CHAPTER 4

Health Care

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HEALTH CARE WAS NOT A big part of the *CSR*. Most of the mentions were promises to not do things. They were designed to protect the Harris Conservatives from the electorate's fears of cuts to health care and from accusations of a hidden privatization agenda. Health care was specifically addressed only sparingly.

> In the Introduction*:* "This plan guarantees full funding for health care. . ."
>
> On Page 3 in a section entitled CUT NON-PRIORITY GOVERNMENT SPENDING: "Total spending will be reduced by 20% in three years, without touching a penny of Health Care Funding."
>
> And on Page 7 in a section entitled Protecting priority services—health care: "We will not cut health care spending. It's far too important. And frankly, as we all get older, we are going to need it more and more. Under this plan, health care spending will be guaranteed."[1]

I was not a part of the *CSR*. I knew some of the "tiny Tories" involved in the Harris Campaigns from "across the aisle" when my Liberal party beat them (handily) in the University of Toronto model parliament in 1985. Several became lifelong friends, but they have never managed to convince me of their belief system. I remain a quiet Liberal and a progressive, albeit with math skills. My last active involvement in politics was with Prime Minister Paul Martin when I was an advisor for the 2004 first minister's meeting on health care.

My opinions on Harris's healthcare record are based upon thirty years as a management consultant and policy advisor across over 400 projects. A decade ago, as a fellow at the progressive Mowat Centre, I said positive things about Premier Harris and the Health Services Restructuring Commission (HSRC). The editor reminded me of this recently and asked me to contribute the healthcare chapter to this planned retrospective. I have (in speeches) commented on the work of the HSRC under Mike Harris, along with two other successful examples of healthcare reform in Ontario—the early Dalton McGuinty wait-times initiatives and the Deb Matthews ECFA/Bill 102/MD payment reforms. I was involved in these Liberal-era reforms as a management consultant or as an order-in-council appointed advisor. There are common elements of these three successful reforms: respect for data and expertise, thoughtful, well-organized processes, and tough-minded decision-making.

In preparing this chapter, I have had access to the files of the HSRC, press clippings from the time, the few published books on the Harris revolution, interviews with a variety of participants, and the critical commentary of several think tanks. Readers will soon learn that my work has increased my high opinion of the Harris healthcare record and particularly their firm support for the HSRC under Duncan Sinclair.

The HSRC was the centrepiece of the Harris healthcare reforms. The commission had authority to make binding decisions when it came

to hospitals and to make recommendations and policy advice on other related matters. Its restructuring of Ontario's hospital system was highly successful, and it provides a model for best practice in effective central planning. Other elements of restructuring were less successful (e.g., primary care, home care, long-term care and mental health) and were recognized as such at the time (and by the commission itself at sunset). Many of these recommendations were excellent, though non-binding. In particular, the work that the HSRC did on primary care groups (REF) and aging-in-place still make for fascinating and relevant reading today.

I will also more briefly review several key policy topics outside of the HSRC purview. These include some novel work in drug benefits, capable (if unexceptional) continuations of negotiations with the Ontario Medical Association (OMA), meaningful long-term care (LTC) capacity expansion, and a few others.

The Harris health program represents exceptionally well-done central planning. This is striking and ironic because a true "revolutionary" of the "common sense" school should not believe in central planning at all.

The Harris Tories were avowed Thatcherites and Reaganites. They read and adopted[2] as guidebooks *The Road to Serfdom* and *The Constitution of Liberty* by Frederick Hayek, a Nobel Prize–winning economist who compellingly warned the British and American publics of the dangers of central planning being combined with the full power of the state (and that socialism leads to totalitarianism). The *CSR* team had read its Hayek (although I suspect most only in the *Reader's Digest* version). They presumably believed that large-scale central planning diminishes individual liberty. In a longish aside, I will try to explain this apparent paradox: how Mike Harris ended up being among the best health care central planners in Canada's history. I will also discuss and address some of the criticisms of Harris in health care.

Obviously, it is fun to tease friends who pride themselves on being free market advocates for their comprehensive use of central planning in health care. But there are important lessons here about the use of, and

the limits of, planning as an allocative method. And, whether you are a progressive or a neoconservative, these deeper questions are foundational ones about what it means to have a national public health system. Harris' health care successes help explain the problems we are currently facing, a generation later, and why we are struggling to address policy areas such as aging, drug coverage, denticare, virtual care, and mental health. While good central planning still worked in the Harris era, different allocation methods and economic models may be needed in the years ahead.

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> The Health Services Restructuring Commission ("HSRC," "the Commission") was an independent body established by the Government in March 1996. Its role was to expedite hospital restructuring in the province, and to advise the Minister of Health on revamping other aspects of Ontario's health services system.[3] — *HSRC Legacy Report, 1996–2000*

The Commission was very well thought-out, and structured with several key characteristics:

It had volunteer commissioners. It was chaired by Duncan Sinclair, former dean of Queen's Medical School. It had a four-year mandate with an automatic sunset. And it had lead commissioners for major urban centres who took ownership of the local report and directions when issued.

There was also a small, skilled professional staff team led by Mark Rochon (1996–1998) and Peggy Leatt (1998–2000) as CEO and David Naylor (of IC/ES) as special advisor. They had deep modeling and analytical support, including architectural and clinical analytics. They used agreed-upon methodologies for assessing current and needed bed capacities. There was 100 per cent public transparency in analytics and regular reports using clearly communicated methodologies.

Everything was published openly, and the local situation was discussed repeatedly with local newspapers.

Clear and declarative "directions" were issued under authority delegated by the minister. These directions were previewed thirty days earlier by the publication of notices of intent to issue directions. These were complete drafts with supporting analytics and, again, 100 per cent open for public discussion and comment. Also, facilitators were appointed after directions were issued to sort through the governance issues and help manage the closure of facilities and transfers of programs.

Over a period of four years, the HSRC issued directions to twenty-two communities.[4] They amalgamated several hospitals to form larger healthcare organizations and ordered the takeover of four hospitals. They directed the closure of thirty-one public hospitals, six private hospitals, and six provincial psychiatric hospitals sites. They also created a variety of provincial and regional networks and rural/northern networks.[5]

The volunteer commission ended on time, produced the well-written and readable 208-page close-out report (*Looking Back, Looking Forward*). It also published "Seven Points for Action" in March 2000, which makes remarkable (and a bit depressing) reading today as it covers topics such as primary care and long-term care that are still very much on the agenda. Several years later, it produced a book-length review published by a well-known think-tank.[6]

The commission's reports and directions make fascinating reading. For policy people of the 2020s, the HSRC language is startlingly clear. There are no flowery political promises. The press clippings and court decisions of the time are full of tough arguments on both sides of many issues. The public was involved and concerned in the debates that were happening. The commission and staff met with the editorial boards of local daily newspapers to answer any community questions.

Here are excerpts from two editorials from major daily newspapers about one year into the commission's work that illustrate how the process unfolded and how successful this transparent approach was:

> The big hurt has been delivered, and now comes the time to deal with the pain. Nonetheless, what the province's restructuring commission brought forward yesterday in dealing with the cumbersome (and expensive) hospital bureaucracy in Ottawa-Carleton was not as painful as many doomsayers anticipated.
>
> In fact, their plan verges on the brilliant. . .
>
> It is obvious, though, that the Commission thought long and hard on what to do with Ottawa Carleton.
>
> And to our way too thinking, it is to be congratulated for both its foresight and its compassion.
>
> *Ottawa Sun*, Feb 25, 1997

[Note: The Ottawa directions closed four hospitals and ordered several amalgamations.]

> Let's try to set the record straight on what Ontario's Health Services Restructuring Commission is up to. Earlier this week it ordered the closings and amalgamations that will reduce the number of hospitals in Metro Toronto to 24 from 39. . . . The first half of the mandate—downsizing the hospital sector, reducing the number of acute care beds, closing some institutions—is in good hands. The decisions the Commission has had to make are never easy ones, but it appears this far to have mostly made the right choices, in Toronto and elsewhere.
>
> *The Globe and Mail*, July 25, 1997

This sense of fairness and tough choices runs through the over fifty newspaper articles I have read. There is anger and hurt and fear as well. After all, they closed forty hospitals. Many were desperately worried about job loss. But people were reassured by direct and honest communication and the commission's commitments to transparency and straightforwardness.

Direct declarative statements with no bullshit, rigorous transparent analytics and well-planned legal foundations were all keys to the success of the HSRC. I will also amplify my point about volunteer governance. Former Queens medical school dean Duncan Sinclair took no pay for his four years of work. His knowledgeable and avuncular style bred trust and was also touched by just a bit of "coolness" (his son is the bass player for The Tragically Hip). The other commissioners were a "who's who" of talented volunteers. This often proves a powerful combination in public policy.

It is important to point out here that Premier Harris and his government were able to attract this extraordinary group and had the courage to back them during some incredibly difficult decisions. This from "a golf pro from North Bay" who was often criticized for not being sophisticated enough.

It is also important to make clear that Harris had tailwinds helping. Underlying the HSRC's tough decisions was a very strong elite consensus that had existed before the Harris government took power and that provided Harris with some non-partisan backing. The basic analytical methodology used had been being developed under the Rae government and trialed by District Health Councils (DHCs). It was a workable approach, if an incredibly blunt instrument. Every DHC in the province had been asked to provide a report on acute care bed utilization and to benchmark themselves against current, and future, best-practice standards. These reports were in hand and available as the HSRC was created by the new government. In fact, Bob Rae and his team almost certainly deserve significant credit for giving the commission a running start. Whether they would want it or not I leave to the reader.

The methods and recommendations made by the HSRC ended up being accepted in a non-partisan way in practice. The McGuinty Liberals never replaced the methodologies used by the HSRC under Harris when they came into power. All three political parties knew that the analytical team was rock-solid. It is worth mentioning at this point that while

similar methodologies continue to be used today, recent governments no longer publish their findings so transparently. This lack of transparency undermines effective policy development and implementation.

In its reports, the HSRC took feedback and eventually standardized the provincial methodology (available in detail in the commission references cited). Parts of this methodology are still used in many parts of the country and at research institutions in part because of the excellent personnel recruited to support the project (Naylor and team, who did great work but also populated many future organizations and consulting firms).

In each planning region, statistics for current and estimations for targeted length of stays, across a projected case mix, were used to establish a needed level of in-patient beds for the community. Often the community already had many closed beds, and because length of stay (LOS) had been declining for at least two decades, when one targeted future usage at better practice levels (75 percentile or current, whichever was lower), the needed number of beds dropped dramatically. This sounds dry and technical, but it is critical to appreciate because it gave confidence to the planning team and Commission to take bold steps.

Let me step back and give an informal history of acute care hospitals to set some context on why all this was so needed.

* * *

Hospitals were originally created as a place to isolate and comfort people, most of whom died. Before 1900, people generally only allowed themselves to be admitted if they had no other choice. Charitable orders dominated eighteenth- and nineteenth-century hospitals, as they were dedicated to alleviating suffering. This began to change with medical advances in Victorian England and in Paris that built on earlier knowledge from ancient Greek and Arabic (Islamist) physicians. Advances in infection control, hygiene and the development of early vaccines started showing that better outcomes were possible.

Surgery, anesthetics, infection control, blood transfusions, and antibiotics changed the game completely for hospitals. The two World Wars accelerated these advances, and, after WWII, hospitals had changed and become a place to go for actual treatment . . . and sometimes even for a cure! Technology adoption in health care was rampant, with new ideas, drugs, devices, and treatments increasing the range of services offered in these increasingly magical places. In Figure 4.1, you can see the impact of that trend on hospital utilization across the developed world.

Treatments and diagnostics moved from the in-patient and hospital setting and could now be offered in ambulatory settings, in physician's offices, in homes, and even virtually. Clinical teachers, under the new models developed by Flexner and Osler were committed to teaching and spreading this knowledge through formal clinical internships and residencies. Academic surgeons and physicians literally trained their next generation of competitors, who moved to community hospitals and to ambulatory centres. By the early 1990s, this trend was visible worldwide.[7]

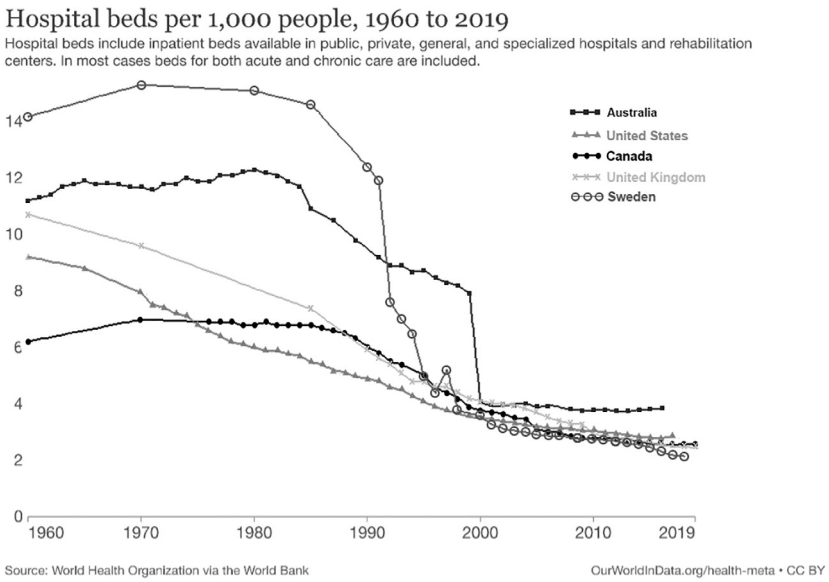

Figure 4.1 Hospital Beds Per 1,000 People, 1960 to 2019

In Canada, we introduced public payment for hospitals in the late 1950s. Our hospital beds-per-thousand-citizens stabilized at about seven. A decline began in the 1980s, with technology diffusion, and accelerated into the 1990s. By the end of the 1990s, we had reduced the number of bed-days available in hospitals on a population basis by as much as half. And this result is mirrored, or even exceeded, in most of our closely comparable countries (e.g., the United Kingdom, Australia, Sweden, the United States). In the Bill Davis and John Robarts years, conservative politicians opened hospital, which brought new technologies to remote communities. All politicians are happy being seen to be building new things for their communities. But, by the 1990s, in-patient beds were no longer what was needed, and beds were wickedly expensive.

The numbers in Canada (above) were stark and are singled out in Figure 4.2.[8] By 1996, Ontario had already closed over 9,000 hospital beds as we benefited from the global trends described above. But *not one single hospital had been closed*. To put this in perspective, 9,000 beds is about thirty mid-size (think Windsor or Waterloo) hospitals. Observers could

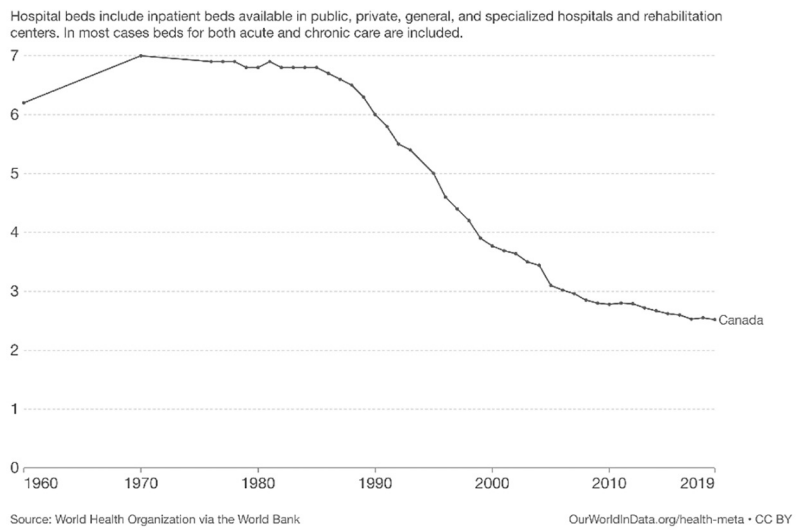

Figure 4.2 Hospital Beds Per 1,000 People, 1960 to 2019 – Canada

see by looking at the changes in practice patterns that this trend was only going to continue.

What's more, the need and function of "a bed" was changing. Patients in hospital beds were there for a shorter period of time, and they were sicker while there. An increasing number of surgeries were being moved to "same-day facilities" (e.g., cataracts) and even into doctors' offices (e.g., dental surgery). The traditional hospital facilities were often out-of-date and unsuitable and very expensive or even impossible (e.g., asbestos) to remediate. Hospitals needed to close to provide better care for patients.

Ontario policymakers realized they had a big problem. In fact, the recognition had come a few years earlier, in 1988, when Minister Elinor Caplan (in the David Peterson government) called an abrupt halt to most hospital building in the province. There was a sudden recognition that every time you build a bed in a public system *you have to pay for its operation*. While this change in the required facilities footprint was most clear in surgery, the impact of technology changes was even broader. Eventually, chemotherapy, much diagnostic imaging, endoscopy, labs, functional testing, and dialysis would all leave the in-patient hospital setting. Our system wasn't necessarily doing less stuff; it was just doing it in a different way. Governments in the pre HSRC era had underfunded hospitals when compared to inflation causing reductions in staff and traditional bed capacity often in an un-coordinated fashion. And, worse still, we had closed pieces and parts of many hospitals, because we couldn't find the courage to choose which ones to close.

The Health Services Restructuring Commission was born from a non-partisan consensus that something had to be done to reduce the number of buildings, continue to bring the number of "beds" down, and move health care to ambulatory sites, alternate levels of care, and the patient's home. This was (and is) seen as self-evidently a better model on many attributes. Whether this remains as true today, twenty-seven years later and post-COVID, it has become an arguable proposition, but in 1995, with a new government taking power, there was very broad

agreement on this reality among healthcare central planners, and all three major political parties recognized that something major had to be done. The case for change was clear.

So, it's 1995 and you are a neoliberal believer in the Thatcher and Reagan revolution. You support the *CSR*, and you want to fix the Ontario healthcare system. What do you do?

Other provinces also recognized the "too-many-beds, too-many-hospitals problem." The whole country was over-bedded, and most provinces reduced beds and hospitals during the late 1980s and 1990s. Most provinces opted for some form of an exercise in governance and a technocratic solution that insulated politicians by setting up a provincial health authority or a set of regional authorities. But in discussions with Harris advisors from this period, I learned that the Harris caucus didn't much like the existing district health councils. And there was respect for independent hospital governance and the hospital boards. As one insider put it: "There was no market-based solution in the air at the time as an alternative in Ontario."

Meanwhile, in the United States, Democrat Hillary Clinton was proposing a purchaser/provider split using pseudo-market mechanisms called "health insurance purchasing cooperatives." But a market solution in Ontario would have involved multiple bankruptcies over multiple years. It was unworkable in a political reality that had already seen 9,000 beds closed but without a single hospital closure. The good thing about central planning combined with the state power is it is fast if one wants to implement massive change or modernization of an industrial process.

The solution was unexpected. Mike Harris became a great healthcare central planner. Or at least his government did.

I need to digress for a bit now about the astonishing irony of all this. This will take us into the intellectual basis of neoconservatism and the thinking of Frederick Hayek. There is a famous anecdote that during a British Conservative party policy meeting, Margaret Thatcher removed her copy of Hayek's *Constitution of Liberty* from her handbag, slammed it

down on the table and declared, "This is what we believe."[9] There are numerous stories about her sitting down with Hayek and listening to him carefully. And she was not the only avid reader. In the United States, *The Road to Serfdom* was abridged for *Reader's Digest*, and 2.4 million copies were produced.

If you were a good Thatcherite/Reaganite, you would've read your Hayek and know what he wrote about central planning in *The Road to Serfdom*:

> In order to achieve their ends, the planners must create power—power over men wielded by other men—of a magnitude never before known. . . . Many socialists have the tragic illusion that by depriving private individuals of the power they possess in an individualist system and transferring this power to society, they thereby extinguish the power. What they overlook is that by concentrating the power so that it can be used in the service of a single plan, it is not merely transformed, but infinitely heightened. By uniting in the hands of some single body power formerly exercised independently by many, an amount of power is created infinitely greater than any that existed before, so much more far-reaching as almost to be different in kind.[10]

Hayek's central argument is that central planning, as an allocation methodology, cannot work without the coercive power of the state backing it up and that, in a democracy, this results in an increasingly ineffective government that then causes the rise of a "strong man" who can get things done quickly. The strongman creates an armed thuggery and an internal or external enemy before ultimately seizing power. He contended that this is what happened in both Russia (Stalin) and Germany (Hitler).

I have to admit that as a twenty-first-century Liberal and after a career in which I have done a lot of "central planning," I found Hayek's *cris de*

coeur compelling. He had lived it as an Austrian Jew who fled to Britain. He identified many issues and behaviours that I have observed in large central planning initiatives. I was surprised to see George Orwell among Hayek's positive contemporaneous reviewers (1944). One can see shades of *Animal Farm* in The *Road to Serfdom*.[11]

Hayek's thesis in *The Constitution of Liberty* (which Thatcher thumped) is that freedom is the cornerstone of progress and innovation. It was written after WWII and is less alarmed about the possible rise of the totalitarian strong man. It is also more thoughtful about why planning is self-limiting and reduces innovation. He argues that no central planner could ever be so omniscient as to see all possible paths. "[T]he case for individual freedom rests chiefly upon the recognition of the inevitable ignorance of all of us concerning a great many of the factors on which the achievement of our ends and welfare depends."

So, how can it be that the Harris revolutionaries who clearly believed these things could establish one of the best healthcare central planning processes in our country's history (my opinion)? At the very least, the irony is striking. There is a paradox here that is worth exploring and understanding better.

As neoconservative revolutionaries, the *CSR*'ers "should" have chosen an allocative method that would allow for freedom of choice for citizens to pick healthcare providers and for healthcare providers to adapt and change to meet the changing needs of the population. Such an approach was used by Thatcher in the United Kingdom and proposed by Democrat Bill Clinton in the United States.

Instead, in 1995, the Harris government imposed a highly coercive, expert regime. The HRSC central planners closed over forty beloved institutions. More than 20,000 workers had their jobs disrupted.[12] Healthcare operational funding was reduced overall, and big chunks of hospital budgets were reallocated into other sectors. There were protests. There were court cases (only one having any success). There was huge media coverage and outrage.

No one would argue that restructuring was easy. But most of the informed people that I have spoken with in research for this chapter agree that it was absolutely needed. And it was well done. These opinions cross party lines, and, even on the left, the most serious criticisms have been about labour dislocation and the handling of union issues.[13]

I have reviewed the commission's reports, court decisions, directions, and other papers (made available to me by Mark Rochon) and press clippings from the time, as well as *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996–2000,* by Duncan Sinclair, Mark Rochon, and Peggy Leatt. I have read the available political books from the time. I have supplemented my own knowledge of the Ontario healthcare system with discussions with people who were involved and affected. I have also read the available *post hoc* criticisms.

I have identified ten attributes that helped make restructuring work. Some were tightly planned; some were accidents of history and some were a combination of the two.

1. Agreement on need: The NDP had commissioned the district health council reports that formed the basic case for change. Global changes in acute care were clear. There was a strong, expert consensus. At least some members of Rae's health leadership helped set favourable conditions. The new government quickly recognized that change was required of a massive nature.
2. Independent and arm's-length: This scale of change could not have easily occurred within the usual political environment. Decisions would always be evaluated through a political lens, but when it created the HSRC as an arm's-length agency it recognized that it needed to operate independently. Premier Harris and his government largely respected this distance in the early years of the HSRC and as regards hospital restructuring.

3. Volunteer governance and a clear time-limited mandate: No commissioner received payment for work. The commission was closed by legislation on March 31, 2000. This early sunset meant that the HSRC never became a self-interested, independent bureaucracy. They were seen as committed and smart but not permanent.[14]
4. Serious legal expertise in drafting legislation/regulation and in litigation: Reading the court opinions was probably my biggest "aha" moment while preparing this chapter. I have heard Rochon make this point, but I had not really understood it until I read the court submissions and the decisions.[15] John Laskin and team were a major source of strength for the HSRC.
5. Excellent analytics and communications: The analyses are clear and clean. They were defensible and understandable even to lay people. I have already quoted the *Globe* and the *Ottawa Sun* as examples of the kind of support. Rochon has told me that they met at least twice with the editorial boards of all major daily newspapers in the province. The messages, designed by an excellent communication team under the leadership of Bruce McLellan, were straightforward, transparent, and honest. They included paid ads and TV clips.
6. Clarity of language in directions and other communications: This clarity is genuinely shocking to people accustomed to the usual political bafflegab that comes out of political and bureaucratic circles in the 2020s. As described earlier, the HSRC, usually with one or two HSRC members acting as the lead commissioner(s), would preview directions about a month before final publication by releasing an intention to issue a directive. They received public comment and then issued the final directive on its own. The minister was usually briefed *one day before release*.[16] As a representative example, the people of Sudbury must have wondered what had happened to the nice Tory party of Bill Davis

when they read the directive to the Sudbury regional hospital corporation on April 30, 1997, which said (in part):

"1. Implement a plan to consolidate all acute hospital services on the Ramsay site and to close the Paris and Regent sites no later than April 30, 1999.
2. Transfer from the Paris and Regent sites all acute, chronic and rehabilitation a hospital programs operated on the sites to the Ramsay site.
3. Implement a plan to achieve the infatuate acute services interim target of 697 patient days/1000 population by April 30, 1998, and the utilization target of 540 patient days/1000 population by April 30, 1999. . ."

Readers of this chapter familiar with healthcare systems and population health management will appreciate how incredibly draconian is the very dry statement regarding a one-year reduction of 157 patient days/1,000 population.

7. Support from the premier and minister: These reforms were incredibly tough stuff, however needed. And particularly tough to implement given the looming date for the next election. Indeed, it took a revolutionary mindset to believe in the process and to see it through. One had to make an argument that the ends justify the means.[17] Think Lenin. Think Robespierre. But also think Hamilton federalism or John A. MacDonald and the railway. What is really impressive about how the Harris team handled this is that they were ruthlessly transparent. Often, the political class tries to deliver good news and to sugar coat announcements. Harris and his health ministers during restructuring (Jim Wilson, David Johnson, and Liz Witmer) seem to have understood that this was not going to work while closing forty hospitals. They shared all the data and trusted the commission. They stayed at

arm's-length deliberately and thereby showed courage. "The Minister used to cross the street if they saw me walking near Queen's Park," quipped one commissioner.

This trust-in-your-people ethos and transparency-in-your-communication-ethic is consistent with what I saw in the two subsequent successful Liberal-era health reforms: the McGuinty first-term implementation of wait-time reforms, family health teams, and local health integration networks, and Deb Matthews' *Excellent Care for All Act*, Ontario Medical Association negotiations, and Bill 102 for drug policy. Again, these leaders spoke honestly about difficult topics. In this way, it could even be argued that Harris demonstrated a best practice in achieving healthcare reform subsequently adopted by his Liberal successors. What is certain is that some excellent analytical leaders started or furthered their careers on the commission's staff team; many are still working within the system for change and quality improvement.

8. Willingness of the core bureaucracy to not block: I suspect that the Ministry of Health was a little bit in awe of what the HSRC was attempting. The (relatively) new deputy minister was seen as (relatively) friendly to Harris, and she and her predecessor had commissioned the DHC reports. Certainly, key players such as Rochon, Sinclair, and others knew the bureaucracy well; there were multiple informal connections. While the hospital restructuring component of the reforms benefited from bureaucratic acceptance, the commission wished for more support for some of its later recommendations outside of hospital downsizing and felt that they did not get it. Overall, I am impressed that there was not more game playing.

   One interesting tidbit is that the HSRC had a "principals only" rule for all meetings. No subordinate replacements could be sent by the ministry or other officials.

9. "Facilitation" strategy, an intentional misnomer: After each directive and report was delivered, a regional facilitator was appointed. When one thinks of facilitation, one usually thinks of nice hand-holding group processes in which people are coaxed toward solutions. This was not that. Very tough-minded and independent-minded men and women were appointed to facilitate regional agreement. The (lead) facilitator had the right to issue their own directive and use the full power of the commission (and hence the minister) under legislation. The team of Graham Scott and Maureen Quigley did five facilitations (including Sudbury). Scott was Bill Davis' deputy minister of health and the CEO of McMillan Binch (later McMillans) for almost two decades. Other facilitators included Michael Decter, who had been Rae's deputy minister of health and Ed Broadbent's executive assistant, and Alan Hudson, the famed neurosurgeon, who was later the CEO of the Toronto General Hospital and created the University Health Network. Each of Scott/Quigley, Decter, and Hudson are accomplished respected and visionary leaders of teams. While I am less familiar with some of the other facilitators involved in the process, I recognize one future Liberal cabinet minister and several respected jurists on the list.

   These people were not selected for their facilitation skills, but neither were they chosen because they were acolytes of the *CSR*.
10. Willingness to admit limits: In an understated but clear way, the commission admitted failure in several key areas. They did so without much blame or handwringing, although there was a palpable anger at their inability to finish the job of moving toward a less institutional and more community-based health system, one that would meet the needs of the populations that they serve rather than serve the elite interests that control it. They also explicitly recognized the limits of their analytical methods and approaches to issues in areas such as mental health

and aging supports. This is a good thing given how blunt these tools were.

As they shuttered their volunteer commission, its leaders documented the key challenges that they saw for the future. Their *Looking Back, Looking Forward* report from March 2000 still reads as a contemporary analysis today. They also used the analytical resources available to undertake research that clearly informed subsequent MOH policy initiatives undertaken in the later Harris/Eves years and under McGuinty. For example, the McGuinty family health teams owe much to the commission's work on primary care groups and other conservative era policy work.[18]

My Harris grade for hospital restructuring? No doubts. Strong implementation of the correctly thought-out policy: A

* * *

The Harris healthcare record, when you look beyond Restructuring, is fairly typical of most governments in Canada in the past three decades. Overall, without including the excellent work done in hospital restructuring, I would grade them as only a B or B+ government on health policy:

- they negotiated with their doctors' union and had only limited success;
- they tried to control spending while dealing with an aging population;[19]
- they recognized that they needed more long-term-care beds and built 25,000 (which is more than anyone else has);
- they implemented rational changes to the Ontario Drug Benefit program that introduced some user fees (accepted by later governments) and introduced some competition;

- they created some limited market-based interventions in cancer services (expanded under McGuinty) and community care services (curtailed by McGuinty) by introducing purchaser/provider splits;
- they introduced public/private partnerships into new hospital constructions, a good idea that was curtailed by election politics in 2003 and then later revived as Infrastructure Ontario.

I will review each of these briefly and provide a high-level report card grade. I will also consider whether there was any particular ideological approach evident in the approach taken by the Harris government in each key area.

The first Harris health minister, Jim Wilson, attempted to introduce some needed market forces into the doctor's fee schedule in the first Harris-era negotiation. The government proposed regional supplements and targeted fees for new physicians, for example. It also challenged the OMA's representation rights and attempted to have a discussion about malpractice expenses. Unfortunately, a comment made to a reporter by a minister's staffer appeared to have breached the privacy of a particular physician. The newspapers played "gotcha" politics with the minister and the government retreated and negotiated the usual centrally planned fee-for-service agreement and preserved "rep rights" for the OMA. No Hayek here. Some serious irony for insiders, though. The newspaper that embarrassed the minister at the time led the freedom-of-information charge twenty years later to have the same information made public about all physicians.

Physician payment was a big, missed opportunity if you were really Hayekians. Fee schedules are massively anti-competitive and restrict who can provide services and offer prices in ways that any self-respecting neoconservative would consider unwarranted. The idea of a massive every-four-year settlement of all fee codes, for all providers, in all parts of the province should make even the most committed Marxist squirm.

Yet it continues in most parts of the country, as if it is a normal way of doing things. It is an innovation killer.

My Harris grade? Good effort. Middling results. C+

Given what the HSRC was doing and the legacy of the Rae regime's Social Contract, it is hardly surprising that the ministry did not undertake separate major cost reduction programs at the time. Nor were they expected to, because the *CSR* had famously "sealed the envelope" and guaranteed total healthcare spending would not be cut. Rather, it appears that they were attempting to create a stable, ongoing funding model through the joint planning and priorities committee, DHCs, and other vehicles that would pick up after restructuring. Just implementing the orders coming across from the commission and following up on the major investments was clearly important. There was no attempt here to introduce market-based methods. In fact, it was McGuinty and Matthews who introduced prospective payments through the quality-based programs (QBP) and health-based allocation model (HBAM) program.

There is some fuzziness in the record about who was responsible for which cuts to which spending envelopes. This is hardly surprising given the complexities of having two side-by-side operational entities, one of which is de novo, with the full powers of the minister of health. In my discussions I have found that members of the HSRC team are skeptical of the government's claims to be budget neutral on healthcare spending while core members of the *CSR* team around Harris point out that it was their vision that drove hospital reductions and that they invested the saved capital in Longterm Care (LTC) and acute care facilities to enable it. There is probably no one right answer to this question, although I would give credit to Mr. Harris for supporting his people (the HSRC) and the commission credit for making tough decisions.

My Harris grade? This one has to be judged on pass/fail as the main work was at the HSRC. Pass.

Later HSRC reports are full of handwringing on the topic of aging in place. By 2000, it was clear that restructuring was only going to accomplish part of its mandate. More specifically, the shift to community-based services was not going to be completed in its four-year mandate. It is remarkable that Sinclair et al. criticize themselves for not moving quickly enough and not issuing clear enough directions (particularly in human resource areas). Most observers were, of course, left breathless from the commission's pace of change. Similarly, the commission cites its own naïveté as a major problem saying, "The commission has to accept full responsibility for its naivety, its failure to consider the reality of the political calendar and the amount of work it could reasonably achieve in the time available."

Here are Sinclair et al. five years after the HSRC:

> The commission was also successful in persuading the government to put money derived from its reduction of the hospital envelope into long-term care and home care. The total investment of $2 billion was decided on arbitrarily and was slow in coming, but it has helped to shift the focus from hospital-based to community-based care. To give credit where credit is due, the shift to out-of-hospital care was one of the declared intentions of Premier Harris's "common sense revolution." While it would have been preferable for the government to strike a different balance between long-term care "beds" and "places," substantial reinvestments were made—and in capital construction in hospitals as well. . .[20]

The Harris team claims 25,000 long-term care beds were funded and created. Sinclair et al. put the figure for the HSRC period at 20,000. In either case, it is the most of any government before or since. The big criticism seems to be that the money for building was given to private operators. This criticism is an example of fuzzy thinking by progressives.

Municipalities must run one home each and few run more; expanding municipal homes is fraught with difficulty. Not-for-profit (NFP) operators can only grow very slowly. LTC financing is based on access to capital; it is often based upon land appreciation and the ability for capital markets to price it. This source of investment is available to NFPs only imperfectly and in the very long term. Yes, religious organizations have made it work over the centuries, but that model does not allow for the kind of rapid accessing of capital markets to build new housing for high-needs seniors quickly. For governments to self-finance, this would be very expensive and a poor use of public sector capital. These beds cost a quarter million dollars each (in a 2021 estimate).

Does private LTC qualify as Hayek inspired? Decidedly not. Highly regulated and constrained LTC is the opposite of open choice for seniors. Twenty years later this is very clear, and even progressives today are becoming more Hayekesque in their rhetoric about aging in the right place.

My Harris grade? Decent job for the time and place. Missed opportunity to be more innovative. B+

Ontario drug benefit reforms appear to have begun during the Rae government and continued into the Harris years. There is no available official history, so I have reconstructed some of this by speaking with colleagues who were officials during this period. By 1996, it had become clear that drugs were going to continue to grow as a part of healthcare costs and that a mixed public/private model of financing was needed. Several historical anomalies around what was paid for needed to be cleaned up, and an income test was introduced. Prior to this point some high-cost drugs were covered, some were covered when delivered in a hospital, and some weren't covered at all.

The reforms were pretty good, and I will split the credit among the ministers, deputy ministers, and premiers of the Rae and early Harris years. An Ontario drug benefit information system was set up with high availability adjudication on some really cool technology (HP Non-stop)

by GreenShield under the leadership on the drug programs branch. The income test (4 per cent of total household income) was established. Importantly, co-pays were introduced in the dispensing but not the drug price costs. There was early work on generic substitution and work on the formulary that was built upon by McGuinty. These smallish co-pays allowed for free dispensing competition to take place.[21]

This area did include some market-based thinking. This was done of necessity because it was clear at the time (as it is today) that 100 per cent public pharmacare was, and is, beyond the fiscal capacity of any government. Once one reaches this conclusion, the question of who pays first versus second dollar and how to build in price competition and consumer satisfaction become questions. These questions are not present in a 100 per cent covered system (e.g., fee-for-service medicine for physical MD visits).

My Harris grade? Surprisingly innovative policy work. A−

Market reforms were introduced into cancer care and home care through purchaser/provider split models in the later Harris/Eves years with Cancer Care Ontario (CCO) and Community Care Access Centre (CCAS). As mentioned earlier, Hillary Clinton had brought these models forward along with her partner-in-reform, Ira Magaziner. Made infamous and ultimately defeated by the "Harry and Louise" television ads, these reform initiatives in the mid-1990s were market-based thinking from Clinton-Era Democrats. As sectoral models in Ontario, they worked well, until subjected to political attack. McGuinty continued the CCO model for radiation and surgical oncology and expanded it under the leadership of Dr. Alan Hudson (the same Hudson who was an HSRC facilitator). CCO operates the same way from within Ontario health even today and no-one admits that it is a market mechanism or talks about it much. Unfortunately for the CCACs, in 2003, one of the century-old home care companies went to Premier McGuinty's first health minister and simply had the process stopped. This was a naive move and has been the source of policy problems ever since.

My Harris grade? These market reforms were limited but useful experiments. A− and C+.[22]

New capital for hospitals was desperately needed and made very difficult to fund because of public sector accounting rules in Ontario. Public–private partnerships were an answer that had been tried worldwide. It worked well in Ontario, in my opinion. Unfortunately, it became a campaign issue in 2003 ("privatizing health care"), and a senior Liberal who was soon to be finance minister made a commitment to shut down PPP. This was a bad mistake and very naive. Sorbara, McGuinty, and the team spent years trying to walk this back and created Infrastructure Ontario and alternate financing partnerships (AFPs) as ways to not do PPP. Real silliness. Clearly, public/private partnerships deserve to be part of any government's toolkit. Studies show that the 100 per cent government control of any major project doesn't work.[23]

To summarize this brief review of other policy areas, there were indeed some limited market-based reforms introduced in health care during the Harris era. However, the privatization attacks routinely made seem largely unsupported or crassly political or both. The Liberals often later regretted their partisan election time attacks as they were forced to make practical policy decisions within fiscal constraints.

In many policy areas, the Harris health ministry was aligned with, or followed in the footsteps of, the later Rae ministry. The elite consensus that I made reference and others have described in many discussions with former officials continued through the later Rae years (e.g., Social Contract) into Harris and from Harris into the McGuinty years. Michael Decter (Rae's health deputy minister) praised the work of the commission in a foreword that he wrote for *Riding the Third Rail*[24] and later McGuinty programs like family health teams, the wait-times initiative, CCAC and CCO restructuring, and even Infrastructure Ontario all owe intellectual debts to either HSRC or Harris or both. Some of McGuinty's wait-times initiatives were also supported by former *CSR* team member Tony Clement when he was federal health minister. The HSRC was the nexus

for this agreement and has been the engine that has powered much policy thinking across party lines and brought more rigorous analytical approaches to the management of Ontario's health care system. During the Ford period, much of that rigour has been lost (in part due to Covid) and must now be regained.

My overall Harris grade, including the A for HSRC? An A−. Mike Harris did a good job in health care.

No sensible person enjoys restructuring complex systems. It is ghastly work that costs one sleep. Doing it well is really hard. This is true in any industry, but I believe it is particularly true in a mission-driven industry like health care. Bringing hard-nosed economic calculations into a place of caring is seen as mean-spirited. Even when almost ten thousand beds had been closed, decision-makers still shrank from closing a single hospital. The Rae New Democrats rolled back negotiated contracts by 5 per cent, but still didn't close hospitals. By contrast, Harris closed over forty hospitals. Very tough stuff.

Today "Harris Health Care Cuts" (HHCC) is taken as a shibboleth. A Google search finds various people accused of HHCC. Premier Ford is accused of HHCC, and yet his true problem (in his first term) was his lack of coherence and tough-mindedness. This is the very antithesis of Premier Harris in health care.

A second critique of Premier Harris is that he wanted to privatize health care. I hope that I have shown in the above analyses and commentaries that this is simply untrue. If anything, Mike Harris was a model central planner.

One particularly silly ad hominem version of this argument is that Harris was feathering his own nest by building all those long-term-care beds as premier so that he could (ten years later) serve on the board of an LTC company. This is bullshit (I struggle to find a more accurate descriptor). Most of the premiers and prime ministers that I have known could be subjected to a similar one. Our men and women in public service deserve to be able to continue to contribute after their public lives

are completed. McGuinty, Peterson, Rae, and Davis have all done so honourably and also in positions where they contribute to areas that were under their prior jurisdiction.

Why do the critics of Harris hate him so much? He seems a nice enough fellow. And is, and was, clearly well intentioned. Yet the blind and impassioned hatred comes through. Thoughtful groups that would never descend to ad hominem attacks in other areas seem to lose their judgment and restraint when it comes to Mike Harris and health care. They literally start talking about his "hula hoops" comment more than twenty years after the guy left office. (On the subject of health care and hospital layoffs in 1997, Harris said: "Just as hula hoops went out and those workers had to have a factory and a company that would manufacture something else that's in, it's the same for government.")

My conclusion is that it has to do with job loss and job insecurity. Thousands lost their jobs, and tens of thousands had their roles change during restructuring. On a human level these care workers and many others lived with uncertainty through this period. It may well have started with the Social Contract pre-Harris. For a period of more than five years, workers who felt that they had a lifetime agreement with society felt unmoored and threatened. People who self-select into life of service to others and a vocation of caring do so because of their values; my experience has been that many do not do well with the kind of uncertainty that other professional types thrive on. They experienced a lot of uncertainty under Mr. Harris. They resented it and hate him. Personally. This is a completely understandable reaction to a very difficult situation.

Twenty years later most of the Canadian groups writing on the Harris years either repeat the HHCC shibboleth or are silently accepting. The Canadian Centre for Policy Alternatives did a twenty-year post summary of the Harris years ominously called: "The Long Shadow of Mike Harris." You can judge the dark corporatist cover and the two facile pages on health care for yourself by following the URL provided.[25]

There is literally no other comment on the entire "Harris Health Care Cuts" in this professionally produced review of the Harris regime by one of its most fervent academic critics. They apparently have nothing of substance to say on the topic. Just Hula Hoops.

Michael Decter, in his foreword to *Riding the Third Rail*, makes my favourite criticism of Harris when he says that the Harris government left the job half done. He paraphrases Sinclair, Rochon, and Leatt as follows:

> The authors are clear that the Ontario government retained—through the powers of the purse—ultimate approval power. They are also direct and honest about the 'deep frustration' of working with a government that failed to move decisively on the larger health service issues. Their recommendations on hospital restructuring were implemented, but those requiring government decisions to invest in community-based services were routinely ignored.

I think this criticism is fair and correct. The community investments that were recommended still await government action twenty-five years and several governments later. Few, other than a policy expert as tough-minded as Michael Decter, could get away with dinging Mike Harris for not moving decisively. It is a measure of how far-sighted the HSRC was under Sinclair's leadership that the same policy imperatives on primary care, health information technology, supporting aging (and others) remain into the third decade of the twenty-first century. Indeed, Sinclair as chair of the HSRC said on several occasions that if he had his druthers, the restructuring of primary care would be their top priority.

One more ridiculous and particularly unfair criticism is made in the post-Covid world and needs to be addressed. It runs like this: "Mike Harris cut hospital capacity and that is why we are having a bed shortage post-Covid." As if the hospitals closed twenty-five years ago would still be architecturally useful and as if there haven't been six intervening elections.

The folks that make this criticism also ignore that if there was an HSRC-like method still used today, then there would be more hospital beds. Particularly in the 905-region around the GTA.

The current system of funding allocation by our health ministry is (in my opinion) intentionally not transparent. Analytical documents in the ministry's possession are not published; there are no editorial board meetings. The system obfuscates bed shortages that are as well known to experts as the over-bedded situation was in 1995. We actually are now seeing the kind of bureaucratic capture of central planning elites that Hayek predicts in his writings. Frankly, I do not understand why there isn't a revolt in Brampton and York region. But it is not Mike Harris' fault, and it is silly polemics to say so.

* * *

It is ironic that Mike Harris is accused of being a free market advocate in health care while overseeing one of the best central planning processes in Canadian history. It's further ironic that he is labeled as a great privatizer. Frustratingly, the ironies obfuscate a really important debate about when we should use free consumer input as opposed to expert opinion to allocate public and private resources to health care. The naiveté in the political discussions in our country on this topic has been disgraceful. And this continues to be the case to this day.

The Harris team did a good job as central planners because they were tough-minded and evidence-driven at a time when there existed solid elite consensus. They took the proposed solution and implemented it. In areas where there was less of a consensus they did less well. As did other governments.

Areas like mental health and aging in place have been hugely challenging for central planners, and for policymakers generally, for exactly the reasons that Hayek identified. Social determinants of health are recognized as important by all parties, but central planners

systematically deny the ability of consumers to use public funds to pay for these important things. We often constrain the mixing of public and private spending arbitrarily, or in the name of quality and appropriateness. A more consumer-oriented model for aging is clearly needed. Similarly, we talk about the need for wellness and investments in health, but we constrain the public from using their own dollars to purchase these. It appears to me that innovation in healthcare policy will almost certainly require an embrace of some of Hayek's free market ideas and a corresponding reduction in the role of central planning, as we move forward with meaningful healthcare reforms in the 2020s.

Fee schedules exemplify interest group capture of the means of production. As Hayek predicts, these set prices and regulatorily constrained supply have resulted in a continued reduction of both competition and innovation. Midwives, nurse practitioners, physiotherapists, pharmacists, and many others are prevented from competing on access, quality, cost, and provider satisfaction. And, ironically, this blocking of competition is done in the name of those quadruple aims.

But fee-for-service pricing is just the most obvious part of a very large regulatory iceberg. Our health care system has developed in such a way that we pay set prices for an increasingly limited set of services. In the main, these are for access to doctors and acute care hospitals; in other words, they are for physical care of the sick a la 1970. This is not the case for mid-level providers, not for drugs, not for virtual care, not for wellness, nor for many things that consumers would choose if they could. The set-price model often favours those with non-financial power and position—insiders and those with friends in health care. The vulnerable, poor, remote and indigenous populations have constrained access. Again and again, we see different choices that would be made by vulnerable groups being disallowed by mainstream rules that are culturally dominant. Allocative models that allow true choice are not permitted; we make "appropriate" decisions and impose our values as planners. This often makes the system less equitable in the name of keeping it public.

What is shocking is that today's conservatives (and Liberals?) still don't recognize the legitimate role of consumer choice in our public health-care system. Constrained choice regimes are the norm. These regimes reduce quality and drive-up prices (as Hayek would predict). This in spite of the success that CCO had with purchaser/provider splits and the later McGuinty success with wait-times spending and quality-based programs. Wait times in Ontario dropped dramatically under this model.[26] This represents a powerful example of how the use of market signals can materially enhance the quality of public health care.

Today's challenges in health care are increasingly the result of mixed public/private payment models in which central planning allocations make less and less sense. And in which rules-based central planning results in bureaucratic producer-dominated systems. Pharmacare, denticare, mental health, ageing in place, virtual care, and team-based care all require different allocative decisions than those are available through public fee schedules—precisely because these are very difficult for central planning models to accommodate. Even if those central planners are as good as Mike Harris was.

Notes

1 *The Common Sense Revolution*, 1994 (p. 2, 3 and 7).
2 Ibbitson, *Promised Land*, p. 28.
3 Looking Back, Looking Forward; The Ontario Health Services Restructuring Commission (1996—2000), March 2020 p.iii.
4 Bound black volumes 3–13 of HSRC documents (1996–2000). Private collection of M. Rochon. These volumes also include related advice to minister and other key geographic artifacts.
5 For those interested in a complete history, I recommend two sources: *Riding the Third Rail by Sinclair et al.* as well as *Looking Back Looking Forward* a legacy report issued at the end of the mandate in March 2000.
6 *Riding the Third Rail, 2005 by Sinclair et al. published by IRPP.*
7 Our World in Data, retrieved by the author.
8 Our World in Data, retrieved by the author.
9 https://www.sothebys.com/en/articles/this-is-what-we-believe-margaret-thatcher-and-f-a-hayek

10 *The Road to Serfdom (condensed), p. 40 1944* Frederich A. Hayek. I quote from the *Reader's Digest* version.

11 George Orwell wrote a review of Road to Serfdom in *The Observer* on April 9, 1944:

> By bringing the whole of life under the control of the State, Socialism necessarily gives power to an inner ring of bureaucrats, who in almost every case will be men who want power for its own sake and will stick at nothing in order to retain it. Britain, he says, is now going the same road as Germany, with the left-wing intelligentsia in the van and the Tory Party a good second. The only salvation lies in returning to an unplanned economy, free competition, and emphasis on liberty rather than on security. In the negative part of Professor Hayek's thesis there is a great deal of truth. It cannot be said too often— at any rate, it is not being said nearly often enough—that collectivism is not inherently democratic.

Strong stuff from an avowed socialist and supporter of the Labour Party. Orwell in 1944 had lived through the Spanish Civil War as a POUM supporter in which he and others were betrayed by the Stalinists. *Animal Farm* was published on August 17, 1945.

12 Ministry of Health figure, provided to the author by M. Rochon.

13 Particularly terrible were some of the ones published twenty years after the fact, who substituted "Hula Hoop" quotes and ad hominem attacks for substantive arguments (see Section 4 "What do the critics of Harris Health care policies actually say?").

14 This actually is a bit Hayekesque.

15 Volume 1: *Mandate & Legislation.* Court Decisions Black bound HSRC reports Volume 1. Courtesy of M. Rochon.

16 I was reminded of the "Directory" Period in the French Revolution, as Directors were sent out from Revolutionary Paris to parts of France to implement the Revolution.

17 Such an argument will be familiar to anyone who has lived through corporate bankruptcies or major corporate restructuring. I have done several and hope never to have to do another.

18 I have not included labour adjustment among the key success factors that I have mentioned. I have left this out in part because there is a lot of noise about this and less clarity and in part because it is an issue broader than just health care, and so I will leave it to better-informed co-authors.

19 For interested readers, I would encourage you to also refer to the chapter on the Harris fiscal record which shows that overall healthcare spending did actually increase over both the first and second terms of the Harris era.

20 *Riding the Third Rail,* p. 221.

21 Most of this section is based upon discussions with ministry officials whom I know. Interestingly, this early reform seems to have been important later to the Deb Matthews Bill 102 reforms.

22 This section is again based upon discussions with former ministry officials. In this case, supplemented by my own experience and direct knowledge.

23 This section is again based upon discussions with former MoH officials. There was an excellent "walk it back" report done early in the McGuinty years by a committee chaired by Decter (I led the consulting team but can't find a copy of the report in any archive).

24 Sinclair et al. pp. xix–xx.

25 https://policyalternatives.ca/publications/reports/onpolicy-long-shadow-mike-harris

26 Fraser Institute, *Waiting Your Turn 2014 report*, https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2014.pdf. *Page 44 Graph 13 shows surgical wait times dropped from 8.7 weeks in 2004/5 to 5.8 weeks in 2008/9.*