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CIVIC AFFAIRS

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Financing Hospital Construction in Metro

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SUMMARY

The Federal and Provincial government contribute about one third of the capital cost of active treatment hospital beds, each of which may cost from $15,000 to $20,000. If grants from these sources remain at their current level, the citizens of the metropolitan area, through municipal grants or voluntary donations, will have to provide a balance of roughly $74 million by 1980 to assure adequate hospital facilities for an anticipated population of 2.3 million.

Since 1958, the Metropolitan Corporation has declined to make grants for hospital construction, though a number of Area Municipalities have contributed to the capital cost of new hospital facilities serving their jurisdictions. The remaining capital requirements, after all government grants, must be raised from private sources, particularly from business and industry.

The policy of the Metropolitan Council is based on the view, subscribed to by many municipal representatives and associations in Ontario, that hospitals are a social service and as such should be a provincial responsibility. By refusing to make capital grants, the Metro Council hoped that, with the support of other municipalities, the Province would be forced to assume a greater share of hospital construction costs. The existence of several teaching and regional hospitals within the metropolitan area strengthened this stand since the cost of facilities for educational purposes and care of non residents represents an inequitable charge if borne entirely by the taxpayers of Metro.

However, many municipalities, including some with teaching and regional facilities make capital grants to hospitals. Why have such grants been made? In some instances, elected members have found it difficult to resist pressure for the provision of as essential a service as hospitals; in others, grants may assure that a proposed hospital is built within one municipality rather than in an adjacent one; and frequently, grants have been made because hospital beds are badly needed and capital funds cannot be found elsewhere.

Such individual action by area municipalities has encouraged inequitable standards of service, poor planning and co-ordination, and inefficient distribution of facilities. These shortcomings could be reduced if the Metro Corporation, in the absence of provincial government action, were to re-enter the hospital field with a system of capital grants designed to encourage the construction and distribution of hospital facilities throughout Metro, according to the needs of the area.

Should Metro revert to its previous policy and again make capital grants for hospital construction? If the Province had shown any inclination to accept greater responsibility for construction costs, there is little doubt that the policy now being pursued by Metro and other municipalities, would be worthy of continued support. Greater provincial responsibility would provide co-ordination of hospital planning at an effective level as well as added financial support. But no change in the Province's policy has been indicated. It appears that any move to improve the existing situation with respect to the provision of hospital facilities can only be made by Metro at the expense of whatever ground it has gained since 1958.

Financing Hospital Construction in Metro

In March 1958, the Council of Metropolitan Toronto established a policy of refusing to make new grants for the purpose of hospital construction. The decision, based on the recommendation of the Special Hospital Committee of Council, has been subject to frequent attack but to date has remained unchanged. Recently two incidents have renewed the whole debate. First, North York Council has committed itself to asking the voters in the December election if they favour the levy of 1 mill yearly, the proceeds of which would be devoted entirely to capital grants to hospitals. Second, Wellesley Hospital's request for financial assistance in extending existing facilities was, for all practical purposes, turned down by the Metro Executive Committee. Metro's refusal caused considerable indignation in all three daily newspapers and aggravated many citizens and organizations. Yet discussion of these particular issues has been conspicuously devoid of reference to the contentious belief on which the municipality's policy on hospitals is based — that hospitals are a social service and that services in this category are properly a provincial responsibility.

Background

When Metropolitan Toronto was created in 1953-54, two of the local municipalities included in the federation were already committed to a schedule of grants to hospitals for construction purposes. The unpaid balance of their pledges totaled $4,990,000. The newly formed Metropolitan Corporation assumed responsibility for honouring these pledges and thereafter became the source, in Metropolitan Toronto, of municipal grants for hospital construction. By March of 1958, Metro had undertaken to pay $7,751,600 in capital grants to various hospitals, the last instalment of which was scheduled for payment in 1962. The instalments, which to that date had been met from current taxes by an annual levy of $1,000,000, ranged from a high of $1,187,000 in 1958, to a low of $230,000 in 1962.

When the Province and Dominion doubled their grants for hospital construction in 1958, Metro announced its intention to discontinue its hospital grants.

Prior to the increase in senior government assistance, municipalities across the province had petitioned the Provincial Government, through the Ontario Municipal Association, Ontario Association of Mayors and Reeves, and Canadian Federation of Mayors and Municipalities, for relief from this financial responsibility. The new payments, totaling $4,000 per new hospital bed, half from the Provincial and half from the Federal Government, gave hospitals $1,000 more per bed than they previously had received from the combined proceeds of provincial, federal and municipal grants. The municipalities interpreted this change as signifying provincial recognition that responsibility for hospital construction costs belonged properly with the two senior levels of government. This interpretation is reflected in the following excerpt from the report of the Special Hospital Committee, in which it was recommended that Metro discontinue capital grants to hospitals:

> "The increase in federal and provincial grants must be taken to be in answer to the representation made by the municipalities that they should be relieved of this social welfare cost. If the Metropolitan Corporation is to continue to make grants — (the) Municipality of Metropolitan Toronto will not receive the relief which was intended . . .". March, 1958.

The Committee's recommendation was subsequently adopted by Council.

Although the leading municipal associations had expressed support for the policy, many of their members across the Province found it politically impossible to follow a similar course in their municipalities. A parallel situation occurred in Metro Toronto where Metro representatives from North York and Etobicoke, for example, voted in 1958 to discontinue Metro's capital grants to hospitals but later made, and are still making such grants in their own townships. Since 1958, the payments made for this purpose by Scarborough, North York and Etobicoke total $860,000. The reason these and other municipalities felt obliged to make grants in the face of their stand that hospitals are a provincial responsibility is discussed later.

Even with the doubled federal and provincial grants, only 1/5 to 1/4 of hospital construction costs is covered. It is readily understandable then, that requests for municipal assistance for hospital building purposes did not cease after 1958.

Sources of Hospital Revenue

The expenditures involved in providing a community with hospital facilities can be divided roughly into capital and operating costs. Hospitals have recourse to particular sources of revenue to meet each of these: capital construction is financed partly by special government grants and partly by fund drives and public subscriptions, operating costs are met, mainly, by payments for services (chiefly from Ontario Hospital Services Commission, but also from Workmen's Compensation, Blue Cross, private individuals, etc.) and provincial per bed maintenance grants. It was hoped that when the Ontario Government established its hospitalization plan, deficits with respect to operating expense, at least, would be a thing of the past. Such has not been the case. Many hospitals are incurring operating deficits which must be met, eventually, by the community. The money to cover these deficits must be raised either by an appeal to the same public that is expected to carry a heavy financial load for hospital building, or by diverting revenue that would otherwise be applied to building construction. Either way, operating deficits compete with capital deficits for funds. Hospitals that run at a loss undertake a building programme at a severe disadvantage.

Capital Grants

Hospitals for treating physically ill or handicapped people are of three types: active treatment, convalescent care and chronic care hospitals. Active treatment hospitals far outnumber the latter two classes and are the most expensive to build. It is generally in reference to this type of hospital that discussion concerning capital grants arises.

The building cost per active treatment bed is estimated at between $15,000 and $20,000 in new hospitals. This figure is reached by attributing a part of the cost of auxiliary services, such as kitchen, laboratories, dispensaries, laundry etc., necessary for servicing beds, and general building costs (architect, landscaping etc.,) to each bed unit. Of this total cost per bed, approximately $6,000 is covered by Federal and Provincial grants — $2,000 per bed from the Government of Canada, $2,000 per bed from the Province of Ontario and an additional estimated $2,000 per bed from the Province toward various auxiliary services. This leaves a balance of approximately $9,000 to $14,000 per bed to be raised from other sources. It is not surprising that with a balance, even for small hospitals, that runs into hundreds of thousands of dollars, hospital boards seek assistance from bodies which are in a position to draw on the financial resources of the entire, or major portion of the area the hospital is designed to serve; namely from the councils of municipalities.

Aside from government, the hospitals' main sources of revenue are the general public, foundations, societies etc., and business and industry.

Taking the Toronto Western Hospital as an example, the following is a breakdown of revenue received from all sources for their new extension.

Source of Capital Funds
Toronto Western Hospital

Government:		
Provincial Government	$2,666,680	
Federal Government	1,077,316	
Metropolitan Government (pledged in 1954)	530,000	
		$4,273,996
Private giving:		
Business and Industry	$2,506,213	
Foundations	621,736	
General Public	723,023	
		3,850,972
Total		$8,124,968

As noted, Metro's contribution was pledged before 1958 and hospitals undertaking building since that time have not received comparable grants. Had there been no municipal contribution to Western Hospital, 13% more money would have had to be raised from private sources. And, of course, the work involved in raising this additional sum, if indeed it could be done, would have far exceeded that expended in obtaining the Metro grant.

If the present situation with respect to grants is maintained, rough calculations indicate that approximately $74 million will have to be raised from private (which includes corporate) donations in the 20 year period between 1960 and 1980 in order to achieve the desirable ratio of bed space to population.

This estimate was made by subtracting the number of beds that existed in 1960 from the total considered necessary by 1980 to serve the anticipated population of 2,300,000. $20,000 less $6,000 in grants was taken as the unmet cost per active treatment bed. $10,000 less $5,000 per chronic and $12,000 less $5,000 per convalescent bed.

Hospitals will have to look mainly to the business community for most of this amount. The figures cited for Western Hospital follow the general tendency in private contributions for hospital building purposes: the donations of business and industry far exceed those from the general public. In the above case, they were three times as large. This is the reverse of the trend shown in other charitable drives, such as the United Appeal, but it is typical of a general swing in corporate giving, away from maintenance and service contributions and towards the support of capital projects.

Areas Where Economies Could Be Effected

The shortage of chronic and convalescent beds, (375 in Metro in 1960, the last year for which complete figures are available), has led to a less efficient use of hospital resources than is desirable. It is generally conceded that many of the patients for whom these beds are needed are now occupying active treatment beds. The building cost of an active treatment bed runs from $15 - $20,000 while chronic and convalescent beds run from $10 - $12,000. Active treatment bed maintenance averages $15.50 per day as opposed to $8.84 - $9.82 per day for chronic and convalescent beds. The inefficiency of not using active treatment beds to the best advantage, that is, for patients requiring intensive and specialized care, is obvious. Aside from the financial considerations, the improper use of active treatment beds, in effect, increases the existing shortage of this type of bed.

It is worthy of mention here, that the type of bed space which is referred to by Ontario Hospital Services Commission as convalescent does not cover as wide a range of treatment as is commonly understood by the term: the Commission's definition refers to bed space for patients who require special services such as occupational or physiotherapy and does not include those who are recovering from an operation, for instance, who require limited supervision and treatment, or who are not yet completely capable of caring for themselves.

Experiments are now being conducted in the care of the latter type of patient. One experiment is the Provincial Government's pilot "home-care" plan whereby convalescing patients are allowed to return to their homes and the care provided by their families is supervised by a visiting nurse. A second is the establishment of progressive care hospitals. Under the system employed here, as a patient's condition improves he assumes greater and greater responsibility for his own needs. In both these plans it is hoped the result will be to effect economies in the cost and bed space expended in caring for convalescent patients.

The Municipal Point Of View

It was stated earlier that the position taken by Metro in 1958 of refusing to make hospital grants was in complete accord with the policy approved by the leading municipal associations. Metro Councillors were and are supported in principle by local government representatives across the Province. Hospitals, maintain the municipalities, provide a social service and all such services should be provincially financed. Local councils have rejected responsibility in this field on the grounds that the property tax, which provides 90% of municipal tax revenue, is an unsuitable base on which to finance social services. The municipalities' position is summarized in the following quote:

> "There are serious differences of opinion, not so much as to the desirability of many of the suggested lines of activities (social services), but rather as to the justification for undertaking them as a municipal activity so long as real property pays the bulk of municipal taxes. In this dilemma, the safe thing for the elected representative is to fight a delaying action and to undertake no more of such activities than they are forced to by circumstances, pending an adjustment in the basis of municipal finance."*

Traditionally, only services that provided benefits to property and property owners have been considered justifiable local responsibilities. Although it could be maintained that the presence of a hospital in a community enhances the desirability of the area as a place in which to live, it would be almost impossible to show a direct effect on property values as can be done, for example, by comparing land prices before and after the installation of services. Nor do hospitals give any kind of priority or preference to property owners over other groups of citizens. Hence hospitals and social services generally fail to meet the classic requirements for municipal sponsorship.

In requiring that municipal services provide direct benefits to real property, local councils have attempted to guarantee that those who pay taxes receive the benefits. This approach assumes that all municipal taxpayers are property owners. The validity of this assumption is, of course, open to serious question since it is unrealistic, particularly in an urban municipality, to assume that tenants avoid property taxes in any but a strictly legal

*Crawford, K. G., CANADIAN MUNICIPAL GOVERNMENT, University of Toronto Press, Toronto, Ont., 1954, page 124.

sense. In Toronto alone, hundreds of thousands of tenants are paying municipal taxes through their rents. If such a wider interpretation of a taxpayer is employed, residence replaces property ownership as the characteristic which distinguishes taxpayers. The overwhelming majority of beneficiaries of hospitals and social services in a municipality are the residents of that municipality. From this point of view, then, there is some justification in considerating these services to be a responsibility of municipalities.

If eventually it were established that responsibility for hospitals and/or other social services rested properly with the municipality, another equally vexing problem would remain to be solved. To establish moral responsibility is useless unless the obligor is in a position to live up to the responsibility, in this case, to support the financial demands involved. Municipalities feel they cannot finance hospitals unless they are given new sources of revenue.

It is commonly accepted that there is a limit to the amount of money that can be raised by the taxation of property. Many people associated with local government believe municipalities are rapidly approaching this limit. Those who subscribe to this view cite as evidence the fact that tax arrears in municipalities across Ontario tripled between the years 1946 and 1956. In respect to Metropolitan Toronto, they point to the Ontario Municipal Board's warning that: "Immediate limits in capital spending will have to be applied in Scarborough and other Metropolitan Municipalities in the near future". This is hardly a healthy state of affairs in which to undertake increased financial responsibility, either as a result of extending old, or assuming new services. The increasing inadequacy of the existing sources of revenue for supporting even those expenditures to which the municipalities are already committed is illustrated in the following brief table:

	Municipal share of total government expenditures*	Municipal share of total government revenue*
1945	6.4%	9.52%
1960	19.14%	15.13%

Even those who are willing to accept hospitals and social services as being within the proper scope of municipal activity, recognize the financial impracticability of supporting them through the property tax. Only an agency with power to collect taxes from a high percentage of the population (e.g. the Province through sales tax, the Federal Government through income tax) is in a position to support such services.

*Based on figures reported in Comparative Statistics of Public Finance Federal, Provincial and Municipal Governments, 1945 and 1951-59, and 1956-60, Dominion Bureau of Statistics.

This is the financial background against which Metropolitan Councillors and their confreres across the province have been acting. They have seized upon provincial capital grants to hospitals as token recognition of responsibility by that level of government. Accordingly, they have maintained that the onus rests with the Province to meet current and capital deficits incurred by hospitals.

Unusual Circumstances in Metro

In Metropolitan Toronto, circumstances peculiar to a few urban centres in this province (Kingston, Ottawa, Hamilton and London) raise arguments for provincial support of hospitals that are in addition to those described above. Each of these centres has one or more Group A hospitals in the municipality. These are general hospitals "providing facilities for giving instruction to medical students of any university". Toronto has ten such hospitals out of a total seventeen in the province.

Teaching hospitals contain a number of facilities not normally provided in general hospitals — classrooms, interns' residence, etc., — and are often equipped with more up to date, specialized instruments and equipment than are generally employed elsewhere. These hospitals serve a dual purpose — healing and education. The level of education provided is one for which municipalities have never recognized a responsibility. Yet this aspect of the hospital's activities involves additional expenditures which are included in the general cost of building and operating the hospital. When Group A hospitals incur an operating deficit or a deficiency of capital funds, part of the deficit is attributable to these educational expenditures. If the Municipality of Metropolitan Toronto were to give financial assistance to such hospitals, they would be contributing, in part, to the post-graduate education of students from across Ontario. There is little justification for imposing a responsibility of this nature on the taxpayers of one municipality and not another.

The same argument applies to the support of regional hospitals. These institutions, although located within the boundaries of one municipality, serve the specialized needs of a large surrounding area or even a province. In Toronto, as in other large centres, the functions of providing medical instruction and providing regional referral services are so closely related that it is almost impossible to describe one hospital as being primarily regional and another as teaching, for both terms

apply equally. It would be unfair to expect the citizens of one municipality to subsidize these hospitals to a greater extent than other residents of the area served. In Metro hospitals, patients from outside Metro Toronto account for 14% of these cases and 18% of the days-of-care provided. Twenty percent of the bed space required in Toronto, according to Dr. R. W. I. Urquhart, Chairman of the Ontario Hospital Services Commission, is attributable to patients from outside Toronto:

> "It should be noted that regional hospitals such as those used for training in medicine not only serve the community in which they exist but also serve the special needs of much of the province as a whole. It is stated usually that the requirements for hospital beds in Metropolitan Toronto, forinstance, is four beds per thousand of population for community needs, 0.5 beds for patients referred from district hospitals and 0.5 for patients referred from the more remote community hospitals."

These added considerations give Metro Toronto and the four other teaching centres in Ontario more than average cause for rejecting any obligation for hospital financing.

Why Have Many Municipalities Relented?

A number of the constituent municipalities of Metro, and indeed municipalities throughout the entire province have made grants to hospitals. Many factors have exerted an influence on councils to bring this about.

Among the most common and effective of factors is the influence of leading citizens and community groups, and the expression of strong public opinion sympathetic to the plight of hospitals. Pressure that is applied on behalf of such essential services as hospitals can be very difficult for an elected representative to resist. A politician who refuses to bow to demands of this nature risks a great deal, particularly in a smaller community where it may prove to be politically damaging.

On occasion, the determining factor in whether to make a capital grant is the council's assessment of the influence the grant will carry with it. Municipal representatives may feel that the voice they gain in determining the location of a proposed hospital overrides other considerations. Their desire to have a hospital built within the boundaries of their municipality is understandable, but local pride expressed in this manner can easily lead to wasteful duplication of coverage and services by hospitals. Gains made by citizens of a city, town or village may be made at the expense of citizens in an adjacent municipality or the area as a whole. From the point of view of hospital planning, it would be most desirable if local government were not in a position to employ this form of suasion.

Finally, when considering a request for a contribution to hospital construction, municipal councils are usually aware and acutely interested in the result that their actions might have on the health and welfare of the community. This is particularly relevent in an area where bed space is at a premium. If they feel that strict adherence to a policy of refusing to make hospital grants might work a hardship on innocent parties, councils may put aside their policy without moderating their views on the basic question of where responsibility should properly rest.

Should Metro Relent?

In Metro Toronto, three methods of financing hospital construction might be employed. First, individual municipalities could continue to make grants independently to particular hospital projects. This alternative, which is the least desirable of the three, is the method now in use. Second, the Province might recognize and assume full responsibility in this field; or third, Metro might return to its former policy of making grants for hospital construction thereby replacing its member municipalities as the source of local grants.

Many of the drawbacks of the present system have already been described. In summary: co-ordination of hospital planning is informal and occasional; hospital officials and boards are open to pressure through the promise of grants from parochially minded local councils; and the building or location of new hospitals may be influenced more by the financial resources of individual municipalities than by the needs of the entire Metro area. Hospital building is too vital and too expensive to be left to such a disorganized arrangement. New construction must be planned to complement existing hospital services and provide for the most efficient use of proposed facilities. It should assure an equitable standard of service throughout the planning area. This is only possible if some central authority is in a position to control and co-ordinate hospital construction. The level of government by which centralized planning could be implemented most efficiently is the provincial level; the means by which authority could be exercised most forcefully is financial.

The Province of Ontario is already imposing a degree of central control. Grants can be withheld if the Hospital Services Commission does

not approve of building plans submitted to it. But to the location of hospital facilities, is not as great as it should be. Because provincial capital grants account for a relatively small proportion of building costs, the Commission, in its negotiations with local officials, must recognize the task a hospital committee faces in raising the balance of funds required, and on occasion, accept a compromise between what is possible and what is desirable. Only by increasing the fraction of cost that is financed by the Province could significant strides be made in making the Ontario Hospital Services Commission an effective co-ordinator of hospital building. No indication has been given recently that any increase in grants is contemplated. Thus, although of the three alternatives, provincial control seems to promise the best results, it is least likely to be adopted.

In the metropolitan area, there is one further alternative — the Metropolitan Corporation could return to its former policy of providing funds for hospital construction. Its refusal in 1958 was designed to bring pressure on the Province to force it to assume this responsibility. To date, Metro's campaign has been unsuccessful. A return to the pre 1958 policy, it is feared, would be an admission of defeat and might be interpreted as recognition by Metro of responsibility in this field. But since the overriding objective must be the provision of an adequate number of hospital beds and since other alternatives are either defective or unattainable, the advantages of returning to the old system, with modifications, would be many.

In the present situation, with individual municipalities making grants, it is very difficult to encourage decentralization of hospital construction. Yet it is in the suburban municipalities that bed space is most badly needed. Metro could, through grants, discourage building in the central area where general care facilities are developed, and tap the financial resources of the high assessment areas to encourage hospital construction wherever it is needed in Metro. For example, if the entire area were divided into geographic sections, Metro could refuse to make construction grants in any area where the ratio of hospital beds to population equalled or exceeded 5:1000, grant $1000 per bed where the ratio was 4:1000, and grant $2000 where the ratio was 3:1000 etc. up to some maximum. The Metro revenues used for this purpose would be raised through the general rate levied across the entire metropolitan area.

Such a system would not be free from risks and complications. There is a suggestion that if new hospital construction were to be financed through taxes, the business community might discontinue its voluntary donations. As pointed out earlier, business and industry are the main source of private donations. Should there be substance in this suggestion, it might be that hospitals in Metro would be no better, or possibly worse off in respect to capital funds than at present. However, there would be some assurance from the point of view of the citizen that money being spent was going where it was most needed.

No matter what course Metro Council follows in the question of hospital grants, it will be criticized. If it relents, members will be accused of lacking the courage of their convictions, of submitting to pressure, and of rendering useless the efforts of councillors since 1958. If it does not relent, metropolitan representatives will be accused of sacrificing the interests of citizens in a jurisdictional dispute which they may never win. It is a situation in which the long term advantages of co-ordinated hospital planning must be delicately weighed against the immediate need for hospital facilities throughout the Metropolitan area.

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