

Where Does the Money Go? A Study of Worker Pay in Ontario's Hospitals

Main Conclusions

- Hospital payrolls used up the entire increase in provincial government transfers to Ontario hospitals between the 1997 funding low and 2002
- Hospitals pay an overall premium for full-time workers, compared to other health sectors, other provinces, and the rest of the economy
- Those earning over \$100,000 in hospitals have tripled in number since 1996. Average pay has risen by almost 60 percent for those holding jobs for at least two consecutive years. Average executive pay has grown twice as fast as non-executive pay.
- These high-earner payrolls increased more than three times as fast as provincial hospital transfers, once spending restraint ended in the late 1990s
- Nurses, mid- and lower-level unionized workers, and senior management have relatively high pay, often 20 percent beyond the private sector and hospitals in other provinces
- Physicians, certain other high-level health professionals, and mid-level administrative staff have relatively low pay by comparison
- Average income for all Ontario physicians has declined for over three decades and is presently three-quarters of its peak 1972 level. Physician pay has dropped by half compared to average Ontario incomes. It is today at least one-third higher in the United States.
- As a result, physician numbers and patient care hours relative to population needs and relative to the experience of other countries are shrinking. This directly affects access to hospital and other health care.
- It is impossible for the public sector health system, as currently structured, to solve access and cost control issues at the same time. One requires more funds, while the other demands less.
- 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.



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Introduction

Ontario spends almost \$32 billion on public sector health programs, up 60 percent in nominal terms over the past decade. And this amount, equal to 6.4 percent of the provincial economy, is set to rise even further under the McGuinty government's four-year plan.¹

Health spending has been and remains the pre-eminent fiscal issue for the provincial government.

For example, public sector health spending rose by \$12.3 billion from 1995 to 2004, more than the cumulative \$9.8 billion provincial tax cut over that same period. The latest public sector health spending increase in 2003 also accounted for the bulk of that year's \$6.2 billion provincial deficit.²

As recent research showed, hospital-based spending likely makes up more than half of total public sector health care costs in Ontario.³ This amount includes hospital spending formally classified by the Canadian Institute for Health Information (CIHI), fee-for-service billings of physician specialists, provincial drug plan amounts spent in hospitals, and capital spending.

Given these multi-billion dollar spending pressures in health care, and high publicity accorded to numerous federal-provincial meetings to determine cost sharing, many people in Ontario wonder: Where does the money go?

This *Alert* answers one aspect of that question by examining worker pay in the hospital sector.

According to the Change Foundation, salaries and wages in Ontario

hospitals were \$8.2 billion in fiscal year 2002/03, exactly 60 percent of total expenses.⁴ To this can be added roughly \$1 billion in fee-for-service payments for physician specialists, covered by the provincial government and ultimately taxpayers. These payments compare to provincial hospital transfers of just over \$12 billion.⁵

This \$8.2 billion hospital payroll cost rose almost \$3 billion between 1997, the recent low in hospital spending, and 2002, the latest available data. That is more than the provincial government added to hospital spending over that period and almost 40 percent of

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the total increase in public sector health spending. Labour costs in hospitals are clearly central to the issue of public sector health spending and its growth.

This *Alert* therefore looks at hospital pay relative to other health sectors (physicians' offices, outpatient, nursing and residential care), other parts of the economy and other provinces. Physicians and those earning over \$100,000 are examined in more detail. The Appendix discusses the details of the databases used to examine these payments.

Hospital Pay by Occupation

The Census of Canada provides income information broken out by occupation and industry. Tables

1 and 2 look at average income, income relative to other sectors, industries and provinces, and the relative size of occupational payrolls.⁶ Table 1 looks at health occupations in hospitals and table 2 at non-health occupations, all ranked by average income within broad occupational categories. The numbers are shown on a full-year, full-time basis so that every occupation can be compared using the same standard.⁷

The tables show that nurses are the largest part of the hospital wage bill and they are relatively well paid compared to other health sectors, industries, and provinces.

This is also true for mid- and lower-level workers in social services, medical technology, administration, and support services.

There is clearly a hospital premium for most occupations, as measured by a high relative income. The very high-

est combined premiums are seen for support services (cleaning and cooking), nurses, social workers, and medical lab technicians.⁸

For example, light duty cleaners are paid 31 percent more in hospitals than in other industries, 17 percent more in Ontario than in other provinces' hospitals and 21 percent more than in the rest of the health sector. Politicized wage determination and an absence of competitive service tendering were the main factors behind these wage premiums in two studies of British Columbia hospitals.⁹

Physicians are the second largest part of the hospital sector wage bill. Here, it is important to distinguish between self-employed workers and those paid wages and

Table 1: Health Occupations in Ontario Hospitals

	Average Income (\$)	% Average Income Relative To:			Hospital Payroll (\$M)
		Other Industries	Other Provinces	Other Health Sectors	
Self-employed Physicians:					
Specialist physicians	\$195,314	N/A	110	102	\$136
General practitioners and family physicians	\$163,379	N/A	109	112	\$73
Wage and Salaried Physicians:					
Specialist physicians	\$103,290	110	99	94	\$178
General practitioners and family physicians	\$95,336	N/A	110	75	\$158
Nursing:					
Head nurses and supervisors	\$58,688	126	110	144	\$41
Registered nurses	\$51,911	109	114	127	\$1,630
Licensed practical nurses	\$37,666	113	113	121	\$121
Other assisting occupations in support of health services	\$33,796	121	108	125	\$72
Nurse aides, orderlies and patient service associates	\$32,755	120	112	120	\$132
Social Services:					
Psychologists	\$67,515	112	116	88	\$45
Therapy and assessment professionals	\$49,565	103	106	93	\$140
Social workers	\$49,093	115	103	125	\$66
Dietitians and nutritionists	\$43,572	95	96	125	\$36
Family, marriage and other related counsellors	\$41,839	113	99	122	\$26
Community and social service workers	\$39,813	113	105	121	\$18
Medical Technology:					
Pharmacists	\$61,220	88	103	N/A	\$49
Medical radiation technologists	\$53,122	94	116	111	\$113
Respiratory therapists, perfusionists and cardio-pulmonary technologists	\$51,106	78	108	80	\$63
Medical laboratory technologists and pathologists' assistants	\$48,187	110	104	117	\$143
Medical laboratory technicians	\$41,989	108	104	125	\$67
All Occupations in Ontario Hospitals	\$49,008	104	115	103	\$4,799

Note: Occupations shown are those comprising more than 0.5% of the total hospital payroll in 2000 for full-year full-time earners

Source: 2001 Canadian Census

salaries, as a majority of Ontario specialist physicians are self-employed while the vast majority of other hospital workers are not.

Even though physicians have the highest average incomes in hospitals, those on wages and salaries are paid at a discount compared to other health sectors. Only self-employed general practitioners (GPs) have a relative income that exceeds the averages for all hospital occupations; this presumably owes much to a different skill set

and activities from the other 92 percent of self-employed GPs outside hospitals. The issue of relative income for physicians will be examined in more detail later in this paper.

Physicians are thus paid absolutely high incomes but their relative hospital income tends to be below average. They are in the same relative income situation as certain other health professionals (psychologists, therapists, pharmacists) and mid-level management and administrative personnel.

The last group worth discussing is hospital management. Here, we see high absolute and relative incomes for high-level managers but low relative incomes for the mid-level professionals and other managers. The high-level group will be examined in more detail in the next section of this Alert.

Table 3 adds a time dimension to the discussion by comparing growth by occupation (both at hospitals and in the rest of the economy) between 1995 and 2000. The

Table 2: Non-Health Occupations in Ontario Hospitals

	Average Income (\$)	% Average Income Relative To:			Hospital Payroll (\$M)
		Other Industries	Other Provinces	Other Health Sectors	
Management:					
Senior managers - Health, education, social and community services	\$96,250	119	117	106	\$73
Managers in health care	\$65,771	108	103	127	\$119
Administrative services managers	\$63,016	87	110	118	\$59
Auditors, accountants and investment professionals	\$61,933	89	109	104	\$29
Computer and information systems professionals	\$50,177	82	95	112	\$33
Health policy researchers, consultants and program officers	\$47,674	89	103	104	\$43
Administration:					
Administrative and regulatory occupations	\$41,823	95	103	109	\$40
Accounting and related clerks	\$33,963	98	107	104	\$23
Recording, scheduling and distributing occupations	\$33,618	96	113	88	\$24
Medical secretaries	\$32,865	109	115	113	\$110
Court recorders and medical transcriptionists	\$32,799	95	103	93	\$22
Administrative clerks	\$32,593	90	107	96	\$45
Secretaries (except legal and medical)	\$32,560	99	108	114	\$44
Clerical occupations, general office skills	\$32,344	100	109	116	\$152
Support Services:					
Janitors, caretakers and building superintendents	\$32,598	105	109	111	\$33
Light duty cleaners	\$30,433	131	117	121	\$86
Food counter attendants, kitchen helpers and related occupations	\$29,709	158	116	113	\$48
All Occupations in Ontario Hospitals	\$49,008	104	115	103	\$4,799

Note: Occupations shown are those comprising more than 0.5% of the total hospital payroll in 2000 for full-year full-time earners

Source: 2001 Canadian Census

table shows five-year growth in employment and average income and also the share of hospital income in total occupational income.

The main point to take away from the table is that rising payroll costs are more a function of increased employment rather than a rise in inflation-adjusted average incomes. Many of the occupations showed large annual growth in jobs in the late 1990s, but only psychologists and pharmacists outpaced province-wide average income growth. The hospital sector as a whole saw full-time employment growth lag the rest of the economy (up 1.5 percent a year) and average income growth was also less than other industries.

Overall then, we see that nurses, mid- and lower-level workers, and senior management have relatively high pay. Physicians, other health professionals and mid-level management and administrative personnel have relatively low pay by comparison. Union power, constrained job markets, and the ability of management to influence pay are tempting explanations for these results.

Hospital Employees Earning Over \$100,000

The overall occupational numbers may mask underlying trends by focusing on averages rather than the full distribution of worker pay.

Ontario has a unique database to examine such detail at the high end of the income distribution: all hospital employees with income over \$100,000 are required to publicly disclose their pay each year.¹⁰

Figure 1 shows a dramatically different picture from the one discussed above. Total spending on these high-level employees has more than tripled since 1996, the first year of required disclosure. This annual average growth rate of 18 percent is almost four times higher than the 4.8 percent annual growth in provincial funding for hospitals over the same period.

Moreover, spending on these workers exactly coincides with the

Table 3: Occupation Growth in Ontario, Annual Growth Rate from 1995 to 2000

	<i>Number of Income Earners</i>	<i>Average Income in \$2000</i>	<i>Hospital Share of Income in 2000</i>
Physicians:			
Specialist physicians	0.1%	0.6%	41%
General practitioners and family physicians	0.1%	0.7%	19%
Nursing:			
Head nurses and supervisors	-8.2%	-1.0%	48%
Registered nurses	3.6%	1.0%	70%
Licensed practical nurses	3.0%	-0.1%	54%
Other assisting occupations in support of health services	7.4%	0.3%	28%
Nurse aides, orderlies and patient service associates	2.0%	0.2%	26%
Social Services:			
Psychologists	3.0%	2.4%	26%
Therapy and assessment professionals	5.7%	0.4%	40%
Social workers	4.7%	0.1%	12%
Dietitians and nutritionists	4.9%	-0.4%	51%
Family, marriage and other related counsellors	-7.1%	-0.4%	14%
Medical Technology:			
Pharmacists	2.6%	2.2%	12%
Medical radiation technologists	1.7%	0.8%	66%
Respiratory therapists, perfusionists and cardio-pulmonary technologists	7.2%	0.4%	83%
Medical laboratory technologists and pathologists' assistants	-0.3%	-0.2%	62%
Medical laboratory technicians	-3.0%	0.3%	44%
Management:			
Senior managers - Health, education, social and community services	9.6%	0.0%	15%
Managers in health care	4.7%	-0.4%	29%
Health policy researchers, consultants and program officers	6.3%	-0.5%	18%
Administration:			
Medical secretaries	1.4%	0.4%	37%
Court recorders and medical transcriptionists	2.9%	-1.0%	41%
Administrative clerks	-1.0%	0.2%	7%
Clerical occupations, general office skills	3.6%	1.0%	6%
Support Services:			
Light duty cleaners	8.0%	1.0%	15%
Food counter attendants, kitchen helpers and related occupations	2.9%	0.5%	11%
All Occupations in Ontario	3.2%	1.5%	3%

Note: Occupations shown are those with more than 0.5% of the total hospital payroll in 2000 for full-year, full-time earners.

Sources: 1996 and 2001 Canadian Census.

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, which have

risen more than three times faster than transfers.

More money placed in the hospital system has therefore led to an even greater proportionate rise in high-level payrolls, as shown in figure 2. Not only that, but there has been a rise in both numbers of

these employees (up almost three-fold) and average income.

That latter fact is shown in figure 3. Average income is calculated there as a true price index of pay, using only individuals with adjacent years of income data and weighting according to their

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

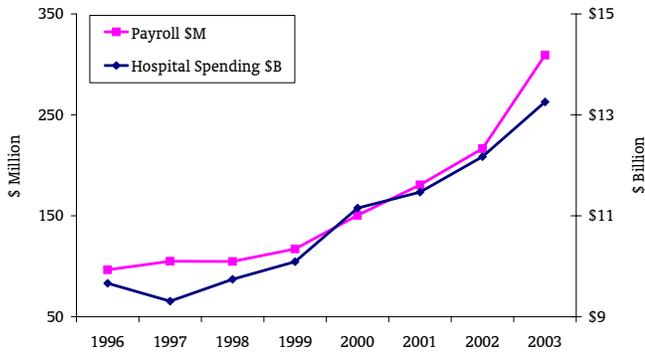


Figure 2: Hospital Employees Earning Over \$100,000

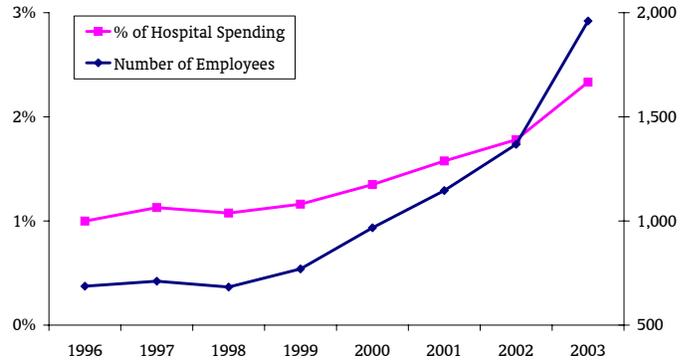


Figure 3: Average Income Annual Growth Rate: Hospital Employees Earning Over \$100,000

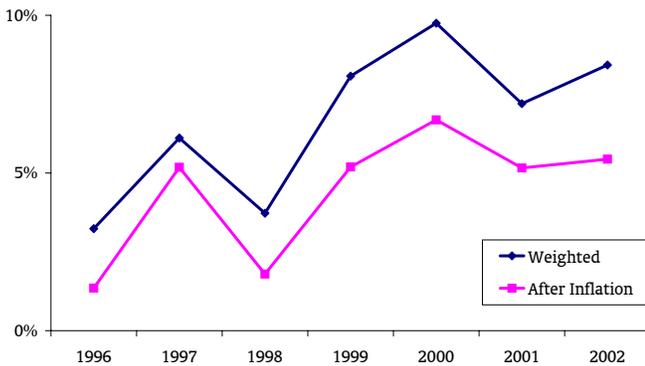
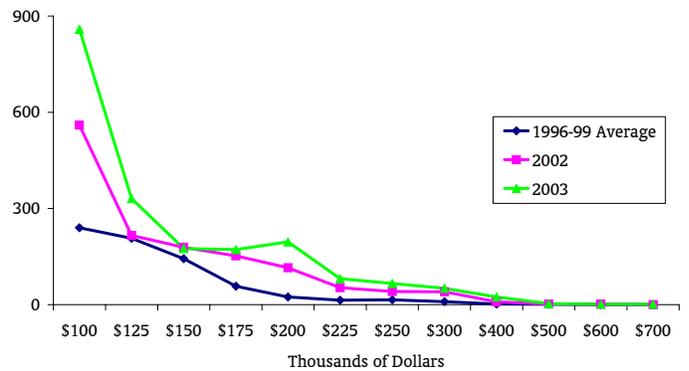


Figure 4: Number of Employees by Income



proportion of income. This average income growth has been 6.6 percent annually (4.4 percent after inflation) since 1996 and it accelerated after 1999.¹¹

Figure 4 shows that the pickup since 1999 has come in every income category, as there are more employees in every range. The distribution has also shifted rightward, indicating that there are proportionately more higher-end workers of those earning over \$100,000.¹² Both 2002 and 2003 results are shown, as there was a SARS effect last year that seemingly boosted the number of employees earning just over \$100,000 and just over \$200,000.

Table 4 breaks out the high-end pay by occupation.¹³ There is unsurprisingly a hierarchy of aver-

age incomes, commensurate with corporate status and responsibility, with presidents & CEOs earning the most and non-executives the least. Average incomes have grown the fastest for the former group, as well as for other non-medical executives, since 1996. Medical ex-

ecutives and non-executives have seen average incomes increase at less than half the pace of these two groups.

However, there has been a much faster pace in terms of employment for high earning non-medical

Table 4: Employees by Occupation

Occupation	Average Income 2003	Average Annual Growth 1996-2003	Number of Employees Annual Growth 1996-2003	Total Income 2003 \$M
Executives	\$208,344	3.8%	8.9%	\$63
President & CEO	\$239,327	5.4%	4.7%	\$28
Medical Executives	\$198,361	2.0%	6.9%	\$14
Other Non-Medical Executives	\$182,674	4.6%	17.6%	\$20
Non-Executives	\$148,620	1.5%	18.0%	\$247
All Earners over \$100,000	\$157,762	1.7%	16.2%	\$309

Source: Government of Ontario; author's calculations

executives and non-executives. This has resulted in those groups accounting for 97 percent of the increase in total payrolls since 1996 for workers earning over \$100,000.

There is often a public fixation on high-level compensation, owing to the limited number of positions involved and the amount of income relative to broad societal averages. The issue of value-for-money, whether the relatively high and rising income of hospital executives is related to performance criteria, is beyond this *Alert*. However, it is noteworthy that Canadian hospital executive pay is roughly in line with US equivalents, while physician income lags by at least one-third.¹⁴

The central fact here, though, is that the entire \$28 million amount paid on wages and salaries for presidents & CEOs is an extremely small fraction of the \$8 billion-plus labour bill for hospitals, or the \$1 billion-plus annual infusions to the public sector health system. Solving health care funding issues on the back of class envy is therefore a non-starter.

In summary, this section has found that those with the highest pay are growing their numbers and increasing their average income faster than the rest of the hospital

employees. There is an emphasis on better pay for executives and on hiring many more non-medical executives and non-executives. High-earner payrolls increased more than three times as fast as provincial hospital transfers, once spending restraint ended in the late 1990s.

This payroll inflation is not, however, directly relevant to the issue of controlling health care costs owing to its small absolute size, aside from a notion that leadership on improving efficiency and effectiveness starts at the top.

Physician Payment and Supply

As discussed, the Census data show that the relative pay of physicians lagged other groups within hospitals, especially senior management, nurses, and mid- and lower-level unionized employees. Also, table 3 shows that there has been negligible growth in the numbers or average pay of physicians in Ontario since 1995.

Figures 5 through 7 add more context to this assessment of what are arguably the most important workers in hospitals, or at the least the ones with the most crucial skill sets to treat patients.

Figure 5 shows inflation-adjusted, after-expenses income for self-employed physicians dating back to 1950. Fee-for-service (FFS) specialists and GPs are shown separately from 1982 onward and the Census data for all physicians are shown for comparison.

The figure shows that average incomes increased continuously for two decades starting in 1950 until peaking at just under \$200,000 in 1972. Inflation eroded incomes until 1981 and then they rose until the recent lower peak in 1987. There has been a steady decline since then, including a period from 1993 to 1996 that involved government-imposed claw-backs. Average income for physicians has therefore been declining for over three decades and is presently three-quarters of its peak level. The decline from the peak is even greater—more than 50 percent—compared to personal income per capita in Ontario.¹⁵

The natural follow-on in a labour market where monetary rewards shrink, other career opportunities beckon, and entry is constrained¹⁶ is that supply will decline. That is seen clearly in the period after the expansion of the public sector health system in the late 1960s and 1970s in figure 6, when the

Figure 5: Physician Income in Ontario

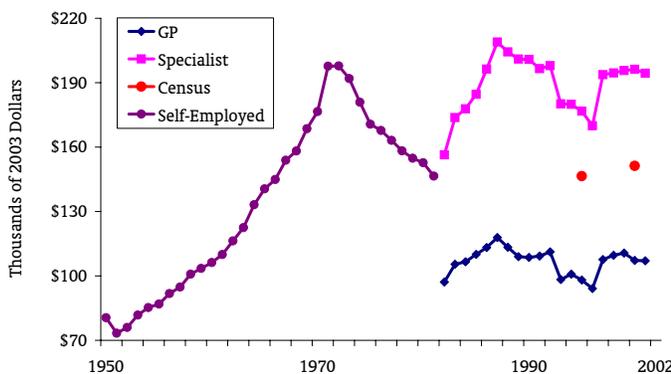


Figure 6: Physicians per 1000 Population

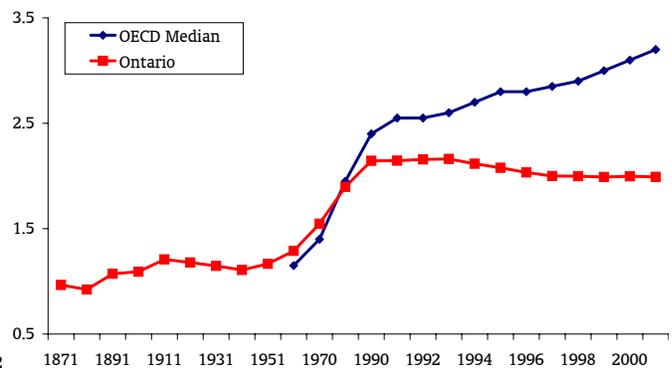
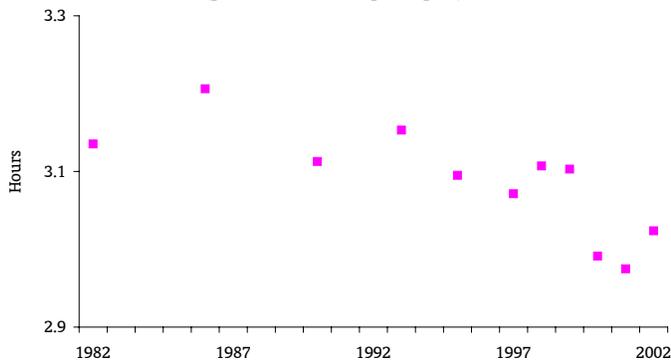


Figure 7: Physician Activity
(patient care hours per capita)



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.

number of physicians per capita first slowed its rise and then declined.

The decline in physician supply since 1989 is even more severe than shown once proper adjustments are made for the rising needs of the aging population in Ontario.¹⁷ It is also noteworthy that the province has been falling behind the median results of the advanced countries in the OECD since 1980 and the gap is now growing wider by the year. Finally, a decomposition of physician type shows that the steepest decline is in GPs and surgeon specialists who screen and perform services in a hospital context.¹⁸

Further supporting evidence for a long-term decline in accessibility is shown in figure 7. The number of patient care hours per active full-time-equivalent physician were estimated and then scaled to population for this figure. This measure of work effort has been in a declining trend since the early 1980s and has declined 5 percent over the past two decades. This is completely at odds with a public sector health system that has doubled its inflation-adjusted spending over the same period and exhibits growing physician access issues due to regional inequities and lengthening waiting lists.¹⁹

In summary then, this section shows that physician pay is declining over time and the supply of physicians is shrinking relative to population needs and falling behind the experience of other countries. These are long-term trends and, as seen above, are reflected in the payment practices of hospitals.

Policy Recommendations

There are two central policy issues here: unsustainable and poorly allocated hospital spending, and access to hospital services.

Solving both at the same time in the current public sector health system is essentially impossible, as increased access requires more funding, especially for physicians (both in terms of average pay and numbers), but inflates system costs even more.

The only way out for the government is to save money by continuing with rationing, which promotes waiting lists and inaccessibility, or to see constant increases in taxation. A combination of these two essentially describes the status quo in Ontario.

One possible alternative is to reallocate resources away from less productive workers to health providers like physicians, keeping total spending from rising.

It is difficult to see how this could be accomplished, however, given the absence of measures on worker productivity, lack of financial incentives, and entrenched interests. It might also require inefficient micro-managed central planning of hospital activities by the health ministry. Hospital boards and managers cannot make these decisions, as they do not allocate or fund most physician resources.

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.

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.²⁰

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 decision-making.²¹

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.²²

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.

Appendix

Data Sources:

Income by occupation and industry: Census of Canada 2001.

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

Physician numbers and income: Southam Medical Database, Chan (1999 - see footnote 17), CIHI, Census, Hamowy (1984 - see footnote 16), and "Family Medicine in Ontario: Present & Future Challenges," *Ontario Medical Review*, Ontario Medical Association, January 2003.

Patient care hours: *Physician Resource Questionnaire 1982 to 2002*, Canadian Medical Association

Population: Statistics Canada and Ministry of Finance

Inflation: 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. 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

Physician numbers: Ontario physicians are defined as active, retired, and semi-retired and include interns and residents. The full-time-equivalent estimate comes from CIHI for 1991 to 1997 and is based on the Southam physician count before 1991 and the active physicians registry after 1997.

Physician income: Net fee-for-service income was calculated from gross payments data using expense ratios from the Ontario Medical Association for 1992 to 2000. Expense ratios from 1982 to 1991 were assumed to be at the 1992 level and for 2001 at the 2000 level. All income numbers were deflated using the Ontario consumer price index. Data from 1950 to 1981 come from Hamowy (1984), *Canadian Medicine: A Study in Restricted Entry*.

Physician hours: Patient care hours per week are the sum of the direct and other patient care categories in the Canadian Medical Association survey. Annual hours are calculated as weekly hours times full-time-equivalent active physicians times 48 working weeks. These total annual hours were scaled to the total Ontario population.

Footnotes

- 1 Data from CIHI and Government of Ontario, Ministry of Finance, Budget Papers, 2004.
- 2 See *Nothing So Certain: Debt, Taxes and Government Spending*, Fraser Alert, Fraser Institute, June 2004.
- 3 See *2028 or Bust: Ontario's Unsustainable Hospital Funding*, Fraser Alert, Fraser Institute, March 2004.
- 4 See *Financial Review of Ontario Hospitals, Trends in Financial Results 1997 to 2003*, December 2003, www.changeofoundation.com. Another 7 percent of total operating spending goes to benefits and medical payments and 23 percent to supplies, leaving 10 percent in miscellaneous expenditures. Capital spending accounts for an additional 10 percent on top of operating expenses.
- 5 See www.changeofoundation.com.
- 6 The relative income is calculated as average occupational income in hospitals as a percent of such income in other sectors, industries and provinces.
- 7 Diane Galarneau, "Health Care Professionals," *Perspectives on Labour and Income*, Statistics Canada, December 2003 also takes this approach. The full-year full-time payments accounted for 68 percent of total hospital employment income in 2000. Benefits like pensions, vacations, work conditions and the like are not examined in this Alert.
- 8 The registered nurses' 14 percent pay premium over nurses working in hospitals in other provinces is probably even more skewed for those with more seniority. The Canadian Federation of Nurses Unions reports that Ontario's minimum salary at \$43,800 is the seventh highest among provinces, while the maximum pay of \$65,800 is by far the highest in Canada. See http://www.ona.org/faq/index.html#union_sal.
- 9 See Cynthia Ramsay, "Labour Costs in the Hospital Sector," *Fraser Forum*, November 1995; and Nadeem Esmail, "Labour Costs in the Hospital Sector Revised," *Fraser Forum*, January 2002.
- 10 See Ontario's Public Sector Salary Disclosure web site at <http://www.gov.on.ca/FIN/english/psecteng.htm>.
- 11 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.
- 12 Galarneau, "Health Care Professionals," *Perspectives on Labour and Income*, p. 17, also notes that the median income for health workers increased less than the average between 1990 and 2000 because of "large increases registered in the upper income groups."
- 13 See the Appendix for a discussion of data issues associated with this classification.
- 14 One comparator comes from an American College of Physician Executives survey in the *Physician Compensation Report*, December 2003. A survey of 2,060 physician executives (within and outside hospitals) found average earned income of US\$225,000 in 2002. This suggests that Ontario executive pay may be in line with US norms, absent purchasing power and net taxation conversion. Meanwhile, US median physician income was one-third higher than the Ontario average in 2000—and the gap would be wider based on a comparison to Ontario median physician income—more support for this Alert's thesis that physicians are relatively underpaid in Ontario. See "Physician Income: The Decade in Review," *Physician Socioeconomic Statistics 2003*, American Medical Association for US data.
- 15 Average physician income was 10.1 times higher than per capita personal incomes in 1971 and was 4.7 times higher in 2000. Data on Ontario incomes comes from the Historical Statistics of Canada at <http://www.statcan.ca/english/freepub/11-516-XIE/sectiona/toc.htm>.
- 16 See Brett Skinner, *Medicare, the Medical Brain Drain and Human Resource Shortages in Health Care*, AIMS Background Paper 7, Halifax: Atlantic Institute for Market Studies, December 2002 on migration issues; Hugh Grant and Ronald Oertel, "The Supply and Migration of Canadian Physicians, 1970-1995: Why We Should Learn to Love an Immigrant Doctor," *Canadian Journal of Regional Science*, vol. XX (1/2), 1997 on enrolment controls; and Ronald Hamowy, *Canadian Medicine: A Study in Restricted Entry*, Vancouver: The Fraser Institute, 1984 on other labour market constraints.
- 17 See Ben Chan, *Supply of Physicians' Services in Ontario*, Institute for Clinical Evaluative Sciences Research Atlas, Toronto, 1999; and Ben Chan, *From Perceived Surplus to Perceived Shortage: What Happened to Canada's Physician Workforce in the 1990s?*, CIHI, June 2002.
- 18 This is at least true for all of Canada. See *The Practicing Physician Community in Canada*, CIHI, 2001.
- 19 See Nadeem Esmail and Michael Walker, *Waiting Your Turn: Hospital Waiting Lists in Canada* (13th edition), Vancouver: The Fraser Institute, 2003 on Ontario waiting lists; and Boris Kralj, "Physician Distribution and Physician Shortage Intensity in Ontario," *Canadian Public Policy*, vol. XXVII (2), 2001 on regional shortages of physicians.
- 20 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/repoct02vol6-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.
- 21 Nadeem Esmail and Michael Walker, *How Good is Canadian Health Care?*, 2004 Report, Fraser Institute Critical Issues Bulletin notes 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 Esmail and Walker (2003), *Waiting Your Turn: Hospital Waiting Lists in Canada* (13th edition)).
- 22 See Daniel Kessler and Mark McClellan, *Is Hospital Competition Socially Wasteful?* NBER Working Paper 7266, Cambridge, MA., 1999; Esmail and Walker *How Good is Canadian Health Care?*; and Brian Lee Crowley et al., *Definitely Not the Romanow Report*, Halifax: AIMS, 2002.