# First Do No Harm:

## Putting Improved Access and Accountability at the Centre of Ontario's Health Care Reform

Phase I Report

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# Executive Summary

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## Summary

Though Ontario's public has never been properly informed about them, plans are underway for dramatic health care cutbacks. According to Ontario's Auditor General, these cutbacks amount to more than $3 billion, targeted primarily at hospitals and OHIP. Yet projected funding for home and long-term care is inadequate to support another round of major hospital cuts. In fact, the cutbacks are being planned in a context of urgent and unmet care needs across the health care continuum from hospitals to long-term care and home care. Currently, more than 30,000 Ontarians are waiting for a hospital bed, long-term care bed or home care service. Disturbingly, the publicly-revealed restructuring plans to date contain serious costing errors and inadequacies that put at risk Ontario's most vulnerable patients, including seniors and people with chronic illnesses.

Over recent weeks and months the public in Ontario has been subject to a barrage of PR from government and appointees dedicated to creating a crisis to justify major restructuring. The only period in which the crisis-rhetoric abated was during last fall's election campaign when planned cuts were barely mentioned to the public. But despite overheated rhetoric about health spending out-of-control, the evidence shows that Ontario's health spending is almost the lowest in the country. As a proportion of our economic output – or GDP – health spending may be growing. But again, the evidence shows that it is near the bottom of any province and the growth rate is less than most industrialized countries. The data shows that there is room for growth to address the urgent care needs of Ontarians without cause for sounding the alarm.

In fact, the evidence reveals that the real problem is on the revenue side. Ontario has engaged in the most prolonged and deepest tax cuts in the country. These tax cuts have mainly benefited the wealthy and corporations, and the evidence shows that they have not resulted in increased business investment. Despite this, the McGuinty government has refused to look at revenue options to restore greater tax fairness and sustainability. The full range of options has not been considered. In this report, we outline two significant tax loopholes in the Employer Health Tax, which, if closed, would create a more equitable funding system and generate $2.4 billion per year to help alleviate some of the cost pressures in the health system.

Ontario's health reform proposals, as revealed to date, have focused around a few key proposals:

**1. Downloading**

- Restrict hospital funding and download patients into home care and other community care.
- Redirect long-term care facility wait lists into home care and other community care.
    - Ration or freeze the supply of long-term care beds, following Denmark's example.

**2. Consolidation**

- Consolidate hospital services into fewer sites.
- Institute "competition" or competitive bidding for hospital funding.

**3. Delisting**

- Delist a number of OHIP-covered services.

**4. Price Controls**

- Cut physician compensation for several procedures.
- Reduce drug prices and increase user fees for higher-income seniors

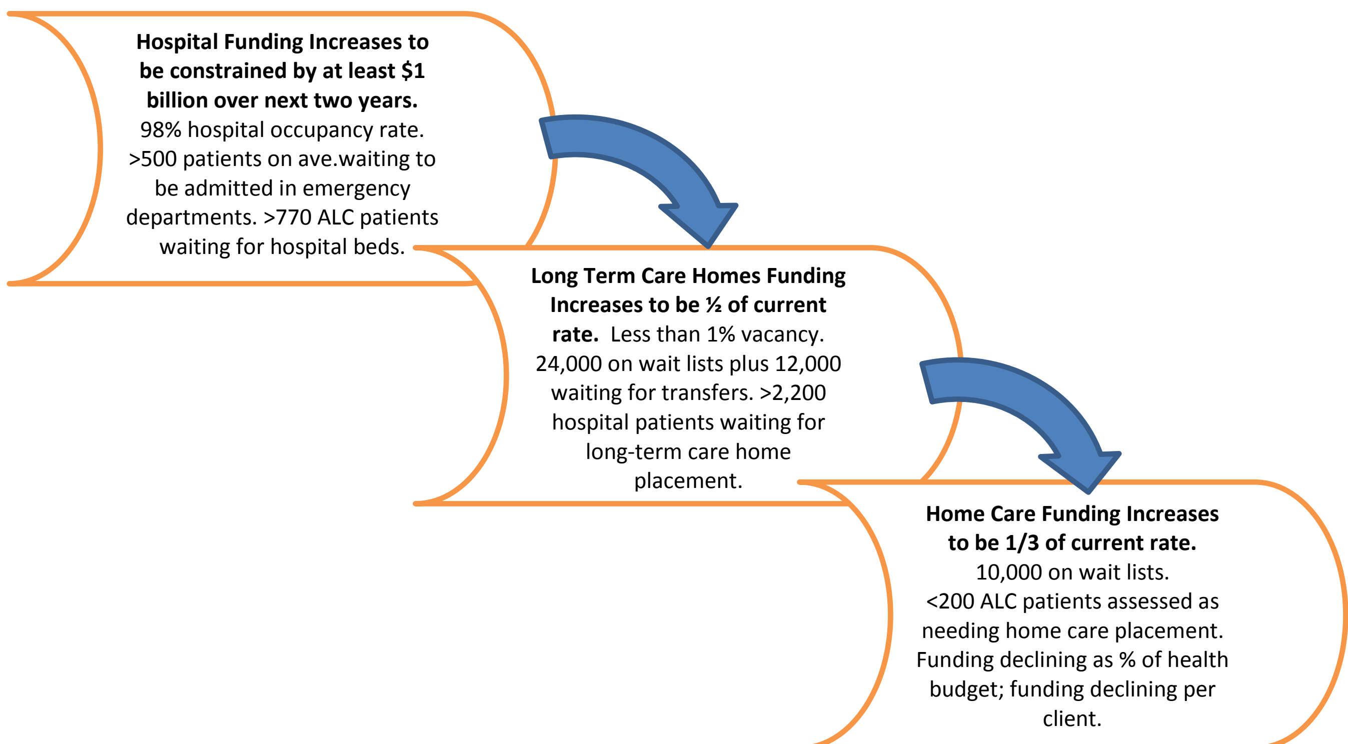
This report is primarily concerned with item 1: downloading. Our Phase II Report will review more closely proposals under items 2, 3 & 4 when they are more fully revealed

## Hospital and Long-Term Care Downloading Plans Implausible: Fail to Address Existing Wait Lists and Funding Constraints

Current government thinking holds that institutional care – in hospitals and long-term care homes – is too expensive. Consequentially, plans are to restrict costs in institutional care in order to save money, regardless of existing backlogs and wait lists. Patients are supposed to be moved en masse to home care (which also has wait lists) despite the fact that government projections reveal that home care is also to be subject to strident cost containment measures. Assessments of care needs and investments required to accomplish this download have not been done. The planned downloading is implausible given the planned funding constraints and existing wait lists. The consequences for patients could be very significant including:

- Worse hospital overcrowding, longer emergency department delays for patients waiting to be admitted to a bed, longer ambulance offload delays
- Longer waits, particularly for Ontarians waiting in the community for a long-term care bed. (Current median waits are 5 months.)
- A heavier case load for home care without the resources to support it, leading to more severe rationing of home care services, reassessment and cut-offs for existing clients and inability for patients to access services upon discharge from hospital.

## Cascading Downloading



## More Than $3 Billion in Health Cost Curtailment Planned

Government speeches and media releases have attempted to redefine spending and program cuts as "reforms" and "trade offs". But the stark reality of government plans has, to date, not been revealed to the public. In fact, the government's cost containment plans are extremely aggressive. A recent Ontario Auditor General's report warns that cutbacks totalling more than $3 billion to health spending growth were planned as early as last spring -- prior to last autumn's provincial election – and include dramatic curtailment of hospital and OHIP funding. The numbers reveal that planned funding levels for home and long-term care will not be enough to offset planned hospital cuts. Since the Auditor General's report, government projections for health care funding have been further reduced, worsening the projected cuts.

> At the 3.6% projected funding increase for health care planned by the McGuinty government prior to the recent provincial election, Ontario's Auditor General reports planned cost curtailment measures include:
>
> **Hospitals** $1 billion in cutbacks over the next two years.
>
> **OHIP** $2.05 billion in cutbacks over the next two years.
>
> **Home care** Funding increases will be ⅓ of what they have been for the last eight years.
>
> **Long-Term Care Homes** Funding increases will be ½ of what they have been for the last eight years.
>
> **Total** More than $3 billion in curtailments to hospitals and OHIP over the next two years.
>
> **Difference between 3.6% (Government projections prior to election) and 2.5% (Don Drummond's reduced health spending recommendation in January)**
> $500 million per year.
>
> **Total at Don Drummond's recommended rate**
> At least $4 billion in curtailments to health spending over the next two years.

The Auditor's projections are based on a 3.6% average annual increase. However, in January, the government's appointed Chair of the Commission on Public Sector Reform, Don Drummond, recommended that health care funding projections would be further reduced to 2.5%.

The difference between the Auditor's projected funding level increase (3.6%) and Drummond Commission recommendation (2.5%) translates to $500 million per year.[1] If the government adopts Don Drummond's recommendations for further curtailment of health care spending, an additional $500 million in cost savings per year, or $1 billion over the two-year period, would have to be found on top of the more than $3 billion in cutbacks reported by Ontario's Auditor General.

## The Truth About Ontario's Health Spending:
### Health Spending is Low Compared to the Rest of Canada and Declining as a Share of Ontario's Total Spending

Despite repeated proclamations about health spending eating the provincial budget, the evidence does not support this contention. Ontario spends less on health care than almost all other provinces in Canada. Indeed, Ontario is near the bottom of the country in spending on *all* government-funded

[1] Health care expenditure for 2010/11 is reported in the 2011 Ontario Budget as $44,949,500,000 (page 227). Using this expenditure figure as a base, the difference between a 3.6% increase per year and a 2.5% increase per year is $494,444,500 per year.

programs and services for its residents. Though health spending is growing as a percentage of our GDP, when compared to the rest of Canada, the evidence is that there is room for growth in health spending to address the urgent unmet care needs of Ontarians without spending becoming "out-of-control".

In fact, the evidence shows that it is tax cuts not health care that are "eating up" Ontario's provincial budget. Health spending is *shrinking*, not growing, as a proportion of Ontario's spending and has been shrinking for at least a decade.

The real story rests primarily on the revenue side, rather than on the spending side. Ontario has reduced its capacity to fund health care and all social programs by engaging in the most prolonged and deepest tax cuts in the country. As a result, Ontario has among the lowest corporate tax rates in North America. While tax cuts have been rationalized as economic stimulus, there is no consensus of opinion on this. Economists point out that business investment has been declining in Ontario despite more than 30% reduction in corporate tax rates in Ontario since 1999.[2]

The evidence reveals that the tax cuts have come at the expense of worsening social inequity. The highest income Ontarians have become substantially richer while putting fewer hours into the workforce as compared to the lowest income groups who have lost ground even while putting more hours into the labour force.

### Ontario's Spending Trends

Health care is shrinking, not growing, as a proportion of Ontario's spending.

Ontario is 8th of 10 provinces in health spending.

Ontario is 8th of 10 provinces in all government spending.

Ontario spends less as a percentage of its GDP than almost all other provinces and is significantly below the average.

Hospitals and home care are *s*hrinking, not growing as a proportion of health spending.

Ontario has engaged in the most prolonged and deepest tax cuts of any province in Canada. These cuts have not resulted in business investment. In fact, business investment is declining.

## Hospitals and home care are shrinking as a proportion of health care spending

Within the health care budget, hospitals are generally targeted first for cutbacks. Yet the evidence shows that hospital spending is shrinking, not growing, as a proportion of provincial health care spending. The trend of declining public spending on hospitals as a share of Ontario's provincial health spending is long-standing. Since 1981, hospital spending has declined from 50% of public health care expenditures to 34% in 2010.

And despite claims that care is being moved into the community, the evidence also shows that home care is also shrinking -- not growing -- as a proportion of provincial health care spending. In 1999, home care funding was 5.47% of Ontario health care spending. By 2010, it had declined to 4.13% of Ontario health spending. In fact, on a per client basis, home care funding has declined significantly meaning that there are less home care resources per client available today than a decade ago. Too often, the claim of

[2] Weir, Erin. "Corporate Taxes and Investment in Ontario", The Progressive Economics Forum, January 23, 2012.

care transferred to the community is simply a cover for cuts to needed care, particularly for seniors. The result is demonstrable levels of unmet care needs, as reviewed in Section II of this report.

## A Closer Look at the Revenue Side:

### Tax Cuts, Not Health Care are Eating Up the Provincial Budget

Even allowing for the offset by McGuinty's health care premium starting in 2004-05 and the reduction in tax base due to the recession beginning in 2008, the tax cuts have dramatically reduced our province's revenue raising potential. By 2010, the impact was a reduction in revenue potential of $15 billion. Without the recession – at full economic potential – the impact of the tax cuts is a revenue reduction of $18 billion per year; more than the entire provincial deficit.

## Ontario's Urgent and Unmet Health Care Needs

Ontario's health care system has been subject to restructuring for more than two decades. Many of the key elements of the new round of planned restructuring have already been done, including: consolidation; delisting; hospital cuts; movement of services to cheaper modes of care; and, rationing.

The last two decades have seen retrenchment followed by reinvestment. The attempt to take almost $1 billion out of hospitals under the Harris restructuring of the mid-1990s, resulted in $3.8 billion in new restructuring costs.[3] After the turmoil of the mid to late 1990s, a period of re-investment bought change and improvements.

While there have been some significant improvements, there are also key areas in which access to care, quality of care and public accountability have suffered.

### Urgent and Unmet Care Needs Across the Continuum

More than 30,000 Ontarians are waiting for a hospital bed, long-term care placement or home care.

- 24,000 Ontarians are on wait lists for long-term care placement.
- 10,000 Ontarians are on wait lists for home care.
- At any given time, 592 Ontarians are waiting in emergency departments for hospital beds.
- 2, 271 Alternate Level of Care (ALC) patients are waiting in hospital for a long-term care bed.
- 773 Alternate Level of Care (ALC) patients are waiting in hospital for another type of hospital bed.
- 135 Alternate Level of Care (ALC) patients are waiting in hospital for home care.

Ontario ranks at the bottom of comparable jurisdictions in emergency department wait times, a key indicator of hospital bed shortages.

Attempts to cut $1 billion out of hospitals in the mid-late 1990s cost $3.8 billion in restructuring costs.

Wait times for long-term care and home care are at or above the high levels of the late 1990s.

[3] Provincial Auditor's report 2001, page 315.

## Hospitals: Urgent and Unmet Care Needs

Since 1990, 18,500 of Ontario's hospital beds have been cut. Despite government claims, these cuts have not been offset by re-investments in community care outside hospitals. In fact, wait lists for long-term care beds in Ontario have never been longer. Funding per home care client is decreasing, and home care suffers from lengthy wait lists and rationing.

The evidence shows that Ontario's hospital bed cuts have gone too far, diminishing access to care, quality of care and patient safety. The evidence showing Ontario's hospital bed shortage is irrefutable:

- Ontario has high emergency department wait times compared to other jurisdictions. Emergency department wait times are a primary indicator of hospital bed shortages.
  - More than ½ of patients admitted to hospital experience emergency department wait times above recommended time limits.
  - At any given point in time, Ontario has 592 patients waiting in emergency departments for a hospital bed.
- Approximately one in five ALC patients – equalling 733 Ontario patients waiting in an Alternate Level of Care (ALC) bed – is actually waiting for another type of hospital bed.
- Ontario has the highest level of hospital occupancy of any jurisdiction for which we could find data. In fact, hospital overcrowding in Ontario is at dangerous levels.
- Ontario has the fewest hospital beds per person of any province in Canada. In fact, Ontario is substantially below the average.
- Ontario is fourth last of industrialized countries in hospital beds per person, followed only by Turkey, Chile and Mexico. In fact, Ontario is substantially below the average.

## Long-Term Care Facilities: Urgent and Unmet Care Needs

Access to long-term care facilities is poor and has been declining over the last half-decade while hospital chronic care patients continue to be downloaded onto long-term care wait lists. The Ontario Health Quality Council describes current long-term care wait times as "far too high".[4] In fact, there is a severe and chronic backlog of Ontarians waiting for access to long-term care homes that has numbered in the thousands for well over a decade. Despite the pressing need for improved access to care, Ontario's Auditor General reports that projected funding increases for long-term care homes will be less than ½ what they have been for the last eight years. With wait lists numbering 24,000 and extremely low vacancy rates, there is no capacity for long-term care homes to offset any planned new hospital cuts.

Without admitting it publicly, the government's evident plan is to save money (and pay for corporate tax cuts) by rationing access to long-term care homes at levels well below population need for care. But despite claims that long-term care beds can be replaced by home care, the numbers simply do not add up. The evidence shows that costing for redirection of patients on long-term care wait lists is flawed and understates the community resources and investments required to accomplish such a shift. Moreover, even with the investments in community support – investments which should be made -- long-term care

[4] Ontario Health Quality Council, page 3.

wait lists would remain at record highs[5] unless the government forges a plan to improve the supply of long-term care beds.

- Ontario's chronic care (complex continuing care) hospital beds have been cut in half since 1990, amounting to a closure of more than 5,600 beds.
- In 2001, the Ontario Health Coalition reported long-term care homes wait lists of 25,000, based on Ministry of Health data at the time.
- In 2011, wait lists for long-term care total 36,000 with 24,000 waiting for a placement plus 12,000 waiting in a long-term care facility not of their choosing for a transfer.
- In 2009, the long-term care vacancy rate was 0.4% (371 beds).
- Wait times for Ontarians waiting in the community average 5 months.
- Wait times for Ontarians waiting in a hospital average 2.5 months.
- 2,271 of Ontario's Alternate Level of Care (ALC) patients are waiting for a long-term care bed.
- Only 40% of Ontarians waiting for a long-term care placement get their first choice of long-term care home.

## Home Care: Urgent and Unmet Care Needs

The Ontario Auditor General reports that planned home care funding increases for the next two years will be 1/3 of what they have been for the last eight years. Despite repeated claims that hospital cuts are being offset by home care investments, home care is shrinking, not growing, as a proportion of health care spending. While the number of home care clients has increased by 66% between 2003 and 2009, funding did not keep pace. Funding per client decreased by 14% over this period.[6] The evidence shows that home care is not sufficiently staffed, organized, and funded to take significant downloads if hospitals are faced with major cutbacks.

## Growing Inequities and the Social Determinants of Health

Socioeconomic status is a key factor in attainment of health. The evidence shows that income has a significant impact on chronic disease and death rates. The highest income disparities between the top 20% and the bottom 20% income groups in Canada are in British Columbia and Ontario. The lowest disparity is in Prince Edward Island.[7] In fact, the gap between the richest and poorest in Ontario has grown significantly. The average earned income of the richest 10% of Ontario families raising children was 27 times as great that of the poorest 10% in 1976. By 2004 it had risen to 75 times.[8]

Affordable housing is a crucial foundation for any poverty alleviation strategies. It is also one of the most important determinants of health. As the Wellesley Institute reports, "lack of housing is directly linked to higher morbidity (illness) and higher mortality (death)".[9]

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[5] Even at an aggressive target of redirecting 20% of the long-term care wait list to home care, almost 20,000 Ontarians would still be waiting for long-term care beds.
[6] See charts on page 15.
[7] Human Resources and Skills Development Canada, Indicators of Well-Being in Canada: Financial Security – Income Dsitribution, statistics are from 2007. See http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=22
[8] Yalnizyan, Armine, Ontario's Growing Gap Canadian Centre for Policy Alternatives, May 2007, page 3.
[9] http://wellesleyinstitute.com/policy-fields/affordable-housing/

Despite a rejuvenation of housing supply programs in the last five years, affordable housing production still falls far short of need. Housing is more unaffordable now than it was twenty years ago. Rising energy costs, rising rents and stagnant or declining incomes have contributed to lengthy wait lists for affordable housing. In January 2011, there were 152,077 households on waiting lists across Ontario representing an increase of 7.4% since 2010.[10]

## Assessing Proposed Cuts & Restructuring

### Targeting Cuts at the 1% of Highest-Needs Patients

The Ontario Hospital Association has been lobbying for the adoption of proposals in their report, "Ideas and Opportunities for Bending the Health Care Cost Curve". In fact, this report contains very few specific proposals. Rather it is made up of broad hypotheses with "order of magnitude" cost estimations. There is no accurate costing of the broad ideas contained in the report, and there is no detailed analysis. Several of the proposals are positive, and should be supported by public interest advocates. A number of proposals project cost savings from offloading hospital patients and cutting care: these proposals pose risks to patients and would be contentious if Ontarians were consulted on them.

Dangerously, at least one of the report's key recommendations for spending cuts targets the neediest of patients who have the fewest options to pay for care privately. A full review of this proposal can be found on pages 41 & 42 of our report.

### The Denmark Experience

In recent speeches, Ontario's Health Minister has cited Denmark as an example to support her plans to close hospital beds and continue the rationing of long-term care homes beds. But a review of health care and population data reveals that this comparison is simply false. Denmark has thousands more hospital and long-term care beds to serve its population than Ontario. In fact, Ontario could double our long-term care bed and complex continuing care hospital beds and still not catch up. Furthermore, Denmark has a population density more than ten times that of Ontario spread over a land mass that is just 4% of Ontario's, meaning that the resources and other factor involved in provision of care in individual homes and the economies of scale in the two health systems bear no resemblance to each other. As a justification for hospital cuts and an inadequate long-term care beds policy, this example is deeply erroneous and misleading.

## Ontario is at Risk of Repeating the Mistakes of Previous Restructuring

Ontario's hospitals have already been restructured for more than 15 years, providing lessons about misalignment, high unforeseen capital and other costs, and deleterious impacts on patients. We remain deeply concerned that the lessons of the last round of restructuring have not been learned. It appears that our provincial government is engaging in a very similar set of decision-making as it did under the damaging health restructuring of the 1990s. This approach will likely yield higher costs – without any

[10] Ibid.

evidence that these costs can be recouped in "efficiencies" from centralization – and will harm patients' access to care, cause downloading to municipalities and damage to local economies.

### The Costs of Restructuring

The evidence shows that restructuring can cost more than it saves.

The Harris government attempted to take $1 billion out of hospital operating budgets in the mid-late 1990s.

- The costs for restructuring were $3.9 billion, according to the Provincial Auditor.
- Restructuring costs went $1.8 billion over budget.

More than 9,000 hospital beds have been cut since the beginning of the Harris-era restructuring, resulting in extraordinary waits for hospital admissions, and extraordinary levels of hospital overcrowding.

There is no capacity to take more hospital patients downloaded into long-term care and home care, where wait lists are already severe.

## Conclusion

The facts simply do not support the contention that health spending is out of control. Nor is there evidence to support claims that significant cuts can be made in our hospitals. Such claims are not grounded in any concrete proposals that can be scrutinized and weighed by the public. There is no costing of any of the broad hypotheses about major hospital cuts. There has been no consideration of patients' needs and the primacy of preserving access to care. Moreover, notions that thousands of patients can be downloaded into long-term care and home care are implausible at best and dangerous at worst. There are already more than 30,000 people on wait lists in these sectors. This report is an appeal for a more democratic process: one in which the voices of public interest groups and the public are given opportunities for meaningful input. It is an appeal to our government to take a step back and exercise caution. At minimum, our government has an obligation to first, do no harm.