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HOLLOWED OUT

Ontario public hospitals and the rise of private staffing agencies

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Hollowed out

Ontario public hospitals and the rise of private staffing agencies

Summary

Ontario public hospitals are under intense pressure. Provincial funding and policy decisions have left hospitals with multi-year budget deficits and severe staffing shortages.

New data from the Canadian Institute for Health Information finds that Ontario had the lowest per capita hospital spending in the country ($1,805), behind B.C. ($1,902), Quebec ($2,028), and Alberta ($2,045) in 2022. In real per capita terms, Ontario hospital spending increased by four per cent from 2013 to 2022, with most of this increase in 2022 and when the province benefitted from federal pandemic funds. Over the decade from 2013 to 2022, Ontario hospitals had seven years of real per capita spending cuts—that is, years in which funding increases did not keep up with inflation and population growth.

As a result, 66 of 134 hospitals—49 per cent—had budget deficits in 2023-24, and the Ontario Hospital Association expects that most hospitals will end 2024-25 in deficit. The hospital funding crisis disproportionately impacts smaller and northern Ontario hospitals with revenues under $100 million: 63 per cent had deficits but only comprised 50 per cent of Ontario hospitals.

Rather than simply funding hospital deficits, the provincial government continues to encourage for-profit involvement that is destabilizing Ontario's health system. This report focuses on the impact of hospital privatization through the dramatic growth of costly for-profit staffing agencies. Among the findings:

Growth in public spending on private agencies has outpaced growth in public hospital staff: The growing number of vacancies has led hospitals to contract private agency staff (nurses, allied health

professionals, and support staff) in an effort to maintain services and prevent closures.

- Ontario public hospitals paid for-profit agencies $9.2 billion for services over 10 years (2013-14 to 2022-23).
- During this period, real per capita private agency costs in Ontario nearly doubled (98 per cent) while spending on public hospital staff increased by only six per cent.
- Real per capita private agency costs outpaced those of public hospital staff in all but one region of the province. In rural and northern regions—where shortages are often most severe—agency costs jumped: they increased by 480 per cent in the North West, by 372 per cent in North Simcoe Muskoka, and by 216 per cent in the North East.

Costly private agencies undermine long-term workforce investment in public hospitals: The use of private agencies is a vicious cycle of parasitic dependence: the more reliant public hospitals become on private agencies, the more they squeeze hospital budgets and hollow out the public sector workforce. Private agency staff can be at least three times more expensive than regular employees.

- While the number of private agency staff hours worked in public hospitals accounted for 0.4 per cent of frontline hours, private agencies consumed six per cent of Ontario hospital labour costs ($725 million in 2022-23).
- In 2013-14, private agency costs as a share of total labour costs were below six per cent in all Ontario health regions. But by 2022-23, private agency costs consumed a larger share of staffing expenditures, especially in the North West (17 per cent), North East (11 per cent), Central West (9 per cent), and North Simcoe Muskoka (7 per cent) regions.

Fast-growing regions left behind: Central West (Brampton, Etobicoke, northern Peel), Central (Markham, Vaughan, and North York), and Central East (Durham region, Peterborough, Scarborough) had the lowest per capita spending on hospital-employed staff and staffing rates in 2022-23. These are among the fastest-growing and most-racialized communities in the province.

Ontario is falling behind: Ontario has become one of the most undercapacity hospital systems in the industrialized world as a result of the hospital funding and staffing crisis.

- Ontario ranked number 33 out of 38 OECD countries in staffed hospital beds per capita, and fell behind many other high-income countries with universal, publicly financed health systems.
- In Canada, Ontario had the second fewest staffed hospital beds per capita in 2022-23.

Stabilizing public hospitals requires urgent attention: Provincial fiscal austerity, population growth and aging, and increasing privatization—including surgical outsourcing and the dramatic growth of private staffing agencies—have created the perfect storm for public hospitals. The impact of the hospital funding and staffing crisis—and the hollowing out of the public sector workforce by private agencies—is that Ontario has one of the most undercapacity hospital systems in the industrialized world. In Ontario, hallway medicine is the norm. In order to address the situation, the Ontario government should take urgent action to:

- Stabilize public hospital finances and increase hospital capacity with an additional $2 billion annually.
- Develop a provincial public health workforce strategy and capital plan.
- Phase out and ban for-profit staffing agencies over three years and create a public sector alternative.
- Build a stronger primary care foundation with Community Health Centres that can increase access to team-based care, improve population health, and help reduce hospital pressures.

Introduction

The Ontario government's funding and policy decisions are responsible for a provincewide hospital funding crisis that has triggered a serious workforce crisis. The lasting effects of unconstitutional wage suppression legislation, now repealed, have made health care work less attractive at a time when it is needed most. Bill 124 imposed a one-per-cent cap on annual wage increases for provincial public sector employees for three years. In 2024, the courts found this legislation to be unconstitutional and it was repealed. A series of labour arbitration awards provided retroactive wage increases for health care workers. However, the provincial government has not fully funded hospitals' increased costs in the wake of those awards.

Rather than simply fund hospital deficits, the provincial government continues to encourage for-profit involvement that is destabilizing Ontario's health system. The first form of hospital privatization—outsourcing publicly funded surgeries and diagnostics—involves shifting the simplest, most profitable procedures out of hospitals and into private, investor-owned facilities.[1] As hospital workloads increase because for-profit facilities serve the least complex patients, hospital financial and staffing challenges are likely to intensify.

The second form of hospital privatization—and the focus of this report—is the dramatic growth of costly for-profit staffing agencies. Drawing on hospital financial data, this report provides a detailed accounting of provincial and regional hospital spending on private staffing agencies relative to hospital-employed staff. The impact of the hospital funding and staffing crisis—and the hollowing out of the public sector workforce by private agencies—is that Ontario has one of the most

undercapacity hospital systems in the industrialized world. In Ontario, hallway medicine is the norm.

This report offers recommendations to immediately stabilize Ontario's hospital system while also reducing demand for acute care through better primary care, disease prevention, and population health. The goal of health systems internationally to "bend the cost curve" is desirable, but this should not be achieved by underfunding much-needed acute care services. We can have better primary and community care *and* well-funded hospitals to meet the health care needs of Ontario.

Methods

This research uses descriptive statistical and financial analysis of publicly available and custom-requested data, and a review of the academic and policy literatures. Specifically, this report examines two fiscal years of financial documents from over 134 individual Ontario hospital corporations as well as data from two large custom requests of hospital workforce (non-physician) hours and expenses. These custom data from the Canadian Management Information System Database (CMDB), held by the Canadian Institute for Health Information (CIHI), and publicly available health services data (also collected by CIHI), were obtained and analyzed. Most financial and workforce data analyzed in this report end in 2023 due to the time-lag of administrative data collection and reporting.

There are several limitations to this analysis. Due to the CIHI hospital staffing and expenditure data being available only by region,[2] the findings cannot be extrapolated to individual hospitals or hospital departments. In some cases, hospital-purchased agency staff ("purchased expenses") are reported in the CMDB without the associated hours. This indicates under-reporting of purchased hours. Therefore, purchased hours should be interpreted with caution. Calculation of hourly costs for agency staff is not advised given year-to-year and organization-to-organization variation. Finally, the hospital workforce staffing and expenditure data exclude physicians since most physicians are independent contractors paid by OHIP, not hospitals.

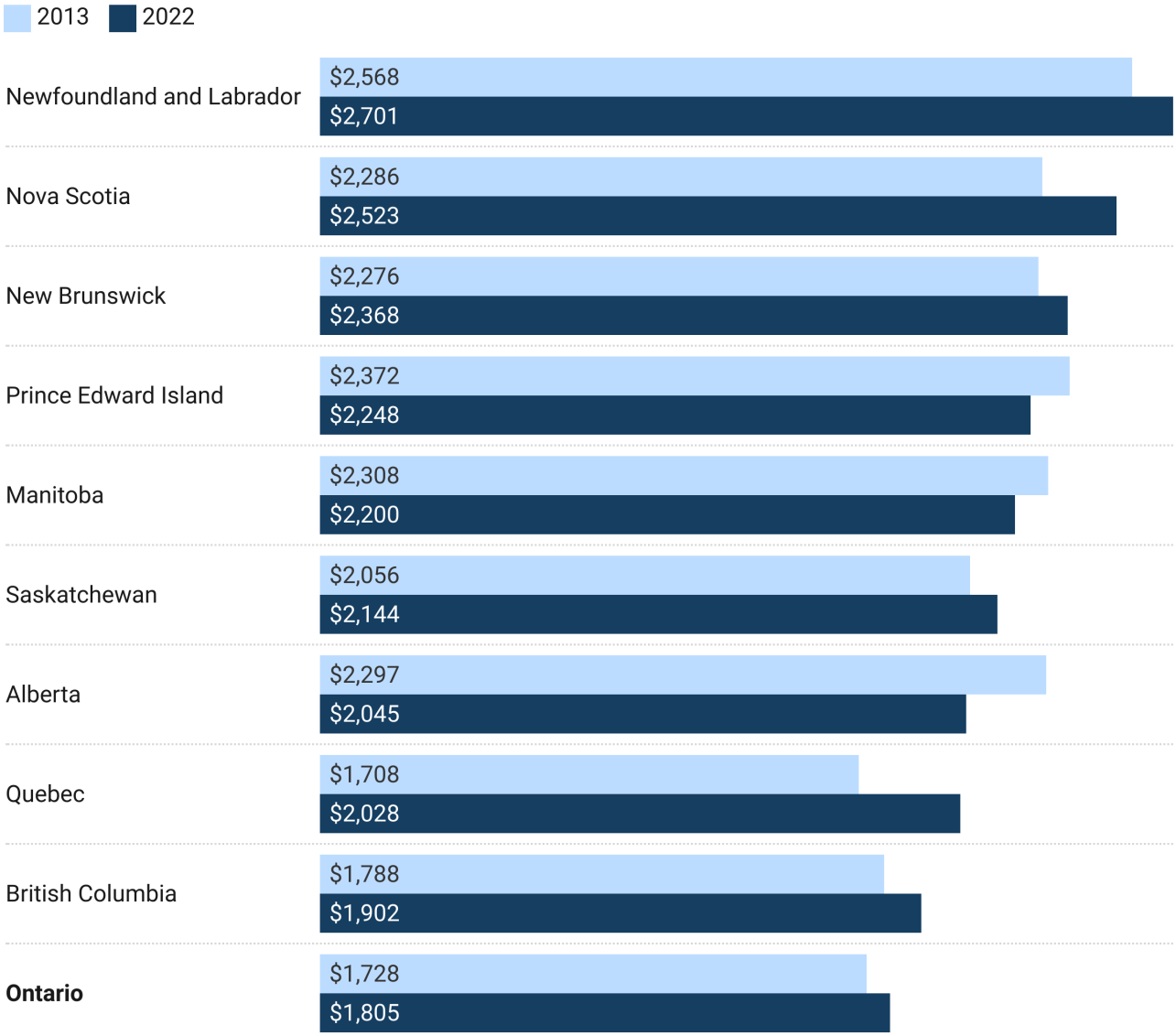
A decade of provincial austerity created today's hospital conditions

Public hospitals are the single-largest provincial expenditure and a top employer in many communities.[3] And while hospitals provide most scheduled procedures and all emergency and intensive inpatient care in Ontario, many are in financial crisis, which is the result of provincial fiscal austerity and underinvestment by consecutive provincial governments. Austerity refers to a set of political and economic ideas and practices that aim to reduce government deficits and the role of the public and non-profit sectors, most commonly through spending cuts.[4]

In 2013, Ontario ranked second last in real per capita hospital spending ($1,728), and by 2022, Ontario had fallen to last place ($1,805), following B.C. ($1,902), Quebec ($2,028), and Alberta ($2,045) (Figure 1). In real per capita terms, Ontario hospital spending increased by a modest four per cent over the last decade,[5] with seven of the 10 years seeing zero per cent funding increases (i.e., real spending cuts) (Table 1).[6] Most of the modest four per cent increase came in 2022 alone, when the province benefitted from federal pandemic funds.[7] Real per capita spending increases of more than one per cent occurred in only two years over the last decade: in 2018 and 2022. Increasing hospital capacity requires

Figure 1 / Real per capita hospital expenditures, 2013 and 2022

2022 constant dollars



Source Author's calculations from CIHI NHEX Series D4 and Appendices, 2024

consistent multi-year investment in order to increase staffing levels and capacity.

By another important measure, investment in Ontario's hospital system is not keeping up with the province's capacity to invest in this critical public good. Ontario hospital spending accounted for 2.6 per cent of provincial GDP in 2022, down from 2.8 per cent in 2013.[8] This is a useful

Table 1 / Ontario real per capita hospital expenditures, 2013-22

2022 constant dollars

	Real per capita dollars	Annual change (%)
2013	1,728	0.2%
2014	1,720	-0.5%
2015	1,713	-0.4%
2016	1,723	0.6%
2017	1,724	0.1%
2018	1,744	1.2%
2019	1,717	-1.6%
2020	1,706	-0.7%
2021	1,697	-0.5%
2022	1,805	6.3%

Source Author's calculations from CIHI NHEX 2024, Series D4 and Appendices

measure because it shows that Ontario's hospital spending, as a share of its capacity to invest, is relatively low and declining. Contrary to claims that public health care spending is unsustainable, hospital spending accounts for a modest share of the provincial economy. Especially in challenging political and economic times, investing in public health care strengthens our collective unity and well-being.

Recent commitments by the Ontario government to invest in public health care are welcome but cannot be easily reconciled with the government's privatization policy directions, which continue to undermine public hospitals. *Your Health: A Plan for Connected and Convenient Care*, released by the Ontario government in February 2023, committed to improve access to home, community, and hospital care.[9] The government stated that 3,500 new hospital beds had been opened since 2018, and promised 3,000 new beds by 2032.[10]

At the same time, the provincial government is encouraging the growth of a for-profit health care industry, undermining public hospitals and the public sector workforce. In May 2023, Bill 60, the *Your Health Act*, was passed to encourage the growth of for-profit facilities to perform publicly funded surgical and diagnostic procedures outsourced from public hospitals.

Previous research found growth in for-profit outsourcing in the year following the passage of Bill 60, with contracts benefitting new corporate

players aiming to channel public funds into the pockets of their investors.[11] A CBC investigation found one investor-owned facility was paid two to three times more than public hospitals to perform the same procedure. The former Ontario health minister, Christine Elliot, lobbied for this private equity-owned chain.[12] Through legislation and funding decisions, the provincial government has encouraged the growth of a for-profit health care sector.

The government has also engaged in an unprecedented attack on the Charter rights of public health care workers to freely bargain wages. In November 2019, unionized health care workers and the broader public sector were targeted by wage austerity legislation passed by the Ontario government. Bill 124 (*Protecting a Sustainable Public Sector for Future Generations Act*) imposed a one-per-cent cap on annual wage increases for provincial public sector employees for three years.

In response, unions launched a court challenge in September 2021. In November 2022, the Ontario Superior Court of Justice struck down the legislation as unconstitutional because it infringed on the claimants' rights to freedom of association and collective bargaining. The Ontario government unsuccessfully appealed the decision to the Court of Appeal for Ontario on February 12, 2024.[13] Then, on February 23, 2024, the Ontario government repealed Bill 124 in its entirety and a series of arbitration awards provided retroactive wage increases for health care workers.[14] Ontario hospitals were required to make retroactive payments to staff. However, the entirety of these labour costs have not been fully funded by the Ministry of Health.[15]

Public sector wage suppression benefits private staffing agencies

Wage suppression legislation, along with pandemic pressures and growing workloads, have contributed to the explosive growth of private, for-profit staffing agencies contracted by hospitals where private staff (nurses, allied health professionals, and support staff) perform the same work alongside public sector employees. Private agency work is attractive because of higher pay relative to the public sector, choice and flexibility regarding shifts and scheduling in the workplace, and reduced workload without mandatory overtime.

The Auditor General of Ontario's 2023 audit of emergency departments concluded that the provincial government itself, through Bill

124, contributed to the vicious cycle of private agency staffing hollowing out the public sector workforce:

> We noted multiple reasons for high staff turnover at emergency departments, especially among nurses. Factors included the higher pay and flexibility offered by private staffing agencies, as well as the introduction in 2019 of Bill 124, which limited annual wage increases for many employed professionals (including nurses) to 1 per cent for three years.[16]

Indeed, Bill 124 encouraged the growth of private agency staffing by devaluing public sector employment. Agency nurses can earn 50 per cent more in wages than they would working as public sector employees, although without the benefits, long-term disability, and pension.

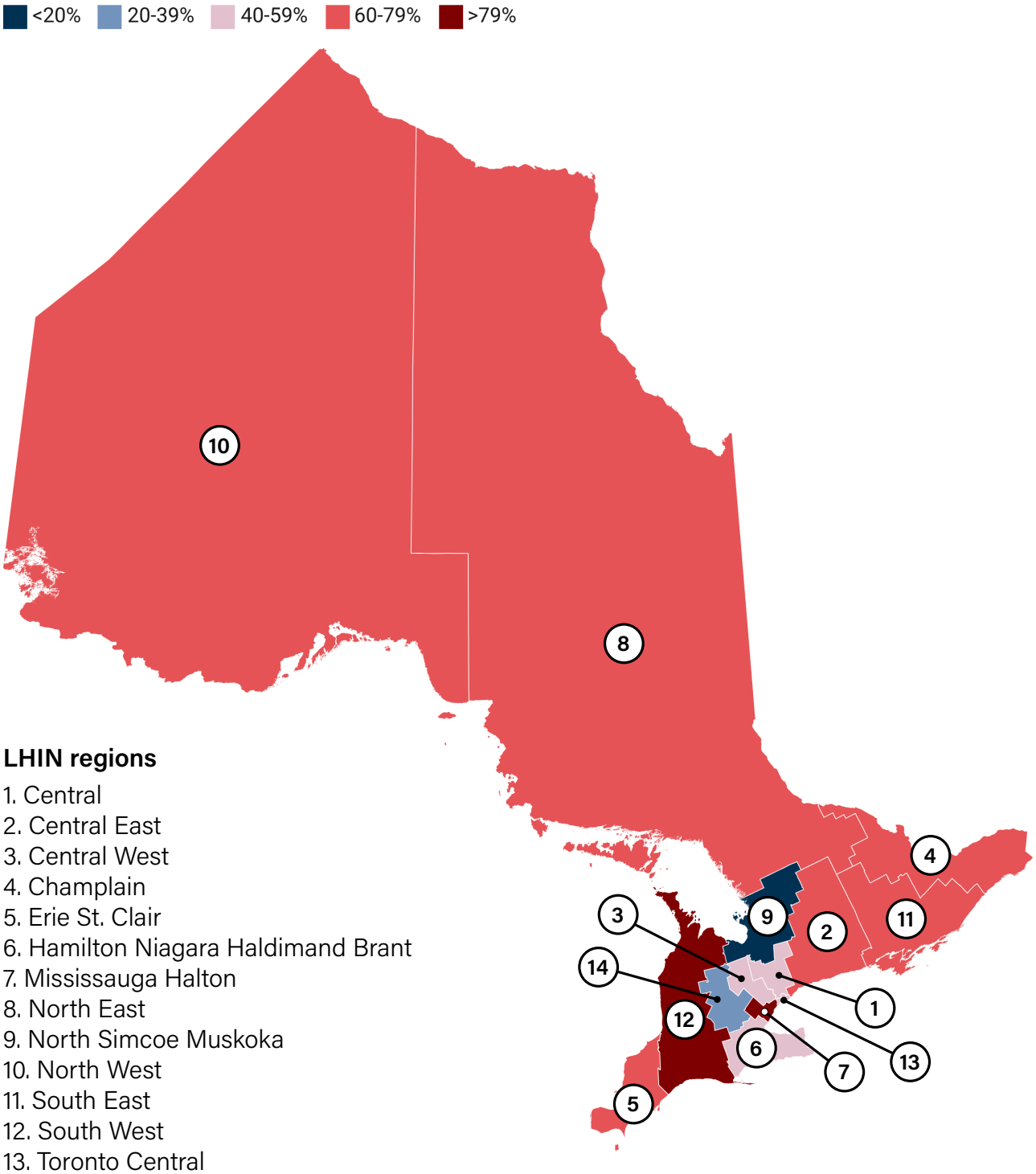
The use of private, for-profit staffing agencies is a financial drain on publicly funded health care organizations. The cost to public hospitals can be more than three times the cost of hiring regular employed staff.[17] However, hospital contracts with private agencies are not public. A study by Queen's University Professor Joan Almost estimated that hospital and long-term care facilities' spending on nursing agencies in Canada increased six-fold, from $248 million in 2020-21 to $1.5 billion in 2023-24.[18]

The use of agency staffing perpetuates a vicious cycle that hollows out the public sector workforce, and some provinces are working to end the practice. It became such a problem that the Quebec government introduced legislation in 2023 to phase out and ban health care staffing agencies by 2026.[19] In B.C., the provincial government plans to establish a public sector alternative to for-profit agencies to meet the needs of health regions.[20] In December 2024, the Ontario government introduced legislation requiring agencies to disclose their rates to government, but did not commit to phasing out their use in publicly funded health care.[21]

Half of Ontario hospitals ended 2024 in deficit

Increasing demand for acute care, ballooning private staffing costs, and provincial underfunding have put many hospitals in multi-year budget deficits. In 2023-24, 66 out of Ontario's 134 non-profit hospital corporations—49 per cent—had operating deficits (Figure 2). Despite an improvement from 63 per cent of hospitals running deficits in 2022-23, the Ontario Hospital Association expects that most hospitals will end 2024-25 in deficit.[22] Some hospitals have taken out high-interest bank loans to fund operating costs.[23]

Figure 2 / Percentage of Ontario hospitals in deficit by region, 2023-24



LHIN regions

1. Central
2. Central East
3. Central West
4. Champlain
5. Erie St. Clair
6. Hamilton Niagara Haldimand Brant
7. Mississauga Halton
8. North East
9. North Simcoe Muskoka
10. North West
11. South East
12. South West
13. Toronto Central

Note Financial statements for two of the 136 hospitals (Homewood Health Centre and West Nipissing General Hospital) were unavailable
Source Author's calculations from hospital financial statements, retrieved from https://www.ontario.ca/page/financial-statements-government-organizations-and-business-enterprises-2023-24

Table 2 / Hospitals in deficit position by operating revenue, 2023-24

	No.	No. in deficit	No. in surplus	% in deficit	% Ontario hospitals
Hospitals with operating revenue under $100m	67	42	25	63%	50%
Hospitals with operating revenue over $100m	67	24	43	36%	50%

Note Financial statements for two of 136 hospitals (Homewood Health Centre and West Nipissing General Hospital) were unavailable.
Source Author's calculations from hospital financial statements, retrieved from https://www.ontario.ca/page/financial-statements-government-organizations-and-business-enterprises-2023-24

Smaller hospitals are more likely to be in deficit

When analyzed by size of hospital, smaller hospitals with operating revenues under $100 million are disproportionately running deficits: 63 per cent had deficits but only comprised 50 per cent of Ontario hospitals (Table 2). Meanwhile, 36 per cent of hospitals with operating revenues over $100 million had deficits but accounted for 50 per cent of Ontario hospitals. Provincial funding decisions are especially affecting smaller hospitals, which tend to serve rural and remote communities.

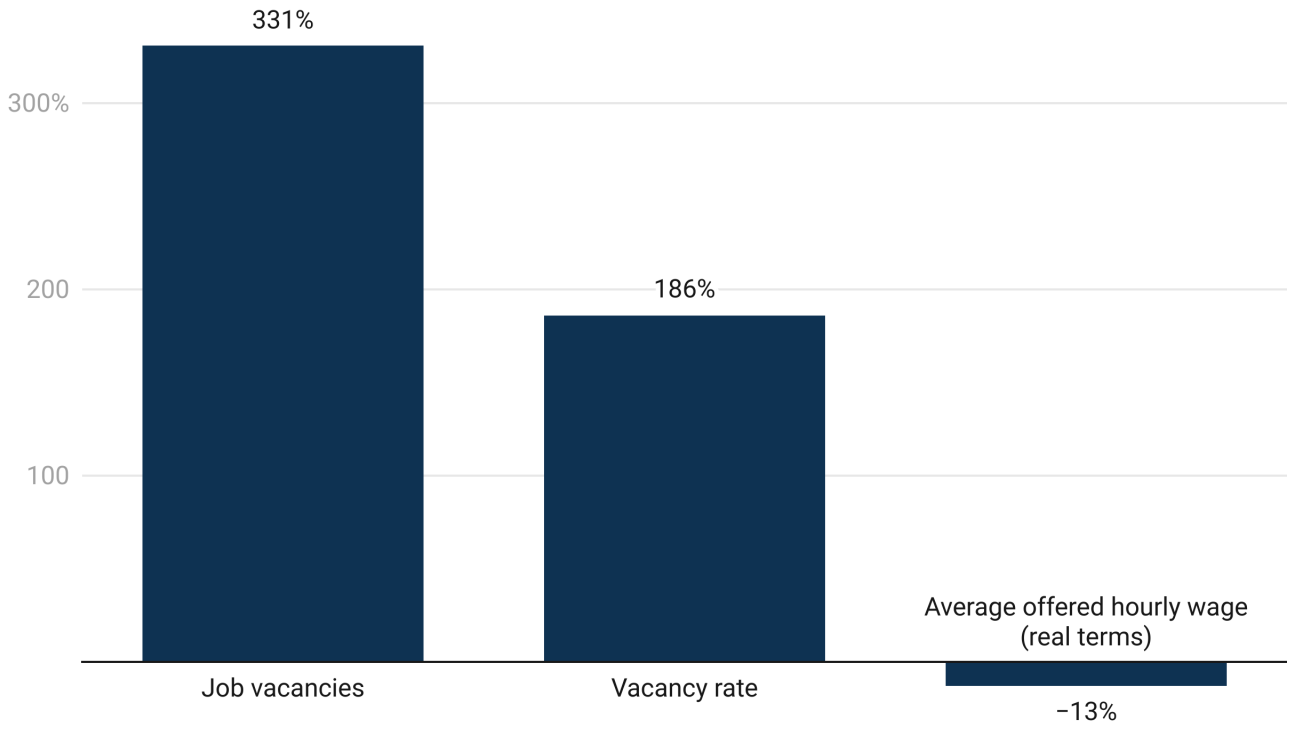
Smaller hospitals generally have fewer resources to draw upon than large urban hospital systems, including cash reserves, if they want to backstop shortfalls and maintain service levels. Northern Ontario is home to some of the province's most financially precarious hospitals, and these hospitals have had private agency spending consuming a growing share of total labour costs and leaving fewer dollars available for permanent employed staff.

The hospital funding crisis triggered a staffing crisis

Inadequate provincial funding prevents hospitals from negotiating fair wages and working conditions that address high living costs and the workload demands of a growing and aging population. While Bill 124 was an explicit attempt by government to suppress public sector wages, spending restraint imposed over the past decade has contributed to the staffing crisis.

From 2015 to 2024, the number of hospital job vacancies in the province increased by 331 per cent and the vacancy rate nearly tripled (Figure 3). The average wage for vacant hospital positions was 13 per cent lower in 2024 than 2015 when adjusting for inflation. This staffing crisis has destabilized many parts of hospitals, including emergency departments, which closed for a record number of hours in 2024 (14,980)—up from 2022 (13,856) and 2023 (14,671).[24]

Figure 3 / Change in number of job vacancies, vacancy rate, and average offered hourly wages in Ontario hospitals, 2015 to 2024



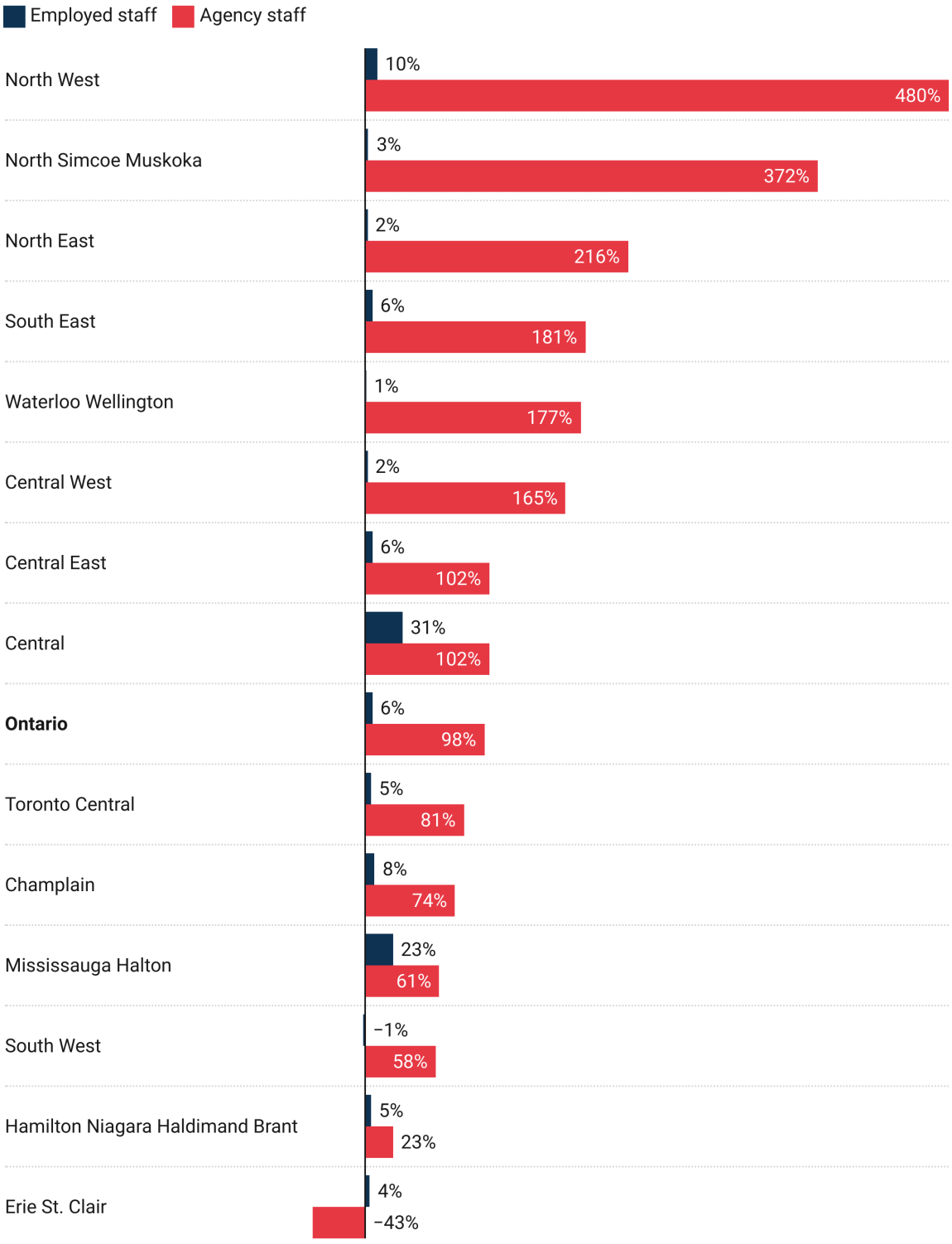
Source Author's calculations using Q2 figures from Statistics Canada, Table 14-10-0442-01, Job vacancies, payroll employees, job vacancy rate, and average offered hourly wage by industry sub-sector, quarterly, unadjusted for seasonality

Public spending on private agency staff outpaced public hospital staff

As the hospital funding and staffing crisis intensified in recent years, the growing number of vacancies led hospitals to contract private agency staff in an effort to maintain services and prevent closures.

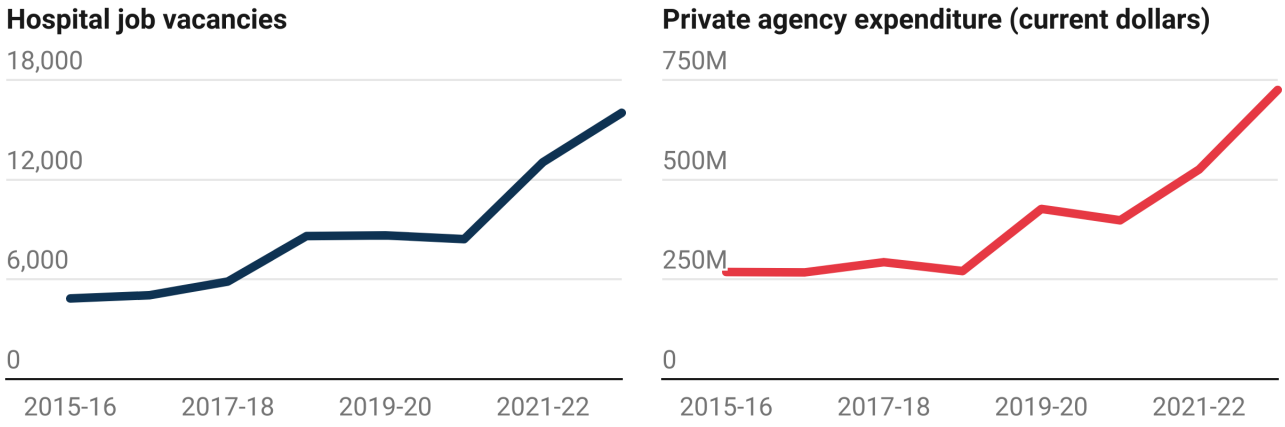
Public hospital spending on private agency staff is extraordinary. Ontario hospitals paid agencies $9.2 billion between 2013-14 and 2022-23 (Table 5). During this period, real per capita agency costs in Ontario nearly doubled (98 per cent) while spending on employed staff only increased six per cent (Figure 4). In all but one region of the province, real per capita agency costs outpaced spending growth on employed staff. Rural and northern regions had the highest spending growth on agency staff from 2013-14 to 2022-23: the North West (480 per cent), North Simcoe Muskoka (372 per cent), and North East (216 per cent).

Figure 4 / Real per capita expenditure growth on hospital employed and agency staff by region, 2013-14 to 2022-23



Source Author's calculations from CIHI custom request FSI.24.0149, Statistics Canada, Table 17-10-0134-01, "Population estimates, July 1, by health region and peer group, 2018 boundaries, inactive," CIHI NHEX Appendices, 2024.

Figure 5 / Job vacancies and private agency expenditures in Ontario, 2015-16 to 2022-23



Note Q2 job vacancy figures used except Q1 for 2020-21

Source CIHI custom request FSI.24.0149, Statistics Canada, Table 14-10-0442-01, Job vacancies, payroll employees, job vacancy rate, and average offered hourly wage by industry sub-sector, quarterly, unadjusted for seasonality

The use of for-profit staffing agencies is a vicious cycle that hollows out the public sector workforce, thereby increasing hospitals' dependence on private agencies. This dynamic is apparent when hospital vacancies and private agency spending growth are analyzed together. As the number of hospital job vacancies jumped between 2015-16 to 2022-23 due to wage suppression and growing workloads, so too did hospital spending on private agencies (Figure 5). Hospital staffing vacancies and private agency costs both increased dramatically with the passage of Bill 124 and the onset of the pandemic.

Costly private agencies undermine long-term workforce investment

The more that public funding entrenches private agency staffing, the harder it becomes to support long-term investment in the more cost-effective public sector workforce. Hospital finances are depleted with this more expensive staffing model, which is a bad deal for hospitals and taxpayers. While the number of agency hours worked in public hospitals accounted for 0.4 per cent of frontline hours, private agencies consumed

Table 3 / Employed and purchased agency hours in Ontario hospitals, 2022-23

	Hours	% total hours
Employed (worked) hours	272,528,615	99.6%
Purchased hours (agency)*	1,219,905	0.4%
Total	**273,748,520**	**100%**

* In some cases, purchased expenses are reported in the Canadian MIS Database (CMDB) without the associated hours. This indicates under-reporting of purchased hours. Public expenditures on purchased agency staff increased significantly in all regions and in current and real dollars, except for Erie St. Clair.

Note Table only includes unit producing personnel (UPP) who are frontline staff and exclude management.

Source Author's calculations from CIHI, FSI.23.0269 custom request.

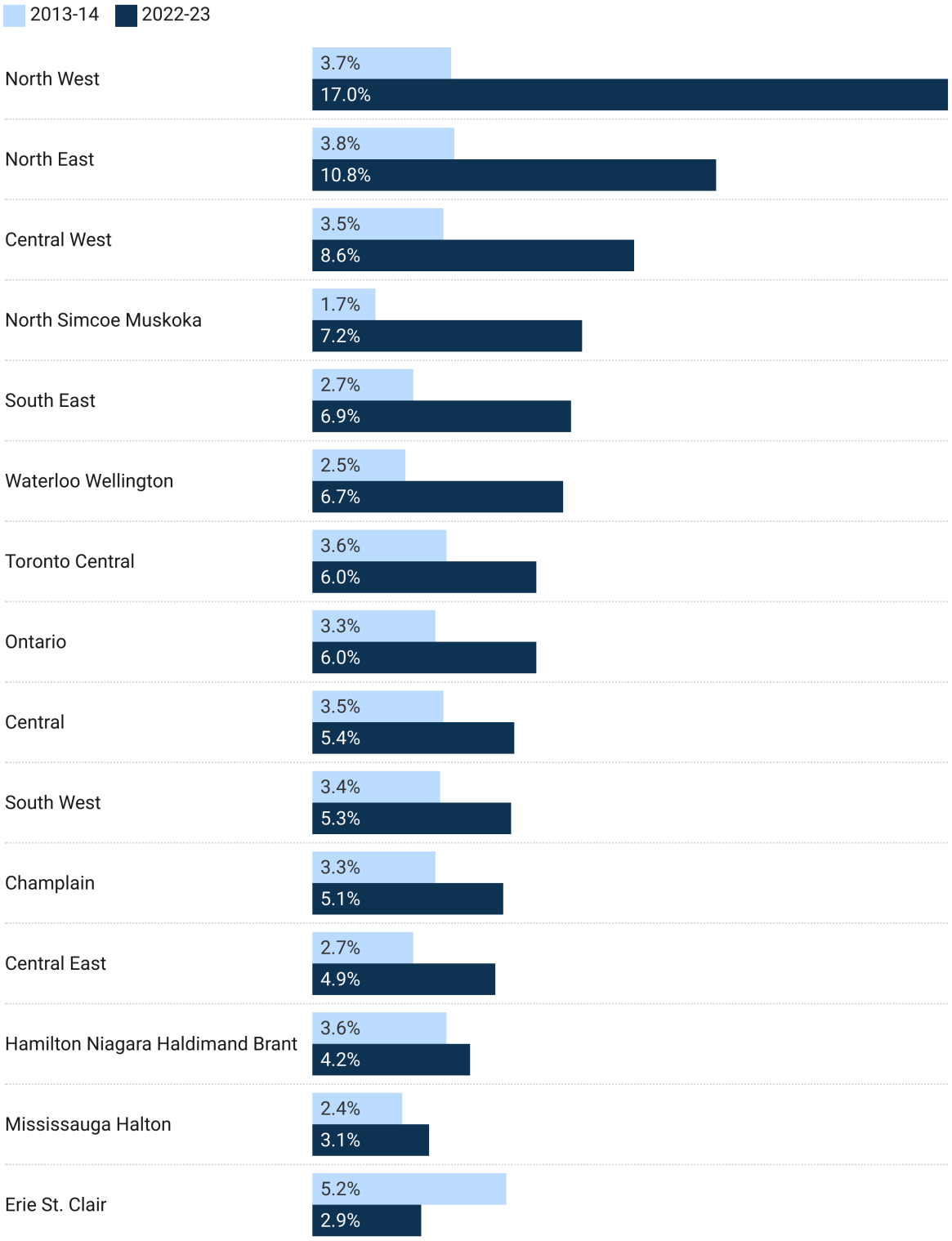
six per cent of hospital labour costs in Ontario ($725 million in 2022-23) (Table 3 and Figure 6).[25]

In 2013-14, agency costs as a share of total labour costs were below six per cent in all Ontario health regions. But by 2022-23, agency costs consumed a larger share of staffing expenditures, especially in the North West (17 per cent), North East (11 per cent), Central West (9 per cent), and North Simcoe Muskoka (7 per cent) regions (Figure 6). Rising agency costs strain budgets and reduce funds for hiring regular employees.

The health care workforce is fixed in the short and medium term, and when professionals work as agency staff, they are not available to accept public sector employment. From 2013-14 to 2022-23, the lowest employed staffing rate increase was in support services (zero per cent), medical imaging (three per cent), and operating rooms (four per cent)—the areas affected by hospital outsourcing (Table 11; see also Definitions, page 37). Even if the workforce grows substantially over the long term, many professionals can be expected to seek higher wages, more manageable workloads, and greater flexibility. This is also true of for-profit surgical and diagnostic facilities, which draw on the same limited pool of specialized health care personnel that are already in short supply, undermining hospitals' ability to increase staffing levels, treat more patients, and reduce wait times for everyone.

Many regions saw real per capita spending cuts to hospital departments because funding or staffing were unavailable. At a time when hospitals should be making long-term investments to grow the workforce and meet the increased demand for services, hospital department spending cuts occurred in many regions (Figure 7). The departments with the greatest number of cuts were nursing inpatient services, diagnostic and therapeutic services, emergency departments,

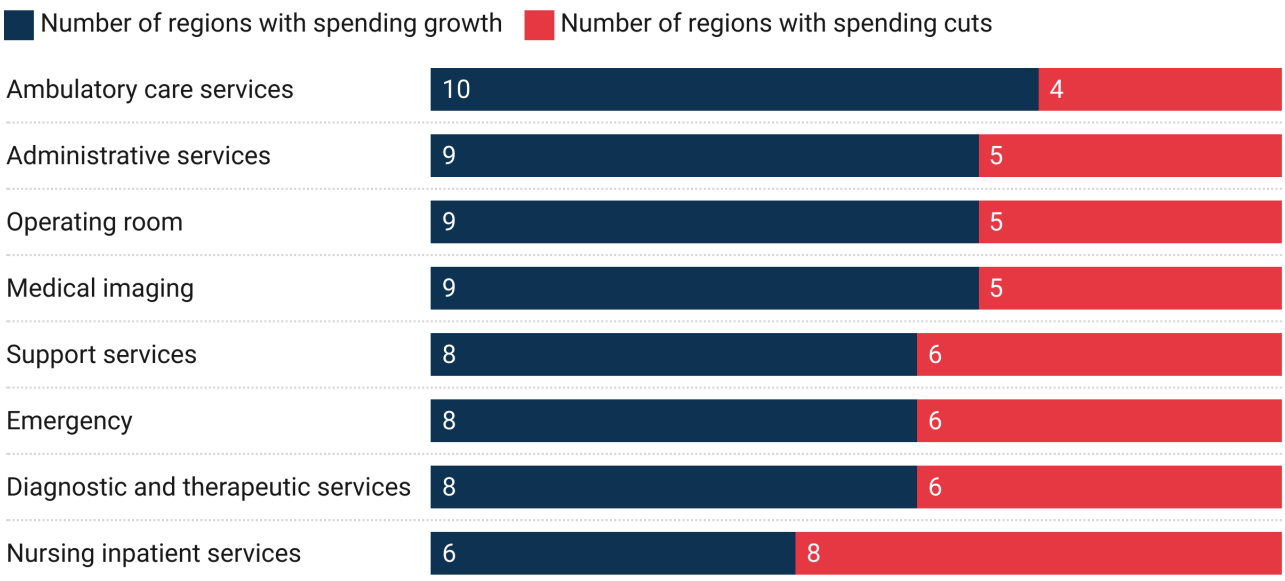
Figure 6 / Agency staff spending as a share of total frontline labour costs



Source Author's calculations from CIHI custom request FSI.24.0149

Figure 7 / Change in spending on employed staff by department, 2013-14 to 2022-23

Number of regions with spending growth and cuts by department, in real per capita dollars



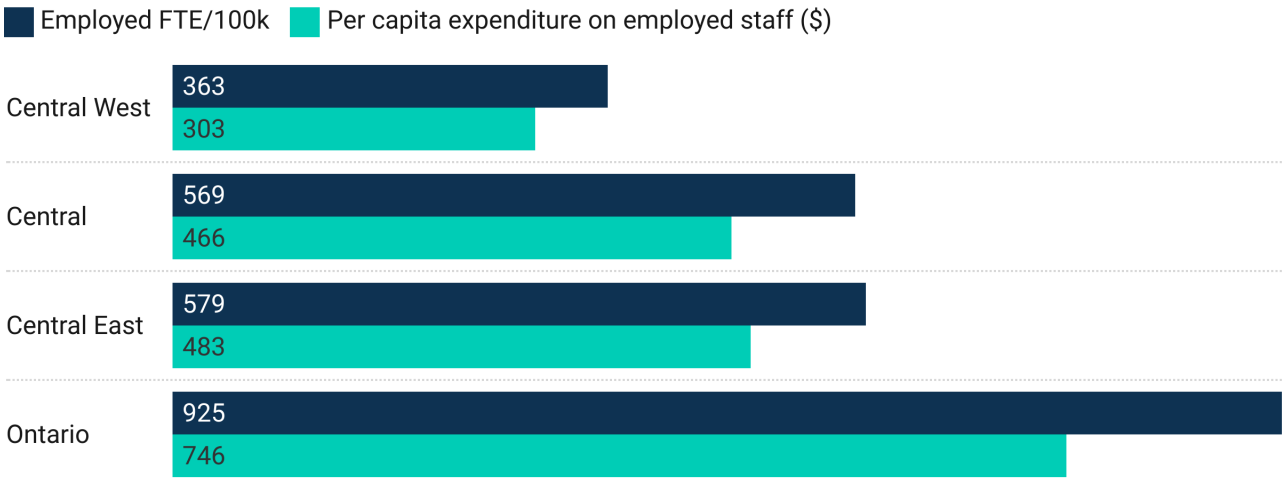
Source Author's calculations from CIHI custom request FSI.24.0149, Statistics Canada, Table 17-10-0134-01, "Population estimates, July 1, by health region and peer group, 2018 boundaries, inactive," CIHI NHEX Appendices, 2024

and support services (Figure 7). Central West (Brampton), Erie St. Clair (Windsor area), North East (Sault Ste. Marie, Sudbury, North Bay), and South West (London, Elgin, Perth) regions had real per capita cuts in five or more hospital department area between 2013-14 and 2022-23.

Fast-growing regions had lowest hospital spending and staffing rates

Among the 14 regions, Central West (Brampton, Etobicoke, northern Peel), Central (Markham, Vaughan, and North York), and Central East (Durham region, Peterborough, Scarborough) had the lowest per capita spending and staffing rates relative to population on hospital-employed staff in 2022-23 (Figure 8; see also Table 9).[26] These are among the fastest-growing and most-racialized communities in the province (Table 4).

Figure 8 / Ontario regions with lowest hospital staffing rates and per capita expenditures, 2022-23



Source Author's calculations from CIHI, FSI.23.0269 and FSI.24.0149 custom requests; Statistics Canada, Table 17-10-0134-01, "Population estimates, July 1, by health region and peer group, 2018 boundaries, inactive"

Undercapacity and overcrowded

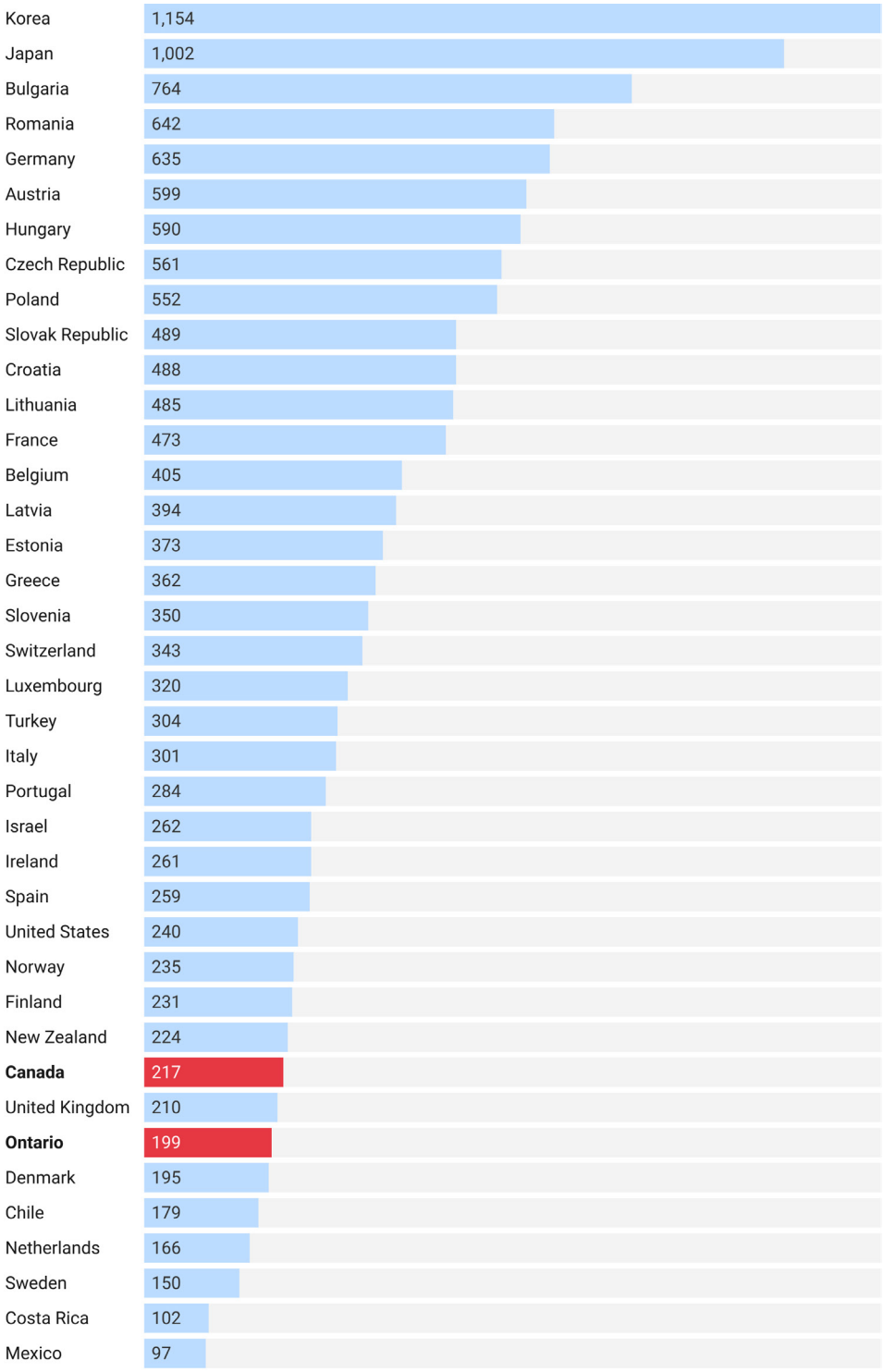
Hallway medicine in Ontario

Provincial fiscal austerity and inadequate hospital funding have created a workforce crisis in Ontario. The province is one of the most undercapacity hospital systems in the industrialized world. In 2022, Ontario ranked number 33 out of 38 OECD countries (Figure 9). At 199 beds per 100,000 people, Ontario had fewer beds than the Canadian average (217 beds per 100,000 people) and fell behind many other high-income countries with universal, publicly financed health systems, including, Norway, Finland, New Zealand, and the UK. Even though many northern European countries generally have stronger systems of primary and community care, these countries still have more hospital beds, per capita, than Ontario.

Among the provinces, Ontario had the second-fewest hospital beds per 100,000 people (Figure 10).[27] In 2022-23, Ontario had 34,782 staffed hospital beds or 198 per 100,000 people (or 1.98 beds per 1,000 people) (beds in long-term care nursing units are excluded, see Tables 13 and 14 for detailed breakdown).[28] Hospital medical and surgical beds are particularly critical when it comes to addressing emergency department overcrowding, surgical wait times, and general hospital strain. Emergency departments require available beds in medical wards to avoid "access block," which occurs when patients cannot be admitted and must remain

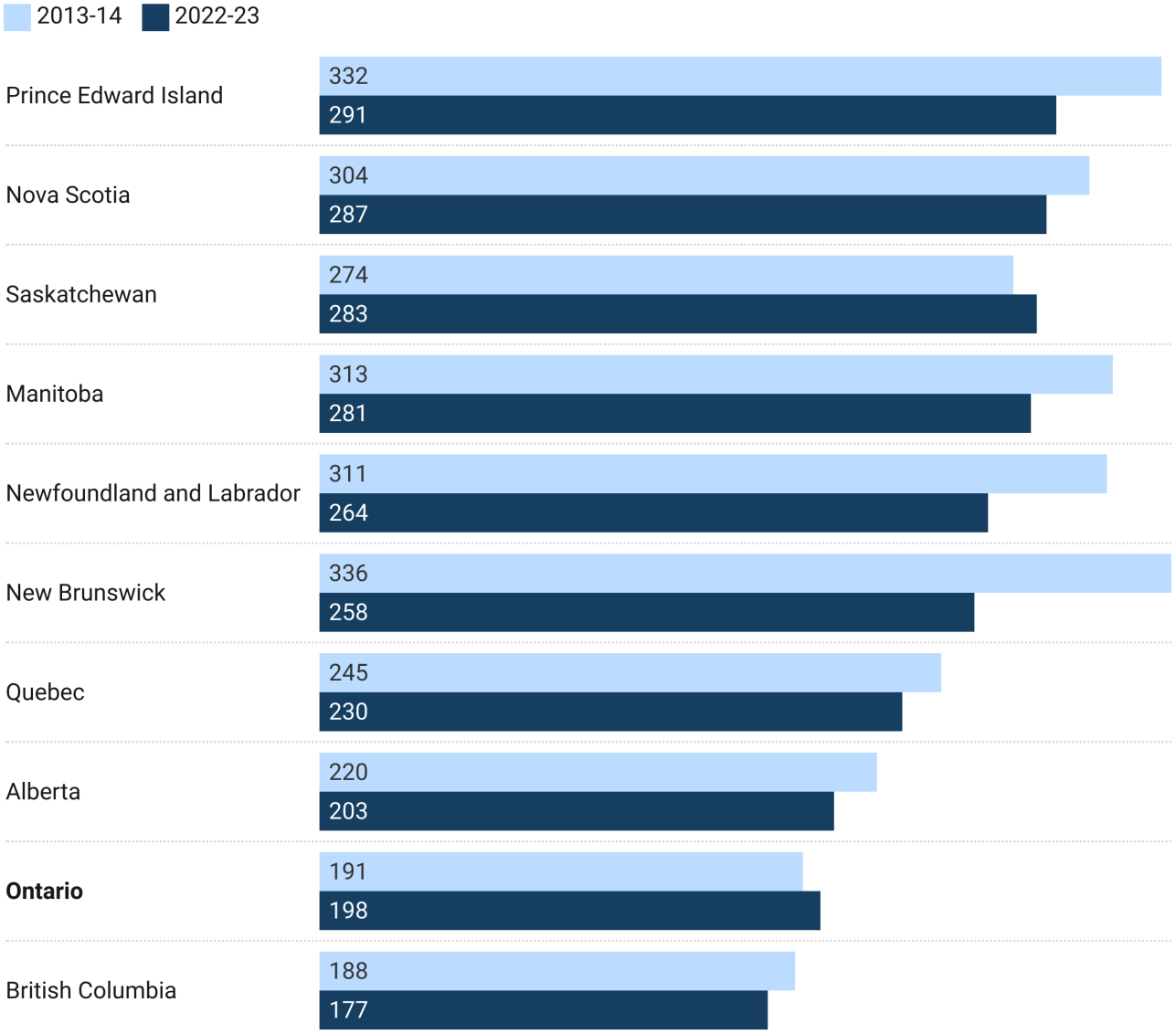
Figure 9 / Hospital beds per 100,000 population, 2022

Excluding mental health beds



Source OECD Data Explorer; CIHI Trends in Hospital Spending 2009–2010 to 2022–2023 — Data Tables — Series D: Beds Staffed and In Operation by Functional Centre (2024)

Figure 10 / Hospital beds per 100,000 population by province, 2013-14 and 2022-23



Note Beds staffed and in operation are reported differently across jurisdictions. Hospital bed counts analyzed above comprise ICU, pediatrics, obstetrics, rehabilitation, mental health and addictions, and medical/surgical beds. Hospital-based long-term care nursing unit/complex continuing care beds are excluded. The exclusion of beds in long-term care units/complex continuing care from total hospital bed counts can lead to different rankings among the provinces. Please interpret with caution.

Source CIHI, Trends in Hospital Spending, 2009–2010 to 2022–2023 — Data Tables — Series D: Beds Staffed and In Operation by Functional Centre, 2024 release

in the emergency department. In 2022-23, Ontario ranked second last in Canada for medical and surgical beds on a per capita basis (Table 12).

Ontario's hospitals are overcrowded

Ontario's low hospital bed rate would not necessarily be so problematic if hospitals could maintain lower occupancy rates and manage patient flow. However, across large and teaching hospitals in Ontario, average occupancy rates remain well above recommended levels.

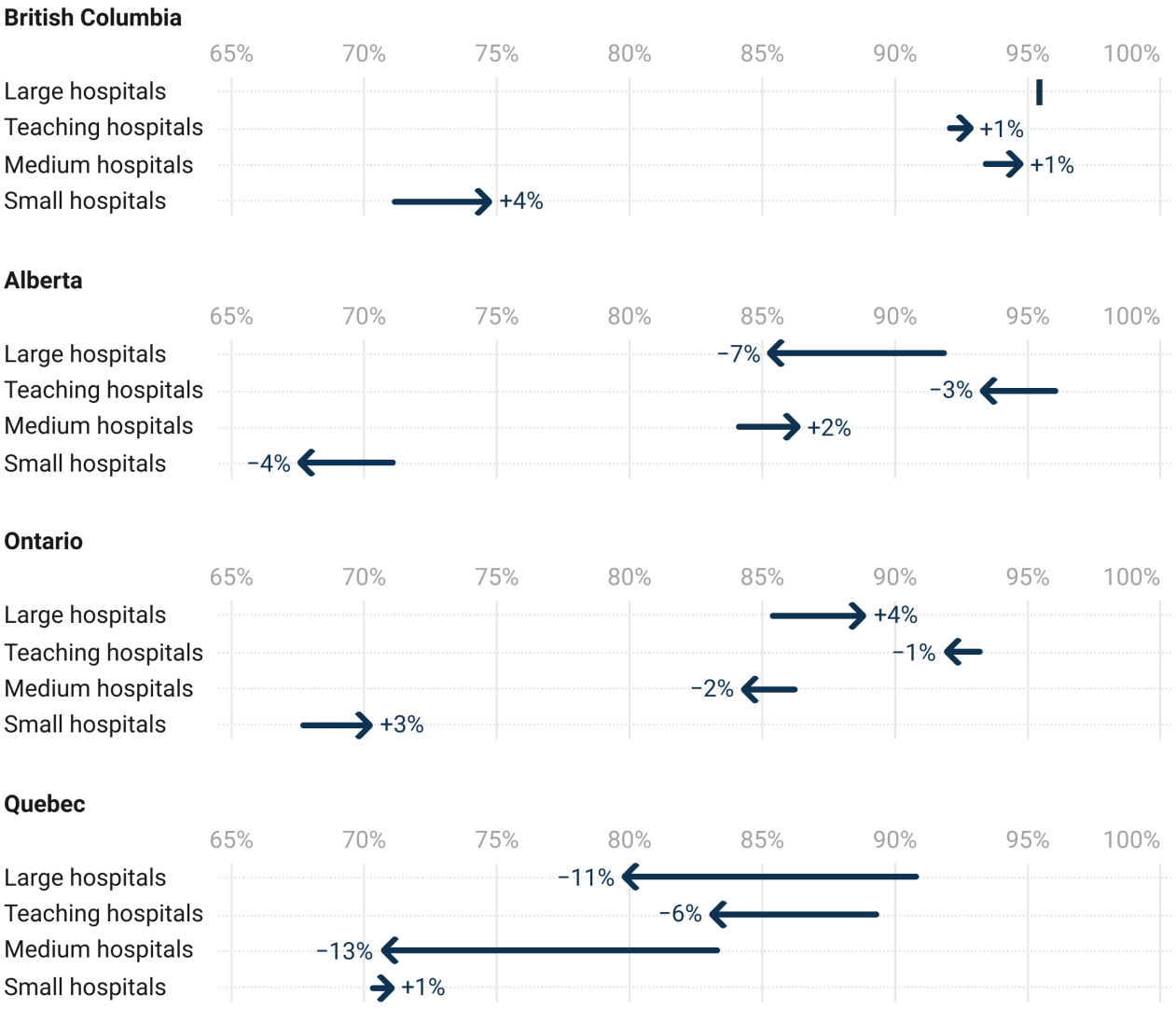
Between 2014-15 and 2022-23, average occupancy rates increased for large hospitals (89 per cent to 91 per cent) and declined for teaching hospitals (92 per cent to 90 per cent) (Figure 11). Importantly, average occupancy rates are just that—they are averages—and hospitals can be operating well above safe levels for many days in a year. A 2020 CBC investigation found that 83 Ontario hospitals were operating beyond 100 per cent capacity for more than 30 days, 40 hospitals averaged 100 per cent capacity or higher, and 39 hospitals hit 120 per cent capacity or higher for at least one day.[29]

When hospitals are over capacity, this results in "hallway medicine", where patients remain in emergency departments because all staffed inpatient beds are occupied. Ontario Health reported that in March 2023, an average of 1,326 inpatients were receiving care in "unconventional spaces"—that is, hallways and spaces not intended for patient care.[30] The Auditor General of Ontario found that in 2022-23, patients waited an average of 13 hours for an inpatient bed, which is a notable increase from the approximately eight hours that patients waited in 2013-14.[31] The Auditor General concluded that "the long wait times were partly the result of the overall lack of inpatient beds in Ontario hospitals and the backlog of patients who did not require hospital level care but were waiting for rooms elsewhere in the health-care system."

A large body of research shows that occupancy rates below 85 per cent are recommended for maintaining patient flow, wait times, and patient safety.[32] When occupancy rates are near 100 per cent, hospital overcrowding can impact working conditions and patient outcomes; it also makes infection control more difficult.[33] As authors of a prominent Canadian study conclude, increased hospital occupancy is "strongly associated with emergency department length of stay for admitted patients, [and] increasing hospital bed availability might reduce emergency department overcrowding."[34] Addressing Ontario's undercapacity hospital system will help reduce overcrowding and support better working and caring conditions.

Figure 11 / Average hospital occupancy rates in largest provinces

Change between 2014-15 and 2022-23



Source Author's calculations from CIHI, "Your Health System," data tables, August 2016 and December 2024 releases

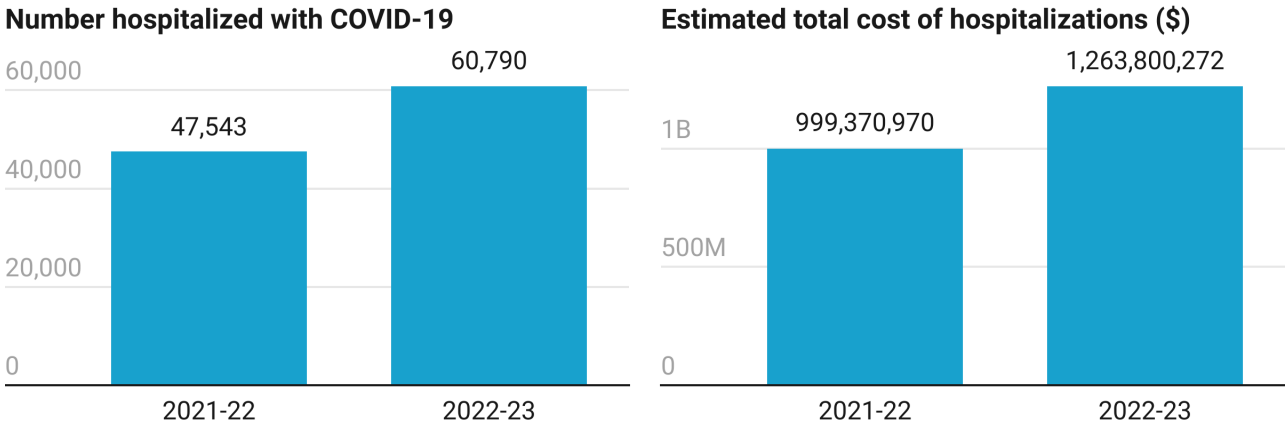
Addressing hospital pressures requires a systems approach

Addressing hospital pressures and growing demand for acute care also requires policy solutions beyond increased funding and staffing. A systems approach recognizes that hospitals do not exist in isolation from public policies and the wider health care and social support systems. Pressures that drive demand for acute care include the burden of COVID-19 and infectious diseases, health inequalities, and the lack of access to primary and community care.

The COVID-19 burden hasn't disappeared

The ongoing burden of unmitigated SARS-CoV-2 transmission contributes to hospital strain. From 2021-22 to 2022-23 in Ontario, the number of people hospitalized for COVID-19 increased by 28 per cent, the average total length of COVID-19 hospital stay increased by 35 per cent, and the estimated total cost of COVID-19 hospital stays increased by 26 per cent (Figure 12).[35] Ontario hospitals spent an estimated $1.26 billion on COVID-19 hospitalizations in 2022-23—a cost pressure that did not exist before 2020. The COVID-19 burden on hospitals has increased and is moving in the wrong direction, even as public health authorities and

Figure 12 / COVID-19 hospitalizations (including ICU) and estimated costs in Ontario, 2021-22 to 2022-23



Note COVID-19 hospitalizations include both confirmed and suspected cases

Source Author's calculations from CIHI, COVID-19 Hospitalization and Emergency Department Statistics, 2019–2020 to 2022–2023, Table 1 (June 2024 release)

governments have ended most measures that reduce viral transmission in health care and congregate settings.

There is growing scientific consensus that we cannot rely on a "vaccine-only" approach to COVID-19, with very limited public health interventions to reduce the burden of this disease on health systems. As we enter the "pandemicene," an age of rapid global warming with greater risk of animal viruses spilling over into humans and causing new pandemics,[36] governments must adapt and use science-informed strategies to reduce the burden of new and existing pathogens.[37] Governments and public health authorities should more effectively use the diversity of public health tools, with a focus on reducing airborne transmission by setting indoor air quality standards as a matter of public health and workplace safety.[38] By reducing community and health care transmission, Ontario could help free up hospital beds for other patients and reduce costs. Prevention is much cheaper than hospitalization.

The role of health inequalities and primary care access

More equal societies tend to have better population health outcomes.[39] Addressing the social determinants of health can reduce health inequalities, including progressive taxation, living wages and income supports, affordable housing, and universal public services across the life course. These public policies support better population health outcomes, thereby reducing demand on the most expensive part of health care: hospitals.

Focusing health systems on primary care can also help reduce health inequalities. Primary care is the foundation of an effective, efficient, and high-performing health system with a focus on preventing and managing chronic conditions and improving population health.[40] Although not all hospitalizations for these conditions are avoidable, hospitalizations for "ambulatory care sensitive conditions" measure admitted patients for whom the onset of their illness or chronic condition might have been managed or prevented through appropriate outpatient or primary care. In 2023-24, Ontario's rate of 290 hospitalizations per 100,000 population was higher than B.C. (251/100,000), Alberta (285/100,000), and the Canadian provincial average excluding Quebec (281/100,000).[41] Second, Statistics Canada's Canadian Community Health Survey shows that 87.6 per cent of the Ontario population has a regular health care provider.[42] However, the percentage declines to 85.8 per cent for the lowest income quintile of Ontarians compared to 88 per cent for the highest quintile. Lower income residents face greater challenges accessing regular primary care.

In October 2024, former federal health minister Jane Philpott was appointed by the Ontario government to connect every person in Ontario to primary care within five years.[43] The contributions of Ontario's Community Health Centre (CHC) model should inform this work. CHCs are leading the country in providing comprehensive and effective primary care and reducing hospital strain. Research studies from 2009 and 2012 comparing Ontario's 75 CHCs with the other primary care models in Ontario show that CHCs are more effective in managing chronic conditions,[44] reducing emergency visits,[45] and improving access to care for people with serious mental health issues.[46] The 2012 study from the Institute for Clinical Evaluative Sciences (ICES) concluded that CHCs "stood out in their care for disadvantaged and sick populations and had substantially lower emergency department visits rates than expected."[47] Due to their focus on the social determinants of health, cross sector collaboration, and community orientation, CHCs are a cost-effective

model for providing primary care for everyone, and particularly for lower-income, higher-needs populations who tend to be higher users of hospital services.[48]

Lack of seniors' home and community care

Too many patients, especially older adults, rely on hospital care because publicly funded community alternatives with the appropriate intensity of support are not available. Better access to publicly funded home and community care, especially for seniors, can play a role in reducing hospital bed shortages and overcrowding, as well as cancellations of scheduled surgeries and wait times for all patients.[49] Seniors' care includes home support (e.g., personal care services and help with housekeeping, cooking, and taking medications), home nursing, rehabilitation therapy, long-term care, and palliative care. These services should be delivered in conjunction with important community-based social services that address food insecurity, social isolation, and transportation, among other social determinants of health. It is important to note, however, that improving out-of-hospital primary and community care will not solve problems that are rooted in undercapacity within the hospital system. More beds and more staff are essential.

The Ontario government committed to build more than 30,000 long-term care beds by 2028 and 15,000 by 2024, which many note is unlikely to be sufficient considering the province's aging long-term care infrastructure and replacement requirements.[50] However, in Budget 2024-25, the government reported opening 2,246 new beds, only 15 per cent and 7.5 per cent of the 2024 and 2028 commitments, respectively.[51] There also appears to be little progress addressing the 43,000-person waitlist for long-term care, and the province missed its own legislated target for frontline care hours in 2024.[52] As well, the province's continued reliance on investor-owned corporate chains to build and operate long-term care does not align with the evidence that shows not-for-profit care homes offer, on average, higher staffing levels and skill mix, superior resident outcomes, and lower costs to government.[53]

Conclusion and recommendations

Ontario hospitals are under tremendous strain. Provincial fiscal austerity, population growth and aging, and provincial policies that encourage privatization have created the perfect storm for public hospitals.

Half of the province's hospitals ended 2024 in deficit and 2025 is expected to be worse. The longer hospitals do not have the funding to stabilize operations, the greater is the risk to patient care and safety. The hospital funding crisis has already triggered a staffing crisis.

This report has provided the first detailed look at Ontario hospital spending on private agency staff relative to employed staff. It documents an alarming trend over the last decade of the rapid expansion of for-profit staffing agencies benefiting from substantial public subsidy:

- Public spending on private agency staff outpaced employed staff. Private agency hours were only 0.4 per cent of frontline hospital hours in 2022-23 but accounted for six per cent of Ontario hospitals' labour costs.
- Costly private agencies are reducing long-term investment in a stable hospital workforce. From 2013-14 to 2022-23, real per capita private agency costs in Ontario nearly doubled while spending on employed staff increased by six per cent. In total, Ontario hospitals paid private staffing agencies $9.2 billion over 10 years.

- Some of the fastest-growing regions had the lowest rates of hospital-employed staff and per capita spending.

Hospitals are struggling to recruit and retain permanent staff while public dollars are working at cross purpose by subsidizing private interests with a business model based on hollowing out the public sector workforce and feeding off the public purse.

Similarly concerning, a significant number of hospital departments across the province experienced staffing and spending cuts on a population-adjusted basis, especially in areas that are subject to privatization by the provincial government, including operating rooms and medical imaging.

This hospital funding and workforce crisis directly affects patient care. Ontario's hospital sector is severely under capacity, by international and Canadian standards. Addressing upstream causes of hospital strain should also form Ontario's health care strategy, including increased access to primary and community care and better population health.

Based on the findings of this report, the Ontario government should adopt the following recommendations:

Immediately stabilize hospital finances and increase hospital capacity

In Budget 2024-25, the provincial government committed $965 million to increase base hospital funding—an increase of four per cent. However, this does not accurately reflect the increased costs associated with population growth, aging, inflation, and unfunded Bill 124 labour costs. Analysis by the Ontario Council of Hospital Unions (OCHU/CUPE) suggests that a seven per cent lift is needed just to maintain service levels, requiring about $2 billion annually.[54] This is a reasonable place to begin stabilizing hospital finances and services. However, it is widely recognized that Ontario's current hospital bed capacity is inadequate. An estimated 10,095 additional hospital beds are required by 2028 to meet growing demand from population growth and aging, with operating costs of at least $4 billion annually.[55]

Develop a provincial health workforce strategy and capital plan

Ontario lacks a health workforce strategy with provincial and regional solutions to address staffing shortages. While the government's 2023 *Your Health* policy directions discuss some workforce initiatives, the document does not offer a comprehensive provincial health workforce plan, including provincial and regional-level targets that can focus government action over the immediate and longer term. Other jurisdictions internationally and in Canada, including British Columbia and Scotland, have developed strategies that enable measurable progress to address health system workforce challenges.[56]

Most importantly, the provincial government and health sector employers must recognize that the conditions of work are the conditions of patient care, and that improving the workplace environment is associated with better-performing organizations that deliver safer patient care and better outcomes.[57] A workforce strategy should be accompanied by a long-term hospital capital infrastructure plan to ensure that physical infrastructure, bed capacity, and equipment planning aligns with workforce expansion.

The Ministry of Health and Ontario Health should establish a provincial advisory table, including researchers, unions, educators, employer representatives, professional associations, and patient and citizen advocacy groups, to inform development and implementation of a provincial health workforce strategy. Policy experience shows that workforce development and health service improvement are most likely to succeed when there is collaboration and common goals from all stakeholders, especially the frontline workforce.[58]

Phase out and ban private staffing agencies over three years and create a public sector alternative

Ontario government legislation tabled in 2024 (Bill 231, the *More Convenient Care Act*) only requires agencies to report billing and rate information to the minister, and the government can choose whether to make this information public. Public disclosure of public payments to individual private staffing agencies, billing rates, and wage rates is a minimum standard to regulate this industry. Following Quebec, Ontario should phase out and ban for-profit staffing agencies over three years

and create a public sector alternative, similar to B.C.'s approach, to ensure that temporary staff are available to prevent closures and disruptions.

Build a stronger primary care foundation with Community Health Centres

In addition to directly addressing Ontario's undercapacity hospital system, the provincial government should focus on improving primary care. The Ontario Community Health Centre model stands out in its ability to reduce hospital strain by addressing the social determinants of health, providing comprehensive team-based care, and helping patients manage chronic diseases that drive demand for acute care.

Definitions

The following definitions are provided by the Canadian Institute for Health Information.

Service area

Administrative Services: The provision of services pertaining to all administrative departments, such as finance, human resources and communications. Includes the earned hours reported in the facility as well as an allocation from any existing shared and centralized service.

Support Services: The provision of all support services required by the health service organization, including provision and management of all physical assets and services necessary to support its operation and maintenance. Includes Systems Support, Emergency Preparedness, Functional Centre Support and service-recipient support services such as Housekeeping and Laundry and Linen.

Nursing Inpatient Services: Nursing services provided to inpatients and their significant others to meet their physical and psychosocial needs.

Operating Room: Nursing units that are specifically designed, staffed and equipped for the provision of services to inpatients and clients during surgical intervention, and the continuous observation and care of inpatients and day surgery clients during the immediate post-operative and post-anesthetic period.

Emergency: The unit providing assessment, diagnostic and treatment services to individuals with conditions requiring prompt attention. May also include services provided to registered scheduled hospital clients receiving care in Emergency (e.g., specialty clinic, pre- and post-operative day surgery), inpatients awaiting placement on a nursing unit or clients receiving emergency mental health services. Includes telephone advice services provided by the staff of Emergency. Excludes telephone health services provided by nursing personnel on a local, regional or provincial/territorial basis.

Other Ambulatory Care Services: Specialized diagnostic, consultative, treatment and teaching services provided primarily for registered clients and their significant others. Access to these services is generally with a referral from a primary care practitioner or a specialist. These services are generally provided in a hospital setting.

Medical Imaging: Production of visual records of body tissues and functions, and interpretation of the records to assist in the clinical investigation and management of the service recipient.

Other Diagnostic and Therapeutic: Diagnostic services include professional and technical services that assist in the clinical investigation of service recipients, either to detect the presence of disease, disability or injury or to assess the severity of known disease, disability or injury. Therapeutic services include professional and technical services provided to service recipients that assist in the alleviation or cure of the causes, symptoms and/or sequelae of disease, disability or injury.

Types of personnel and hours

Management and operational support personnel (MOS): Those personnel whose primary function is the management and/or support of the operation of a functional centre. Examples include directors, managers, supervisors, medical personnel fulfilling a management role and secretaries. Excluded are practicing physicians, medical residents and interns and all types of students.

Unit producing personnel (UPP): Those personnel whose primary function is to carry out activities that directly contribute to the fulfilment

of the service mandate. Examples include RNs, LPNs, laboratory technologists, accounts payable clerks, pharmacists, housekeepers, home care workers and public health officers. Excluded are practicing physicians, medical residents, interns and students and, in most cases, diagnostic, therapeutic, nursing and support services' students.

Worked hours: Hours spent carrying out or supporting the mandate of the functional centre. They include regular scheduled hours, overtime, call back, coffee breaks and worked statutory holiday hours. Worked hours do not include the lunch hour and standby hours.

Benefit hours: Hours of entitlement to paid absence that accrue to the credit of the employee. It includes vacation, statutory holiday, sick leave, education hours received and the percentage of gross pay in lieu of benefits expressed in hours, which may be paid to part time staff.

Purchased hours: Hours spent carrying out the mandate of a functional centre by personnel hired from a purchased third-party provider for which the external agency/organization will receive remuneration for services provided.

Appendix data tables

For detailed data tables please refer to the on-line version of this publication at www.policyalternatives.ca/news-research/hollowed-out

Notes

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