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Ontario's (Canada) deficit crisis and health reforms: Lessons for England

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In the 1990s, the Canadian province of Ontario proposed radical health reforms to address the growing economic deficit and curtail health spending. The financial climate and health system priorities in Ontario in the 1990s and England in 2010 are not identical. However some distinct parallels can be drawn in the way Ontario and England have addressed issues like funding, workforce productivity, patient safety, health outcomes and quality of care, especially as people are living longer with more complex and multiple care needs.

While a few organisations have reviewed Ontario's health care reforms in the 1990s as a learning opportunity for England, there has been little focus on the impact of these reforms on the nursing workforce and consequences for patient care. This briefing will discuss the 1990s health sector reforms in Ontario under the Mike Harris Conservative government. The RCN in collaboration with its sister nursing organisation in Canada have highlighted a few key lessons for England based on Canada's experience and discuss the impact of health sector reforms (whilst in an economic downturn) on nursing, nurses and the wider health care system.

I. Canadian health care system

In 2009, Canada spent 11.4 percent of its GDP on health care. The Canadian health care system, known as 'Medicare', is a single-payer, publically-funded, not-for-profit system where health care is financed through general taxation and health care services (hospital care and physician services) are universally accessible and free at the point of use. Hospitals are largely private not-for-profit organisations and receive an annual operating budget from the provinces or territories; however, this hospital funding system is currently transitioning away from global hospital funding and moving towards a 'patient-based funding' model. Most family physicians work on salary for hospitals and/or community services, or a combination of fee-for-service and salary remuneration schemes. Primary health care services are more commonly provided by inter-professional teams consisting of family physicians, nurse practitioners, registered nurses (RN), registered practice nurses (RPN) and allied health professionals, acting as gatekeepers to secondary and specialist services. In Ontario, health care is financed through the Ontario Health Insurance Plan (OHIP) that is available for residents only.¹

II. The Canadian economic backdrop and context for reforms

In the early 1990s, Canada's economy had reached a tipping point after it was pushed into an economic recession following a savings and loan industry crisis in the United States. The federal and provincial governments in Canada were forced to make large-scale cuts to address the country's growing deficit which were results of:

- a six per cent reduction in real per capita GDP from 1990-1992

¹ Ministry of Health and Long-term Care (2008). *Ministry Programs- OHIP*. <http://www.health.gov.on.ca/en/public/programs/ohip/>

- federal debt was approaching 70 percent of GDP ^{2,3}

To address the deficit, the Canadian provinces introduced major structural health reforms to cut costs. Canadian health care reforms continue to reflect a balancing act between national uniformity driven at a federal level and regional plurality at provincial level to address local need and autonomy.⁴ Each of the Canadian provinces reacted differently to the recession, depending on its provincial deficit and reserves. Ontario's manufacturing sector was massively affected during the recession, forcing the Ontario government to make dramatic budget cuts.

III. Ontario's health reforms in the 1990s

Since the mid 1980s there has been a political push in Canada to reduce hospital readmissions and average length of stay (LOS), and invest in community services. Between 1986 and 1994, Ontario public hospitals reported a decrease in staffed beds in short-term care units and acute bed days (per thousand population) fell by 40 per cent. Approximately 10,000 acute care beds became inactive by the year 1996.⁵ Around the same time, in the early 1990s the federal deficit reached C\$90.4 billion, there was further push from the incoming government to restructure hospital services. The Ontario provincial government was committed to cut hospital budgets by 18 percent in three years from 1995 to 1998, focusing its restructuring on hospitals in the 8 largest municipalities that accounted for 65 per cent of the hospital spend.⁶ Between 1990 and 1999, the number of hospitals was reduced from 225 to 150. A significant number of hospitals closed between 1990 and 1995.

Between 1995 and 1998, the newly elected Conservative government under Premier Mike Harris introduced radical structural reforms to the health system in Ontario. Reforms^{7,8} were:

- *centrally driven*: an arm's length body, the *Health Services Restructuring Commission* (HSRC) was set up with the mandate to design and implement the reform agenda. The HSRC also advised the government on hospital bed/ ward closures and restructuring health services in the community
- *hospital restructuring*: HSRC was given legal responsibility by the Government (through legislation) to close hospitals. Approximately 44 hospitals were merged into 14 new hospitals – in fact, many of the hospitals supposedly closed by the HSRC are still open today as part of a larger hospital corporation or as having some other specialty usage. 27

² Nuffield Trust (2011). *Managing health reforms through an economic downturn*.

http://www.chsrf.ca/Libraries/Canadian_Masterclass_presentations/2011-10-ManagingHealthReformEconomicDownturn.sflb.ashx

³ Canadian Health Services Research Foundation (2011). *Healthcare challenges in an era of fiscal restraint*.

<http://www.chsrf.ca/PublicationsAndResources/EventPresentationsAndReports/HealthcareChallengesInAnEraOfFiscalRestraint.asp>

⁴ Naylor (1999). Health care in Canada: incrementalism under fiscal duress. *Health Affairs* 18(30): 9-26

⁵ <http://content.healthaffairs.org/content/18/3/9.full.pdf>

⁶ *Ibid.* 4

⁷ *Ibid.* 2

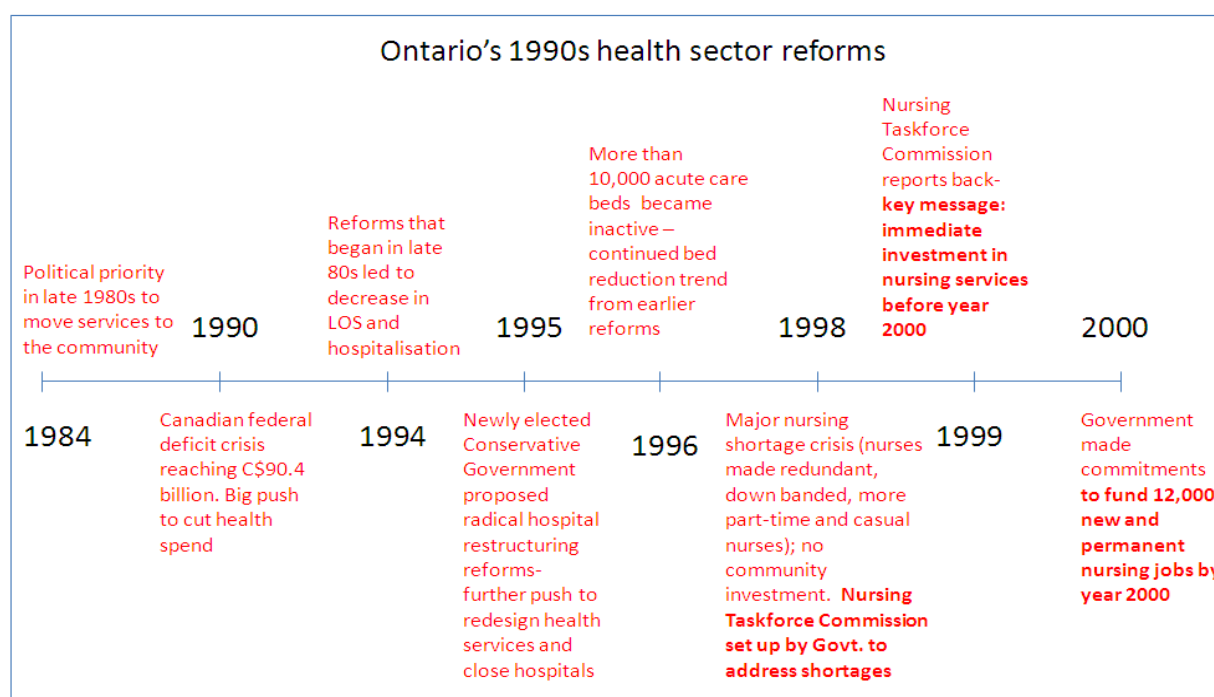
⁸ Clemens J (2011) *Reforming the Canadian health transfer: Applying the welfare reform lessons of the 1990s to today*. A Macdonalds-Laurier Institute Publication. <http://www.macdonaldlaurier.ca/files/pdf/Reforming-the-Canada-Health-Transfer-October-2011.pdf>

public hospitals were closed and all ‘savings’ were to have been reinvested in other sectors like long-term care.

- *workforce cuts*: many nurses lost their jobs due to hospital closures and physician wages were capped. There was a strong focus on developing a ‘lean workforce’, despite previous hospital budget cuts.
- *welfare reforms*: The federal government restructured and reduced its federal transfers to the provinces for social programmes in 1995, placing further pressure on health and hospital budgets. A new body was created called the *Canadian Health and Social Transfer*, moving away from a cost-sharing programme between federal and provincial levels and toward a block transfer scheme. This new system gave the provinces greater flexibility to shape and redesign the welfare and social assistance programmes. Reforms also included a significant reduction in benefit levels for single employable persons that had a major adverse impact on the health of Ontarians and represented another pressure on health and hospital spending.

Once the scale of the reforms and budget cuts were made known there was strong opposition from the public and health workers. To address public and health professional concerns, the HSRC took on a rigorous consultation process involving local stakeholders and communities. The Commission developed an assessment framework (that looked at indicators like performance of acute care, projected changes in population and capacity building in the community) and visited communities, local stakeholders and media to consult on their plans.

Figure1: Timeline of Ontario’s health reforms in the 1990s



IV. Implications of the health care reforms

1. Nursing workforce shortages

“The 1990s produced the largest displacement of nurses in Canada’s history”.^{9,10} Between 1994 and 1999 a four percent decline in the number of RNs and a five percent decline in the number of registered practice nurses¹¹ was reported in Ontario (81,301 RNs in 1994 compared to 78,197 RNs in 1999).¹² Overall, the decline in RN headcount across Canada during this period was approximately 6,000, however Ontario’s RN headcount decline accounted for nearly half of the total Canadian figure. Massive hospital bed closures and acute sector reforms led to huge nurse layoffs and nursing budget cuts. This mass exodus put a huge dent in the Canadian nursing workforce and raised serious concerns regarding nurses’ ability to properly care for patients and address growing health care needs. Anecdotal evidence of ‘poor workforce conditions’, inadequate staffing level, and a decline in staff morale were frequently articulated.^{13,14} In order to cut hospital expenditure, RNs were forced into part-time and casual work in both hospital and community sectors. RNs and RPNs were also frequently replaced by unregulated health care support staff. In 1998, national statistics showed that Ontario had fewer RNs per capita (6.7 RNs per 1,000 population) compared to the average in other Canadian provinces (7.6 RNs per 1,000 population).¹⁵

The Registered Nurses’ Association of Ontario (RNAO) surveyed a group of nurses who had left Ontario to practice overseas to understand trends in migration. Results showed that 82.9 per cent of the respondents left Ontario after 1991 while 52 per cent left Ontario between 1996 and 2000. The main reason for leaving was a lack of nursing opportunity, workplace pressures and the deteriorating economic climate (table 1 and 2).¹⁶ About 4,568 Canadian nurses emigrated to the United States between 1993 and 1997 per US immigration data.

⁹ Ministry of Health and Long-term Care (2003) *Good Nursing, Good Health- The return on our investment*.
<http://www.ontla.on.ca/library/repository/mon/9000/247824.pdf>

¹⁰ Grinspun, D. (2002). A flexible nursing workforce: Realities and fallouts. *Hospital Quarterly, Fall*, 79-84.

¹¹ Currently known as licensed practice nurses (LPN). RPNs are a regulated nursing workforce that work below a RN and have specific responsibilities, skills and competence.

¹² Canadian Institute for Health Information (2000). *Supply and distribution of registered nurses in Canada, 1999*.
https://secure.cihi.ca/free_products/fsdrnc.pdf

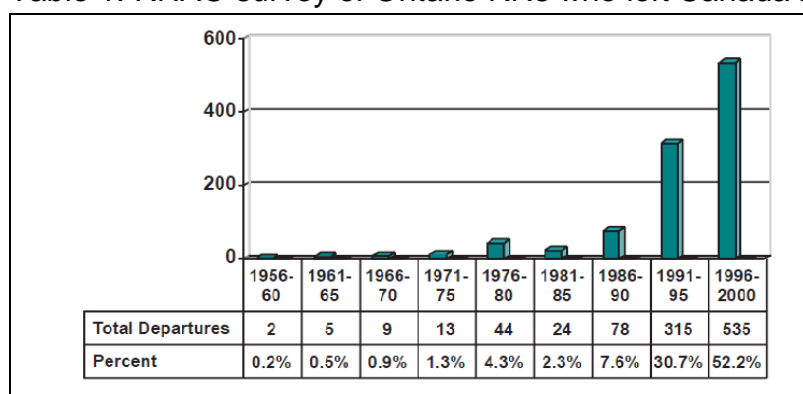
¹³ Registered Nurses Association of Ontario (2001). *Earning their return: When and why Ontario RNs left Canada and what will bring them back*. http://rnao.ca/sites/rnao-ca/files/storage/related/717_RNAO_Earning_Return.pdf

¹⁴ *Ibid.* 9

¹⁵ Ministry of Health and Long-term Care (1999). *Good Nursing, Good Health- An investment for the 21st Century*.
http://www.health.gov.on.ca/en/common/ministry/publications/reports/nurserep99/nurse_rep.aspx

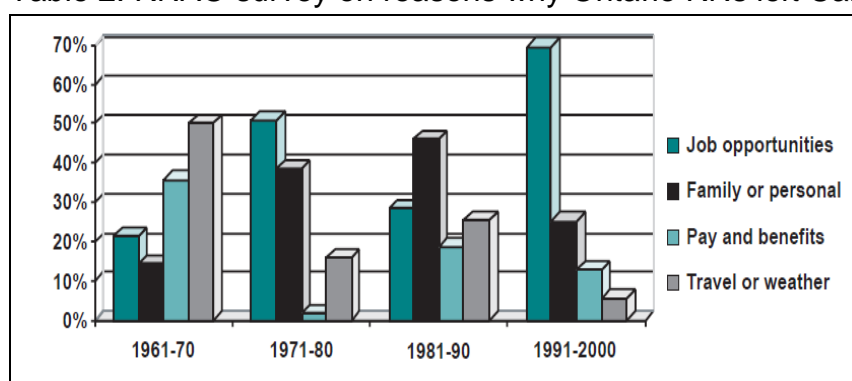
¹⁶ *Ibid.* 13

Table 1: RNAO survey of Ontario RNs who left Canada from year 1961 and 2000



Source: RNAO, 2001

Table 2: RNAO survey on reasons why Ontario RNs left Canada over time



Source: RNAO, 2001

2. Re-investing in the community and nursing

A key priority for health sector reforms in Ontario was to move selected services out of hospitals and closer to the patient's home. However, during the restructuring process many stakeholders felt that insufficient resources were earmarked for investment in primary health care and long-term care. The number of public health nurses in public health units decreased by 50 per cent between 1988 and 1998.^{17,18}

3. Waiting times and productivity

A negative consequence of the reforms was longer waiting times for surgeries, diagnostic tests and specialist appointments. More patients were waiting longer for specialist services like cardiac and orthopaedic surgery in the follow up to hospital reforms. Evidence also pointed to patients waiting longer for hip and knee replacement surgeries, leading to increased anxiety, limitations in patient functioning status and reduced quality of life.^{19,20} Median wait times for cancer surgical treatment between 1993 and 2000 increased by 36 per cent for breast cancer, 46 per cent for

¹⁷ *Ibid.* 15

¹⁸ RNAO/ RPNAO (2000). *Ensuring the care will be there: Report on nursing recruitment and retention in Ontario.* http://rnao.ca/sites/rnao-ca/files/storage/related/719_R&R_Full_Report050100.pdf

¹⁹ J.I. Williams et al. and the Ontario Hip and Knee Replacement Project Team, (1997). The burden of waiting for hip and knee replacements in Ontario. *Journal of Evaluation in Clinical Practice* 3 (1):59-68.

²⁰ Nuffield Trust with CHSRF (2011). *Managing health reforms through an economic downturn.* http://www.chsrf.ca/Libraries/Canadian_Masterclass_presentations/2011-10-ManagingHealthReformEconomicDownturn.sflb.ashx

colorectal cancer, 36 per cent for lung cancer and four per cent for prostate cancer (see table 3).²¹ Long waiting times is an ongoing issue in Ontario.

Table 3: Cancer surgical waiting times in Ontario

Case volumes and median (and 75th-percentile) surgical waiting times for cancer surgery in Ontario, 1993-2000								
Year	Breast cancer cases		Colorectal cancer cases		Lung cancer cases		Prostate cancer cases	
	Patients, n	Median wait (and 75th %ile), d	Patients, n	Median wait (and 75th %ile), d	Patients, n	Median wait (and 75th %ile), d	Patients, n	Median wait (and 75th %ile), d
1993	4479	14 (25)	2642	13 (23)	943	25 (40)	798	80 (124)
1994	4655	15 (24)	2929	14 (26)	869	26 (43)	894	83 (126)
1995	4799	14 (23)	2930	14 (27)	931	28 (45)	876	96 (140)
1996	4922	15 (24)	3007	14 (25)	892	27 (42)	1106	107 (158)
1997	5239	16 (27)	3087	15 (28)	1071	29 (46)	1411	99 (151)
1998	5138	16 (27)	3294	16 (29)	1068	32 (47)	1369	99 (157)
1999	5245	18 (31)	3391	19 (33)	977	33 (50)	1481	92 (134)
2000	5127	19 (31)	3510	19 (34)	965	34 (51)	1565	83 (120)

*Linear change in median wait over single years: $p < 0.001$.

Source: Simunovic *et al.* 2005

4. Patient safety and quality of care

National polls assessing quality of care reported six in ten Canadians viewed the health care system as 'excellent' or 'very good' in 1991 compared to a similar poll taken in 1996 where only four in ten rated the system as 'excellent' and one-quarter of respondents rated the system as 'fair' or 'poor'.²² In 1998, Ontario's Hospital Association Report Card found nearly 50 percent of patients were concerned that staffing levels in hospitals were 'poor or fair'. Patient safety concerns was also voiced by the College of Family Physicians of Canada where nearly 70 percent of family physicians felt that the health and well-being of their patients were adversely affected by inadequate or delayed access to home care and specific nursing services.²³

5. Cost of the reforms

The cost of the hospital restructuring reforms in the mid 90s outweighed the savings. Between 1997 and 2001, half of the increase in government expenditure was due to restructuring expenses—\$1.9 billion of \$3.8 billion. This included operating costs (severance, benefits, legal fees, counselling and training for terminated employees, consulting and auditing etc.) and capital costs.²⁴

²¹ Simunovic M, Theriault ME, Paszat L, Coates A, Whelan T, Holowaty E, Levin M. (2005). Using administrative datasets to measure waiting times for patients undergoing major cancer surgery in Ontario, 1993-2000. *Canadian Journal of Surgery*, 48(2): 137-142. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3211622/>

²² C D Nalor (1999) Health care in Canada: incrementalism under fiscal duress. *Health Affairs*, 18, no.3:9-26
<http://content.healthaffairs.org/content/18/3/9.full.pdf>

²³ *Ibid.* 14

²⁴ Registered Nurses' Association of Ontario data

V. Rebuilding the nursing workforce

The Government set up a Nursing Task Force Commission in 1998 to identify solutions to stabilise and invest in the nursing workforce^{25,26}. The Nursing Task Force launched a pivotal report in 1999 entitled *Good Nursing, Good Health: An investment in the 21st Century* and made short and medium-term recommendations to tackle nursing shortages and improve access and quality of nursing services. These included:

- calling on the Government to make an immediate investments in nursing services –C\$375 million before the year 2000 to create permanent front line nursing positions
- create a provincial chief nursing officer role
- secure funding for 106 primary health care nurse practitioner roles
- change entry to practice for RNs and move towards a degree level entry into the profession by 2005

To stabilise the nursing workforce and reduce nurse migration, in 1999 the Ontario government made commitments to boost numbers by funding 12,000 new and permanent nursing jobs (both RNs and RPNs) before the year 2000.²⁷ The Ministry of Health and Long-term Care also funded several initiatives to increase recruitment and improve retention.

A decade later and nursing shortages still continue to be an issue in Ontario. However, since the 1990 reforms there have been significant investments in nurse practitioner-led primary health clinics, expanding the role of RNs and RPNs, building a network of community health centres and aboriginal health access centres, investing in home care and home care community support.

VI. Lessons for England

The economic climate in England is quite strained with the National Health Service (NHS) asked to deliver £20 billion in efficiency savings by 2015. This has led to many NHS trusts making short-term savings by reducing nursing numbers, bed numbers and community services.^{28,29} With the scale and uncertainty surrounding specific reforms outlined in the English 2012 *Health and Social Care Act*, there are some lessons England can learn from the Ontario experience, specifically:

- *Nursing shortages, down banding, substitutions and nurse migration:* One of the biggest unintended consequences of Ontario's reforms was the displacement and shortage of nurses leading to a 'nursing crisis'. As part of the hospital restructuring, RN and RPN roles

²⁵ Ontario Ministry of Health and Long-Term Care (2001) *Good nursing, good health: A good investment*. http://www.health.gov.on.ca/en/common/ministry/publications/reports/nurserep01/nurse_rep.aspx

²⁶ Ontario Ministry of Health and Long-term Care (1999) *Good nursing, good health: an investment in the 21st century* <http://www.ontla.on.ca/library/Repository/mon/8000/206177.pdf>

²⁷ Registered Nurses Association of Ontario (2001) *Earning their return: When and why Ontario RNs left Canada and what will bring them back*. http://rnao.ca/sites/rnao-ca/files/storage/related/717_RNAO_Earning_Return.pdf

²⁸ RCN (2012) *Frontline First Congress 2012 Update*.

http://www.rcn.org.uk/_data/assets/pdf_file/0008/450539/10.12_Frontline_First_Congress_2012_Update.pdf

²⁹ RCN (2012). *Community Nursing Workforce in England*.

http://www.rcn.org.uk/_data/assets/pdf_file/0003/450525/09.12_The_Community_Nursing_Workforce_in_England.pdf

were often down banded from full-time to part-time or casual positions; the nursing workforce was frequently substituted with unregulated care support staff (especially in long-term care settings); nurses were made redundant following bed/ hospital closures; and middle-management nursing positions like nurse supervisors were eliminated which meant that there was less support for front line nurses. Stressful workplace conditions and fewer jobs forced many RNs and RPNs to leave the province and country to work elsewhere. The Ontario Ministry of Health and Long-Term Care had to later set up a Nursing Task Force to recommend strategies to rebuild the nursing workforce.

Lesson: Cutting nurse numbers is very short-sighted as the evidence shows that higher nursing numbers can improve patient outcomes and lower infection rates.^{30,31,32} Furthermore nurse specialist and practitioner roles can save money and improve quality of care when nurses work to the full scope of their practice and training.^{33,34}

- *Loss of hospital beds and investment in the community:* The political rhetoric for Ontario's hospital restructuring reforms was to reduce hospital spend and invest in the community; however the strategic plan for re-investment in Ontario's communities was not clearly outlined at the beginning of the restructuring process. This has led to fragmentation across primary, secondary and tertiary services.

Lesson: Reinvestment in the community must go hand in hand with restructuring plans for the acute sector. Some stakeholders would even say that investment in the community must come before restructuring so that patients can access services while systems are under transition, reducing the likelihood of a transition gap (the period in-between from when services are cut to when they are re-provided elsewhere).

- *Impact on quality:* Overall, quality of care and access to services were partially compromised when hospital beds were closed without adequate investment in long-term care or primary care services. Anecdotal evidence captured by the Nurse Taskforce revealed bedside nursing care diminished as nurses were often short-staffed. Patients expressed concerns over the lack of continuous care as examples of patients navigating through the health care system on their own or self-administering treatments when at home were reported. Previously this coordination and navigation role was performed by a nurse.

Lesson: Patient safety and quality of care should be a top priority during any reform. Warning systems must be put in place to detect care or system failures and address concerns in a timely fashion by the appropriate regulators.

- *Assessing cost and risk:* Looking back at Ontario's hospital restructuring, it is unclear if the reforms generated any savings, especially as there is little evidence to show that services were integrated and re-provided in the community. Furthermore, the risks— displacement

³⁰ RCN (2011). *Mandatory nurse staffing levels*.

http://www.rcn.org.uk/_data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_levels_v2_FINAL.pdf

³¹ Griffiths P (2009). Staffing levels and patient outcomes. *Nursing Management* 16(6): 22-23

³² McGillis Hall L & Doran D I (2001). *A study of the impact of nursing staff mix models and organisational change strategies on patient, system and nurse outcomes*. Ontario Council of Teaching Hospitals (OCOTH) & Canadian Health Services Research Foundation (CHSRF). <http://fhs.mcmaster.ca/nru/documents/web.McGillis%20Hall.pdf>

³³ MacMillan Cancer Support (2011). *Cancer Clinical Nurse Specialists: An evidence review*.

<http://www.macmillan.org.uk/Documents/AboutUs/Commissioners/ClinicalNurseSpecialistsAnEvidenceReview2011.pdf>

³⁴ Multiple Sclerosis Trust (2012). *Defining the value of MS specialist Nurses*. <http://www.mstrust.org.uk/downloads/defining-the-value-of-ms-specialist-nurses-2012.pdf>

and shortage of nurses and consequences for patient care– might have outweighed any short-term monetary savings.

Lesson: Impact assessments should be undertaken before reforms are implemented to plan for intended and unintended consequences. Moreover, reforms should be transparent and communicated clearly to ensure stakeholder buy-ins.

“The most important lesson from Ontario in the 1995-99 years: saving money by laying off nurses, driving them out of the country or substituting those with lesser skills does not work. All the evidence shows that RNs improve health outcomes and save money. Where the best place for the best care is in the community, then that’s where it should be, but provided by the best provider”

-Registered Nurses’ Association of Ontario, 2012

V. The RCN’s position

The RCN is keen to shine a light on international case studies where England can learn from the experiences of other health systems facing similar concerns and issues. In this case, the RCN has worked closely with its sister organisation in Ontario to outline more generally the intended and unintended consequences of austerity driven reforms and more specifically its impact on the nursing workforce.

Health sector reforms in Ontario and England are not identical; however strong parallels can be drawn– for example both health systems have pushed for reforms to tackle a wider financial deficit; have reduced hospital services with commitments to invest in the community; made huge cuts to the nursing workforce; and downbanded and diluted the nursing skill mix. In Ontario, this led to a major nursing shortage crisis with a large cohort of highly experienced and skilled nurses leaving the province and country. Patient care was partially compromised; wait times increased; reinvestment in the community was not evident and overall patient satisfaction levels fell. Ontario’s experience also reaffirms that despite temporary savings, in the medium to long term these cuts are likely to result in increased costs to a health care system.

The RCN has repeatedly cautioned against short-sighted cuts to the nursing workforce and the risks to patient care through its *Frontline First* campaign. Continued workforce shortages can have long-term implications on patient access to quality care and overall performance of a health care system.