0.7	7	2.1	5	2.4	2	---	---
**	**	---	---	0.7	8	2.6	3	2.2	3	---	---
55.5	2	35.8	6	0.4	9	1.2	9	---	---	---	---
67.2	8	51.4	2	0.8	6	2.3	4	---	---	---	---
---	---	---	---	---	---	---	---	---	---	---	---
61.7	5	62.5	1	---	---	---	---	3.8	1	---	---
64.9	7	37.7	5	0.7	7	2.2	4	**	**	---	---
---	---	---	---	---	---	---	---	---	---	---	---
64.5	7	53.3	1	0.8	7	2.4	3	2.5	2	---	---
64.8	7	43.2	3	**	**	2.0	5	1.9	5	14.3	2
---	---	---	---	---	---	---	---	---	---	---	---
---	---	---	---	---	---	---	---	---	---	---	---
65.2	8	51.2	2	1.3	2	3.5	1	2.2	3	---	---
80.6	10	44.9	3	0.8	7	3.6	1	---	---	---	---
60.5	4	38.7	5	0.5	9	1.6	8	1.7	7	---	---
60.0	4	61.1	1	---	---	**	**	---	---	**	**
---	---	---	---	---	---	---	---	---	---	---	---
54.8	1	41.4	4	1.1	3	1.9	6	1.8	7	---	---
64.2		**45.1**		**0.8**		**2.0**		**2.1**		**13.4**	
52.5	1	35.9	6	**	**	1.9	5	**	**	6.3	9
64.8	7	---	---	---	---	---	---	---	---	5.8	9
62.5	6	31.7	9	0.8	7	2.2	4	2.1	4	6.9	8
74.9	10	39.4	4	1.4	2	0.0	10	1.9	6	5.6	9
60.1	4	38.3	5	1.3	2	---	---	2.3	3	---	---
67.4	8	31.3	9	0.6	8	1.7	7	1.7	7	12.1	3
64.9	7	32.8	8	0.3	10	2.7	2	2.7	2	6.7	8
53.9	1	37.8	5	1.3	3	1.2	9	2.0	5	7.5	8
66.7	8	39.9	4	0.4	10	1.3	9	2.7	2	15.3	1
62.9	6	54.9	1	1.2	3	3.3	1	2.0	5	6.3	9
63.6	6	58.6	1	1.1	3	2.5	3	**	**	8.2	7
62.2	5	33.3	8	0.7	8	1.8	6	2.1	4	---	---
62.5	6	38.6	5	0.6	8	1.2	9	2.0	5	14.1	2
60.7	5	49.0	2	1.0	5	---	---	**	**	11.6	4
79.6	10	57.0	1	0.6	8	2.8	2	---	---	---	---
73.6	10	37.1	5	0.8	6	1.0	10	2.2	4	7.5	8
59.0	3	34.1	7	0.5	9	0.8	10	1.2	10	5.6	9
55.0	1	34.3	7	0.3	10	0.7	10	2.0	5	8.6	7
63.6		**38.2**		**1.2**		**1.0**		**2.1**		**7.0**	

Table C1.4 Part 1

Hospital Financial Performance Indicators, 2000–2001, British Columbia

Province/Territory	Total Margin		Current Ratio		Administrative Services Expense as a Percentage of Total Expense *		Information Systems Expense as a Percentage of Total Expense		Cost per Weighted Case	
	%	Decile	Ratio	Decile	%	Decile	%	Decile	$	Decile
British Columbia, by Regional Health Board and Community Health Council										
Arrow Lakes/Upper Slocan Valley CHC	4.4	8	2.5	10	10.7	3	---	---	2,726	7
Bella Coola and District THA	1.5	6	0.9	4	10.4	3	---	---	**	**
Boundary Health Council	8.8	10	0.7	2	10.5	3	1.4	5	2,336	9
Bulkley Valley Health Council	7.5	10	1.3	7	9.6	4	---	---	3,427	3
Campbell River/Nootka CHC	1.3	5	1.2	6	7.3	7	0.5	2	3,005	5
Capital Health Region	1.4	5	1.2	6	6.9	7	1.3	5	3,467	3
Cariboo Community Health Services Society	3.5	8	2.7	10	**	**	---	---	---	---
Castlegar and District Health Council	2.6	7	**	**	5.0	9	---	---	2,613	8
Central Cariboo Chilcotin Health Council	6.9	10	1.3	7	5.7	8	---	---	2,892	6
Central Coast Transitional Health Authority	**	**	1.5	8	**	**	---	---	**	**
Central Vancouver Island Health Region	0.2	4	1.1	6	6.3	8	1.5	6	2,910	6
Coast Garibaldi CHSS	2.8	7	1.9	9	12.1	2	1.6	7	---	---
Columbia Valley Health Council	9.2	10	1.1	6	11.0	3	1.0	4	3,068	4
Comox Valley Community Health Council	1.8	6	1.3	7	6.0	8	0.0	1	3,025	5
Cranbrook Health Council	1.4	5	2.0	9	6.5	8	0.7	3	3,685	2
Creston and District Health Council	9.5	10	0.4	1	7.7	6	---	---	3,639	2
East Kootenay CHSS	2.6	7	**	**	17.5	1	---	---	---	---
Elk Valley and South Country Health Council	3.5	8	1.9	9	10.9	3	---	---	2,986	5
Fort Nelson-Liard Community Health Council	0.7	5	1.7	9	13.4	1	---	---	2,826	6
Fraser Valley Health Region	2.1	6	0.8	4	8.2	5	2.0	9	2,644	8
Golden Health Council	4.5	9	2.4	10	10.1	3	---	---	2,998	5
Greater Trail Community Health Council	0.9	5	0.8	3	7.7	6	1.2	4	3,783	1
Kimberly Community Health Council	-0.8	3	0.6	2	**	**	1.0	3	5,071	1
Kitimat and Area Health Council	5.1	9	1.8	9	10.7	3	0.5	2	3,826	1
Kootenay Boundary CHSS	**	**	2.4	10	12.5	1	1.3	5	---	---
Mount Waddington Health Council	-1.2	3	1.8	9	14.8	1	0.1	1	**	**
Nelson and Area Health Council	0.5	5	1.0	5	8.6	5	1.1	4	3,014	5
North Coast Community Health Council	3.9	8	0.9	4	13.0	1	2.1	9	4,012	1
North Okanagan Health Region	2.4	7	1.3	7	6.8	7	1.4	5	2,862	6
North Peace Health Council	0.5	4	1.2	6	9.2	4	0.5	2	2,538	8
North Shore Health Region	0.2	4	0.8	4	7.5	6	1.8	8	3,522	2
North West Community Health Services Society	6.3	9	**	**	**	**	---	---	---	---
Northern Interior Health Board	4.5	9	1.3	7	8.1	5	2.2	9	3,599	2
Okanagan Similkameen Health Region	2.4	7	1.6	8	9.1	4	1.8	7	2,813	7
Peace Liard Community Health Services Society	4.1	8	**	**	14.5	1	1.0	3	---	---
Powell River Community Health Council	1.6	6	0.5	1	8.8	5	1.1	4	3,452	3
Queen Charlotte Islands/Haida Gwaii CHC	-5.2	1	0.5	2	14.1	1	---	---	**	**
Quesnel and District Community Health Council	6.5	10	0.5	1	2.9	10	---	---	3,761	1
Sea to Sky Community Health Council	3.4	8	1.1	5	13.6	1	1.0	3	3,544	2
Simon Fraser Health Region	1.1	5	1.0	5	5.2	9	1.1	4	2,678	7
Snow Country Health Council	**	**	**	**	12.9	1	0.8	3	**	**
South Cariboo Community Health Council	7.4	10	2.0	9	**	**	---	---	---	---
South Fraser Health Region	2.8	7	1.0	5	6.1	8	0.7	3	2,635	8
South Peace Health Council	4.2	8	1.6	9	11.9	2	---	---	3,698	2
Special Agencies	**	**	0.9	4	9.0	4	2.6	10	**	**
Stikine Health Council	**	**	0.9	4	**	**	---	---	---	---
Sunshine Coast Community Health Council	2.1	7	1.2	6	7.9	6	0.5	2	2,680	7
Terrace and Area Health Council	4.1	8	1.0	5	11.1	2	0.5	2	3,055	4
Thompson Health Region	1.0	5	1.3	7	7.5	6	1.8	8	3,007	5
Upper Island/Central Coast CHSS	0.0	4	1.3	7	2.8	10	0.5	1	---	---
Upper Skeena Community Health Council	2.9	7	2.5	10	11.7	2	---	---	1,347	10
Vancouver/Richmond Health Board	**	**	1.0	5	7.7	6	2.1	9	4,155	1
Provincial Average	**1.9**		**1.1**		**7.5**		**1.6**		**3,130**	

* Administrative Expense includes: Administration, Finance, Human Resources, Communications and Systems Support Functional Centres.
"**" = Value was outside of reportable range. See Methodology for Identification of Outliers in Methodological Notes
"---" = Not applicable or not reportable

Table C1.4 Part 2

Hospital Financial Performance Indicators - 2000-2001, British Columbia

Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked		Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case		Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case		Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case		Pharmacy Unit-producing Personnel Worked Hours per Weighted Case		Average Age of Equipment	
%	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Years	Decile
60.8	5	20.6	10	0.8	6	1.3	8	---	---	12.3	3
56.1	2	15.0	10	0.2	10	1.2	9	1.1	10	9.5	6
69.6	9	27.1	10	1.3	2	2.6	2	---	---	19.0	1
---	---	---	---	---	---	---	---	---	---	12.5	3
73.0	10	35.4	6	1.0	4	3.4	1	1.6	8	10.5	5
64.2	7	33.0	8	1.3	2	3.0	1	1.4	9	16.4	1
---	---	---	---	---	---	---	---	---	---	2.4	10
52.1	1	27.9	10	0.3	10	1.3	9	1.0	10	15.2	1
63.5	6	25.7	10	0.5	9	1.6	8	2.3	3	19.9	1
60.1	4	59.7	1	0.5	9	1.7	7	0.7	10	---	---
68.8	9	32.2	8	1.2	3	2.1	4	1.5	8	6.2	9
---	---	---	---	---	---	---	---	---	---	1.9	10
54.4	1	41.1	4	0.3	10	1.1	10	---	---	**	**
65.6	8	28.7	10	0.4	10	1.4	8	1.5	9	11.8	4
67.9	9	41.0	4	1.6	1	---	---	2.0	5	12.6	3
57.7	3	37.6	5	0.6	9	---	---	1.1	10	6.4	9
---	---	---	---	---	---	---	---	---	---	2.6	10
53.2	1	29.7	9	0.4	10	1.5	8	1.6	8	14.7	1
55.0	1	30.3	9	0.7	8	1.0	10	---	---	---	---
78.2	10	34.8	6	0.7	7	2.6	3	2.1	4	16.6	1
60.3	4	31.8	8	0.5	9	1.9	6	---	---	11.3	4
63.7	6	42.9	3	0.9	5	2.6	2	1.6	8	10.9	4
---	---	---	---	---	---	---	---	---	---	12.3	3
49.3	1	33.3	8	0.5	9	2.5	3	---	---	13.3	2
---	---	---	---	---	---	---	---	---	---	0.8	10
57.5	3	**	**	0.2	10	0.4	10	---	---	---	---
**	**	36.6	6	0.7	7	3.2	1	2.9	1	15.1	1
55.6	2	27.7	10	0.5	9	2.9	2	2.5	2	---	---
68.1	9	39.6	4	1.2	3	1.2	9	2.3	3	---	---
59.2	4	29.4	9	0.5	9	1.8	6	1.1	10	---	---
63.8	7	35.3	6	1.8	1	2.0	5	1.9	5	4.6	9
---	---	---	---	---	---	---	---	---	---	2.4	10
64.2	7	39.5	4	1.0	5	1.7	7	2.3	3	---	---
71.1	10	32.4	8	1.3	2	1.7	7	2.1	4	9.9	6
---	---	---	---	---	---	---	---	---	---	1.8	10
64.7	7	35.8	6	1.1	4	3.2	1	1.8	6	**	**
71.1	10	**	**	1.8	1	**	**	**	**	---	---
65.5	8	49.7	2	0.7	8	3.4	1	1.6	8	3.3	10
65.0	7	33.8	7	0.8	7	2.6	2	2.0	5	**	**
76.0	10	27.3	10	1.5	1	2.1	5	1.8	6	11.6	4
69.6	9	**	**	**	**	3.8	1	**	**	12.5	3
---	---	---	---	---	---	---	---	---	---	6.1	9
76.4	10	31.4	9	0.8	6	1.9	6	1.7	7	10.5	5
64.6	7	41.1	4	0.6	9	1.7	8	2.7	2	8.0	7
59.5	4	53.0	1	1.6	1	1.3	8	3.2	1	8.6	7
---	---	---	---	---	---	---	---	---	---	3.7	9
60.7	5	28.4	10	0.3	10	1.7	7	2.5	2	14.1	2
72.8	10	44.2	3	0.5	9	2.2	4	1.3	9	---	---
65.2	8	32.7	8	0.6	8	1.2	10	1.6	8	8.5	7
---	---	---	---	---	---	---	---	---	---	2.0	10
56.6	2	16.8	10	0.2	10	0.9	10	0.3	10	10.9	4
60.4	4	38.2	5	1.5	2	2.4	3	2.9	1	8.1	7
65.7		**34.7**		**1.2**		**2.2**		**2.1**		**9.4**	

Table C1.5 Part 1

Hospital Financial Performance Indicators, 2000–2001, Yukon Territory, Northwest Territories and Nunavut

Province/Territory	Total Margin		Current Ratio		Administrative Services Expense as a Percentage of Total Expense *		Information Systems Expense as a Percentage of Total Expense		Cost per Weighted Case	
	%	Decile	Ratio	Decile	%	Decile	%	Decile	$	Decile
Yukon Territory	-1.4	3	1.6	8	10.9	3	2.6	10	4,616	1
Northwest Territories	---	---	---	---	---	---	---	---	---	---
Nunavut	---	---	---	---	---	---	---	---	---	---

* Administrative Expense includes: Administration, Finance, Human Resources, Communications and Systems Support Functional Centres.
"***" = Value was outside of reportable range. See Methodology for Identification of Outliers in Methodological Notes
"---" = Not applicable or not reportable

Table C1.5 Part 2

Hospital Financial Performance Indicators - 2000-2001, Yukon Territory, Northwest Territories and Nunavut

Unit-producing Personnel Worked Hours for Patient Care Functional Centres as a Percentage of Total Worked		Nursing Inpatient Services Unit-producing Personnel Worked Hours per Weighted Case		Diagnostic Services Unit-producing Personnel Worked Hours per Weighted Case		Clinical Laboratory Unit-producing Personnel Worked Hours per Weighted Case		Pharmacy Unit-producing Personnel Worked Hours per Weighted Case		Average Age of Equipment	
%	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Hours	Decile	Years	Decile
55.9	2	42.0	3	1.0	4	3.1	1	3.0	1	2.2	10
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