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Chatham Kent Health Coalition
Sarnia Lambton Health Coalition

Shirley Roebuck, Reg. N., Co-Chair CKHC, SLHC

I am a Registered Nurse; I retired in July 2015; I have earned a living as a Registered Nurse since 1972. I have worked in tertiary care centres, like Toronto General Hospital and rural hospitals like Sydenham campus of the Chatham Kent Health Alliance.

Over the years, and indeed decades, I have witnessed many changes to health care in this province, some good and some bad.

The Ontario hospital system has experienced serious cuts to funding since Mike Harris was Premier. Funding decreases and cuts continued under Mr. McGuinty, and now Ms. Wynn is aggressively cutting hospital funding, which in turn has caused bed closures, service cuts, and staff lay-offs.

Hospital global funding has seen real dollar cuts for 9 years in a row. In the end despite all promises, our hospital health care system is fragmented, erratic and of poor quality.

Today, I have one request: please restore hospital funding to satisfactory levels, so that every community has access to hospital services and Ontario can once again be proud of the healthcare it delivers.

The municipalities of Chatham Kent and Sarnia Lambton cover a large geographical area, and two thirds of the Eric St. Clair

LHIN. These municipalities are different, but they do share some commonalities.

Both have medium sized urban populations, rural populations, as well as First Nations communities. Sarnia Lambton is home to "Chemical Valley", a concentrated area of chemical product producers; Chatham Kent is more rural, with a focus on agriculture.

Both municipalities have suffered job loss related to the 2008 recession, leaving many people unemployed, after the closure of small businesses, which have never re-opened. Examples of these closures would include Navistar in Chatham, numerous tool and dye shops in Wallaceburg, and numerous downsizings in the Sarnia refineries, leaving many people out of work.

Both communities have an aging population; Chatham Kent's population is shrinking, whereas Sarnia-Lambton's population seems to beholding steady, but not increasing; there are more employment opportunities in Sarnia Lambton, due to "Chemical Valley".

Both have community hospitals, with "satellite rural campuses". These multi-campus community hospitals serve the populations of the two municipalities, as well as First Nations reserves.

Both hospitals have had to cut beds and services, due to funding policies set out by the provincial governments. This has left 2 small rural hospitals devastated with complete closure of numerous services, and downsizing of the remaining services. The medium sized community hospitals have also lost beds, services and staff.

Bluewater Health in Sarnia, which includes Charlotte Eleanor Englehart Hospital in Petrolia suffered 33 job loss last January to balance its' budget; $5.8 million dollars were saved at the expense of workers in Medicine, Surgery, the laboratory, diagnostic imaging, dietary and housekeeping. Petrolia lost Endoscopies and patient registration.

Since 2013, Chatham Kent Health Alliance has downsized its' Medicine program, and Surgery program, Gynecology beds, Complex Continuing Care; staff were downsized and RPN's replaced RN's on the step down unit from ICU.

Sydenham District Hospital in Wallaceburg has lost Complex Continuing Care, Surgery, ICU, Day Surgery; Medicine beds were lost to Chatham, outstanding of 5 admission beds, the Laboratory, patient registration were lost, and housekeeping was downsized.

The result of these downsizings, consolidations, service cuts and closures have resulted in negative delivery of the health care that the province delivers to the public in Chatham Kent and Sarnia Lambton. Patients and families have to drive further for access to care, services are provided in some cases, on a part-time basis, which is inconvenient to patients and families. Access and delivery of needed health care services are in essence, provided in an erratic, haphazd way, and often involves travelling outside the LHIN to receive service due to lack of beds or available services.

The map below was taken from the Erie-St. Clair LHIN website.


Grand Bend
Port Franks
Kettle Point
Ipperwash Beach
Northville
Ravenswood
Thedford
Forest
Arkona
Brights Grove
Camlachie
Warwick
Point Edward
Reeces Corners
Sarnia
Mandaumin
Watford
Lucasville
Wyoming
Petrolia
Corunna
LAMBTON
Mooretown
Courtright
Brigden
Oil City
Inwood
Oil Springs
Alvinston
Wilkesport
Edys Mills
Sombra
Oakdale
Cairo
Shetland
Port Lambton
Rutherford
Florence
Walpole Island
Wallaceburg
Tupperville
Croton
Bothwell
Dresden
Wabash
Thamesville
CHATHAM - KENT
Muirkirk
Dover Centre
Eberts
Kent Bridge
Louisville
Highgate
Duart
Mitchell's Bay
Grande Pointe
McKay's Corners
Pinehurst
Ridgetown
Palmyra
Chatham
Pain Court
Morpeth
Prairie Siding
Eatonville
St. Clair Beach
Tecumseh
Belle River
Emeryville
Puce
Deerbrook
Stoney Point
Jeannettes Creek
Lighthouse Cove
Blenheim
Guilds
Shrewsbury
Windsor
North Buxton
Charing Cross
Fletcher
Cedar Springs
Elmstead
LaSalle
Erie Beach
St. Joachim
Tilbury
Merlin
Erieau
Oldcastle
Oliver
Comber
Dealtown
North Woodslee
Maidstone
South Woodslee
Ruscom Station
Essex
Staples
Paquette Corners
McGregor
ESSEX
Port Alma
Blytheswood
Amherstburg
Gesto
Cottam
Malden Centre
Wheatley
Ruthven
Harrow
Kingsville
Leamington
Linden Beach
Willow Beach
Seacliffe
Cedar Beach
Cedarhurst Park
Colchester
Oxley
Scudder
Pelee Island

Hospital funding has seen real dollar cuts in their money allotment, for the last ten years, with a 0% raise in funding for the last four years.

In-patient beds have been cut; staff numbers have decreased. Staff mixes have changed, in an effort to save money. Services have been moved out of hospitals; these services are added to community health services or to "for profit" establishments. Much money has been spent trying to improve homecare, yet in this region, only 61 cents of every dollar delegated to homecare is actually spent on patient care.

Health outcomes and statistics from Ontario lag behind the rest of Canada, and have done so for some years. Certainly, you all have seen and heard these statistics, this year and in past years.

Ontario ranks last in the country, in public hospital funding, per person.

Ontario ranks 8th out of 10 provinces in hospital funding as a percentage of the provincial GDP.

Ontario Public Hospital Spending Per Person 2012 Compared to Other Provinces (Current $)	
Newfoundland	$ 2,519
Alberta	$ 2,194
New Brunswick	$ 1,962
Manitoba	$ 1,843
PEI	$ 1,831
Saskatchewan	$ 1,784
Nova Scotia	$ 1,762
British Columbia	$ 1,557
Quebec	$ 1,381
Ontario	$ 1,372

Average Other Provinces	$ 1,870
Difference Between Ontario and Average of Other Provinces	- $ 498 per person x 13,529,000 people = $6.7 billion less

Source: all per capita spending data is from the Canadian Institute for Health Information (CIHI), National Health Expenditures Database, 2012. Percentages of GDP calculated using CIHI GDP figures from the National Health Expenditures Database, 2012.

Public Hospital Funding Per Person, 2015 Current $	
Newfoundland & Labrador	$2,406
Alberta	$2,245
Prince Edward Island	$1,995
New Brunswick	$1,971
Nova Scotia	$1,907
Manitoba	$1,818
British Columbia	$1,797
Saskatchewan	$1,761
Ontario	$1,419
Quebec	$1,382

Average of Rest of Canada	$1,920
Difference between Ontario and the average of the rest of Canada	Ontario funds hospitals at $501 per person less

Many billions of dollars have been spent in the name of bettering health care, streamlining the health care process and decreasing healthcare costs. However, governments have also had other priorities, such as stimulating the economy, and tax cuts. Today, there is less money in the Ontario coffers, exaggerating the true cost of delivering health care services and other public services that Ontario's citizens have come to expect.

Regionalization of health care services, i.e. providing certain healthcare services in one place, while eliminating them in small centres, does not serve people well; small hospitals should be able to provide a core group of health services to local residents, and not force people to drive to other centres for the services they need.

Privatization of health care services, i.e. allowing health care providers to charge extra fees for services, as well as billing

OHIP, prohibits some patients from obtaining service, and is fundamentally illegal under the Canada Health Act.

Indigenous peoples rely on the fiduciary responsibilities of the Canadian federal government for their health care; the federal government delegates funds to the provincial government to deliver many of these services. As the provincial government downsizes services at smaller hospitals, or closes them outright, First Nations peoples' access to health services suffers.

The reality is that we have poorer patient outcomes, decreased access to local health services, longer wait-times for hospital beds, longer waits for Emergency room care, homecare services and LTC beds, overcrowding in our hospitals, increased nosocomial infections, decreased hospital rescues, erratic and insufficient delivery of homecare services, and improper admissions to nursing home beds.

Today's ER's are not prepared for the changing demographic which will occur in approximately 10 years. Today 1 in 12 ER patients are over 75 years of age; in 10 years, almost 1 in 3 ER patients will be over 75. These patients will require more specialized health services, with more emphasis on integration between Primary care and ER care.

Discussion of how the government's hospital funding policies have affected health services in Chatham Kent and in Sarnia Lambton follows.

1) Nosocomial infections in hospitals are rising; this is due to the downsizing of housekeeping staff, which has the huge responsibility of cleaning the hospital, including the ER.

Nosocomial infections will complicate patient stays in hospital, will lead to isolation of entire wards or floors, and have even led to death.

2) Hospital rescues are decreased. This term refers to situations wherein a patient's condition deteriorates while in hospital, which will result in adverse outcomes for the patient, if not "rescued" in time. Registered nurses have the skills and experience to recognize deterioration of their patient's condition and to intervene accordingly. Put another way, Registered nurses (RNs) are in a position to recognize critical changes and to rescue patients at the most opportune moments. With decreased hospital funding always comes staff decreases, and staff mix changes, which decreases the number of hospital rescues. Hospitals are dangerous places for patients, these days.

3) The lack of recognition and respect for indigenous patients and families' beliefs and practices can be seen through the ongoing downsizing of small rural hospitals; in Chatham Kent a primary care centre is planned for Walpole island First Nations (WIFN); this was attempted before through the Chatham Kent Community Health Centre; this plan failed due to erratic and sparse staffing, and inadequate administrative practices where WIFN people were concerned; primary care is much needed, but still such clinics do not offer hospital services. First Nations peoples often do not have transportation to Chatham; when admission is required, family cannot visit; when

transportation to a tertiary care centre is required the patient and family often do not have the means to travel. This means admitted patients in Chatham will be isolated from friends and family, and patients who are referred to specialist care may not keep appointments, because of transportation problems.

The previous Federal Conservative government had cut First Nations health programs to a "bare bones" level, and now the Ontario provincial government is proceeding with it's regionalization plan, which negatively affects small rural hospitals.

The fiduciary responsibility of the Federal government to provide access to health services to aboriginal people is being provided in an erratic fragmented manner. This does not equal quality health care for First Nations peoples.

Please see below for statements from the Auditor General, obtained from T. Stevens, Aboriginal Health Advocate.

The Auditor General's report - April 28tth 2015:

Findings, Recommendations, and Responses:

Nursing stations

Health Canada did not ensure that nurses had completed mandatory training courses

Health Canada had not put in place supporting mechanisms for nurses who performed some activities beyond their legislated scope of practice

Health Canada could not demonstrate whether it had addressed nursing station deficiencies related to health and safety requirements or building codes

Health Canada had not assessed the capacity of nursing stations to provide essential health services

Medical transportation benefits

Some First Nations individuals had not registered and were therefore ineligible for Health Canada's medical transportation benefits

Health Canada did not sufficiently document the administration of medical transportation benefits

Support allocation and comparable access

Health Canada did not take into account community health needs when allocating its support

Health Canada did not compare access to health services in remote First Nations communities to access in other remote communities

Coordination of health services among jurisdictions

Committees to resolve inter jurisdictional challenges have generally not been effective

2015 - 2016

Federal First Nations health funding is projected to decrease by $44 million in 2015-16, and is planned to decrease next fiscal year from $853 million to $772 million, partially due to the sun setting of the Indian Residential School Health Support Program.

The renewed investments offered in the budget for mental health can only be guaranteed if the Conservatives are re-elected.

Some First Nations have reported significant difficulties accessing funding, programs and supports through Local Health Integration Networks (LHINs). LHINs are operated as a non-government, corporate entity, meaning that LHINs do not take the Crown-First Nations relationship into account when making decisions.

The delivery of health care services has become fragmented and erratic; few funding decisions are made based upon community needs, but upon financial policies. Recognition of the coming changes in health care, due to changing demographics has resulted in more empire building amongst health care groups, while what is needed is a more streamlined approach to entering the health care system. (**http://www.cbc.ca/1.3383998)**

With the early discharge of frail patients, out-sourcing of health services, regionalization of health services, and the overall erratic delivery of health services, and patients not being directed to the proper follow up, more and more return visits to Emergency are being seen. Emergency rooms cannot fill all patient's needs.

Within 15 years, 1 in 3 patients in Emergency will be over 75 years of age. These patients are one of the most vulnerable groups to care for, and as well their health histories are complex, with more than one medical problem. If you talk to ER physicians or nurses they will tell you that frail, elderly patients take up beds in the ER now: this happens due to a lack of available beds in hospitals, and also because there are no other options for care than Emergency rooms.

4) The main issue, which has resulted in the problems that have been listed above, is that hospital funding is inadequate; hospitals have been asked to do the impossible, and community care cannot provide all the health services that a patient might need. Funding must be restored in order to make our health care system work for everyone.

When I look at health care services in the communities of Chatham Kent and Sarnia Lambton I see so much potential for wonderful and vibrant health care.

Small rural hospitals like Petrolia and Wallaceburg would be much needed support hospitals for the cities of Chatham and Sarnia, if the funding were there. Patients could be treated locally or transferred back to their own communities to finish their recovery. Admission beds would be readily available for the larger centres. Emergency rooms would not be “clogged” with patients waiting for admission, and wait times would decrease.

If a true integration of health services through hospitals were to exist, patients arriving at the hospital would not have to

enter the health care system through Emergency; a specialty geriatric multidisciplinary health team could “triage “ these patients from the ER, and direct them to the care they need; family doctors could have access to same day referrals with specialists or same day diagnostics; a patient’s medications could be reviewed and adjusted, by the team; support services could be set up at this point of entry. Patients could be directed back home or to respite beds or to hospital admission, as is deemed necessary. A patient’s medical information could be automatically shared with all concerned parties.

All of this, of course, requires money. However, given the problems that the health care system has now, with ER backloads, lack of hospital beds, increased nosocomial infections, lack of qualified RN’s to intercede when a patient’s condition deteriorates, erratic, fragmented homecare services, which do not serve Ontarians’ needs, and lack of long term care beds, funding a re-organized, streamlined and integrated health care system would, in my opinion, more certainly save money…and return to Ontario, a health care system whose priority is the patient and his or her family.

Thank you for your attention.

Shirley Roebuck, Reg. N.

http://www.cbc.ca/1.3383998