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While 30-40% of all primary energy use is in buildings (UNEP, 2007), hospitals account for a proportionally higher amount as they operate around the clock and have extra requirements for clean air, disease control, imaging equipment and waste management (Kolokotsa et al., 2012). In Ontario, an increase in demand due to an aging population is driving up health care costs and as a result hospitals in Ontario have been under increased pressure to improve services and to reduce costs (Ontario Ministry of Finance, 2010). While investment in energy efficiency can lead to significant cost savings and free up funding for patient care, there is evidence that Ontario hospitals fail to invest in energy efficiency even though it is profitable to do so (Jefferson, 2006), a phenomenon referred to as the “energy efficiency gap” (Jaffe & Stavins, 1994). Institutional theory attributes the behaviour of individuals and organisations to the social context that they operate within allowing a broader tool to solve challenging social issues. This theory contrasts with rationalist theories, which attribute individual and organizational behavior to the characteristics or motives of individuals or organisations operating in isolation. This study makes use of a three-level model developed by Crittenden (2014) to investigate the organisational fields of energy management practices in Ontario Hospitals, including government, hospitals, energy consultants, energy suppliers, non governmental organisations (NGOs), foundations, energy teams, facilities departments and other individuals. The stakeholders within the organisational field were revealed inductively through the use of interviews and analysis of secondary sources of data, including conservation and demand management (CDM) plans, which provide information about how a hospital will conserve energy over a five-year period. The study documented the interactions between multiple actors, and the ways in which their behavior and risk aversion influenced energy management practices in small and large, urban and rural hospitals in Ontario. The study addresses the following questions: Who are the key organisational stakeholders that have an interest in energy management practices in Ontario hospitals? How do they interact and influence the development of adopting energy management practices? How does the hospital and organisational field-level context influence individual decision-making on energy efficiency projects? Preliminary findings include an analysis of policy instruments, including those that require Ontario hospitals to run a balanced budget, making it illegal for expenses to surpass revenues in any given year. While this provincially mandated act promotes fiscal responsibility, a seemingly unintended consequence is a reduction in Ontario hospitals’ willingness to take on risk through investment in energy efficiency. Risk aversion related to an unbalanced budget impacts hospitals’ behaviour in implementing energy efficiency projects and affects individual-level behaviour due to risk of job loss. Several recommendations have been developed to mitigate risk aversion and promote collaboration in advancing energy efficiency in Ontario hospitals.