Ontario Health Coalition	REPORT

Response to the Metropolitan Toronto Health Services Restructuring Commission Report

April 21, 1997

from the

Ontario Health Coalition

The Ontario Health Coalition comprises 90 organizations representing seniors, women, low income and unemployed people, health care workers, people with HIV/ AIDS, Native people, trade unions and many other individuals and organizations with a keen interest and stake in their health care system.

We were established as a vehicle through which member organizations could work for the strengthening of our publicly-funded, publicly-administered health care system. We are committed to the principles of the Canada Health Act and believe they must be honoured and enhanced.

With respect to the foregoing, we are profoundly alarmed by the decisions in all areas of the province that you have thus far reviewed, and are fundamentally opposed to the role you have been assigned in dismantling a cherished health care system that Ontarians have fought for, paid for with their contribution to this society and rely on. Unless these recommendations are amended, they will push us towards massive privatization, onerous out-of-pocket expenses for citizens, seriously diminished across-the-board quality of care and the eventual introduction of two-tier health care.

Most troubling to us is the absence of planning tools that illuminate the real experiences of people with their health system. The use of rigid mathematical models that are devoid of any human element is dangerous. Benchmarking techniques, in particular, contain no experiential information and therefore should be rejected as a flawed tool in utilization decisions.

In particular, we urge you to review your assumptions for Metro, specifically that 11 hospitals can be closed or merged, an additional 1743 beds cut, lengths of stay further shortened and $430 million extracted from the health care system; and that "a significant number of patients in chronic care settings could be appropriately cared for in long-term care facilities, or other settings such as supportive housing or in their own homes with home care."

Until genuine and meaningful reform of the health care system occurs, we strongly oppose the closure of any hospitals in Metro or elsewhere**.** The lack of a systemic overview, the crisis in

Long Term Care and Home Care, the inadequate reinvestment recommendations, the enormous amount of information outstanding, and provincial government health policy has the potential to catapult patient care into a crisis of unparalleled proportions.

We have many areas of concern. However, this brief will focus on some of the worst facets of the commission's decisions -- the ones that will have the most serious consequences for the people of Metropolitan Toronto and elsewhere.

Our brief will address the following issues:

1. Summary of Recommendations:

Given the calibre of HSRC decisions to date and its biases particularly against women, seniors, lower income and homeless people, we again call for full public hearings and democratic consultation with all stakeholders and interested parties.

The Wellesley, Women's College, Doctor's and the Montfort should remain intact in their present locations with ample funding to carry on the superior service to their communities. In addition, we do not support recommendations for any hospital closures. Until genuine and meaningful reform of the health care system occurs, we strongly oppose the closure of any hospitals in Metro or elsewhere.

We see as urgent the need for methodologies and planning tools that are focused on the patient as a human being, not as a digit in a mathematical equation. The commission and government have become experts at number crunching in their efforts to reach their financial objectives. However, there is more relevant and rich information to be found in the realities of patient experiences.

We cannot overemphasize our opposition to the use of benchmarking techniques to arrive at conclusions about acute and chronic care utilization rates. The use of benchmarking is a race to the bottom without any relevance to patient care.

There will always be a need for quality acute care. This is no longer available in Metro hospitals. There are not enough staff left to adequately deliver care. We believe staffing levels must be now increased in order to ensure quality care for patients in Acute Care Hospitals.

More nursing home beds must be established and an additional level of care must be recognized and funded for those formerly classified as "Continuing Care" patients in Chronic Care hospitals.

Even if the total of the new sub-acute/transitional care beds you finally recommend proves to be adequate for persons needing post-acute care in an institutional setting, the steadily increasing numbers who rely on in-home care will require a substantially greater increase in funding. We urge you to adopt the Metro Toronto Home Care Program figure of $60-$80 million in additional funds.

In order to alleviate the crisis situation for elderly patients no more facilities on which they rely must be closed or reduced and instead**,** more chronic care beds must be reopened until legislative, staffing and funding initiatives are in place for long term care facilities.

A mental health bed rate of greater than 34.9 beds/100,000 must be adopted. A more realistic approach to determinant of health issues must be factored in to the new bed rate and must be reviewed and revised periodically according to need.

The Commission must rescind its "recommendation" to merge the Queen Street Mental Health Centre, the Clarke Institute of Psychiatry, the Donwood Institute and the Addiction Research Foundation.

The Commission must rescind its "recommendation" with respect to the divestment of Queen Street Mental Health Centre which must remain a facility directly owned and operated by the Government of Ontario.

We support the MTDHC recommendation for a new investment of $51 million/year and warn that no further cuts, closures or reductions in the institutional sector should take place until this money has been allocated. This funding may not be adequate to meet the needs of the population and must be reviewed and revised periodically according to need.

Emergencies should not be closed unless and until there are an adequate number of properly located, fully equipped and staffed primary care and urgent care venues that can deal with genuinely deferrable cases. Seniors, in particular, must have full after-hours access.

The legal requirement placed on all provincial hospitals requiring them "to submit a plan to maximize the efficiency of the delivery of administrative services, support services and diagnostic services which must address alternative delivery systems, including services that can be provided by the private sector" should be withdrawn. We cannot afford increased private sector involvement in our health care system.

The scope of the HSRC review is too narrow. It must make recommendations on recovering the necessary dollars for a quality health care system by examining physician and other professional services, along with drug costs, which together account for approximately 36% of the total health expenditures in Canada.

The HSRC must stop promoting the provincial government's perspective that we can no longer afford our health care system. This is untrue and misleading.

2. Composition of the HSRC and lack of accountability

In our submission to you of July 10, 1996, we highlighted our concerns with respect to the composition of the commission, its lack of public representation and consultation and warned that in the absence of these crucial factors, decisions could not be made that adequately reflected the public's interest in the availability and quality of its health care services. For example, we asked who represents consumers' and the public's interest? Who represents the experience of people working in our public hospitals and whose daily reality of the consequences of understaffing and underfunding of patient care would go a long way in illuminating your discussions? Who represents women's interests, seniors, people with mental health needs, average working and unemployed people, and so on?

These were not rhetorical questions. Among other characteristics, all commissioners appear to be people who are advantaged -- people who can afford to purchase their health care and who have therefore less stake in a quality public system.

In addition, we believe some of the commissioners, such as Hartland M. MacDougall, Deputy Chair of London Life, are in a conflict of interest. Insurance companies stand to gain huge benefits in supplementary insurance lines as the commission's recommendations become part of a systematic weakening of public health care. As a consequence, the public system will become increasing cash-strapped and gaps develop in the quality and quantity of available care.

We feel the unrepresentative composition of the commission and its policy of closed door deliberations are related to the hasty and destructive decisions that you have imposed on every area of the province.

It is also directly connected to the unparalleled cultural insensitivity you display in your recommendations to close the Wellesley, Montfort, Women's College and Doctors. It has been pointed out to you that cultures are not mechanical products that can be moved from one place to another, and that human values that have rooted and grown in the relations between these hospitals and their communities cannot be transported and simply dropped into other locations. We are dealing with complex human issues of trust, of culture, of contribution both financial and human, and of superior medical care and quality services. We are extremely troubled by the insensitivity to women, minorities, people with HIV/AIDS, and Francophones that you have demonstrated in ordering these particular hospitals closed.

The four hospitals and their communities have all made their case known to you far more eloquently than we can, but we do want to emphasize our support of them.

In addition, we do not endorse your recommendations for any hospital closures. There have been very few successful restructuring initiatives worldwide. In Denmark, where reform has worked, more is spent on home care and community care than on institutional care. The government of Ontario is not moving in this direction. Until genuine and meaningful reform of the health care system occurs, we oppose the closure of any hospitals in Metro or elsewhere.

Recommendation:

The Wellesley, Women's College, Doctor's and the Montfort should remain intact in their present locations with ample funding to carry on the superior service to their communities. In addition to these hospitals, we do not support recommendations for any hospital closures in Metro or elsewhere, until genuine and meaningful reform of the health care system occurs.

3. Acute Care

From the perspective of many patients who have been in acute care hospitals in Metro, quality care is difficult to find. We receive calls from patients' families or from patients themselves who report a much-changed environment in Ontario hospitals. Call bells go unanswered, patients fall on the way to the bathroom and injure themselves because there is no one to assist them, rooms and bathrooms are often dirty, creating the probability of rising infection rates. Basics such as water and Kleenex are often unavailable. People without a family member or advocate present are often left in pain, without the energy and resources required to get help. In the absence of much needed assistance, they are expected to simply endure the best they can.

Even those people with families often feel isolated and abandoned as their relatives are increasingly hard-pressed to get time off work or to squeeze basic care requirements into an already pressured workday. A number of patients have related stories of a threatening environment as a result of Alzheimer's and other difficult patients wandering floors, entering rooms, sometimes interfering with their IV, or even sitting on top them.

There will always be a need for quality acute care. This is no longer available in Metro hospitals. Since 1988, 2,200 acute care beds have been closed, a 26% decrease to 1996/97. The years of cuts to hospital funding have forced institutions to eliminate staff and rationalize services. The additional $1.3 billion planned reductions has virtually thrown patient care into crisis.

We do not believe that you have an adequate understanding of today's hospital environment. Part of the problem stems from the fact that you ignore the degree to which your recommendations must deal with a changing, not a static situation brought about by significant cuts that have already taken place. The other crucial element missing throughout your planning deliberation is the absence of any tools that speak authoritatively to the human element.

Planning Tools

The Planning Decision Support Tool (PDST), which was developed by the Ministry of Health, is not capable of conveying this reality to you.

In determining the appropriate number of hospital beds, the HSRC has adopted a target that benchmarks the city to the top quartile of peer hospitals in Ontario. This method of measuring and evaluating current and future hospital inpatient care requirements relies on the PDST. However, this tool does not contain any qualitative measures which are essential for the task. It is unreliable and flawed in other ways as well. The PDST manual acknowledges serious limitations. It states that "calculated data and statistics employed in the PDST are intended to highlight areas requiring further research and analysis and cannot be used without qualifications and in most cases, additional investigation".

The problems are compounded by an HSRC and government lack of data on hospital readmission statistics and complications deriving from early discharge, both critical tools in evaluating the impact of reductions in length of stay and changes in technology on quality of patient care. The underlying assumption that reducing hospital stays and shifting ratios from inpatient to outpatient care is always appropriate is both unfounded and untested.

In part, your use of the PDST, which underestimates the need for acute care services in Metro, has resulted in your extremely aggressive recommendations for patients who rely on these institutions.

We cannot overemphasize our opposition to the use of benchmarking techniques to arrive at conclusions about acute and chronic care utilization rates. The use of benchmarking leads to a dangerous game that has terrible implications for staff and for patients, who can never win. This approach appears to have been imported from private sector production lines, specifically from Toyota's Continuous Quality Improvement and the constant push for ever-greater levels of leanness. No matter how fast and well workers have produced, there is constant pressure to beat the last quota. Its use in the private manufacturing sector results in incredible stress, product errors and, all-too-often, serious injury. We disagree vehemently with its application in the health sector.

As an example of the very risky use of benchmarking, we call your attention to individual hospital funding that is now tied to a formula that ranks acute care hospitals by levels of efficiency (measured by average costs per patient). Individual hospitals that operate less "efficiently" are penalized. As a result, hospitals take ever more drastic action to send people home quicker and sicker. But as this happens, the benchmark drops. This then becomes the new target to beat if a hospital wants to retain its funding. It is a race to the bottom without any relevance to patient care. At what absolute level is the 75th percentile for acute service utilization compatible with good quality and safe care? Some hospital, somewhere in the world, will have set a new record which then will become the new standard.

Average Length of Stay (ALOS)

One of the most frightening consequences for patients of HSRC recommendations is a further shortening of average length of hospital stay. The target of 439/1000 population is dramatically lower than the provincial average of 607.

In Ontario, length of stay had already been cut by 20% since 1989/90. This has created enormous hardship for patients being pushed out of hospital long before they feel ready to cope. Many people do not have families and support networks to supplement the often too-short hours provided by in-home care. For those who do, the financial consequences are great for caregivers forced to take significant periods of time off work, or give up their jobs entirely. The job market is tight, unemployment rates high and the bleak economic climate is creating enormous stress for average Ontarians who are working harder and faster than ever before. In still other cases, the increasing levels of acuity are quite simply beyond their skill level.

Almost invariably, women end up supplementing the missing care. A further shortening of length of stay will produce an even more massive shift of the burden of responsibility to women and will likely become a major issue for women and women's organizations as they justifiably protest public policy that makes them a captive of family and home and attempts to force them out of the job market and back to an earlier century.

The HSRC's recommendations to reduce lengths of stay from the low 1996 levels of 574 days/1000 population to 439 by the year 2003 will eventually produce a backlash from caregivers, and from patients themselves. The assumption that the December 1996 level of 5,922 beds in Toronto hospitals was too high and that 767 more beds could therefore be eliminated from the system is once against based on the substitution of rigid mathematical calculations for more relevant and useful data that illuminates the experiences of patients and their caregivers.

We do not believe that any such planning tools are presently in use. We therefore see as urgent the need for methodologies that are focused on the patient as a human being, not as a digit in a mathematical equation. The commission and government have become experts at number crunching in their efforts to reach their financial objectives. However, there is more relevant and rich information to be found in the realities of patient experiences.

Finally, the desperate situation for those pushed out of hospital too soon is exacerbated by the insufficient investment you have recommended for Home Care. As we note in Chronic and Care for the Elderly section of this report, Metro Toronto Home Care has estimated that it requires $60 to $80 million to meet the demand placed on it by shortened length of stay and other changes in the system. We endorse this figure and urge you to adopt it.

Staffing

We were extremely frustrated in the Stakeholders briefing session March 6, held to highlight key aspects of the HSRC Metro decision. Despite several questions from those in attendance, we were unable to get any information on the number of layoffs these recommendations would entail. To date, there has been no further information from the HSRC with respect to this crucial issue.

We have two concerns. Firstly, your lack of attention to a fundamental issue of patient care gives us no confidence that anyone, anywhere is looking out for patients' interests. These are women and men upon whom we rely during some of the most traumatic events of our lives. To ignore the connection between the service they give and our need for it places us in jeopardy. Housekeepers, for example, are responsible for keeping infection rates down. Clean rooms and bathrooms are not just perks as they might be for hotel guests, but often a life and death issue in hospital where patients' immune systems are already compromised. Nursing staff are not just

record keepers, but have a vital role to play in reducing pain and ensuring a full recovery. It is a serious error to have dealt so off-handedly with one of the most important issues for patients.

Our second concern is with the numbers themselves. The Health Sector Training and Adjustment Panel estimates that 10,000 workers could be laid off. This will result in enormous disruption to patient care. We cannot contemplate how even a downsized system could cope with this loss. As we pointed out earlier, there are not enough staff now to adequately deliver care. We are convinced by many sources of information to which we have access that we cannot afford to lose even one more hospital worker. Indeed, we believe staffing levels must be now increased in order to ensure quality care for patients in Acute Care Hospitals. The loss of any workers will inevitably lead to a lowering of standards for patient care and increased risks. We urge you to rethink your system sizing recommendations with respect to their impact on staffing levels.

Recommendations:

We see as urgent the need for methodologies and planning tools that are focused on the patient as a human being, not as a digit in a mathematical equation. The commission and government have become experts at number crunching in their efforts to reach their financial objectives. However, there is more relevant and rich information to be found in the realities of patient experiences.

We cannot overemphasize our opposition to the use of benchmarking techniques to arrive at conclusions about acute and chronic care utilization rates. The use of benchmarking leads to a race to the bottom without any relevance to patient care.

There will always be a need for quality acute care. This is no longer available in Metro hospitals. There is not enough staff left to adequately deliver care. We believe staffing levels must be now increased in order to ensure quality care for patients in Acute Care Hospitals.

4. Chronic Care and Care for the Elderly

We urge you to review your assumption that "a significant number of patients in chronic care settings could be appropriately cared for in long-term care facilities, or other settings such as supportive housing or in their own homes with home care."

We are already in the midst of a crisis with respect to care for the elderly that will be greatly aggravated by your proposal to close an additional 299 chronic care beds. During the period from 93/94 to March/96, 555 beds were closed in Chronic Care Hospitals and Units, that makes for a total of 854 beds.

The loss of these 854 beds is in large part due to the change in admission criteria after the publication of the Chronic Care Role Study. At that time, hospitals began an informal process of refusing admission to patients deemed to be "simple" rather than medically "complex" chronic patients. This change resulted in a decrease of 13% in continuing care beds between 1993/94 and 1995 and evidently a further reduction between 1995 and March 1996. It has also created an unprecedented crisis in Metro's long term care facilities.

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) reports 16,000 people on provincial waiting lists, with 4,000 waiting for nursing home admission in Metro Toronto. The same study found that 58% of nursing home residents are now heavy care patients who require 3.5 hours of care/day, which further compounds the crisis.

The reality is that, even now, staff is stretched beyond the limits of endurance and that most long-term care facilities are ill-equipped to deal with chronically ill persons who are being displaced by cutbacks to hospitals. Many of these patients require services such as dialysis, are on ventilators, or have feeding tubes and tracheotomies. The Metro Toronto Placement Coordination Services estimates that it will take their facilities five to six years to absorb these types of higher care patients who will be downloaded from the institutional sector as it is restructured.

To make matters worse, even though more staffing and funding are urgently required now, staffing levels in long term care facilities have been reduced, hours of nursing care per patient are now at a low of 2.16, and there has been no increase in funding to help facilities care for patients with higher acuity levels. Indeed, the elimination of the requirement for 2.25 hours of nursing care and the proposal to download long term care to the municipal level, suggest the government is moving in the opposite direction.

As a result of the present crisis in long-term care, many facilities are refusing to take in any more heavy-care patients.

This is the situation now. The additional reductions you have ordered in Chronic Care hospital beds cannot be compensated for by the conversion of four small hospitals into nursing homes. Dramatic changes must made in the long-term care facility sector and the in-home care sector before any further cuts are made to Chronic Care beds. In order to alleviate the situation for elderly patients, more beds must be reopened until legislative and funding initiatives are in place.

In addition, we support the Task Group on Transitional Care's recommendation that calls for more beds in long term care facilities, more funding for new and existing facilities and an additional level of care recognized and funded for those formerly classified as "Continuing Care" patients in Chronic Care hospitals.

We also caution that "appropriate" care must not be adopted as a code for cheaper care. Continuing care beds in chronic care hospitals are funded on average at $200 a day, while the equivalent figure for long-term care beds in nursing homes and homes for the aged is in the area of $90 a day. Many patients will require a higher level of care and we must ensure that quality institutional care with appropriate staffing levels is there for them when they need it.

We also warn against the use of a planning ratio based on the Windsor rate of 11.4 beds per 1000 population 75 and older. The current chronic care bed rate for Metro is 17 beds/1000, which is already substantially below the provincial rate of 20 beds/1000. We are concerned that the Windsor rate is not adequate to the situation created by the changes in chronic care. As we noted earlier, benchmarking techniques are an inappropriate and unreliable tool upon which to base such serious considerations.

Transitional and sub-acute beds

Seniors organizations have undertaken much work in this area and have developed considerable expertise in both defining and lobbying for this level of care. And while we welcome your recognition that these beds are needed, we are concerned that in the absence of a definition and specific funding allocation, this new definition may become a mechanism for providing inadequate chronic care at a lower funding rate. Since you have not yet developed a methodology to plan for the correct number of beds, we do not know if the 512 you have recommended will be sufficient. We would urge you to work closely with the Task Group on Transitional Care and the Older Women's Network as you continue your planning.

Funding for in-home long-term care

As with the long-term care facility sector, the delivery of long-term care services to patients in their homes in Metro is under pressure of crisis proportions. While some extra funding has been provided for this sector, it has been sufficient neither to bring Metro up to the provincial per capita average nor to keep up with the 16% annual increase in the caseload of in-home service providers.

Your recommended investment does not account for the $1.3 billion cuts to hospital budgets, part of which has already been removed by the government. This has resulted in a much higher acuity levels of patients being discharged to home care. Even before your recommendations for further reductions in the acute care sector are implemented, in-home care is struggling to keep up.

Sicker patients mean more professional visits; more attendant care and longer periods on acute home care than have normally been necessary in the past. Yet, your recommended investment levels do not account for the reality of reductions that have already taken place, let alone of those planned.

We are also alarmed at the lack of consideration given to the projected higher costs of providing advanced technology in home settings, as pointed out by the York University Centre For Health Studies, "Who's Counting?".

The shift to community care is one of the key foundations upon which rests the success of restructuring. If in-home care services are not funded, staffed and adequately supported, the consequences for patients will be catastrophic and will produce an increased demand on the acute care sector. The Metro Toronto Home Care Program has estimated that between $60 to $80 million in additional funds will be required to meet the needs arising from your restructuring proposals which we completely endorse.

Recommendations:

More nursing home beds must be established and an additional level of care must be recognized and funded for those formerly classified as "Continuing Care" patients in Chronic Care hospitals.

Even if the total of the new sub-acute/transitional care beds you finally recommend proves to be adequate for persons needing post-acute care in an institutional setting, the steadily increasing numbers who rely on in-home care will require a substantially greater increase in funding. We urge you to adopt the Metro Toronto Home Care Program figure of $60-$80 million in additional funds.

In order to alleviate the crisis situation for elderly patients, more chronic care beds must be reopened until legislative, staffing and funding initiatives are in place for long term care facilities.

5. Mental Health

We are opposed to the divestment of Ontario's provincial psychiatric hospitals and reject any notion that this is in the best interests of people with mental health needs. We also oppose your decision to merge Queen Street Mental Health Centre (QSMHC), The Clarke, The Donwood and the Addiction Research Foundation.

The merger of these institutions is a reversal of the recommendations of many credible organizations with expertise in Mental Health. In fact, you choose to completely disregard the work of the Substance Abuse Bureau of the Ministry that recommended the Donwood become a multi-functional addiction treatment agency and serve as a pilot model for the future development of other multi-functional agencies. The report, "Substance Abuse Treatment Rationalization Project," also emphasized the role of the Addiction Research Foundation in the provision of vital support to the development of the Central East system of addiction services.

Nowhere in the report is there any suggestion of a merger of addiction services with mental health.

We would strongly support an increased collaboration among programs with respect to clients with concurrent disorders of substance abuse and mental illness. However, the forced integration of these institutions may well result in the replacement of a more specialized approach to addiction treatment by a psychiatric model. The accumulated experienced of experts working in this field tells us that addiction must be treated as a problem in its own right. The Addiction Research Foundation and the Donwood are internationally renowned in this field of endeavour. In order to continue the specialized addiction treatment, education and research, it is imperative the autonomy of the institutions is safeguarded.

The merger also places at risk clinical services to the patient population of Queen Street Mental Health Centre. This institution has distinct programs and a vitally-important mandate to provide care to those with complex, severe mental illness. This population cannot endure a haphazard and ill-considered approach that contains within it an enormous possibility for failure. These patients are extremely vulnerable. That you are willing to gamble with their well-being by assuming that a merged program could still retain a first clinical priority for them is absolutely insupportable. The problem for these patients is exacerbated by your proposal that the province divest itself of QSMHC and thereby abandon responsibility for the most vulnerable in our society. The potential consequences for patient care with the concomitant risk of reduced levels of funding are too frightening to contemplate.

You have adopted the MOH inadequate guideline of 30 beds/100,000 population. This results in a substantial reduction of 253 beds. When the additional loss of medical beds in closed facilities is factored in, we have more cause for alarm. This MOH figure is based on a major shift to alternative community based options. In its planning, the Metro Toronto District Health Council (MTDHC) projected a 19.1% increase in mental health service needs by 2001 which it attributed to the growth and aging of the population and the goal of meeting unmet need.

Metro is estimated to have more than 20,000 homeless people, with an estimated incidence of serious mental health problems at 30%, or higher.

30%-35% of Metro's population are from racial minorities. This figure is projected to grow to 53% by the year 2001 (Visible Minorities in Canada. A projection, Race Relations Advisory Council on Advertising, 1992). The MTDHC pointed out to you that immigrants suffer from many stresses that impact on the incidence of mental health problems, for example, racism, unemployment, separation from family and friends, poor language skills.

The Ministry's Policy Framework and Implementation Guidelines for Mental Health and Long Term Care Interface for Older People with Mental Health Needs (1996) notes that 8% of all Canadians over 65 suffer from dementia and for over 85, the rate climbs to 34.5%. By 2001, Metro's elderly population is expected to rise from 12.8% to 16%.

The MTDHC recommends that 34.9 beds/100,000 be utilized by the commission for the purpose of estimating mental health bed needs. Given the legislative and policy initiatives of the Harris

government that are resulting in increased poverty, unemployment, homelessness, insecure working conditions and the concomitant stresses experienced by the majority of Ontarians, an even greater emphasis must be placed on these determinant of health issues.

In addition, as we review your inadequate reinvestment rates across the province and in Metro for community-based alternatives, we are struck by a strong sense of deja vu. In fact, in Metro you have made no recommendations for a substantial investment in Mental Health and have instead noted that equity in funding across the province is required. You cannot be unaware of the devastating impact bed closures, services reductions and deinstitutionalization had on people with mental health needs during the late 70's and early 80's. Your apparent disinterest in the tragedies and failures of that era is what makes HSRC recommendations to cut beds and services and close psychiatric hospitals so hostile.

We are therefore relieved to learn that the Ontario Public Service Employees Union has been successful in an application to have the HSRC recognize that they do not have the authority to direct a provincial psychiatric hospital to close, and that the Minister of Health is responsible for these facilities.

Finally, it has not escaped our notice that the almost identical communities targeted by the HSRC in your decisions to close the Wellesley, Women's College and Doctor's are again the victims of a blinkered and discriminatory approach to access to quality mental health services. Once again, racial minorities, women, the poor, and to this we now add the elderly, are left to bear the brunt of ill-conceived and experimental policies that are bound to have a devastating impact on their lives.

Recommendations:

A bed rate of greater than 34.9 beds/100,000 must be adopted. A more realistic approach to determinant of health issues must be factored in to the new bed rate and must be reviewed and revised periodically according to need.

The Commission must formally withdraw its recommendation to merge the Queen Street Mental Health Centre, the Clarke Institute of Psychiatry, the Donwood Institute and the Addiction Research Foundation.

The Commission must formally withdraw its recommendation with respect to the divestment of Queen Street Mental Health Centre which must remain a facility directly owned and operated by the Government of Ontario.

We support the MTDHC recommendation for a new investment of $51 million/year and warn that no further cuts, closures or reductions in the institutional sector should take place until this money has been allocated. This funding may not be adequate to meet the needs of the population and must be reviewed and revised periodically according to need.

6. Emergency services

The closing of Metro hospitals also includes the closing of their emergency rooms. More than 35% of all admissions to hospital are through the ER. Yet, your report makes no mention of alternative primary or urgent care venues that will make after hours care available to those in real and perceived medical crisis. Ontario Health Survey information reveals significant variations in ER use among different socio-demographic groups:

- Low income adults visit the emergency department more frequently

- Individuals with a primary language of English or French use emergency more often than those with other primary languages
- Children of single parents visit the emergency department more often than children with two parents at home
- Unemployed adults and those with lower educational status are more likely to report repeat emergency department use
- Marginalized populations including the homeless are believed to rely heavily on emergency for medical care.
- Included in these groups, but not explicitly stated, are seniors.

There were 21 ER's in acute care hospitals in Metro. Your proposal to cut emergency access without ensuring that necessary primary care and urgent care venues are available to patients who need care outside of physicians office hours will lead to unnecessary health risks and possibly compromised outcomes for citizens, but especially for the groups we have noted. Seniors in particular must have access to services at any hour that they feel they need it.

We are not at all convinced that Metro's population can make do with fewer emergency departments. With patients being sent home quicker and sicker, more chronic care patients being cared for in inadequately resourced nursing homes, an aging population and the completely inadequate transfer of funding to the community and in-home care sector, hospitals will be hard-pressed to reduce emergency visits unless they turn people away untreated. Even deferrable cases can produce enormous pain and stress on the individual and therefore timeliness of access to the right care is crucial.

Recommendation:

Emergencies should not be closed unless and until there are an adequate number of properly located, fully-equipped and staffed primary and urgent care venues that can deal with genuinely deferrable cases. Seniors, in particular, must have full after-hours access.

7. Privatization

It is unfortunate that virtually no media exposure has been given to your direction to all provincial hospitals (including those in Metro) legally requiring them "to submit a plan to maximize the efficiency of the delivery of administrative services, support services and diagnostic services which must address alternative delivery systems, including services that can be provided by the private sector." Similar to your dismissal of the consequences of deinstitutionalization of mental health patients that we referenced earlier, you have also chosen to ignore data and research that demonstrates that publicly-administered and publicly-delivered health services can be delivered cheaper and can produce better health outcomes. For example, research shows that the privatization of labs has contributed to higher, not lower, costs for our health system.

As you force gaps in the public end of the system, it cannot have escaped your notice that the private sector is rapidly moving in to fill the void.

For example, on June 10, 1996, the Toronto Hospital sent a letter to Chiropody patients warning that it would be cutting the number of patients due to the significant government-imposed funding reductions. The letter stated that patients would have to seek alternative care and that "those chiropody clinics which provide care free of charge have long waiting lists. Private chiropody services are also available, but a fee is charged for each visit." This pattern is repeated in every sector of health care, as services, staffing levels, and care are cut in the public system.

The massive layoffs of men and women who care for us in hospital are triggering significant expenses for individuals and booming profits for insurance companies, home care and rehabilitation companies and many others. There have been reports of hospitals telling patients that if they want good quality nursing care, they should hire a private duty nurse or have their families provide the care, because there are not enough nursing staff left to adequately cope with patient need. That is expensive care for us to purchase and will lead to a bonanza for private insurers marketing supplementary insurance lines. As well, CBC reported that the huge and growing demand for private nurses due to thousands of beds closed, more restrictive admittance policies and shorter stays was great for business. The president of one company that provides nurses and aides in hospital and home noted that business had doubled in the last year alone.

The long waits for public-based rehabilitation, and the often too-short courses of treatment, are forcing people in serious pain to private sector providers and is leading to a booming business for those rehabilitation companies. For example, US-based Sun Healthcare Group planned to pump $10-12 million per year into capital investment in Canada to help take advantage of this shift.

The underfunding of in home services is already forcing clients to pay for additional service when their needs are not being adequately met by the public system. Corporations are already marketing their services to those who either cannot get in-home care or for whom the hours provided are woefully inadequate.

As we review the pattern of your decisions in Metro and provincially, we note that fundamentally they are designed to open new markets for the private sector by shifting costs to individuals and will consequently create a two-tier system.

At every opportunity, Mr. Duncan Sinclair continues to advance the government perspective that we can no longer afford our health care system. This is not only duplicitous and self-serving, it is wrong. Where, exactly do these health care costs go? People do not stop being sick or suddenly stop requiring health services. Your attempt to grossly mislead the public by not informing them that they will increasingly have to bear the burden of these costs is reprehensible.

We obviously can and must afford our health care system. The government has located $5 billion a year in tax savings, refuses to implement a basic revision of the corporate tax structure that would flow billions of dollars into health and education and has not dealt with soaring primary care and drug costs that in themselves would sufficiently resource a quality health care system.

Recommendations:

- ***The legal requirement placed on all provincial hospitals requiring them "to submit a plan to maximize the efficiency of the delivery of administrative services, support services and diagnostic services which must address alternative delivery systems, including services that can be provided by the private sector" should be withdrawn. We cannot afford more private sector involvement in our public health care system.***
- ***The scope of the HSRC review is too narrow. It must make recommendations on recovering the necessary dollars for a quality health care system by examining physician and other professional services, along with drug costs, which together account for approximately 36% of the total health expenditures in Canada.***
- ***The HSRC must stop promoting the provincial government's perspective that we can no longer afford our health care system. This is untrue and misleading.***

8. HSRC and government approach to restructuring

Despite government and HSRC acknowledgment of the compelling need for a systemic approach to our health care system, and the vital interconnection of all it parts, you have produced a document that more than any we have reviewed, sharply delimits individual areas as though they bear no relationship to each other. For example, emergency departments are cut but there are absolutely no recommendations for replacement primary or urgent care centres; Length of stays and chronic and acute care beds reduced, but insufficient funding has been recommended for reinvestment in Home Care and Long Term Care.

According to your report, you are still in the midst of studying the effect on home care services of shortened lengths of stay in the acute care setting, utilization management and increased levels of day surgery. You also state that you are engaged in ongoing research in order to re-examine the current methodology for determining reinvestments. Your premature and destructive recommendations contradict those very preconditions for judgment.

You continue to speak with confidence and promote dramatic alterations and cuts even though you have reached no conclusions on vital areas of care**.** The absence of data and satisfactory planning tools lends credibility to the conclusions that your review of Metro and other areas of the province are little more than abbreviated planning exercises intended to extract millions of dollars from the hospital sector. For example:

- The details regarding the costing of both transitional and sub-acute beds remain to be established.
- You have not yet completed research to establish a policy and population-based planning ratio for inpatient-based rehabilitation services, outpatient services and sub-acute care and use the inappropriate provincial average of 0.17 beds/1000 to determine the sizing of hospital-based rehab.
- You have not yet completed your funding growth methodology, used in allocating funding for acute care services to estimate service requirements for future populations. Yet, your exceedingly aggressive recommendations for cuts and closures are in part based on your presumption "that current levels of service may not be a sufficient proxy for levels of activity when utilization improvements are taken into account . . . and that in all likelihood, extrapolating existing practices will overstate the growth in demand for services".
- In the area of Child and Adolescent Mental Health Services, you have done no research to determine the number of paediatric beds required per 100,000 population.
- You have either not started, or not concluded, research on optimal levels of institutional long-term care services, including chronic care, for the demographic mix in any community; Yet, your directions for Metro will seriously impair the ability of patients needing access to this range of services. The research not done also includes palliative care, respite care and transitional care.
- In our earlier submission to you, we also pointed out that to our knowledge neither you, nor the government, has conducted any authoritative research on costs to the system of people who are not admitted to hospital or whose admission is delayed until their illness or disabilities reach a more acute phase. We are not aware of any comprehensive studies on how many people are released from hospital before they can cope and how many are affected by the current underfunding and lack of services across the spectrum of the health care system. Also missing is research that provides a critical analysis of other international models, including the US-style managed health care system.
- You have ignored the concerns raised with respect to your planning timeframe which is far too short. By the year 2003, the size of the 75+ age group is expected to increase by 36.3%. And by 2011, almost 16% of Toronto's population will be over the age of 65. The tip of baby boom turns 50 in 1997. This generation represents a huge challenge to health services over the next 25 years. While it is true that this seniors population will have a tremendous impact on chronic/rehab services, it is also true that seniors are the highest users of acute care services.

- You have also ignored the research published by York University's Centre for Health Studies, "Who's Counting?", that challenges the tools and conclusions of the Metro Toronto District Health Council, upon which many of your recommendations are based. A primary justification for restructuring of Metro's system given by the HSRC was the need to move services away from the downtown core to the high-growth GTA. York did superb work in researching claims about a shift in Metro's population from the centre to the periphery. Their formidable body of work, which challenges the premise, has merited no attention or consideration. The study also concludes that the Hospital Restructuring Committee "grossly underestimated the number of young women, aged 15-44 in the downtown core." The fact that you have not referenced this particular study in your report suggests that you have either not read it, or summarily discounted it. In either case, we would like to know why.
- You have also ignored studies which compare the costs of private versus public health care.
- Even though the announcement on the government's intention to download Long Term Care, Public Health and Supportive Housing to the municipalities was made prior to the commission's report, you provide absolutely no analysis or recommendations, nor do you factor in the impact of the additional curtailment of services you recommend as these services and the people who need them are virtually abandoned.

The failure to collect evidence before setting policy and initiating system-wide changes can only lead to enormous disruption and increased risks for patients and their families which we do not accept.

If not amended, the magnitude of the changes proposed will have serious and far reaching consequences for all citizens and for generations to come.

We are convinced that growing public disapproval of the efforts to foist a two-tier system on Ontarians will oblige the government to abandon a restructuring initiative that is exclusively driven by financial considerations and by the belief that significant components of the health care system should be managed by the private sector.

Submitted April 21, 1997

Dan Benedict **Tracey Mussett** **Lynn Simmons**

Co-Chair **Co-Chair** **Coordinator**