Evaluating the Effect of the Progressive Conservative Party of Manitoba's Austerity-Centred Approach on Manitoba's Healthcare System From 2016 to 2022

by

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Abstract

Austerity – a set of economic policies intended to reduce or eliminate yearly budget deficits and diminish the overall size of the state – is often enacted by governments when they believe saving, rather than spending, is the most effective way to stimulate the economy. The effects of austere policies, such as budget cuts, privatizations, and contracting out, have been and continue to be the subject of debate and exploration amongst policymakers, economists, and scholars alike. This paper examines the effect of austerity on the healthcare system – specifically on healthcare workers and their ability to deliver care – in Manitoba in the years since 2016, when the Progressive Conservative Party of Manitoba (PCP) reclaimed governing power from the New Democratic Party of Manitoba (NDP). It analyzes a series of quantitative measures of Manitoba's healthcare system funding and performance, including expenditures, wait times, and job vacancy rates within the sector, supplemented by a qualitative analysis of survey responses from more than 450 of the province's healthcare workers. It shows that 1) the PCP has included healthcare as part of its broad austerity agenda and 2) the effects on healthcare workers and their ability to provide care have been and continue to be overwhelmingly negative, which accords with the existing literature on austerity and healthcare. Although most provinces have found their healthcare systems in crisis in recent years, the findings presented in this paper suggest that Manitoba under an austerity-focused-PCP fares worse than the national average by almost every measure.

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Table of Contents

Abstract……i

Acknowledgements……..ii

List of Tables……..iv

List of Figures…….....v

Chapter I: Introduction…….1

Chapter II: Theory of Austerity……...3

Chapter III: Literature Review……6

Chapter IV: Methods & Data……12

Chapter V: Results……...16

Inputs……..16

Mechanisms……...22

Outputs……...27

System-Related Outputs…….27

Supply-Side Outputs……..32

Perspectives From Manitoba's Healthcare Workers……..39

Chapter VI: Discussion……...51

Chapter VII: Conclusion…….55

Reference List……57

Appendix: Full Survey……...62

List of Tables

Table 1: Summary of variables……..13

Table 2: Survey responses: the presence of austerity……41

Table 3: Survey responses: the effect of austerity (non-worker-related outcomes)……..45

Table 4: Survey responses: the effect of austerity (worker-related outcomes)……..46

Table 5: Survey responses: the effect of austerity on cost savings……....49

Table 6: Survey responses: the evolution of austerity……...50

List of Figures

Figure 1: Percent change in Manitoba healthcare expenditure 2011-2019……19

Figure 2: Annual per person total provincial healthcare spending 2011-2021……..21

Figure 3: Annual per person provincial COVID-19 response funding……..22

Figure 4: Timeline of cuts and changes to healthcare under the PCP in Manitoba 2016-2022….26

Figure 5: Annual provincial median wait times for elective surgeries 2011-2021……29

Figure 6: Annual provincial median wait times for diagnostic procedures 2011-2021…….30

Figure 7: Annual provincial physician-to-100,000 population ratio 2011-2020……...31

Figure 8: Annual provincial wage for Health & Social Assistance workers 2015-2022……...34

Figure 9: Annual provincial Health & Social Assistance job vacancy rate 2015-2022…….36

Figure 10: CMA provincial average reported weekly working hours 2017 & 2019…….38

Figure 11: CMA provincial average reported satisfaction 2017 & 2019……...39

Figure 12: Survey responses: the impact of austerity on employment……..43

Figure 13: Survey responses: the impact of austerity on patient care……44

Introduction

To save or to spend? That is the question. At least, that tends to be the question which plagues governments at every level as they contemplate how best to generate economic growth and consequently, improve their citizens' overall health and welfare. While some economists and policymakers believe that it is worthwhile to increase spending in areas such as education, healthcare, and social services, others worry about the effect of potential overspending on the ability of governments to pay off their debts, attract investment, and incentivize consumer demand. They therefore may choose to pursue austerity rather than stimulus in an effort to reduce or eliminate their yearly deficits and cumulative debt. This has been precisely the stated policy posture of the Progressive Conservative Party of Manitoba (PCP) since it was first elected to replace the New Democratic Party of Manitoba (NDP) as the province's governing party in October of 2016.

By the time of the 2016 election, the provincial New Democrats had governed for a remarkable sixteen plus years. While they had led the province quite successfully out of the 2008-09 financial crisis and had kept unemployment fairly low in the years since, they had fallen out of favour with many Manitobans, who were tired of their government running large deficits year after year and who did not feel as though they could trust a party who raised the provincial sales tax (PST) to eight percent, after promising it would not do so (Levasseur et al., 2016). The PCs seized on Manitobans' discontentment with then-Premier Greg Sellinger and his New Democrats. Under the leadership of then-candidate and soon-to-be Premier Brian Pallister, they campaigned on a platform to return the PST to its former seven percent rate and improve Manitoba's fiscal health by restoring a closer balance between revenues and spending. Following their decisive victory, the PCs delivered. In each of the three fiscal years following the 2016

election, the provincial deficit steadily declined, dropping from $932 million in 2015-16 to $149 million by 2018-19 (Royal Bank of Canada [RBC], 2022, p. 2). Further, on July 1, 2019, the PCs followed through with their PST promise, reducing the rate to seven percent (Siragusa, 2019). Then-Premier Pallister called an early election for September 2019, and following another majority victory, the PCs continued on the same path toward fiscal balance, achieving a $5 million surplus in 2019-20 (RBC, 2022, p. 2). In March 2020, Premier Pallister announced his party's intention to further reduce the PST rate to six percent on July 1, 2022 (Dacey, 2020a). The onset of the COVID-19 pandemic, however, stood in the PCs' way. To respond to the crisis, they were forced to defer the PST reduction – which has yet to be revisited – and to run sizeable deficits of $2.1 billion and $1.4 billion in the 2020-21 and 2021-22 (projected) fiscal years, respectively (RBC, 2022, p. 2). Their goal has and continues to be, though, to return to a more balanced fiscal position.

Many have argued that the PCs' policies since assuming office in 2016 represent an example of austerity (Fernandez, 2017; Hajer, 2019; Wilt, 2019; Brown, 2020). Austerity, though, can mean a number of things. There are three main types of austerity, all of which aim to balance government budgets – 1) by raising taxes while maintaining or even increasing spending, 2) by raising taxes while reducing nonessential government functions, and 3) by reducing taxes while simultaneously reducing government spending (Hayes, 2021). Therefore, the type of austerity that they – and I – contend Manitoba's PCP has practiced is the latter. In addition to strictly reducing yearly deficits and cumulative debt, austerity can also include transferring responsibilities from the public sector to the for-profit private sector, contracting out positions that were previously held by unionized government employees, underspending relative to projected spending stated in annual budgets, and generally reducing the size of the state. While

there is broadly a consensus that the PCs have practiced austerity as their overall modus operandi since 2016, there is space to debate the extent to which it has affected individual government departments. I intend to focus on one of these departments. It is in this context that my research topic emerges – an examination of the effect of the Progressive Conservative Party of Manitoba's austerity-centred approach on the quantity and quality of healthcare services that have been and continue to be provided in the province since 2016. The remainder of this paper will explore the theory behind austerity, review the existing literature on austerity and healthcare, establish the significance of my contributions, outline the manner in which I complete my research, and present my findings.

Theory of Austerity

The idea of austerity is not new. In fact, while it was not explicitly labelled as austerity until the beginning of the 20th century, Blythe (2013) traces its origins as far back as the 17th and 18th centuries, attributing them to John Locke, David Hume, and Adam Smith (pp. 105-113). For his part, Locke laid the intellectual groundwork for austerity by establishing the supremacy of the individual – specifically, individual property rights – above the state, which he believed should perform an extremely minimalist role. He contended that the state had no right to tax the property of individuals unless it was given express permission by the citizenry to do so. Hume took this argument one step further, noting there was almost no acceptable role for the state, as it merely interfered with the economic growth facilitated by merchants by demanding revenues for its activities, which would eventually accumulate into limitless public debt. Smith, on the other hand, acknowledged the necessity of the state to do such things as defend its borders, protect private property, and train workers, but also feared an accumulation of public debt, and therefore argued for the state to exercise frugality and to save as much as possible. Savings, he said,

stimulated investment by merchants, which would further grow the economy. Taking the views of these three men together, who feared both an overactive state and a buildup of public debt, forms the historical basis of a case for austerity. While it is not a new concept, austerity began to be discussed in the 20th century and has once again come to the fore in the past fifteen years, perhaps because governments around the world have had to grapple with not one, but two global crises, the first in 2008-09 and the second beginning in 2020.

Austerity measures are most often characterized as any "set of economic policies….used by governments to reduce budget deficits" (Bondarenko, 2015). As noted, deficit reduction can be tackled in a number of different ways, typically either by raising taxes or by cutting back on government spending. More comprehensive definitions – definitions to which I refer – also include privatization, contracting out, underspending, and an overall goal to diminish the size of the state. The argument for austerity generally possesses both ideological and practical considerations. Ideologically, savers are often seen to be virtuous, while spenders are seen to be sinful (Blythe, 2013, p. 115). Practically, austerity measures are typically put in place when a government has had to or has chosen to run large deficits for a number of consecutive years, and when it therefore feels as though it needs to reign itself in to restore fiscal balance (Knowledge at Wharton Staff, 2015). Proponents of austerity, then, contend that running deficits year after year make it increasingly difficult for governments to pay off their debt, risking default or sharper fiscal contraction in the future. Therefore, they claim that in order for governments to restore their economic health and inspire confidence from present and future creditors, they must close the gap between spending and revenues (Hayes, 2021). As noted, Manitoba's PCP has opted to pursue austerity by cutting taxes while also cutting spending. Proponents of this particular method of austerity tend to be free market advocates, who suggest that individual economic

actors know best. Thus, for them, in order to stimulate growth, the government should reign in their spending and citizens should be taxed as little as possible, with the expectation that they will choose to invest their extra untaxed income back into the economy on their own accord. Locke, Hume, and Smith would likely have approved of this line of thinking.

Of course, neither this specific type of austerity, nor austerity more broadly, are without their criticisms. While proponents contend that fiscal health should be prioritized above all else and that austerity can promote long-term growth, opponents worry about its effect on unemployment, overall consumer demand, and its ability to realistically reduce debt-to-GDP ratios (Hayes, 2021). Austerity measures are often enacted during periods of recession, when private sector employers are already struggling to employ workers at normal levels. Consequently, during these periods, unemployed or underemployed individuals often cut back their personal consumption, further exacerbating the economy's contraction. Austerity's opponents, then, argue that instead of cutting program spending, governments would do well to increase spending and specifically, to increase public sector employment, as to reduce overall unemployment and encourage consumer spending. In doing so, they would stimulate the economy and more effectively reduce the debt-to-GDP ratio, as occurred, for instance, during the post-war period from the mid-1940s to the 1970s in the US and other developed nations. The multiplier, in essence, calculates "how many dollars of future economic growth are created for each dollar of government spending" (Stuckler & Basu, 2013, p. 64). In essence, the larger the multiplier is, the greater is the impact of additional government spending on economic growth. Stuckler & Basu (2013) claim that health, education, housing, and social protection spending have the largest multipliers, while defense spending and bank bailouts tend to have the lowest (p. 65; p. 144). Aside from strictly macroeconomic concerns, cutting government spending –

especially in areas such as health, education, and social protection programs – can negatively impact the quality and quantity of the services that can be publicly provided, and consequently, can affect population health and wellbeing, especially amongst the most vulnerable. My research focuses on this latter point.

Literature Review on Austerity in Healthcare

As noted, austerity measures are not a new government policy. They do, however, tend to make their way into conversations amongst policymakers more frequently when there is an economic crisis, such as during and after the Great Depression, the Great Recession, and more contemporarily, the COVID-19 crisis. My objective is to analyze the effect of austerity on a specific public sector unit in a specific context. Namely, the effect on healthcare – especially on healthcare workers and their ability to deliver care – in Manitoba in the years since 2016, when the Manitoba PCP reclaimed governing power from the Manitoba NDP. Of course, though, others have explored this or similar topics in different periods and in different contexts, attempting to determine whether austerity works as well in practice as it is purported to in theory. Austerity can have two very separate effects, dependent both on how it is put into practice and the way in which it is analyzed. The first is its effect on the social determinants of health and consequently, on population health outcomes, such as morbidity, mortality, and the prevalence of various illnesses. This is to say a government might choose to cut things like education, housing, and welfare spending, thus potentially making its citizenry more vulnerable to contracting or developing an array of infectious and chronic diseases. The second effect is on the provision of healthcare itself, delivered at the point at which members of the population already find themselves in need of care. In this case, a government may cut healthcare spending specifically, resulting in a potentially diminished level of care. My research focuses on the latter of these

effects. Both streams of thought, though, warrant due consideration, and both have been explored by others in alternative contexts.

Regarding the effect of austerity on the social determinants of health, one of the most famous tests came in the context of the Great Depression in the United States (US) between 1929 and 1939, in which close to 100,000 businesses went bankrupt and one in four workers lost their jobs (Stuckler & Basu, 2013, p. 7). In the wake of the stock market crash, suicide rates in the US rose by 16 percent, while a debate emerged between those who proposed austerity to prevent further economic collapse and those who argued that public spending would stimulate the economy and support the millions of Americans who had become unemployed (p. 11). Eventually, Democratic President Franklin Delano Roosevelt (FDR) enacted a series of progressive programs – including the Public Works Administration, the Food Stamp Program, and the Social Security Act – collectively referred to as the New Deal. Stuckler & Basu (2013) refer to the New Deal as "the [inadvertently] biggest public health program ever to be implemented in the United States" (p. 16).

The implementation of the New Deal provided a natural experiment to test the effect of spending compared to saving on health, as some states – mostly those with left-leaning governors – chose to invest more in New Deal programs than others. States that supported the New Deal and implemented its measures saw significant declines in infectious diseases, child mortality, and suicides compared with those that did not. Specifically, each $100 of New Deal spending was associated with a decline of 18 cases of pneumonia per 100,000 people, a decline of four suicides per 100,000, and a decline of 18 infant deaths per 1,000 live births (Stuckler & Basu, 2013, pp. 17-18). Further, employment only began to rebound in the context Roosevelt's public finance-intensive programs, not in the face of austerity (Blythe, 2013, p. 188). What the

Great Depression demonstrated, then, was that measures of both human and economic health improved along with government spending, even in times of extreme crisis.

Moving beyond the Great Depression, there have been numerous examples of other natural experiments in the decades since, which have allowed for similar tests of austerity on the social determinants of health. Following the collapse of the Soviet Union in the early 1990s, men in Russia and in ex-Soviet republics saw their life expectancies drop dramatically as the economic system transitioned from communism to capitalism. Millions of young men died from alcohol poisoning, heart attacks, suicide, or homicide (Stuckler & Basu, 2013, pp. 21-25). Some former Soviet republics, though, transitioned rapidly, heeding the advice of the International Monetary Fund (IMF) and significantly cutting their government budgets, including their health budgets, while others did so more gradually. Those that transitioned rapidly and implemented mass privatizations, such as Russia and Kazakhstan, saw a two-year drop in life expectancy and increases in male suicides by five per 100,000, heart disease by 21 per 100,000, and alcohol-related deaths by 41 per 100,000, compared to those that transitioned and privatized gradually, such as Poland and Belarus (Stuckler & Basu, 2013, p. 36). This case serves as an example of the effect of austerity on both the social determinants of health and on the provision of healthcare, since Russia and some of the former Soviet republics made broad cuts to their government budgets, but these certainly included healthcare and social spending.

It was not solely former Soviet republics, though, that experienced a turn to austerity and cuts to healthcare spending. Many European countries opted to pursue fiscal health, often times at the expense of human health, beginning in the 1990s, and even more so after 2008-09. Turning to the effects of austerity on the healthcare system, in conducting a comparative analysis of 27 European countries from 1995 to 2011, Reeves et al. (2013) find that countries that accepted

loans from the IMF, made general government cuts, or both, had the greatest probability of practicing healthcare austerity. From their sample, countries that borrowed from the IMF had an 80 percent probability of making cuts specifically to healthcare spending, demonstrating that when a country decides it needs to pursue deficit reduction, at least part of the burden tends to fall on the healthcare sector (p. 5).

Following the financial crisis of 2008-09, most European countries either chose to or were required to make budget cuts as a condition of receiving loans from the IMF, which were supposed to help get their economies out of a deep slump. The overall effect of accepting IMF loans on healthcare, though, has been demonstrated to be definitively negative, both due to the impact of broad spending cuts on the social determinants of health and the impact of specific cuts to healthcare spending. IMF recipients made cuts to healthcare budgets that were approximately 50 percent larger on average than non-recipients and they reduced per capita healthcare spending by $44.80 USD (Reeves et al., 2013, p. 4). A report by the Organization for Economic Cooperation and Development (OECD) shows a number of statistically significant differences between countries that enacted moderate healthcare cuts compared with those that enacted high healthcare cuts, most robustly that countries with higher cuts had fewer overall admissions to hospital, but more cases of obstetric trauma (van Gool & Pearson, 2014, p. 27). Of the countries that accepted IMF loans, Ireland and Greece were forced to make some of the most drastic cuts to healthcare. Between 2008 and 2014, Ireland reduced its number of whole-time equivalent health service positions by 7.2 percent, which led to the closure of acute beds, longer wait lists for procedures, a reduction in home-care services, and a sustained productivity drop in the system as a whole (Williams & Thomas, 2014, pp. 4-5). Meanwhile, when Greece accepted IMF loans in 2010, it agreed to cut its government budget by an amount equaling 10 percent of its

entire economy over three years and to keep public healthcare spending at or below six percent of its GDP, which was dismal compared to most other Western countries. The effect was clinic closures, excessively long wait times, prohibitively high costs of care, outbreaks of infectious disease, and consequently, a 40 percent rise in infant mortality and a 47 percent rise in unmet healthcare needs between 2008 and 2010 and 2011, respectively (Stuckler & Basu, 2013, pp. 85-90).

The UK, on the other hand, chose to make budget cuts on its own accord, specifically after the Conservatives, led by David Cameron, assumed office in 2010. While real per capita healthcare spending increased by 3.82 percent between 2001-02 and 2009-10, it increased by a much smaller 0.41 percent from 2010-11 to 2014-15. Over the same periods, real per capita social care spending rose by 2.20 percent, but then declined by 1.57 percent. Martin et al. (2021) estimate that the loss of health and social care spending in the latter period compared to the former was associated with 57,550 more deaths than would have occurred had the Conservatives maintained the spending levels of their predecessors (p. 11). More generally, they find that a one percent decrease in healthcare spending results in 2,484 additional deaths, while a one percent decrease in social care spending results in 1,569 additional deaths. While the Irish and Greek analyses speak to the effects of austerity on the healthcare system, the British case illustrates its impact on health outcomes in a particular period and context.

In the aftermath of the 2008-09 crisis, both the federal Canadian government and many provincial governments made similar choices to Cameron and the Conservatives in the UK, including those of British Columbia, Alberta, Saskatchewan, and Ontario. At the federal level, the Conservative government, led by then-Prime Minister Stephen Harper, enacted stimulus measures in 2009 and 2010, which from the outset, were only intended to last two years. They

were then followed by years of federal spending cuts and reductions in provincial transfers, even as Canada's economy struggled to fully recover from the crisis (Evans & Fanelli, 2018, pp. 6-7). At the provincial level, Manitoba's NDP was much less austere than its provincial counterparts, opting to minimize cuts and invest in areas such as infrastructure and healthcare. Compared to the 2007-08 fiscal year, real provincial expenditure on health was 18.6 percent higher in 2012-13 (Camfield, 2018, p. 118). Nevertheless, when the New Democrats realized they would have to work toward a balanced budget in their fourth – and as it would happen, final – term in office, program mergers, wage pauses for public sector employees, and reductions in staffing and resources all became part of the equation. Camfield (2018) interviewed a number of nurses and regional health authority (RHA) managers in late 2013, who noted that their workload and intensity of work had significantly increased, as Manitoba's RHAs had been cut from eleven to five and as the number of patients per nurse had risen. Nurses reported, for instance, having to skip breaks and meals, having to cover for coworkers when they were sick or on vacation and had not been replaced, and having to increasingly call on nursing managers who had little to no prior healthcare experience to make patient care decisions (Camfield, 2018, p. 116). Therefore, whether it is a choice that is made independently or through coercion, these cases show that austerity tends to have a negative effect on both healthcare and health outcomes where it is enacted.

The existing literature has laid the groundwork for my own research. It has established a precedent for analyzing the effect of austerity on healthcare spending, and consequently, the effect on health indicators. The majority of the literature, however, focuses on the American and European contexts and emphasizes quantitative indicators of health, such as mortality and prevalence of disease. I supplement it by studying austerity in a previously less-explored

geographical context – Manitoba – and within a more current time frame. Camfield (2018), for instance, has certainly examined austerity in Manitoba, but not as it has been practiced by the current PC government. Further, my analysis includes both quantitative measures of the healthcare system and qualitative insights provided by healthcare workers, thus centring the frontline point of view. While examinations of austerity's effects on both the social determinants of health and on the healthcare system are important, this paper focuses on the latter.

Methods and Data

The principal goal of my research is to answer the following question – to what extent has the Progressive Conservative Party of Manitoba's austerity-centred approach bled into the healthcare sector and what effect has it had on the quantity and quality of healthcare services that have been provided in the province since 2016? To meet my objective, I conduct both a quantitative analysis of already-existing data and a qualitative analysis of survey responses from some of the province's frontline healthcare workers.

I collect already-existing quantitative data from the Government of Manitoba, the Canadian Institute for Health Information (CIHI), Statistics Canada (StatCan), and the Canadian Medical Association (CMA). I also consult two reports conducted by the Canadian Centre for Policy Alternatives (CCPA) (Macdonald, 2021; Macdonald, 2022), which analyze federal and provincial COVID-19 spending and the state of provincial deficits in the context of COVID-19 and beyond. I use them as a point of comparison with my results. Data from the Government of Manitoba include annual health expenditure and annual health expenditure as a percentage of the total provincial budget. Data from the CIHI include annual provincial health expenditure by use of funds, annual percentage change in health expenditure from the previous year, supply of physicians by province and specialization, and wait times for priority procedures by province and

type of procedure. Data from Statistics Canada include job vacancies and job vacancy rates in the healthcare sector by province. Finally, data from the CMA are drawn from the organization's Physician Workforce Survey (last conducted in 2019) and National Physician Health Survey (last conducted in 2021) and include worker satisfaction by province, workplace setting by province, and average weekly working hours by province. A summary of the indicators I examine can be found in Table 1 below.

The data collected from these sources allow me to assess whether or not austerity has been applied to Manitoba's healthcare sector and they provide a snapshot of the way in which it could be affecting Manitoba's healthcare workers and the services they are able to deliver. Where feasible – such as with annual provincial health expenditure, supply of physicians by province, wait times by province, and job vacancy rates by province – I compare Manitoban data with that for other provinces. This proves especially useful for analyzing austerity in the context of the COVID-19 pandemic, as it allows me to assess how much Manitoba has done to respond relative to its provincial counterparts.

Table 1: Summary of variables

Variable	Definition	Data Source	Applicability of Variable
Provincial health expenditure	Annual millions of per capita spending in real dollars.	Government of Manitoba; CIHI	Financing
Change in provincial health expenditure	Annual percentage change in per capita real spending from previous year.	Government of Manitoba; CIHI	Financing
Provincial health expenditure by use of funds	Annual millions of real dollars, broken down by use of funds, including use by hospitals, other institutions, physicians, other professionals,	CIHI	Financing

	drugs, public health, administration, and COVID-19 response funding.		
Provincial wait times for priority procedures	Annual median number of days spent waiting for priority procedures, including hip replacement, cataract surgery, CT scan, and radiation therapy.	CIHI	Performance
Provincial job vacancies	Number of vacant jobs reported quarterly in the Health and Social Assistance category of the North American Industry Classification System (NAICS). Jobs are considered vacant if they are vacant on the first day of the month or will become vacant in the month, if there are tasks to be carried out as part of that job, and if the employer is actively seeking an employee to fill that job.	StatCan	Performance
Provincial job vacancy rates	Percentage of all labour demand, including both occupied and vacant jobs, in the Health and Social Assistance category of the NAICS that are vacant.	StatCan	Performance
Worker satisfaction, by province	Percentage of healthcare workers who report they are very satisfied, satisfied, neutral, dissatisfied, or very dissatisfied with their professional life and the balance	CMA	Performance

	between their personal and professional commitments in the Physician Workforce Survey.		
Working hours, by province	Mean number of weekly working hours, excluding on-call activity, broken down by type of activity, including direct patient care, indirect patient care, practice management, administration, and teaching.	CMA	Performance

The second component of my analysis – the qualitative data – come from survey responses from Manitoba's healthcare workers. Analysis of quantitative measures, such as expenditures and wait times, is extremely valuable. It allows me to tease out trends and paint an overall picture of the healthcare system in Manitoba under PC leadership. However, only so much can be gleaned from observing system-level trends from an outsider's point of view. There are certain aspects of the healthcare system which can only truly be known and experienced by those within the system itself, such as the day-to-day burden of delivering care, the effect of austerity on staffing and resources, and the degree of job satisfaction amongst healthcare workers. To gain this type of information, it is necessary to ask healthcare workers for their perspectives, which is where surveys provide additional value.

My research exits as a small part of a larger project led by the University of Manitoba's Jesse Hajer, the goal of which is to examine the effect of the PCP's austerity-centred approach on workers in a wide array of provincial government departments. In collaboration with Dr. Hajer, myself, Ian Hudson, and Robert Chernomas designed a series of survey questions, which

he then distributed to workers by email through their respective unions, such as the Manitoba Government and General Employees' Union (MGEU), the Manitoba Federation of Labour (MFL), the Manitoba Association of Health Care Professionals (MAHCP), Doctors Manitoba, and the Manitoba Nurses Union (MNU). We then collected the responses from union workers who are employed in a healthcare setting in order to both draw aggregate conclusions regarding Manitoban healthcare workers' feelings toward the PC government's austerity-centred policies and to supplement any conclusions with individual comments, as survey participants had the opportunity to provide additional written feedback after a number of questions.

Results

The purpose of my research, as expressed in my research question, is twofold. First, I must examine and determine the extent to which the PCs' austerity-centred approach to governance has bled into the healthcare sector. Then, assuming that healthcare has not been excluded from the austerity agenda, my second goal is to assess the effect of austerity on the quantity and quality of services that healthcare providers have been able to deliver since 2016. With these in mind, I have divided my findings into three categories – 1) inputs, 2) mechanisms, and 3) outputs. The first of these categories examines healthcare financing in Manitoba over the past 10 years in order to fulfill the first of my objectives. The second takes a closer look at the ways in which austerity has played out in the healthcare sector, including cuts, closures, and restructuring of various aspects of Manitoba's healthcare system. The third explores the impacts of austerity, as they pertain to both system-related outputs and worker-related outputs.

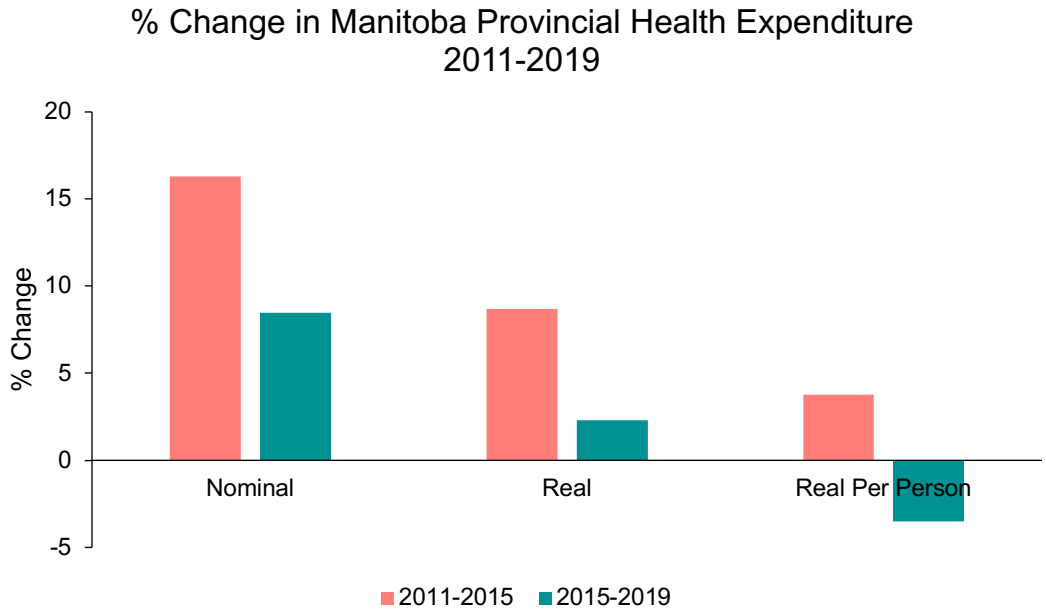
Inputs

The key input into Manitoba's healthcare system is financing, which is provided in part by the federal government and in part by the provincial government, though a declining share is

covered federally. It is possible to analyze Manitoba's finances devoted to healthcare under PC leadership both by comparing them to the province's own historical record and to its provincial counterparts. Turning first to historical within-province comparisons, Figure 1 shows changes to the province's expenditures on healthcare between 2011 and 2015 and from 2015 to 2019. The reason for selecting this time period is that it allows for a comparison of expenditures under a term of NDP leadership compared to a term of PC leadership, as the NDP's last term in office spanned 2011 to 2015, while the PC's first term after succeeding the NDP spanned 2016 to 2019. It also excludes the exceptional COVID-19 years of 2020 and 2021, though both are accounted for when comparing Manitoba's healthcare expenditures to those of other provinces. At first glance, it appears as though Manitoba's healthcare expenditures increased quite steadily from 2011 to 2019, from $5.238 billion in 2011 to $6.092 billion in 2015, and further to $6.609 in 2019, an increase of 16.3 percent under NDP leadership and 8.5 percent under PC leadership in nominal terms (CIHI, 2021a). However, these numbers overstate the extent of the growth of the province's expenditures for two reasons. The first is that they fail to account for inflation. Over time, there is a general trend for the average prices of goods and services – paid for both by the private and public sector – to rise. This is the distinction between nominal (the stated price) and real (how much a given amount of money will actually buy) values. In order to calculate the real value of provincial expenditures, the effect of inflation must be considered. Viewing the province's healthcare expenditures in real terms, then, accounting for inflation using the total healthcare implicit price index (IPI) for Manitoba with 1997 as a base year, the increase has been much more modest, from $3.540 billion in 2011, to $3.848 billion in 2015, to $3.937 billion in 2019, an increase of 8.7 percent during the NDP years and 2.3 percent during the PC pre-COVID years (CIHI, 2021a; CIHI, 2021b).

The second reason that the nominal figures overstate the increase in Manitoba's healthcare expenditures is that they fail to account for the increase in population. More people mean both greater demands on the healthcare system within the province and more people paying taxes. Therefore, both revenue and expenditures should increase alongside population growth. Thus, population growth must also be accounted for by measuring healthcare expenditure per person. Over the last 10 years, Manitoba's population has increased by more than 130,000 people, from 1,233,649 in 2011 to 1,369,954 in 2019. It has since further increased to 1,383,765 in 2021 (Statistics Canada [StatsCan], 2022). Viewing the province's healthcare expenditures on a real per capita basis, then, the increase was relatively small under the NDP, but nonexistent under the PCs. From 2011 to 2015, per person expenditures rose from $2,869.90 to $2,977.98, an increase of 3.8 percent. From 2015 to 2019, however, under PC governance, they actually declined from $2,977.98 to $2,874.04, a decrease of 3.5 percent (CIHI, 2021a; CIHI, 2021b; StatCan, 2022a). Comparing these three approaches, then, expressed as a percent change, the province's total healthcare expenditures under the NDP increased in nominal terms by 16.3 percent from 2011 to 2015, in real terms by 8.7 percent, and in real terms per capita by 3.8 percent. Meanwhile, under the PCs, they increased by a much smaller percentage in nominal and real terms from 2015 to 2019, by 8.5 percent and 2.3 percent, respectively, while they actually declined by 3.5 percent in real terms per capita. Looking strictly at healthcare under Manitoba's PCP relative to it under Manitoba's NDP, it seems as though the PCs have applied their austerity agenda to this sector.

Figure 1: Percent change in Manitoba healthcare expenditure 2011-2019



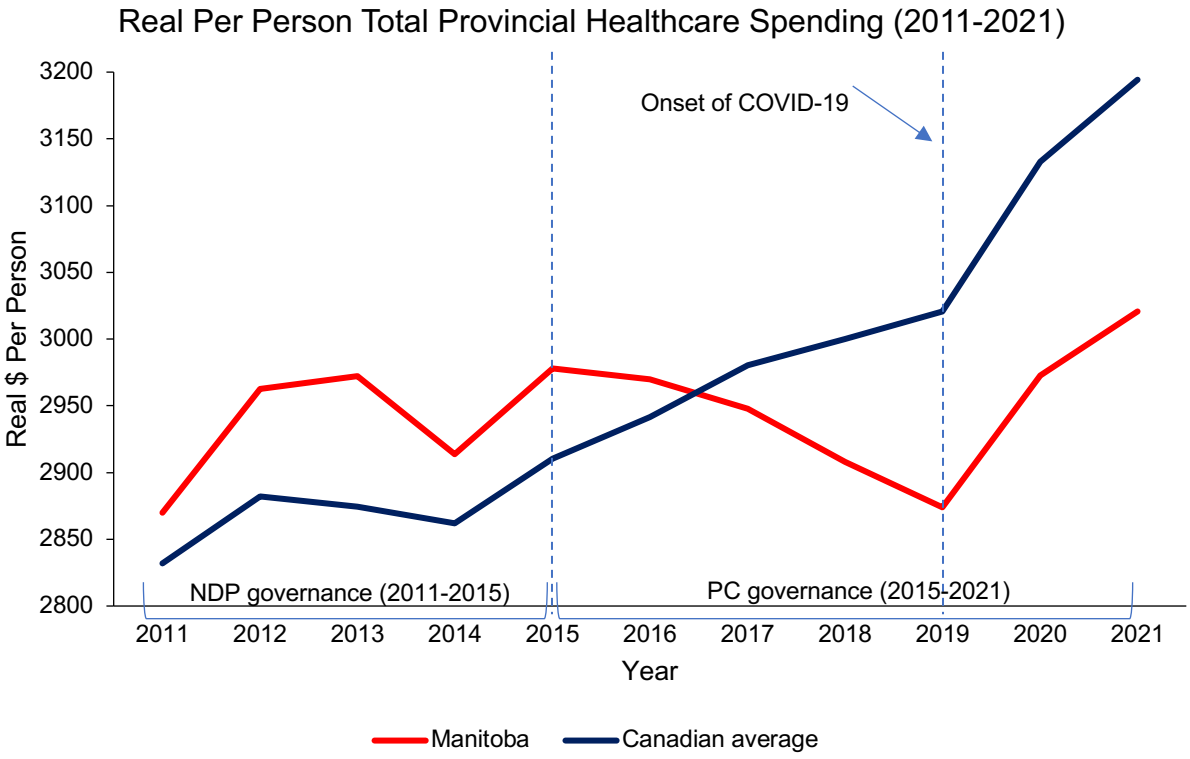
Source: CIHI National Health Expenditure Database: Table D.4.7.1 (2021a); CIHI National Health Expenditure Database: Appendix B.3 (2021b); StatCan: Table 17-10-0005-01 (2022).

Turning to inter-provincial comparisons, Figure 2 shows the annual real per person total spent by Manitoba and the average spent by each Canadian province on healthcare from 2011 and 2021, spanning the NDP's last term in office, the PCs' first term in office, and the first two years of the COVID-19 pandemic under PC leadership. As noted, during the NDP's reign, real per capita healthcare spending in Manitoba increased quite steadily, increasing from $2,869.90 in 2011 to $2,977.98 in 2015 (CIHI, 2021a; CIHI, 2021b; StatCan, 2022a). Also during this period, Manitoba was consistently in the top four for provincial spending on healthcare, outpacing the Canadian average each year from 2011 to 2015.

In contrast, during the PCs' first term in office, real per person healthcare spending declined every year, dropping from $2,977.98 in 2015 to $2,969.68 in 2016, and eventually to $2,874.04 by 2019 (CIHI, 2021a; CIHI, 2021b; StatCan, 2022a). In 2016, Manitoba spent just slightly more than the Canadian average, which was $2,941.32 of provincial spending per capita. In the five successive years of the PCs' reign, however – including during the COVID-19 years –

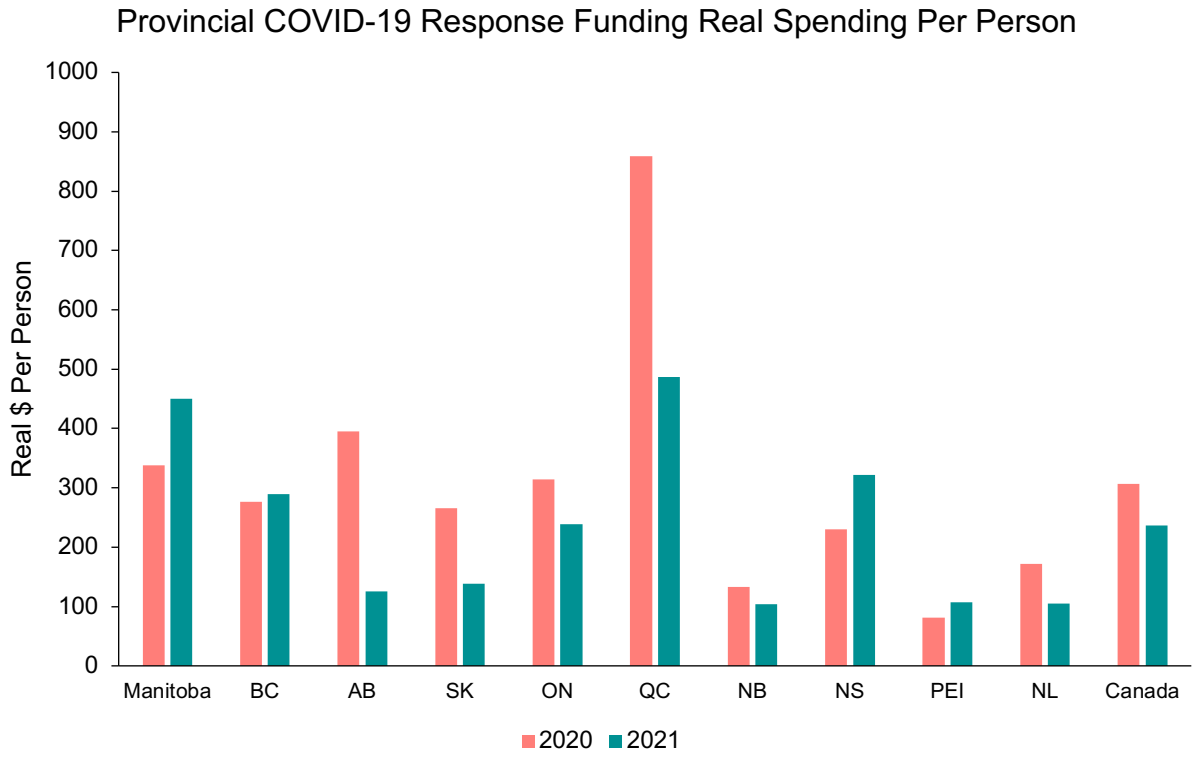
Manitoba was consistently one of the lowest-spending provinces on healthcare, landing below the Canadian average each year. Moreover, the gap between Manitoba's per person spending under PC leadership and the Canadian average widened each year, increasing from a $33.08 per person gap in 2017, to $146.80 in 2019, and even further in the wake of COVID-19, to $173.60 by 2021 (CIHI, 2021a; CIHI, 2021b; StatCan, 2022a). It should be noted that Manitoba's per capita healthcare spending *did* increase during the COVID-19 years, from $2,874.04 in 2019 to $3,020.69 in 2021, as the PC government – like all provincial and federal governments – had to invest in healthcare in order to respond to extraordinary circumstances. Compared to their provincial counterparts, though, an argument could be made that Manitoba did not do nearly enough. Looking strictly at COVID-19 response funding, it appears as though Manitoba was a model for investment in healthcare. Manitoba exceeded the Canadian average for COVID-specific funding in both 2020 and 2021, spending $337.88 and $450.42 per capita, respectively, compared to the Canadian averages of $306.49 and $236.59 in 2020 and 2021, respectively, as illustrated in Figure 3 below (CIHI, 2021a; CIHI, 2021b; StatCan, 2022a). However, looking at total healthcare spending, Manitoba performed well below the Canadian average and was the fourth lowest-spending provinces during the crisis, demonstrating that the entire increase in per person healthcare spending was devoted to COVID-19 response funding, rather than to improving the system as a whole. Looking at Manitoba compared to other Canadian provinces, then, only strengthens the case that the PCP has applied its austerity agenda to the healthcare sector.

Figure 2: Annual per person total provincial healthcare spending 2011-2021



Source: CIHI National Health Expenditure Database: Table D.4 (2021a); CIHI National Health Expenditure Database: Appendix B.3 (2021b); StatCan: Table 17-10-0005-01 (2022a).

Figure 3: Annual per person provincial COVID-19 response funding



Source: CIHI National Health Expenditure Database: Table D.4 (2021a); CIHI National Health Expenditure Database: Appendix B.3 (2021b); StatCan: Table 17-10-0005-01 (2022a).

Mechanisms

As previously noted, austerity measures are mostly commonly characterized as those taken by governments with the purpose of reducing yearly deficits and balancing the budget. Broader definitions of austerity, though, encompass a wider array of policy options, including cuts, closures, restructuring, privatizations, and contracting out. Healthcare providers in Manitoba have had to contend with austerity in all of these forms since the PCP was elected in 2016. Figure 4 presents a timeline of the various measures that the PCs have undertaken to alter healthcare in the province from 2016 to 2022 (Manitoba Health Coalition, 2022). Their measures have been far-reaching and inclusive of policy levers that affect both patients and providers. It is worth drawing special attention, though, to several of the most impactful actions taken by the

PCs. Regarding cuts, they wasted no time once assuming office, cancelling $1 billion worth of new health infrastructure projects in February 2017, less than a year after being elected, including a new CancerCare Manitoba facility, a personal care home in Lac Du Bonnet, and several new clinics. They further cut all the regional health authorities' (RHA) budgets for the 2017-18 fiscal year in March 2017, followed by additional cuts to staffing across the health authorities, including 197 jobs cut in June 2017. Winnipeg's personal care homes, in particular, were hit with a $1 million cut to their funding in 2017, followed by a subsequent demand by the WRHA in 2018 to cut their budgets by an additional 0.25 percent. More recently, the PCP cut acute care by $14 million in its 2021 budget.

With regard to closures, then-Minister of Health Kelvin Goertzen and the WRHA announced in April 2017 that the emergency rooms would close at Concordia, Victoria, and Seven Oaks Hospitals, and that the urgent care centre would close at Misericordia Hospital. Since then, the ERs at Concordia, Victoria, and Seven Oaks have been converted to urgent care facilities, leaving only four emergency departments – including the Health Sciences Centre (HSC)'s Children's Emergency Department – in the City of Winnipeg. While both types of facilities are open 24/7 and provide urgent care, only emergency departments are equipped to treat patients in potentially life-threatening situations. Further, following the onset of the COVID-19 pandemic, many emergency rooms in rural and Northern Manitoba experienced closures. In June 2022, the PCs announced that after more than a year of being closed, 18 rural and Northern ERs would not reopen, and an additional 34 would reopen only part-time, either with reduced hours, temporary suspensions, or both.

Concerning restructuring, the province announced in 2017 that it would begin to restructure and reorganize frontline care in the WRHA, specifically at the Health Sciences and

Grace Hospitals (Canadian Union of Public Employees [CUPE], 2017). As part of this initiative, position deletion letters were sent to 500 WRHA nurses beginning in August 2017, indicating that they would be moving to new positions, either in the same unit or a different one. This meant that either the location of their work, the type of work they were doing, or both, changed. If none of the available alternative positions were acceptable, nurses had the option to be laid off. The consequences of this transformation could still be seen as of 2022, and likely will be for years to come. As of May 2022, Grace Hospital had a 28 percent vacancy rate for nurses, while HSC had a rate of 18 percent for the same positions (Harewood, 2022). A further 700 position deletion letters were sent to hospital support staff beginning in September 2017, including healthcare aides and housekeeping staff (CBC News, 2017). In this case, some workers lost their jobs entirely, while others lost their current positions, but had the option to be moved to a new one, similarly to the nurses. Further, in September 2018, the WRHA announced it would be consolidating its mental health services and its surgery services to three hospitals each, and in September 2020, CancerCare Manitoba announced a similar consolidation of its facilities to four hospitals, eliminating services at Concordia and Seven Oaks Hospitals. These types of consolidations make care less accessible to patients when they need it most.

Finally, with respect to privatizations and contracting out, services such as diagnostics and air ambulance have been most affected. In recent years, Dynacare has emerged as a private medical company, offering diagnostic services to Manitobans. In November 2019, Dynacare closed 26 of its 54 diagnostic labs in Winnipeg, making patients seeking their services travel further to access them. Despite these closures, the PCs have placed more reliance on the company in recent years. In April 2020, they began to rely on Dynacare to provide COVID-19 testing in the province, and in May 2021, they announced they were outsourcing viral sequencing

of COVID-19 variants to the private company. Regarding air ambulance services, the province announced in June 2019 its plans to privatize its Lifeflight Air Ambulance program, which came to fruition one year later when in September 2020, private provider STARS took over from Lifeflight. In 2019, when the province was still fielding requests for proposals for privatization, the CCPA published an op-ed in which it noted that air ambulance privatization would likely lead to lower wages, less qualified on-board healthcare professionals, inexperienced pilots flying the planes, out-of-date jets being used, and jets not being able to land in some Northern communities due restrictions on private carriers imposed by Transportation Canada (Goertzen, 2019). On top of the transition toward privatized diagnostic and air ambulance services, Manitoba's nurses have reported a surge in contract or agency nurses being brought in to fill gaps left by previously full-time, permanent positions. This will be discussed further when reviewing survey responses provided by the province's healthcare workers on the effect of austerity. All in all, while both healthcare providers and patients in almost every area have been affected by the PCs' austere policy levers, it seems that emergency services, rural and Northern services, diagnostics, and personal care homes have been particularly hard hit.

Figure 4: Timeline of cuts and changes to healthcare under the PCP in Manitoba 2016-2022

Source: Manitoba Health Coalition (2022).

Outputs

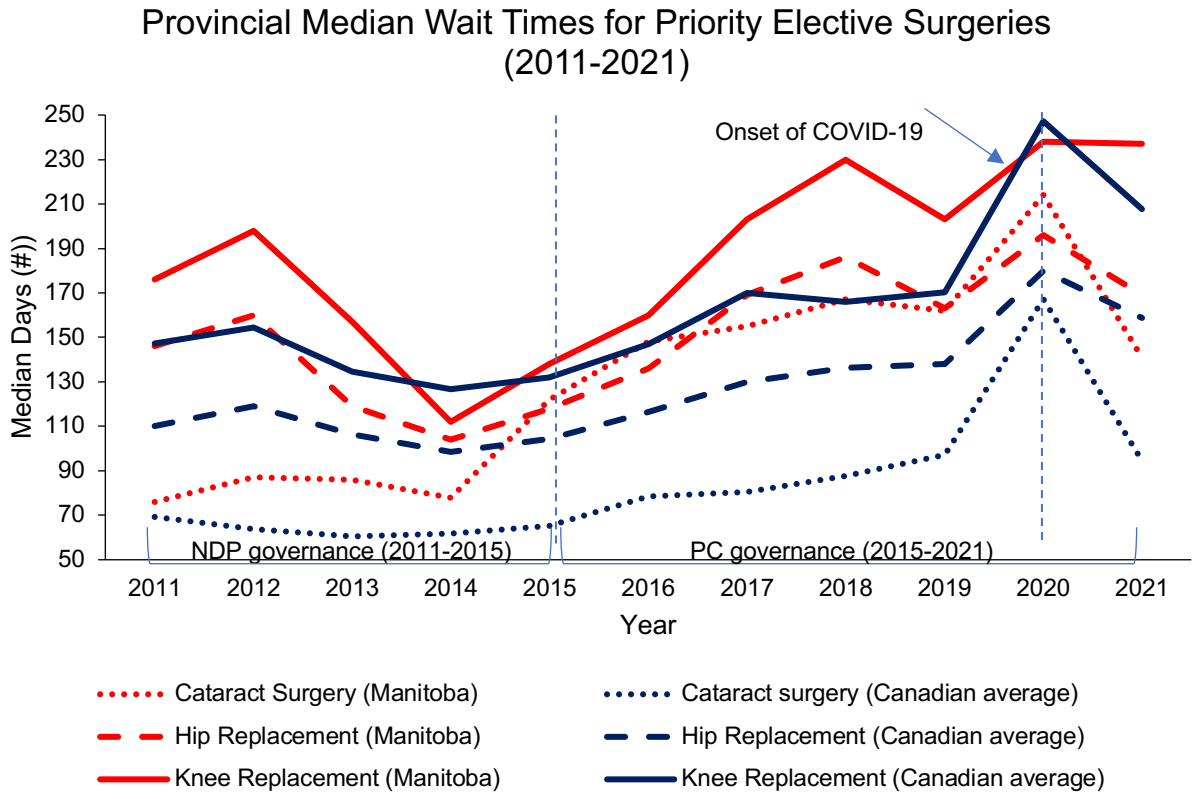
Looking both at Manitoba's expenditures on healthcare relative to their provincial counterparts and the mechanisms by which the PCs have revamped the healthcare sector, it is clear that healthcare has been included in the austerity agenda of the past several years. It could conceivably be possible, though, for the PCP to be spending less but achieving better outputs. In other words, the austere approach to healthcare could theoretically be a model of efficiency. In fact, this has often been the way in which the PCs tout their aspirations and accomplishments for healthcare in Manitoba. In order to test whether or not this has been the case in reality, it makes sense to examine a series of healthcare outputs, divided into system-related outputs – including wait times and number of physicians – and supply-side outputs – including wages, job vacancy rates, working hours, and worker satisfaction. In doing so, it appears that the purported model of efficiency generally does not represent reality.

System-related outputs

One way to assess the quality of the healthcare system is by looking at how easy and accessible it is to obtain care in times of need, often indicated by wait times. Wait times can be broken down into wait times for priority procedures and wait times when someone seeks emergency care at a hospital. Figures 5 and 6 show the annual median wait times for various surgeries and diagnostic procedures for Manitoba and the average amongst all Canadian provinces from 2011 to 2021, again spanning the NDP's last term in office, the PCs' first term in office, and the first two years of the COVID-19 pandemic under PC leadership. Wait times are expressed as the median number of days for a patient to undergo the procedure after determining that it is required.

Turning first to elective surgeries, Manitoba has generally had consistently higher wait times than the average of all other Canadian provinces for the last 10 years, including under both NDP and PC leadership. However, there are two important points to note. First, while a gap existed between Manitoba's wait times and the Canadian average during the NDP's time in office, it widened under PC leadership. For instance, in 2015, the median wait time for cataract surgery in Manitoba was 122 days, compared to the Canadian average of 65.1 days (CIHI, 2021c). In other words, in the last year during which the NDP was in office, Manitobans had to wait on average 56.9 days longer for cataract surgery than patients in other provinces. By 2019, that gap had widened to 64.7 days. The same trend can be seen for other surgeries. For hip replacement surgery, Manitobans had to wait 13.7 days longer than the Canadian average in 2015, compared to 25 days longer by 2019. For knee replacement surgery, they had to wait six days longer in 2015, but 32.7 days longer by 2019. During the first two years of the COVID-19 pandemic, wait times for elective surgeries increased across the country, but Manitoba's wait times for cataract surgery and hip replacement surgery continued to outpace the Canadian average. The second point to note is that while wait times for elective surgeries were still higher than the Canadian average under the NDP, they were generally trending downward or at least remaining stable from 2011 to 2014, then increased slightly in 2015, before skyrocketing in 2016 and remaining high since.

Figure 5: Annual provincial median wait times for elective surgeries 2011-2021

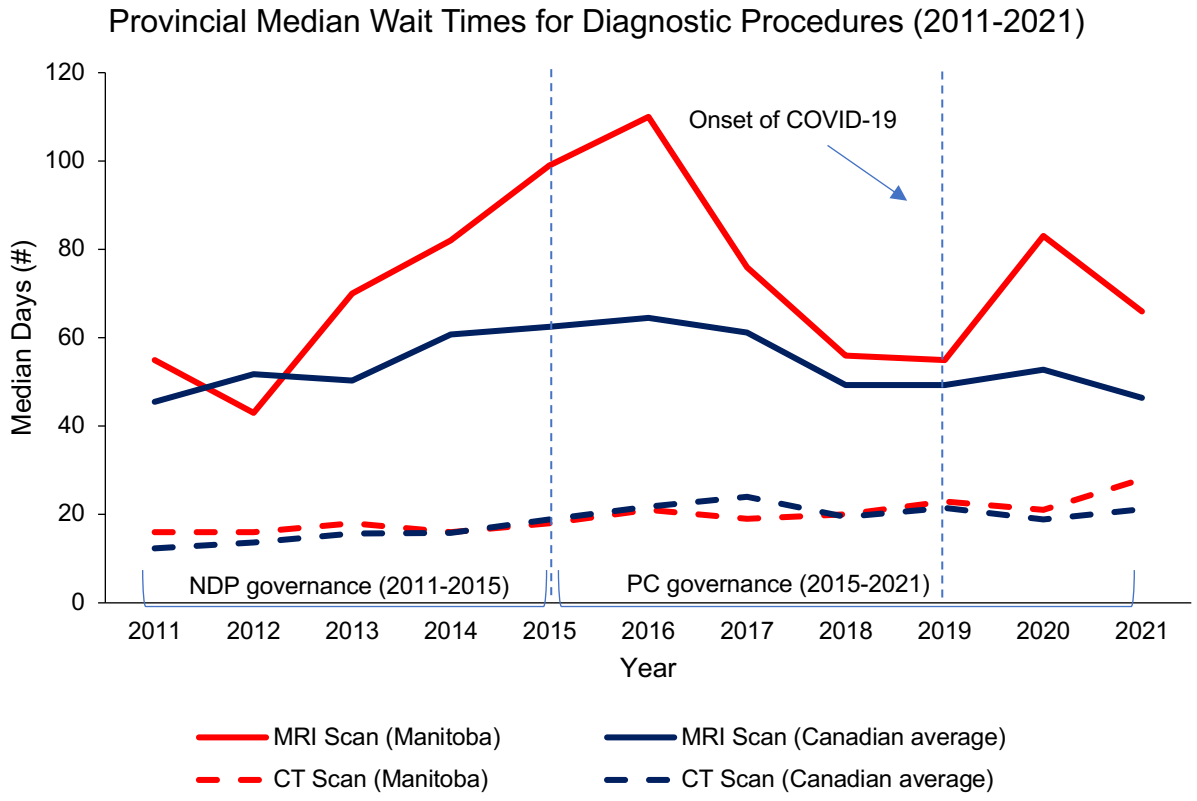


Source: CIHI Wait Times for Priority Procedures in Canada (2021c).

Turning to diagnostic procedures, Manitoba's wait times for CT scans have been roughly comparable to its provincial counterparts over the last 10 years, with little meaningful divergence from the Canadian average. That being said, while Manitobans had to wait fewer days for a CT scan during the first couple years of the PCs' reign than the average for patients in other provinces, they have had to wait longer than the average each year since 2018 (CIHI, 2021c). The case of MRI scans is a bit more interesting. Manitobans awaiting MRIs have had to wait longer than the average amongst patients in other provinces quite consistently over the past decade, spanning both NDP and PC regimes. During the last several years of NDP rule, median wait times for MRIs rose fairly dramatically, increasing from 43 days in 2012 to 110 days by 2016, the year of the provincial election in which the PCs assumed governing power (CIHI, 2021c). Unlike other procedures, wait times for MRIs actually declined under PC rule, so while a

gap remained between wait times in Manitoba compared to the Canadian average, it closed substantially during their first few years in office. In 2016, Manitobans had to wait on average 45.5 days longer than patients in other provinces, but only 6.7 days longer by 2019. This improvement can likely be attributed both to an $1.8-million investment made by the NDP as it was close to being on its way out of office in January 2016 and to the opening of a new MRI scanner in Dauphin in December 2018 (Government of Manitoba, 2016; Laychuk, 2018).

Figure 6: Annual provincial median wait times for diagnostic procedures 2011-2021

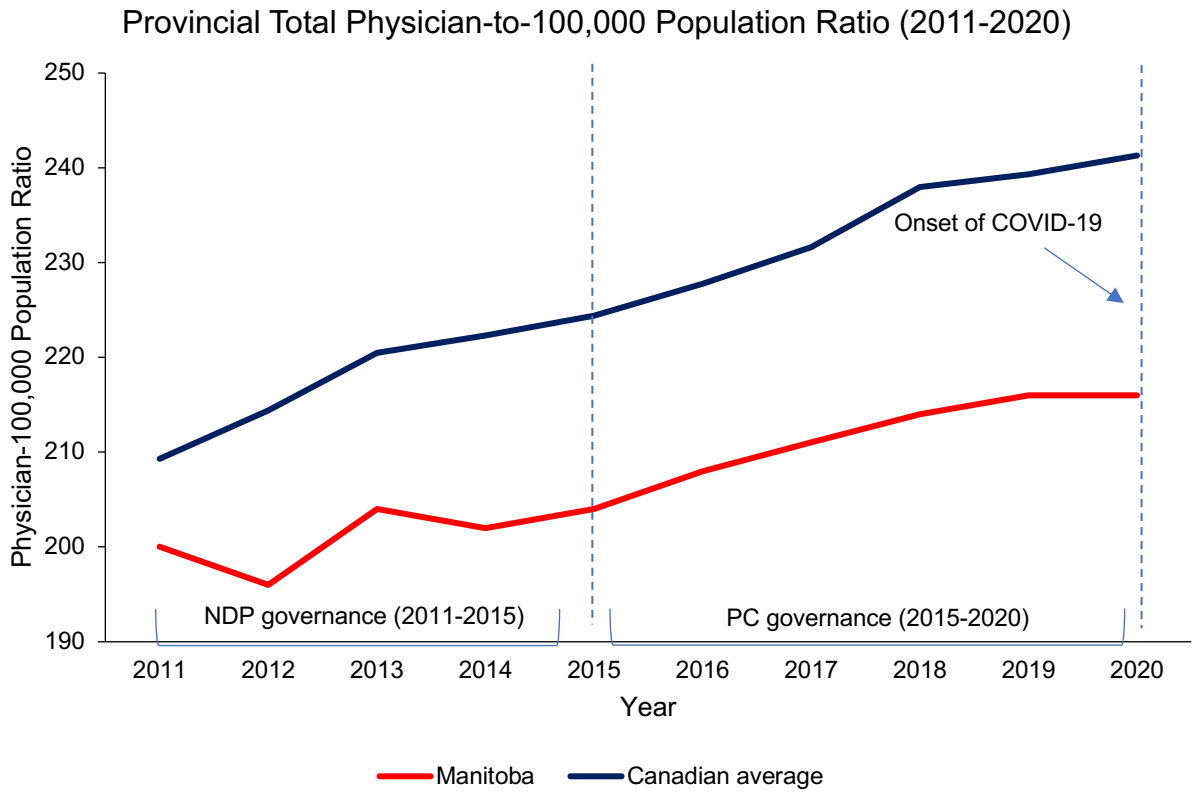


Source: CIHI Wait Times for Priority Procedures in Canada (2021c).

Another way to assess the quality of Manitoba's healthcare system is to look at the number of physicians who are ready to care for patients when they are in need. Figure 7 shows the total physician-to-100,000 population ratio for Manitoba and the average amongst all Canadian provinces from 2011 to 2020, providing a standardized method to compare Manitoba to its provincial counterparts. Manitoba has had a consistently lower physician-to-100,000

population ratio over the past decade, spanning both the NDP's and the PCP's terms in office (CIHI, 2021d). In other words, patients in Manitoba have had fewer doctors to care for them on a per capita basis than patients in other provinces. However, while there has been a consistent gap between Manitoba and other Canadian provinces throughout the past 10 years, it has widened since the PCs assumed governing power. Specifically, in 2015 – the last full year during which the NDP was in power – Manitoba had 204 physicians per 100,000 population, compared to 224.4 on average in other provinces, or 20.4 fewer. By 2019, that gap had widened to 23.3 fewer physicians, and further to 25.3 by 2020, in the midst of the COVID-19 pandemic. Therefore, while Manitoba's total physician-to-100,000 population ratio has been increasing, it has not been keeping up with the other provinces.

Figure 7: Annual provincial physician-to-100,000 population ratio 2011-2020



Source: CIHI Supply, Distribution, and Migration of Physicians in Canada (2021d).

Supply-side outputs

While it is invaluable to examine system-related outputs, it is just as useful to look at indicators related to those who work within the system, and which in turn feed into the system. After all, it only makes sense that healthcare workers who are fairly compensated, feel supported by their peers and superiors, and are overall happy with their work environment are better equipped to provide quality care.

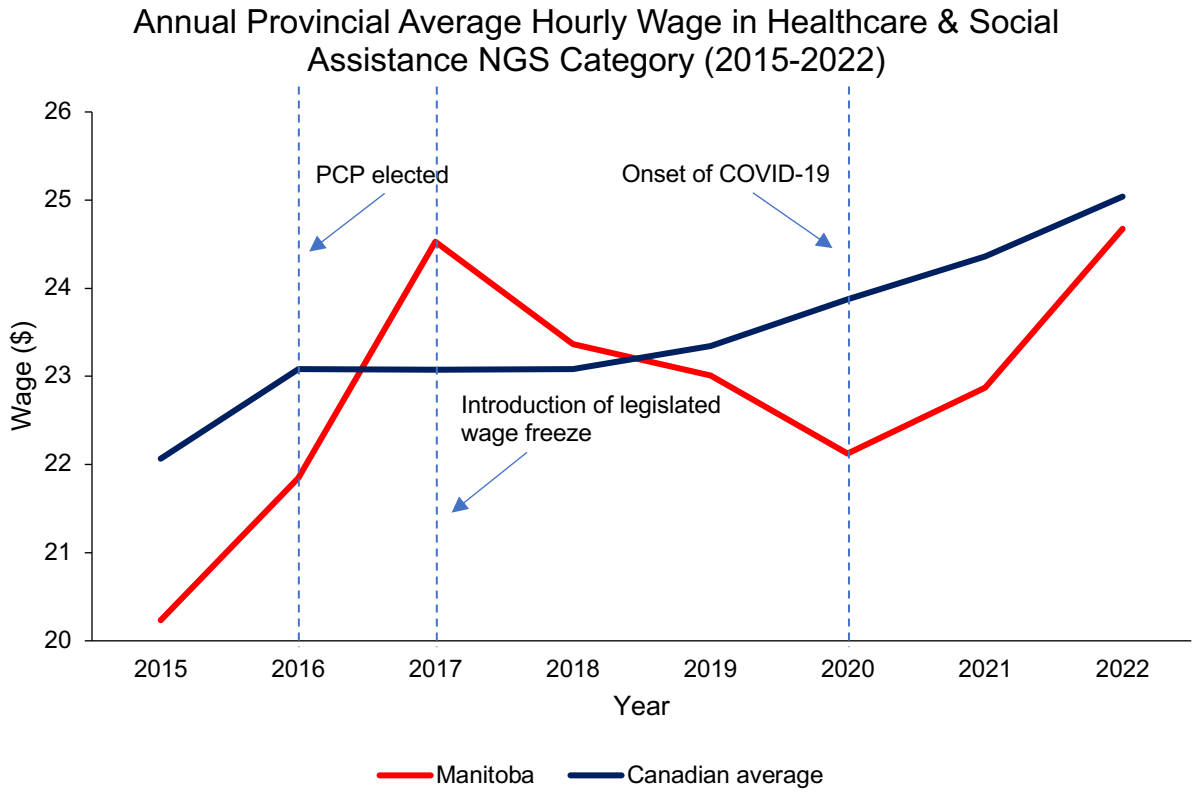
Figure 8 shows the annual average nominal hourly wage for Manitoba healthcare and social assistance workers, as categorized under the National Grouping System (NGS), and the average amongst all Canadian provinces from 2015 to 2022. This wage is expressed as the lowest between the hourly wage offered by employers for vacant positions and the actual wage paid to the hired employee, if a discrepancy exists between the two, and it excludes any overtime pay, tips, bonuses, and commissions (StatCan, 2022b). Though data on wages and vacancy rates are only available for more recent years, in contrast to other indicators, it is still possible to examine what has happened under PC leadership. From 2015 to 2022, the Canadian average nominal hourly wage experienced a steady upward trend, increasing from $22.07 to $25.04 over this period. This is generally what one would expect to happen, as nominal wages tend to rise over time.

The case in Manitoba, however, was less straightforward. From 2015 – the last full year during which the NDP was in government – until 2017, average hourly wages were increasing, peaking in 2017 at a higher offered wage than the Canadian average in the Health and Social Assistance category. However, this increase, which continued for a short time even after the PCs were elected, cannot be attributed to PC-driven policies, but rather to contracts that were negotiated with the previous NDP government which stretched into the beginning of the PC era.

Many contracts negotiated between healthcare workers represented by the MAHCP, CUPE, or MGEU and various public health bodies – including the regional health authorities (RHAs) – expired in 2017 or 2018, and were not renegotiated after their expiration (MAHCP, 2022). The Manitoba Nurses Union (MNU), in particular, had been quite vocal about their struggle to negotiate a new contract with the province, prior to finally ratifying one in 2021, after their former contract had expired in 2017 (CBC News, 2021).

In 2017, around the time that many contracts were expiring, the provincial government introduced legislation to mandate a two-year wage freeze on public sector workers' wages, followed by miniscule wage increases in the two successive years (Lambert, 2022). It should come as no surprise, then, that hourly wages for health and social assistance workers steadily declined in the years following, dropping below the Canadian average, from $24.53 in 2017 to $22.13 by 2020 (StatCan, 2022b). Of course, a wage freeze alone cannot account for a decline in nominal wages. However, it is possible – and perhaps likely, given the wage data from Statistics Canada – that the freeze coincided with older, more experienced, higher paid workers leaving the profession, only to be replaced by new, less experienced workers, who the government and the RHAs could justify hiring for a lower wage, which was kept frozen for multiple years, therefore bringing the average wage down. Over the past two years, wages offered to Manitoba's healthcare and social assistance workers have finally begun to rebound, likely due in part to the end of the legislated wage freeze, in part to the negotiation of at least some new contracts with public sector unions, and in part to wage top-ups for frontline workers in the context of the COVID-19 pandemic, made possible almost entirely by federal emergency funding (CBC News, 2020; Dacey, 2020b). Still, though, the wages of Manitoban workers lag behind the Canadian average.

Figure 8: Annual provincial wage for Health & Social Assistance workers 2015-2022



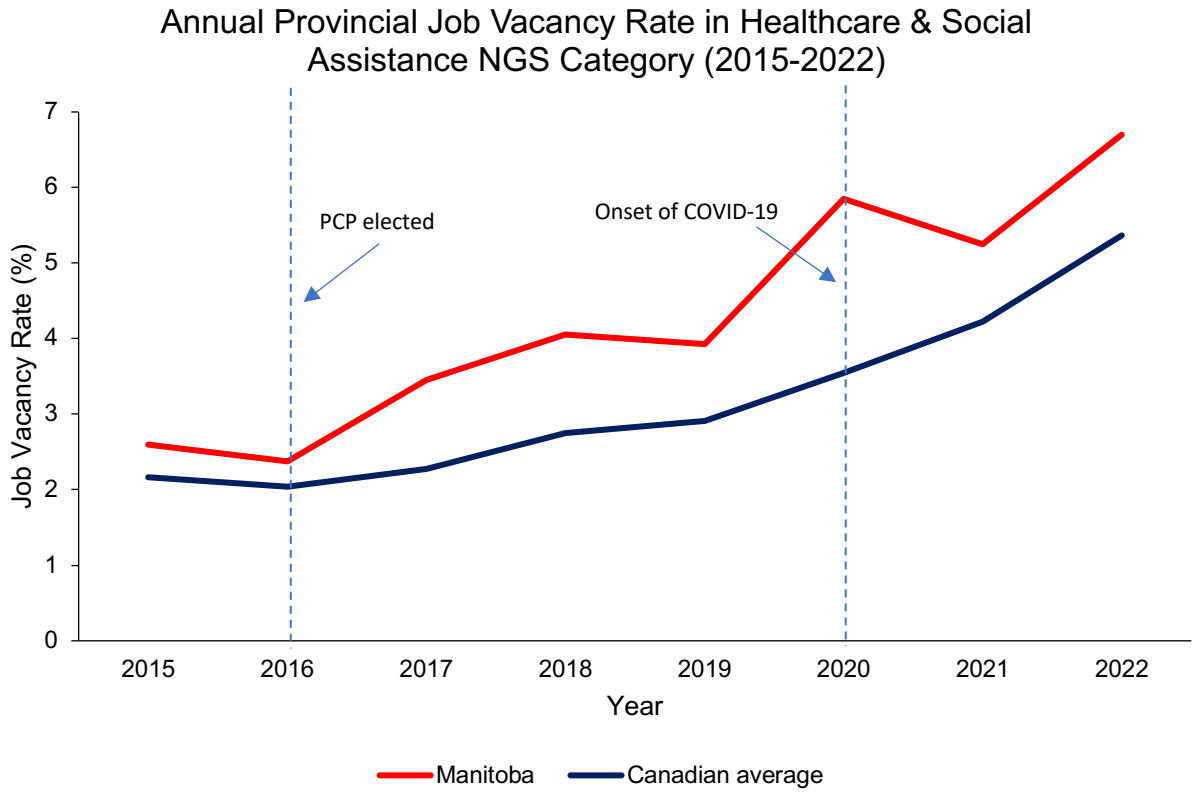
Source: StatCan Average Offered Hourly Wage (2022b).

Another indicator of a healthcare system's performance is the degree to which healthcare positions that are deemed necessary are filled – or are not filled – at a given time, as expressed by job vacancy rates. Figure 9 shows Manitoba's annual job vacancy rate under the NGS Healthcare and Social Assistance category, and the average amongst all Canadian provinces from 2015 to 2022. Over this period, job vacancy rates for health and social assistance workers rose fairly consistently, both in Manitoba and amongst the other Canadian provinces (StatCan, 2022b). In Manitoba, the job vacancy rate increased from 2.6 percent in 2015 to 6.7 percent by 2022. In Canada, it grew from 2.2 percent to 5.4 percent.

However, there are two important points to note. First, the vacancy rate for jobs in Manitoba was higher than the Canadian average each year from 2015 to 2022. This means that in each year, Manitoba's healthcare system had to contend with more unfilled jobs than its

provincial counterparts, leaving workers to do more with less support. Second, while a gap existed between the Manitoban and Canadian averages when the NDP was in power, it widened in the years after the PCP formed government. Specifically, 2016 represented the last year during which the NDP led the province – at least for the majority of the year – and incidentally, was the year of the lowest job vacancy rate in the Health and Social Assistance category in both Manitoba and across Canada during the period for which data are reported. In 2016, the vacancy rate was 0.4 percentage points higher in Manitoba than amongst its provincial counterparts. By 2020, that gap had widened to 2.4 percentage points, and while it narrowed moderately in the years after the initial onset of COVID-19, it still stood at 1.3 percentage points in 2022. Therefore, it seems that through a combination of comparatively low wages and likely other on-the-job factors, Manitoba's healthcare and social assistance workers felt less willing or compelled to fill open positions than workers in other provinces.

Figure 9: Annual provincial Health & Social Assistance job vacancy rate 2015-2022



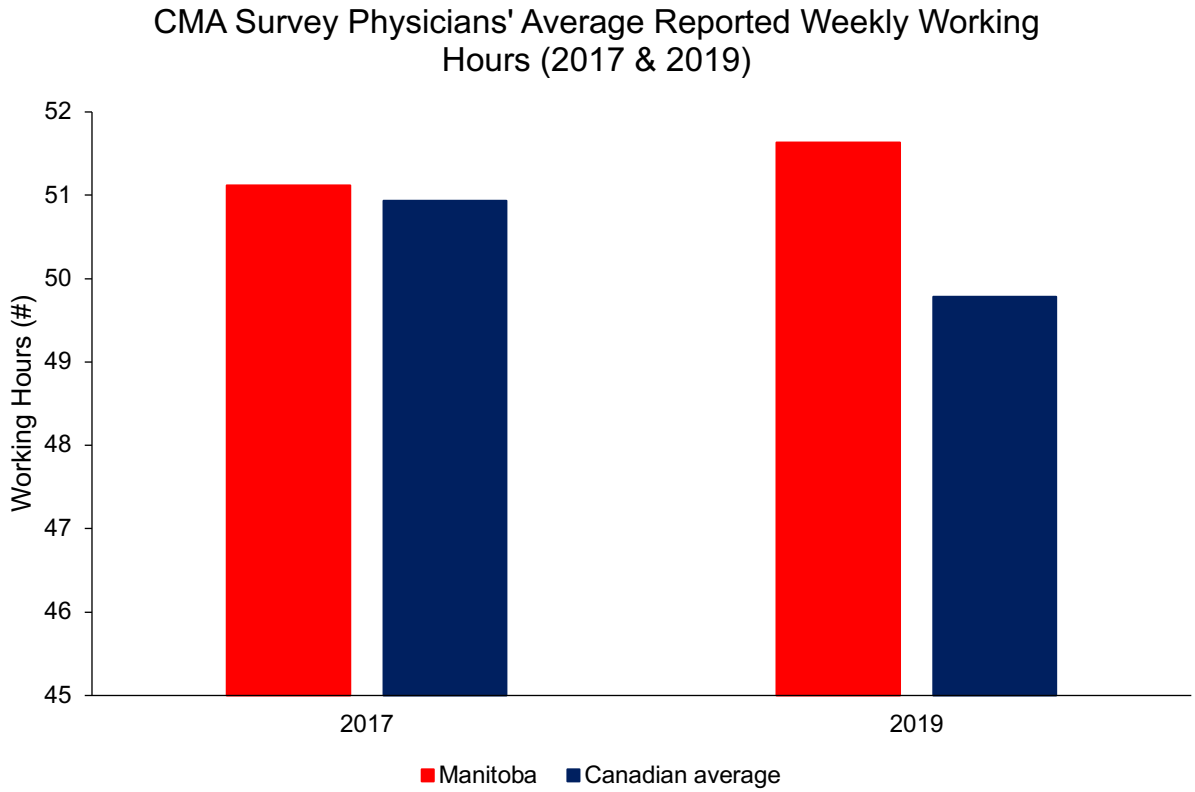
Source: StatCan Job Vacancy Rate (2022b).

While the job vacancy rate amongst frontline health and social assistance workers has been steadily rising throughout the PCP's time in office, it pales in comparison to the vacancy rate amongst Manitoba's civil service workers in the Department of Health. Unfortunately, 2022 was the first year that the government reported vacancy rates by department. We can report, though, that for this year, the vacancy rate in Health stood at a staggering 42 percent, representing 245.46 vacancies in a department of 588.75 full-time equivalent staff (Government of Manitoba, 2022, pp. 62-67). While the vacancy rates in many government departments were high – a number exceeding 20 percent – no other came close Health. This means that in addition to being short workers that actually administer healthcare in our province, we are even more tight on civil servants to establish and maintain the infrastructure to carry out healthcare, including

financing, health policy and planning, public health administration, and system performance oversight.

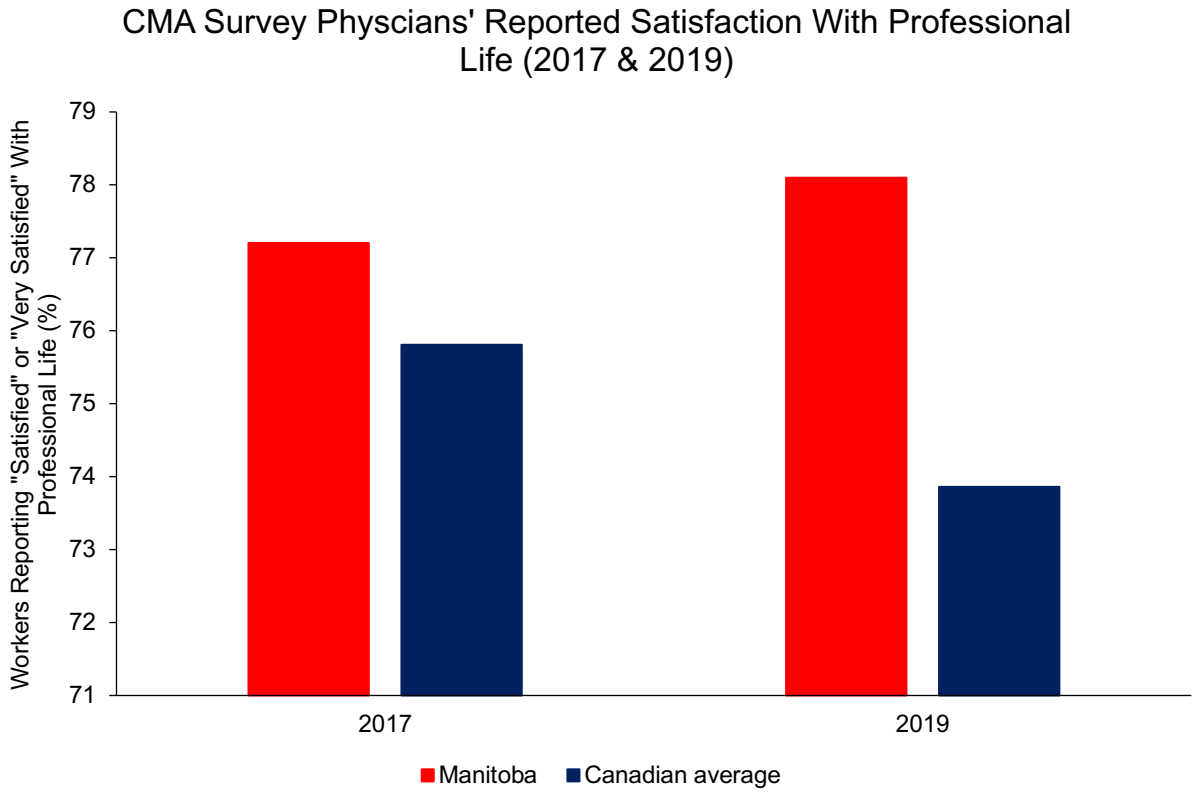
In addition to looking solely at quantitative metrics, it is valuable to hear from workers themselves to decipher what might be keeping their peers from filling vacant positions or for those who are on the frontlines, what might be challenging them in their workplace. The Canadian Medical Association (CMA) has, on two occasions, conducted their Physician Workforce Survey, which asked doctors, specifically, to respond to questions related to various components of their practices, including workplace setting, method of renumeration, practice management, workload, and worker satisfaction. Figures 10 and 11 show the results of two survey questions asked of physicians on both the 2017 and 2018 Physician Workforce Survey. The first asked doctors to estimate their average weekly working hours, exclusive of on-call hours and inclusive of everything from direct patient care, to research, to managing their practice. In both surveys, Manitoban doctors reported that they worked more hours per week than the average for doctors in other provinces, with the average number of hours increasing from 51.1 in 2017 to 51.6 in 2019 (CMA, 2017a; CMA, 2019a). This is in contrast to the Canadian average number of weekly working hours, which declined from 50.9 in 2017 to 49.8 in 2019. The second asked doctors to rate their satisfaction with their professional life on a sliding scale from “very dissatisfied” to “very satisfied.” In both the 2017 and 2019 surveys, a greater percentage of Manitoban physicians reported to be “satisfied” or “very satisfied” with their professional life than did physicians in other provinces on average (CMA, 2017b; CMA, 2019b). Further, Manitoban doctors’ professional satisfaction increased from 77.2 percent in 2017 to 78.1 percent in 2019, while it declined on average for doctors in other provinces, from 75.8 percent in 2017 to 73.9 percent in 2019.

Figure 10: CMA provincial average reported weekly working hours 2017 & 2019



Source: CMA Physician Weekly Working Hours (2017a; 2019a).

Figure 11: CMA provincial average reported satisfaction 2017 & 2019



Source: CMA Physician Reported Satisfaction. (2017b; 2019b).

Perspectives from Manitoba's healthcare workers

As part of a larger project led by the University of Manitoba's Dr. Jesse Hajer on the effect of the province's austerity agenda on a variety of public sector units since 2016, I am also able to report the responses provided by hundreds of the province's healthcare workers to a series of survey questions. Survey participants were solicited via email by their unions and the survey was administered online using Qualtrics software. It was left open for several weeks during the months of November and early December of 2022 to all union members. During this period, 471 public sector healthcare workers took the time to share their thoughts and opinions by responding to the survey, from doctors, to nurses, to healthcare aides, to technologists, to cooks, to maintenance staff, to health policy analysts, and beyond. Of the respondents, 26 percent worked directly for the Province of Manitoba, 69 percent worked for an arms-length

provincial entity, such as a health authority, and 5 percent worked for an independent non-profit, contractor, or professional, receiving public funding. 84 percent identified themselves as front line workers, 7 percent as supervisors or managers, and 8 percent as not fitting into either of these categories. This latter group included policy analysts, accountants, educators, coordinators, and office staff. Finally, 75 percent of all respondents identified as women, 19 percent as men, and 6 percent as non-binary/conforming or preferred not to say. Survey participants were asked questions about the ways in which their job experience has changed since 2016. The full survey can be found in the Appendix.

Table 2 shows the survey responses to questions pertaining to the presence of austerity in the healthcare sector. To initially gauge what the austerity agenda has looked like in healthcare, we asked healthcare workers if the work done in their area had been scaled back or eliminated (Q1). The majority – 67 percent of respondents – said that it had not. However, this does not in any way mean that austerity has not affected healthcare. Rather, based on the data on annual provincial health spending and on the closures and layoffs that have taken place since 2016, it makes much more sense to conclude that the workers who remain feel as though their work has been ramped up, rather than scaled back, as they have been forced to do the same job, but with much less support. This is corroborated by the comments of those who replied that their work had been scaled back – accounting for 20 percent of respondents. Many of the "yes" respondents cited cuts to staffing, prolonged job vacancies, and hiring of inexperienced management to support their response. One nurse noted that "[their] workforce was cut in half" (respondent #102, 2022).

Table 2: Survey responses: presence of austerity

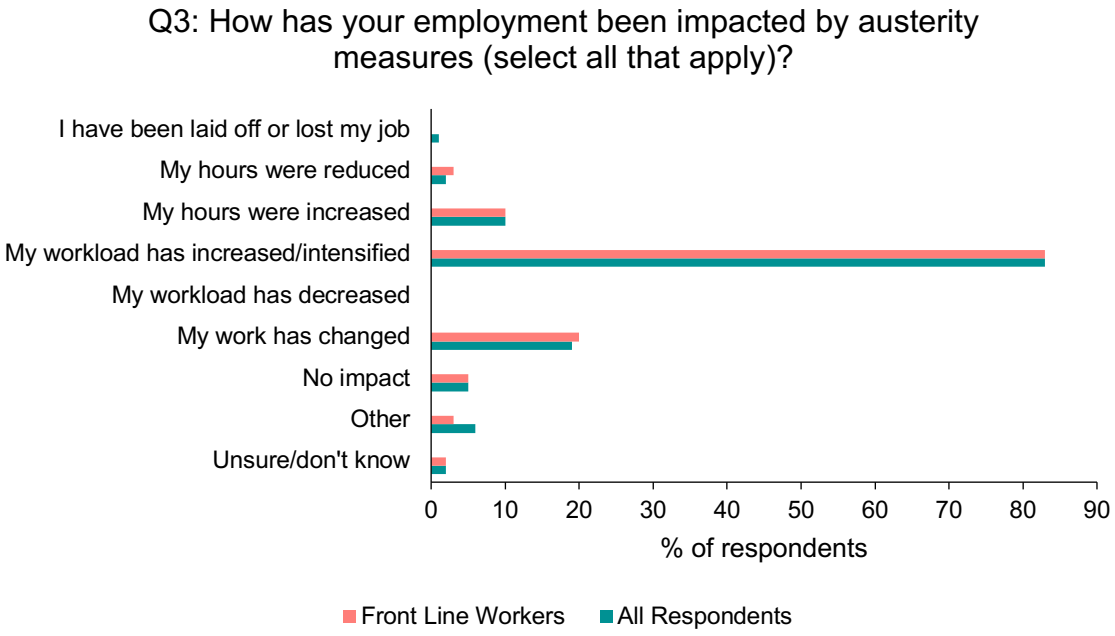
	Yes	No	Unsure/Don't Know
Q1: Has work done in your area of work been scaled back or eliminated?	20% (93)	67% (312)	13% (62)
Q2: Has (more) work in your area been privatized or contracted out to private companies or other non-government organizations?	29% (130)	52% (229)	19% (82)

We further asked survey respondents if more work had been privatized or contracted out since the PCs took office, to which 52 percent of healthcare workers said no and 29 percent said yes (Q2). Many of those who replied "yes" cited things such as outpatient occupational and physiotherapy, mental health supports, and diagnostic services being outsourced to private contractors. A number of respondents specifically mentioned Dynacare. Overwhelmingly, though, the most frequently cited example of contracting out was the increased use of agency workers, particularly nurses, to perform jobs that were previously done by full-time, public sector staff. One supportive housing worker noted that "as [they] don't have enough staff, they have called an agency for workers at a way higher pay than [the regular staff] have ever been paid" (respondent #339, 2022). A healthcare aide further said that "both of the health regions [they] work for hire private companies with trained healthcare staff to fill in shifts that can't be filled with regular staff, but they pay them more per hour and mileage…to do the same job" (respondent #306, 2022). This worker expressed concerns with this model, as "the regular employee staff know the patients and the facility way better than a contracted provider can most of the time because of familiarity of the situational basis of the job and the facility's procedures." Another healthcare aide conveyed similar concerns with agency workers, noting, "there's been

days where half or more of the workers have been agency, which is a safety risk waiting to happen" (respondent #316, 2022). Therefore, contracting out jobs to private agencies not only makes public sector healthcare workers feel less valued, but it also jeopardizes the consistency of patient care.

We were also interested in the ways in which austerity has manifested itself, so we asked healthcare workers if their employment – including their hours and workload – had been affected (Q3). The responses are shown in Figure 12. Less than 10 percent of respondents said they had been laid off, that their hours had been reduced, or that austerity had not affected their employment. Even more poignantly, zero said that their workload had decreased. Meanwhile, 19 percent of all respondents said that their work had changed – 20 percent of front line workers – and a staggering 83 percent said that their workload had increased. One health policy analyst said that "[they were] voluntold to take on a director position while remaining in [their] current position" (respondent #440, 2022). An Allied Health worker further noted that "[they] are so short staffed in every area…that [they] are all experiencing very heavy caseloads and performing many tasks outside [their] roles in trying to assist each other and make sure clients are safe" (respondent #423, 2022). Of those who said that their work had changed, repeated explanations included being short-staffed, being forced to work overtime on a regular basis, and being forced to take on more tasks than in the past.

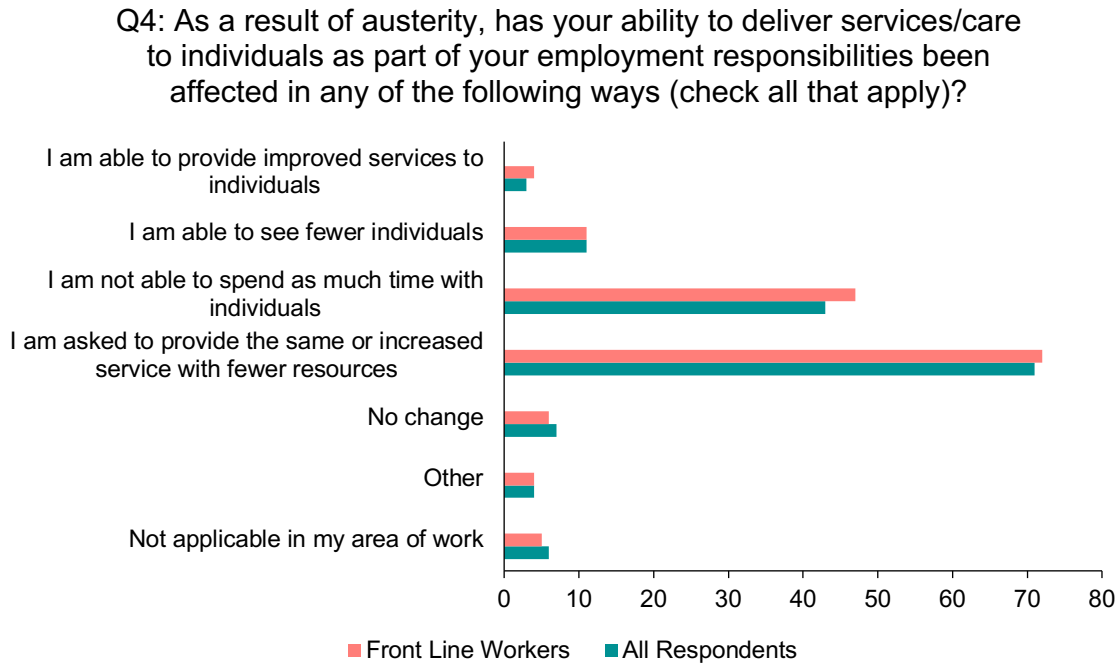
Figure 12: Survey responses: impact of austerity on employment



Moving beyond merely its presence, we wanted to find out the specific ways in which austerity had impacted both workers and the care they are able to provide to their patients. Tables 3 and 4 show the survey responses to questions regarding the effects of austerity, pertaining to non-worker-related outcomes and to worker-related outcomes, respectively. With regard to non-worker-related outcomes, we wanted to decipher what effect the PCs' austerity measures had on the quality of service provided to service users broadly – in our case, patients – as well as the effect on low-income users specifically. Overwhelming, healthcare workers who responded to the survey said that in their opinion, austerity policies led to a reduction in service quality, both for patients generally and for low-income patients (Q5&6). A similarly large majority – 70 percent – said that expenditure cuts and restraints worsened public safety (Q7). One worker said that "the lack of funding to support expanding [their] clinic and staff meant [they] had to make severe restrictions on [the] clinic's referral criteria. Patients who used to get care through [their] clinic no longer met the very stringent referral criteria" (respondent #197, 2022). We also asked

healthcare workers about the specific ways in which their ability to deliver care had been impacted, the responses to which are shown in Figure 13 (Q4). More than 70 percent of respondents said that they were asked to provide the same or more resources, but with fewer resources. Close to 50 percent said that they were not able to spend as much time with individual patients. Consistent with previously discussed survey questions, barely any survey respondents expressed that patient care had been improved as a result of the PCs' austerity agenda.

Figure 13: Survey responses: impact of austerity on patient care



Meanwhile, 43 percent said that other measures, such as privatization and contracting out, worsened public safety (Q8). Most of those who replied otherwise to this last question, though, said either that they did not know or said that there was no privatization or contracting out, which aligns with the previous responses regarding the presence of austerity in healthcare. The key takeaway from the responses to all of the questions pertaining to non-worker-related outcomes is that the majority of healthcare workers felt that austerity measures had a negative effect, and very few – less than 5 percent for each question – felt that they had positive effect.

Table 3: Survey responses: effect of austerity (non-worker-related outcomes)

	Improved/ positive	No change	Reduction/ worsened	Unsure/don't know	There were no austerity measures in my area
Q5: Effect on service quality for stakeholders/ users of the service:	0% (2)	7% (35)	75% (352)	13% (62)	4% (17)
Q6: Effect on service quality for lower-income service users:	1% (4)	15% (72)	56% (261)	24% (114)	3% (16)
Q7: Effect of expenditure cuts and restraints on public safety:	3% (15)	10% (46)	70% (324)	14% (67)	2% (11)
Q8: Effect of other measures, such as privatization and contracting out, on public safety:	4% (20)	8% (35)	43% (202)	27% (127)	18% (82)

With regard to worker-related outcomes, the survey results were even more starkly negative. Between 85 and 90 percent of survey respondents working in the healthcare sector said that austerity measures worsened their working conditions, job satisfaction, mental health, and overall employee recruitment and retention (Q9-11). A smaller proportion, but still a majority – 54 percent – said that expenditure cuts and other measures, such as privatization and contracting out, worsened worker safety (Q12). Concerning working conditions, many respondents noted unfilled job vacancies, low wages, inconsistent or skipped breaks, and exhausting workloads. One long-term care worker said that "previous to 2018, maybe 2019, this was a good place to

work. It has now become a toxic mess. Everyone is working short and [they] barely make enough to pay for the gas to come to work" (respondent #461, 2022). Another worker expressed that "[emergency medical services (EMS)] in Winnipeg regularly do not get breaks during [their] 12 hour shift…and regularly have zero ambulances to respond to emergency calls" (respondent #385, 2022).

Table 4: Survey responses: the effect of austerity (worker-related outcomes)

	Improved/positive/ more satisfied	No effect	Worsened/worse/ less satisfied	Unsure/don't know/other	There were no austerity measures in my area
Q9: Effect on working conditions and job satisfaction:	0% (1)	4% (17)	89% (415)	4% (21)	3% (13)
Q10: Effect on employee mental health:	0% (0)	3% (14)	90% (420)	4% (17)	3% (17)
Q11: Effect on employee recruitment and retention:	0% (2)	4% (18)	87% (404)	6% (26)	3% (16)
Q12: Effect on worker safety:	1% (6)	11% (53)	54% (249)	27% (127)	6% (30)
Q13: Effect on job satisfaction:	0% (2)	7% (34)	85% (391)	3% (14)	4% (20)

As to mental health and job satisfaction, numerous respondents talked about staff morale taking a hit in recent years, along with increased stress, exhaustion, burnout, and feelings of being undervalued in their workplace. One Allied Health worker noted that "employees are incredibly stressed and undervalued. Everyone is stretched so thinly and there is a very high rate of sick time being used. Many that would have worked longer are considering retirement" (respondent #423, 2022). A WRHA social worker further said that "team morale in healthcare is

low. Workers are burnt out. Many of [their] coworkers…often discuss how to get out of working in healthcare. The caseloads and job demands have increased and have put so much more pressure on staff…[who] don't have the time to provide quality care and honestly, there will likely be critical incidents that occur because of these pressures. The mental health of [them] and [their] coworkers has noticeably declined" (respondent #395, 2022). Additionally, in a radio interview in May 2022, Manitoba Nurses Union President, Darlene Jackson, noted that "nurses, [especially], are experiencing unsustainable workloads and mandated overtime, which, combined with relatively lacklustre salaries and benefits, has them seeking employment in other provinces" (Harewood, 2022). She further expressed concern for the future of nursing in the province, as new nurses feel disenfranchised by the poor environment they are stepping into, and far too many experienced nurses are leaving before they are able to show them the ropes.

It should come as no surprise, then, that these kinds of added stressors have made many healthcare workers leave – or consider leaving – their jobs. Regarding employee recruitment and retention, a large number of survey respondents said that they had either left their job, had considered leaving, had retired earlier than they otherwise would have, were regretting their choice to work in healthcare, or were actively looking for other positions or careers. A senior policy analyst reported that "[they] were on medical leave and a reduced work week, as well as anxiety medication, while the transformation occurred. [Their] mental health was impacted significantly…[They] left [their] job of over 12 years with the Manitoba Government and [their] mental health has improved significantly since" (respondent #410, 2022). Another health analyst said that austerity "led to the exodus of staff with significant experience and expertise, leading to overwork of remaining staff as well as reduced efficiency…[They] have had a significant loss of staff with not only experience and expertise, but passion and creativity, because they have

burned out" (respondent #305, 2022). A healthcare aide said that "the work environment was so toxic [they] had to quit after a year-long battle with union and management regarding toxicity in the workplace" (respondent #17, 2022). Finally, in no uncertain terms, one paramedic poignantly expressed that "[they] can't wait to quit this hellhole" (respondent #192, 2022).

Based on the responses we received, it is clear that the healthcare workers who responded to our survey felt that austerity had a negative effect both on their work environment and on the quality of care they are able to provide. However, the justification given for austerity is often twofold – that it will improve 1) effectiveness and 2) efficiency. The latter is commonly measured in terms of cost savings. It might, for instance, conceivably be possible for healthcare workers to be less contented with the way their workplace is operating, but for the implemented austerity measures to be saving their funder – the government – money. We therefore also asked respondents if they felt that the PCs' austerity measures had saved the public sector money, and if they would in the long run, the responses to which are shown in Table 5. More than 50 percent of respondents did not think that austerity measures saved money for either healthcare specifically, or for the public sector as a whole, both in the short term or the long term (Q14&15). The next most common responses that workers gave were either that they were unsure, or that the austerity measures had possibly created savings in healthcare, but had transferred costs elsewhere in the public sector.

Table 5: Survey responses: will austerity save the public sector money?

	Yes, both in my area and the public sector as a whole	They create savings in my area, but transfer costs to other areas in the public sector	No, neither in my area or the public sector as a whole	There were no austerity measures in my area	Unsure/don't know	Other
Q14: In the immediate or short-term (within 1-2 years):	3% (13)	15% (69)	53% (243)	5% (25)	16% (74)	8% (35)
Q15: In the long-term:	3% (16)	8% (38)	70% (321)	5% (22)	12% (54)	2% (8)

In their comments, a number of survey respondents discussed a shift in the approach to healthcare from proactivity to reactivity, meaning that patients are not seen until they are in crisis or close to, at which point they require more intense, more expensive care. Many respondents also articulated what they see as the consequences of constantly working short-staffed, especially in hospitals, and especially amongst nurses and healthcare aides. They noted that instead of keeping or hiring regular staff, facilities often have to pay overtime to the staff that they do have, or bring in workers from private agencies, both of which end up being more expensive than maintaining a consistent, reasonably paid workforce. One crisis clinician noted that "[they] work a lot of overtime. In the long term, it doesn't make sense because they are paying the limited staff 1.5 times or 2 times regular pay for overtime, instead of just creating more fulltime positions" (respondent #226, 2022). Therefore, even if the goal of the austerity agenda had solely been cost savings, without concern for quality improvement, it does not appear the PCP has fully succeeded.

Finally, we wanted to know how healthcare workers thought provincial austerity had evolved in Manitoba since the PCP took office. Of course, we recognized that budgetary frugality was not an approach held exclusively by the current government. As Camfield (2018) revealed in his own research, measures like program mergers, wage freezes, and staffing and resource reductions began under the NDP. We asked survey respondents, though, if these types of measures had intensified under PC leadership. The responses are shown in Table 6. The vast majority of respondents – 65 percent – said that austerity had indeed become more intense since 2016 (Q16). Moreover, 50 percent said that provincial austerity had further intensified since the beginning of the COVID-19 pandemic, which is consistent with the data on real provincial spending on healthcare (Q17).

Table 6: Survey responses: the evolution of austerity

	Provincial austerity in my area has been relaxed	The intensity of provincial austerity has remained about the same	Provincial austerity has become more intense	Unsure/don't know	Other
Q16: Comparing the NDP government versus that of the PCP government:	2% (8)	11% (52)	65% (298)	20% (92)	2% (11)
Q17: Before and after the start of the COVID-19 pandemic (March 2020):	7% (33)	27% (123)	50% (230)	14% (63)	3% (13)

What we garnered from the healthcare workers who responded to our survey was that although the austere approach to healthcare is not necessarily exclusive to the PCs, it has

certainly intensified since they were first elected in 2016. The vast majority of respondents not only acknowledged the presence of austerity in the healthcare sector, but also felt that it had – and continues to have – a negative effect on their workplace and their ability to provide the best possible quality of care to patients. It is apparent that many workers feel frustrated, burnt out, and undervalued. This is unfair both to the workers themselves, as well as to the members of the public they are expected to treat, with the same level of care as they always have, but with less support.

Discussion

As noted earlier in this paper, the narrowest definition of austerity involves governments cutting their spending, with the purpose of reducing or eliminating yearly budget deficits and cumulative debt. A more comprehensive definition, though, includes additional policy levers aside from strict expenditure restraint, such as specific program cuts, restructuring, privatization, contracting out, underspending, and an overall goal to diminish the size of the state. My results not only show that Manitoba's PCP has adopted an austerity agenda in its narrowest sense, but that it has made use of various other policies tools that encompass a broader definition in its mission to reform healthcare in the province since 2016. Further, they weaken the case for austerity as an effective policy approach, as the quality of healthcare in Manitoba has diminished according to almost every measure since the PCP's election. This aligns with the pre-existing literature on the effect of austerity on healthcare systems, notably in Ireland and Greece in the aftermath of the 2008-09 financial crisis (Williams & Thomas, 2014; Stuckler & Basu, 2013), in the UK during the same period (Martin et al., 2021), and in Manitoba during the previous NDP government's last term in office, when it started to introduce some of the measures that would be greatly intensified under its successors (Camfield, 2018). In each of these contexts, austerity was

found to diminish the quality of the healthcare system, including increased wait times, fewer available staff, clinic and hospital bed closures, and disenfranchised workforces. My findings have shown similar outcomes in the PCP-led Manitoban context.

In accordance with a narrow definition of austerity, I have shown that while the PCP's healthcare spending may look to have been increasing in nominal terms since it was elected in 2016, this is not the case once accounting for inflation and population growth. On a real per capita basis, the PCP spent less than its NDP predecessors, and moreover, spent a declining amount each year from 2016 to 2019. Further, Manitoba very quickly went from being one of the highest-spending provinces on healthcare under NDP leadership to one of the lowest under the PCP's reign, including in the midst of the COVID-19 pandemic. Even though its healthcare spending *did* increase during this period of extraordinary strife and it *did* spend more than many of its provincial counterparts on COVID-specific relief, Manitoba under the PCP failed to invest in improvements to the system as a whole and failed to keep up with the necessary total spending increases of other provinces. Therefore, viewing austerity strictly as expenditure restraint, it is safe to say the PCP has applied their agenda to the healthcare sector.

The case becomes even stronger if we characterize austerity more holistically, as involving an array of policy tools designed to diminish the overall size of the state. Since 2016, the PCP has made – and continues to make – cuts to specific programs and staffing units, has undertaken a drastic restructuring of the province's largest health authority, and has offloaded or contracted out an increasing number of services. Most notable have been the cancelation of more than $1 billion worth of health infrastructure projects, the closures of emergency rooms and urgent care centres both in Winnipeg and in rural communities, the layoffs or relocations of hundreds of hospital staff within the WRHA, and the contracting out of diagnostics, air

ambulance services, nurses, and other healthcare staff and services. With the benefit of hindsight and the insights of our survey participants, we now know that these ill-considered austere actions have resulted in significant job vacancies across the healthcare sector, and consequently, inconsistent healthcare planning and patient care.

No matter if austerity is defined strictly as expenditure restraint or more broadly as including other policies levers that diminish the size of the state, it is clear that the PCP's approach to healthcare since 2016 fits the bill. This conclusion, though, only answers half of my research question. Not only did I set out to see whether or not the PCP had applied their austerity agenda to healthcare, but also to see what effect it had had on the quantity and quality of services Manitoba's healthcare workers have been able to provide. In other words, my goal was to assess the validity of the theory behind austerity in a specific context. The theory – which purports that austerity can reduce or eliminate deficits, stimulate consumer demand, improve service delivery, all while transferring duties to the supposedly better-performing private sector – can be judged on two fronts. The first is effectiveness, or quality improvement. The second is efficiency, or cost-savings.

Regarding effectiveness, based on the quantitative outputs analyzed and the responses received from workers, it appears that the PCP has quite definitively failed to improve both the quality of healthcare services provided in Manitoba and the environment in which they are delivered. Since 2016, Manitoba has performed progressively worse relative to its provincial counterparts in terms of wait times for surgeries and diagnostic procedures, availability of physicians, wages offered to healthcare workers, and job vacancy rates across the healthcare sector. Further, our survey respondents provided insights that numbers alone simply cannot – that they feel overworked, burnt out, underappreciated, understaffed, and under resourced, and

that this has negatively affected things like patient care, public safety, worker safety, job satisfaction, and employee recruitment and retention.

Efficiency, or cost-savings, is a bit more difficult to assess, especially in the short term. Nonetheless, my results illustrate that the PCP has been spending a declining amount on per capita real healthcare expenditures each year it has been in office, save for the COVID-19 years, during which it still spent less per person than other provinces. At the same time, the quality of care has gone down almost ubiquitously. Therefore, while the PCP may have succeeded in attainting short-term cost-savings on healthcare since taking office, it came at the expense of quality, and thus, it has failed to improve efficiency in the healthcare sector. Moreover, while it difficult to *know* with certainty what the effect on overall system-wide efficiency will be until years from now, the vast majority of our survey respondents indicated that they expect the PCP's austere measures will cost the public sector more than they will save it in the long run. For instance, the province could save money in the short term by having an individual come in less frequently for regular check-ups, but may have to flip a much larger bill down the road should that same individual develop diabetes, heart disease, or another chronic disease that they may not have, had preventative measures been made a priority. Therefore, at least in my chosen research context – Manitoba's healthcare system under PCP rule since 2016 – the theory behind austerity has proven to be unsound, both in terms of effectiveness and efficiency.

While the approach a provincial government takes to budgeting for healthcare plays a key role in determining system outcomes, it is not the sole consideration. To gain a better and more thorough understanding of the quality and efficiency of Manitoba's healthcare system, other factors should ideally be considered, factors that extend beyond the scope of this paper. For instance, healthcare is unique in that it is financed jointly by the provinces and the federal

government. While my research has focused almost exclusively on Manitoba's provincial expenditures, future projects may examine the provincial-federal financing blend to assess the role that both levels of government play. Further, I have limited the scope of my research to examining *healthcare system* inputs and outputs, rather than *health* outcomes. An examination into the social determinants of health – the economic and social conditions which affect the propensity of members of society to contract various illnesses – also deserves due consideration. Future research could incorporate a wider array of factors that affect health in conjunction with an austerity agenda – the food we eat, where we live, the kind of work we do, the chemicals to which we are exposed – as well as examine the effects on health outcomes, such as mortality, morbidity, and the prevalence of various illnesses. This type of research, which involves a more complete study of the upstream factors that affect Manitobans' health, may not be possible for years or even decades, as the consequences of an austerity agenda take time to fully manifest themselves. Nevertheless, it will eventually be a crucial project to undertake.

Conclusion

Governments at every level are constantly confronting the question – to save or to spend? The answer is often dependent on factors such as the province or state's economic position, the government's priorities, what it thinks its electorate expects, and its ideological leanings. Ever since Manitoba's Progressive Conservative Party was first elected in 2016, and then subsequently in 2019, it has opted – wherever possible – to save rather than spend. They have unmistakably pursued an austerity agenda as their modus operandi, centred on lowering both taxes and spending, cutting existing programs, cancelling previously announced projects, privatizing, contracting out, and restructuring. This much is clear to any casual observer of the PCP's election promises, press conferences, and yearly budget announcements.

The purpose of my research was to examine whether Manitoba's healthcare sector, specifically, had been included in this broad austerity agenda, and if it had, what effect that had had on both patients and practitioners. My results, as presented in this paper, have demonstrated that the PCP has indeed applied its austere approach to healthcare, both through strict expenditure restraint and through a series of other actions, including limiting access to care, cutting and reorganizing staff, and contracting out services such as diagnostics, air ambulance, and nursing. They have further illustrated the adverse effects on almost every measure examined, including wait times, quality of patient care, physician availability, vacancy rates, wages, and employee satisfaction and mental health. In recent years, the word "crisis" has increasingly been applied to healthcare in Canada, and the results presented in this paper suggest that Manitoba fares worse than the national average according to nearly every criterion. These are not inherent, inevitable problems with a public healthcare system, but the result of deliberate political decisions. Perhaps it is time for our provincial leaders to reassess, reprioritize, and revalue their commitment to healthcare, for the sake of workers and patients alike.

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Appendix

Full survey administered to participants via Qualtrics Survey Software

Consent Form

Public Service in Tough Times: Working Under Austerity in Manitoba

CONSENT FORM – ONLINE SURVEY

This consent form, a copy of which can be downloaded for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Name of Researchers:

- Jesse Hajer, Assistant Professor, Department of Economics and Labour Studies Program, University of Manitoba
- Ian Hudson, Professor of Economics, University of Manitoba
- Jennifer Keith, PhD candidate, Department of Indigenous Studies, University of Manitoba

Title of Project:
Public Service in Tough Times: Working Under Austerity in Manitoba.

Specific Activities to be Completed by Project Participant and Time Frame:
Online Survey. Expected time: 20-30 minutes.

Description of Research Project:
From 2016 to 2020, the government of Manitoba prioritized balancing the budget through expenditure reductions. To achieve this, the government undertook a number of measures that could be considered part of an "austerity" agenda, including but not limited to:

- Eliminating approximately 17% of the civil service workforce;
- Directing the broader public sector to cut 15% of management staffing;
- Reduction and/or elimination of funding to external organizations for public and social services delivered by non-profit organizations and municipalities;
- Implementing a public sector wage freeze directive; and
- Privatizing or contracting out services to the private sector.

In 2019, the auditor general declared that the province was successful in this goal and had eliminated the budget deficit. During the initial onset of the COVID-19 pandemic in 2020, the government sought further reductions in expenditures in non-health public service areas, to reallocate to COVID-19 related spending. Both prior and throughout the pandemic the government has under-spent budgeted expenditures.

Through surveys and interviews with public service workers, we seek to document the opinions, experiences, and perspectives on the impact of provincial government austerity during this period including:

- the impact of austerity on public services and programs, with special attention paid to the impact on lower-income households;
- what efficiencies have been achieved with or without privatization;
- the effect on value for money for provincial government funds spent in different areas; and
- the impact of the changes on working conditions and job quality for front-line workers.

Benefits

This research provides you the opportunity to share your perspective on the impact of austerity on public services and public sector working conditions, and see those perspectives reflected in our publication. Our research aims to be useful and of interest to public sector workers, and as a resource to educate and share knowledge with decision makers and Manitobans more broadly. We hope this research will shape public policy going forward. Summary of the research findings is expected to be available by September 2023 and will be posted on the following website: https://mra-mb.ca/austerity-in-manitoba/

Risk
The risk of participating in the survey for this project is no greater than risks encountered in everyday life. One potential risk is a breach of confidentiality: that information may be shared in ways that enable you to be identified. To minimize the risk of this occurring, the following procedures will be undertaken.

Confidentiality

The data collected through the survey is anonymous such that your responses are not linked to your email address the survey is sent to. If you enter such information in the survey comments, this information will be linked to your survey responses and will be confidential. This means that participants' names or any other personal or identifiable information will not be included in presentations or reports arising from the study.

Use of Data, Secure Storage and Destruction of Research Data

Information collected from participants will be used as part of the "Public Service in Tough Times: Working Under Austerity in Manitoba" research project and subsequent edited collection. It may be used for conference presentations and/or publication in newspapers, journals and other academic and professional resources, including the University of Manitoba's MSpace (https://mspace.lib.umanitoba.ca) institutional repository. All information will be treated as confidential and stored in a private and secure place (Qualtrics and University of Manitoba's SharePoint servers), and subsequently destroyed 6 months after research is published, no later than December 2024. The principal investigator, Jesse Hajer, is responsible for destroying the data. Copies of consent will be securely kept on file by the researchers for information purposes only for two years and then destroyed, in accordance with university ethics policies.

Notice Regarding Collection, Use, and Disclosure of Personal Information by the University
Your personal information is being collected under the authority of The University of Manitoba Act. The information you provide will be used by the University for the purpose of this research project. If you agree to an interview, your email address and/or phone number may be used to contact you. Your personal information will not be used or disclosed for other purposes, unless permitted by The Freedom of Information and Protection

of Privacy Act (FIPPA). If you have any questions about the collection of your personal information, contact the Access & Privacy Office (tel. 204-474-9462), 233 Elizabeth Dafoe Library, University of Manitoba, Winnipeg, MB, R3T 2N2.

There will be an option to submit contact information, to be contacted to participate in the interview portion of this research. Please be aware that any personal information you enter in the survey may be stored on Qualtrics (the software used to host the survey) servers. The University of Manitoba cannot and does not guarantee protection against the possible disclosure of your data including, without limitation, against possible disclosures of data in accordance with the laws of a foreign jurisdiction.

By clicking "Yes"/ “agree” and “submit” (once you have completed the survey) you are indicating that you have understood to your satisfaction the information regarding participation in the research project, agree to participate as a subject, and have given consent to the dissemination of material provided to the researchers for use in their Research Project.

I understand that the information I provide will be incorporated in a presentation, report and academic publications. I understand also that all research data will be treated as confidential, stored in a private and secure place, and subsequently destroyed at the end of the project by the researchers.

In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the survey at any time during the survey, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. **Since the survey is anonymous, withdrawal from the survey is not possible after submission.** To obtain a copy of this consent form for you to keep for your records and reference please click here: consent form Austerity MB project.pdf

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry Campus. If you have any concerns or complaints about this project, you may contact any of the above- named persons or the Human Ethics Coordinator at 204-474-7122 or humanethics@umanitoba.ca.

CONTACT INFORMATION:

- Jesse Hajer, Assistant Professor Department of Economics and Labour Studies Program, University of Manitoba, Telephone: 204-474-9057 e-mail: jesse.hajer@umanitoba.ca
- Ian Hudson, Professor Department of Economics, Telephone: 204-474-9274 e-mail: ian.hudson@umanitoba.ca
- Jennifer Keith, PhD Candidate Department of Indigenous Studies University of Manitoba Telephone: 204-330-5611 e-mail: keithj3@myumanitoba.ca

Thank you for participating in this project. Your cooperation and insights are valuable and are greatly appreciated!

To be included in this study, you must be:

- 18 years of age or older, and
- have worked for the Manitoba government, a Manitoba municipality, Manitoba crown corporation or other third-party organization or service provider (school, hospital, municipality, non-profit organization, etc.) that delivered public services **funded (at least partially) by the Province of Manitoba**, anytime between 2015 and 2022.

I confirm that I meet this criteria (If uncertain please contact jesse.hajer@umanitoba.ca requesting further clarification):

- Yes

If we quote the comments you provided in this survey, how can we refer to you? Please select your preference:

- A public sector employee in the following department, area, branch or government entity:
- A public sector employee (generic)
- An employee with a non-profit organization that [please briefly describe type of services provided and/or target population]:
- An employee with a non-profit organization (generic)
  A contractor providing publicly funded services in following sector:
- Other:

- None of the above – do not reference my place of employment in relation to my comments and refer to me as a generic “worker delivering public services”

I give permission for my comments to be referenced back to my occupation or job title:

- Yes. My occupation or job title is: No, do not reference my occupation or job title.

*Note: If fewer than 4 workers from any particular department, area, branch or government entity participate in the study (including both survey and interviews), place of employment will not be referenced when reporting comments from survey and/or interviews.

I agree to participate in this study:

- Yes

Part A: Workplace Characteristics

Please note: In addition to completing the survey, you must click “submit” at the end of the survey to finalize your submission. If you do not click “submit” your data will not be recorded.

Reminder: You may skip any question you do not wish to answer.

Part A: Workplace Characteristics

Please select your current or last public sector employer:

- The Province of Manitoba (member of civil service) Municipality
- Arms-length provincial entity (ex. school division, health region/authority, university, crown corporation, etc.)
- A non-profit organization, contractor or professional office (ex. physician practice) that independently delivers public services with provincial funding
- Other:

Select government department/secretariat:

- Advanced Education, Skills and Immigration Agriculture
  Crown Services
- Economic Development, Investment and Trade
- Education and Early Childhood Learning
- Environment, Climate and Parks
- Families

- Francophone Affairs
- Status of Women
- Treasury Board
- Finance
- Mental Health and Community Wellness
- Seniors and Long-term Care
- Health
- Indigenous Reconciliation and Northern Relations Intergovernmental Affairs
- Justice
- Labour, Consumer Protection and Government Services
- Municipal Relations
- Natural Resources and Northern Development
- Public Service Commission
- Sport, Culture and Heritage
- Transportation and Infrastructure

Select area in Advanced Education, Skills and Immigration where you are/were employed:

- Advanced Education Immigration
  Adult Learning and Literacy
- Other:

Select area in Education and Early Childhood Learning where you are/were employed:

- K-12 Education
  Early Childhood Learning / Child care
- Other:

Select area in Families that you are/were employed in:

- Child Welfare / Child and Family Services Housing
  Income Assistance (EIA, Rent Assist, etc.) Disability supports
- Other:

Select area in Labour, Consumer Protection and Government Services you are/were employed with:

- Labour
  Consumer Protection Government Services
- Other:

Select your area in Municipal Services:

- Community Development
  Other branches supporting municipalities
- Other:

Select the sector/type of arms-length provincial entity you are/were employed with:

- Crown corporation
  Schools and School Divisions
  Adult Learning and Literacy Centres
  Post-Secondary Education (Universities and Colleges) Healthcare
- Other:

Select crown corporation you are/were employed with:

- Manitoba Hydro
- Manitoba Liquor and Lotteries Corporation
- Manitoba Public Insurance Corporation Efficiency Manitoba
- Manitoba Arts Council
- Manitoba Centennial Centre
- Manitoba Film and Music
- Workers Compensation Board
- Other:

Select type/area of health care:

- Mental Health/Addictions
- Home Care
- Long-term Care
- EMS
- Health Regions/Authorities, including Hospitals
- Community-based Clinics
- Other Health:

Select the category that best represents your program/policy area of work:

- Agriculture
- Arts, Culture, and Sport
- Adult Learning and Literacy
- Child Welfare
- Childcare
- Economic Development, Investment and Trade
- Income Assistance and Disability supports
- K-12 Education and Schools
- Environment or Conservation
- Seniors

- Mental Health, Addictions and/or Harm reduction
- Healthcare
- Housing
- Immigration
- Indigenous Reconciliation and Northern Development
- Justice
- Labour and Consumer Protection
- Natural Resource Management
- Post-Secondary Education (Universities, Colleges, and Apprenticeship)
- Skills Training and Workforce Development
- Transportation and Infrastructure
- Community Development, Poverty Reduction
- Municipalities
- Women
- Other:

Select the type of organization that you work for:

- Indigenous authority
- Non-Indigenous authority
- Indigenous child welfare agency Non-Indigenous child welfare agency
- Other:

Select the category that best represent your area of work in health:

- Home Care
- EMS
- Long-term Care Hospital
- Community-based Clinic
- Physician Practice
- Other Health:

For the remainder of the survey, please restrict your answers to your current or last area of public service work/employment, as selected above.

Part A: Workplace Characteristics (Continued))

In my current or last public service job, I would describe myself as:

- Senior management
- Supervisor or Manager
- Front Line Worker
- Other:

Please list your current/last occupation/profession and/or job title, or briefly describe your employment-related responsibilities:

My employment responsibilities apply to the following geographic areas (select all that apply):
[For a map depicting these regions, see: https://www.gov.mb.ca/health/rha/map.html]

- Northern Manitoba
  Prairie Mountain / Wesman
- Southern Manitoba
- Interlake and Eastern Manitoba
- Winnipeg
- All of Manitoba
- Other:

You can elaborate on your responses to any of the above questions here:

Part B: Presence of Austerity

From 2016 to 2020, the government of Manitoba prioritized balancing the budget through expenditure reductions and restraints. To achieve this, the government undertook a number of measures that could be considered part of an "austerity" agenda, including but not limited to:

- Implementing a public sector wage freeze directive;
- Eliminating approximately 17% of the civil service workforce;
- Directing the broader public sector to cut 15% of management staffing;
- Froze funding or below inflation increases for core public services;
- Privatizing or contracting out services to the private sector; and
- Reduction and/or elimination of funding to external organizations for public and social services delivered by some non-profit organizations and municipalities;

In 2019, the auditor general declared that the province was successful in this goal and had eliminated the budget deficit. During the initial onset of the COVID-19 pandemic in 2020, the government sought further reductions in expenditures in non-health public service areas, to reallocate to COVID-19 related spending.

Has the work done by you and your close co-workers in your area of work been impacted by the Government of Manitoba's austerity measures aimed at reducing expenditures and balancing the budget?

- Our work was greatly impacted
- Our work was moderately impacted
- Our work was impacted in a minor/marginal way
- Our work was not impacted

How has your employment been impacted by these austerity measures (select all that apply)?

- I have been laid off or lost my job
  My hours were reduced
  My hours were increased
  My workload has intensified/increased
- My workload has decreased
- My work has change. Explain:
- No impact
- Other. Explain:
- Unsure / Don't know

You can elaborate on your responses to any of the above questions here:

Has work done in your current area of work been scaled back or eliminated as a result of austerity measures?

- Yes. Explain:
- No
- Unsure / Don't know

Has (more) work in your area been privatized or contracted-out to private companies or other non-government organizations?

- Yes. Explain (service type contracted out, to what type of provider, etc.):
- No
- Unsure / Don't know

Did you experience any of the following changes to your work scheduling (select all that apply):

- Assigned more shifts than desired
- Assigned longer shifts than desired
- Shorter or missed breaks/meals

- Staffing shortages
- Other Resource shortages (reduced budgets or limiting of spending to support people's work/tasks)
- Increased number tasks requested of me
- More contract/casual staff hired (opposed to permanent staff)
- No change
- Other:

You can elaborate on your response to any of the above questions here:

Part C: Consultation on Austerity Measures

Did management or other senior government officials explain or justify to stakeholders in your area of work the need for austerity measures in your area?

- Yes
- No
- There were no austerity measures or efforts to reduce expenditures in my area.

Please briefly describe the rationale provided:

Please rank your agreement/disagreement with the following three statements:

	Strongly Disagree	Somewhat Disagree	Neutral (Neither Agree nor Disagree)	Somewhat Agree	Strongly Agree	Not Applicable	Don't Know/Unsure
Prior to austerity measures noted above being implemented, I had meaningful opportunities to contribute ideas on how to reduce expenditures in my area:	○	○	○	○	○	○	○
My work-related experience, expertise and opinions were reflected in the austerity/expenditure reduction measures	○	○	○	○	○	○	○

that were implemented:							
I feel the work-related experience, expertise and opinions of front-line workers in my area of work were reflected in the austerity measures implemented:	○	○	○	○	○	○	○

You can elaborate on your response to any of the above questions re. consultation on austerity measures here:

Part D: Impact of Austerity on Service Quality

In your opinion, the austerity measures implemented in your current/last area of work and related changes led to:

- Improved service quality for stakeholders/users of the service
- No change in service quality for stakeholders/ users of the service
- A reduction in the quality of service or stakeholders/users of the service
- Unsure / Don't know
- There were no austerity measures or efforts to reduce expenditures in my area

As a result of austerity, has your ability to deliver services/care to individuals (clients, members of public, students, patients, other public sector workers, etc.) as part of your employment responsibilities been affected in any of the following ways (check all that apply):

- I am able to provide improved services to individuals
- I am able to see fewer individuals
- I am not able to spend as much time with individuals
- I am asked to provide the same or increased service with fewer resources
- No change
- Other:
- Not Applicable in my area of work

Thinking specifically about lower income Manitobans and/or those living in poverty, in your opinion, the austerity measures implemented in your area and related changes led to:

- Improved service quality for low-income service users

- No change in service quality for low-income service users
- A reduction in service quality for low-income service users
- Unsure / Don't know
- There were no austerity measures or efforts to reduce expenditures in my area

What is your opinion on the current model for delivering the Employment and Income Assistance (EIA) program?

- The current model for delivering EIA is well adapted to the needs of clients
- The current model for delivering EIA requires minor adjustments and improvements. Please elaborate:
- The current model for delivering EIA requires a fundamental overhaul. Please elaborate:
- Unsure / don't know

In your opinion, expenditure cuts and restraints implemented in your area of work:

- Positively impacted public safety
- Did not affect public safety
- Worsened public safety
- Unsure / Don't know
- There were no expenditure cuts or restraints implemented in my area

In your opinion, other austerity measures implemented in your area of work, such as privatization and contracting out:

- Positively impacted public safety
- Did not affect public safety
- Worsened public safety
  Unsure / Don't know
- There were no other austerity measures, such as privatization and contracting out, in my area

You can elaborate on your responses to any of the above questions re. public service quality and public safety under austerity here:

Part E: Impact of Austerity - Cost Savings and Value

Thinking about cost savings in the immediate or short-term impact (within 1-2 years), do you believe the austerity measures implemented in your area of work save the public sector money?

- Yes, they create savings for both my area and the public sector as a whole.

- They created savings for my area, but transferred costs to other areas of the public sector (other departments, areas, branches, levels of government etc.)
- No, they ended up increasing costs in both my area of work and for the public sector as a whole.
- There were no austerity measures or efforts to reduce expenditures in my area
- Other. Please explain briefly:
- Unsure / Don't know

Thinking about cost savings in the long-term, do you believe the austerity measures implemented in your area save the public sector money?

- Yes, I expect they will create savings for both my area and the public sector as a whole.
- They create savings for my area, but transfer costs to other areas of the public sector (other departments, areas, branches, levels of government etc.)
- No, I expect they will increase costs in both my area of work and for the public sector as a whole.
- There were no austerity measures or efforts to reduce expenditures in my area
- Other. Please explain briefly:

In your opinion, the austerity measures implemented in your area of work will lead to Manitobans getting:

- Better value from the government/taxpayer money spent on public services
- About the same value
- Less value for money
- Unsure / Don't know
- There were no austerity measures or efforts to reduce expenditures in my area
- Other:

Please elaborate on your responses to the above questions re. cost savings and value under austerity here:

Part F: Impact of Austerity - Working Conditions

In your opinion, austerity measures implemented in your current/last area of work led to:

- Improved working conditions and job satisfaction
- Did not affect working conditions and job satisfaction
- Worse working conditions and job satisfaction
- Unsure / Don't know
- There were no austerity measures or efforts to reduce expenditures in my area

In your opinion, austerity measures implemented in your area of work led to:

- Improved employee mental health
- Did not affect employee mental health
- Worsened employee mental health
- Unsure / Don't know
- There were no austerity measures or efforts to reduce expenditures in my area

In your opinion, austerity measures implemented in your area of work led to:

- Improved employee recruitment and retention
- Did not affect employee recruitment and retention
- Worsened employee recruitment and retention
- Unsure / Don't know
- There were no austerity measures or efforts to reduce expenditures in my area

In your opinion, expenditure cuts and other austerity measures implemented in your area of work, such as such as privatization and contracting out:

- Positively impacted worker safety
- Did not affect worker safety
- Worsened worker safety
  Unsure / Don't know
- There were no austerity measures or efforts to reduce expenditures in my area

Reflecting on the impact of austerity implemented in your area of work:

- It made me more satisfied with my job
- It did not have any impact on my job satisfaction
- It made me less satisfied with my job
- There were no austerity measures or efforts to reduce expenditures in my area

Reflecting on the impact of austerity on your desire to stay with current/last public service employer:

- It resulted in no change on my desire to stay with current/last public service employer
- It made me want to stay in my current/last job longer
- It led to me to consider jobs elsewhere or with other employers
- It led me to leave my public service job
- There were no austerity measures or efforts to reduce expenditures in my area
- Other:

You can elaborate on your responses to any of the above questions re. working conditions and austerity here:

Part G: Austerity Over Time

Comparing expenditure restraint under the NDP government prior to 2016 versus that of the Progressive Conservative government after 2016:

- Provincial austerity in my area has been relaxed (expenditures have been more generous, staffing levels have increased, etc.) since 2016.
- The intensity of provincial austerity has remained about the same
- Provincial austerity in my area of work has become more intense (greater expenditure restraint/cuts, larger staff reductions, etc.)
- Other:

Thinking of provincial austerity before and after the start of the COVID-19 pandemic (March 2020)

- Provincial austerity in my area has been relaxed (expenditures have been more generous, staffing levels have increased, etc.) since the pandemic started.
- The intensity of provincial austerity has remained about the same
- Provincial austerity in my area of work has become more intense (greater expenditure cuts, etc) since the pandemic started
- Other:
- Unsure / Don't know

Thinking of provincial austerity under Premier Heather Stefanson (November 2021 to present) versus when Brian Pallister was Premier (April 2016 to October 2021):

- Provincial austerity in my area has been relaxed (expenditures have been more generous, staffing levels have increased, etc.) since November 2021
- The intensity of provincial austerity has remained about the same
- Provincial austerity in my area of work has become more intense (greater expenditure cuts, etc.)
- Other:
- Unsure / Don't know

You can elaborate on your responses to any of the above questions re. austerity over time here:

Part H: Policy Alternatives

Do you believe the private sector would perform your unit/organization's tasks in a more efficient manner?

- Yes. Please briefly describe:
- No. Please briefly explain:
- Unsure / Don't know

Are there opportunities in your area of work, if your budget was increased, to provide value-for-money (provide additional or higher quality services in a cost-effective way) for Manitobans/taxpayers?

- Yes. Please briefly describe:
- No. Please briefly explain:
- Unsure / Don't know

Do you have ideas for how government services can be delivered more efficiently (better or more services for same or less cost) in your area?

- Yes. Please briefly describe:
- No

Are there opportunities in your area of work to provide value-for-money for Manitobans/taxpayers by eliminating or reducing expenditures and/or services in your area of work, and transferring the funding elsewhere?

- Yes. Please briefly describe:
- No. Please briefly explain:
- Unsure / Don't know

Part I. Final Comments

Use this space to add any additional comments or information you think relevant for this study:

Part J: Worker Characteristics

The following four questions will be used to determine if survey responses differ significantly based on racialized status, gender identity, work experience and level of education. Again, you may skip any question you do not wish to answer.

With respect to gender identity, how do you describe yourself? Choose all that apply.

- Man
- Woman
- Transgender Non-binary/non-conforming
- Prefer not to say

What is your cultural background? Choose all that apply.

- African European
  East Asian
- South Asian
- South East Asian
- First Nations
- Métis
- Inuit
- Indigenous
- Hispanic or Latinx
- Middle Eastern
- Another cultural identity:
- Prefer not to answer

Enter your years of experience working in the public sector and/or delivering public services:

What is the highest level of education you have completed?

- Less than High School
- High School Diploma
- Vocational or College Diploma or Degree
- Some University but no Degree
- University Bachelor's Degree
- Graduate or Professional Degree
- Prefer not to say

Part K: Interview

Would you be willing to participate in a one-on-one interview to discuss how austerity has impacted services to Manitobans and working conditions? Interviews will be recorded to facilitate transcription.

- Yes. If yes, please enter your name, phone number and email address at which to contact you. Alternatively, please email jesse.hajer@umanitoba.ca to volunteer for an interview.
- No

Please click “submit” to finalize the submission of your survey responses. If you do not click “submit” your data will not be recorded.

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