Submission to the Standing Committee on Finance and Economic Affairs

Pre-Budget Hearings

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Ontario Health Coalition

Mission and Mandate

Our primary goal is to protect and improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. We are a non-partisan public interest activist coalition and network.

To this end, we empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. We seek to provide to member organizations and the broader public ongoing information about our health care system and its programs and services, and to protect our public health system from threats such as cuts, delisting and privatization. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information.

Who We Are

The Ontario Health Coalition is comprised of a Board of Directors, Committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than 400 member organizations and a network of Local Health Coalitions and individual members. Our members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

Contents

KEY NEW ISSUE

Ministry of Health's Plan to Cut Hospital Services and Contract them to Private Clinics (IHFs)

The government has announced plans to bring in new legal regulations to expand the use of private clinics (called Independent Health Facilities or IHFs) to take hospital services out of our community hospitals. The proposal is to begin to implement these plans over the next six months. These changes would expand the use of private clinics (IHFs) and the transfer of hospital services out of public hospitals into private clinics. The LHINs would have the power to transfer services from hospitals to private clinics (IHFs). The changes also enable Cancer Care Ontario to contract private clinics (IHFs) to provide services.

The province already has the ability, if it chooses, to work with local hospitals to set up non-profit specialty clinics under the quality and performance rubric of the Public Hospitals Act. There is no need to expand the use of Independent Health Facilities, and the evidence is that these facilities already have serious oversight problems regarding cost, quality and safety.

We strongly recommend that IHFs not be expanded, indeed they should be reduced and services integrated into the public hospital system.

Our Key Concerns

Based on the evidence, we have grave concerns about clinical services safety and quality and also equity impacts of this plan. However, for the purposes of this submission, we will focus on the serious implications for costs of health care services as follows:

- On top of ongoing cuts to local hospital services, this plan would further destabilize local hospital budget and worsen staffing shortages.
- The evidence shows that this plan will likely cost more to OHIP and Ministry of Health budgets as well as for patients who are frequently confronted with user fees and extra-billing in private clinics.
- The evidence, as outlined in the Ontario Auditor General's Report of 2012, shows that the Independent Health Facilities sector already has inadequate oversight and monitoring. It should not be expanded.

We have outlined some of the key evidence related to these issues showing that this plan will result in higher health costs, increased quality concerns, worse staffing shortages (and associated costs), and increased requirements for oversight and monitoring of private clinics.

Recommendation 1: If reorganization of hospital services is planned, it should take place under the rubric of the Public Hospitals Act. Private clinics (ie. Independent Health Facilities) should not be expanded.

Higher Costs

The government's plan to cut public hospital services and contract them to private clinics bears close resemblance to the English government's contracting of public hospital services to private clinics called Independent Sector Treatment Centres. In the U.K. and in other jurisdictions, including Canada, multiple reports and many studies report lighter caseloads and evidence of "cream-skimming" by private clinics, leaving the more expensive and heavier caseloads to the public non-profit hospitals while depriving hospitals of the resources – both human and financial – to treat them. In the U.K., multiple British Medical Association Journal studies report that private clinics (Independent Sector Treatment Centres) are paid higher prices for surgical procedures. Indeed the U.K. Department of Health has publicly admitted that higher prices are paid to the private clinics for procedures. Former Health Minister Frank Dobson reports that the private clinics were being paid 11% more than public hospitals for the same procedures.

Our own research into private clinics across Canada conducted in 2008 found that the cost of procedures was significantly higher in private clinics than in public hospitals. Colleen Fuller, health policy expert in British Columbia reports similar findings in her cost comparisons between hospital funding per procedure and private clinics billings for the same procedures. These findings echo the Ontario Auditor General's conclusions in his special audit of the for-profit cancer treatment centre established by the Conservative government in 2001. The Auditor General found that the clinic had been paid $4 million extra to set up and was being paid a premium of $500 more per procedure than public Cancer Care Ontario treatment centres.

2-Tier Health Care, User-Fees and Extra-Billing of Patients

In addition to billing public health plans, in a 2008 study we conducted of private clinics across Canada, we found that the majority of for-profit clinics charge user fees and engage in extra-billing of patients, even in violation of the Canada Health Act. This finding was supported by a 2011 study in the Canadian Journal of Gastroenterology that found one-third of the patients receiving colonoscopies in private clinics in Toronto were being charged user fees for this service (in violation of the Canada Health Act). Toronto Star columnist Thomas Walkom found that even the non-profit Kensington Eye Institute (one of the few "non-profit" IHFs) surgeons recommend a non-medically necessary "refractive lens implant" to patients (a co-mingling of insured and uninsured services used by the for-profits to extra-bill patients) and the clinic charges a $50 "handling fee" or user fee to patients in addition to the charge for the lens.

Findings of the Ontario Auditor General

In addition to the wealth of evidence of higher costs in private clinics, the Ontario Auditor General's 2012 Report found that the existing IHFs are subject to inadequate oversight, particularly of unnecessary testing and inappropriate billing practices. While the government has proposed to expand this sector which is dominated by for-profit entities, the evidence is that poor oversight has persisted for years and key problems in oversight that have been identified for more than a decade have not been addressed. Among the Auditor's findings:

- According to AG there are more than 800 IHFs in Ontario and more than 97% of IHFs are for-profit.

- The Ministry of Health does not track professional fees paid to physicians in IHFs. (These are fees for service.)[1]
- The Ministry had not completed any recent audit work on IHFs.[2]
- The reasonableness of overhead fees paid to IHFs had not been assessed by the Ministry.[3]
- The Ministry has not analysed patterns of self-referral by physicians to their own for-profit clinics.[4]
- The Ministry estimates that about 20% of facility fees are inappropriate for example, due to unnecessary testing (for which the IHFs make profit). In 2009, the Canadian Association of Radiologists estimated that 30% of CT scans and other diagnostic imaging scans contributed no useful info and/or are inappropriate.[5]
- The College of Physicians and Surgeons had not assessed 12% of facilities to see if scans are being properly read in last 5 years. Of those facilities where assessments had taken place, not all physicians were assessed.[6]
- 60% of x-ray facilities had not been inspected by the Ministry as required to ensure patients are shielded from excess radiation. In fact, the Ministry did not even know the location of 12 radiation-using facilities that had moved. [7]
- A 2011 review of questionable billing practices of physicians in IHFs had not been completed and no action had been taken on questionable billings.[8]
- From 2000 – 2012, though the need to reassess the appropriateness of facility fees paid to physicians in these facilities had been repeatedly noted in various technical reports, this has not been done.[9] (Technological advances have reduced the work required for a number of procedures meaning that fees being paid are likely too high, but no action has been taken to address this.)
- Though a 2011 review of billing practices found that about 25% of facilities had unusual billing patterns, the Ministry's opted not to take any action against the facilities or physicians in question. Their only response was to create educational materials for facility owners/physicians which was in process at time of audit.[10]
- Overall, it appears that there is no auditing to ensure that tests that are billed for have actually been performed.

[1] Ontario Auditor General Annual Report Chapter 3, 2012. Page 149.
[2] Ibid. Page 150.
[3] Ibid. Page 151.
[4] Ibid.
[5] Ibid.
[6] Ibid. Page 152.
[7] Ibid.
[8] Ibid.
[9] Ibid. Pages 156-157.
[10] Ibid. Page 160.

Recommendation #2: After 7 years of hospital funding increases that have been set below the rate of inflation, hospital cuts are very severe and access to vitally needed hospital services has been compromised. Hospital funding needs to be improved and stabilized and a moratorium must be placed on cuts to hospital services and expanded user fees for seniors.

2013 BUDGET PLAN:

Funding for hospitals frozen (less than inflation again this year) forcing more and more cuts.

More user fees and means-testing announced for seniors' drugs.

OHC Analysis:
Hospital base operating funding was held to zero per cent increase in 2013–14 and has been held to less than the rate of inflation since 2006/07. Budget constraints on hospitals have resulted in damaging cuts to needed services. Ontario has the fewest hospital beds per capita of any province in Canada, by far. Our province 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. Continual pressure on hospital budgets has meant cuts to needed services across Ontario, offloading and privatization of hospital clinics and services to the detriment of patients.

For the second year in a row, in the 2013 budget the government has announced a plan to increase user fees for seniors' drugs. In 2012, the budget introduced new user fees for the wealthiest 5 per cent of seniors. The 2013 budget expands that to "higher-income" seniors. The dismantling of the universality of the drug program is not a progressive approach. Progressive taxation is a fairer and more compassionate way to raise funds for the program. User fees hit people when they are elderly and sick, shifting the burden of cost to the sick and dying whereas a fair tax system does the opposite – it supports people when they are sick and dying. Already seniors are subject to an increasing burden of out-of-pocket health care costs including equipment and supplies, travel, and long-term care. Expanding user fees and means testing to more and more seniors and more services is not in the public interest and should be stopped.

Recommendation #3: Real protections for rural and small communities hospitals are needed. Full public disclosure on the use of previously-announced funding should be made.

The 2013 budget re-announced $20 million for rural hospitals from the 2012 budget but none of that money flowed during the 2012-13 fiscal year until April when two local announcements were made. Most of the money appears never to have actually flowed. In the two local announcements, it appears that none of that money that did flow is actually being used to save or protect small and rural hospital services. It is being used for community care. Full public reporting on this money should be made by the Ministry of Health. Our proposed moratorium on hospital service cuts should cover small and rural hospitals and concrete measures should be taken to restore services in communities such as Picton, Wallaceburg and Leamington where devastating service cuts have severely impacted local access to care.

Recommendation #4: Home care should be reformed to create an equitable public home care system and ensure that public funding is used for care.

2013 BUDGET PLAN:

Home and community care increases to be upped to 5 per cent from 4 per cent per year; 2013 increase to be $260 million.

The government's continual claims that hospital cuts are offset by increases in home care are demonstrably false. Home and community care funding increases, while welcome, are not sufficient to meet existing backlogs and take the increasing offloading of patients and services due to hospital cuts and inadequate long-term care spaces. In the autumn of 2012 for example, thousands of patients were wait-listed or cut off from home care because of funding shortfalls. The 2013 budget set "targets" (not guarantees) for home care to be provided within 5 days. However, this "target" is largely a PR exercise. It has no teeth and is contradicted by the Ministry's own performance requirements of the LHINs which have set a target for wait times for home care services to be 26 days (or almost a month). While patients are being discharged ever more quickly from hospital, Ontario's extremely high hospital readmissions rates indicate that these patients are either discharged too quickly or without adequate supports.

Recommendation #5: Long-term care minimum care standards should be adopted to provide accountability for public funds, improve outcomes and protect against harm.

2013 Budget:

No measures to address 20,000+ wait list for long-term care homes.

2 per cent funding increase for long-term care homes to be earmarked to improve direct care. This is positive, if it happened. We have not been able to ascertain whether this money flowed and whether funding went to direct care.

Twenty thousand Ontarians remain on wait lists for placement in long-term care homes. There is no plan to address this. Instead, wait lists are being reduced by withholding information from patients who are being discharged from hospitals about their right to access care in long-term care homes. Patients are increasingly being coercively discharged from hospitals under "Home First" policies without care in place. Frequently patients are told, though it is unlawful to do so, that they have to go home first – whether or not appropriate care is available for them there – to wait for placement in long-term care homes, or they are simply not told that long-term care is an option.

In addition, the high acuity of hospital and mental health patients downloaded into long-term care means that higher care levels are required to meet their needs. We are recommending, based on the evidence, a required minimum care standard of 4 hours per resident per day of hands-on care. This would ensure that funds go to improving care levels. It is based on the best available evidence which shows that this minimum care level improves outcomes and protects against harm.

Recommendation #6: Stop the P3 privatization of Ontario's hospitals and direct the savings to needed health care services.

The body of evidence demonstrating unnecessary high costs and exorbitant profit-taking in P3 hospitals has grown every year that the Ontario government has continued to expand the P3 policy.

A 2012 study by University of Toronto researchers that reviewed 28 Ontario P3 projects worth more than $7 billion found that the P3s cost an average of 16 per cent more than if the projects were built publicly.

A recent British study of more than 154 P3 projects found "astronomical" profits, averaging more than 50 per cent, and that P3 consortia involved in large hospital projects saw the biggest profits averaging more than 66.7%.

In Ontario, public oversight of P3 projects is anemic. There have been no audits of more than $4 billion in P3 hospital deals.

The only audit that has been done of any P3 hospital found that the privatized model cost more than $200 million more than if the government had built the hospital publicly as follows:

The 2008 report of the Auditor General of Ontario supports our concern that the decision to use P3 financing for hospitals is redirecting millions of dollars in public funds that could be used for patient care. In the Brampton P3 audit, the auditor concludes: "that the all-in cost could well have been lower had the hospital and the related non-clinical services been procured under the traditional approach, rather than the P3 approach implemented in this case."[1]

- On page 114, the auditor calculates all the changes that should have been made to the comparators used to determine the costs if the hospital was built publicly versus the P3. He calculates these in 2003 dollars. He finds that the total P3 costs were $1,153 and the total costs if the hospital was to be built and operated publicly (traditional procurement) were $959. The difference is $194 million in 2003 dollars.
- This also does not include $63 million in modifications that were required after close.

Thus, the total cost of the Brampton P3 hospital is more than $200 million higher in present dollars (2003/04) than if the hospital was built publicly. This money would be much better spent preserving services for people rather than enhancing profits for a multinational consortium.

We question where else in government is more than $5 billion in public funds committed to multinational corporations without any independent Value for Money assessments that actually test any of the numbers provided either by the for-profit corporations or by the Ministry in question?

There is plenty of cause for better scrutiny:

All of Ontario's P3/AFP hospitals have experienced significant cost overruns. None have been compared to the publicly-procured hospital project in Peterborough, where the auditor found that cost overruns warrant a 5% risk transfer, unlike the 13% found in the Brampton P3 accounting.

There is less public disclosure in the newer P3/AFP projects: all financial information is redacted from the publicly-available template Project Agreement documents; the so-called Value for Money documents posted online contain caution notes that state that PriceWaterhouse Coopers did not test any of the figures used to derive the bottom line totals for the public sector comparator and the final private sector bid price; and the Ministry of Public Infrastructure Renewal has refused to disclose any other Value for Money documents. We have asked Infrastructure Ontario the names of consultants involved in the internal creation of risk data. We have not been given this information.

Table 4. Comparison of Traditionally (Public) Financed Peterborough Hospital with Brampton P3

Hospital Type	Peterborough Hospital (traditional/public procurement)	Brampton Hospital (P3 financing & procurement)
Time Period	June 20, 2000 initial announcement of approval to June 8, 2008 patients moving in	November 30, 2001 initial announcement of approval to October 2007 patients moved in
Bed Capacity	494 beds	608 beds
Total Cost (capital only - exclu. equipment)	$197 million	$650 million
Total Cost (including equipment, all other approved contracts)	$276 million[17] including equipment	Approx. $900 million including equipment[18], >$3 billion with service contracts

Table 4 shows the comparison of cost, size and timelines between the two hospital projects. The new Peterborough Hospital with its traditional (public/non-profit) procurement is significantly less expensive in capital and equipment costs, even taking into account its smaller bed capacity. In addition to the savings in capital costs, the Peterborough project entails no additional risky 25 year service privatization, bifurcated management, overly complex Project Agreement, land deals, etc.

Despite the claims of P3 proponents regarding “risk transfer”, a review of the costs of the Brampton P3 hospital and the Peterborough Public Hospital built at the same time shows the high costs of the P3s. The Peterborough Hospital was constructed in the same timelines as the Brampton project and within a year of the North Bay project. It cost $559, 000 per bed for capital including equipment costs. In comparison, the Brampton privatized P3 hospital cost was $1.5 million per bed for capital including equipment costs.

The evidence of exorbitant costs in the P3s here and around the globe should cause a re-assessment of the P3/AFP policy. The provincial government should place a moratorium on further P3/AFP hospital redevelopments and conduct an immediate review of the policy. The data pertaining to risk calculations and the internal assessment of value for money by Infrastructure Ontario for the North Bay, St. Catharines, Woodstock, Bridgepoint and Sault Ste. Marie deals should be disclosed to the public.

The Cost of Employer Health Tax Exemptions

For the last several years, the Ontario Health Coalition has recommended that the Ontario government make changes to the Employer Health Tax to close loopholes and exemptions that have resulted in $2.7 billion annually in forgone revenue that could go towards improving health care services for Ontarians.

In its 2013 Budget, the Government of Ontario announced plans to change the system of exemptions under the Employer Health Tax. These were subsequently been passed in Bill 105. The changes are all effective 1 January 2014.

There are four main changes: the value of the EHT exemption is being increased by $50,000 to $450,000, and will be adjusted to reflect inflation every five years beginning with 2019; the exemption will apply only to employers with payrolls under $5,000,000 and to registered charities; and employers considered to be associated within the rules of the Federal Income Tax Act will not be permitted to claim separate exemptions.

There is relatively little information on the record concerning the impact of the changes. The Government's Budget and Economic Statement documents indicate the following:

- Over 5,000 employers will be required to pay an additional $7,800 in EHT, which comes to an additional $39 million in additional revenue;
- According to the Budget, this revenue gain, together with the gain from limiting associated employers to a single exemption, will be slightly more than offset by the revenue losses from increasing the exemption from $400,000 to $450,000.
- According to the Budget, annual revenue from the EHT will decline by approximately $5 million.

OHC Analysis:

In eliminating the exemption from employers with large payrolls, the government is essentially reverting to the original design of the tax under the Peterson government in the late 1980s, which included a graduated clawback from employers with larger payrolls, albeit with a much less generous exemption regime at the low end. The Harris Government increased the exemption to its current $400,000 and eliminated the claw-back of the exemption from larger businesses.

This measure could hardly be less responsive to calls to generate additional revenue linked to health care costs by converting the EHT to a universally applicable flat tax on all wages, salaries and like income.

The exemption regime for the Employer Health Tax is unique among payroll taxes in Canada, and is extremely costly in lost revenue, amounting to $2.7 billion annually as of 2012.

The exemption regime has been justified on the basis that such provisions offered desirable benefits to small business, in part in the form of tax relief and in part in the form of reduced compliance costs.

Neither of these claimed advantages is well-founded. Looking at compliance costs first, employers are required to collect and file exactly the same information – and more – for income tax compliance. Indeed, because EHT payments do not have to be reported on an individual basis, compliance is substantially less onerous than it is for any other taxes related to employment that are collected and/or remitted by employers.

As a benefit for small business, an exemption from EHT is extremely poorly targeted. The reversal of the exemption in Bill 105 makes only a slight improvement in that poor targeting. The $5 million payroll threshold for reversing the value of the exemption, in itself, is, to say the least, a generous definition of a small business. A $5 million payroll represents 100 employees earning the average wage in Ontario; 250 employees earning the minimum wage.

Beyond that, the use of payroll as the basis for a definition of a small business is questionable, to say the least. It is not at all difficult to imagine businesses which, by anyone's definition, would be considered large but which have payrolls below $450,000, (the new exemption level) or for that matter, below $5 million. For example, a business which contracts out a significant portion of its work and which pays its owners in the form of dividends could easily qualify as a small business for EHT purposes. Similarly, professional practices are often structured so that their support staff are technically employed by single purpose corporations owned by the partners. Each of those single purpose corporations would qualify for the exemption.

The structure of the tax also raises significant questions of fairness. Income from self-employment and partnership income is not subject to tax, creating a significant issue of horizontal equity – unequal treatment of equals.

The exemption also creates substantial inequities in the ultimate incidence of the tax. It is generally accepted among economists that payroll taxes are absorbed into an employer's total compensation package and are ultimately paid by employees in the form of lower amounts in other parts of the compensation package than would be paid in the absence of the tax. Working for an employer with a payroll below $400,000 does not mean that one is a low-paid employee any more than working for a large employer would mean that one is not a low-paid employee. As a consequence, highly-paid employees of "small" employers benefit from the exemption while low-paid employees of "large" employers bear the tax.

In addition to the problems of fairness and targeting of the EHT exemption, there is a further problem in principle. Public health insurance is not only a major benefit to Canadian individuals and families, it is also a significant competitive advantage for Canadian business. The EHT is the only tax levy that reflects in any way that competitive advantage, and in fact covers only a fraction of the cost of OHIP.

The exemptions and gaps in the Employer Health Tax base are not just poorly-targeted and unfair, they are also extremely costly to the public purse, and therefore indirectly to all Ontarians who collectively pay the price in the form either of reduced services or higher taxes in other areas.

Bill 105 is in no way, shape or form responsive to the efforts of the Ontario Health Coalition to generate additional revenue for health care by broadening the base of the Employer Health Tax. Compared with the $2.7 billion revenue potential from eliminating the exemption entirely, the government's proposal would reduce EHT revenue by $5 million.

OVERVIEW OF BUDGET ISSUES

Ontario is Lagging Behind Other Provinces in Health Care Funding

Far from "eating the provincial budget", Ontario's funding of health care services now lags behind the vast majority of Canadian provinces. Rhetoric about alarming health cost escalations is neither true nor in the public interest. It should have no place in serious budget debates and political discussion. As this government knows, the Ontario deficit is the creation of budget choices: choices that have prioritized tax cuts that mainly benefit the wealthy and corporate tax cuts that have not yielded promised business investment.

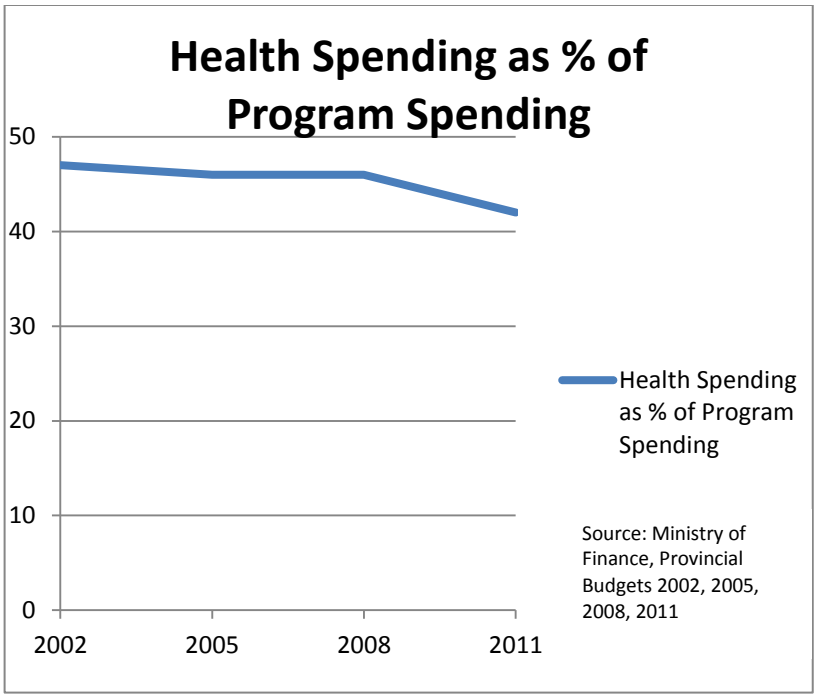
- Ontario is now almost at the bottom of the country – 8th of 10 provinces in health care funding. In hospital funding, we are even lower, ranking last among provinces.
- Health care is shrinking, not growing as a percentage of provincial spending on all programs and services. It was 47% in 2002 and has declined to less than 42% today.
- Health care would not take up 42% of spending, if Ontario was not so low in funding all programs and services. By 2011, Ontario was projected by CIHI to be 8th of 10 provinces in all program spending. In 2012, it was projected to be last among all provinces.
- Tax cuts since 1995 have removed $15 billion annually from Ontario's revenue that could have been used to fund programs and services that all Ontarians need. These tax cuts have primarily benefited the wealthiest and corporations.

Ontario Public Health Care Spending Per Person 2012 Compared to Other Provinces (Current $)	
Newfoundland	$ 5,399
Saskatchewan	$ 4,952
Alberta	$ 4,896
Manitoba	$ 4,816
PEI	$ 4,663
Nova Scotia	$ 4,463
New Brunswick	$ 4,377
Ontario	**$ 3,963**
British Columbia	$ 3,937
Quebec	$ 3,792
Average Other Provinces	$ 4,588
Difference Between Ontario and Average of Other Provinces	**- $ 635 per person x 13,529,000 people = $8.6 billion less**

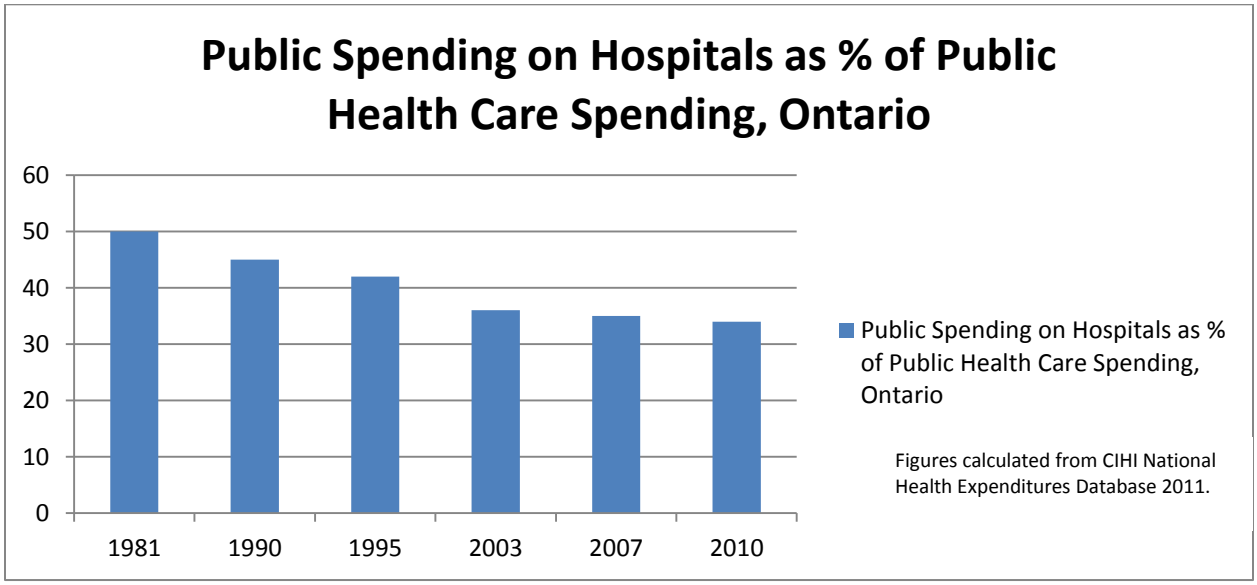
Ontario Public Health Care Spending As a Percentage of Provincial GDP Compared to Other Provinces 2012	
PEI	12.79 %
Nova Scotia	10.97 %
New Brunswick	10.63 %
Manitoba	10.14 %
Newfoundland	8.97 %
Quebec	8.77 %
British Columbia	8.16 %
Ontario	**8.07 %**
Saskatchewan	7.30 %
Alberta	6.21 %

Source: all per capita spending data is from the Canadian Institute for Health Information (CIHI), National Health Expenditures Database, 2012. Percentages of GDP calculated using CIHI GDP figures from the National Health Expenditures Database, 2012.

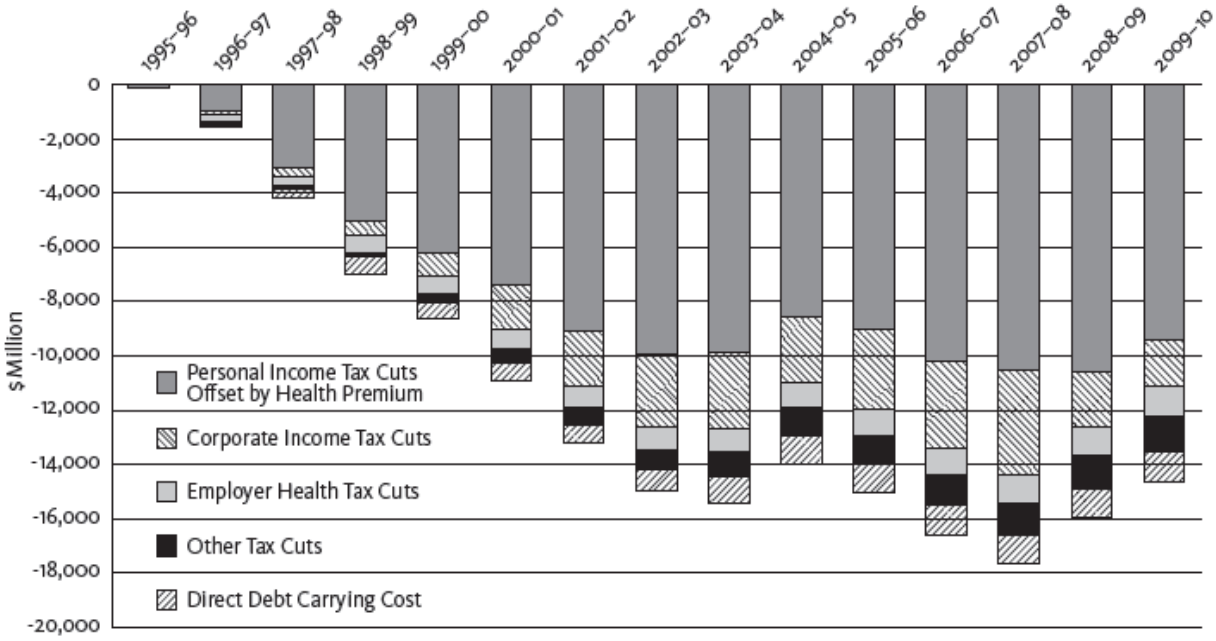
Ontario Public Hospital Spending Per Person 2012 Compared to Other Provinces (Current $)	
Newfoundland	$ 2,519
Alberta	$ 2,194
New Brunswick	$ 1,962
Manitoba	$ 1,843
PEI	$ 1,831
Saskatchewan	$ 1,784
Nova Scotia	$ 1,762
British Columbia	$ 1,557
Quebec	$ 1,381
Ontario	**$ 1,372**
Average Other Provinces	$ 1,870
Difference Between Ontario and Average of Other Provinces	**- $ 498 per person x 13,529,000 people = $6.7 billion less**



Year	Health Spending as % of Program Spending
2011	42
2008	46
2005	46
2002	47

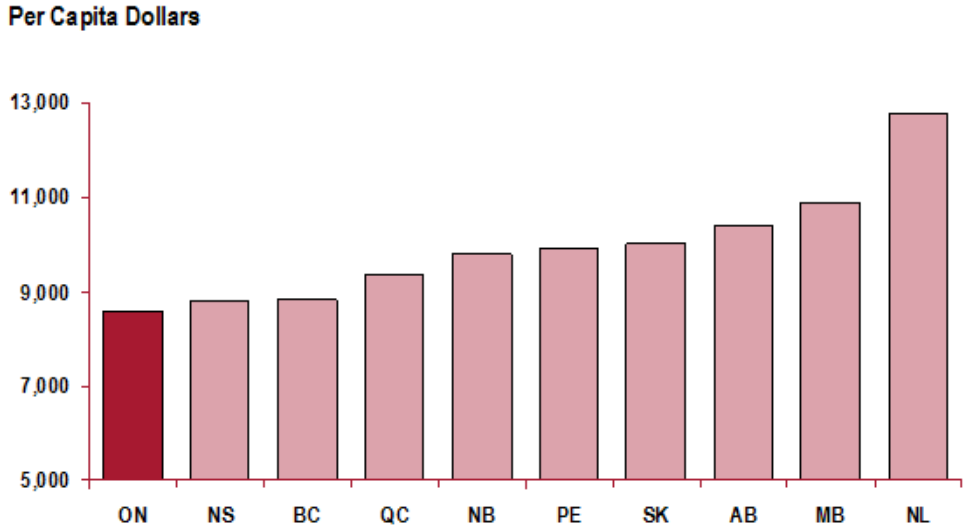


Annual Tax Cut Impact on Provincial Budget Capacity Ontario 1995/96 to 2009/10



Source: Economist Hugh Mackenzie in Ontario Alternative Budget Technical Paper "Deficit Mania in Perspective" February 2010.

Ontario Funding of Public Programs (All Public Services) 2011-2012 Compared to Other Provinces



Source: Ontario Budget, Ministry of Finance.

Negative Impacts on Equity, the Social Determinants of Health and Health Care Services

2013 BUDGET PLAN:

Funding for all programs and services will held to below 1 per cent increase, less than the rate of inflation in many cases.

However, some improvements to social assistance including a rate increase and increased allowances for earnings and assets were announced.

Ontario's approach to the provincial budget has been to cut taxes for the wealthy and corporations and to cut or severely constrain funding for public services. Yet Ontario already funds all public services at a lesser rate than the rest of Canada. This approach has profound implications for equity and health.

Ontario already ranks last of all provinces in funding all public services. These include roads and transit, education, justice, poverty-alleviation programs, housing, social services and health care. The result is cuts to services and a burgeoning array of user fees and out-of-pocket costs for residents. Many of these impact the social determinants of health as well as access to health care services for Ontarians.

Income inequality is on the rise, and income inequality for seniors – particularly elderly women -- has risen more steeply in Ontario than in the rest of Canada. Ontario students already have the highest tuitions in the country and user fees are soaring for everything from parks to roads. Access to safe, healthy, affordable housing is poor. Of particular note: the growth rate of poverty among Ontario's seniors has soared in recent years, far exceeding the national average growth rate. While the incidence of poverty among seniors across Canada rose 25 per cent, Ontarians 65 years and older saw an extremely high poverty growth rate of 41.9 per cent, although the overall proportion of seniors in poverty still remains below 9 per cent. Single women over 65 were the largest group among unattached individuals of all age categories that has fallen into poverty since 2007. Seniors are the most impacted by health care service cuts – and in particular the ongoing severe cuts to publicly-funded long-term care and chronic care services in hospitals, long-term care homes and home care. So as poverty among seniors has increased, so too have requirements for out-of-pocket payment for needed health care.

In health care, we already have excessive user fees for seniors' health care, worsening access to chronic and longer-term care, cuts to rural health services, extra-billing and user fees charged to patients in private clinics, overcrowded hospitals, strictly rationed home care, and a high out-of-pocket health burden compared to the rest of Canada.

We are paying for the shortfall in public service investment in a myriad of ways. This is not a vision for Ontario that advocates of public health care and improved health can support.

Increasing Poverty Among Ontario Seniors

Growth in Poverty Rates in Ontario Compared to the Rest of Canada By Age/Adults Living Alone 2007 and 2009			
	2007 % Living Below the Low Income Measure	**2009 % Living Below the Low Income Measure**	**% Rate of Growth(+) or Decrease (-) 2008-2009 LIM-AT**
Regional Poverty In Canada			
Atlantic Provinces	16.3	15.6	-4.3
Quebec	14.6	13.7	-6.2
Ontario	**11.2**	**13.1**	**+17.0**
Prairies	10.0	10.8	+8.0
British Columbia	13.5	15.0	+11.1
CANADA	**12.5**	**13.3**	**+6.4**
Life Stage Poverty (Ontario)			
Children (>18 yrs)	14.1	14.6	+3.5
Adults (18-64 yrs)	11.2	13.4	+19.6
Seniors (65 and over yrs)	6.2	8.8	+41.9
Adults Living Alone (Ontario)			
Unattached Males Under 65 yrs	24.5	26.2	+6.9
Unattached Females Under 65 yrs	30.4	28.2	-7.2
Unattached Males 65 and over	13.9	14.3	+2.9
Unattached Females 65 and over	16.9	20.3	+20.1

Source: Poverty Free Ontario, Bulletin #2 (June 16, 2011) from Statistics Canada CANSIM Table 202-0802