

Buying Health Change? The 2005 Survey of High Earner Pay in Ontario's Hospitals

Main Conclusions

- Ontario hospital payrolls for employees earning at least \$100,000 rose by more than 18 percent to \$365 million in 2004, a surprisingly large amount given that SARS temporarily boosted payrolls in 2003
- Average salaries for employees holding jobs for at least two consecutive years rose by 6.6 percent last year, compared to inflation of 1.8 percent and an average economy-wide wage gain of 1.2 percent
- Forty percent of the payroll increase came from employees newly crossing the \$100,000 threshold. Just over a quarter came from executive wage gains and the other 35 percent was generated by non-executive wage gains.
- There were 342 more of these high earning workers (of 2,302 in total) last year. Pay for high earners ranges from an average of almost \$149,000 for non-executives to an average over \$250,000 for presidents and CEOs.
- The number of high earners in hospitals has more than tripled since 1996 and average pay has risen by more than two-thirds for those holding jobs for at least two consecutive years.
- Once spending restraint ended in the late 1990s, the high earner payroll increased more than three times as fast as provincial hospital transfers. Thus, greater health transfers are seemingly driving wage inflation
- It is difficult to assess the value-for-money benefits arising from these wage increases, as individual- or hospital-level productivity data are mostly unavailable
- However, statistical tests show no relationship between pay increases and hospital performance measures—and waiting lists also lengthened in 2004. This suggests that the extra pay did not necessarily buy better health care.
- The public sector health system, as currently structured, is driving costs higher without producing better health services. The best way to encourage better allocation of hospital funds and to increase access and quality of care is to introduce competitive markets in health services and insurance.



Mark Mullins is the Director of Ontario Policy Studies at the Fraser Institute in Toronto. He has a doctorate in economics from the London School of Economics and was formerly a chief economist in the financial markets and a public policy consultant.

Introduction

Half of Ontario's \$33 billion in public health care spending goes to the hospital sector and at least three-quarters of that amount is labour income.¹ Since health spending is the largest single factor affecting provincial finances (and is expected to be over 46 percent of all program spending during the current provincial government's mandate), it is crucial to monitor hospital pay trends.²

Accordingly, this is the second annual Fraser Institute survey of hospital pay that focuses on high earning employees, those making over \$100,000. This survey is the only comprehensive and detailed database that can be monitored on an annual basis, though it is a somewhat limited indicator of overall pay trends for all hospital workers.³

This *Alert* examines the recently released 2004 pay information in the context of recent trends.⁴ A value-for-money assessment follows, as do various policy recommendations. The appendix provides details of data and methodology.

Hospital employees earning over \$100,000

Ontario has a unique database from which to examine the high end of the income distribution: all hospital employees with income over \$100,000 are required to publicly disclose their pay each year.⁵

Figure 1 shows that total spending on these high-level employees has more than tripled since 1996, the first year of required disclosure. The annual average growth rate of 18.1 percent is more than three times higher than the 5.5 percent annual growth in provincial funding for hospitals over the same period. Payrolls rose 18.3 percent in 2004, slightly above the eight-year average rate.

Moreover, spending on these workers exactly coincides with trends in hospital financing by the government. Restraint in spending transfers from 1996 to 1999 was reflected in little growth in high-level payrolls. The acceleration in overall provincial transfers to hospitals since then has led to a sharp increase in payrolls, suggesting that funding is driving wage inflation and the number of high

earners (up 17.4 percent, as shown in Figure 2).

Figure 3 shows average income growth, calculated as a true price index of pay, using only individuals with adjacent years of income data and weighting according to their proportion of income. This average income growth has been 6.6 percent annually (4.5 percent after inflation) since 1996 and it accelerated after 1999.⁶ The 2004 increase of 6.6 percent (4.8 percent after inflation) is just above the eight-year average growth rate.⁷

Last year's salary survey suggested that there might be a SARS effect that boosted the number of employees earning just over \$100,000 and just over \$200,000, owing to overtime pay (shown in figure 4). Though that might still be true, the number of high earners by income category in 2004 has continued to go up in line with historic trends. Thus, there has been no apparent post-SARS savings from moderation in high earner payroll growth.

Table 1 shows high earner pay by occupation.⁸ There is, unsurprisingly, a hierarchy of average incomes, commensurate with

Figure 1: Hospital Spending and Employees Earning Over \$100,000

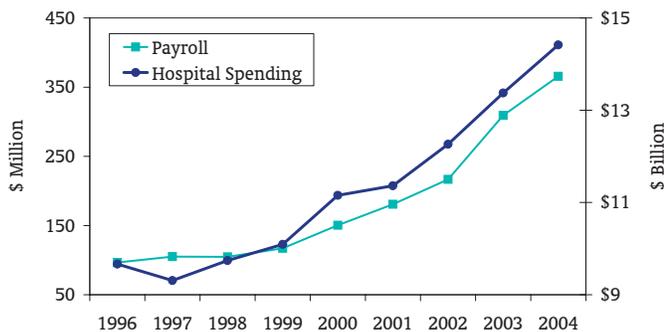
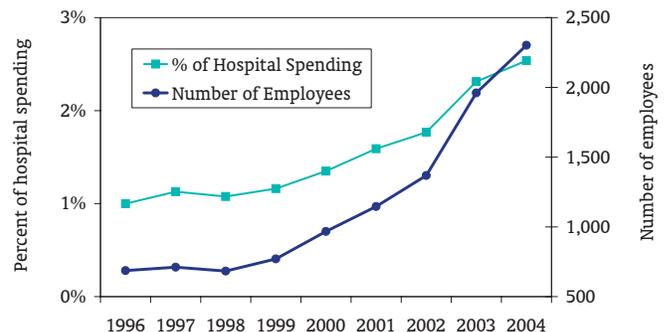


Figure 2: Hospital Employees Earning Over \$100,000



**Figure 3: Average Income Growth Rate
Hospital Employees Earning Over \$100,000**

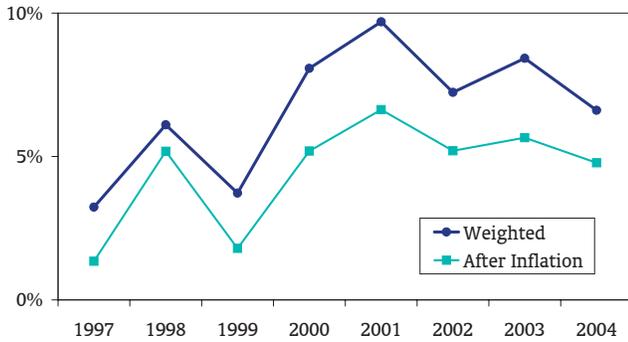


Figure 4: Number of Employees by Income

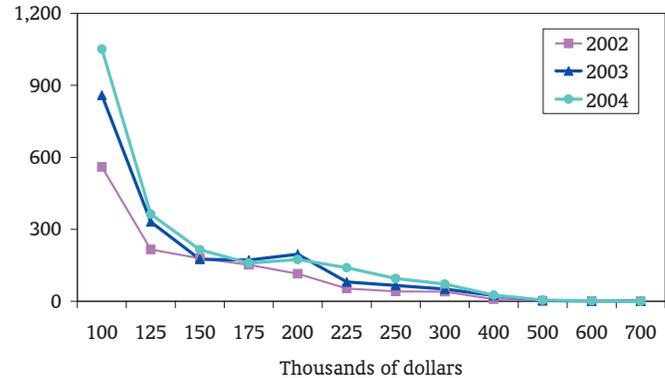


Table 1: Employees by Occupation

Occupation	Average	Total
	Income 2004	Income 2004 (\$m)
Executives	\$213,254	\$77
President & CEO	\$250,549	\$31
Medical Executives	\$202,749	\$21
Other Non-Medical Executives	\$187,800	\$25
Non-Executives	\$148,697	\$288
All Earners over \$100,000	\$158,877	\$366

Source: Government of Ontario; author's calculations.

corporate status and responsibility, with Presidents and CEOs earning the most and non-executives the least.⁹ A breakdown shows that 40 percent of the payroll increase came from employees newly crossing the \$100,000 threshold, just over a quarter came from executive wage gains, and the other 35 percent was generated by non-executive wage gains.

In summary, this section has found that numbers of, spending on, and average pay of high earners have increased sharply again in 2004. The gains are slightly above historical norms and there is no evidence of post-SARS savings.

Value-for-money assessment

The appropriate level and growth of earnings is a relative concept, related to the value of labour services delivered. Unfortunately, it is very difficult to assess the value-for-money benefits arising from these wage increases, as individual- or hospital-level productivity data are mostly unavailable.

As an alternative, this *Alert* examines wage growth in relation to various hospital-level measures of performance. Specifically, nine

indicators were taken from the latest *Ontario Hospital Report*¹⁰ and they were correlated to an index of high earner pay at the hospital level. The nine indicators are: total margin, unit cost, corporate services, days in inventory, current ratio, working capital, equipment expenditure, nursing hours and patient hours.¹¹

As Table 2 shows, none of these performance measures except for the current ratio are statistically related to pay growth.¹² In fact, the combined impact of all of the indicators accounts for less than 5

Table 2: Explaining High Earner Pay Growth

Variable	All Variables		
	Estimate	T-Stat	
Type of Hospital	Teaching hospital	-0.014	-0.6
	Small hospital	-0.016	-0.6
Financial Viability	Total margin	-0.007	-1.1
	Unit cost	-0.001	-0.1
Efficiency	Corporate services	0.003	0.5
	Days in Inventory	0.004	0.5
Liquidity	Current ratio	0.043	2.0
	Working capital	-0.021	-1.0
Capital	Equipment expenditures	-0.007	-1.1
	Nursing hours	-0.009	-1.2
Human Resources	Patient hours	-0.011	-1.6
	Constant Term	0.072	1.3
Adjusted R-squared	4.6%		

Source: Author's calculations.

percent of the hospital-to-hospital variation in pay growth. A further examination using five-year annual average pay growth and the average level of pay showed the same absence of any relationship between pay and these measures of performance.

Another measure of productivity is the extent to which the system is accessible by patients. Figure 5 shows that waiting times for hospital procedures have increased by 46 percent since 1996 (from 5.6 weeks to 8.2 weeks last year),¹³ at the same time that hospital spending has risen 49 percent (from \$9.7 billion to \$14.4 billion). The increase in waiting times was especially marked in 2004. As discussed above, high earner pay and numbers grew much faster than this over the same period.

In summary then, this section shows that there is no relationship between pay increases and hospital performance measures—and waiting lists also lengthened in 2004. This suggests that the extra pay did not necessarily buy better health care.

Policy recommendations

The public sector health system is driving costs higher by raising pay without producing better health services. The current policy mix rations care, thus promoting waiting lists and inaccessibility to save money, and relies on constant increases in taxation to fund the rise in health spending.

A better approach would be to encourage a market structure that would impose a competitive discipline on health providers and offer more choice and responsibility for patients.¹⁴

Such a structure would result in worker pay reflecting relative skills and productivity, rather than being a function of political allocation by the Ministry of Health to competing stakeholders. Funds for expanding the amount and quality of health care would come from private producers and a dynamic competitive insurance market.

A first reform is to move the hospital funding model from an annual grant to a service-basis, where money flows follow patient

volumes and the type of treatment, thus beginning to introduce market demand preferences to the system. International evidence suggests that equity, resource use efficiency, and patient outcomes would improve.¹⁵

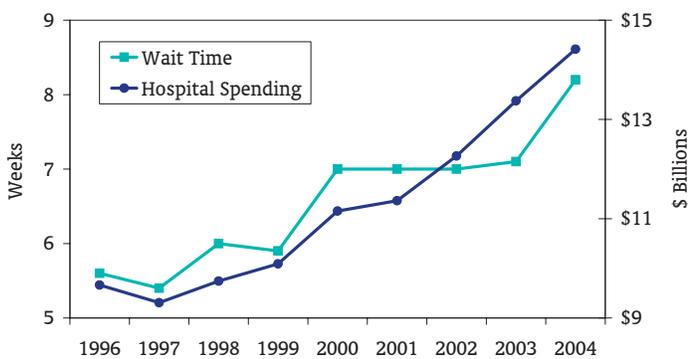
A second set of reforms would introduce incentives for appropriate use of funds.

Hospital services priced at true cost, explicit charges for specialist use of facilities, and competitive tendering for provider services would provide pricing signals for supply-side service provision. The introduction of insurance concepts of co-payment, deductibles, cost sharing, and user fees would introduce patient responsibility for service and further decentralize and depoliticize decision-making.¹⁶

The third major reform would be to introduce competitive markets in hospital service provision and health insurance. International evidence from Sweden, France, Australia, the United Kingdom, Japan, the United States, and elsewhere suggests that competitive forces can reduce costs and enhance patient outcomes.¹⁷

Some of these reforms would require modifications to the Canada Health Act and the way that its provisions are enforced. This political obstacle stands in the way of a better allocation of health care dollars and an increase in the amount and quality of health care in Ontario.

Figure 5: Hospital Spending & Wait Times After Specialist Appointment



Appendix

DATA SOURCES:

Income for employees earning over \$100,000: Government of Ontario, Ministry of Finance

Consumer price inflation and hourly compensation: Statistics Canada

METHODOLOGY:

Income for employees earning over \$100,000: Hospital employees were separated from those at public health boards and the data files were corrected for clerical errors. Data were collected separately from several hospitals that had not been included in the Ministry database. Income is defined as salary paid plus taxable benefits. Hospitals were consolidated according to industry changes since 1996. An income range field was added, as was one for occupation. The occupational definitions are as follows:

President & CEO: President and/or CEO

Non-Medical Executives: CAO, CFO, CHRO, CIO, COO, Executive Director, Executive VP, Executive and/or Chief of management section

Medical Executives: CMO, CNO, and/or Chief of medical section

Non-Executives: All others

Notes

- ¹ See *Where Does the Money Go? A Study of Worker Pay in Ontario's Hospitals*, Fraser Alert, Fraser Institute, September 2004, for a discussion of the derivation of these figures.
- ² See Government of Ontario, Ministry of Finance, *Budget Papers*, 2004.
- ³ See *Where Does the Money Go?* for a broader discussion of Canadian Census and other data sources that are published less frequently. That study found that hospitals have wage premiums for most occupations, especially executives and unionized employees, but that physicians are relatively underpaid.
- ⁴ The pay information was released on March 31, 2005 by the Government of Ontario.
- ⁵ See Ontario's Public Sector Salary Disclosure web site at <http://www.gov.on.ca/FIN/english/psecteng.htm>.
- ⁶ Note that this index captures the effect of individual promotions and job changes for individuals and ignores the impact of those who are dismissed or leave the hospital sector. This will impart an upward bias to the pay index. However, it is a reasonable representation of income changes for those workers with a minimal amount (two consecutive years) of job tenure in the hospital sector.
- ⁷ For comparison, the consumer price index rose 1.8 percent in 2004 and average Canadian hourly compensation rose by 1.2 percent.
- ⁸ See the Appendix for a discussion of data issues associated with this classification.
- ⁹ See *Where Does the Money Go?* for a discussion of other occupational results.
- ¹⁰ See *Hospital Report 2003: Acute Care*, Canadian Institute for Health Information, 2003.
- ¹¹ See *Ontario Hospital Report* for more information about these measures. Seventy-three hospitals had a full set of these performance data and the pay index, defined as above for employees with two consecutive years of employment. The performance indicators are measured on a quintile basis. The statistical regression also includes dummy variables to test for the impact of the three types of hospitals: teaching, small, and community (with the effect of the latter included in the constant term estimate).
- ¹² Statistical significance is commonly defined as t-statistics for individual indicators of at least 1.96. The current ratio is marginally significant and suggests that hospitals with more liquidity tend to have higher pay increases. However, the other liquidity variable, working capital, is statistically insignificant and has a negative relationship to pay raises. This contradiction places the current ratio result in some doubt.
- ¹³ See Nadeem Esmail and Michael Walker, *Waiting Your Turn: Hospital Waiting Lists in Canada* (14th edition) Vancouver: Fraser Institute, 2004.
- ¹⁴ This approach is discussed by Mike Harris and Preston Manning in *A Canada Strong and Free*, Fraser Institute, 2005, and includes guaranteed universal insurance coverage.
- ¹⁵ See Chapter Two of the "Kirby Report," *The Health of Canadians—The Federal Role*, The Standing Committee on Social Affairs, Science and Technology, 37th Parliament of Canada at <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/repoc02vol6-e.htm>. Nadeem Esmail, "A Better Way to Pay for Hospital Services," *Fraser Forum*, June 2004 also shows the gains from introducing such a payments system in Canada.
- ¹⁶ Nadeem Esmail and Michael Walker, *How Good is Canadian Health Care?* Fraser Forum Special Issue, Fraser Institute, August 2002 note that several countries with these payment schemes produce superior access to health treatments and superior health outcomes at lower cost than Canada. The existence of lengthening waiting lists for elective surgery, while hospital funding grows, also suggests that structural change is required to improve access to health care, see Nadeem Esmail and Michael Walker (2004).
- ¹⁷ See Daniel Kessler and Mark McClellan, *Is Hospital Competition Socially Wasteful?* NBER Working Paper 7266, Cambridge, MA., 1999; Esmail and Walker (2002); and Brian Lee Crowley *et al.*, *Definitely Not the Romanow Report*, AIMS, Halifax, NS, 2002.