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First Do No Harm:

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

Phase I Report

Ontario Health Coalition

February 10, 2012

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Ontario's largest public interest group dedicated to protecting and improving public health care for all.

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Introduction

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 as they headed to the ballot box. 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.

It is disturbing to witness the process with which reform is being determined. A narrow sliver of elites – executives and managers who benefit from restructuring and whose wealth and perspective hold little in common with the majority of Ontarians – now has a virtual monopoly on policy-making. The public has never been given opportunity to debate, nor provide any meaningful input into the restructuring plans underway for months behind the scenes. Ontario's Minister of Health has launched a new period of health reforms without benefit of a discussion paper, legislative debate, or public consultation of any kind. Basic parliamentary processes have been omitted, including the establishment of Standing Committees of the Legislature with proper pre-budget hearings open to the public across Ontario.

Overall this report is a response to the ill-considered proposals that cloak health care cutbacks under the guise of reform. It is an attempt to inject a cautionary message: first do no harm. But more than this, our report is an appeal for balance; an appeal for our government to put improved access, quality and accountability at the centre of Ontario's health care reform. It is an attempt to share a public interest perspective on the lessons of the last twenty years of restructuring; including lessons that faulty restructuring can lead to much higher costs, damage to our health care system and cause suffering for Ontarians. And it is an attempt to instill some balance into discussions on health spending and revenues.

In the following pages, we have compiled the evidence of assessed patient needs and the most urgent unmet care needs. Grounded in the evidence regarding spending and costs, we have made recommendations to begin to restore sustainable health care funding through closing tax loopholes in the Employer Health Tax. And using a lens that puts access and accountability at the centre of our health system, we have reviewed the major proposals for health reform, as revealed to date.

This is the first phase of a two-phase process. Our Phase II report will respond to the government's Drummond Commission on Public Sector Reform and will include a discussion paper that contains recommendations for reform to enhance access to care and public accountability, under the principles of equity and fairness that underlie our public health care system.

Section I

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.

In June, the Ontario Auditor General reviewed the government's projections for health care funding over the next three years.[1] The auditor reports that government spending projections for health care are based on a 50% reduction in annual health funding increases over the next three years compared to the rate of the last eight years, amounting to a 3.6 % funding increase for health care annually. The auditor warns that these targets would entail "aggressive" cuts. Since June when the auditor released his report, the government has twice further reduced health care spending targets.

According to the auditor's report:

- Ontario hospitals must find $1 billion in cutbacks over the next two years[2]
- OHIP will have to carve out $2.05 billion over the next two years[3]

The Bottom Line

At the 3.6% projected funding increase for health care planned by the McGuinty government prior to the recent provincial election:

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 $^1/_3$ 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.

[1] Office of the Auditor General of Ontario, The Auditor General's Review of the 2011 Pre-Election Report on Ontario's Finances, June 28, 2011.
[2] Ibid, page 23.

- Funding increases for home care will be $^1/_3$ of what they have been for the last eight years[4]
- Long term care homes funding increases will be less than ½ of what they have been for the last eight years[5]
- Drug program funding increases will be ½ of what they have been for the last eight years[6]

The Auditor General reports that the government was not able to provide him with detailed plans and costing estimates to achieve the very significant curtailment of more than $3 billion in hospital and OHIP funding.[7] He raises questions about the viability of government plans to move more patients out of hospitals into home care and long-term care homes given the lack of funding planned and the already-existing waiting lists for these services.[8]

In contrast, Ontario's Auditor General found the government's plan to reduce drug program costs to be viable and concludes that the projected $250 million reduction over two years is "reasonable".[9]

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.[10] 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. To date, the government has provided no details about their plans to make these further cuts to Ontarians. The public has never been informed about, or consulted on these plans and has never been asked about any alternative solutions.

[3] Ibid, pages 25 & 26.
[4] Ibid, page 27.
[5] Ibid, page 27.
[6] Ibid, page 26.
[7] Ibid, pages 25 & 26.
[8] Ibid, page 28.
[9] Ibid, page 27.
[10] 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.

Section II
Assessing the Case for Radical Restructuring

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 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.[11]

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

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 down.

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

more hours into the labour force. As shown in Section III of this paper, Ontario's ranking in key social determinants of health, including income equality and access to housing are worsening. These factors demonstrably contribute to better population health.

Within the health care budget, spending trends yield evidence that cutbacks over recent decades have reduced health care services to less than the public's need for those services, and have resulted in burgeoning wait lists and urgent unmet care needs that risk health and safety of patients and caregivers. Attempts to reduce health care spending over the last two decades have primarily focused on limiting longer-term care to below population need in all settings (hospital, long-term care homes and home care). The result is a severe rationing backlog of patients suffering on wait lists. Yet the same old ideas for rationing longer-term care are central to the Health Minister's new reform plan. Another focus of health spending reductions has been on cutting hospital outpatient care to the detriment of access to needed rehabilitation, laboratory and other services for Ontario patients. In the last decade, in particular, hospital care in rural and smaller communities has also become a target for cuts, regardless of community need and increased risks for patients.

Ontario Ranks 8th of 10 Provinces in Health Spending

In recent years, Ontario's government has repeatedly justified cuts to health care services by invoking potent images of out-of-control health care spending. Health care is a "Pac Man" eating the provincial budget, we have been told. The public is routinely exhorted to reduce their expectations and accept poor access to certain types of health care: after all, health care is about to gobble up 80 per cent of the provincial budget.

Yet the evidence does not support this contention. In fact, Ontario's health spending ranks among the lowest in Canada. On a per person basis, Ontario spends $440 less than the average of other provinces on health care. Multiplied by Ontario's 13 million population, this means an aggregate shortfall of $5.72 billion compared to the average of other provinces.

Tables 1 & 2 show Ontario's health spending ranking; on a per-person basis and as a percentage of GDP. By both measures, Ontario ranks eighth out of ten provinces.

Table 1.

Public Health Care Spending by Province – Per Capita 2010 Ontario 8th of 10 Provinces	
Newfoundland	$ 4,982.9
Alberta	$ 4,762.9
Manitoba	$ 4,611.5
Saskatchewan	$ 4,602.1
PEI	$ 4,389.6
New Brunswick	$ 4,210.5
Nova Scotia	$ 4,192.9
Ontario	**$ 3,911.7**
British Columbia	$ 3,801.8
Quebec	$ 3,603.3

Table 2.

Public Health Care Spending by Province 2010 as a % of Provincial GDP Ontario 8th of 10 Provinces	
PEI	12.8
Nova Scotia	11.0
New Brunswick	10.8
Manitoba	10.7
Newfoundland	9.3
Quebec	8.9
British Columbia	8.5
Ontario	**8.4**
Saskatchewan	7.9
Alberta	6.6

Figures calculated from CIHI 2011 National Health Expenditures data.

Summary

Ontario spends $3,911.7 per person on health care.
Rest of Canada (average): $4,351

Difference:
$440 per person
x population (13 million)
= **$5.72 billion**

Compared to other provinces, Ontario spends $440 less per person on public health care. On an aggregate basis, this means Ontario spends $5.72 billion less on health care than other provinces.

Though health spending is increasing as a percentage of GDP, Ontario still ranks 8th out of 10 provinces in terms of health spending to GDP; yielding evidence that there is room to grow as needed to provide better health care for Ontarians.

Ontario Ranks 8th of 10 Provinces in all Government Spending

Table 3.

Total Government Spending Per Person 2010 Ontario 8th of 10 Provinces	
Newfoundland	14,956
Saskatchewan	12,473
Quebec	12,105
PEI	11,497
Alberta	11,054
New Brunswick	10,623
Manitoba	10,134
Ontario	**9,853**
Nova Scotia	9,205
British Columbia	8,848

Tables 3 and 4 show Ontario's total government spending compared to other Canadian provinces. Total government spending includes spending on all programs and services as well as debt servicing charges. Again, Ontario ranks near the bottom of the country, yielding further evidence that spending in general – and health spending – are not "out of control".

In fact, there is room, as Table 4 shows, for growth in spending as a proportion of our GDP. Using CIHI data projections for 2010, we can see that Ontario is 3.14 percentage points of GDP less than the average of all provinces in total government spending as a proportion of provincial GDP.

Table 4.

Total Government Spending as a % of Provincial GDP 2010 Ontario 8th of 10 Provinces	
PEI	33.55
Quebec	30.00
Newfoundland	27.86
New Brunswick	27.36
Nova Scotia	24.08
Manitoba	23.52
Saskatchewan	21.29
Ontario	**21.26**
British Columbia	19.70
Alberta	15.41

Summary
Ontario: $9,853
Rest of Canada (ave): $11,211
Difference:
$1,358 per person
x population (13 million)
= **$17.65 billion**

Compared to other provinces, Ontario spends $1,358 less per person on all government programs and services.

On an aggregate basis, this means Ontario spends $17.65 billion less than other provinces.

Figures calculated from CIHI 2011 National Health Expenditures data.

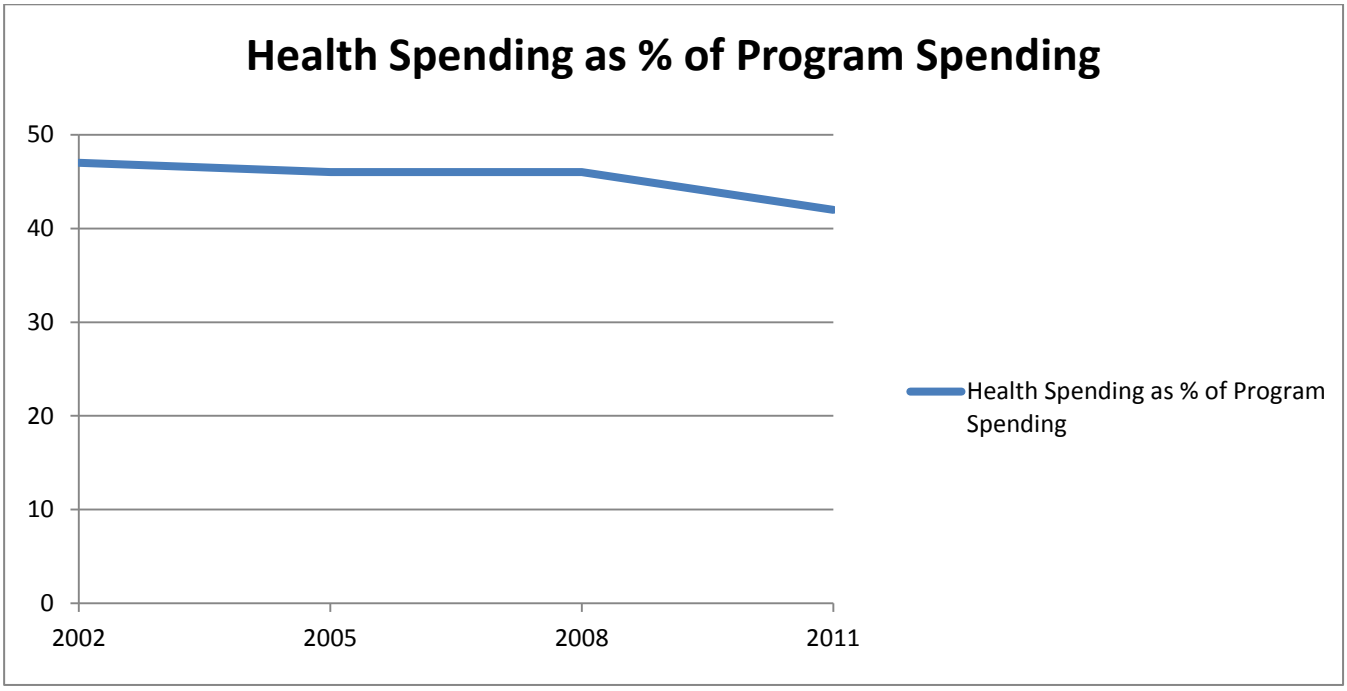
Health Care is Declining as Share of Ontario Spending

Contrary to the claims of the crisis-manufacturers, Ontario's health spending is not poised to wipe out all other social programs. In fact, it is *shrinking* as a share of provincial spending. A review of Ministry of Finance budgets for the last decade reveals the trend, as captured in Chart 1 and Table 5.

Table 5.

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

Chart 1.



Source: Ontario Budgets, Ministry of Finance, 2002, 2005, 2008, 2011

The Truth About Health Spending Trends

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. 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 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 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.

Hospital Spending Declining as Share of Health Care Spending

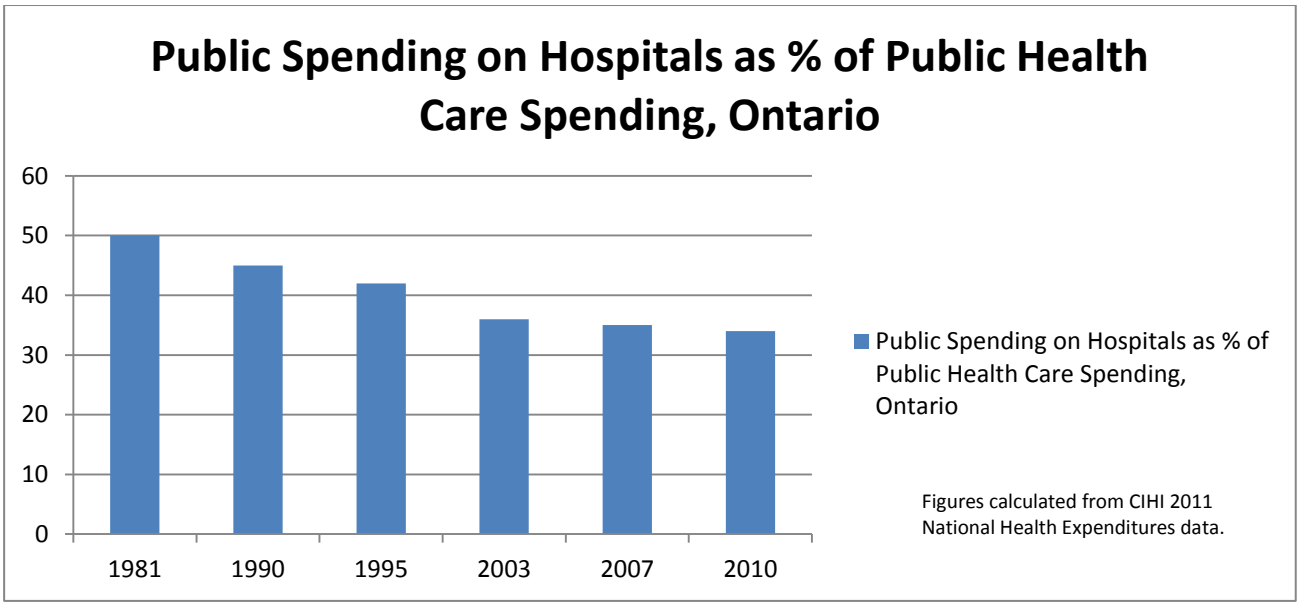
Table 6.

Year	Public Hospital Spending as % of Ontario Public Health Care Spending
1981	50.34
1990	44.65
1995	42
2003	36.14
2007	35.15
2010	34.04

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.

This data shows the long history of health care restructuring in Ontario. But investments in community care have never kept pace with hospital cuts, as evidenced by the extremely long wait lists and rationing of care that we see today. Moreover, there is sufficient evidence of extraordinary hospital overcrowding and bed shortages to consider that hospital cuts have gone too far and are eroding access to vital public health care services for Ontarians.

Chart 2.



Ontario Hospital Spending 2nd Lowest in Canada

Table 7.

Province	Public Spending on Hospitals Per Person 2010
Newfoundland	2,380.8
Alberta	2,046.2
New Brunswick	1,924.0
Nova Scotia	1,771.2
Manitoba	1,716.5
P.E.I.	1,694.1
Saskatchewan	1,571.2
British Columbia	1,564.8
Ontario	**1,331.7**
Quebec	1,276.2

Summary

Ontario is second from the bottom of all provinces in terms of public spending on hospitals per person.

2010 average per person hospital spending by provinces outside of Ontario: $1,771.7

Ontario: $1,331.7

Difference: $440 per person

X 13 million (Ontario population)

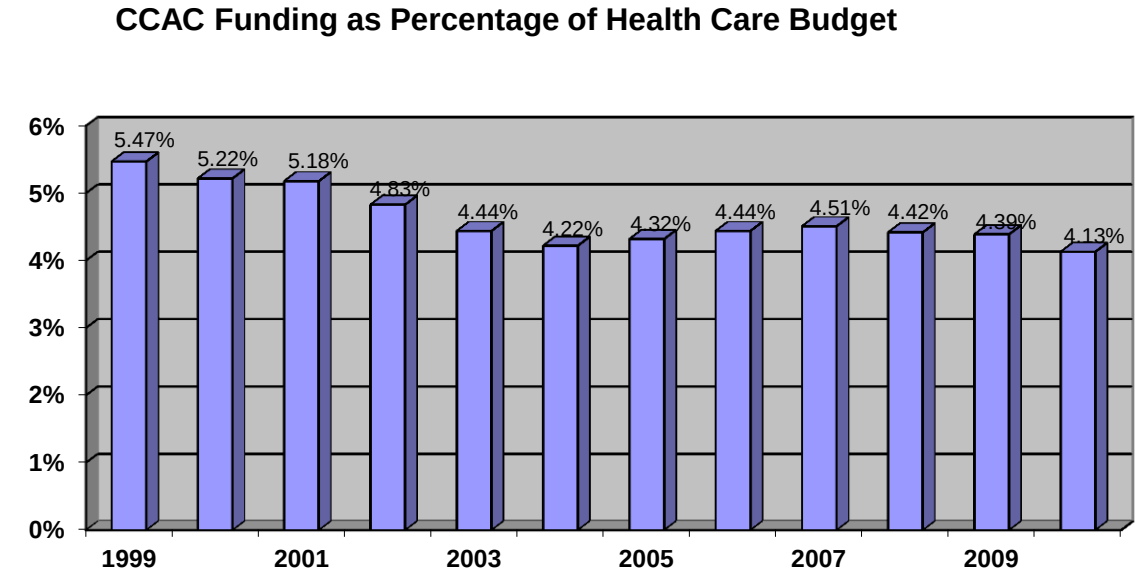
= $5.7 billion

We spend $5.7 billion less than the average of the rest of Canadian provinces on hospitals.

Home Care Funding Declining as Share of Health Spending

Despite repeated claims about moving patients into the community, the evidence shows that home care funding is declining as a share 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.

Chart 3.



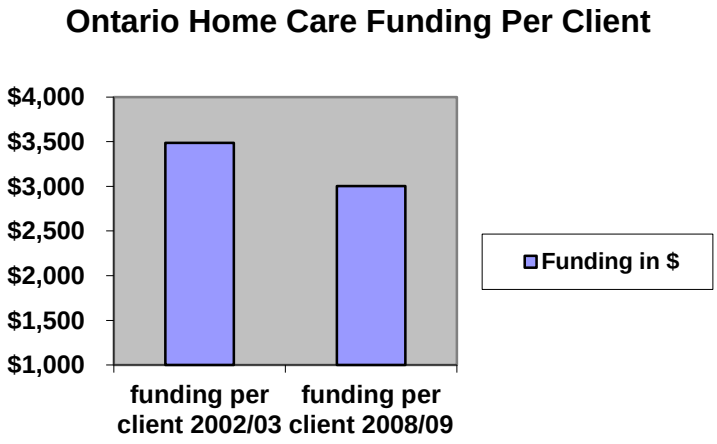
Source: OACCAC

On a per-client basis, home care funding has also declined, meaning that there are less available resources per home care client. This results in rationed and inadequate care for home care clients.

From the 2004 report of the Ontario Auditor General to the 2010 audit, total expenditures for home care increased from $1.22 billion to $1.76 billion. In the same period, the total number of clients increased from 350,000 to 586,000. This means that while the number of clients has increased by more than 66%, funding has increased by just over 40%.

Based on the auditor's figures, average per person funding for home care clients was $3,486 per client in 2002/3 and declined to $3,003 per client in 2008/9.

Chart 4.



A Closer Look at the Revenue Side:

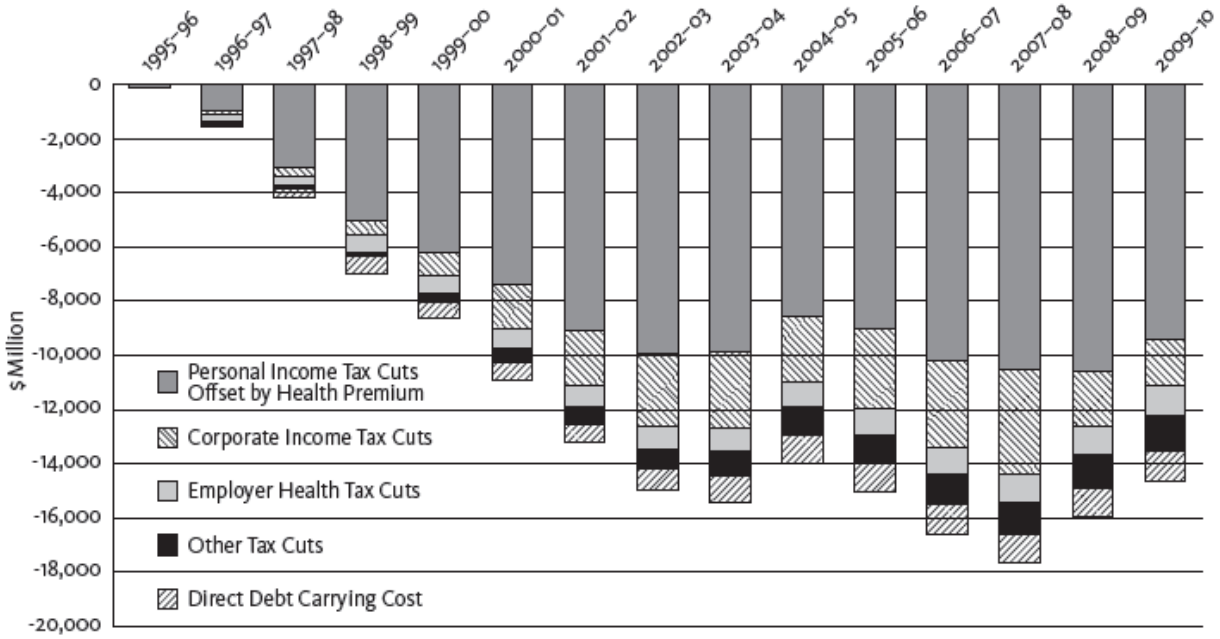
Tax Cuts, Not Health Care are Eating Up the Provincial Budget

The McGuinty government has refused to consider revenue measures to address the provincial deficit, choosing instead to focus exclusively on spending. But, as evidenced in the previous section, a review of the spending data reveals that Ontario in near the bottom of the country in health care funding. Despite overblown rhetoric about health care spending, the evidence shows that if anything is "eating up" Ontario's provincial budget it is tax cuts, not health care.

The common mantra of the business lobbyists holds that tax cuts stimulate the economy. Yet despite the deepest and most prolonged tax cuts in the country, Ontario is facing several years of relatively low economic growth and has experienced a decline in business investment. In fact, the evidence reveals that the tax cuts across Canada over the last fifteen years have mainly benefited the wealthy and corporations. And as we will show in the next section, needed health care services are suffering.

There are other options. One possibility is to close the tax loopholes in the Employer Health Tax (EHT) which could, alone, generate billions of dollars in additional revenue to address the most urgent health care needs of Ontarians. For details, see Section V.

Chart 5. Annual Tax Cut Impact on Provincial Budget Capacity, Ontario 1995-96 to 2009-10



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

Chart 5 shows the annual impact of the Harris government's tax cuts from the mid-late 1990s on Ontario's fiscal capacity. 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.

Section III
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.[12] 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.

- On average, access to primary care (family doctors, nurse practitioners and primary care teams) has improved. In fact, Ontario has made great strides in introducing nurse practitioners and increasing medical school enrollment for family health care. But some areas of Ontario suffer from very poor access to this "front door" of health care and Ontarians still wait lengthy periods for appointments.
- While access to a whole array of surgeries has improved considerably, wait times for urgent cancer and cataract surgeries remain too long.
- Our public health system has expanded to embrace new technologies for wait times management, cancer treatment and diagnostics.
- But longer-term and chronic care is severely rationed and increasingly subject to user fees in

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.

Home care funding per client declined by 14% between 2003 and 2009.

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

all settings including hospitals, long-term care homes, and home care.
- In fact, wait times for long-term care have never been higher.
- Care traditionally provided through outpatient clinics, including rehabilitation, laboratory and other services, has been cut all across Ontario, leading to increased inequity, user fees and poorer access.
- Services in rural and smaller communities have been eroded and access to vital care in some regions is now at grave risk.

Perhaps the most hurt through the decades of health restructuring are Ontario's seniors. Despite repeated promises that health care reform will focus on enabling the elderly to age at home and move services from hospitals "to the community", wait times for long-term care outside of hospitals has remained persistently high for more than a decade and are now higher than ever. The evidence shows that despite claims by various Health Ministers, increases in long-term care homes and home care have never kept pace with hospital cuts. The movement of services out of the umbrella of the Canada Health Act (which covers hospital and physician care) has been accompanied by an ever-increasing array of out-of-pocket costs and user fees for patients. The creation of a stable integrated home care system has been stalled and access to longer-term care, rehabilitation, and other services has become more inequitable. Ontario's hospitals report the shortest average lengths of stay (how quickly patients are discharged) in the country. But complaints of coercive tactics used to force patients out of scarce hospital beds are more frequent than ever.

Indeed Ontario's shortage of hospital beds has contributed to truly extraordinary and unprecedented levels of hospital overcrowding risking the health and safety of patients. While constant erosion has damaged access to local hospital care in many smaller and rural communities, Ontario's larger urban centres suffer with hospital occupancy rates that are higher than virtually anywhere in the industrialized world. Well-publicized emergency department backlogs and long ambulance offload delays are the most visible consequence of hospital overcrowding. But equally serious are the cancellations of surgeries and other procedures, high hospital-acquired infection rates, and greater risk for patients' health and safety that result. Not captured in the bed cuts and emergency department wait times are the consistent cutbacks to hospital outpatient services including rehabilitation, laboratories and a host of needed services. Indeed Ontario's laboratory system is increasingly fragmented, privatized, inefficient and unnecessarily costly. Access to public rehabilitation has been ruthlessly cut all across the province without regard for patient need.

Hospitals

The evidence shows that investments in hospital care over the last eight years have bought significant change and improved access to certain types of care. However, while there have been significant improvements in surgical wait times in Ontario[13], patients waiting for hospital beds face serious wait times. In addition, overall hospital occupancy rates in Ontario are dangerously high. The shortage of hospital beds in Ontario has created backlogs that are causing negative impacts on patient access to care and increasing risks to patient safety. And surgical wait times, while considerably improved, are not entirely vanquished.

Ontario's Auditor General reports that hospitals will have to find savings of $1 billion (or more) over the next two years to meet government targets for cost containment, as outlined in Section I. The Ontario Hospital Association is lobbying for a reduction in hospital spending equalling $800 million.[14] Don Drummond, the provincial government's Chair of the Commission on Public Sector Reform has recently advocated for a reduction in hospital spending equalling $1.5 billion.[15] There is a very real risk that cutbacks targeting hospitals will exacerbate backlogs in emergency departments, worsen already-dangerous levels of hospital overcrowding and harm patients; particularly seniors and those with complex chronic illnesses.

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.

Hospitals: Urgent and Unmet Care Needs

- 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.

[13] The Ontario Health Quality Council reports that while wait times for a number of surgical procedures are almost all done within prescribed time frames, wait times for urgent cancer and cataract surgeries, in particular, remain too long. See: Health Quality Ontario, "2011 Report on Ontario's Health System" Health Quality Monitor, 2011: page 9.
[14] Ontario Hospital Association, Ideas and Opportunities for Bending the Health Care Cost Curve: Advice for the Government of Ontario, April 2010.
[15] Cohn, Martin Regg "Brace for a budget firestorm across Ontario" Toronto Star, January 5, 2012.

    - 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.

Emergency Department Wait Times: The Canary in the Mine Shaft

In their recent report, Ontario's Health Quality Council advised that Ontario fares poorly on international comparisons of emergency department wait times.[16] While wait times for many surgeries and other procedures have improved over the last decade, emergency department backlogs remain very high. The Canadian Wait Times Alliance reports that Ontario measures the most procedures and receives the highest rankings among provinces for those procedures that are measured, except wait times in emergency departments for patients who need to be admitted to hospital. In this measure, Ontario is given failing marks.[17] More than half of patients who are admitted to hospital through the Emergency Department face wait times that are longer than recommended time frames.[18] In fact, Ontario has, on average, 592 patients waiting in emergency departments for admission to an inpatient bed. This represents almost 4% of Ontario's total acute care beds.[19]

Overcrowded emergency departments not only compromise the privacy and dignity of patients, they increase the risk of poor outcomes and death. A new study by Ontario researchers has demonstrated that long waiting times increase the risk of death and hospital readmission for patients who have been discharged from the emergency department. This study, published in the British Medical Journal looked at 22 million patient visits to Ontario emergency departments over a five year period, and found that the risk of death and hospital readmission increased with the degree of overcrowding at the time the patient arrived in the emergency department. The authors estimate that if the average length of stay in the emergency department was an hour less, about 150 fewer Ontarians would die each year.[20]

Though it has persistently ignored its own findings, the Ontario Ministry of Health and Long-Term Care has acknowledged that backlogs in emergency departments are a warning sign of lack of capacity within Ontario hospitals. In 2006, a tri-partite committee of the Ontario Ministry of Health and Long-Term Care, Ontario Medical Association and Ontario Hospital Association the Ministry of Health released a report, "Improving Access to Emergency Care: Addressing System Issues". As the report's authors note:

> "Many myths exist as to the causes of emergency department overcrowding, including overuse by nonurgent patients and seasonal outbreaks. The main overarching causes of overcrowding are twofold: a lack of bed availability, and a lack of integration between community and hospital healthcare resources. The number of acute care beds in Ontario fell by 22% during the mid to late 1990s. Acute care bed occupancy rates rose from 85.6% in 1994/95 to 96% in 2000, and have remained consistently well above 90% since then. Occupancy rates above 85% are linked with poor patient flow, including delays in admitting patients from the emergency department, and with a lack of bed surge capacity."[21]

[16] Health Quality Ontario, "2011 Report on Ontario's Health System" Health Quality Monitor, 2011: pages 9, 25.
[17] Wait Times Alliance, Time Out: Report Card on Wait Times in Canada, June 2011.
[18] Health Quality Ontario, "2011 Report on Ontario's Health System" Health Quality Monitor, 2011.
[19] Ontario Hospital Association, "ALC Study", June 2011.
[20] BMJ 2011; 342:d2983
[21] Physician Hospital Care Committee, a Tripartite Committee of the Ontario Hospital Association, the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care, Improving Access to Emergency Care: Addressing System Issues, August 2006.

Hospital Bed Cuts Leave Patients Waiting for Care

Recent statements by Ontario's Health Minister and the proponents of health care restructuring imply that hospital cuts can be achieved by moving significant proportions of patients (and costs) from hospitals to home care. While there is no question that enhanced home care is needed, and that some patients waiting for long-term care placement could be redirected to home care with additional investments and supports; however, the evidence does not support the contention that hospital beds - which are already too scarce - should be cut to shift resources to home care. In fact, not only is there a significant backlog of patients waiting in emergency departments for hospital beds, the data shows that approximately one in five of Ontario's Alternate Level of Care (ALC) patients is waiting in an ALC bed for another type of hospital bed.

The Ontario Hospital Association has conducted regular surveys of all Ontario's hospitals to collect ALC data since 2007.[22] In their most recent report, the OHA data reveals that at least 733 of 4,073 patients designated "ALC" are waiting for hospital-level care, including rehabilitation, complex continuing care, palliative care and convalescent care.[23] This represents almost 1 in 5 ALC patients. The OHA data shows that only 135 of 4,073 ALC patients are assessed as requiring home care.[24] This represents about 1 in 30 ALC patients.

It should be noted that the assessed level of care needs for Ontario's hospital patients are determined by physicians and registered nurses, and subject to multiple levels of controls all of which are dedicated to moving patients out of hospital. Care coordinators are required to follow a "Home First" policy of directing ALC patients onto home care rolls as a first priority.

As shown in Table 8 below, 18,500 hospital beds have been closed since 1990 in Ontario. While there have been increases in psychiatric and rehabilitation beds, these are more than offset by the dramatic cuts to acute care and complex continuing care (chronic) beds. Not captured in these figures are cuts to outpatient services in areas such as rehabilitation which have an impact on access to care and the number of required hospital beds. Ontario's acute care and complex continuing care beds have been cut in half since 1990. Overall, Ontario's hospital bed capacity has been cut by almost 40% since 1990.

Though successive governments have claimed that hospital cuts are offset by home care and long-term care institutions, the evidence shows that home and long-term care funding has never kept pace with hospital cuts. Chronic wait lists for these services since at least the late 1990s. In fact, home care is more stringently rationed than ever, with less funding per patient than five years ago. Long-term care homes' wait lists are now higher than they have been since at least the late 1990s. The provincial auditor reports that home care funding increases for the next two years will be $^1/_3$ of what they have been for the last eight years and long-term care homes funding increases for the next two years will be less than ½ of what they have been for the last eight years. These figures do not support the contention that further hospital cuts will be offset by moving patients "into the community" or "integrating home and community care".

[22] In Ontario the "ALC" is almost always used by the media as if it refers only to patients who should not be in hospital. This is incorrect. In fact, the definition adopted by Ontario's Ministry of Health in 2009 includes patients waiting for hospital beds that they cannot access because of lack of availability (likely either there are no funded beds available or there is inadequate staffing to provide the service). These can include patients waiting for convalescent care beds, palliative beds, complex continuing care beds, rehabilitation beds/facilities. For the MOHLTC definition go to: http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc_definition.aspx

[23] Ontario Hospital Association, Alternative Level of Care (ALC) Survey, June 2011: see slides 4 & 18.

[24] Ibid.

Table 8.

Ontario Hospital Beds Staffed and in Operation 1990 – 2010[25]					
Year	Acute	Psychiatric	Complex Continuing Care	Rehabilitation	Total
1990	33,403	2,505	11,435	2,048	49,391
1991	31,907	2,430	11,506	1,975	47,818
1992	29,826	2,331	11,425	1,902	45,484
1993	27,940	2,276	10,935	1,926	43,077
1994	26,097	2,166	10,592	1,905	40,760
1995	25,386	2,182	10,325	1,853	39,746
1996	24,014	2,147	9,639	1,890	37,690
1997	21,929	2,142	8,678	1,875	34,624
1998	20,317	2,094	8,149	1,815	32,375
1999	19,740	2,062	7,788	1,802	31,392
2000	19,558	2,505	7,505	1,924	31,492
2001	19,912	3,444	7,455	2,137	32,948
2002	19,355	3,709	7,428	2,240	32,732
2003	18,781	3,620	6,896	2,349	31,646
2004	18,552	4,547	6,537	2,362	31,998
2005	18,433	4,511	6,402	2,397	31,743
2006	18,444	4,368	6,094	2,478	31,384
2007	18,445	4,305	5,972	2,415	31,137
2008	18,702	4,333	6,039	2,410	31,484
2009	18,773	4,332	5,927	2,392	31,424
2010	18,355	4,335	5,798	2,322	30,810
Difference 1990 - 2010	-15,048	+1,830	-5,637	+274	- 18,581
Difference	- 45%	+ 73%	- 49%	+ 13%	- 38%

[25] Source: Ontario Hospital Association at http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large

Hospital Overcrowding and Lack of Beds

Ontario's hospital occupancy levels are extraordinarily high. According to Ministry of Health data, there are, on average, 30,164 inpatients[26] in Ontario's 30,810 hospital beds.[27] The provincial hospital bed occupancy rate is 97.8%, much higher than other jurisdictions. By comparison, the OECD reports an average occupancy rate for acute care beds of 75%.[28] In the United States, the average hospital occupancy rate is 68.2%.[29] Most often cited in the academic literature, a target hospital occupancy rate to reduce access blockages and improve outcomes is 85%.

In fact, among Canadian provinces, Ontario ranks last in numbers of hospital beds per person. Among industrialized countries of the OECD, Canada ranks at 26 of 32. We have inserted Ontario into the OECD chart to see where this province stands in comparison. Ontario is fourth from the bottom, followed only by Turkey, Chile and Mexico. See Tables 9 & 10.

Within hospitals, overcrowding is associated with serious quality of care issues. Overcrowded emergency departments do not have appropriate staffing ratios for critical care or intensive care patients who require intensive monitoring by specially trained staff. Across Europe, hospital occupancy rates have been cited as a determining factor in hospital-acquired infections. Cancelled surgeries and prolonged waits are associated with poorer health outcomes. Ontario's extremely high occupancy poses a significant threat to patient safety and quality of care.

Consequences of Emergency Department Overcrowding

- Patient suffering, dissatisfaction and inconvenience
- Poor patient outcomes
- Increased morbidity and mortality
- Poor quality of care
- Contribution to infectious disease outbreaks
- Violence aimed at hospital staff and physicians
- Decreased physician and nursing productivity
- Deteriorating levels of service
- Increased risk of medical error
- Negative work environments
- Negative effects on teaching and research

Source: Physician Hospital Care Committee Report to the Ministry of Health and Long-Term Care, Ontario Medical Associaiton and Ontario Hospital Association Tripartite Committee, Improving Access to Emergency Care: Addressing System Issues, August 2006.

[26] See: http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Average+Number+of+Inpatients+on+Any+Given+Day+Ontario

[27] Ontario Hospital Association at http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large

[28] OECD "Health at a Glance 2009" page 95.

[29] National Center for Health Statistics, "Health, United States 2010", 2011, page 354.

Table 9.

Hospital Beds Staffed and in Operation Per 1,000 Population by Province 2008-09[30]	
PEI	4.3
Newfoundland	4.1
New Brunswick	4
Nova Scotia	3.8
Manitoba	3.7
Saskatchewan	3.4
Alberta	2.8
British Columbia	2.6
Ontario	**2.5**

Average hospital beds per 1,000 in Canadian provinces outside Ontario: 3.6

Ontario hospital beds per 1,000: 2.5

Difference: Ontario has 1.1 fewer hospital beds for each 1,000 people.

Aggregate shortfall: 1.1/1000 x 13 million (population) = **14,300**

[30] Note: CIHI data does on hospital beds does not include Quebec. Sources: CIHI Hospital Beds Staffed and in Operation 2008-09, StatsCan population demographics 2008.

Table 10.

OECD Total hospital beds per 1,000 population 2008[31]	
Japan	13.8
Germany	8.2
Korea	7.8
Austria	7.7
Czech Republic	7.2
Hungary	7.1
France	6.9
Belgium	6.6
Poland	6.6
Slovak Republic	6.6
Finland	6.5
Estonia	5.7
Luxembourg	5.6
Switzerland	5.2
Ireland	4.9
Greece	4.8
Slovenia	4.8
Netherlands	4.7
Australia	3.8
Italy	3.8
Denmark	3.6
Israel	3.6
Norway	3.5
Portugal	3.4
United Kingdom	3.4
Canada	3.3
Spain	3.2
United States	3.1
Sweden	2.8
Ontario	2.5
Turkey	2.4
Chile	2.3
Mexico	1.7

OECD average hospital beds per 1,000: 5.2

Canada hospital beds per 1,000: 3.3

Ontario hospital beds per 1,000: 2.5

[31] Source: OECD Health Data 2011.

Long-Term Care Facilities

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".[32] 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 wait lists would remain at record highs[33] unless the government forges a plan to improve the supply of long-term care beds.

Complex continuing care hospital beds have been cut in half since 1990, leaving Ontario's long-term care facilities to replace chronic care hospitals. In the late 1990s, the Harris/Eves provincial government planned to open 20,000 new long-term care beds to take downloaded hospital patients. Most, though not all of these beds were built. Since its election, the McGuinty government claims it has added more than 8,000 additional long-term care beds.[34] Though new capacity has been built in long-term care homes, the evidence shows a severe backlog of patients waiting for long-term care has never kept pace with the downloading of hospital patients and population need. Government funding increases have primarily been taken up by opening new beds and care levels have not kept pace with

Long-Term Care Facilities: Urgent and Unmet Care Needs

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.

[32] Ontario Health Quality Council, page 3.
[33] 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.
[34] Ministry of Finance, Ontario Budget 2011, page 13.

the increase in long-term care resident acuity (level of need). Care workers frequently report an influx of psychogeriatric patients with heavy care needs and behavioural issues that require significant staff time and training. Their claims are supported by data from provider organizations. The Ontario Association of Non-Profit Homes and Services for Seniors (OHNSS) describes the situation as follows:

> "There is also an increasing number of residents suffering from mental health and/or behavioural issues that can put themselves or others at risk. One in three residents display aggressive/angry behaviour, 94% represent a potential risk, of varying degrees, for injury to themselves or others, and roughly 96% display ineffective coping ability that requires up to 30 minutes of intervention daily. These factors contribute to increased incidents of aggressive and violent behaviours from which homes are having great difficulty protecting residents and staff. Statistics from a group of five municipal homes will illustrate: in 2008 there were 250 acts of aggression, averaging roughly 1 per week per home – most of the aggressive acts were resident to resident.
> In addition to referrals directly from the community, most residents are transferred to long-term care from hospitals, psychiatric facilities, and crisis situations in the community. This is a very high and specialized need population that the LTC system is not adequately resourced and equipped to provide for."[35]

OHNSS also substantiates the deterioration of access:

> "The overall demand for beds is increasingly outstripping supply. Waitlists are growing and there are virtually no beds available. The Ministry of Health and Long-Term Care (MOHLTC) places the current wait list count at 25,680, a 5.1% increase over last year. Vacancy rates continue to decline, in August of 2009, the average province-wide vacancy rate was approximately 0.4% (371 beds); down from last year's average rate of 0.7% (550 beds).1 Beds are becoming scarcer."[36]

The evidence shows that as hospital beds have been cut, more long-term care has been privatized, and access to care and equity for seniors and people with chronic illnesses has eroded.

Wait lists for long-term care homes have never been higher. Ontario Ministry of Health and Long-Term Care data shows that there are approximately 24,000 Ontarians waiting for placement into a long-term care home (see Table 11). Ontario's Health Quality Council reports that median wait times for long-term care are 5 months for people waiting at home and 2.5 months for patients waiting in hospitals.[37] Average waits across the board for an LTC bed have tripled since the spring of 2005 and are now over three months. Table 11 shows long term care wait lists by health region.

The shortage of beds is restricting patient choice. Only 40% of those needing LTC care got their first choice of home when placed for the first time. In addition to the 24,000 Ontarians waiting to be placed into a long-term care home, there are 12,000 residents in long-term care homes who are waiting to be transferred to another long-term care home. This group includes spouses waiting for reunification, people who have been forced to take a long-term care bed outside of their home community and are trying to return, and residents who are unhappy in their facility and want to move. 2,271 of hospital ALC patients (55%) are waiting for a space in a long term care home.

[35] Ontario Association of Non-Profit Homes and Services for Seniors, Submission to the Standing Committee on Finance and Economic Affairs, January 2010.
[36] Ibid.
[37] Health Quality Ontario 2011, pages 3 & 16.

Table 11. Long-Term Care Homes Wait Lists by LHIN[38]

LHIN Number	LHIN Name	Total Long-Stay Waitlist with Transfers	Total Long-Stay Waitlist	Waiting in Acute Care	Waiting in Community
1	Erie St. Clair	1892	1121	148	973
2	South West	2434	1546	146	1400
3	Waterloo Wellington	2092	1394	124	1270
4	Hamilton Niagara Haldimand Brant	4140	2547	311	2236
5	Central West	740	377	58	319
6	Mississauga Halton	1890	1181	124	1057
7	Toronto Central	2349	1514	185	1329
8	Central	3549	2370	221	2149
9	Central East	5941	4100	405	3695
10	South East	1621	1170	108	1062
11	Champlain	4770	3256	295	2961
12	North Simcoe Muskoka	1890	1440	132	1308
13	North East	2232	1432	390	1042
14	North West	856	500	124	376
Ontario		**36396**	**23948**	**2771**	**21177**

[38] Ministry of Health and Long-Term Care, Health Data Branch Information Management Support Centre, Long-Term Care Eligible Clients on Wait Lists at June 30,2010. Most recent data available as at March 30, 2011.

Home Care

Though the right to access publicly-funded hospital and physician care across Canada is clearly established in the Canada Health Act, as patients have been moved out of hospitals they find an array of ad hoc and inadequate care in home care, community services and long term care facilities. Often patients are forced to pay out-of-pocket for needed care.

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.[39] The evidence shows that home care is not sufficiently staffed, organized, and funded to take significant downloads if hospitals are faced with major cutbacks.

Every report since the late 1990s has found home care to be rationed and insufficient. The result is wait times that are chronic and pervasive across Ontario. According to the provincial auditors' reports and Ministry data, home care wait lists have numbered more than 10,000 people consistently since 1998.

Wait list figures, however, do not capture the whole picture. The unmet need for care is currently not measured. Wait lists are not tracked in consistent manner across Ontario's CCACs and in many cases there is simply no access to care. While the Ontario government and CCACs have made a priority of procedures that assess clients, maintain competitive bidding, and ration care, over 15 years they have failed to set clear standards establishing the right to access needed care.

Despite modest reforms, home care services remain ad hoc and uneven across the province. The institution of service caps – a system of strictly rationing the amount of care available to home care clients – started formally in 1999 when the Ministry of Health issued service guidelines and later a

Home Care: Urgent and Unmet Care Needs

- **1999** - The Ontario Association of Community Care Access Centres (OACCAC) reported that more than 11,000 Ontarians were on wait lists for home care.
- **2000 – 2003** – As of March 31, 2003 there were 13,613 Ontarians on wait lists for home care, according to the provincial auditor. These figures were consistent with the trend over the previous two years.

Findings of the Provincial Auditor **2010**:

- 10,000 Ontarians are on wait lists for home care services, with wait times ranging up to 262 days.[1]
- 11 of 14 CCACs across Ontario have wait lists for services.[1] The causes for wait lists were attributed to inadequate funding for homemaking and personal support services and shortages for health professionals' services.
- Wait lists vary significantly. In some areas of Ontario, wait times are extremely long. One CCAC had 1,400 people waiting for speech language pathologists. Another had more than 1,300 people waiting for personal support services. Another had more than 770 people waiting for occupational therapy services.[1]

1998-2010 - In each report of the Ontario Auditor General, from 1998 – 2010, it is noted that wait times are inconsistent and poorly tracked.[1] Some CCACs do not wait list when their services are full and others do. Ontarians with the same need for services may get services in one area but not in others.

[39] See charts on page 15.

regulation strictly limiting access to care.[40] Rationing and poor access to care have persisted ever since.

Recently, the provincial government has undertaken a number of funding and policy initiatives in an attempt to address poor access to care. In 2007, the government introduced a new "Aging at Home" strategy. Announced funding for the strategy has amounted to $1.1 billion over three years, but only a portion of that funding has flowed. The focus of the strategy is to keep people out of hospitals and reduce emergency department wait times. The Aging at Home services are contracted through the 14 Local Health Integration Networks (LHINs), not the CCACs, and are not integrated with CCAC home care services.

In addition, in 2008, the government announced a change in the regulations rationing care available to clients:

- Caps were entirely eliminated for people waiting for a long term care bed.
- For all other home care clients, caps were raised from 80 to 120 hours of service per month for the first 30 days and 60 to 90 hours of service per month after the first 30 days.

The government provided targeted funding increases to facilitate early discharge from hospital for patients waiting for hip and knee surgeries by providing in-home rehabilitation and support services. In addition, the government increased funding to increase the hours of personal support and homemaking in tandem with the increases in the hours permitted under the service caps.

Despite the changes since 2007, chronic home care underfunding, increased demand and poor organization of the sector mean that care continues to be severely rationed and inadequate. In reality, funding per client has gone down.[41] The number of people trying to access care and failing is not measured. Moreover, inadequate measuring and restructuring of home care has resulted in an inability to assess whether the targeted funding accomplished its goals.[42] The auditor notes that the CCACs reported that the funding increase was not sufficient to meet the new allowable hours of care.[43]

Findings of the Provincial Auditor (December 2010)

- 10,000 Ontarians are on wait lists for home care services, with wait times ranging up to 262 days.[44]
- 11 of 14 CCACs across Ontario have wait lists for services.[45] The causes for wait lists were attributed to inadequate funding for homemaking and personal support services and shortages for health professionals' services.
- Wait lists vary significantly. In some areas of Ontario, wait times are extremely long. One CCAC had 1,400 people waiting for speech language pathologists. Another had more than 1,300 people waiting for personal support services. Another had more than 770 people waiting for occupational therapy services.[46]
- There is an absence of standard service guidelines for frequency and duration of services resulting in each CCAC developing its own guidelines.[47]
- Funding is not allocated on the basis of locally-assessed client needs. Therefore clients with similar needs do not access similar levels of service.[48]

[40] Regulation #386/99 passed by the Harris cabinet. This meant home care was not to be provided based on need, but according to strict service caps.
[41] See the next section for calculations.
[42] Ontario Auditor General, page 118.
[43] Ibid, page 119.
[44] Ibid, page 122.
[45] Ibid, page 115.
[46] Ibid, page 122.
[47] Ibid, page 115.
[48] Ibid, page 114.

- Even in managing wait lists there is a lack of policy and standards. The auditor found that a lack of direction and guidance from the Ministry of Health on management of wait lists and ranking of clients has continued since before 2004.[49]
- There is inequitable access to care. In one CCAC profiled by the auditor, clients assessed to be of moderate risk were deemed ineligible for services. In two other CCACs, these clients were deemed eligible and were either provided with services or were put on wait lists.[50] Thus, even the spotty data on wait lists that is available to the public understates the insufficiency of the services available.

[49] Ibid, page 121.
[50] Ibid, page 115.

Growing Inequities and the Social Determinants of Health

Health is more than the provision of health care through various institutions and services. It is, in the words of the World Health Organization:

> "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

Socioeconomic status is a key factor in attainment of health. Social factors, including income equality, employment, education, housing, freedom from violence, and a healthy environment are crucial to developing and maintaining good health. In 1998, Health Canada developed a comprehensive list of the Determinants of Health, including: income, social support, education and literacy, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture.[51]

The last major public service restructuring in Ontario and Canada worsened social and economic inequality. Tax cutting for the last decade has been accompanied by significant growth in incomes for the wealthiest, and stagnant or declining incomes for the poorest. According to Human Resources and Skills Development Canada, "Income disparities increased after 1995. There was a rise in the after-tax income of the top income group and very little change for other income groups over the period 1995 and 2007."[52] Despite a period of prolonged economic growth after the mid-1990s, Ontario's income inequality increased. Despite putting more hours into the work place, Ontario's lowest income families lost ground. At the same time, Ontario's richest families worked less hours and got richer. The evidence shows that increased socioeconomic inequality contributes to poorer health.

Income Inequality

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.[53] 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.[54]

Economist Armine Yalnizyan reports in her 2007 study of Ontario's growing gap in income and wealth that even prior to the economic recession of 2008, in a period of prolonged economic growth, income inequality worsened in Ontario:

> "Income disparities in Ontario have soared for the past decade, though the economy has been strong. And it's not just a story about the tail ends of the distribution, the richest and the poorest. Fully 40% of Ontario's families have seen almost no income gains or, worse, actual income losses compared to their predecessors 30 years ago.

[51] Ontario Chronic Disease Prevention Alliance and Health Nexus, Primer to Action: Social Determinants of Health, May 2008.
[52] http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=22
[53] 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
[54] Yalnizyan, Armine, Ontario's Growing Gap Canadian Centre for Policy Alternatives, May 2007, page 3.

These kinds of trends are expected during recessionary periods, but this is occurring during one of Ontario's most sustained periods of economic expansion."[55]

Many middle class and working families did not see gains during the recent period of economic growth, making it more important than ever to guard against exacerbation of income inequalities as the provincial government plans significant cuts to public services and jobs.

Income is perhaps the most important social determinant of health. Eminent Canadian researcher, Dennis Raphael, reports, "Level of income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours such as quality of diet, extent of physical activity, tobacco use, and excessive alcohol use. In Canada, income determines the quality of other social determinants of health such as food security, housing, and other basic prerequisites of health."[56]

The evidence shows that income has a significant impact on chronic disease and death rates. Researchers have found that men in the wealthiest 20% of neighbourhoods in Canada live on average more than four years longer than men in the poorest 20% of neighbourhoods. Women in poorer neighbourhoods live two years less than their wealthy counterparts.[57] This Canadian study also found out that those living in the most deprived neighbourhoods had death rates that were 28% higher than the least deprived neighbourhoods. The suicide rates in the lowest income neighbourhoods were found to be almost twice those in the wealthiest neighbourhoods. A host of studies show that adult-onset diabetes and heart attacks are far more common among low- income Canadians.

Table 12.
Working Harder is Not Paying Off For More than Half of Ontario's Families With Kids
Percentage change in average annual weeks worked and annual (inflation adjusted) earnings at the median, comparing the periods 1976–1979 and 2001–2004

	Average Annual Weeks Worked				Average of Annual Median Earnings		
Decile	1976–1979	2001–2004	Average Difference	% Change	% Change	1976–1979	2001–2004
1	45	51	6	14%	-60%	$4,220	$1,681
2	64	67	3	5%	-30%	$28,920	$20,225
3	69	78	9	13%	-12%	$40,686	$35,842
4	73	85	12	17%	-1%	$49,124	$48,698
5	81	90	9	11%	9%	$56,089	$61,183
6	84	98	15	18%	14%	$63,578	$72,536
7	91	100	9	10%	18%	$71,370	$84,367
8	99	109	10	10%	22%	$81,799	$99,485
9	108	114	6	6%	29%	$95,507	$122,869
10	125	113	-12	-10%	41%	$128,264	$180,683
Total	**85**	**93**	**8**	**9%**	**11%**	**$60,044**	**$66,785**

[55] Ibid, page 4.
[56] Mikkonen, Juha and Dennis Raphael, Social Determinants of Health: The Canadian Facts, York University, 2010.
[57] Wilkins, R. "Mortality by Neighbourhood Income in Urban Canada from 1971 to 2001" HAMG Seminar, January 16, 2007. Ottawa: Statistics Canada.

Housing and Homelessness

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)".[58]

Key trends:

- Housing affordability is increasingly out of reach for many low and modest income Ontarians and new data indicates the gap between homeowners and tenants' incomes is growing wider.
- Waiting lists for assisted housing are long and have swelled to over 152,000 Ontario households since last year.
- Overall vacancy rates have tightened considerably across the province – most noticeably in Ontario's major urban centers.
- One in five renters pay more than 50% of their income on rent, putting them at risk for homelessness.
- Affordable housing production remains a small fraction of what is required to meet housing need (estimated at requiring 10,000 new units per year over the next decade).

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. Between 1990 and 2008, average rents in Ontario for one- and two-bedroom apartments in private rental units increased by twice the level of median tenant incomes and well above the overall rate of inflation.[59] 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.[60]

Tenants who are required to pay high proportions of their incomes on rent are forced to forego other needs, and are at risk of homelessness. In 2005, 261,000 or a fifth of all households living in rental housing in Ontario were in this category, paying 50% or more of their income on rent. Almost one quarter of single parent families (24%) - equalling 43,100 families - were paying 50% or more of their income on rent. In addition, 142,300 individuals (or 26% of single renters) were paying 50% or more of their income on rent.[61]

[58] http://wellesleyinstitute.com/policy-fields/affordable-housing/
[59] Ontario Non-Profit Housing Association and Co-Operative Housing Federation of Canada, Where's Home? The Need for Affordable Rental Housing in Ontario, 2011, page 9.
[60] Ibid.
[61] Ibid, page 28.

Section IV

Review of Proposed Cuts & Restructuring

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

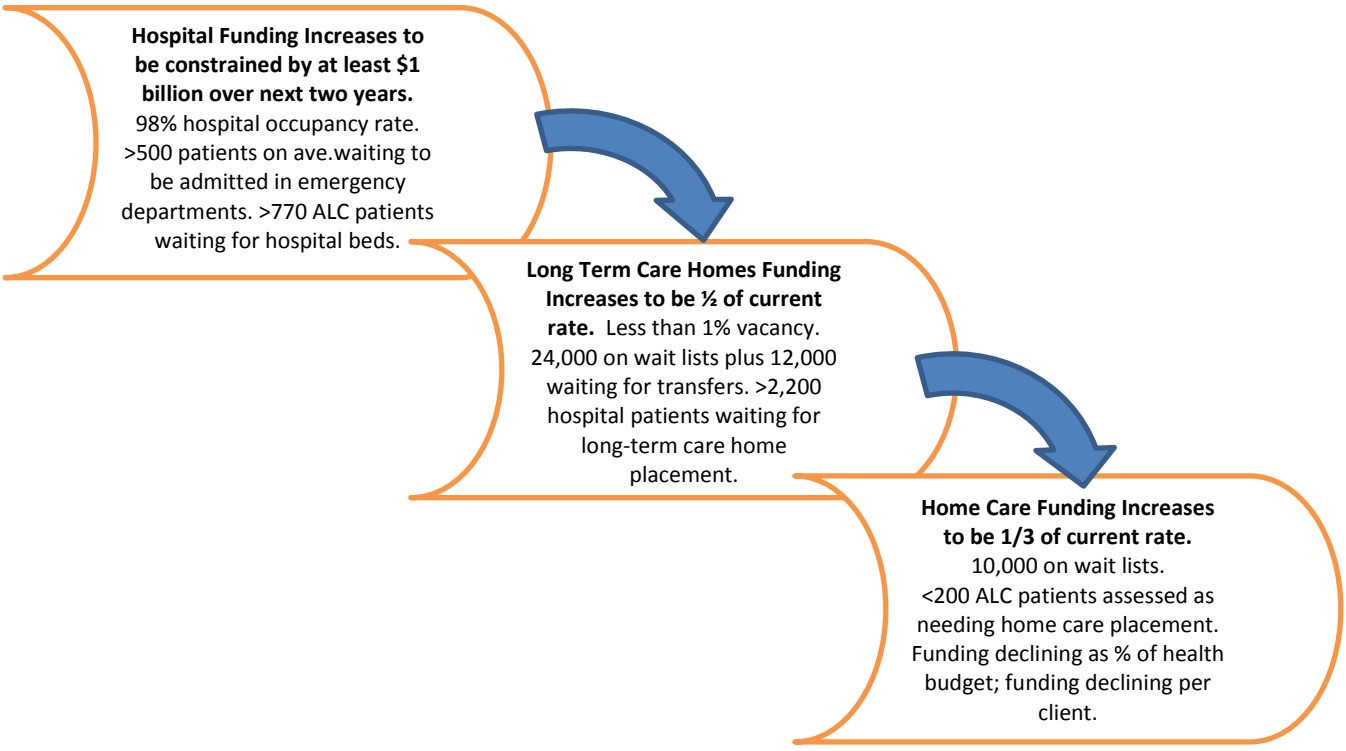
This report is primarily concerned with item 1: downloading. Our Phase II Report will review more closely proposals under items 2, 3 & 4 when they are more fully revealed.

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



A Closer Look at the OHA/Drummond Proposal to Cut 10% or more from Hospital Funding for the Neediest 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. Nonetheless, these proposals have gained credence with top policy makers.

The OHA report is deeply problematic. It does not consider access to care as paramount. It contains no mention whatsoever of the impact of the proposals on access to care, quality of care and risk for patients. It postulates that there are all kinds of cuts to be made, without any evidence whatsoever. The costing for transferring patients to home care understates the home care subsidies, respite and other investments (including renovations, medical equipment etc.) required to make such redirection viable. In fact, there are no risk mitigation strategies included in the report. Moreover, many of the proposals are implausible since the report fails to properly cost and consider issues such as availability of health care human resources, restructuring costs, current unmet patient need, among others.

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. We have focussed on this assertion because it has found currency with policy makers without due consideration.

According to the OHA:
"New data shows that 1% of the population accounts for 49% of combined hospital and home care costs; and 5% of the population accounts for 84% of combined hospital and home care costs….For 2009, the forecasted expenditure on hospitals by the Ontario government is $16 billion for a total population of 13 million. If roughly half this expenditure is attributed to 130,000 people then significant opportunities exist to achieve savings on $8 billion using specific, focused initiatives….Every 10% reduction on the $8 billion expenditure used by 1% of the population equals $800 million in savings."[62]

In fact, there are no "specific, focused initiatives" included in the report that would support such a contention.

Don Drummond, the government's appointed chair of the Commission on Public Sector Reform has taken this information from the OHA and has gone further:

> "He is staggered by the statistic that a mere 1 per cent of the population accounts for fully half of all hospital spending, or about one-third of total health expenditures. "That just flabbergasted me," Drummond says, arguing that even a 10 per cent gain in efficiency — through better integration and expansion of community and chronic care or mental health services — could save $1.5 billion a year, without even affecting the other 99 per cent of the population. "There are very tangible things you can do that would save a lot of money.""

Toronto Star, January 5, 2011

[62] Ontario Hospital Association, Ideas and Opportunities for Bending the Health Care Cost Curve: Advice for the Government of Ontario, April 2010, page 5.

This proposal is dangerous for several reasons:

- It implies that $800 million in cost-cutting for hospitals would be easy to find, even though hosptials have already been restructured for 15 years or more, stating that there are "significant opportunities" to achieve such savings. But there is not a single piece of evidence to support this claim.
- It ignores current unmet need for hospital service, and fails to include this in its costing.
- It targets health care cost cutting on the neediest of patients without giving any consideration to their assessed needs. There is no consideration of patient risk whatsoever.
- CIHI data shows that health care costs are concentrated in the very oldest age groups. These frail elderly have the least options to pay for needed health care in the event of serious cutbacks.
- It mixes hospital and home care spending data to make conclusions about hospital cutbacks and leads to erroneous conclusions, as outlined below.

Table 13. Assessing the Claims About Cutting Costs for the Neediest 1%

Claim	Concern
Drummond's statement that 1% of the population accounts for 50% of hospital costs is incorrect, rather: 1% of the population accounts for 49% of hospital *and home care* costs.	The actual spending breakdown from the Ministry of Health not only includes hospital costs, it also includes home care costs. Obviously there is no potential to move patients from home care onto home care, and thus no savings to be achieved by it.
The OHA uses this figure to recommend that: "If roughly half of this expenditure is attributed to 130,000 people then significant opportunities exist to achieve savings on $8 billion [or half of hospital expenditures]."	This is a non sequitur. The mere fact that 1% of hospital and home care costs are attributable to 49% of the population does not mean that the care is unneeded. The causal link is never established and there is no data whatsoever in the OHA report (nor anywhere else) that supports such a link. In fact, the OHA report fails to provide one iota of evidence to support their hypothesis that therefore 10% of half of hospital spending (or $800 million) can be cut.
Don Drummond states that a 10% cut could save $1.5 billion – without impacting 99% of the population.	The OHA report bases its projections on reducing the 50% of hospital spending used by the neediest 1% of the population. Thus a 10% cut to 50% of hospital funding yields a reduction of $800 million. Here, what Drummond is actually proposing is a 10% cut on *all* hospital funding – or a 20% cut in hospital funding that is accounted for by the neediest 1% of patients – in order to achieve a total cut of $1.5 billion. Moreover, the glib assertion that 99% of Ontarians would not be impacted by such a cut is false. Not only are the 1% of patients targeted for cuts – equalling 130,000 Ontarians – family members and community members whose health and well-being affects many others, but the 1% of high-needs patients is not a static group of patients. Patient A may be high needs this year, When Patient A dies or recovers, Patient B may be high needs next year. A 20% cut to hospital services for the most needy will impact the most elderly, ill and vulnerable hospital patients, their families and their communities for years to come.

A Closer Look at the Claims Supporting Limiting Capacity in Long-Term Care: 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:

> *"We could borrow a page from Denmark…where, as a matter of public policy, community care takes precedence over residential care and long-term care."*[63]

> *"Matthews cited examples of other jurisdictions, such as Denmark, which have actually decreased the number of long term care beds and established strong home-based care systems."*[64]

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.

Denmark Compared to Ontario: The Facts Do Not Support the Case for More Hospital and Long-Term Care Bed Cuts/Rationing

Denmark has 14,000 more hospital beds on an aggregate per capita basis than Ontario.

Denmark has more than double Ontario's number of long-term care beds.

Denmark is 43,000 square kilometers with a population density of 128 per square kilometre.

Ontario is more than 1 million square kilometres with a population density of 12 people per square kilometre.

Denmark as 14,000 more hospital beds on an aggregate per person basis than Ontario. Table 10 on page 27 shows OECD data for hospital beds per 1,000 population. Even after Denmark's hospital bed cutbacks over the last decade, Denmark still has 3.6 hospital beds per 1,000 population compared to Ontario's 2.5 hospital beds per 1,000 population. This translates to a shortfall of more than 14,000 hospital beds in Ontario compared to Denmark, on an aggregate per capita basis. Even with significantly more hospital beds than Ontario, health policy experts report that Denmark's hospital cuts may have gone too far resulting in wait times and problems admitting patients due to bed shortages.[65]

Denmark has more than double the number of long-term care beds per person than Ontario. In 2008, Denmark had 14.5 long-term care beds per 1,000 population aged 65 years old and over.[66] OECD definitions for long-term care beds include what we term chronic or complex continuing care hospital beds but may also

[63] Deb Matthews speech at Leading Healthcare Quality Summit and Innovations Expo, November 9, 2011.
[64] Fantoni, Beatrice, "Health minister pitches Ontario action plan: funding for hospitals may shrink" Windsor Star, February 4, 2012.
[65] McKee, Martin, European Observatory on Health Systems and Policies, Reducing Hospital Beds: What are the lessons to be learned? 2004.
[66] OECD, Denmark Long-Term Care Key Facts, May 2011 at http://www.oecd.org/dataoecd/60/58/47877588.pdf

include some other types of beds. Clearly comparable definitions for bed types were not included in the OECD data. However, by any possible definition of beds, Ontario lags far behind Denmark. Ontario has approximately 76,300 long-term care beds[67] for a population of 13 million, equalling 5.9 beds per 1,000. Ontario has 5,798 complex continuing care (chronic care) hospital beds for a population of 13 million, equalling 0.4 beds per 1,000. Totalled together, Ontario has 6.3 beds per 1,000. No matter if there are minor differences in definitions, the magnitude of the difference in bed totals is huge. Despite the Health Minister's assertion, the Denmark comparison would have Ontario double its long-term care bed capacity and still not catch up to Denmark.

The only similarity we could find is that Denmark has similar population aging demographics:

- Approximately 16.1% of the Danish population is aged over 65 (OECD average 15%) while 4.1% of the population is over 80.[68]
- 13.9% of Ontario's population is aged over 65 while 3.9% of the population is over 80.[69]

But here is where the similarities stop.

Finally, important considerations in assessing the viability of transporting health care services to individuals' homes are geography and population density. The differences are profound. Denmarks' aging population is spread over a fraction of the land mass of Ontario:

- Denmark is 43,094 square km with a population of 5,529,888.[70] Its population density is 128 people per square km.
- Ontario is1.07million square km with a population of 13.2 million. Our population density is 12 people per square km.

[67] OAHNSS, January 2010.
[68] OECD, Denmark Long-Term Care Key Facts, May 2011 at http://www.oecd.org/dataoecd/60/58/47877588.pdf
[69] Statistics Canada, (CANSIM Table 051-0001) accessed February 5, 2011.
[70] Central Intelligence Agency, USA, "World Fact Book" accessed February 5, 2011.

Ontario is at Risk of Repeating the Mistakes of Previous Restructuring

Ontario's hospitals have already been restructured for more than 15 years yielding 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 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.

In 1999 and 2001, the report of the provincial auditor revealed the costs of hospital restructuring under the Harris government. The Harris government attempted to cut $1 billion from hospital funding. Over two years, from 1996/97 to 1998/99 $800 million was cut from hospital operating budgets.[71] While estimated costs for hospital restructuring under the Harris-era Restructuring Commission were originally set at $2.1 billion, the Provincial Auditor revealed that costs had escalated to $3.9 billion; an increase of $1.8 billion over expectations.[72] In total, over the four-year period between1997-98 and 2000-01, the province spent $1.9 billion dollars on costs associated with hospital closures. This included $1.2 billion for capital spending, $55 million for renovations, and $643 million for restructuring. In 1999 the provincial auditor estimated that 78% of restructuring costs resulted from severance and other benefits.[73] In fact, fully 51% of the increase in hospital spending over the period was accounted for by costs associated with restructuring.[74]

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.

Thus, billions were spent cutting beds, closing hospitals and laying off staff in the four years of the last round of restructuring. Hundreds of millions were spent in subsequent years reopening beds and recruiting staff to deal with the planning errors and to restore some stability to the health system.

[71] http://www.web.net/~ohc/docs/fact_hospitalpolicy.htm
[72] See pp. 315 from provincial auditor's 2001 report.
[73] 1999 Provincial Auditors Report, http://www.gov.on.ca./opa/english/e99/309en99.html

[74] Block, Sheila "Health Spending in Ontario: Bleeding Our Hospitals" Technical Paper #4 Ontario Alternative Budget 2002, page 7.

In his analysis, the auditor criticized the provincial government for failure to budget for demand for health care services, poor sequencing of restructuring and failure to plan for necessary capital costs leading to cost overruns in restructuring.

Key Concerns:

- Since 1996, more than 9,000 hospital beds have been cut and thousands of patients have been moved out of hospitals into long-term care homes and home care. The evidence shows that the hospital cuts have now gone too far: population need for hospital services already exceeds demand. On virtually all efficiency measures, Ontario's hospitals are the most efficient in Canada, while hospital bed shortages and staffing shortages already pose a threat to patient health and safety (as well as staff health and safety).

- Currently, proposals are being made for massive hospital spending cuts that rival the magnitude of the Harris-era cuts. Yet these proposals are so vague that they do not even comprise real proposals. If specific, targeted proposals for the hospital service changes that would be required to cut the $1 billion or more proposed exist, they have not been made available for public scrutiny. Crucially, the evidence from the provincial auditor and the OHA report shows that the vague ideas that are being touted as "proposals" have never been costed and consequences for patients have not been assessed.

- There is a dangerous trend of simply abandoning any attempt to make a connection between health planning proposals and population need for care. In recent years, the Ontario government has conducted hospital cost containment without consideration of patient need. Hospital operating budgets have simply been lowered to below inflation and population growth rates. As resulting hospital deficits have risen, an array of needed services have been cut, including hospital beds, entire rural hospitals, pain clinics, outpatient rehabilitation, diabetes care services, stroke clinics, labs, breast feeding clinics, mammography services, emergency departments, long-term care beds, and many others. In fact, ad hoc hospital cutbacks without any proper population-based health planning has become the norm. Risks are not measured and mitigated, emergency services are not protected, cuts are not evaluated, needs are not assessed. There is a very real risk that the Ontario government will adopt this poor planning process to accomplish the very significant cutbacks it is currently planning. Such a process is irresponsible and poses very significant dangers to patients.

- To date, no consideration has been given to increased costs as a result of restructuring, despite the evidence of almost $4 billion in restructuring costs during the last round of restructuring.

- There is no capacity to take more hospital downloads into long-term care homes. Wait lists already number 24,000. There are an additional 12,000 Ontarians in long-term care homes not of their choosing, waiting for placement in another home. In addition to the lack of beds, human resource shortages in long-term care are epidemic and care levels are insufficient to meet the acuity of residents. Existing shortfalls in care will be exacerbated by plans to curtail long-term care budgets to ½ of what they have been over the last eight years.

- There is no capacity to take more downloaded patients into home care. Wait lists already number 10,000 and home care funding per client is declining. Insufficient funding is available to increase care to meet the needs of existing clients and wait lists. In addition to funding constraints, staffing shortages are contributing to wait times in home care. Existing shortfalls in care will be exacerbated by plans to curtail home care budgets to 1/3 of what they have been over the last eight years.

Section V

Addressing the Revenue Side: Closing the Employer Health Tax Loopholes

The Employer Health Tax (EHT) was introduced in Ontario in the 1980s to replace OHIP premiums. While it was never actually earmarked for expenditures on hospital and medical insurance, as a replacement for the OHIP premium, it was clearly intended to cover a share of provincial expenditures on Medicare. However, the share of hospital and medical care costs in Ontario accounted for by the Employer Health Tax has declined considerably, from 17% in the first full year of the tax in 1991 to 13% in 2009.

The Ontario Health Coalition commissioned economist Hugh Mackenzie to review options for reform of the EHT, with a particular focus on the impact of closing tax loopholes in the EHT. The following recommendations are based on data and recommendations made by Mr. Mackenzie.

Closing the tax loopholes

There are two primary tax loopholes in the Employer Health Tax.

1. When the Ontario Employer Health Tax (EHT) was introduced, it included a graduated rate structure. The rate was 0.98 per cent for employers with total payrolls of less than $200,000, increasing on a graduated scale to 1.95% on payrolls exceeding $400,000. It was the only payroll tax levied in Canada with a graduated rate structure. In the late 1990s, the Conservative government replaced the graduated structure with a full exemption – or loophole - excluding the first $400,000 in an employer's payroll. It is the only payroll tax in Canada with such an exemption.
2. Income from self-employment and partnership income is not subject to the tax, creating a significant issue of inequity.

Neither loophole conforms to public policy and public interest goals of tax fairness and sustainability of public health care. As Hugh Mackenzie reports:

> *"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."*

A closer look at the issues

The graduated structure and then the exemption were 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. However, neither of these claimed advantages is well-founded.

Compliance Costs
The compliance cost claim is a red-herring. 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.

Poor Targeting
As a benefit for small business, an exemption from EHT is extremely poorly targeted. In its review of the EHT – the only review of the tax that has ever been made public – the Ontario Fair Tax Commission found that fully two-thirds of the benefit from an exemption of the first $100,000 in payroll would accrue to businesses with payrolls in excess of $400,000. Using that analysis as the foundation, the Ontario Alternative Budget estimated that 54% of the additional benefit from the Harris Government's replacement of the graduated rate structure with a flat exemption for the first $400,000 of payroll would have gone to businesses with payrolls in excess of $400,000.

Furthermore, 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 $400,000. 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 'first $400,000' exemption.

Inequities
The structure of the tax also raises significant questions of fairness. The loophole that excludes income from self-employment and partnership income from the tax creates 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 entirely conceivable that a business with one or two employees each earning more than $100,000 per year would be exempt from this tax using the $400,000 payroll exemption. 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 exemptions, 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 revenue impact of the loopholes

Using 2010 as the basis for comparison, the Ontario Ministry of Finance reports that, on a National Accounts basis, the total of wage, salary and supplementary income was $333.8 billion. Income from unincorporated small business – a reasonable proxy for income from self-employment – amounted to a further $39.7 billion.

At the current EHT tax rate of 1.95%, a tax on this broad base would generate revenue of $6.99 billion, compared with the actual revenue received from the tax in 2009-2010 of $4.66 billion. The exemptions described above represent a loss in revenue for 2009-2010 alone of $2.33 billion.

Over the period from 1990-1 to 2009-10, EHT loopholes (varying over time) have reduced potential provincial revenue by a total of more than $33 billion.

Chart 6 shows actual EHT revenue, potential EHT revenue and foregone revenue resulting from exemptions annually, from 1990-1991, the first full year of operation for the EHT, to 2009-2010.

Chart 6.

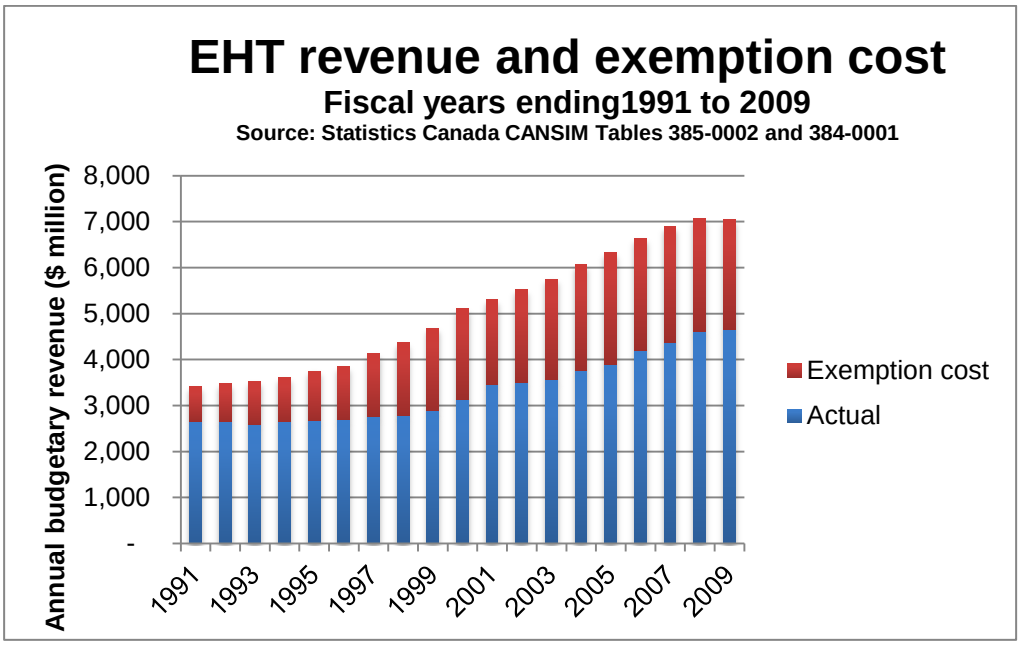
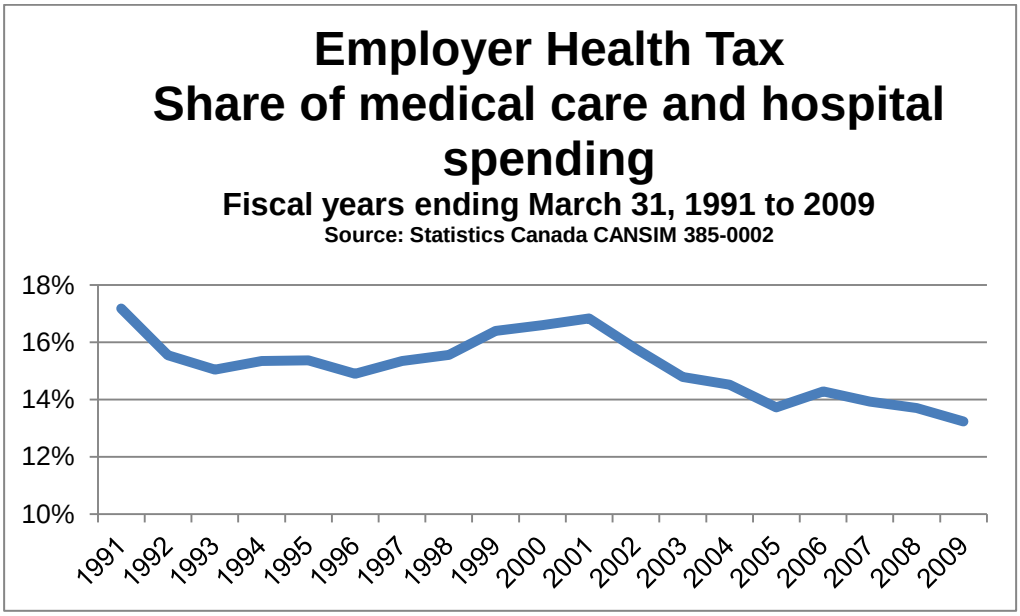


Chart 7 shows the share of hospital and medical care costs covered by EHT revenue, from 1990-1991 to 2008-2009. Over that period, the share of medicare costs covered by EHT revenue has fluctuated between 13% and 17%, with a general downward trend from 17% in the first full year of its application to 13% 2008-2009, the most recent year for which comparable data are available.

Chart 7.



Recommendation:

In today's fiscal environment, it is difficult to justify wasting 1/3 of the potential revenue from the Employer Health Tax on a poorly-targeted, unfair and ill-considered tax exemption. At a minimum, the exemption should be eliminated so that all employers contribute proportionally to the support of Ontario's public health insurance system. Closing the EHT loopholes would add at least $2.4 billion to the provincial revenue base.

Section VI

Conclusion:
First Do No Harm

While fiscal prudence is in line with Ontarians' values and priorities, the evidence does not support the claims of the spending crisis-manufacturers in Ontario's government and among its appointees. Health care is not poised to eat up the provincial budget: it is actually shrinking as a proportion of overall spending. Spending in Ontario is not out-of-control: it is among the lowest in Canada.

In fact, the evidence shows that the real problem is on the revenue side. If anything is "eating the provincial budget" it is tax cuts. And despite the assertion that tax cuts benefit us all through stimulating business investment, the evidence shows that key elements of business investment in Ontario are down – and have been declining steadily through the last fifteen years of tax cuts. Today, the highest income Ontarians are earning more than ever, while putting fewer hours into the workplace. Working families, on the other hand, have stagnant or declining incomes despite the fact that they are putting more hours into the workforce. The tax cuts are benefitting the wealthiest and corporations while threatening cuts to our vital public services.

Ontario already has urgent and unmet needs for health care services. We have a severe shortage of hospital beds resulting in extraordinary waits for hospital admissions and emergency department backlogs. Wait lists for long-term care beds have never been higher. Home care, where patients are routinely downloaded, is declining as a proportion of health care funding. The money available for each home care client has reduced significantly.

We have proposed some options for revenue-generation that would take some of the pressure off. Ontario has loopholes in its Employer Health Tax that are inequitable and do not serve any public interest purpose. Closing the two major EHT loopholes would generate $2.4 billion per year to help address the most urgent unmet health care needs.

On the cusp of the Drummond Commission report on restructuring Ontario's public services, this report is an appeal to our government:

> The facts simply do not support the contention 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 simply do not hold water. There are already more than 30,000 people on wait lists in these sectors. We appeal for a more democratic process: one in which the voices of public interest groups and the public are given opportunities for meaningful input. We appeal to our government to take a step back and exercise caution. At minimum, our government must first, do no harm.