Ottawa Health Coalition

Protecting public healthcare for all.

Presentation to the Ontario Pre-budget Consultation Committee

January 17, 2018

Thank you to the Standing Committee on Finance and Economic Affairs for giving the Ottawa Health Coalition the opportunity to present its concerns and proposals for the 2018 Ontario Budget.

My name is Al Dupuis, Co-chair of the Coalition. I am here with Mary Catherine McCarthy, the Chair of our Communications and Outreach Committee and a former health care worker at the Civic Campus.

The Ottawa Health Coalition is a local volunteer-based organization of individuals and organizations who advocate for the preservation and enhancement of our public and accessible health care system in Canada. We support the principles of the Canada Health Act. We include in our membership health care advocates, health care workers, retirees, students, faith and community groups.

As an affiliate of the Ontario Health Coalition we participated in the 2016 province-wide referendum in May asking whether the people of Ottawa supported stopping the cuts to our public community hospitals and to restoring services and staff to meet our communities' needs. Of the over 9,000 Ottawa citizens who participated, 8,942 voted to send this clear message to the Ontario government. Our Coalition also presented to this Committee in January of 2016 and December of 2016 to highlight the impact of the health care cuts in Ottawa.

In 2017 we hosted a community consultation on hospitals where several health care workers, union representatives and community members participated. We heard from patients who confirmed stories in the media of patients waiting for days in ER for admission, or days in Recovery Room after surgery for a bed on a ward. We learned that The Ottawa Hospital (TOH), for example, has been at 100% capacity or over (often over 110%) since 2009. While there's been a decrease in the number of beds of 5% since then, admissions are up 25%, surgeries 46% and ER visits up 40%. Contrasting the increasing need for services with the updated numbers on cuts to staffing, we note that support staff has now seen 611 notices of elimination since 2011, the Allied Professional sector has seen a 5% drop in Dietitians and Occupational Therapists, an 8% drop in Social Workers, and 19% decrease in Physiotherapists. In practical terms, due to the need to triage cases, many patients don't actually get seen during their shortened hospital stays by these professionals and must seek these services in the community where, outside of hospital and the public system, they may not be able to afford these services. Add to this that around the province we have less nursing care

per patient than any other province, and yet, the Royal Ottawa Hospital, just a few weeks ago, announced a cut of 19 nursing positions.

We have also seen local ER doctors addressing concerns of patients waiting too long for care and overworked staff experiencing difficulty with workloads trying to deliver compassionate care in what Dr. Andrew Gee **recently wrote in the Ottawa Citizen**,is a beleaguered system. He writes:

> We function within the confines of a beleaguered system. How do I care for you when I don't even have space for you? It is not my choice to see you in the waiting room. It is not my choice that I see your grandmother in the exposed hallway. It is not my choice that you wait eight hours with a broken wrist. But it is my reality.

I also quote at length Dr. Allan Drummond, an ER physician for 28 years, **also commenting on our current ER spectacle:**

> Rather than providing hands-on acute medical care, those who staff the nation's ERs now find themselves increasingly doing after-hours primary care, social work, crisis intervention, substance abuse counseling and mitigation of violence. The ER has also, regrettably, morphed into a hospital ward of convenience, warehousing frail elderly patients who would be better served in a hospital bed; instead they languish on stretchers in noisy, brightly lit hallways, robbed of their dignity and deprived of the essentials of basic care.
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> It is the latter circumstance that deserves some attention and focus and principally defines what is wrong with our medical system.
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> Crowding has been allowed to pervert the delivery of health care since the mid-1990s. Contrary to the widely held view, crowding in the ER has absolutely nothing to do with inappropriate overuse by patients presenting with non-urgent problems. Rather, it is a function of hospital overcrowding and the inability to transfer admitted patients from the ER to the wards.
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> When sick patients can't be transferred to an appropriate ward, they occupy treatment stretchers for prolonged periods, thus denying patients in the waiting room and ambulances timely access to care. When hospitals function at 85 per cent bed occupancy, ER crowding never exists; at 95 per cent occupancy rates, it is a given. Ottawa hospitals routinely find themselves at greater than 100 per cent occupancy.

Dr. Drummond goes on to point out how this translates into patient frustration that leads to an increase in the level harassment, abuse and assault.

So we have to ask, emphatically why this remains the case in Ottawa and Ontario hospitals?

While we are somewhat pleased the Ontario Government has raised the level of funding by 3% over the last year, we note that it is accepted analysis that while that accounts for inflation, it does not count for increasing population or need for services which would

require 5.2%. And while the Province has announced temporary increases in beds that it claims is for the expected surge for flu season, we note that hospitals locally have had patients in hallways since last summer. And to add to that, the Liberal Party's 5 year plan indicates that the temporary increase in funding is due to be withdrawn after the election in the spring. To sum up, we must remind the Committee that Ontario funds health care at the lowest level of all provinces. Our hospitals are funded at the lowest rate in the country, meaning we have the fewest beds per person, in hospitals and in Long Term Care. Both require significant and permanent increased funding. Bringing funding levels even to the levels of the average of other Canadian provinces, which, as we've pointed out in **earlier submissions to this Committee,** would be consistent with what this province has done in the past, would make a very significant difference to the many Ontarians suffering needlessly with inadequate care.

And while we endlessly hear of the need for fiscal restraint, we will point out again, that the total impact of tax cuts to corporations and the wealthy (15$ Billion under the Tories until 2003 and an additional 4.5 Billion under the Liberals since) leaves a gap in fiscal capacity of $20 Billion annually. This is equal interestingly to the gap also reflected in the difference between "own source revenue" as a percentage of GDP compared to other provinces, which shows that there is considerable room for the government to maneuver without compromising its "competitiveness" as a jurisdiction.

We also want to draw the Committee's attention to the recent **Toronto Star article** and editorial calling for an end to this belief in tax cuts as a "panacea" for economic growth.

To quote from the main article:

> The result of these 'trickle down' policies which started in the 1980s is now clear: Income and wealth have boomed for a tiny fraction of the population, but this has not benefited the rest of the population at all. We must learn the lessons from this big natural experiment. The main lesson is that to have broad-based growth, we need an equitable tax system, where big corporations and high-earners in the financial industry and elsewhere pay their fair share — otherwise Trumpism will prevail.

And from the editorial:

> The result of all of this is that governments have less revenue to do what's needed, our tax system is less progressive and corporations pay a reduced share for our public goods and services even as their profits continue to break records.

Given the demonstrated need for improved health care and other social services and the demonstrable suffering the shortfalls are causing, this commitment to a discredited ideological position needs to be challenged. It's time for the Government of Ontario to realign its commitment to serve the broader public interest that it often claims to care about.

Mary Catherine McCarthy

We continue to have some major concerns about the proposed new Ottawa Hospital Civic Campus. We are not here to discuss parking or location of the Civic site – the two issues getting the most coverage here in Ottawa. We are very concerned about the capacity of the new hospital and further privatization of health care in our community.

1. The new site must not be developed with a view to shifting patients to private clinics and private for profit long term care facilities. We are concerned that privatization of elective surgeries including knee and eye surgeries as well as diagnostic procedures like endoscopies to private clinics will result in reduced access, user fees increased costs and poorer care.

The provincial government who is contributing 80 percent of the cost for the new facility should insist that the hospital be constructed with a view to not contracting out services to private for-profit clinics or corporations for hospital support services.

A good friend needing cataract surgery was told by her physician that the wait would be about a year to have the procedure done in hospital. Her doctor said that this long wait is due to a provincial cap on the number of surgeries he is funded for. The doctor also proposed that the wait time could be about 2 months at a cost of $1200 to my friend at his private clinic. This places an undue burden on people particularly seniors who most frequently require this surgery to either cope with diminished capacity while they wait or pay out of pocket . Many do not have the income to pay out of pocket. The province must re-examine the numbers of surgeries supported in hospitals and increase the numbers so that patients are not forced to have necessary surgery done at clinics where they have to pay fees.

The provincial government has the opportunity to take leadership to provide funding to improve wait times, access and quality by ensuring that surgical and other medically services are provided for in our 21st century hospital.

2. We hear that the development model for the new site is likely to be a 'modified' Public Private Partnership (P3). P3s continue to be discredited because they will likely cost more and deliver less. There are several examples of cost overruns, secrecy, corruption, decreased services and lower accountability to the community with Hospital P3s in Ontario, British Columbia, Quebec and the UK. They have shown that governments should no longer be pushing this model.

3. In the last few days we have heard about the collapse of Carillion, one of the UK's largest contractors, who has construction and maintenance contracts with hospitals in Toronto, Sault Ste. Marie, Brampton, Oakville and Ottawa.

Here in Ottawa the Royal Ottawa Hospital is confident that services will not be disrupted. But this is another example of how we cannot rely on Multinational companies to provide public services. Unlike Sears, hospitals cannot just liquidate and close up. Hospitals have to continue to operate and take the responsibility and the risk associated with operating a hospital especially an essential service like mental health care in a large city**. We ask that this Committee recommend that the Ontario government provide the support needed to bring these service contracts back in house and not just find another private sector contractor.**

Bonnie Lysyk, the Ontario Auditor General noted that the government in pushing the P3 model has again this year identified problems with the maintenance of P3 facilities including*:*

1. Long-term ongoing disputes with privatized P3 contractors over the P3 agreements
2. Hospitals are required to pay higher than reasonable rates to the P3 contractor for work the contractor deemed to be outside of the P3 contract
3. P3 contractors with poor records are still winning contracts
4. Hospitals are experiencing funding shortfalls for their P3 maintenance agreements – some have had to reduce funding in other areas of their existing budgets to make up for the shortfall.
5. Two key areas where hospitals expected benefits from the agreements have not been realized including: that the monthly payments would cover the maintenance costs and that the hospital would transfer the risk of maintaining the hospital to the contractor.
6. The dispute resolution methods have become time-consuming and ineffective

The AG also comments on problems with privatization and insufficient hospital capacity with regards to lab services, surgery wait times and needing to send patients to the USA for stem cell transplants.

Previously the AG had reported that the ON government did not adequately assess the 'all in costs' of P3s and that the traditional method of public procurement would cost less with public financing and operation.

We request that this Committee recommend that the province act on the Auditor General's recommendations and take leadership to ensure that the procurement for public hospitals be fully transparent and open to public scrutiny and accountability.

4. Long Term Care

We recommend the "Time to Care" Bill 33 legislation be passed as soon as possible before the government shuts down for the election and that the budget provide the funding required for implementation in this year's budget.

Specifically we request:

a. An amendment (i.e. Bill 33) be made to the Long-Term Care Homes Act (2007) for a legislated care standard of a minimum 4 hours per resident each day adjusted for acuity level and case mix;

b. Public funding for LTC homes must be tied to the provision of quality care and staffing levels that meet the legislated minimum care standard of 4 hours;

c. Ensure funding accountability by making public reporting of staffing levels at each Ontario LTC home mandatory;

d. Immediately provide funding for specialized facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers;

e. The province must stop closing complex continuing care beds and alternative level of care beds to end the downloading of hospital patients with complex medical conditions to long-term care homes.