

**Public Health Care  
In the Public Interest:  
Protecting and Expanding  
Public Health Care for  
Ontarians**

**Ontario Health Coalition  
Policy Proposals for the Provincial Election 2011  
September 6, 2011**

# **I. Access to Care:**

## **Hospital Cuts and Downloading of Patients Has Led to a Serious Erosion in Access to Acute, Longer-Term, and Rehabilitative Care**

After two decades of health care restructuring, access to public health care services in Ontario is suffering. Acute care hospital beds have been cut in half. While patients are moved out of hospital more quickly than ever, extreme levels of hospital overcrowding yield evidence that hospital bed cuts have gone too far.

Patients who require longer-term care have also endured the consequences of restructuring. Chronic care hospital beds cut in half while new nursing home beds and increased home care have never caught up. Wait lists for long-term care beds, now numbering more than 23,000, have never been higher, while home care wait lists have numbered over 10,000 for more than a decade. In some areas of Ontario “home care” is not provided through home visiting at all. Instead in a direct privatization of formerly public hospital care, home care is now provided in wound clinics to which patients must travel, sometimes great distances, and bring their own medical supplies. Too often, complex and high-needs patients are moved out of hospitals into long-term care homes that are short-staffed and have inadequate levels of care. Too often, home care is rationed, leaving a heavy burden on families to provide care without adequate respite.

Rehabilitation beds have increased in hospitals, but out-patient physiotherapy and other health professionals’ services have been dramatically cut from community hospitals across the province, leaving thousands of patients languishing on long wait-lists for home care physiotherapy or without any access to publicly funded rehabilitation whatsoever.

Mental health beds have also increased slightly, but mental health services have so long been inadequate that these services cannot meet the need for care in hospitals, and mental health services in the community remain insufficient.

Rationing and cuts have also hit smaller and rural communities, affecting access to hospital care particularly in those communities in which hospitals were amalgamated in the restructuring of the mid-1990s. Hospital deficits, a lack of democratic governance, few regulatory protections, poor planning and an ideology of centralization have converged to create a “perfect storm” for these communities. Acute care, surgeries and emergency departments in the southern Niagara towns of Port Colborne and Fort Erie have been cut and closed. Hospitals in Shelburne and Burk’s Falls have been shut down. Acute care beds in Wallaceburg have been slashed. Emergency Departments in Petrolia, Wallaceburg, St. Marys, South Hampton and other small communities have been put at risk.

Since 1990, more than 18,500 hospital beds have been cut. Governments of differing political stripes have insisted that care moved out of hospitals is not being cut, but rather shifted. Care would be provided in the community and closer to home. These promises have fallen short. Though home care and long-term care home beds have increased, they have never kept pace with hospital downloading. Instead, the effect of continual health care

restructuring has been a serious erosion in the scope of public health care. Attempted cost-cutting has come at a cost for patients whose safety and access to timely care has been compromised.

The result is that the principle of equity that underlies our health system is at risk. Patients, particularly the elderly, are forced to pay out-of-pocket for needed care if they can afford it, while many do not receive the care they need. These patients have been downloaded out of hospitals, sometimes subject to coercive tactics to move them out, even when there are no long-term care beds or home care available. Recently, as the long-term care crunch has become extreme, hospital patients have been moved into private retirement homes – not health care facilities – without adequate staff and regulatory systems to protect them from harm and meet their needs.

Reforms have too often increased administrative requirements. And every round of hospital cuts has been accompanied by increased for-profit privatization and user fees for patients.

The solutions most often proposed are not adequate to address the shortfalls in access to care. Increased home care (seen as the cheapest way to provide care) cannot take the burden of heavy-care chronic and acute patients, though there is a total consensus of opinion that home care services should be ameliorated. We agree wholeheartedly. But based on the evidence, alone, improvements in home care will not address the problem.

Continued underfunding and cuts to hospital beds will result in worse access to needed care, particularly for seniors. Staffing shortages must be addressed and capacity improved across the spectrum of health care. Hospital beds and services need to be restored while capacity in public non-profit home and long-term care is developed. The current government's commitment to improving primary health care through community and aboriginal health centres, nurse-led clinics, family health teams, and family doctors in underserved communities must continue. Social programs that improve equity and population health must be supported.

Our next provincial government must commit to a principled vision of reform: one that embraces the deeply-held principles of Ontarians that health care should be equitable, accessible, public and non-profit, and that our health care institutions and services must be democratically governed and accountable to the public.

## **i. Extraordinary Levels of Hospital Overcrowding**

Ontario has a serious shortage of hospital beds resulting in dangerous levels of hospital overcrowding. This province has the fewest hospital beds per person of all the provinces. Compared to all industrialized countries, Ontario is fourth from last. We have significantly fewer beds per person compared to both national and international averages.

In fact, Ontario's average hospital occupancy rate (how full our hospitals are) is far above levels considered safe. While care has indeed shifted out of hospitals to other venues including home care and long term care homes, lengthy wait lists in these sectors combined with Ontario's extraordinarily high hospital occupancy rate yield evidence that that hospital bed cuts are not being offset by a shift in services to the community or other institutions.

There is sufficient evidence to conclude that Ontario's hospital bed cuts have gone too far. Yet hospital cuts are continuing despite evidence that hospital overcrowding is a serious problem that threatens patient safety and timely access to care, and despite the shortage of community care outside hospitals.

The consequences of hospital overcrowding are serious. Poor access to care – including emergency department backlogs, cancelled surgeries, and patients on stretchers in hallways - is reported in most large- and medium- sized hospitals all across the province. Patients are increasingly subject to coercive tactics to move them out of hospital to settings not of their choosing, sometimes far away from their home communities. Quality of care is impacted, including inadequate staffing ratios in overcrowded emergency departments and outbreaks of hospital-acquired infections.

The effect of continual hospital cuts and downgrading over more than 15 years has been an erosion in the scope of public health care coverage. Cost-cutting has come at the expense of patients, particularly those needing acute, longer-term and rehabilitative care. While mental health beds have increased slightly, patients requiring mental health care, long-underserved, continue to suffer from inadequate access to care in hospitals and in the community, as well as a lack of safe and affordable housing and other social supports.

In fact, 18,500 hospital beds have been closed since 1990 (see Figure 6). While there have been increases in psychiatric and rehabilitation beds, these are 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.

**Figure 6. Ontario Hospital Bed Cuts 1990 - 2010**

<b>Ontario Hospital Beds Staffed and in Operation 1990 – 2010<sup>1</sup></b>					
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%

<sup>1</sup> Source:

[http://www.healthsystemfacts.com/Client/OHA/HSF\\_LP4W\\_LND\\_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large](http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large)

Occupancy rates in Ontario’s hospitals are extraordinarily high. According to Ministry of Health data, there are, on average, 30,164 inpatients in Ontario’s 30,810 hospital beds. 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%.<sup>1</sup> In the United States, the average hospital occupancy rate is 68.2%.<sup>1</sup> Most often cited in the academic literature, a target hospital occupancy rate to reduce access blockages and improve outcomes is 80- 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 Figure 8 on the next page.)

**Figure 7. Ontario Hospital Beds Compared to Other Provinces**

Hospital Beds Staffed and in Operation Per 1,000 Population by Province 2008-09 <sup>2</sup>	
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
<b>Ontario</b>	<b>2.5</b>

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

Ontario hospital beds per 1,000: 2.5

<sup>2</sup> 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.

**Figure 8. OECD Total hospital beds per 1,000 population 2008<sup>3</sup>**

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

<sup>3</sup> Source: OECD Health Data 2011.

## ii. Emergency Department Overcrowding Compromises Safety and Access to Care

Emergency room overcrowding is epidemic among large and medium-sized community hospitals in Ontario. A frequently noted factor in ER wait times is the unavailability of acute care beds.<sup>4</sup> Ontario has each day, 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.<sup>5</sup> Ontario's extremely high hospital occupancy poses a significant threat to patient safety and quality of care.

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 (HAIs), and Ontario has experienced repeated waves of HAI outbreaks. Cancelled surgeries and prolonged waits are associated with poorer health outcomes.

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.<sup>6</sup>

---

<sup>4</sup> See: Forster, A.J. et al "The Effect of Hospital Occupancy on Emergency Department Length of Stay and Patient Disposition" *Academic Emergency Medicine*, 2003; CIHI "Understanding Emergency Department Wait Times"; B.H.Rowe et al., "Frequency, Determinants, and Impact of Overcrowding in Emergency Departments in Canada" 2006; OHA, OMA, MOHLTC, "Improving Access to Emergency Care: Addressing System Issues" 2006.

<sup>5</sup> Ontario Hospital Association, "ALC Study", June 2011.

<sup>6</sup> BMJ 2011; 342:d2983

### iii. More than 23,000 Waiting for Long-Term Care Homes

Not only is there a problem getting into hospitals, there is also a serious issue of patients being discharged too early or without placement in home care and in long term care homes. The Advocacy Centre for the Elderly reports that they receive frequent complaints from patients who are subject to pressure tactics to move them out of hospitals. Hospital policies may include statements that if person refuses to pick from short lists of long term care facilities that are not of their choosing, or if the patient refuses to take first available bed, then will be charged a large per diem ranging from \$600 a day to \$1800 a day.<sup>7</sup> In many cases the charges levied against patients in an attempt to move them out of hospital are unlawful.

According to Ministry of Health and Long-Term Care data, there are 23,948 people on wait lists for long –term care beds in Ontario. Figure 9 shows the wait lists by region.

**Figure 9. Long-Term Care Wait List Ontario, by Region<sup>8</sup>**

Local Health Integration Network (LHIN)	Long-Term Care Wait List <sup>9</sup>
1. Erie St. Clair	1,121
2. South West	1,546
3. Waterloo Wellington	1,394
4. Hamilton Niagara Haldimand Brant	2,547
5. Central West	377
6. Mississauga Halton	1,181
7. Toronto Central	1,514
8. Central	2,370
9. Central East	4,100
10. South East	1,170
11. Champlain	3,256
12. North Simcoe Muskoka	1,440
13. North East	1,432
14. North West	500
<b>Ontario Total</b>	<b>23,948</b>

<sup>7</sup> Wahl, Judith, Advocacy Centre for the Elderly. “ALC, Hospital Discharge, Long Term Care and Retirement Home – What Happened to the Law and Ethics ?” Power Point presentation 2011.

<sup>8</sup> Data accessed March 30, 2011 through information request. Data is the most recent available from the Ministry of Health and Long-Term Care. It contains the eligible clients wait list for Long-Term Care Homes by LHIN June 30, 2010.

<sup>9</sup> These numbers include only people waiting in hospital or in the community for a long-term care home placement. Those waiting in a long-term care facility for a transfer to another long-term care home are excluded. People on wait lists for more than one home are counted once only in the area that includes their first choice home.

## iv. 10,000 Waiting for Home Care

According to the Provincial Auditor General in December 2010 there were 10,000 Ontarians on wait lists for home care.<sup>10</sup> Tracing back through provincial auditors' reports and Ministry data, we found that publicly-reported 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. In December 2010, the provincial auditor found:

- 11 of 14 CCACs across Ontario have wait lists for services.<sup>11</sup> 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.<sup>12</sup>
- There is an absence of standard service guidelines for frequency and duration of services resulting in each CCAC developing its own guidelines.<sup>13</sup>
- Funding is not allocated on the basis of locally-assessed client needs. Therefore clients with similar needs do not access similar levels of service.<sup>14</sup>
- 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.<sup>15</sup>
- 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.<sup>16</sup> Thus, even the spotty data on wait lists that is available to the public understates the insufficiency of the services available.

Despite regulatory changes that allow home care clients more hours of care, staffing shortages and inadequate funding mean that care continues to be severely rationed. For family members caring for a loved one at home, respite is too often inadequate or unavailable.

---

<sup>10</sup> Ontario Auditor General *2010 Annual Report*, page 118.

<sup>11</sup> *Ibid*, page 115.

<sup>12</sup> *Ibid*, page 122.

<sup>13</sup> *Ibid*, page 115.

<sup>14</sup> *Ibid*, page 114.

<sup>15</sup> *Ibid*, page 121.

<sup>16</sup> *Ibid*, page 115.

## **v. Recommendations to Improve Access to Care**

### **Hospitals**

Institute an immediate moratorium on hospital cuts and closures

Restore hospital beds and services to bring Ontario up to the national average

- Create a provincial plan to increase the number of hospital beds to achieve a target of 80% hospital occupancy.
- Conduct a bed study to evaluate population need for beds and services, based on national and international comparators and the evidence regarding best practices for the reduction of infectious disease.
- Regulate hospitals to prevent inappropriate discharge:
  - o No removal of patients with need for medical services unless a care plan is in place and care is available without delay in the appropriate setting, respecting the patient's right to consent.
- Re-open emergency departments at Fort Erie and Port Colborne and restore the acute care beds across Niagara.
- Commit to protecting acute care services and emergency departments in rural hospitals under threat, including Wallaceburg, Petrolia, St. Marys, South Hampton, Markdale and others.
- Create policy to guide the development and operation of rural hospitals, including a basket of services that ensures local access to needed hospital services. Amalgamated governance should not be taken as a carte-blanche to close down rural and smaller hospitals.
- Restore democratic, accountable hospital boards.
- Amend the Ontario Ombudsman Act to ensure ombudsman oversight for hospitals.

### **Long-Term Care Homes**

Tie funding increases to improvements in hours of care for residents

- Regulate long-term care homes to provide an average minimum care standard of hands-on daily care of 3.5 hours.
- Improve access to long-term care by increasing the number of long-term care beds. Build all new capacity in the public and non-profit sectors.
- Improve public reporting including public access to information on hours of care.

## Home Care

- Stop competitive bidding and create a stable, public-non-profit home care system.
- Create provincial standards to protect Ontarians' right to access care and to ensure that all patients in need are at least put onto waiting lists.

## Rehabilitation and Palliative Care

- Restore publicly funded outpatient physiotherapy in Ontario's public hospitals.
- Prevent closure of palliative care in hospitals, particularly in small and rural communities, unless there is an equivalent public, non-profit service in that community to replace this vital care.

## Primary Health Care

- Approve waiting proposals for new Community Health Centres.
- Create emergency task forces for critically underserved areas, bringing together municipalities, physician recruitment committees (where they exist), Ministry of Health, regional planning bodies and local hospital management. Leverage the connections, knowledge, skills and resources of these groups to create and implement meaningful plans to alleviate shortages.
- Support mentorship, locums, partnerships between local hospitals and nursing/medical school programs to bring interns, residents and nurses to small hospitals.
- 
- Build upon the recent initiatives to improve the supply of nurses and family physicians, coupled with recruitment processes to encourage rural and northern applicants and those committed to practicing in rural and northern communities.
- Actively promote the team of health care professionals, including nurse practitioners and allied health professionals working to their full scopes of practice by creating or expanding funding mechanisms and support, targeted first to those areas with severe access to care issues and those at risk of declining access due to retirements.

## Retirement Homes

- Institute a moratorium government funding of retirement homes to take hospital patients, including funding provided through hospitals and Community Care Access Centres.

- **Conduct a public study of the range of services provided by retirement homes to determine violations of Canada Health Act through selling medically-necessary services and the risk to existing standards in long-term care homes.**
- **Repeal the deeply flawed Retirement Homes Act and create new legislation that reflects the public interest rather than the interests of the corporations that own and operate these facilities, many of them for-profit.**

## **Protect Public Non-Profit Health Care**

- **Make a clear commitment to building all new capacity in public and non-profit sectors.**
- **Take action against for-profit clinics through enforcing the Commitment to the Future of Medicare Act and the Canada Health Act.**

## **II. Recommendations for Reform: Improve Public Accountability and Democratic Governance**

### **i. Improve Care Levels in Long-Term Care Homes**

Long-term care homes funding has increased by than \$1 billion. But after an initial increase, hours of care for residents has remained stagnant for several years. Regulations that tied funding increases to increases in care and minimum care standards have been removed. In recent years, the for-profit long-term care lobby has overturned government promises to bring in improved care standards. Yet hours of care data from the Ministry of Health and Long-Term Care shows that municipal (publicly-owned) homes provide more hours of care and have increased care hours more than private for-profit homes. Concerned Friends, a lobby group for families of long-term care residents report that is the most frequent complaint they receive is from families and residents that there not enough care provided to meet residents' needs.

The next provincial government must establish government independence from the long-term care corporations, particularly the for-profit lobby group. The evidence is clear that accountable, minimum care standards that provide on average 3.5 hours of care per day for average acuity residents will minimize harm and improve health outcomes.

### **ii. Create a Public Non-Profit Home Care System**

A recent report by the Ontario Auditor shows home care administrative costs that are extraordinary without any evidence of improved quality or access to care as a result. Competitive bidding, introduced in the 1990s ushered in the for-profit privatization of home care in Ontario, preventing the establishment of a public non-profit home care system as exists in the rest of Canada.

The costs of competitive bidding have never been properly assessed by the provincial government, though 30% ( 1/2 billion dollars) of CCAC budgets that are spent on administration and case management. Competitive bidding necessitates extra tiers of administration and redundancies. In addition, to the direct administrative costs in the CCACs, each contracted agency has a mark-up in their pricing for services that covers their own administrative costs and profit-taking, cumulating in additional costs for maintaining a vast array of duplicate provider companies simply in order to facilitate competition. In fact, in Ontario's home care system, public funds are transferred through four separate levels of administration before any money reaches the front-lines of care.

These issues raise serious questions that have not been addressed in the 15-year experience of competitive bidding in Ontario. In his latest audit, the Ontario Auditor recommends a full review of competitive bidding. This review is long overdue and must include a value-for-money analysis of the administrative costs and redundancies entailed in the competitive bidding model as compared to an integrated public non-profit home care system.

### **iii. Establish Public Access to Information**

Public access to information about the health system and its institutions and services is too often difficult - if not impossible - to obtain. Though our health system is publicly funded and is supposed to be publicly governed, our experience is that the health and infrastructure ministries seem to do what they think they can get away with, delaying information, obfuscating, or responding to questions and request for information in a haughty and unaccountable way. In Ontario, information that is routinely available to the public in other jurisdictions is delayed, subject to political games, or outright denied. There is no real accountability without public access to information. Our next government must take steps to improve the culture of public accountability and respect for democracy within the Ministries for health care and infrastructure. Some recent examples:

- The provincial government extended access to information legislation to cover hospitals. Within a few months, at the behest of the hospital lobby and without consultation with patients, public interest groups, health professionals, nurses and unions, the government clawed back access to information on quality of care through a “Hospital Secrecy Clause” in the Budget Bill.
- The Ministry of Public Infrastructure and Energy has repeatedly delayed answering information requests about literally billions of dollars in privatized P3 hospital projects. When information was finally provided earlier this year, virtually all financial information that would enable experts to compare public procurement and privatized P3 costs has been removed. These projects are all paid by public funds.
- While the Ministry of Health and Long-Term Care provides a password-protected website of information accessible to the Long-Term Care industry (facility owners and operators, the majority of whom are for-profit), it has refused to provide access to the same information for seniors’ organizations, public interest groups, nurses and unions. Obtaining basic information that is posted publicly in American long-term care homes, such as daily hours of care provided to residents, has required repeated requests, appeals and months of follow-up.
- Local groups trying to access financial information about the operation of their local hospitals have been refused access.
- Repeated request for information about the ownership status (for-profit or non-profit) of publicly-funded MRI/CT clinics have been met with obfuscation.
- Requests for financial information about privatized laboratories that are paid through public funds have been denied.
- The majority of Ontario’s hospitals refused to provide us with information on their occupancy levels, not returning phone calls or outright refusing to provide the data.
- The majority of Community Care Access Centres refused to provide us with information about wait lists and wait times, not returning phone calls or obfuscating.

### **iv. Restore and Improve Democratic Governance**

In part, in an attempt to cut and ration services without sparking public ire, the trend in health care is towards eliminating democratic, accountable governance. Governments of differing political stripes have eliminated elected local boards for home care and hospitals, and have

created a variety of unelected and unaccountable restructuring entities. These have not succeeded in stunting public anger at the spectre of local service cuts. Appointed and self-appointing boards have, however, reduced public oversight and accountability of CEOs. Public anger at the excesses of executives and consultants is at a very high level.

Our next provincial government should restore democratic governance in health care. Stifling democratic governance has not succeeded to stunt democratic discussion and debate about health cuts and rationing, but it has served to erode public confidence and oversight. Communities do not want unaccountable and fiscally imprudent health care. Improved public accountability will enable public scrutiny that is essential to ensure health funding gets to the front-line and support services needed by patients.

Some examples of undemocratic governance:

- Community memberships and democratically-elected local hospital boards are under threat. After hospital amalgamations in the mid-1990s, newly amalgamated hospital boards rewrote their by-laws, quietly eradicating elected boards and replacing them with self-appointed boards. More recently, the move to eliminate publicly-accountable hospital boards by CEOs has become more overt. A number of government-appointed hospital supervisors have wiped out all community memberships in local hospitals, disenfranchising thousands of Ontarians. In addition they have removed municipal leaders, who have publicized cuts to services, from hospital boards, and they have rewritten hospital by-laws to create self-appointing rather than elected boards. The eradication of elections has been accompanied with closed board meetings in some hospitals, difficulty in obtaining financial and service-planning information, and less accountability for hospital CEOs and executives.
- Community memberships and democratically-elected Community Care Access Centres were wiped out after these organizations publicized severe service rationing in the late 1990s. Since then, homecare governance has persisted as undemocratic.
- While municipal governments and school boards are elected, Local Health Integration Networks (LHINs) that are supposed to fund and oversee regional health services, are not.
- The provincial ombudsman does not have jurisdiction to investigate complaints about hospitals, home care and long-term care homes.

### III. Bending the Revenue Curve

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

A comparative analysis of Ontario's health spending reveals that Ontario spends significantly less than other provinces on health care (see Figure 10). So, how are proponents of privatization claiming that Ontario's health spending is a "Pac Man" eating up the provincial budget? If other provinces and territories can do it, why has Ontario not?

Almost without exception, those that are most stridently prognosticating Medicare's unsustainability have vested interests in the private for-profit health care industry. What many pundits spreading crisis rhetoric do not make clear is that any look at health spending as a proportion of the provincial budget compares two figures. One is health spending. The other is the size of the provincial budget.

Ontario health spending on a per person basis is actually lower than almost all of Canada. On the same basis - per person - our entire provincial budget is the lowest compared to the rest of the country. Figures 11 and 12 show the comparative data. So, though health care takes up a relatively larger proportion of provincial expenditures, this is not because health care expenditures are higher. In truth they are lower than in other provinces. The reason that health care appears higher is because total provincial expenditure is less. It is easy to look like a bigger fish when the pond keeps getting smaller.

Figure 11. Comparing the Size of Provincial Budgets: Ontario Third Last in Total Public Spending as % of GDP

Total Public Spending as a Proportion of GDP Ontario Compared to Rest of Canada				
	1981	1995	2003	2008
Ontario	14%	16%	14%	16%
Rest of Canada	20%	21%	19%	19%

Source: Canadian Institute for Health Information. (2009). *National Health Expenditure Trends, 1975 to 2009: appendices*. Figures include all government spending minus interest payments on government debt.

Figure 10. Ontario Public Health Care Spending Second Lowest in Canada

Public Health Spending by Province 2009 \$ per person	
Nun.	8,342
N.W.T	6,563
Yuk.	5,072
Nfld.	4,270
Alta.	4,096
Sask.	3,929
P.E.I.	3,791
Man.	3,775
N.S.	3,722
N.B.	3,585
B.C.	3,522
Ont.	3,458
Que.	3,191

Source: Canadian Institute for Health Information (2009)

Figure 12. Comparing the Size of Provincial Budgets: Ontario Dead Last in Public Spending Per Person

Total Public Spending Per Person Ontario Compared to Rest of Canada				
	1981	1995	2003	2008
Ontario	\$2,040	\$4,270	\$5,603	\$7,284
Rest of Canada	\$2,834	\$5,335	\$6,923	\$8,774

Source: Canadian Institute for Health Information. (2009). *National Health Expenditure Trends, 1975 to 2009*. Figures include all government spending minus interest payments on government debt.

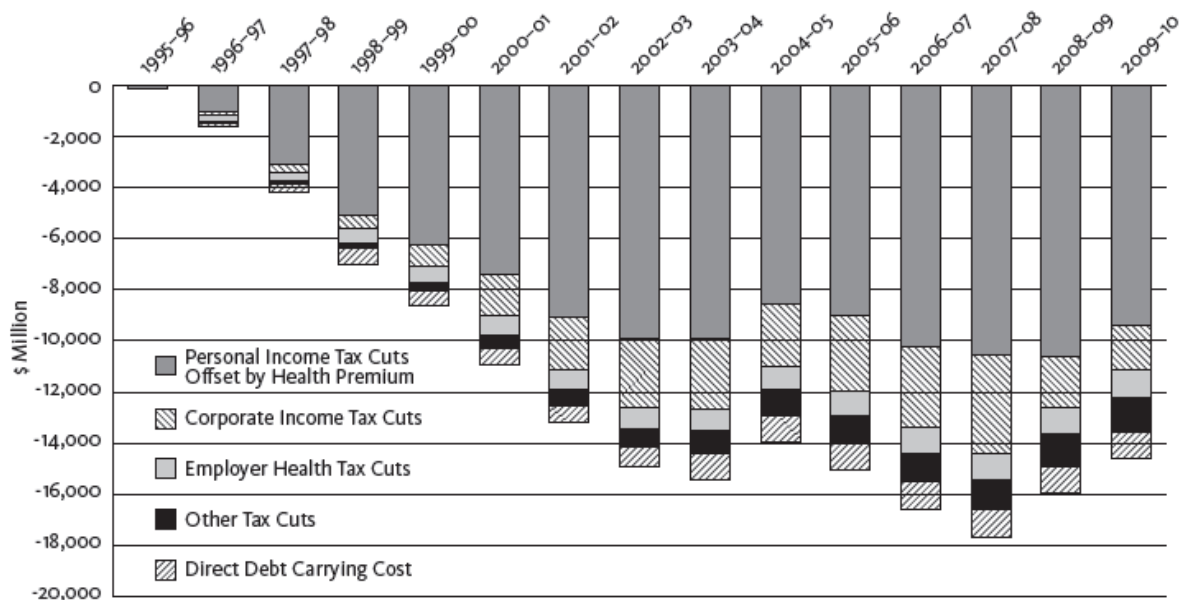
## i. Tax Cuts Are Eroding Ontario's Budget by up to \$18 billion

Since 1995 Ontario has engaged in the deepest tax cuts of anywhere in Canada. The impact on the provincial budget has been dramatic. Economist Hugh Mackenzie has tallied the annual loss in provincial revenues as a result of these tax cuts (see Figure 13). By 2008, the annual loss in government revenue totalled approximately \$18 billion. The slight improvement in 2009 – 2010 has since been erased by a new slate of corporate tax cuts, announced in the 2010 budget, which will total a loss of an additional \$2.4 billion annually. This means approximately \$18 billion each year is no longer available to fund the public services that Ontarians need.

The total yearly loss of revenue to the provincial government as a result of tax cuts is more than the entire provincial deficit. These figures highlight the choices that governments have made to prioritize tax cuts over access to needed care and other public services.

The results are evident. After more than a decade of hospital restructuring and cuts, Ontario has the fewest hospital beds per person of anywhere in the country. Hospitals are running at an average occupancy rate of 98%: a level of overcrowding unheard of in the industrialized world. As a result, emergency departments in larger hospitals are overflowing with patients waiting on stretchers for days until a hospital bed opens up, ambulance paramedics are forced to spend hours waiting to offload patients, surgeries and other procedures are cancelled as there are no available beds. Outside of hospitals, access to care has been similarly compromised. Huge wait lists have become the norm for long-term care homes and home care. The scope of Medicare is under threat as acute care and longer-term care has been rationed, rehabilitation has been severely cut, and mental health continues to be gravely underfunded.

Figure 13: Annual Tax Cut Impact on Ontario's Fiscal Capacity 1995 - 2010



Source: Hugh Mackenzie, *Ontario Alternative Budget 2010* Technical Paper, February 2010.

What if Ontario had not engaged in the last fifteen years of very aggressive tax cuts that have compromised our province's fiscal capacity?

Figure 14 reveals the result. Across the country in 2008, provincial governments spend an average of \$8,774 per person per year on all public services and programs while Ontario spent \$7,284. To imagine a scenario in which Ontario pursued budgeting trends more like those in the rest of Canada, we have compared Ontario's health care spending as a proportion of the average total public spending by other provincial governments.

**Figure 14. Ontario's Actual Public Health Care Spending Compared to Average Total Government Program Spending in the Rest of Canada 2008 (Current \$, Per Person)**

Province	Public Health Care Spending 2008	All Program Spending (Canadian Average without Ontario)	Percent
Nfld.	\$3,943	\$8,774	45%
P.E.I.	\$3,336	\$8,774	38%
N.S.	\$3,518	\$8,774	40%
N.B.	\$3,491	\$8,774	40%
Que.	\$3,038	\$8,774	40%
Ont.	\$3,318	\$8,774	38%
Man.	\$3,622	\$8,774	41%
Sask.	\$3,708	\$8,774	42%
Alta.	\$3,892	\$8,774	44%
B.C.	\$3,360	\$8,774	38%

Source: Extrapolated from Canadian Institute for Health Information. (2009). *National Health Expenditure Trends, 1975 to 2009*, and appendices.

The results are instructive. Though other provinces have also engaged in tax cutting, none have cut so deeply as Ontario. If Ontario had not dismantled so much fiscal capacity through tax cuts (which have primarily benefitted corporations and the highest income categories) and had followed the Canadian average, we would be spending much less of our provincial budget on health care. In fact, Ontario would be spending less than 38% of our provincial budget on health care – about the same level of health spending as a proportion of the provincial budget as we were spending in the mid-1990s prior to the Ontario tax cuts.

This illustration serves to make the point that tax cuts, not health spending are the biggest threat to Medicare's sustainability in Ontario. Public budgets are a reflection of policy choices and priorities. Health care is sustainable if we pursue a path of sustainable investments in health care and maintain a fair tax system.

## **ii. Recommendations to Begin to Restore Financial Capacity: Cancel Corporate Tax Cuts and Close Employer Health Tax Loopholes**

Our next government needs to back up its promises to protect public health care by abandoning “unsustainability” rhetoric as dangerous, unhelpful and untrue. Instead, the government should undertake to put the province on sounder financial footing by eliminating the loopholes in the employer health tax (EHT) and cancelling current corporate tax cuts.

Economist Hugh Mackenzie calculates that the elimination of the Employer Health Tax loopholes would provide \$1.9 billion in revenue, according to 2009/10 figures.

There are three major loopholes:

1. The exemption of employers with payrolls under \$600,000
2. The exemption of partnerships
3. The exemption of self-employed people

The most significant of these is the exemption for employers with payrolls under \$600,000. This may be the most expensive loophole in Ontario’s tax system. Since the EHT is a flat tax, there is no public policy goal that is served by the exemption. Moreover, exemptions from the Employer Health Tax are inconsistent with the history behind its creation and the role that it plays in funding the health care system. The EHT is the replacement for the OHIP premium. As such, it is the contribution expected of employers in return for the substantial competitive benefit they receive from the existence of public Medicare in Ontario.