Ontario Health Coalition
Submission to the Finance Committee
Ontario Pre-Budget Consultations
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The Ontario Health Coalition is a network of more than 400 organizations representing hundreds of thousands of individuals in all areas of Ontario. Our primary goal is to empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to health care and healthy communities. To this end, we seek to provide to member organizations and the broader public ongoing information about their health care system and its programs and services. 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 for good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly-funded, publicly-administered health care system. We work to honour and strengthen the principles of the Canada Health Act.

Our members include over 50 local health coalitions; women's groups such as the National Action Committee on the Status of Women, the Older Women's Network, Immigrant Women's Health Centre, Voices of Positive Women; seniors' groups including the Ontario Coalition of Senior Citizens Organizations, Canadian Pensioners Concerned, CAW retirees, Alliance of Seniors to Protect Social Programs; low income and homeless peoples' organizations including Low Income Families Together, Food Share of Metro Toronto, Ontario Coalition Against Poverty; health sector unions such as CUPE, OPSEU, SEIU, USWA and CAW; service providers; social service organizations; workers' advocacy organizations; health professional associations; ethnic and multiracial minorities; the Ontario Federation of Labour; and other organizations such as the Canadian Council of South Asian Seniors (Ont.), Ontario Coalition for Social Justice, Medical Reform Group, Social Planning Councils, Native Women's Resource Centre, Aids Action Now, Birth Control and Venereal Disease Centre, the Canadian Federation of Students (Ontario division), Oxfam Canada, the Ontario Nurses' Association and the Injured Workers Resource Centre, among others.

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INTRODUCTION

In October, Ontarians voted for the fundamental change in direction promised by the Liberal Party during the election. Over the last month, literally hundreds of our members have contacted us in shock and dismay in response to a series of government announcements. What has alarmed them is the impression that the Government's priority appears to be the adoption of a regime of asset sales, i.e. privatization and constraint, rather than reinvestment in our social programs through a progressive tax system. Ontario's public health care system has been severely battered in the past eight years while the previous government gave first priority to tax cuts for the wealthy, leaving the sustaining of health and social programs in a distant second place. Current priorities don't appear much different. We are hearing almost daily that the inherited deficit has to be remedied before anything can be done to improve health care or education, even though the crying needs in both sectors remain Ontario voters' highest priority. But our health system, and Ontarians who need it, cannot sustain more of the same.

We have learned a few key lessons from the last eight years in Ontario and from world-wide evidence that privatization and restricting services do not save money and threaten the future of the health system. From our experience, it is clear that:

1. Delisting and attacks on universality of Medicare are a false economy, replacing progressive taxation with regressive and inefficient out-of-pocket costs – another form of taxation. After the recent years of Conservative government, Ontarians now have the highest out-of-pocket expenses for healthcare of any province in the country -- an average of $1,072 per person each year. For many of the working poor, for example, this more than wipes out what they received in "tax cuts". For middle-income families it diminishes significantly any tax cut savings.

2. Privatization has increased our healthcare costs and fostered a system that is less accountable and responsive - less easy to "steer" to use the words of Mr. McGuinty and David Osbourne - not more. The public private partnerships being considered for our hospitals will cost more and will simply hide a higher debt off the province's books. The most efficient use of society's resources is thoughtful investment in necessary public infrastructure and restoration of public non-profit delivery of services.

3. Hospital restructuring did not yield expected savings under the Conservative government

   and will not yield savings if your government follows the same path.

4. Health promotion and disease and injury prevention are cost-effective, yet

governments fixated on this year’s bottom line have failed over and over again to invest now to save costs later.

5. To see an example of the characteristics that make for-profit health care a danger to the sustainability of the health system, one need only look at the behaviour of the pharmaceutical industry. Ontario’s drug costs have increased by a whopping 130 % since 1995/96 while pharmaceutical corporations top the Fortune 500 list in profits. Governments face choices – either to shrink the health system for people or to shrink the exorbitant profit-taking of the industry. The solution is not to destroy the universality principle of the health system. It is imperative that the province work to advocate for improved federal controls on drug pricing

6. After the deep cuts of the mid-1990s, the restored funding in the health system has gone disproportionately to hospital management personnel and private health corporations rather than front-line health care services. Improved transparency, democracy and other measures must be taken to ensure that funding reaches front-line staff and patient care.

It is our belief that the goal of a public Medicare system is to create the best health and health care possible for all residents. We believe that reform and revitalization of Medicare needs to stem from this premise. For too long, public policy regarding health care and the determinants of health has been based on short-term financial planning. In the meantime, closed-door negotiations have upheld old-fashioned monopolies of power and the health care reform agenda has been captured by an increasingly powerful private health care industry.

Unlike policy makers, Ontarians do not see health care as a commodity. We see it as an essential social program - an integral part of our social infrastructure. Medicare must not be seen merely as a public insurance scheme covering parts of a largely private industry. It will not be sustainable if defined this way.

The future sustainability of Medicare will depend on stable and adequate funding. It will depend on governments limiting profit-taking and resisting the commodification of health services. It will depend on the efficient utilization of resources -- with a greater percentage of health spending directed to patient care rather than advertising, profit, and excess administrative costs. Medicare’s future depends on restoring public confidence through building democratic decision-making, improved transparency, accountability, and public access to information. It depends on rebuilding and extending the application of the principles of universality, comprehensiveness, accessibility and public administration. It depends on modernization through progressive reform and the extension of the principles of the Canada Health Act to cover home care. It depends on control and coverage of drug and treatment costs. It depends on stable coverage of preventive services including homemaking, physiotherapy and other therapies, and

access to timely treatment. It depends on a serious commitment to combat the social causes of ill health: poverty, lack of safe and healthy housing, barriers to the access of public services and education, and unhealthy environments and workplaces.

1. Delisting: A False Economy

In the last decade, cuts and increases in pharmaceutical prices have increased the out-of-pocket burden Ontarians carry for health costs. According to the Canadian Institute for Health Information, Ontarians now pay $1,072 per person per year in out-of-pocket costs, up from $860 in 1995. OHIP de-listing, high pharmaceutical costs, shortened hospital stays, poor funding of rehabilitation therapies, inadequate home and long term care have contributed to an escalating burden of out-of-pocket health care costs for Ontarians. Forty-five procedures amounting to approximately $100,000,000 in services have been de-listed from OHIP in the last eight years. With the passage of Ontario's Bill 26 in 1996, seniors and those on fixed incomes began to pay user fees for their drugs. The same legislation forces those waiting in hospitals for beds in long term care facilities to pay more than $40 per day for their hospital beds. Inadequate funding and cuts to homecare budgets have caused thousands of Ontarians to lose homemaking and homecare services if we cannot afford to pay for them. Almost three million Ontarians have inadequate drug coverage, according to a recent report commissioned by Health Canada.

While the temptation to delist services as a means of cost control may work to move costs off the province's books, it does not eradicate those costs. Mr. Romanow noted in his report that these cuts were a "false economy" simply shifting the burden of payment from the progressive tax system to individuals. If we must pay either way for health services, why not pool our resources through the tax system and increase our efficiency through bulk purchasing and non-profit public services as the Medicare system is designed to do? The proposed delisting of substance abuse programs and hearing aids, and the proposed dismantling of universal drug coverage for seniors must be abandoned and a renewed commitment to universal, publicly funded services must be made.

2. Privatization and P3s increase costs

The global evidence is that the most privatized the health systems are the most costly. Certainly, we can look to the results of the massive privatization in the United States over the last 10 - 15 years to see the impact of privatization. In 1971 when the last province signed onto Medicare in Canada, both Canada and the U.S. spent approximately 7% of our GDPs on health care. Since then, U.S. costs have grown exponentially faster, now accounting for almost 15% of GDP compared to our 10%. This year, U.S. health costs shot up by 9%, the largest increase in 11 years[1]. Weighed

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[1] U.S. Department of Health and Human Services.

down by unequalled administrative costs, duplication, white-collar fraud, advertising-fed demand and profit taking, Americans now pay $5,440 (U.S.$)[2] per person for health care, more than double our per person cost. Even though more than 43 million Americans have no health coverage whatsoever, the U.S. devotes more resources to healthcare than any other industrialized country, according to the Organization for Economic Cooperation and Development[3]. As in Canada, the multinational pharmaceutical industry is one of the main cost drivers in the system, accounting for about 1/6 of the increase in health spending over the last year[4]. Also a big cost driver are U.S. hospitals that have seen an unprecedented for-profit takeover in the last decade.

A growing portion of Ontario's health services is controlled by private profit-seeking corporations, many of the same companies that are operating in the U.S. The outcomes of this experience provide evidence of the negative effects of privatization of health service delivery. In Ontario, the evidence is that an increase in private delivery amounts to an increase in cost and a diversion of resources away from patient care. In homecare, the introduction of so-called managed competition in 1997 attracted a flood of for-profit provider companies into the province, creating a host of concomitant ill consequences. Laboratory privatization has not reduced costs, but has diminished service levels and has had negative consequences for the remaining public providers. Privatization of cancer care and emergency triage systems have been accomplished only at a greater cost than public provision with unproven results. Drug costs have the dubious distinction of being the greatest growing provincial budget item. The net effects of privatization have been higher per-unit costs, erosion of service levels, erosion of working standards, money redirected from care to profit, higher out-of-pocket costs and inefficiencies. Cost control in Ontario's health system relies on non-profit delivery of services. We need less privatization, not more.

a. P3 Hospitals

The evidence that so-called public private partnership (P3) hospitals cost more is overwhelming. Following the same model as the privatization in Britain termed PFI (private finance initiative), Ontario's P3 hospitals are already showing cost increases from initial projections. In Brampton, capital costs alone have increased from a projected $300 to over $350 million. In Ottawa costs are up from an original cap at $100 million to over $125 million.

In Britain, where the world's most extensive experiment with these hospitals is underway, the editors of the prestigious British Medical Association Journal call them "perfidious financial idiocy". A recent survey by the British Association of

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[2] Ibid.

[3]OECD 2001 figures. These are the most recent comparative figures available.

[4]"Health Spending at Record Rate" by Robert Pear, New York Times, January 9, 2004.

Chartered Certified Accountants found its members think P3s are such poor value for money that they should not be used in public sector investment. The deputy controller of the national audit office described the PFI value for money test as "pseudo-scientific mumbo jumbo". Andy Wynne, ACCA head of public sector said, "There is still a deep scepticism about the benefits of the PFI. Many finance professionals have real concerns over the cost, bureaucracy, time taken in progressing schemes and long term revenue commitments involved[5]. Consultants for the first 18 British P3s costs over $110 million alone.

In Australia, the New South Wales state auditor found that their P3 hospital could have been built two times over in the public sector for what they will eventually pay in the private sector. The Enron-style accounting for these schemes has been similarly criticized by Auditors General in the U.K., Scotland, New Brunswick, PEI and Nova Scotia. They all note that the public gets stuck with higher costs and the majority of the risk.

In addition to higher costs, P3s hide debt from the province's books in their complex long term lease deals. The contract for Coventry's Walsgrave Hospital was 17,000 pages long. Britain's auditor general and deputy contoller says the accounting exercise used to justify these projects, "becomes so complicated that no one, not even the experts really understand what's going on." What is clear is that in the P3 model we will pay more to simply hide debt from the public, and we will lose vital control over our hospitals and health system as a result.

It is imperative that the government stop these P3 deals and revert to public finance and control over our hospitals.

b. Home care

Privatized delivery of homecare through the competitive bidding model adopted by Ontario is redirecting precious health care dollars out of patient care and into ballooning administration. Six years after its inception, Ontario's homecare system is rife with duplication, inability to use staff efficiently, excess administration and profit taking. A recent report by the Canadian Union of Public Employees uses the data that is available to estimate that these problems cost approximately $247 million per year, or 21% of the provinces CCAC budget[6]. There is no Ministry assessment of the inefficiencies in the system they have created.

Expenses incurred by tendering requests for proposals, preparing bids, evaluating proposals and monitoring companies are all components of an unnecessary administrative cost burden. Each of Ontario's 43 Community Care Access Centres (CCACs) has often more than ten provider agencies involved in the delivery of care. The CCAC and each of these agencies have administrations: CEOs, financial officers, human resource departments and

[5] "PFI is poor value, say accountants" by Anne Perkins, The Guardian, October 12, 2002.

[6] See "Secrets in the House: Homecare Reform 1997-2000" Ontario Health Coalition at www.ontariohealthcoalition.ca

frontline managers. Far from streamlining the process of community care governance, this model drives up administrative requirements and escalates costs.

Further costs are incurred because both the CCACs and each of the direct service provider agencies need to keep record systems to monitor the same set of patients and the same set of visits. Maintaining multiple computer systems -- with the related hardware, software and data entry costs, all performing essentially the same function -- is a significant and unnecessary financial drain on the system. Furthermore, with average daily visits of 1,500 to 2,000 per day per CCAC, it is inevitable that discrepancies arise between the computer records. The costs in staff time needed to reconcile discrepancies between the systems often mean hiring dedicated staff in provider agencies and thousands of additional hours of staff time in CCACs.

The common practice of using multiple agencies to provide the same service creates inefficiencies in geographical assignments and results in increased travel costs and staff time. For example, rural neighbours may be visited in the same afternoon by two separate caregivers from two separate companies, each paid for having to travel great distances -- an unnecessary duplication of costs and scarce staff time. Moreover, the multiplicity of service providers have to work through CCAC case managers to communicate, adding extra communication time requirements and the increased possibility of miscommunication, with attendant extra cost and safety concerns.

Tinkering with the competitive bidding model adopted by the province will not be enough to solve the core problems in homecare. A core component of the system's inefficiency is profit-taking. The competitive bidding system has led to an increase in for-profit companies involved in the delivery of care. Under a bidding process that is weighted in favour of opening the market to profit-seeking companies - without support for continuity of care and sound human resource practices - we have seen exponential growth in the proportion of the industry controlled by private interests. It has been estimated that $ 42 million per year of public money is currently paid out in profit to owners and shareholders of these companies. The contracting out of the therapy services by the Ottawa CCAC provides a graphic example of this system creating extra costs. In that region, the CCAC has documented that they are paying over $500,000 more per year to provide exactly the same service that would have been provided had they been allowed to keep the therapists as direct employees. If there were public access to financial and contract information across the province, more examples of this sort would likely be found.

The inherent redundancies and extra costs involved in the privatization of home care delivery is not a wise use of our public health care dollars nor does it result in people receiving adequate home care when they need it. "Managed Competition" has created instability in the industry, has redirected health funds to profit and administration, has contributed to severe staffing shortages and has caused a decline in patient care. The province should move immediately to

restore public non-profit homecare and allow CCACs to hire staff directly to eliminate the duplications and profit taking.

c. Labs

In a report on health care privatization commissioned by the Ontario Health Coalition and written by Paul Leduc Browne of the Canadian Centre for Policy Alternatives, summarized below, an investigation of public-private partnerships for laboratory services reveals that increased private delivery has not contained costs and has created new user fees and problems for the remaining public labs[7].

Many years ago, Ontario's private laboratory industry was comprised of small companies funded by the private insurance industry and serving physician's offices. The consolidation of the industry has evolved to the point where three major private lab companies control 90% of the market. After a decade of 15% per year in increases in private lab expenditures through the 1980's the province negotiated an 8.9% reduction in payments over three years to bring expenditures from $456 million in 1992-93 to $415 million by 1995-96. In 1993-94, payments soared to $480 million. In 1998, the government negotiated a new cap of $425 million with scheduled increases of 1.5% for the next two years. Under a subsequent negotiation, private labs received a retroactive payment of $26.6 million for 1998-99 and a 1999-2000 global envelope of $458 million. Despite claims of private sector efficiency, a number of studies indicate that private laboratory services in fact cost more. It has been inferred from these studies that OHIP's laboratory costs could be reduced by $200-250 million a year, if the public sector were to take over the business. Not only are publicly funded costs escalating, but new user fees have also been introduced. Nursing homes and patients report that mobile-unit pick up laboratory services that used to be provided at no charge are now subject to a user fee of $15 per pick-up.

Public laboratories operate at a disadvantage. Where private labs bill OHIP on a fee-for-service basis, public labs are funded out of hospitals' block funding. They do not have the means to deal with higher volumes of services, especially out-patient work, and they do not have the means to invest in new technology or facilities. While for-profit labs have taken the higher-volume and lower cost services, public labs must deal with more complicated, specialized, non-routine and less profitable tasks involving skilled technologists and high-cost equipment.

d. Long Term Care

The Ontario government is funding - for the first time - for-profit corporations to build long term care facilities that the corporations own and operate on a profit-seeking basis. While government and out-of-pocket spending is on the increase, staffing and care levels are among the lowest in the country and new funding has

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[7] "Tipping the Balance" CCPA 2000.

disappeared into a black hole of unaccountability. Recently, there have even been lay offs in some homes, and lack of preventative care contributes to expensive hospitalizations. Last November one of the biggest for-profit nursing home companies in Ontario, Extendicare, reported record profits. In a Toronto Star article, the CEO was quoted as attributing the Ontario profits to the funding increases. New regulations to force nursing homes to spend their funding on care through minimum staffing levels and improved inspection and enforcement regimes are desperately needed to protect staff and residents and ensure efficient use of resources in this sector.

3. The costs of restructuring and unequal reinvestment

In the mid 1990s, approximately $800 million was cut from hospital budgets, with little warning and inadequate planning. Funding instability has not only caused deep cuts to services, it has also created new monetary and other costs. The cuts and restructuring have combined to create grave inefficiencies and redirection of precious resources from patient care to administration, capital costs, consulting fees, and others. Non-monetary costs such as demoralization of staff, increased stress, accidents, injuries and staffing shortages are increasing. Insecure budgets have diminished the ability of facilities to hire permanent full-time staff and to create working conditions to attract and retain personnel.

The justification for the cuts was that savings would be reinvested in community care. However, the costs of cutting proved to be much higher than anticipated and the anticipated savings never materialized. In Ontario, literally hundreds of millions were spent on consultants and restructuring to reduce patient length of stay, lay off staff and close hospital beds. The system was sent spiralling into crisis, forcing refunding of hospitals. Ironically, millions more were spent on trying to hire back staff and reopen hospital beds. The former provincial government regularly used hospital re-funding as a public relations exercise, delaying and stretching out announcements to maximize public exposure, and routinely re-announcing monies that had been previously announced. The results of these policies have lasted longer than the cuts themselves.

As important as overall funding totals, is where funding goes inside the health system. It is evident that the refunding of hospitals and funding increases in long term care have not improved population access to staff and beds. By last spring, Ontario was spending more than ever on hospitals, but 5,900 beds remained closed from the cuts in the mid-1990s. According to Statistics Canada figures, staffing per population has declined since 1995 when there were 168 hospital staff and 93 long term care staff for every 10,000 Ontarians. By 2003, hospital staff had been reduced to 153 and long term care

staff to 75 per 10,000[8]. While hospital executive salaries increased substantially, front line staff wages did not keep pace with cost of living increases.

Looking at the evidence from the last decade, the government should be wary of restructuring plans that cut access to services. Our experience is that demand does not decrease with decreased funding and over a decade of hospital restructuring has wasted hundreds of millions on consultants, closures, reopenings and staffing instability. Improved democratic control over institutions and within the institutions and vastly improved transparency is necessary to ensure health funding reaches its intended destination.

CONCLUSION

Ontario's health system has been substantially weakened through a decade of privatization and restructuring. It cannot sustain more of the same. It is because of the decline of Medicare over the last decade, in part, that Ontarians voted for change. We expect the government to fulfill its promises to stop profit-taking and privatization in healthcare, to rebuild access to care and to promote population health. The evidence is clear. A refusal to reinvest in healthcare through a progressive tax system is a false economy. Privatization will simply increase costs and hide debt. We will pay - and pay more - if this policy direction is not stopped. This government has both the mandate and an obligation to Ontarians to institute a fair taxation system to reinvest in Medicare. The situation is critical. The future sustainability of our health system relies on your recommendations.

[8] Stats Can, Survey of Employment, Payroll & Hours CANSIM II, Table 281-0023.