The Ontario Alternative Budget 2003

The Harris-Eves health care prescription:

The cure is worse than what ails us

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The Harris-Eves health care prescription: The cure is worse than what ails us

Executive summary

On the eve of an Ontario election, this paper reviews the Conservative government's record on health care spending. It raises questions about the government's health care priorities and accountability for its spending. It describes the impact of the recent Federal-Provincial Health Accord on Ontario. Finally, it considers what the Conservatives' recent budget tells us about what we can expect if the government is elected for another term.

Key findings include:

- Staffing levels in Ontario's hospital and long-term care facilities have dropped dramatically during the two terms of this government. In 1995, there were 168 hospital staff and 93 long term care staff for every 10,000 Ontarians. Today there are 153 hospital staff and 75 long-term care staff per 10,000.
- Ontario has handed over the majority of contracts for long-term care to for-profit corporations. Ontario now has one of the worst staffing and care levels in the country and among the highest costs.
- The Government has privatized homecare, cut seniors' home support services, and exempted the sector from public access to information. The government introduced legislation giving themselves the power to replace community Boards and wipe out community membership on governing bodies for homecare.
- The recent Health Accord contains no provision that would prevent increased federal dollars from going toward the Ontario Conservatives' program of tax cuts, or toward for- profit health care. Indeed, the first $967 million in new federal health care funding arising from the accord has already been used to offset what would otherwise have been a deficit in the 2002-3 budget caused by the failure of the government's hydro policy.
- Increases in federal CHST payments to Ontario since 1999-2000 have virtually paid for the increases in provincial health care funding over the period.
- The recent federal-provincial Health Accord will provide $11.4 billion in new funding for Ontario over the next five years. The Tories have already spent $967 million of that money paying off last year's deficit. A further $3.7 billion of the new federal transfer is so loosely conditional that it, too, may be used for the next round of tax cuts. Coincidentally, the cost of eliminating the surtaxes on incomes above $75,000 will come in at about $3 billion.

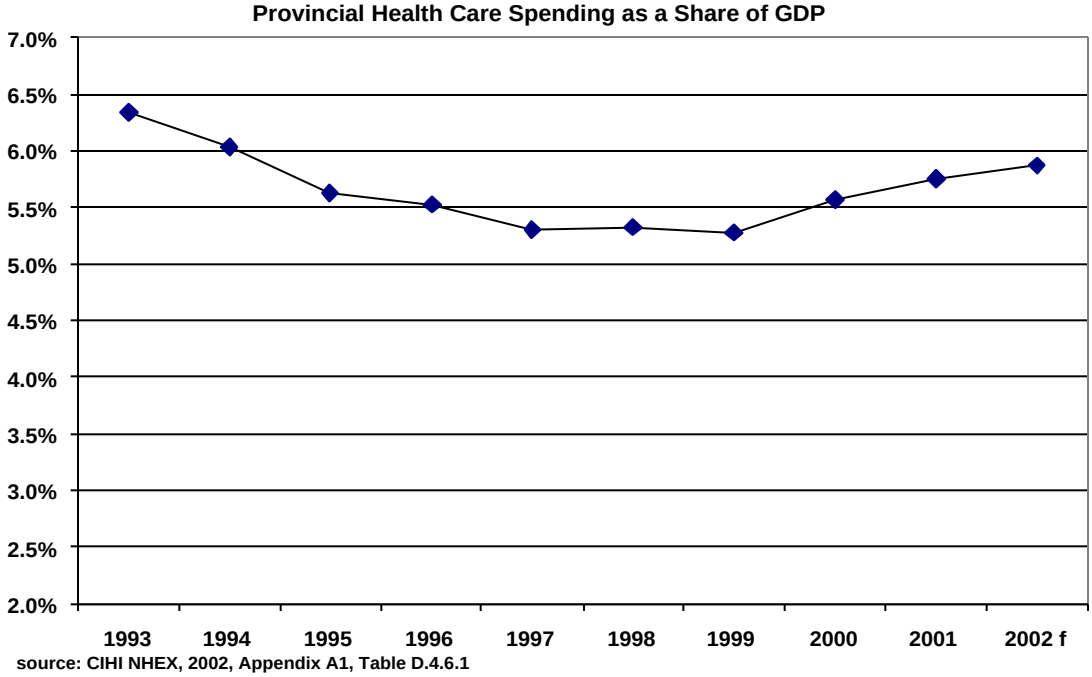
Where have the Tories' neoliberal experiments led us?

The Ontario government's record on health policy has been erratic and without focus. It has been characterized by a series of neoliberal policy experiments and reversals, with disastrous results. The government decided that there were too many nurses and provided subsidies for severance pay. Then it had to scramble, and offer subsidies, to hire more. It closed hospital beds and laid off staff. Then it had to try to re-hire the health care workers who had been laid off so that beds could be reopened. It shifted funding to for-profit home and long-term care. Then it had to put some provider companies under trusteeship. And now, in the latest experiment the Government is turning to the private sector to build capacity through "public-private partnership" (P3) hospitals, a policy that the Romanow Report suggested could be more costly and less effective than investing directly through the public purse.

After cutting spending in the first year of their first term, the Tories provided increases that were below the increase in inflation and population growth during the next two fiscal years. After that experiment in "restructuring" proved unsuccessful, the Tories began to put some funding back into the health care system.

The government then began to claim that health spending was growing at unsustainable rates. Figure 1 shows provincial health care spending as a share of GDP. It measures whether or not an increasing share of the province's economic resources is being used for health care. The figure shows that provincial government health care spending is not taking up an increasing share of the province's resources, and has actually moved over a very narrow range of between 5.3% and 6.3% of GDP since 1993.

Figure 1. Spending definitely not out of control



source: CIHI NHEX, 2002, Appendix A1, Table D.4.6.1

Another way to put health care spending in Ontario in context is to compare it with other industrialized countries. Combined public and private health spending in Ontario is expected to account for 9.7% of GDP in 2002. Compared to G-7 nations, Ontario's spending in relation to GDP is in the middle: a little more than two percentage points above the UK; three percentage points below the U.S. (see Figure 2).

But, despite obvious differences in economies, population age, geography and culture, the fact is that, according to the OECD[1], most other developed countries (except the U.S.) spend roughly the same share of their GDP on health care (between 8% and 10% of GDP).

Where did the money go?

Over the Conservatives' two terms, health care spending has increased by almost $9 billion. However, these increases have not resulted in major components of the system receiving stable funding. Figure 3 shows the year-to-year changes in the cornerstone of public health care, hospital operating spending. The graph shows dramatic shifts in spending from one year to the next. In its first term, the government tried to cut back on spending to finance its tax cuts. When it became clear that the system could not sustain the cuts, the government was forced to increase funding again. But even during the period of increased spending, the variability in funding from one year to the next continued.

The Harris-Eves team is spending more on health care than Ontario ever has. And we all know you need *people* to run the health care system. You need them to take your temperature, fill out your charts, perform tests, make diagnoses, perform surgery, handle files, clean hospital rooms, wash the sheets, and—more than we like to admit—hold your hand and

Figure 2. Ontario in middle of the pack
(healthcare spending as % of GDP, 2000)

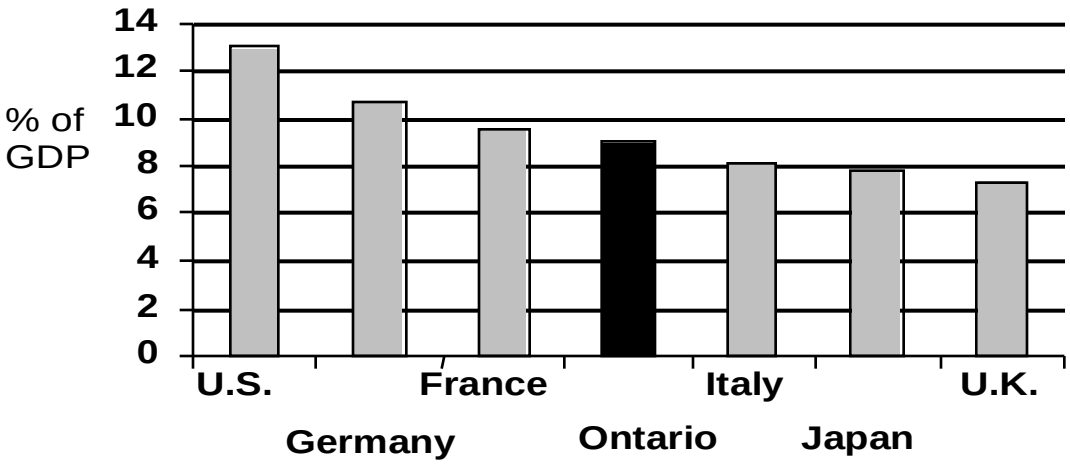
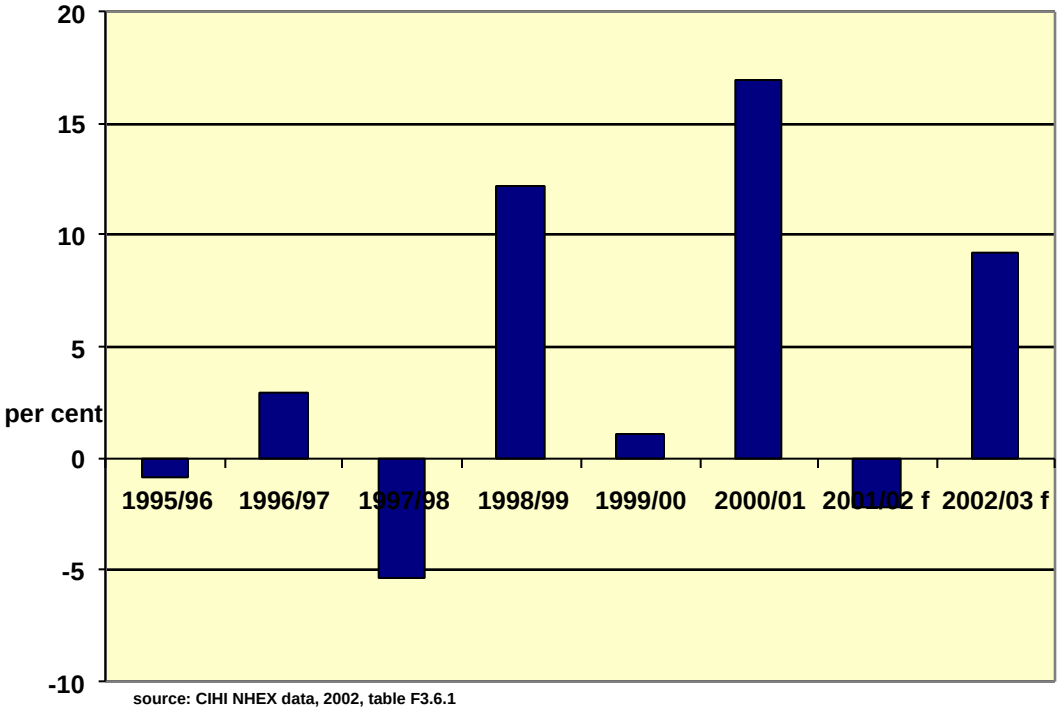
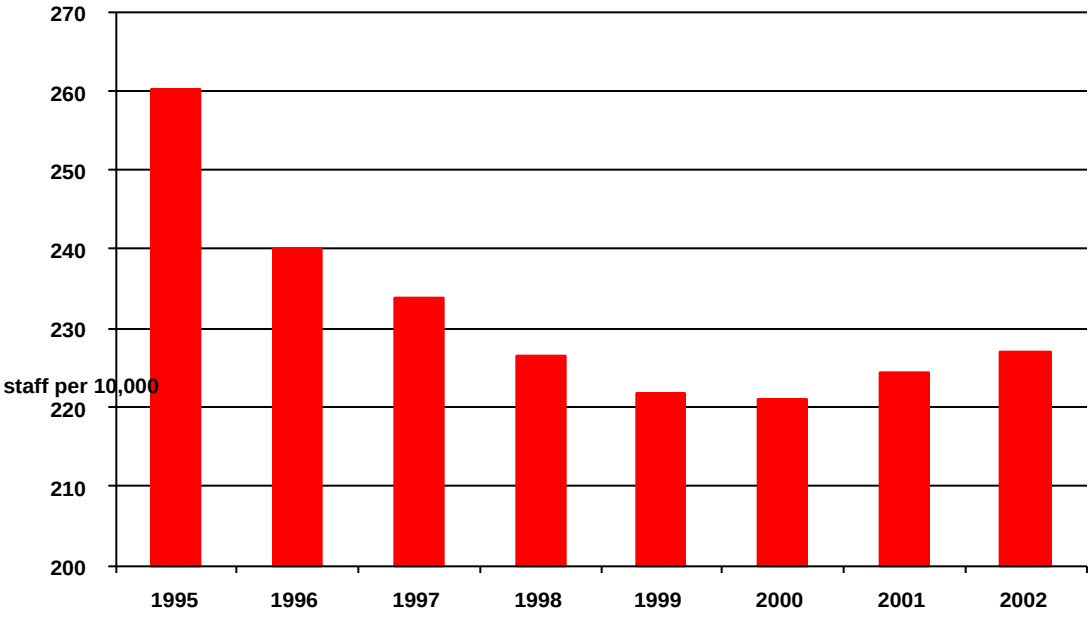


Figure 3. Tories' inconsistent commitment to hospitals



source: CIHI NHEX data, 2002, table F3.6.1

Figure 4. Hospital and long-term care staff per 10,000 population 1995 to 2002



Sources:
Statistics Canada, Survey of Employment, Payroll and Hours, CANSIM II, Table 281-0023
Statistics Canada, Estimates of Population, CANSIM II, Table 0051-0001

comfort you. People make our health care system work.

Despite the extra money, however, staffing has not recovered. The chronic shortages of personnel in our health care system are no surprise to anyone who has visited a hospital or nursing home, or who has waited for a test or to see a doctor. The shortage of people-power in our system is one of the most apparent indicators of the health care crisis created by this government.

Since 1995, Ontario's population has grown by 10%—there are now over 1.1 million more people living in this province. Yet today we have virtually the same number of hospital staff as eight years ago, and fewer long-term care staff serving this much larger population.

In 1995, for every 10,000 Ontarians there were 168 hospital staff and 93 long-term care staff. Today, for every 10,000 Ontarians there are only 153 hospital staff and 75 long-term care staff. Had the Harris-Eves team not gutted spending, and the ratio of staff to population been maintained, there would be 18,000 more hospital workers and nearly 22,000 more long-term care workers in Ontario today (see Table 1 and Figures 3 and 4). Imagine what 40,000 more front-line health care staff would do to improve the system.

To see what this staffing deficit means for your community, take a look at where these 40,000 missing staff might be if staff were spread more or less evenly throughout Ontario's major metropolitan areas. By this measure, Kitchener-Waterloo/Cambridge/Guelph, for example, is missing some 1,454 staff; Windsor needs 1,062 more people; and the Greater Toronto Area would need a staggering 16,693 health care workers to get back to its 1995 coverage level (see Table 2).

Should anyone think that health care spending has gone to big pay increases for existing staff, consider the following. Between January 1995 and January 2003, the cost of living in Ontario increased by 18.6%. In the same period, average hospital workers' pay (not including overtime) increased by 15.7%; the average pay of ambulatory care workers increased by 17.2%.[2] For hospital workers, this adds up to a cut of nearly 3% in real pay over eight years. For workers in the ambulatory care sector, it adds up to a cut of nearly 1.5% over the same period.

Table 1.

Year	Ontario Hospital Staff	Ontario Long-Term Care Staff	Ontario Population	Hospital Staff Per 10,000 Population	Long-Term Care Staff Per 10,000 Population	Missing Hospital Staff	Missing Long-Term Care Staff	Total Missing Staff
1995	183,912	101,565	10,964,925	168	93	-	-	-
1996	177,239	89,433	11,100,876	160	81	8,953	13,391	22,345
1997	173,864	89,417	11,249,490	155	79	14,821	14,784	29,605
1998	169,640	88,361	11,387,413	149	78	21,358	17,117	38,476
1999	167,708	88,089	11,527,866	145	76	25,646	18,690	44,336
2000	169,756	88,767	11,697,569	145	76	26,444	19,584	46,029
2001	177,836	89,251	11,894,863	150	75	21,674	20,928	42,601
2002	184,233	89,921	12,068,301	153	75	18,186	21,864	40,050

Sources:
Statistics Canada, Survey of Employment, Payroll and Hours, CANSIM II, Table 281-0023
Statistics Canada, Estimates of Population, CANSIM II, Table 0051-0001

Table 2. How many hospital and long-term care staff are missing from your community ?

Missing staff, by region

	Population (,000)	Missing Staff
Ottawa	862,800	2,863
Oshawa	310,000	1,029
GTA	5,030,000	16,693
Hamilton	686,900	2,280
St. Catherines/Niagara	392,300	1,302
Kitchener/Waterloo/Guelph/Cambridge	438,000	1,454
London	427,300	1,418
Windsor	320,000	1,062
Sudbury	155,900	517
Thunder Bay	125,100	415
Total of above	8,748,300	29,032
Other areas	3,320,000	11,018
TOTAL	12,068,300	40,050

And it isn't just hospitals and long-term care facilities that are understaffed. We now know that there is a severe doctor shortage—a shortage that keeps getting worse.

The Ontario Medical Association reported last year that the province is short some 1,500 physicians. Even the government's own report, by Robert McKendry, highlighted a severe shortage of physicians. And the Canadian Institute for Health Information (CIHI) says that Ontario has the second lowest number of registered nurses per capita among the provinces.

We know that the increased funding isn't going consistently to hospitals, and we know that it isn't going to increasing the number of health care workers, or to ensuring their wages keep up with inflation. So, where is the money going? How much of it is going to for-profit health care providers? And even more importantly, how many of our health dollars are going into the pockets of the owners of for-profit health care providers? To try to piece together the answer, all we can do is consider what the government is telling us, what the government would like to tell us and can't, and what evidence we do have.

The Conservatives tell us that for-profit health care costs less, is more efficient and provides higher quality health care. But they have no evidence to back those claims up. The evidence that we do have on Ontario for-profit health care is quite clear. In long-term care, home care, and cancer treatment, for-profit provision has neither saved money nor improved wait times, staffing levels, or other indicators of quality of care.

The Conservatives have increased funding to long-term care (LTC) facilities, and handed contracts out in such a way that now the majority of services in the sector are provided by for-profit operators. But the Harris-Eves team has not been able to provide any evidence that the shift of public funds toward these businesses has resulted in increased staffing or care levels. This conclusion is reinforced by evidence from a Price Waterhouse Coopers study.

That study showed that LTC staffing and care levels in Ontario are the lowest of all jurisdictions Price Waterhouse Coopers exam-

ined, suggesting that the increased funding is going into operators' profits.[3] Furthermore, research by the Ontario Health Coalition has shown that privatization in the LTC sector has led to some very successful lobbying efforts. For-profit providers have successfully lobbied for deregulating staffing levels and increasing the proportion of premium-pay beds in relation to general ward accommodation.

The provision of home care was another disastrous experiment. The community care access centres were supposed to make the provision of home care more efficient by introducing "market discipline." In fact, the opposite occurred. A 2001 study by the Ontario Health Coalition found that these reforms resulted in: a lack of standards and quality control; burgeoning waiting lists; a lack of assessment of population need; severe staffing shortages; and increased administrative costs through duplication, waste and profit-taking.[4]

Since the writing of that report, the government introduced new legislation that made access to information about the operations of the home care system almost impossible. As a result, it has become much more difficult to monitor the impact of privatization and for-profit providers in this sector of the health care system.

Another failed experiment was Cancer Care Ontario's contract for the private-for-profit operation of an after-hours cancer treatment centre at Sunnybrook Hospital in Toronto. A special audit was conducted by the Provincial Auditor in 2001. The Auditor found no evidence that Cancer Care Ontario (CCO) had considered public not-for-profit delivery options nor that it had compared costs in the for-profit and public realms before privatizing the after-hours cancer treatment clinic at Sunnybrook Hospital. The Ministry funded the privatized cancer treatment centre at a higher level than it is funding public cancer treatment centres—$500 more per treatment. In addition, the government provided $4 million in start-up funding. The government has since closed this centre down.

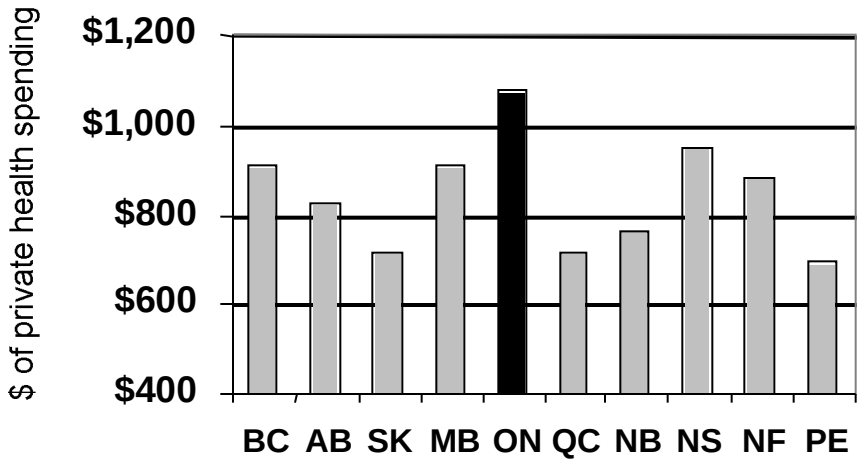
Looking outside Ontario, and toward the planned P3 hospitals, we see similar evidence about for-profit health care. A study conducted by Dr. P.J. Devereux and 13 others used one measure of the quality of care – the incidence of the risk of dying. In this study, the authors found that the risk of death while in a for-profit hospital was higher than in a not-for profit hospital. [5] This study is particularly relevant because it is a meta-analysis, reviewing all the available studies in the field.

Private spending continues to climb

If the Tories are spending enough money on health care and spending it wisely, then why is private spending on health care so high and rising so quickly? Whether to pay more for drugs because we are sent home from hospitals "quicker and sicker," or for that little "extra test" that isn't covered by OHIP, or through lost wages as your employer pays more for supplemental health care premiums, the impact of problems in our health care system are felt directly in your pocketbook. The Canadian Institute for Health Information (CIHI) reported in 2002 that Ontarians paid more out of pocket for health care than residents of any other province (see Figure 5)[6].

The CIHI report also highlights what we know already: poorer households spend a

Figure 5. Private spending highest in Ontario at $1,072 per person



greater share of their income on health care. The decision to pay for health care is not like deciding to buy new furniture: you can't decide to do without it, or maybe get half now, and half later. You must pay for what you need now. You usually have no choice.

Health care spending represents about 4% of after-tax household spending for the bottom 40% of households, but just 2.5% for the top 20%. We simply can't "cut back" on our health care needs, and we'll pay more in the years ahead. The same report shows that household spending on health care in Ontario grew by 4.5% per year between 1996 and 2000 (the latest available information), far outpacing inflation.

The implications are clear:

- inconsistent funding for hospitals;
- staffing levels that are not meeting our needs;
- privatization experiments that are expensive and show no evidence of maintaining let alone improving the quality of care; and
- increased private spending on health care.

This record raises the important question of accountability for health care spending in Ontario. This question has more urgency today than ever, given a renewed infusion of federal cash that is flowing through to this province.

What's in the Health Accord for Ontario?

Can we look to the recently signed Health Accord to provide the funding we need? Does the Accord have the provisions necessary to ensure increased accountability and compliance with the Canada Health Act? Will the accord ensure that health care is provided in

the most effective way—through not-for-profit providers?

The context

In 1995, the Liberal government fundamentally changed the manner in which health care funds were transferred to the provinces. With the 1995 Paul Martin federal budget, health care transfers became part of the Canadian Health and Social Transfer. This block funding replaced the separate transfers for health, post-secondary education, social housing, child welfare, and social assistance. These transfers are structured so that the federal government puts no conditions on the money. As a result, we do not know what share of federal transfers to the provinces goes toward health care.

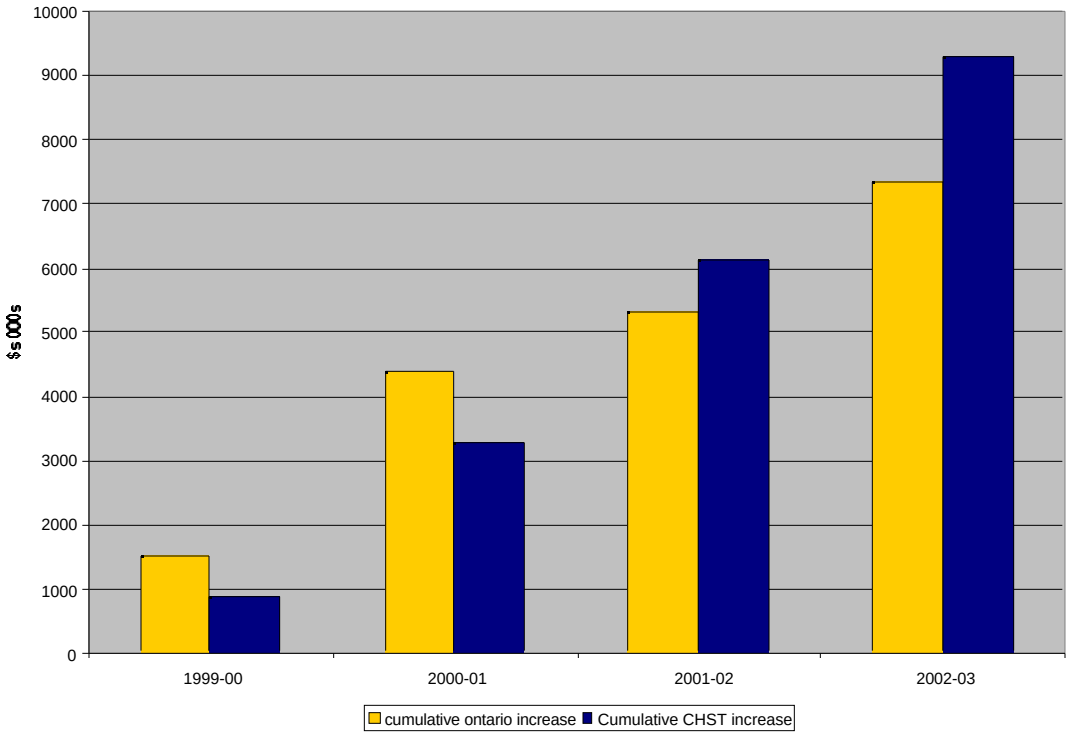
From 1995-96 to 1998-99, the federal government dramatically reduced CHST transfers to Ontario. As Table 3 below shows, transfers dropped from $6.2 billion in 1995-96 to $3.9 billion in 1997-98, where they stayed until 1998-99. Over this period, the impact

Table 3. CHST transfers to Ontario

	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03
CHST base	6,200	4,800	3,900	3,900	4,800	5,200	5,400	5,400
2000 increase						1,069	1,376	1,649
Total	6,200	4,800	3,900	3,900	4,800	6,269	6,776	7,049
Cumulative loss		-1,400	-3,700	-6,000				
Cumulative increase					900	3,269	6,145	9,294

Source: Government of Canada, Backgrounder on Federal Support for Health Care in Canada, March 29,2000 and Unpublished Department of Finance Data

Figure 6. Increase in federal CHST transfers pay for increases in Ontario health spending



was a cumulative loss of $6 billion. The decreases in federal transfers were occurring at the same time that the Ontario Conservatives were implementing the first stages of the tax cuts. Federal Department of Finance estimates put the cost of those tax cuts between 1996-97 and 1998-99 at $9.2 billion.[7] The combined impact of these federal and provincial policies, at $15.2 billion, had an enormous effect on the public sector in Ontario – and on health care in particular.

In fiscal year 1999-2000, the federal government began to reverse the cuts. Only in 2000-01, after the September 2000 Agreement between First Ministers, did CHST transfers to Ontario once again reach their 1995-96 nominal level.

Figure 6 (see Page 11) compares the cumulative increases in Ontario government health spending with the cumulative increases in the CHST since 1999-2000 when these transfers began to rise again. Cumulative increases in health care spending over that period were $7.4 billion while CHST transfers increased by $9.3 billion. In effect, the federal government has paid the entire bill, and more, for the growth in health care spending in Ontario since 1999-2000.[8]

The Accord

The federal and provincial governments signed an Accord on Health Care Renewal on February 5, 2003, providing another very large infusion of cash to the system. The federal government has stated that the goals of the Health Care Accord were to improve access, enhance accountability for how health dollars are spent and the results achieved, and ensure sustainability over the long-term.[9]

However, a closer reading of the agreement suggests that it will fall short of meeting those goals. True sustainability of our health care system can only be achieved by maintaining and increasing the publicly-funded, not-for-profit nature of the system. There is nothing in the Accord that will prevent the Ontario government from continuing to direct an increasing share of public health care dollars to for-profit providers, or using these resources to fund further tax cuts.

The Accord will also fall short on its goal of accountability. Nothing in the Accord requires the increased federal funding to be directed to not-for-profit providers. The Accord provides for a National Health Council to be established in the next three months. However, it is unclear that the Health Council will be an effective means of enforcing the principles of the Canada Health Act. The Health Council could be dominated by provinces in favour of two-tier medical care and include for-profit industry representatives. Such a council will not address the need for accountability in Ontario—where we don't know how many health care dollars are going to for-profit providers.

Table 4. Ontario allocation — by year

(Includes CHST Increases, CHST Supplement, Health Reform Fund and Medical Equipment Fund)

($ millions)

	2003-04	2004-05	2005-06	2006-07	2007-08	Total
Ontario	1,234	1,664	2,485	2,728	3,362	11,473

Source: unpublished data from the Department of Finance

Table 5. Ontario allocation — by funding category 2007-08
($millions)

	CHST Health Supplement	CHST Increases	Health Reform Fund	Medical Equipment Fund	Total
Ontario	967	3,697	6,229	580	11,473

Source: unpublished federal department of finance data

Table 4, below, shows the total amount of money flowing to Ontario as a result of the Accord. In total, over the next five years, transfers to Ontario will increase by almost $11.5 billion under the auspices of the Health Accord. The allocation of the increased spending over the five-year period reflects the federal government's assumption about the annual spending pattern. As we will see later in this paper, this is not the annual spending that will, in fact, occur.

CHST transfers are unconditional and have no strings attached to them. In fact, only the health reform fund and the medical equipment fund are targeted. As a result, the Accord left $4.7 billion available for the Tories to use for tax cuts.

What was in the "Budget"?

The Tories' "budget" has exploited the weaknesses of the Health Accord. First and most immediately, it used federal transfers for health to cover up last year's budget deficit. The government allocated $967 million of the CHST supplement to the 2002-03 fiscal year.

That money was part of the Health Accord. It was to be used to relieve existing pressures in the system. Instead, it was used to cover up the losses from the government's failed Hydro policy in 2002-3.

The Eves "budget" proposes to increase total health spending by $1.9 billion in 2003-04.

It announced multi-year funding for hospitals providing increases of $500 million, or 5%, for 2003-4 and $300 million, or 3%, for 2004-5. These increases, however, address only inflationary cost increases since 2002-3, and do nothing to address the financial crisis that hospitals are in today—with cumulative debts of $2.8 billion.

More important for the longer term, the economic statement contains no response whatsoever to the sweeping recommendations for reform in the Romanow Report—the recommendations which formed the basis for the new federal health transfers announced in February. No measures were announced on primary care reform, home care, catastrophic drug coverage, or any of the other important issues raised by the Romanow Report.

Conclusions

The Romanow Commission presented a road map for the maintenance of Medicare. Its research clearly showed that there was no evidence that for-profit health care was more efficient or provided a higher quality of care. It called for increased government investment in and expansion of the health care system.

The Ontario Conservative government, in its actions since the report was released, has clearly indicated that it is more willing to pawn than polish this crown jewel of the Canadian social safety net.

Endnotes

1 OECD Health Data, 2002.

2 Statistics Canada, *Average Weekly Earnings (SEPH)*, CANSIM II, Table 281-0026: All employees, excluding overtime, ambulatory health care services; All employees, excluding overtime, hospitals.

3 *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*. Prepared by PricewaterhouseCoopers LLP for the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Long Term Care Association January 11, 2001.

4 *Secrets in the House: Home Care reform in Ontario: 1997-2000*. Ontario Health Coalition, 2001.

5 "A systematic review and meta-analysis of studies comparing death rates between investor owned private for-profit and private not-for-profit hospitals." *Canadian Medical Association Journal* (May 28, 2002).

6 CIHI, *National Health Expenditure Trends, 1975-2002*. Some of the difference between Ontario and other provinces is undoubtedly explained by this province's higher per-capita income and the greater availability in Ontario of alternative services.

7 Finance Canada estimates, unpublished backgrounder to *The Fiscal Balance in Canada: The Facts*, January 2002, Department of Finance Canada (updated October 2002).

8 Technically, a portion of the CHST increase was for policy areas other than health that are funded from the CHST. As a practical matter, however, the fact that Ontario's funding for the other areas has either been frozen or further reduced since 1999-2000, means that all of the increased funding was available to be directed towards health. And the data show that not even the entire amount of the Federal CHST increase has been allocated to increased health care spending.

9 *Federal Budget 2003*, Chapter 3, http://www.fin.gc.ca/budget03/bp/bpc3e.htm, accessed March 14,2003.

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