Chapter 1

Summaries of Value-for-money Audits

3.01 AUTISM SERVICES AND SUPPORTS FOR CHILDREN

The prevalence of autism has been increasing. In Ontario, children diagnosed with autism may access general services and supports including speech therapy, occupational therapy and mental health services, funded by various ministries. Our audit focused primarily on services and supports funded by the Ministry of Children and Youth Services (Ministry) and provided exclusively to children with autism.

The Ministry funds two types of autism intervention services or therapies—intensive behaviour intervention (IBI) and applied behaviour analysis (ABA)-based services. These services and other supports exclusively for children with autism are delivered through approximately 90 community or hospital-based agencies that are usually not-for-profit organizations. In 2012/13, transfer payments for autism services and supports totalled $182 million.

In December 2012, the Ministry convened an expert panel to give it advice on some of the contentious issues the government has faced surrounding IBI, and it introduced an independent review mechanism to deal with disagreements between families and service providers regarding decisions on IBI eligibility or discharge.

Some of our key observations are as follows:

- Over the last decade, the Ministry has quadrupled autism funding. Despite this, there are more children with autism waiting for government-funded services than there are children receiving them.
- Although scientific research shows that children with milder forms of autism have better outcomes with IBI, the program is currently available only to children assessed with more severe autism. Research also shows that children who start IBI before age 4 have better outcomes than those who start later. However, due to long wait lists, children do not typically start IBI until almost age 7.
- We estimated that children with autism are diagnosed in Ontario at a median age of a little over 3 years, later than the 18-to-24-month screening period endorsed by the Canadian Pediatric Society for children with risk factors. The median wait time for accessing IBI services in the three regions we visited was almost four years.
- ABA-based services, the only type of provincially funded therapy available in Ontario to children with mild to moderate forms of autism, allow a child to work on only one goal at a time, and, thus, might not be sufficient for those who have many behavioural problems or goals to achieve. After achieving one goal, the child returns to the end of the wait list for the next available spot.
- The Ministry has not assessed whether resources are being distributed equitably across the province.

- It is up to the lead service agency to decide how to allocate ministry funding between two IBI service-delivery options: direct service, where the child receives service directly from a service provider at no cost; or direct funding, where the family gets funds from the lead service agency to purchase private services. Wait times for IBI services can differ significantly between the two options and among regions. In one region in 2012, the average wait for IBI services under the direct-funding option was five months longer than the average wait under the direct-service option. In another region, the situation was reversed.
- Of the children discharged from IBI services in 2012/13 province-wide, those under the direct-funding option received on average almost one year more of services than those under the direct-service option (35 months versus 25 months). In general, children receiving IBI under the direct-service option received fewer hours of therapy than they were approved for. One of the key reasons that this arises is because missed appointments cannot be rescheduled.
- Since 2006, the Ministry has reimbursed up to 60 people for a total of $21 million for the ongoing cost of IBI outside of the regular service program. Per child, this represents more than twice the amount that a child in the regular service system typically receives. This practice of special treatment continues while others are on a wait list for services.
- More work is necessary to ensure that ABA methods are being effectively used in schools to educate children with autism.
- Ontario does not have a provincial autism strategy. However, in May 2013, the provincial legislature passed a motion creating a select committee to work on a comprehensive developmental services strategy that is planned to include autism.

3.02 HEALTH HUMAN RESOURCES

The Ministry of Health and Long-Term Care (Ministry) and the Ministry of Training, Colleges and Universities jointly developed the HealthForceOntario Strategy (Strategy) in 2005/06 to address concerns over shortages of physicians and nurses in Ontario and long wait times. The intent is to ensure that Ontario maintains the right number, mix and distribution of qualified health-care providers. Total expenditures for the Strategy in 2012/13 were $738.5 million, an increase of about 65% from the $448 million spent in 2006/07. Over the last six years, the Ministry has spent $3.5 billion on the Strategy.

As part of the Strategy, the Ministry established the HealthForceOntario Marketing and Recruitment Agency (Agency) in 2007. The Agency focuses on recruitment and retention of health professionals.

Overall, Ontario has not met its goal of having the right number, mix and distribution of health-care professionals to meet its future health-care needs, despite the fact it has seen an 18% increase in physicians from 2005 to 2012 and a 10% increase in nurses from 2006 to 2012.

Our most significant observations include the following:

- Access to health care is still a problem for some Ontarians, particularly those who live in rural, remote and northern areas of the province. As of 2011, 95% of physicians in Ontario practised in urban areas and 5% in rural areas. At the same time, 14% of the population lived in rural areas.
- Many specialists who are trained in Ontario—at a cost of about $780,000 each (including $375,000 for resident salaries and benefits)—do not stay in and practise in Ontario primarily because there are few full-time employment opportunities for these graduating specialists. Statistics show that, on average, 33% of Ontario-funded surgical specialist graduates left the province each year from 2005 to 2011 even though there are long wait

times for some of the same services (such as forefoot surgery and knee replacement surgery) these physicians are trained to provide.

- Locum programs, which are meant to provide access to health-care professionals in eligible communities, particularly in Northern Ontario, to cover short-term vacancies, are instead being used for long periods of time. The latest data available at the time of our audit indicated that there were about 200 permanent positions for specialists vacant in Northern Ontario. At the time of our audit, one-third of the hospitals that were using temporary physician services as part of the Emergency Department Coverage Demonstration Project had been using them continuously since 2007.
- At the end of 2011, 66.7% of nurses were working full-time in Ontario, which was just slightly under the Ministry's goal of 70% of nurses working on a full-time basis. However, the Ministry needs to improve its oversight and assessment of the effectiveness of its nursing programs and initiatives. For example, the Nursing Graduate Guarantee Program provides organizations with funding for up to six months with the expectation that they will offer permanent, full-time jobs to participating new graduate nurses. However, only about a quarter of these new graduate nurses in 2010/11 and a third in 2011/12 actually were given permanent full-time jobs.
- Although the physician forecasting model built in partnership with the Ontario Medical Association was a positive step in determining physician workforce requirements, it is hampered by the limited reliability and availability of data, especially on physician productivity. These limitations make planning the optimal numbers, mix and distribution of physicians with appropriate funding, training and employment difficult.
- As well, the model currently being developed to determine the supply of nurses does not consider the number of nurses needed to meet the population's needs.

3.03 HEALTHY SCHOOLS STRATEGY

The increasing incidence of overweight children in Canada has become a significant public concern. Nearly one in three students is overweight. Almost 12% are considered obese—almost twice as many as in the late 1970s. In 2012, the Ontario government set a goal of reducing childhood obesity by 20% in five years.

The Ministry of Education (Ministry), which has primary responsibility for publicly funded schools, has established the Healthy Schools Strategy to support students' learning and growth through proper nutrition and physical activity. In this endeavour, the Ministry relies on the support of other government ministries, such as Health and Long-Term Care and Children and Youth Services.

Ontario's 72 publicly funded school boards operate 4,900 elementary and secondary schools with an enrolment of approximately 2 million students. The Ministry told us it spent about $4 million annually over the three fiscal years 2009/10 to 2011/12 on activities related to the Healthy Schools Strategy.

The Ministry has developed policies for the nutritional requirements of food and drinks sold in schools. It has also revised the school curriculum to require that all elementary students get 20 minutes of physical activity each day. We found, however, that the Ministry and school boards need to put more effort into ensuring that schools are complying with these requirements, and they need to work more effectively with other organizations and stakeholders, including parents, to share effective practices for encouraging healthy living and increased physical activity throughout the system.

Our key observations were as follows:

- Neither the Ministry nor the school boards we visited had effective monitoring strategies to ensure that food and drinks sold in schools complied with the nutrition standards in the

Ministry's policy. Officials at the three school boards we visited had not reviewed the food and drinks sold in their cafeterias to ensure they met the standards.

- Our review of a sample of menu items at one school board identified a number of items that did not meet nutrition criteria in the food and drink policy, some to a significant degree.
- After healthier food choices were introduced, secondary school cafeteria sales at the three school boards we visited decreased between 25% and 45%. Vending machine revenue also dropped between 70% and 85%. Principals we spoke with said many students now preferred to eat at nearby fast-food restaurants.
- There was no formal monitoring by the Ministry, school boards and schools we visited to ensure students in grades 1 to 8 had the 20 minutes of daily physical activity during instruction time as required by the elementary school curriculum. Two of the three school boards we visited conducted surveys of school representatives, and more than half of those who responded said that students at their schools did not get the required 20 minutes a day.
- The Ministry's requirement for physical activity at the high school level is much lower than it is in some other jurisdictions. In Ontario, students must complete only one credit course in health and physical education during their four years of high school. In Manitoba, students must obtain four such credits to graduate, and in British Columbia, students must participate in at least 150 minutes of physical activity per week.

3.04 LAND AMBULANCE SERVICES

Under the *Ambulance Act*, the Ministry of Health and Long-Term Care (Ministry) must ensure "the existence throughout Ontario of a balanced and integrated system of ambulance services and communication services used in dispatching ambulances."

The Ministry oversees land ambulance services in Ontario. It is responsible for setting patient-care and ambulance equipment standards, monitoring compliance with those standards and, through service reviews, certifying ambulance service providers. Municipalities (42 municipalities and eight other designated delivery agents) are responsible for providing land ambulance services.

In total, 50 Ontario municipalities have about 830 ambulances and 300 other emergency response vehicles, which carry paramedics but do not transport patients.

There are 22 Ministry-controlled dispatch centres in Ontario—11 run by the Ministry, six by hospitals, four by municipalities and one by a private operator. Physicians in seven base hospitals are responsible for providing medical support to paramedics with complex or risky medical procedures. In 2012, about 1.3 million ambulances were dispatched and about 970,000 patients were transported, an increase of about 15% for both since 2008.

Over the last few years, the Ministry has funded about 50% of each municipality's prior-year costs for ambulance services, plus an increase for inflation, as well as 100% of approved costs for ambulance dispatch centres and base hospitals. The Ministry funds 100% of the cost for the 10 First Nations ambulance services and for those in certain other remote areas. For 2011/12, total ambulance costs were $1.1 billion, $627 million of which were funded by the Ministry and $477 million by municipalities.

From 2004/05 to 2011/12, Ministry funding to municipalities for land ambulance services nearly doubled. However, the number of patients transported increased by only 18% during that time. The Ministry does not know whether the increased funding has resulted in faster response time or better patient outcomes.

The Ministry's funding formula automatically provides more funding each year to ambulance services that spend more, regardless of the level of service they provide. The Ministry does not analyze the relationship between funding and levels of service, and it does not determine the reasons

that some municipalities spend and receive more compared to others. In 2012, only about 60% of the 50 municipalities responded to 90% of their emergency calls within 15 minutes.

We noted other areas where action is needed, including the following:

- The Ministry has set meaningful response-time standards for the most time-sensitive patients, such as those who are choking or experiencing cardiac arrest, but not for other urgent cases, such as strokes. Each municipality sets its own response-time targets for these patients and they vary significantly, from 9% (rural) to 85% within eight minutes.
- The Ministry does not have a patient-centred measure of the ambulance service system's overall response time, that is, from the time of call receipt to when an ambulance arrives at the patient's location.
- While the Ministry expects to publicly report ambulance response times starting in 2014, the reporting method used is to be based on patient urgency measured by paramedics after they reach a patient (i.e., retrospectively) rather than on information provided by callers at the time of dispatch. Most other jurisdictions report response times based on information available at the time a call is dispatched. We found no other jurisdiction that used a retrospective response time measure.
- In 2012, none of the 20 dispatch centres that measure their time to respond to emergency calls complied with the Ministry's policy of dispatching 90% of calls within the target of two minutes. However, all dispatched 90% of these calls within three and a half minutes. As of 2013, each dispatch centre was allowed to choose the percentage of urgent calls it would need to dispatch within two minutes. As a result, dispatch centres' required compliance rates ranged from 70% to 90%, depending on the dispatch centre.
- While dispatch protocols are generally designed to over-prioritize calls when there is uncertainty about a patient's condition, the Ministry's dispatch protocol prioritized more than two-thirds of calls at the most-urgent level, when only about 25% of patients actually required an urgent response. This can leave few or no ambulances available to respond to new calls that are truly urgent.
- The Ministry has not assessed whether the current number of dispatch centres is optimal, or whether centralized dispatch would be more cost-effective.
- The Ministry has no provincial policy to ensure appropriate care of certain heart attack patients, and a June 2013 survey indicated that some ambulances did not have trained paramedics and appropriate equipment to ensure proper patient care for such heart attack patients.
- Municipalities acquired patient-care record software that cannot electronically share patient records with hospitals. As a result, hospital emergency room staff often do not have access to such records until a day or two later, relying instead on verbal briefings from ambulance paramedics.
- Municipalities are responsible for overseeing most paramedic patient-care activities, even though base hospital physicians have indicated municipal land ambulance service providers may not have the expertise to provide proper oversight.
- In 2012, over 25% (or about 350,000) of ambulances dispatched did not transport a patient. The Ministry has not assessed the underlying reasons.
- The Ministry has not evaluated the patient offload nurse program for value-for-money. Between 2008/09 and 2012/13, ministry funding for this program totalled $40 million. We found that since this program was implemented, ambulance waiting time while stationed at the hospital has actually increased at 20% of the hospitals funded.

3.05 ONTARIO POWER GENERATION HUMAN RESOURCES

Ontario Power Generation (OPG), a corporation owned by the province, is one of the largest power generators in North America. However, the amount of power OPG produces has decreased by 23% over the last decade because the demand for electricity has decreased, coal-fired plants have closed and there is more private-sector involvement in new power generation.

Despite the declining electricity demand, electricity prices have been rising in Ontario. Given that OPG still generates 60% of the province's electricity, its operating costs have a significant impact on the cost of electricity, particularly with respect to labour costs, which in 2012 were about $1.7 billion, or 64% of its total costs for operations, maintenance and administration.

OPG initiated its Business Transformation Project in 2010, with a target of reducing staffing levels by 2,000 employees through attrition by 2015. While OPG has made some progress in reducing its overall staffing levels, we found several areas where its human resource management and compensation and benefit practices need improvement. Many of our concerns were echoed by respondents to our anonymous survey of more than 800 OPG staff.

Some of our key observations were as follows:

- While OPG's overall staffing levels have gone down about 8.5% (to 11,100 in 2012 from 12,100 in 2005), the size of its executive and senior management group has increased by 58% (to 238 in 2012 from 152 in 2005).
- OPG rehired some former employees, almost all of them shortly after they left OPG, indicating ineffective knowledge transfer and succession planning. Some continued to receive significant allowances and Annual Incentive Plan (AIP) awards, and some had already drawn their pensions in lump sums after they left.
- Even after staff reductions at nuclear facilities starting in 2011, the area of maintenance, janitorial and custodial services was still staffed at a level 170% above the industry benchmark in 2013. Meanwhile, some operational functions were significantly understaffed, including nuclear plant operations, while their associated support functions were overstaffed.
- We found areas of non-compliance in OPG's recruitment and security clearance processes. About 700 pairs or groups of employees live at the same addresses and appear likely to be related. However, OPG had no documentation to show whether family members of staff had been hired through the normal recruitment process. As well, more than 50% of OPG staff, including senior staff with access to confidential nuclear information, had never obtained the required security clearances or had expired clearances.
- OPG gives Annual Incentive Plan awards to all non-unionized staff, ranging from $1,600 to $1.3 million, depending on the job level, base salary and AIP score on a scale of 0 to 4. However, high scores were given much more frequently to staff in senior positions and there were a number of cases with limited documentation to support the score achieved.
- Earnings were significantly more generous at OPG than for comparable positions in the Ontario Public Service (OPS) and many of OPG's senior executives earned more than most deputy ministers. As well, since 2005, OPG's employer-employee pension contribution ratio has been around 4:1 to 5:1, significantly higher than the 1:1 ratio for the OPS. OPG is also solely responsible for financing its pension deficit, which was about $555 million in its latest actuarial valuation.
- Some of OPG's employees received generous benefits that seem questionable. For example, an employee received over $392,000 in relocation benefits from OPG, on top of the proceeds of $354,000 from the sale of his old residence. Another employee who moved further away from his new work location received $80,000 in housing and moving allowances.

- The number of OPG staff earning more than $50,000 in overtime pay per year had doubled since 2003. Planned nuclear outages have resulted in high overtime pay, especially for inspection and maintenance technicians.

3.06 PRIVATE SCHOOLS

Private schools in Ontario must be registered with the Ministry of Education (Ministry). In the 2012/13 school year, more than 1,000 elementary and secondary private schools were registered and they reported a total enrolment of 110,000 students. These schools are considered to be independent organizations, and are not required to follow policies developed for publicly funded schools or to follow the Ontario curriculum unless the school offers credits toward the Ontario secondary school diploma.

The Ministry conducts program inspections at only those registered private schools that offer credits toward an Ontario secondary school diploma. The programs offered at non-credit-granting schools are not inspected by the Ministry. The results of standardized academic tests suggest that the quality of education provided by participating private schools varies from well below average to excellent. Based on standardized test results we reviewed, a greater percentage of public school students achieved the provincial standard than private school students.

Ontario has one of the least regulated private school sectors in Canada. The Ministry provides very little oversight to ensure that private school students receive satisfactory instruction and, on its website, cautions parents to exercise due diligence before entering into a contract to educate their children at a private school.

Our major observations included the following:

- The Ministry noted significant concerns at 100 of the 400 schools that offer high school diploma credits. Many of these concerns related to credit integrity, meaning whether a student actually earned the credits granted toward his or her grade 12 diploma.
- To help prevent diploma fraud, the Ministry reconciles blank diploma requests from public schools to grade 12 student enrolments. However, this procedure is not applied to private schools and, for example, 30 private schools received a total of 1,500 more diplomas than their grade 12 enrolment. The Ministry also issued 2,300 diplomas to 50 schools, even though they had not submitted the required enrolment data.
- There is a risk that some private schools may be operating unlicensed child-care centres. According to ministry information, there may be more than 15,000 children younger than compulsory school age enrolled in private schools. The Ministry allows private schools registered before June 1993 to operate child-care facilities without a licence. In contrast to licensed daycare, there is no limit to the number of children of any age that private school staff can oversee, there are no fire safety requirements, and private school staff are not required to have child-care qualifications.
- For the more than 600 elementary and non-credit-granting secondary schools, education officers conduct a brief visit to validate newly registered schools, but there is no process in place to ever visit these schools again. The Ministry does not evaluate the curriculum for quality or content; does not check for any health and safety issues; and has no process to inform other oversight agencies of any concerns noted.
- Given the limitations of the validation process, private schools are not permitted to state that the Ministry has approved their academic program. However, we identified several cases where private schools were advertising that their programs had been accredited by the Ministry. Parents, students and the public could be misled into thinking that the Ministry ensures some level of education quality at these schools.

- Approximately 250 private schools had still not submitted required information on their students for the 2011/12 school year by June 2013, a full year after the school year had ended.

3.07 PROVINCIAL PARKS

The *Provincial Parks and Conservation Reserves Act* (2006) (Act) governs the development, operation and management of Ontario's 334 provincial parks, about a third of which are operating parks that provide recreational opportunities like day-use areas and overnight camping. The Ministry of Natural Resources (Ministry) is responsible for establishing, operating and managing provincial parks in accordance with the Act.

The purpose of the Act is to permanently protect a system of provincial parks and conservation reserves that contain significant elements of Ontario's natural and cultural heritage and provide opportunities for ecologically sustainable recreation.

In 2012/13, the 114 operating parks, which charge fees for the use of the parks and facilities and services offered within them, attracted more than 9 million visitors. (Non-operating parks, while still accessible to the public, have no staff on site and offer only limited facilities.) Provincial parks generated about $69 million in revenues, while operating expenses, including head office expenses, totalled $80 million. Historically, revenues generated by user fees have recovered more than 80% of the parks' operating costs, with the province making up the difference. Expenditures related to the planning and protection of the park system are funded solely by the province, which also funds park infrastructure.

Over the last 10 years, provincial parks have grown in number and in size. The 2006 Act expanded the requirements for ensuring that the natural values within the parks are protected. The growth of the park system and the expanded responsibilities in the Act have challenged the Ministry's ability within its funded resources to meet its legislated mandate to protect the park system and provide opportunities for ecologically sustainable recreation.

Specifically, we found the following:

- According to the Act, maintaining ecological integrity is the first priority in managing the parks. As a result, the Act requires each park to have in place a management direction that provides policies for the protection, development and management of the park's resources and values. An ecologist we retained for the audit reviewed a sample of the directions that the Ministry had deemed to be consistent with the Act and concluded that none contained a clear statement that ecological integrity was the first priority in managing the park. In fact, every management direction reviewed noted significant damage to environmental conditions within the park, but none put forward meaningful strategies to address them.
- The Ministry's own 2011 survey of park planners, ecologists, biologists and park superintendents revealed that the Ministry lacked the baseline scientific data on the park system that it requires to meet the rigorous standard of the Act. We noted that in Ontario one ecologist, aided only by a seasonal assistant and a few park biologists, might be responsible for research and monitoring in 20 to 50 provincial parks. As a comparison, Parks Canada told us that each park in the federal system has a science team of at least one ecologist supported by a team of technicians.
- Significant portions of the provincial park system are subject to little or no enforcement of regulations on hunting and fishing, and of the prohibition of such activities as commercial timber harvesting and mining.
- The Ministry has a significant backlog for expenditures on capital assets. We estimated that assets such as buildings, roads, bridges, drinking water systems and septic systems listed as being in "poor" or "defective" condition require more than $590 million

to replace. Since our last audit of provincial parks in 2002, the backlog has increased by approximately $160 million.

- There are nearly 600 private cottage properties held under lease in two provincial parks. We noted that the lease payments are significantly below fair market value and should generate approximately $6.7 million more in revenue than the Ministry receives.

3.08 REHABILITATION SERVICES AT HOSPITALS

In coming years, the demand for rehabilitation services, such as physiotherapy and occupational therapy, in Ontario is expected to increase significantly, especially after 2021 when the first baby boomers turn 75. In 2012/13, about half of regular rehabilitation inpatients were over 75 years of age.

The Ministry of Health and Long-Term Care (Ministry) funds inpatient rehabilitation services in 61 hospitals through 14 Local Health Integration Networks (LHINs). There are two kinds of inpatient rehabilitation: regular (frequent sessions for a short term) and restorative (slower-paced and over a longer term). The 61 hospitals have almost 2,500 regular rehabilitation beds to which more than 30,000 patients were admitted in 2012/13. Orthopedic conditions (including hip and knee replacements) and stroke were the most common reasons people were admitted to regular rehabilitation inpatient programs. There is no information available on the total number of restorative rehabilitation beds or admissions.

The Ministry funds rehabilitation services for eligible Ontarians. This includes hospital rehabilitation inpatients and hospital-registered outpatients. The Ministry also funds community-based services for qualified people, including those 19 and under and 65 and over; people who require physiotherapy at home or in long-term-care homes; and people who are eligible for social or disability assistance from the province.

The Ministry does not have information available on the total public funding spent on rehabilitation services or on the number of patients who use hospital-run outpatient programs.

There is currently no co-ordinated rehabilitation system in Ontario. Instead, individual hospitals—some with input from their LHIN—generally determine which inpatient and/or outpatient rehabilitation services they will offer, if any. This means that each hospital establishes its own policies and procedures for determining patient eligibility for its services, prioritizing patients and providing care. As a result, a patient deemed eligible for services at one hospital might not be eligible for similar services at another. Many stakeholder associations have called for better provincial co-ordination of rehabilitation programs, to help transition people from acute care to rehabilitation and to ensure patients receive rehabilitation when needed.

Some of our other significant observations include the following:

- There is wide variation in the supply of regular rehabilitation inpatient beds across the province, which could mean that patients have to travel outside their LHIN for services. The number of beds ranged from 57 per 100,000 people in the Toronto Central LHIN to only six per 100,000 in the Central West LHIN. The provincial average is 18 beds per 100,000.
- The lack of information on the use or outcomes of restorative inpatient rehabilitation or on outpatient rehabilitation means the Ministry does not know if those services are effective.
- Approximately a third of patients admitted to inpatient rehabilitation at the two hospitals we visited with stroke programs had been assessed by an acute-care hospital as having mild functional impairment. This suggests they might have been better served in outpatient programs if these less costly services were available.

- Patients who no longer required hospital care may be occupying beds needed by other patients. The Ontario Hospital Association reports that as of March 2013, about 2,300 alternate-level-of-care patients who were ready to be discharged were waiting in acute-care hospital beds for arrangements to be made. Of these, 25% were waiting for a regular rehabilitation bed or a complex continuing care (which includes restorative rehabilitation) bed.
- With the exception of stroke, for most conditions requiring rehabilitation, there are few best-practice standards in Ontario for such matters as when therapy should start and frequency of treatment. Practices varied at the hospitals we visited.

3.09 SERVICEONTARIO

ServiceOntario, a separate part of the Ministry of Government Services, has a mandate to provide centralized service delivery to individuals and businesses for a number of programs involving vital events, such as birth, marriage and death certificates; business services, including company registrations; personal property security registration and services; and land registration services.

ServiceOntario also processes, for 14 other ministries, high-volume routine transactions, most significantly driver licensing renewals and vehicle registrations and health-card renewals and registrations.

In the 2012/13 fiscal year, ServiceOntario handled more than 35 million transactions, with in-person service centres accounting for 70% and the Internet 30%. ServiceOntario also handled about 12 million requests for information and referrals—55% of these were made online, 38% through the telephone contact centres and 7% at in-person service centres.

ServiceOntario has made substantial accomplishments in centralizing service and is generally meeting its service level targets, but it needs to improve in several key areas. It needs to continue to strengthen its systems and procedures to reduce service delivery costs, effectively monitor service levels and customer satisfaction, and reduce its risks in issuing and managing licences, certifications, registrations and permits.

Specifically, action is needed in the following areas:

- In 2012/13, only 30% of ServiceOntario transactions were done online, well short of its 2008 forecast that 55% to 60% of transactions would be online by 2012. Further savings could be achieved if ServiceOntario could encourage people to switch to doing business online instead of in person. For instance, we estimated that operating costs would decrease by approximately $2.9 million annually if 50% more licence plate sticker renewals were done online.
- ServiceOntario has improved its website services, but its online customer satisfaction rating has remained at 71% to 75% since 2009/10.
- ServiceOntario rated 43% of its 289 in-person service centres as high-risk locations because of the number of processing errors uncovered by its audits. These ranged from incorrect financial charges to missing signatures on health-card applications to renewing the wrong licence plate number to transferring a vehicle to a name other than the one on the application.
- ServiceOntario did not measure or report on the customer wait at peak times or at specific service centres, which often far exceeded its target time of 15 minutes.
- In 2012/13, none of ServiceOntario's seven telephone contact centres met its service standards for answering calls. The range of success in answering calls within targeted times was 51% to 77%, compared to its goal of 80%.
- Significant fraud risk still exists 18 years after the government announced its plan to reduce costs and risks by replacing the red-and-white health card, which has no expiry date, with the

more secure photo health card. As of August 1, 2013, 3.1 million red-and-white cards remained in circulation, or 23% of the total of 13.4 million health cards issued in Ontario.

- We estimated that as of March 31, 2013, approximately 1,500 people in Ontario had been issued duplicate health cards, increasing the risk of misuse. As well, more than 15,000 active health cards and 1,400 driver's licences were circulating in the names of people who were reported to ServiceOntario as deceased.
- ServiceOntario had weak processes for issuing and controlling accessible parking permits to ensure they were not being misused by people who did not require them.
- ServiceOntario did not verify that people registering large commercial agricultural vehicles—which are registered at a reduced rate compared to other commercial vehicles—were indeed farmers. We estimate this could be costing the province about $5 million annually.
- ServiceOntario had no plans in place to stop printing birth certificates on paper and switch to higher security polymer (plastic) documents and a new design to minimize identity theft, forgery and loss as recommended by the Vital Statistics Council for Canada. Eight other provinces have already switched to polymer documents.

3.10 VIOLENCE AGAINST WOMEN

The Ministry of Community and Social Services (Ministry) provides a number of community programs and services to help women and their children who are victims of domestic violence find safety and rebuild their lives.

The Ministry provides transfer payments to more than 200 community not-for-profit agencies, which are governed by volunteer boards of directors, to deliver supports and services to abused women and their children. In 2012/13, the Ministry spent $142 million on transfer payments, of which $82 million went toward the operation of 95 shelters and $60 million toward other supportive services, including community-based counselling, crisis help lines, and services to help women secure more permanent housing.

During the last decade, Ontario released two action plans to address violence against women: the Domestic Violence Action Plan (2004) and the Sexual Violence Action Plan (2011). As well, in 2009, the Domestic Violence Advisory Council (Council), created by the Minister Responsible for Women's Issues, released a report with 45 recommendations for improving the system of services for abused women and their children. The Ontario Women's Directorate (Directorate) is responsible for co-ordinating the implementation of the action plans and the Council's recommendations.

By 2013, we would have expected the government to have assessed whether the 2004 Domestic Violence Action Plan was meeting its objectives of preventing domestic violence and improving supports for abused women and their children. However, the progress reports that have been issued publicly by the Directorate have been mainly anecdotal and have not offered clear reports on the status of the implementation of individual commitments.

Meanwhile, Statistics Canada data on the prevalence of domestic violence before and after the release of the 2004 plan showed some change in Ontario. The percentage of women who reported experiencing spousal abuse decreased from 7% in 1999 to 6.3% in 2009.

Our more significant observations included the following:

- The Ministry does not have the information it would need to identify the unmet demand for services and, in turn, allocate resources to close the gap. For example, in 2011/12, emergency shelters reported that they turned away 15,000 women, or 56% of the women who sought their help. However, this figure overstates unmet demand because the Ministry does not track how many of these women were referred to another agency and received services there.

- Ministry funding to transfer-payment agencies is generally based on what an agency received in previous years, with little or no correlation to identified needs or past performance. As a result, we found significant variations in unit costs among agencies providing similar services. In 2011/12, Ministry-approved annual funding for 10-bed emergency shelters ranged from $334,000 to $624,000, so that the per-day cost of care ranged from $90 to $575.
- The Ministry's client satisfaction survey provides limited value because of its low response rate. In addition, no surveys were completed for 20% of agencies and fewer than 10 surveys were completed for another 40%.
- In 2009, an assessment of the condition of shelter buildings identified more than 500 safety and security issues that needed attention. As of March 31, 2012 (the latest available update), the Ministry had provided funding for only 10% of those deficiencies and it did not know whether the funded projects had been completed or whether the agencies themselves had paid to fix any of the other problems.