Freedom Party of Ontario

2015

Opposition Budget

Freedom Party of Ontario's 2015
OPPOSITION BUDGET

Submitted on Tuesday, February 10, 2015 to The Honourable Charles Sousa, Minister of Finance, and to Members of the Ontario Provincial Legislature

Table of Contents

Part I: The Essential Problem....1

Part II: Non-Solutions....1

Treating Health, Education, and Welfare as Untouchables....2

Erroneous Proposals to Eliminate ABCs....2

"Eliminating Waste" and "Cutting Red Tape"....3

Logan's Run Revisited....4

The Annie State....5

Part III: The Need for Prompt Action....6

Health Care: the Elephant in the Room....6

Why Balance the Budget in 2015?....8

Part IV: The Opposition Budget....9

Overview of the Opposition Budget....9

Competition & Choice, Not Privatization....10

Federal Funding Implications of Ending the Government Health Care Monopoly....11

Budget Implications of Ending the Government's Health Care Monopoly....12

Federal HST Windfall Transfer....13
Tax Administration Cost Reduction, Welfare Recipients....13
Balancing the Budget....14

Conclusion....15

PART I: THE ESSENTIAL PROBLEM

According to the 2014 Ontario Economic Outlook and Fiscal Review[1] (hereinafter referred to as the "Outlook"), Ontario is anticipating a 2014=15 budget deficit of $12.5B. Ontario's government is operating on a plan that it submits will balance the budget by 2017-18 without making cuts to education or health care. As recently as March 20, 2012, then-Premier Dalton McGuinty opined that the province's then $214B debt was acceptable because, he explained, the federal government did not remedy its debt crisis until its debt to GDP ratio was 67%, whereas Ontario's ratio, he then claimed, stood at 35%. Three years later, Ontario's net debt to GDP ratio is at 39.9% and rising[2]. The Outlook states that Ontario's debt is projected to stand at $287.3B effective March 31, 2015. There is mounting evidence that Ontario's 2015 budget will fail to take serious steps to balance the budget any time soon.

Yet, on February 15, 2012, the report[3] of the Commission on the Reform of Ontario's Public Services (a.k.a. the "Drummond Report") submitted that, far from achieving a balanced budget in 2017-18, the government's plan has Ontario on a path that will give it a $30.2B deficit in 2017-18, together with an accumulated debt of $411.4B. The government has rejected the adoption of the Drummond Report's two key explicitly quantified expenditure cuts: elimination of the $1.5B full-day kindergarten program, and elimination of the $1.0B Ontario Clean Energy Benefit.

Meanwhile, the two opposition parties having seats in Ontario's Legislature are nearly mute when it comes to numerically explicit proposals demonstrating how they would get Ontario's budget deficit to zero. Little wonder, given that both parties campaigned, in both election 2011 and election 2014 to balance the budget years down the line (typically saying that they would do it without making cuts to health care or education, but not explaining how that would be possible). Were the PC party or the NDP currently to hold a majority in the Legislature, it would not have any more inclination to balance the budget in 2015 than has the governing Liberals.

Ontario does not merely deserve better. We *need* better, and we need it *now*. Ontario both deserves and needs a counter-proposal to the anticipated government budget, which it appears will make no serious effort to avoid saddling Ontario taxpayers with crippling debt, hence higher taxes, hence an undesirable locale for business, jobs, and earning. Ontario needs a mature, responsible, rational proposal for balancing the budget in the immediate term, without further undermining the quality of the one service most important to all Ontarians: health care.

Freedom Party of Ontario's Opposition Budget provides a framework for achieving a balanced budget in 2015, and for thereby avoiding the fiscal calamity about which the Drummond Report has warned the province. Moreover, it provides a solution that will take Ontario off of its current trend of ever-increasing expenditures by remedying fundamental economic and medical problems inherent in the current system of delivering health care.

PART II: NON-SOLUTIONS

Before considering the Opposition Budget set out in Part IV, it is important to take a clear look at the fallacies inherent in the alleged solutions typically proposed by opposition parties. The fiscal situation in Ontario is too critical to play make believe with easy-sounding non-solutions.

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1. http://www.fin.gov.on.ca/en/budget/fallstatement/2014/chapter3d.html Table 3.6

2 http://www.fin.gov.on.ca/en/budget/fallstatement/2014/chapter3d.html Table 3.11

   c.f. http://www.ofina.on.ca/borrowing_debt/borrowhistory.htm

3. http://www.fin.gov.on.ca/en/reformcommission/

Treating Health, Education, and Welfare as Untouchables

Table 3.11 of the Outlook provides the following "Actual" Revenue, Expense and Deficit figures for the 2013-2014 year (the most recent year for which "Actual" figures have yet been published by the Ministry of Finance):

Total Revenue:	$115.911B
Total Expense:	$126.364B
Deficit:	$ 10.453B

There are four areas of expenditure that are considered by some to be politically Untouchable: health care, education, welfare, and debt service. Table 3.8 of the Outlook provides the following Actual totals for Untouchables in the year 2013-14:

Health and Long Term Care	($48.909B)
Training, Colleges and Universities	($7.581B)
Education	($23.644B)
Community and Social Services	($10.001B)
Interest on Debt	($10.572B)

The total expense for the five Untouchable items listed above is $100.707B. Therefore, after removing the cost of Untouchables from the provincial government's $126.364B total Actual expenditures for 2013-14, total Actual expense for all other ministries (i.e., the 22 remaining "Touchable" ministries) *combined* is only $25.675B.

As noted above, the "Actual" deficit in the same period is represented, in the Outlook, to be: $10.453B. Therefore, if one seeks to balance the Ontario budget in 2015 without making cuts to Untouchables, 40.7% of the total ($25.675B) expenditure on Ontario's 22 Touchable ministries (i.e., the 22 other ministries listed in the Outlook) must be eliminated.

To get a better sense of just how large that reduction would be, if the government were to refuse to reduce expenditures in Untouchable ministries, then, of the 22 Touchable ministries, the government would have to eliminate *entirely* as many as 19 (i.e., 86.4% of) Touchable ministries (i.e., the 19 smallest Touchable ministries, having total expenditures of $10.477B) to balance the budget in 2015. Whether by making cuts to the expenditures of all Touchable ministries, or by closing as many as 19 of them, the impact on such things as justice, child services, transportation, aboriginal affairs, energy, the environment, citizenship/immigration etc. would be so large as to render some or all of those ministries either utterly dysfunctional or non-existent.

Clearly, if the budget is to be balanced we cannot rule out changes to health, education, or welfare. Nothing can be treated as an Untouchable.

Erroneous Proposals to Eliminate ABCs

It is sometimes suggested[4] that, without making cuts to health care or education, the budget could be balanced first and foremost by eliminating any Ontario agency, board, or commission (the so-called "ABCs" of government) that cannot justify its existence. For several reasons, that argument cannot withstand serious scrutiny.

First, the ABCs are funded by provincial Ministries. For example, for the year ending March 31, 2014, the operating expenses of ABCs funded by the budget of Ministry of the Attorney General totaled $537,546,632 (source: *Public Accounts of Ontario 2013-2014*[5], p. 2-36; hereinafter referred to as the "*Accounts*"). Contrary to what you will hear from those who pretend that the budget can be balanced by cutting ABCs, most people have indeed heard of these ABCs, which include: Assessment Review Board, the Environmental Review Tribunal, the Conservation Review Board, the Ontario Municipal Board, the Board of Negotiation, Landlord and Tenant Board, Human Rights Tribunal of Ontario, Social Benefits Tribunal, Custody

4 "Waste in the PC Election Platform: Tim Hudak's Non-Existent Plan for a Balanced Ontario Bud get" (video compilation) - http://www.youtube.com/watch?v=8uOORiY2as0

5 http://www.fin.gov.on.ca/en/budget/paccts/2014/

Review Board, Child and Family Services Review Board, Special Education Tribunal - English and Special Education Tribunal - French, Licence Appeal Tribunal, Animal Care Review Board, Fire Safety Commission, Ontario Civilian Police Commission, Ontario Parole Board, the Criminal Injuries Compensation Board, Alcohol and Gaming Commission of Ontario, the Ontario Human Rights Commission, the Human Rights Legal Support Centre, the Office of the Independent Police Review Director, the Special Investigations Unit, Legal Aid Ontario and the Bail Verification and Supervision Program. Eliminating such ABCs to eliminate their associated expenditures would have *no effect* on the provincial budget *unless* the budgets of the Ministries that funded the closed ABCs were reduced by the same amount.

Second, many of Ontario's ABCs receive their funds from the Untouchable health and education ministries: the very ministries whose budgets the Liberal, NDP, and PC parties usually vow not to reduce. For example, the Ministry of Health and Long-term Care not only funds 14 Local Health Integration Networks (the "LHINs"), but also funds administrative support to: Ontario Review Board, Consent and Capacity Board, Health Services Appeal and Review Board, Health Professions Appeal and Review Board, and the Ontario Hepatitis C Assistance Plan Review Committee. (*Accounts*, p. 2-232). Similarly, the Ministry of Education funds the Ontario Education Communications Authority (a.k.a. TVO; *Accounts*, p. 2-147). If one were on the one hand promising not to make cuts to health care and education, and promising on the other hand to eliminate ABCs that cannot justify their existence, then even if one were to eliminate all ABCs funded by the Untouchable health and education ministries, there would be no actual decrease in expenditures because there would be no corresponding cut to the budgets of the ministries that funded them (i.e., to the budgets of the health and education ministries).

Third, the vast majority of Ontario's ABCs have budgets so small that they do not even need to be reported in Ontario's Public Accounts. Even if one were to eliminate *all* ABCs, including those funded by the Untouchable ministries, one could not come close to eliminating Ontario's $10.453B budget deficit.

"Eliminating Waste" and "Cutting Red Tape"

It is sometimes proposed that the budget can be balanced by "eliminating waste" or "cutting red tape", without making cuts to health care or education. However, if no reductions were made to the budgets of Untouchable ministries, the government would be left trying to find $10.453B in "wasted" government expenditures in the $25.675B spent on Ontario's 22 Touchable Ministries. In other words, it would have to be true that an incredible 40.7% of all of the money spent by all Touchable Ministries is pure waste.

In fact, even if health care were treated as the *only* Untouchable, and waste were also sought in the education and welfare files, 15.6% of the resulting $66.901B in touchable expenditures would have to be waste. Even that percentage stretches plausibility.

It might well be argued that "waste" includes paying public sector employees wages that are higher than that paid to people who do the same kind of work in the private sector. And, given that wages account for a large percentage of all government expenditures, one most certainly could significantly reduce the deficit by bringing public sector wage rates down to market rates. However, those who are currently speaking of eliminating waste and cutting red tape do not include above-market wages in their definition of "waste". Public sector "wage freezes" that are sometimes proposed typically are not proposals to reduce wages: to the contrary, they are usually implicit promises *not* to reduce them. Nor would market rate equivalency be achieved by allowing all companies to bid on government work (i.e., open tendering), because all companies making a tender would seek compensation greater than that which they can obtain in the private sector due to government's taxation powers and its greater spending capacity. With above-market wages excluded from the

definition of “waste”, it is highly doubtful that the government would be able to identify as waste 40.7% of the budgets of Touchable ministries.

Logan’s Run Revisited

The most recent proposal for helping to deal with the budget deficit is also the most morally reprehensible: giving physicians the obligation of encouraging healthy middle-aged individuals to enter into “living wills” in which they give instruction to be put to death by lethal injection in the event that they end up suffering an impairment that leaves them unable to give instructions to health-care providers. Most worrisome of all: discussing the implementation of such a law has the support of all three parties in the Ontario legislature: Kathleen Wynne’s Liberals, the PCs, and Andrea Horwath’s NDP.

With respect to health care, the Drummond Report stated that:

> *“Beyond 2017–18, spending will probably accelerate as a consequence of population aging. This is why our recommendation for a 20-year plan and full public debate is crucial.”* (p. 27).

Recommendation 5-70 of the Drummond Report was that “All Family Health Team physicians must begin engaging in discussions with their middle-aged patients about end-of-life health care.” It stated that “Informing people about the importance of using an advance health care directive (also known as a “living will”) as opposed to the last will and testament as the legal document to express one’s end-of-life care wishes is essential.” The report set out a chart (page 168 of the report) comparing what it called the “current [health care] system and an ideal reformed system”. Within that chart the current approach “extraordinary interventions at end of life” was contrasted with the proposed reformed system’s “pre-agreements on end-of-life care”.

In its publication *Powers of Attorney and “Living Wills”: Questions and Answers*[6], the Ministry of the Attorney General makes clear the provincial government’s interpretation of the term “living will”:

> *“The expression “living will” is sometimes used to refer to a document in which you write down what you want to happen if you become ill and can’t communicate your wishes about treatment. It is quite common, for example, for people to write a “living will” saying that they do not want to be kept alive on artificial life supports if they have no hope of recovery.”* (p. 5)

On June 12, 2013, Bill 52, titled “An Act respecting end-of-life care” was introduced in the Quebec provincial Legislative Assembly. It provides, in part, for “physician assisted dying” (a euphemism for “assisted suicide” via lethal injection) where a person is incurably ill and suffering from “constant and unbearable physical or *psychological* pain” (*emphasis* added). The patient need merely sign a request form but, where the patient is physically incapable of doing so, a “third person” can sign the form instead.

A June 18, 2013 report[7] in the Toronto Sun reported, in part, as follows:

> *“The Silver Tsunami — the huge number of baby boomers poised to retire and who’ll require greater medical care as they age and die — will prompt debate about when to end life, as governments across the country struggle to cope with this ticking time bomb and as seniors seek to take control of their own lives and destinies.*

6 http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/livingwillqa.pdf

7 http://www.torontosun.com/2013/06/18/discussion-on-end-of-life-decisions-unavoidable-wynne

> *"I think it raises enormous questions, but I think it's a national discussion," [Ontario Premier Kathleen] Wynne said. "I think it's going to happen across the country.*
>
> *"It's a huge ethical debate, so I think it's something that every person in this country is going to have to confront and discuss and obviously the people of Ontario are not going to be exempt from that. It's going to be thrust upon us."*

In the days that followed, Ontario PC Party leader Tim Hudak called[8] for a committee to look into the issue, and Ontario NDP health critic France Gélinas agreed.

The Drummond Report was not a report on better treatment for patients. It was a budget document, filled with proposals to balance the budget. Recommendation 5-70 was a budget recommendation, not a recommendation about compassion for, or the rights of, patients. For budgetary reasons, it essentially perverts the role of a physician: from one who helps one to live and cope with pain, to one expected to canvas with his or her patients - while they are still relatively young and healthy - the possibility of agreeing to a lethal injection as an alternative to the governmental expense associated with treating the medical issues they might face as seniors.

The role of government, first and foremost, is to defend every individual's life, liberty and property. Encouraging healthy middle-aged people to sign up for lethal injections so as to balance the government's budget runs contrary to the purpose of government. Contrary to what Premier Wynne suggests - with the support of Tim Hudak and Andrea Horwath - it is not a "discussion we need to have": those who want to commit suicide are free to do so already, but it is wrong for the government to seek to balance its budget by encouraging healthy people to sign up years in advance for lethal injections. Moreover, unless a "Logan's Run" type of *mass* suicide is contemplated by the boosters of this ghoulish proposal, there is no basis for their implicit belief that killing old people when they are incapable of saying "no" would have a significant effect upon an effort to balance the budget.

The Annie State

Underlying all of the above proposals is an article of faith that, if Ontario just waits long enough - if it waits for a distant tomorrow - revenues will increase sufficiently to eliminate the annual budget deficit. Underlying that faith in waiting is not only the hope that inflation will help close the gap but, also, that there will be a rebound from the economic slump in which Ontario has found itself since 2009. There are at least four problems with waiting around and hoping that tomorrow's revenues take care of everything.

First, Ontario's economic slump was not simply a by-product of the bursting of the U.S. housing bubble. A rebound in housing prices there will not fix what ails Ontario. In 2003, when the McGuinty Liberals assumed office, Canada's dollar was worth only about 74 U.S. cents. The dollar's value rose sharply eventually hitting and exceeding parity by 2007. Ontario having been a cheap-labour location - with taxpayer-subsidized electricity - before the dollar's rise, after the dollar's rise it ceased to make economic sense for the world to hire or retain relatively expensive Ontario labourers.

Second, compounding that problem was the fact that by 2006, the McGuinty government - which to that point had only plans to close coal-powered electricity generation plants - was finally getting around to thinking about attempting to cope with a problem caused while the dollar was low and industrial activity was high: insufficient electricity to meet industrial and commercial demand. Power generation companies having been scared away by Ernie Eves' (2002) and Dalton McGuinty's (2003) legislated caps

8 "Rare agreement in Ontario on need for end-of-life discussions: Editorial" (Toronto Star, June 24, 2013) - http://www.thestar.com/opinion/editorials/2013/06/24/rare_agreement_in_ontario_on_need_for_endoflife_discussions_editorial.html

on the retail price of electricity, there was no appetite amongst the world's power generation companies to build generators in Ontario and attempt to make a profit: the Ontario government had made it clear that it was willing to eliminate profits for electoral gain. Price caps having scared away investors, the McGuinty government chose to enter into contracts for the building and operation of new generation capacity, in which the private sector contractees would have a contractual right to be paid at well-above the market price of electricity. Thinking themselves to be protected by the courts, private investors lunged forward to accept the Liberals' offer to make a killing by skinning the Ontario public for its electricity. Armed with contracts, they believed that they would have the protection of the courts against an electorally-motivated reneging on inflated electricity prices.

Third, there is little sign that the industrial and service industries that left Ontario have any near-term plans to set up shop in Ontario. The exodus of industrial and service jobs - to low-cost places like China and India - left Ontario a have-not province. Canada's still relatively high dollar leaves labour too expensive, while the Eves/McGuinty/Wynne government's electricity mismanagement has left Ontario with extremely high and unattractive electricity prices. To make matters worse, skyrocketing minimum wage levels, congested transportation routes, punitive taxation levels, and the sheer amount of regulatory machinery set up to slow, impede or ban productive activity leave Ontario a relatively unattractive place to make goods or provide services that can be shipped in from a less hostile jurisdiction, with tax avoidance made possible via transfer pricing (i.e., selling at cost in a high-tax jurisdiction, while generating profits from those sales in a low-tax jurisdiction). And, as the availability of well-paying jobs diminishes, so to does the importance of the province as a market for the sale of goods and services.

Fourth, although the Liberal government has attempted to limit increases in government expenditures since 2010, the Outlook anticipates a $3.8B increase in spending for 2014-15. The government simply has no political will to hold down spending long enough for a relatively meagre $2.5B increase in revenue to close the gap between revenue and expense. The clear impression left by the government's pattern of taxing and spending is that the sun will come out tomorrow...somehow. Tomorrow, however, is indeed always a day away.

PART III: THE NEED FOR PROMPT ACTION

Health Care: The Elephant in the Room

According to the Outlook, the Actual 2013-14 cost of health care in Ontario was $48.909B, which figure represents 38.7% of all provincial expenditures in the same period. Actual health care costs for 2013-14 represented 42.2% of total provincial revenue from all sources, and consumed fully 61.2% of Ontario's $79.966B in provincial tax revenues. Numerous credible reports warn that escalating health care expenditures will increasingly undermine Ontario's fiscal health.

The Drummond Report stated that were no changes made to Ontario's policies, programs, or practices, "...the deficit would more than double to $30.2 billion in 2017–18 and net public debt would reach $411.4 billion, equivalent to just under 51 per cent of the province's GDP" (p. 2). It explained that, to balance the budget, "most of the burden of eliminating the $30.2 billion shortfall in 2017–18 must fall on spending" (p. 2).

A 2011 Fraser Institute report[9] cites 19 other reports opining that the current growth in health care spending simply is not sustainable. The Fraser Institute elsewhere[10] has projected that health care spending will consume 75% of pro-

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9 *Canada's Medicare Bubble: Is Health Spending Sustainable without User-based Funding?* (Fraser Institute, April 18, 2011) - http://www.fraserinstitute.org/research-news/display.aspx?id=17414

10 *Healthcare at a Crossroads* (Fraser Forum, February 2010, p. 10) - http://ww.fraserinstitute.org/research-news/research/display.aspx?id=10758

vincial tax revenues by 2019, and 100% of provincial tax revenues by 2030, unless Ontario significantly restructures health care.

A February 2, 2012 report[11] by the Conference Board of Canada submitted that if Ontario's health care expenditures were increased more slowly than they currently increase, such that they would account only for an aging population and the effect of price inflation, health care spending would grow an average of 4.7% per year. The report concluded that, under that scenario, the provincial government would be unable to balance its budget even by 2031. The report also concluded that if Ontario instead were to keep health care spending in line with what it said was an historically-observed annual 5.6% rate of increase, Ontario's budget could be balanced by 2017-18 by increasing the provincial portion of the HST from 8% to 15%: a staggering 54% increase in the HST burden of people living in Ontario.

The Drummond Report also submitted that:

> *"Adjusted for age, Canada definitely has one of the most expensive systems."* (p. 154).

11 *Ontario's Economic and Fiscal Prospects: Challenging Times Ahead* (Conference Board of Canada, February 2012) - http://www.conferenceboard.ca/e-library/abstract.aspx?did=4662

Toronto Star, February 18, 1970

Social service bills too high

Trudeau: 'Costs must be cut'

By FRANK JONES
Star staff writer

OTTAWA—Prime Minister Pierre Trudeau said yesterday Ottawa would launch a nation-wide drive to hold down spending on medicare, hospital, welfare and federally assisted education programs.

He said the drive is necessary because of a "really appalling" anticipated increase in expenditures on these programs of $2 billion over the next two years.

Trudeau spoke to reporters at the conclusion of a two-day federal-provincial conference which examined the state of the nation's economy.

The $2 billion estimate was included in a report of the federal-provincial tax structure committee.

The committee, made up of federal and provincial treasurers and their advisers, predicted shared-cost programs in the health, welfare and education fields

It continued:

> *"The high cost of our health care system could perhaps be forgiven if the spending produced superior results. It does not.*

The take home message is clear. The spending side of Ontario's budget deficit problem is attributable primarily to rising expenditures of the Untouchable health ministry, not to the expenditures of Touchable ministries. To balance the budget, health care must be the *focus* of the effort.

Ontario must decide whether its goal is to provide for the health of the government health care *monopoly*, or to provide for the health of *patients*. If the government wishes to save patients, it can no longer make saving the current system its priority. Tax revenues cannot be expected to rise sufficiently to afford the soaring costs of saving patients within Ontario's health care monopoly. The monopoly, and its tax-funded, single-payer implications, must be ended if patients are to be well served, and if the budget is to be balanced.

Why Balance the Budget in 2015?

Ontario's 2014 provincial budget[12] set out a plan alleged to have the province balancing its books by 2017-18. The Drummond Report submitted that the government's plans would not allow it to balance the budget by 2017-18. The aforementioned Conference Board of Canada report suggests that, without a staggeringly high tax increase, Ontario will not even manage to balance its budget by 2031, due to the cost of the government's health care monopoly.

Though such reports differ in their conclusions, the reports make one thing abundantly clear: all talk of balancing the budget three or nineteen years hence is ultimately the stuff of

12 http://www.fin.gov.on.ca/en/budget/ontariobudgets/2014/

Toronto Star, September 10, 1979

Canada's unhealthy crisis

☐ This is an editorial reprinted from the Vancouver Sun

Canada's system of medicare has never been considered perfect, but few will quarrel with the notion that it has been one of the best in the world.

After all, it provides comprehensive coverage for all medically required services, with no dollar limit, universal accessibility to all residents, portability of benefits between provinces, and non-profit public administration.

Those were the four basic principles built into the National Medical Care Insurance Act in 1966 and finally adopted in 1971 by every province on the understanding that the federal government would pay half of the cost.

Between 1971 and today, however, some serious questions have arisen about our ability to deliver on the promises. In the last year those doubts have taken on many ominous forms, the latest of which is the suggestion by University of Western Ontario economist Ake Blomqvist that Canada should turn back the clock to a system of unsubsidized health insurance.

His premise is that in the process of ensuring equal access to medical services the system is becoming unacceptably inefficient and costly.

Governments, hospitals and doctors might possibly agree with him if the test of the marketplace were the only criterion, but since it isn't, the suggestion is no more acceptable today than it was before 1966.

Having said that, however, it is evident that a crisis is building, if it hasn't already arrived.

The latest issue of the British Columbia Medical Journal talks of widespread antagonism, aggravation and resentment among doctors toward medicare. It points to government restraints, fees that have fallen behind the rate of inflation, and a profession that sees itself isolated from everything but the public it serves.

"In truth," it says, "union leaders in the hospital non-professional staffs probably have more input to administration than do doctors."

So far the disillusionment of B.C.'s 4,500 doctors has not led to the kind of militancy evident in Alberta, Manitoba, Saskatchewan, Ontario, and the Atlantic provinces, where doctors are either billing more for their services or are opting out. But it could happen here, unless the erosion of confidence is soon stopped.

A lot of what has happened can be traced back to 1977 and the seemingly innocuous Established Programs Financing Act, under which Ottawa transferred to the provinces responsibility for medicare.

Until then, a province could get a federal health care dollar only by laying out a matching dollar. Now it gets a number of dollars determined, essentially, by the size of the Gross National Product — entirely unrelated to its own health care outlays.

The end result is that some provinces have been putting the federal funds into their treasuries rather than into their health care systems, forcing citizens to make up the difference.

That is not only breaking faith with Ottawa and breaching the trust of Canadians. It is risking the collapse of the entire system.

Blomqvist's views are those of an economist looking at what The Fraser Institute's book title describes as The Health Care Business. We don't think it should be a business at all, but a service. And so should any government that made a commitment to Canadians in 1966.

pure speculation about future revenues, together with overly optimistic assumptions about health care and other costs going forward. In other words: such talk is based upon speculation about the future state of the economy. Moreover, such target dates serve only to get an incumbent government past any election that will precede the target date for balancing the budget.

Given the fact that planned future budget balancings founded on speculation may never be realized, and given the various budgetary problems associated with allowing the debt to climb in a period of limited economic growth, there is no justification for waiting for the right time to balance the budget. The right time is *now*.

Fortunately, there is a way to balance the Ontario budget now. Moreover, it can be done now in a way that actually *improves* health care while keeping its cost within an economically feasible range.

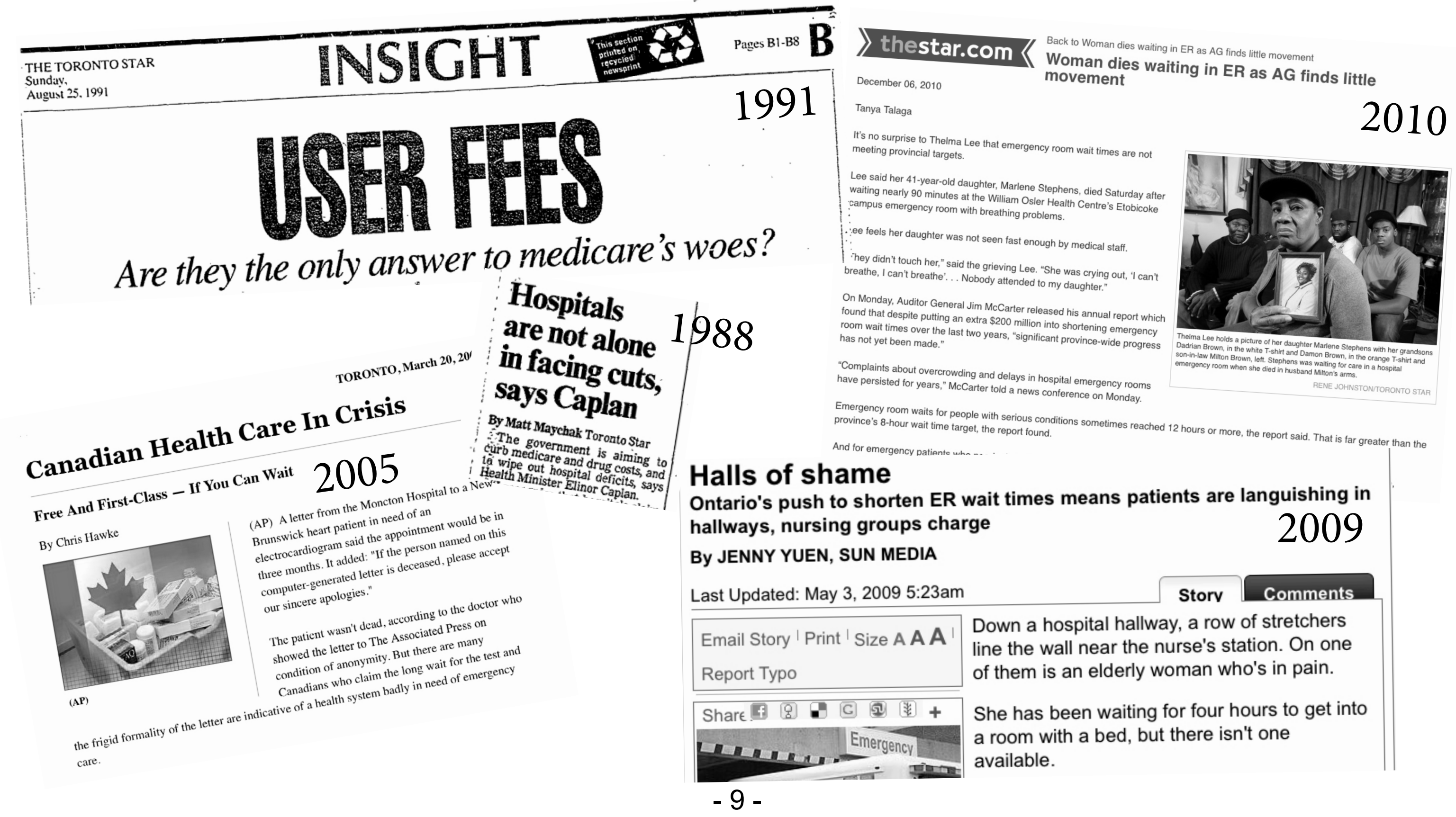
What follows is Freedom Party of Ontario's Opposition Budget for the year 2015. We acknowledge from the outset that some of the associated changes required might take months to implement, but we regard the commencement of that implementation to be something done pursuant to a 2015 budget.

PART IV: THE OPPOSITION BUDGET

Overview

The Opposition Budget makes 11 recommendations in respect of the 2015 Ontario provincial budget, which are discussed in greater detail in the remaining sections of Part IV:

1. Take health care off-budget - discontinue tax funding for health care - thereby immediately reducing annual budgetary expenditures by $48.909B, and thereby insulating the Ontario budget from any future increase of health care expenditures.



THE TORONTO STAR
Sunday, August 25, 1991

INSIGHT

Pages B1-B8 B

1991

USER FEES

Are they the only answer to medicare's woes?

Hospitals are not alone in facing cuts, says Caplan

1988

By Matt Maychak Toronto Star

The government is aiming to curb medicare and drug costs, and to wipe out hospital deficits, says Health Minister Elinor Caplan.

TORONTO, March 20, 20

Canadian Health Care In Crisis

Free And First-Class — If You Can Wait

2005

By Chris Hawke

(AP) A letter from the Moncton Hospital to a New Brunswick heart patient in need of an electrocardiogram said the appointment would be in three months. It added: "If the person named on this computer-generated letter is deceased, please accept our sincere apologies."

The patient wasn't dead, according to the doctor who showed the letter to The Associated Press on condition of anonymity. But there are many Canadians who claim the long wait for the test and the frigid formality of the letter are indicative of a health system badly in need of emergency care.

(AP)

thestar.com

Back to Woman dies waiting in ER as AG finds little movement

Woman dies waiting in ER as AG finds little movement

December 06, 2010

Tanya Talaga

2010

It's no surprise to Thelma Lee that emergency room wait times are not meeting provincial targets.

Lee said her 41-year-old daughter, Marlene Stephens, died Saturday after waiting nearly 90 minutes at the William Osler Health Centre's Etobicoke campus emergency room with breathing problems.

Lee feels her daughter was not seen fast enough by medical staff.

"They didn't touch her," said the grieving Lee. "She was crying out, 'I can't breathe, I can't breathe'. . . Nobody attended to my daughter."

On Monday, Auditor General Jim McCarter released his annual report which found that despite putting an extra $200 million into shortening emergency room wait times over the last two years, "significant province-wide progress has not yet been made."

"Complaints about overcrowding and delays in hospital emergency rooms have persisted for years," McCarter told a news conference on Monday.

Emergency room waits for people with serious conditions sometimes reached 12 hours or more, the report said. That is far greater than the province's 8-hour wait time target, the report found.

Thelma Lee holds a picture of her daughter Marlene Stephens with her grandsons Dadrian Brown, in the white T-shirt and Damon Brown, in the orange T-shirt and son-in-law Milton Brown, left. Stephens was waiting for care in a hospital emergency room when she died in husband Milton's arms.

RENE JOHNSTON/TORONTO STAR

Halls of shame

Ontario's push to shorten ER wait times means patients are languishing in hallways, nursing groups charge

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Down a hospital hallway, a row of stretchers line the wall near the nurse's station. On one of them is an elderly woman who's in pain.

She has been waiting for four hours to get into a room with a bed, but there isn't one available.

2. Set up a Crown corporation, funded solely by OHIP insurance premiums, to administer OHIP. Premiums initially to be set for all insured individuals at the approximate $3,575 per annum *per capita* cost of health care for 2013-2014[13].

3. Repeal Ontario's production taxes, so that Ontario residents have the money they need to purchase their choice of health care payment options: OHIP, private health insurance, or cash/credit payment.

4. With the exception of the HST, repeal Ontario's consumption taxes. Transfer from the Ministry of Finance to the Ministry of Community and Social Services the estimated $0.554B savings resulting from the discontinuation of provincial tax administration.

5. Impose a 2.3% increase in the HST rate to fully offset the revenue lost from the repeal of Ontario's other consumption taxes.

6. Secure from the federal government - on an inflation-indexed annual basis - the $2.974B federal portion of the HST windfall that will result from repealing the aforementioned production and consumption taxes.

7. Eliminate all-day kindergarten (a savings of over $1.5B per annum) as recommended by the Drummond Report.

8. Immediately eliminate the Ontario Clean Air Benefit ($1.0B) as recommended by the Drummond Report. Redirect that $1.0B to the Ministry of Community and Social Services.

9. Institute a health premium voucher system for those individuals (and their dependents) who are unable to work due to a disability, and who are receiving ODSP so that an inability to earn health premiums is not a bar to the purchase of OHIP or other, competing health insurance.

10. Impose an overall budgetary spending reduction of 6% as compared to 2013-2014 expenditures on non-health items.

11. With respect to reducing budgetary spending by 6%, focus upon bringing public sector wages in-line with average private sector wages paid for similar work via a *Public-Private Pay Equity Act*.

Competition & Choice, Not Privatization

Ending the Ontario government's health insurance monopoly does *not* require privatization of OHIP. It requires the restoration of *competition*, and a re-establishment of the economic link between the provider of health care services, and the purchasing decisions of the patient. Competition does not imply that the government should cease to offer insurance (i.e., OHIP) for health care services. It means that patients should be able to choose alternatives to OHIP, such as private insurance or cash/credit payments. It means that health care should cease to be funded by tax revenues; that it should be an *off-budget* expense of Ontario residents. That implies that taxes currently collected to pay the cost of health care must be reduced or eliminated so that Ontario residents have the money they need to purchase the health care or health insurance of their choice. It means that those who choose to continue to be covered by OHIP will pay OHIP directly for that insurance, rather than paying for OHIP through taxes. It means that those who choose to be covered by another insurer will pay that insurer for the insurance, and that those who choose not to purchase insurance will be free to save their money and pay health care providers directly for the services they obtain, when they obtain them.

Nor does ending the government's monopoly necessarily imply discontinuing the practice of

13 Ontario's population as at July 1, 2014 was 13,678,740 (Source: Ontario Fact Sheet January 2015 - http://www.fin.gov.on.ca/en/economy/ecupdates/factsheet.html

providing free health care to those who can produce little or no income. According to the Ministry of Community and Social Services, the number of disability (ODSP) benefits beneficiaries (including adults and children) was 448,515 in September of 2014, all of whom are entitled to free health care from Ontario's health care monopoly by virtue of their Ontario residency. The *per capita* cost of health care in Ontario (based on population figures set out in the Ministry of Finance's January 2015 Fact Sheet) is approximately $3,575. The maximum annual cost of providing $3,575 health premium vouchers to all ODSP beneficiaries would be approximately $1.603B.

Federal Funding Implications of Ending the Ontario Government's Healthcare Monopoly

Owing to early 20th century fiscal arrangements between the federal and provincial governments respecting the jurisdiction to tax income and respecting the federal government's adoption of central planning, the federal government to this day transfers federal revenues to Ontario's provincial coffer. Currently, the federal funds are categorized as transfers relating to health, education, and welfare (i.e., the Untouchables). According to the Outlook, one such transfer - the Canada Health Transfer - amounted to a $11.940B contribution to the provincial coffer in 2013-14.

The *Canada Health Act* ("*CHA*") is a federal statute. Two common fallacies - promoted by proponents of a government health care monopoly - continue to fog the path to a sustainable system of health care. One fallacy is that the *CHA* limits the legislative discretion of the provinces in respect of health care. That is false because Canada's constitution dictates that the making of health care legislation falls *exclusively* within the jurisdiction of the provincial Legislature.

The other fallacy is that allowing such things as private sector health insurance, direct payments by patients to health care providers, or the elimination of tax-funding for government health insurance would violate the *CHA* and cause a reduction in Ontario's portion of the Canada Health Transfer. As explained below, that assertion is equally false.

Section 15 of the *CHA permits* (but does not require) the Governor in Council to order a reduction in the Canada Health Transfer to a province that lacks a "health care insurance plan" meeting the five conditions or "principles" set out in sections 8 through 12 the *CHA*.

> **Subsection 8(1)(a):** "In order to satisfy the criterion respecting public administration, the *health care insurance plan* of a province must..."
>
> **Section 9:** "In order to satisfy the criterion respecting comprehensiveness, the *health care insurance plan* of a province must..."
>
> **Section 10:** "In order to satisfy the criterion respecting universality, the *health care insurance plan* of a province must..."
>
> **Section 11(1)(a)/(b)/(c):** "In order to satisfy the criterion respecting portability, the *health care insurance plan* of a province must..."
>
> **Section 12(1)(a)/(b)/(c)/(d):** "In order to satisfy the criterion respecting accessibility, the *health care insurance plan* of a province must..."

In each partial quotation above, the phrase "health care insurance plan" has been italicized because to know what sort of health care system satisfies those five conditions requires one to take note that the five conditions apply *only* to what section 2 of the *CHA* defines as a "health care insurance plan":

> "health care insurance plan" means, in relation to a province, *a plan* or plans *established by the law of the province* to provide for insured health services (*emphasis* added)

That definition makes it clear that, throughout the *CHA*, the term “health care insurance plan” does *not* refer to a plan that is *not* “established by the law of the province”. It does *not* refer to the provision of health care services, to *private* health insurance plans, or to *private cash payments* for health care services.

A proper interpretation of the *CHA* requires a recognition of the fact that:

1. the *CHA* neither states nor implies that the “health care insurance plan” of the province” be the *only* health insurance plan in the province;

2. the *CHA* neither states nor implies that the province prohibit the purchase and sale of for-profit or non-profit health care insurance that is administered and operated by private persons; and

3. the *CHA* neither states nor implies that the province must compel individuals to pay for, or be covered by, the province’s “health care insurance plan”: the *CHA* does not require that all Ontarians be covered by OHIP. Rather, section 12 (“Accessibility”) of the *CHA* requires only that the health care insurance plan of a province “...provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province.” The *CHA* is crafted to be compatible with a wide variety of payment models. Nothing in the *CHA* requires the province’s “health care insurance plan” to be paid for with provincial revenues (e.g., tax revenues). Even a *voluntary* payment of premiums by only those who choose to participate in a province’s “health care insurance plan” constitutes a “system of payment” that could be “authorized by the law of the province”.

In short, the *CHA* does not require Ontario to have a tax-funded government health insurance monopoly, or to prohibit health care providers from receiving their pay from patients or their respective private sector health insurers. Accordingly, the discretion given to the Governor in Council in section 15(2) of the *CHA* would not be triggered by allowing private sector payment alternatives to OHIP (e.g., private health insurance or cash payment), or by allowing health care providers to accept payment not only from OHIP but also directly from patients or from their private sector insurers. Ending Ontario’s governmental health monopoly would *not* give the Governor in Council the discretion to reduce Ontario’s Canada Health Transfer.

Budget Implications of Ending the Ontario Government’s Health Care Monopoly

As explained in Part I, the broad budgetary picture is as follows. Based upon the most recent “Actual” budget data set out in the Outlook (i.e., data for 2013-2014):

Total Revenue:	$115.911B
Total Expense:	$126.364B
Deficit:	$ 10.453B

Ontario health care spending is chiefly comprised of Health and Long Term Care ($48.909B). Making OHIP the responsibility of a Crown corporation funded by insurance premiums rather than tax revenues would remove this spending from the budget, leaving a net budgetary expenditure of:

$126.364B - $48.909B = **$77.455B**

The Harmonized Sales Tax (“HST”) is a *consumption* tax administered not by Ontario’s Ministry of Revenue, but by the Canada Revenue Agency (“CRA”). In 2013-14, Actual revenue from the 8% provincial sales tax portion of the HST was $20.481B.

According to the Outlook, in 2013-14, the remaining Ontario provincial taxes raised the following revenues (in Billions), respectively:

Consumption Taxes

Gasoline Tax	2.363
Land Transfer Tax	1.614
Tobacco Tax	1.110
Fuel Tax	0.718
Beer & Wine Taxes	0.557
Electricity Payments-in-Lieu of Taxes	0.543
"Other Taxes"	0.360
Sub-total	7.265

Production Taxes

Personal Income Tax	26.929
Corporations Tax	11.423
Education Property Tax	5.457
Employer Health Tax	5.283
Ontario Health Premium	3.128
Sub-total	52.220
Total Revenue from Provincial Taxes other than HST	**59.485**

It will be noted that Ontario's health care expenditure of $48.909B is paid for entirely by production taxes totaling $52.220B. This indicates a further disadvantage of our single-payer, tax-funded model of health care funding: it accounts almost entirely for a regime of taxes that discourages production, earning, and saving in the province.

Federal HST Windfall Transfer

This Opposition Budget recommends that Ontario's Consumption Taxes and Production Taxes, listed above, be repealed, leaving HST as the sole source of provincial revenue. The $59.485B revenue no longer collected through the repealed Ontario Consumption and Production taxes will thereby be left in the hands of the taxpayer. Those funds will be used to purchase goods and services, which will be taxed by the HST. Accordingly revenues from the HST will increase. Given that the HST revenue increase will be attributable to the repeal of Ontario's production and consumption taxes (other than HST), there can be no justification of a $59.485B x 5% = $2.974B federal windfall. The 5% federal portion of the HST windfall is rightly payable to the province given that the windfall will be the result solely of tax restructuring at the provincial level. It is therefore recommended that the province demand an annual federal HST Windfall Transfer of $2.974B indexed to the rate of inflation.

Tax Administration Cost Reduction, Social Assistance Beneficiaries: Voucher

Following the election of 2011, Ontario's Ministry of Revenue was merged with the Ministry of Finance. In 2012, the Ontario government adopted a new accounting standard, and modified its historical record of ministerial expenses. Accordingly, it is now difficult to disentangle the effects of these two changes. For example for the 2010-11 year, Ontario's 2011, 2012, and 2013 economic outlooks have stated the Ministry of Finance's expenses to be $0.496B, $1.115B, and $1.050B, respectively. The Ministry of Revenue's expenses for 2010-11 was not reported in the 2012, 2013, and 2014 economic outlooks but, in the 2011 outlook, that ministry's expenses for the year 2010-11 were reported to be $0.900B. Accordingly, the responsibilities of the former Ministry of Revenue can be estimated now to represent approximately $0.900B / ($0.496B + $0.900B) = 64.5% of the budget of the Ministry of Finance following its merger with the Ministry of Revenue. The Ministry of Finance's 2013-14 expense, as reported in the Outlook for 2014, is $0.889B, such that 65.5% of that budget ($0.573B) is the approximate cost associated with collecting Ontario's consumption and production taxes (other than the provincial sales tax, which is collected at the expense of the Canada Revenue Agency as part of the HST).

As at September of 2014, the number of adults and children receiving Ontario Works ("OW") employment and financial assistance sat at 446,537 (resulting from 246,880 claims by individuals or families)[14]. The number receiving Ontario disability income and employment support

14 Ontario Works Monthly Statistical Report for September 2014 - http://www.mcss.gov.on.ca/documents/en/mcss/social/reports/OW_EN_2014-09.pdf

(“ODSP”) was 448,515 (resulting from 324,641 claims by individuals or families)[15]. Statistics are not readily available concerning how many ODSP claimants are also OW claimants. Statistics are similarly elusive with respect to the number of OW and ODSP recipients who are working and earning an income. Actual health care expenditures totaled approximately $3,575 *per person* for 2013-14. Were unemployment to entitle one to free health care, the per person cost of health care could provide a perverse disincentive to accept employment that would disentitle one to social assistance yet leave one earning less, after paying for ones family’s health care, than one would be left with were one unemployed and receiving social assistance. Accordingly, it is recommended that all earnings or federal assistance (e.g., Employment Insurance benefits) spent by a social assistance claimant upon health care premiums (for the claimant or his/her dependents) - to a maximum of $3,575 per claimant or claimant’s dependent - be excluded from the claimant’s deemed income for the purposes of assessing the claimant’s eligibility for social assistance. Those individuals who are unable to work due to a disability, and who are receiving ODSP, should be provided with a health premium voucher having a value of $297.92 per month ($3,575 per year) per ODSP claimant or ODSP claimant’s dependent.

Assuming the worst-case scenario in which all 448,515 ODSP beneficiaries are unable to work, the cost of extending $3,575 health premium vouchers to all ODSP beneficiaries would be $1.603B. The $0.573B saved from eliminating the Ministry of Finance’s tax collection role should be earmarked for the Ministry of Community and Social Services to offset some or all of the latter Ministry’s added budgetary burden resulting from the health premium voucher system. Almost all of the remaining cost of the system (up to $1.030B) should be offset by eliminating the Ontario Clean Energy Benefit ($1.000B), as recommended by the Drummond Report, and shifting that $1.000B to the Ministry of Community and Social Services.

Balancing the Budget

Based on 2013-14 Actual figures set out in the Outlook, the provincial sales tax portion of the HST raised revenues of approximately $20.481B. The aforementioned $59.485B in tax savings realized by taxpayers from the repeal of Ontario’s production and consumption taxes (other than the provincial sales tax component of the HST) would be spent by taxpayers on goods and services, such that total provincial revenues (including the federal HST Windfall Transfer) would be increased by virtue of the application of the 13% HST to those expenditures: $59.485B x 13% = $7.733B.

Taking $48.909B in health expenditures off-budget, repealing $59.485B in Ontario taxes, and increasing provincial HST revenues by $7.733B changes the budget picture as follows:

Current Total Expenditures........	$126.364B
minus Health Expenditures.......	(48.909B)
Net Expenditures	**77.455B**
Current Total Revenues......... ...	$115.911B
minus Ontario Taxes...............	($59.485B)
plus additional HST revenue......	$7.733B
Net Revenues	**64.159B**
Surplus/(Deficit).........................	(**13.296B)**

The following recommendations would reduce the $13.296B deficit noted above to the point of balancing the budget:

1. As recommended by the Drummond Report, eliminate all-day kindergarten ($1.5B).

2. Increase the HST rate sufficiently to offset the $7.265B in revenues lost from the repeal of the aforementioned Consumption Taxes. After taking into account ad-

15 Ontario Disability Support Program Statistical Report for September 2014 - http://www.mcss.gov.on.ca/documents/en/mcss/social/reports/ODSP_EN_2014-09.pdf

ditional HST revenue realized from the repeal of Ontario's Consumption and Production Taxes, the 8% provincial portion of the HST (excluding the federal HST Windfall Transfer) would provide Ontario with $20.481B + $7.733B - $2.974B = $25.240B. Each percentage point of increase in the provincial portion of the HST would account for $25.240B / 8 = $3.155B. Accordingly, a 2.3% increase in the HST rate would result in an HST revenue increase of 2.3 x $3.155B = $7.265B. A 2.3% rate increase to the Ontario portion of the HST (i.e., 10.3% instead of 8%) is recommended in order to offset fully the $7.265B revenue loss resulting from the proposed repeal of Ontario's other Consumption Taxes.

3. The two recommendations above would leave a difference of:

Gross Deficit	$13.296B
Kindergarten	($1.500B)
Increased HST	($7.265B)
Net Deficit	**$4.531B**

It is recommended that the remaining $4.531B deficit be addressed through an additional overall budgetary spending reduction of **6%** as compared to 2013-2014 Actual spending on non-health budget items:

6% x 77.455B = $4.647B

The reduction would leave a surplus of: $3.750B - $3.630B = $116M. It is recommended that that surplus be earmarked for any shortfall of funds needed to fund health care vouchers to ODSP recipients and for the costs of transitioning to a competitive, off-budget health care system, including the creation of a crown corporation to administer OHIP.

Conclusion

This Opposition Budget provides a means of balancing Ontario's budget in 2015. It strikes the right balance between spending restraint and tax rate increases.

This Opposition Budget also provides a fix to the economic flaw inherent in the single-payer, tax-funded government monopoly system of health care delivery currently in place in Ontario. By re-establishing the economic link between patient and health care provider, and restoring competition, market forces will act to control health care costs while maximizing the per-dollar quality of health care provided.

If implemented, this Opposition Budget will stimulate economic activity in the province by providing North America with a jurisdiction having a low tax burden, and low tax administration burden. In fact, Ontario will be one of only 8 Canada-US jurisdictions imposing no tax on income (the other seven are Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming). It will position Ontario as North America's preferred centre for production, earning, saving, investment and innovation. With an aging population, the opening of health care to competition will make Ontario the site of a growing health sector.

As leader of Freedom Party, I hereby heartily recommend a serious consideration of this Opposition Budget by the honourable members of the Ontario Legislature, and by those who dutifully report on their actions...and omissions.

All of which is hereby respectfully submitted this 10th day of February, 2015.

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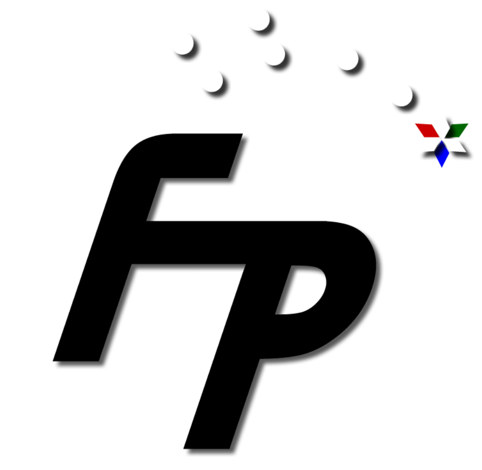

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