Submission to the Standing Committee on Finance & Economic Affairs

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Ontario Health Coalition
Protecting public healthcare for all.

Mission and Mandate

Our primary goal is to protect and improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. We are a non-partisan public interest activist coalition and network.

To this end, we empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. We seek to provide to member organizations and the broader public ongoing information about our health care system and its programs and services, and to protect our public health system from threats such as cuts, delisting and privatization. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information.

Who We Are

The Ontario Health Coalition is comprised of a Board of Directors, committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than 400 member organizations and a network of Local Health Coalitions and individual members. Our members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

Devastating Hospital Cuts

As I write this submission to you today, a significant portion of Ontario's hospitals in larger communities are on code gridlock. This means the hospitals' beds are full. Surgeries have to be cancelled as there are no beds in which patients can recover. Emergency departments are full and there are stretchers lined in hallways because there are no beds to put patients into. Ambulances have to wait to offload because the emergency departments are backed up. All staff are expected to work feverishly to discharge patients – ever quicker and sicker – however they can.

The President of the Ontario Medical Association noted in a speech in November that his hospital – Kingston General Hospital – was on code gridlock for 18 days in October. By the time he made his speech in mid-November, the hospital had been on code gridlock for 25 days in a row. This, despite the hospital meeting or exceeding provincial benchmarks for so-called "efficiencies" like throughput or length of stay (how fast the hospital pushes patients out).

Much has been made of the so-called "Alternate Level of Care" patients. Too frequently, top policy makers mistakenly state that these ALC patients are patients who can be or should be discharged out of hospital. Ontario's current state of overcrowded hospitals is justified by the notion that these patients should not be in hospital. Some policy leaders have recommended that ALC patients be discharged and the beds closed behind them, despite clear evidence that there is not adequate care outside of hospital for a number of these patients and despite the fact that closing the beds will worsen hospital overcrowding and backlogs.

According to the Ontario Hospital Association survey from November 2014:[1]

- On November 30, 2014 there were 4,165 patients designated acute or post-acute ALC.
- 45% of these patients – or 1,874 – were waiting for long-term care placement.
- Almost 1,000 of these ALC patients were waiting for another type of hospital bed – complex continuing care, rehabilitation, palliative care, convalescent care, mental health or other.
- Approximately 600 were waiting for home care.

About ¼ of ALC patients are actually waiting for a hospital bed. Almost ½ are waiting for long-term care placement but there either are no spaces or their care needs are too great for any of the spaces available. Even if all patients waiting for long-term care placement from ALC were discharged, Ontario would still have too few hospital beds to be safe.

The bottom line is that Ontario's hospitals in virtually every large community are working at levels of overcrowding that are unsafe. The literature from Europe that is internationally accepted, holds that safe levels of hospital occupancy do not exceed 80%. Higher levels of crowding than this result in higher rates of hospital-acquired infections and superbugs.

Hospital bed and service cuts are too deep. They are depriving patients of access to needed care and resulting in high out-of-pocket costs for Ontarians. According to the most recent data from the Canadian Institute for Health Information, Ontarians have the lowest proportion of our health care publicly funded of any province in Canada. We pay the most out-of-pocket (privately) for care. Despite this, every year for the last seven years there have been more cuts, even though there is no plan to provide

[1] Report prepared by Access to Care for the Ontario Hospital Association, Alternate Level of Care, November 2014 at http://www.oha.com/CurrentIssues/Issues/eralc/Documents/ALC%20November%202014%20Report.pdf

needed care for patients, and even though hospital occupancy levels are the highest here of anywhere in the developed world.

Hospital global funding increases have been set below the rate of inflation since at least 2008. Since 2012/13 global hospital budget funding levels have been frozen. In sum, this means that global hospital budgets have been cut in real dollar terms (inflation-adjusted dollars) for 7 years in a row. This is the longest period of hospital cuts in Ontario's history and there is no end in sight.

At the Ontario Health Coalition we have been deeply disturbed at the devastating cuts we are seeing to needed public hospital care all across Ontario.

Under the Canada Health Act, hospital and physician services are to be provided without financial barrier on equal terms and conditions to all Canadians. That means that the cost of illness and injury is to be shared by all Canadians, and care is to be provided through our public taxes so that people are not burdened when they are ill, injured or dying; when they are least able to pay. The fundamental principles of compassion and equity, of which Canadians are rightfully so proud, are embodied in this system of health care for all. The Canada Health Act was passed with unanimous support from all political parties in Parliament.

Provincial governments are expected to uphold the principles of Public Medicare for all, as enshrined in the Canada Health Act.

But when public hospital services are cut, and services are offloaded from public hospitals, services are inequitable, subject to user fees, ad hoc and almost always privatized. Patients are faced with burgeoning user fees and costs that cause hardship and suffering, just when people are least able to bear them.

In Ontario the evidence is all around us that needed hospital care is being slashed. Wait times, for which we had seen real and significant progress across the board in the mid-late first decade of the 2000s, are climbing back up again as the hospital cuts take hold. Rationing of home care is extreme. Long wait lists, numbering tens of thousands of Ontarians, for long-term care placements are causing suffering for families.

The depth and severity of the hospital cuts in Ontario are shocking. The Ontario Health Coalition has tracked the cuts for the last four years. Here is just a sample from recent months:

- In Leamington birthing and maternity services are slated for closure. At top speeds it takes 45 minutes to 1 hour to drive to the nearest hospital in Windsor. In the snow, that time can be doubled or more. There is no question that women will be unsafe having to travel so far while in labour. In addition, the Windsor hospital is full and does not have capacity to take patients from Leamington. The Essex County EMS reported in its 2014 budget report that ambulance offload delays at the Windsor Hospital continues to be a "persistent and significant burden" on EMS.[2]
- The next closest hospital is in Chatham. It takes an hour in good weather with no traffic to drive to Chatham. Chatham's hospital has itself recently suffered severe cuts. In 2013, the Chatham hospital announced it was cutting 22 -- equivalent to 7% or 1 in every 14 -- of its remaining hospital beds.
- In fact, the Chatham Hospital itself is also overburdened, with the Chatham-Kent Health Alliance having cut all the remaining complex continuing care beds, endoscopies, and the labs in

[2] EMS Budget Presentation, February 5, 2014.

Wallaceburg's hospital in 2013. Wallaceburg's Sydenham hospital campus has been ruthlessly cut for years. It is now down to an emergency department with no lab and five beds.

- In New Liskeard in the late fall, it was made public that the Operating Room was to be closed for 50% of the time, and 18,000 hours of nursing time per year were to be cut. In total, 15 positions equalling 10% or 1 in 10 of the total staff at the hospital were told that they would be cut. A full list of the hospital departments impacted by the cuts was not made public. This community is isolated in northeastern Ontario. There is no viable option for patients seeking surgeries or other hospital care, other than to travel great distances at great cost.
- In Timmins in October, it was announced that the hospital plans to cut 26 of its remaining beds, equalling a cut of 16% of its beds (or one of every six remaining hospital beds to be closed). In addition, the plan is to close outpatient physiotherapy leaving patient to have to pay hundreds or thousands of dollars for needed physio, and to cut 40 staff positions. We do not have a full list of the hospital departments affected by these cuts at this time.
- In North Bay, the mental health rehabilitation unit is closing, including 8 beds. There are no community services to provide the level of care required by these patients. They will end up in the emergency department as a result of the cuts. In addition, more than 56 staff, including our current estimate of more than 50,000 hours of nursing care per year, are being cut, affecting departments across the hospital.
- In Sault Ste. Marie currently planned cuts include 50 hospital beds (20 acute and approx. 30 complex continuing care) and 12,500 hours of nursing care per year, plus approximately 24 Personal Support Workers. These cuts are planned for a hospital that is in "code gridlock" the majority of the time, according to the staff. This claim is supported by a December report to city council in which EMS reports that offload delays have been up to 7 hours while paramedics wait for the hospital to be able to take their patient. In October 2014, offload delays amounted to more than 200 hours of paramedic time.
- On December 1, all the inpatient beds at the Penetanguishene Hospital, which had been providing French language services in the community for more than 100 years, were closed. This community has had hospitals dating back to the 1600s. Among the cuts to the Georgian Bay General Hospital (amalgamation of Penetanguishene and Midland hospitals) are the closure of 36 complex continuing care, rehabilitation and palliative care beds, amounting to a cut of approximately 30% of the remaining hospital beds cut. The community has twice fought off attempts to close down their cataract surgeries and move them out of the community to Barrie. Both hospitals are running at 100% capacity or close to it. The beds have been cut despite this.
- In December the endoscopy unit was closed at the Charlotte Eagle Englehart Hospital in Petrolia.
- In the fall, the Huron Perth Health Alliance, including hospitals in Stratford, St. Marys, Seaforth and Clinton saw 17 beds cut across all the hospitals. The three smaller hospitals are disproportionately losing acute care services. In Seaforth, half of the remaining acute care beds are being closed. In St. Marys one-third of the acute care beds are being closed.
- A new slew of major cuts are being planned again for Quinte where the Trenton and Picton Hospitals have already seen devastating and disproportionate cuts.

These comprise just a small sampling of the most recently announced cuts. Over the last year there have been many many more:

- In 2013/14 the Scarborough hospital made public its plans to close 20 surgical beds and two operating rooms, cutting thousands of surgeries per year. The rheumatology (arthritis clinic) which saw 2,000 patients per year closed. The hospital planned to cut 200 nurses, health professionals & support staff, equalling more than 345,000 hours of patient care, therapy, and hospital support.

- The Ottawa hospital revealed plans to cut 290 nurses, health professionals and support staff, equalling more than 500,000 hours of patient care, therapy and hospital support per year. The Riverside endoscopy unit was closed and more than 1,600 cataract surgeries per year were slated to be cut.
- Out-patient physiotherapy was closed at the Markham-Stouffville Hospital.
- Major cuts including 20% - or 1 in 5 of – of the beds at the Winchester and District Memorial Hospital were slated to be axed. This is in addition to previous cuts to beds and programs at other hospitals in the south east including hospitals in Renfrew, Perth, Smiths Falls and Arnprior.
- Wingham hospital also faced huge cuts.

In fact, from small and rural communities to our province's largest cities, truly draconian cuts to needed hospital services have been forced upon Ontarians despite overwhelming public opposition.

The total lack of population needs-based health care planning must stop. Endless hospital cuts cannot continue.

The Ontario Health Coalition is calling on the provincial government to stop the cuts to public hospital services.

Inadequate Access to Long-Term Care

Lest anyone believe that the shrinking of our public hospitals is anything other than a cut to needed health care, a sampling of the Community Care Access Centre wait times from the four corners of Ontario shows the huge backlog of thousands of people waiting for access to long-term care placements across the province.

According to CCAC (Community Care Access Centres – which are Ontario's crown corporations responsible for home care) long-term care wait times data:[3]

- Erie St. Clair CCAC - January 2015 – 2,015 people waiting for long-term care
- Champlan CCAC – December 2014 – 7,163 people waiting for long-term care
- North East CCAC -- October 2014 – 1,377 people are waiting for an initial long-term care placement and 723 people have been placed in a long-term care home that was not their preferred choice, waiting to get into a home of their choice.
- North West CCAC – December 2014 – 872 people waiting for long-term care

- Total for these four CCACs only: more than 11, 400 people waiting for long-term care. This does not include the other 10 CCACs in Ontario.

In fact, wait lists for long-term care in Ontario have never dipped below 20,000 over the last 15 years, and often are closer to 30,000.

The Ontario Association of CCACs does not currently report home care wait times for each CCAC.

Recently, health care executives, and government MPPs have begun to talk about the relatively high cost of hospital care compared to other health care sectors. In fact, Ontario's hospital spending levels are at the very bottom of all provinces in Canada by every reasonable measure. Moreover such comparisons are meaningless because levels of care are not equivalent between emergency departments or hospitals and long-term care homes and home care. Long-term care homes are not staffed and lack the facilities, training and regulatory regimes to deal with more highly complex patients. Home care is ad hoc, inequitably, insufficiently funded and severely rationed. For far too long care workers have lived in poverty despite working full time. Patients only get a few hours of care per day, at most. Of course the costs are less. These comparisons are more about PR than they are about reasonable benchmarks or comparisons of costs across similar levels of service. They are unethical and misleading and should not be continued.

[3] Inexplicably, the CCACs do not report wait times data in a consistent format or with consistent frequency. We have reported the most recent data available publicly from these four CCACs and have endeavoured to report the numbers so as to compare the same type of data – ie. comparing "apples to apples".

Disproportionate Impact on Small and Rural Hospitals

For several years, there has been a moratorium on the closure of small and rural hospitals and their emergency departments. This moratorium was broken with the closure of all the inpatient services at the Penetanguishene Hospital in December. We must voice our opposition to the disproportionate cuts and even entire closures of small and rural community hospitals in the strongest possible terms.

In virtually every town, the local hospital has been built and supported for a century. With the renewal of rural hospital closures, many more entire towns hospitals are at risk. Such closures are bitterly damaging to communities.

The implications for the health and safety of rural residents are serious. In every case, there is no capacity at regional larger hospitals to take the patient load from the closed rural hospitals. The crucial "stabilize and transfer" function of these hospitals saves lives in the case of car and farm accidents, serious allergic reactions and many other instances. This should be recognized in policy.

In many cases, municipalities are left to bear the brunt of higher ambulance costs when local services are closed down. Not only does their communities' access to care suffer – they have to pay more to transport patients further for care. The evidence does not support any contention that highly-specialized centralized care saves money, while it is abundantly clear that these closures violate the priorities and values of Ontarians as well as damaging their access to needed care.

In fact, there is no policy to support the closure of rural hospitals. The government has no mandate to pursue this plan. There is no transportation system, no plan to mitigate increased patient risk, and worsening access to care for everyone.

The Ontario Health Coalition is calling for a halt to the closures of and cuts to vital services in Ontario's small and rural hospitals.

Stop the Closures of Niagara's Hospitals

Under previous Health Minister, Deb Matthews, the Ministry of Health approved the closure of 5 community hospitals in Niagara to be possibly replaced with one hospital, likely a decade or more from now. The planned hospital closures are in the following communities:

- Welland (pop. 50,000)
- Port Colborne (pop. 20,000)
- Fort Erie (pop. 30,000)
- Niagara-on-the-Lake (pop. 15,400)
- Niagara Falls (pop. 50,000)

The entire closure of hospitals in communities of this size is unprecedented and reckless. The first hospital closure, in Niagara-on-the-Lake is slated for the beginning of April. No capacity planning has been done to establish a proper plan to provide hospital care to meet population need across the Niagara peninsula. Transportation is poor, and it is extremely difficult to get from Niagara-on-the-Lake to Port Colborne and Fort Erie where the complex continuing beds will be housed until those facilities close. Patients are being shuttled all over the peninsula as services have been centralized and moved out of local towns. Ambulance costs have skyrocketed. This will only worsen under the current plan. There

has been no real costing of the restructuring, no proper public consultation, no normal hospital planning and among the very worst cuts in Ontario across the whole Niagara Health System are continuing.

The Ontario Health Coalition is calling for the closure Niagara's hospitals to be repealed and evidence-based planning to meet population need to care to be undertaken.

Ontario Hospital Funding is the Lowest in Canada

As noted above, for the last seven consecutive Ontario budgets, public hospitals have faced real dollar cuts to global budgets. Ontario now funds its hospitals at among the lowest rates in Canada.

The evidence is that real dollar cuts to hospital global budget are not necessitated as a result of overspending. In fact, by every reasonable measure Ontario's funding of public hospitals is low. Hospital funding as a proportion of public health care spending in this province has declined every year since the 1980s. According to Canadian Institute for Health Information statistics in 2014, public hospital funding had declined to 35.5 per cent of total public health care spending.

As shown in the charts that follow, both on a per capita basis, and as a percentage of our provincial GDP, Ontario's public hospital funding is less than virtually all other provinces in Canada. In fact, Ontario and Quebec are neck-and-neck at the bottom of the country in hospital funding per capita.

1. **Ontario ranks at the bottom of the country in public hospital funding per person.**

Ontario Hospitals Public Funding Per Capita 2014 (in 2014 $)	
Newfoundland	2,329.86
P.E.I.	1,938.93
Nova Scotia	1,892.15
New Brunswick	1,956.20
Quebec	1,424.15
Ontario	1,424.90
Manitoba	1,814.67
Saskatchewan	1,784.46
Alberta	2,208.77
British Columbia	1,652.42

Source data for hospital spending charts:

Canadian Institute for Health Information
National Health Expenditures Database 2014.

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

Ontario Hospitals Public Funding As % of Provincial GDP 2014	
Newfoundland	3.24
P.E.I.	4.88
Nova Scotia	4.38
New Brunswick	4.54
Quebec	3.03
Ontario	2.74
Manitoba	3.71
Saskatchewan	2.37
Alberta	2.60
British Columbia	3.24

The Ontario Health Coalition is calling on the provincial government to restore hospital funding to meet population need for care and bring our province's hospital funding into line with the rest of the country.

Ministry of Health's Plan to Cut Hospital Services and Contract them to Private Clinics (IHFs)

The government has announced plans to bring in new legal regulations to expand the use of private clinics (called Independent Health Facilities or IHFs) to take hospital services out of our community hospitals. The proposal is to begin to implement these plans over the next six months. These changes would expand the use of private clinics (IHFs) and the transfer of hospital services out of public hospitals into private clinics. The LHINs would have the power to transfer services from hospitals to private clinics (IHFs). The changes also enable Cancer Care Ontario to contract private clinics (IHFs) to provide services.

The province already has the ability, if it chooses, to work with local hospitals to set up non-profit specialty clinics under the quality and performance rubric of the Public Hospitals Act. There is no need to expand the use of Independent Health Facilities, and the evidence is that these facilities already have serious oversight problems regarding cost, quality and safety.

We strongly recommend that IHFs not be expanded, indeed they should be reduced and services integrated into the public hospital system.

Our Key Concerns

Based on the evidence, we have grave concerns about clinical services safety and quality and also equity impacts of this plan. However, for the purposes of this submission, we will focus on the serious implications for costs of health care services as follows:

- On top of ongoing cuts to local hospital services, this plan would further destabilize local hospital budget and worsen staffing shortages.
- The evidence shows that this plan will likely cost more to OHIP and Ministry of Health budgets as well as for patients who are frequently confronted with user fees and extra-billing in private clinics.
- The evidence, as outlined in the Ontario Auditor General's Report of 2012, shows that the Independent Health Facilities sector already has inadequate oversight and monitoring. It should not be expanded.

We have outlined some of the key evidence related to these issues showing that this plan will result in higher health costs, increased quality concerns, worse staffing shortages (and associated costs), and increased requirements for oversight and monitoring of private clinics.

The Ontario Health Coalition is calling upon the government to stop private clinics and uphold the Canada Health Act's prohibition on extra-billing and user fees. If reorganization of hospital services is planned, it should take place under the rubric of the Public Hospitals Act. Private clinics (ie. Independent Health Facilities) should not be expanded.

Higher Costs

The government's plan to cut public hospital services and contract them to private clinics bears close resemblance to the English government's contracting of public hospital services to private clinics called Independent Sector Treatment Centres. In the U.K. and in other jurisdictions, including Canada, multiple reports and many studies report lighter caseloads and evidence of "cream-skimming" by private clinics, leaving the more expensive and heavier caseloads to the public non-profit hospitals while depriving hospitals of the resources – both human and financial – to treat them. In the U.K., multiple British Medical Association Journal studies report that private clinics (Independent Sector Treatment Centres) are paid higher prices for surgical procedures. Indeed the U.K. Department of Health has publicly admitted that higher prices are paid to the private clinics for procedures. Former Health Minister Frank Dobson reports that the private clinics were being paid 11% more than public hospitals for the same procedures.

Our own research into private clinics across Canada conducted in 2008 found that the cost of procedures was significantly higher in private clinics than in public hospitals. Colleen Fuller, health policy expert in British Columbia reports similar findings in her cost comparisons between hospital funding per procedure and private clinics billings for the same procedures. These findings echo the Ontario Auditor General's conclusions in his special audit of the for-profit cancer treatment centre established by the Conservative government in 2001. The Auditor General found that the clinic had been paid $4 million extra to set up and was being paid a premium of $500 more per procedure than public Cancer Care Ontario treatment centres.

2-Tier Health Care, User-Fees and Extra-Billing of Patients

In addition to billing public health plans, in a 2008 study we conducted of private clinics across Canada, we found that the majority of for-profit clinics charge user fees and engage in extra-billing of patients, even in violation of the Canada Health Act. This finding was supported by a 2011 study in the Canadian Journal of Gastroenterology that found one-third of the patients receiving colonoscopies in private clinics in Toronto were being charged user fees for this service (in violation of the Canada Health Act). Toronto Star columnist Thomas Walkom found that even the non-profit Kensington Eye Institute (one of the few "non-profit" IHFs) surgeons recommend a non-medically necessary "refractive lens implant" to patients (a co-mingling of insured and uninsured services used by the for-profits to extra-bill patients) and the clinic charges a $50 "handling fee" or user fee to patients in addition to the charge for the lens.

Findings of the Ontario Auditor General

In addition to the wealth of evidence of higher costs in private clinics, the Ontario Auditor General's 2012 Report found that the existing IHFs are subject to inadequate oversight, particularly of unnecessary testing and inappropriate billing practices. While the government has proposed to expand this sector which is dominated by for-profit entities, the evidence is that poor oversight has persisted for years and key problems in oversight that have been identified for more than a decade have not been addressed. Among the Auditor's findings:

- According to AG there are more than 800 IHFs in Ontario and more than 97% of IHFs are for-profit.
- The Ministry of Health does not track professional fees paid to physicians in IHFs. (These are fees for service.)[4]

[4] Ontario Auditor General Annual Report Chapter 3, 2012. Page 149.

- The Ministry had not completed any recent audit work on IHFs.[5]
- The reasonableness of overhead fees paid to IHFs had not been assessed by the Ministry.[6]
- The Ministry has not analysed patterns of self-referral by physicians to their own for-profit clinics.[7]
- The Ministry estimates that about 20% of facility fees are inappropriate for example, due to unnecessary testing (for which the IHFs make profit). In 2009, the Canadian Association of Radiologists estimated that 30% of CT scans and other diagnostic imaging scans contributed no useful info and/or are inappropriate.[8]
- The College of Physicians and Surgeons had not assessed 12% of facilities to see if scans are being properly read in last 5 years. Of those facilities where assessments had taken place, not all physicians were assessed.[9]
- 60% of x-ray facilities had not been inspected by the Ministry as required to ensure patients are shielded from excess radiation. In fact, the Ministry did not even know the location of 12 radiation-using facilities that had moved. [10]
- A 2011 review of questionable billing practices of physicians in IHFs had not been completed and no action had been taken on questionable billings.[11]
- From 2000 – 2012, though the need to reassess the appropriateness of facility fees paid to physicians in these facilities had been repeatedly noted in various technical reports, this has not been done.[12] (Technological advances have reduced the work required for a number of procedures meaning that fees being paid are likely too high, but no action has been taken to address this.)
- Though a 2011 review of billing practices found that about 25% of facilities had unusual billing patterns, the Ministry's opted not to take any action against the facilities or physicians in question. Their only response was to create educational materials for facility owners/physicians which was in process at time of audit.[13]
- Overall, it appears that there is no auditing to ensure that tests that are billed for have actually been performed.

[5] Ibid. Page 150.
[6] Ibid. Page 151.
[7] Ibid.
[8] Ibid.
[9] Ibid. Page 152.
[10] Ibid.
[11] Ibid.
[12] Ibid. Pages 156-157.
[13] Ibid. Page 160.

Home Care Reform Needed

The government's continual claims that hospital cuts are offset by increases in home care are demonstrably false. Home and community care funding increases, while welcome, are not sufficient to meet existing backlogs and take the increasing offloading of patients and services due to hospital cuts and inadequate long-term care spaces. In the autumn of 2012 for example, thousands of patients were wait-listed or cut off from home care because of funding shortfalls. The 2013 budget set "targets" (not guarantees) for home care to be provided within 5 days.[14] However, this "target" which was largely a PR exercise. It has no teeth and was contradicted by the Ministry's own performance requirements of the LHINs which have set a target for wait times for home care services to be 26 days (or almost a month).[15] Over the last year (2014) major home care cuts in Windsor-Essex and the Champlain CCAC were announced, despite funding increases. Hundreds of home care clients were cut off. At the Ontario Health Coalition we receive frequent complaints from families whose loved ones are being denied or cut off from needed home care. While patients are being discharged ever more quickly from hospital, Ontario's extremely high hospital readmissions rates indicate that these patients are either discharged too quickly or without adequate supports.

Home care should be reformed to create an equitable public home care system and ensure that public funding is used for care. Patients should not be discharged from public hospitals without needed care in place. To do so is the equivalent of denying access to public hospital care in the first place. All patients with demonstrated need should be admitted to home care and wait lists should reflect the total need for care, not be arbitrarily limited to those with only the highest care needs when budgets are inadequate.

[14] Ontario Ministry of Finance Ontario Budget Papers 2013.
[15] LHIN Hospital Accountability Agreements 2013.

Increasing Acuity in Long-Term Care Not Met With Increasing Care Levels

Twenty thousand Ontarians remain on wait lists for placement in long-term care homes. There is no plan to address this. Instead, wait lists are being reduced by withholding information from patients who are being discharged from hospitals about their right to access care in long-term care homes. Patients are increasingly being coercively discharged from hospitals under "Home First" policies without care in place. Frequently patients are told, though it is unlawful to do so, that they have to go home first – whether or not appropriate care is available for them there – to wait for placement in long-term care homes, or they are simply not told that long-term care is an option.

In addition, the high acuity of hospital and mental health patients downloaded into long-term care means that higher care levels are required to meet their needs.

The Ontario Health Coalition is recommending, based on the evidence, a required minimum care standard of 4 hours per resident per day of hands-on care. This would ensure that funds go to improving care levels. It is based on the best available evidence which shows that this minimum care level improves outcomes and protects against harm.

Further, we have reviewed the pre-budget recommendations for the for-profit long-term care sector which amount to a lobby for the provincial government to:

- increasing the scope of services provided by the long-term care industry to enable them to become essentially for-profit hospitals
- increase their funding, and
- decrease their regulation and accountability.

The majority of this sector is operated by large multinational for-profit companies. It is not in the public interest to follow these recommendations. Funding should be tied to improving hours of care for residents. Hospital services should not be handed over to for-profit companies. The Ontario Health Coalition vigorously opposes these recommendations.

High-Cost P3 Privatization is Contributing to Major Health Care Cuts

In the most recent annual report of Ontario's Auditor General, it was revealed that Ontario's 74 P3 projects have cost $8 billion more than if they were properly managed and funded publicly. Ontarians will have to pay $28.5 billion in long-term costs in private financing schemes, she reports. Importantly, the Auditor noted that there is no empirical evidence in the constructs used to adjust higher private sector financing costs to make them look lower.[16]

Plainly put, there is no concrete evidence to support $8 billion in higher costs paid from public funding for private financing and management of public infrastructure. As a point of reference, $8 billion could have built 27 entire community hospitals.

In response, Infrastructure Ontario's leadership claims that Infrastructure Ontario, a decade-old 493-person bureaucracy, cannot develop the expertise to manage large-scale construction projects. To do so would be a "travesty", claimed the CEO prior to Christmas. But the evidence from multiple auditors and slews of independent reports is that publicly managed projects have come in far closer to target than is reported by Infrastructure Ontario.

The senior leadership and Board of Infrastructure Ontario, with a very few exceptions, comes out of the industries that benefit from expanding high-cost P3 privatization: global consulting firms, the real estate industry, banks, multinational finance companies, the construction industry and law firms involved in P3 consulting contracts. Nowhere on the list are public interest voices, experts in public auditing, and the like.

That this leadership, whose former companies were able to oversee the creation of complex multinational consortia and the management and financing of large-scale complex infrastructure projects for their own benefit when they worked in the private sector, are no longer able to do so in government.

The fact is that Infrastructure Ontario can develop a centre of excellence in project management and deliver these projects without middle-man corporations reaping billions at public expense.

This week's provincial auditor's report is not the first that has looked askance at enormous costs of P3s. In 2008 Ontario's Auditor General reported on Ontario's first two P3 hospital projects. It found that the Brampton P3 hospital cost almost $200 million more than if it had been built publicly. That is $200 million more on a hospital that was projected to cost a total of $350 million prior to P3 privatization. In the end, the public is paying almost double that amount for a hospital that was significantly smaller than projected.

Like in this week's report, the 2008 audit found serious flaws amounting to hundreds of millions in the value-for-money assessment on which the financial case for private finance was founded. It found the

[16] Ontario Auditor General 2014 Annual Report.

risks of public management were overstated; the same findings of the current auditor this week – 6 years later.

Today, the privatized P3 projects are even more secretive than the first projects in Brampton and Ottawa. The government proclaims that the project agreements are available on line. This is true. What they don't say is that virtually every financial number in the contracts has been removed. In the 695 pages of the North Bay Hospital P3 project agreement, for example, the term "redacted" – the legal equivalent to blacking out sections of the document - appears 359 times. The public is not allowed to scrutinize these schemes for which we are paying billions.

The Auditor notes that the each of the so-called "Value for Money" assessments contains a disclaimer by the consultants noting that they did not independently attempt to audit or assess the figures provided to them by Infrastructure Ontario to justify the private financing. They did not scrutinize the claims of hundreds of millions of dollars in risk transfer contained in the deals – though these have been highly controversial around the globe.

In fact, the body of evidence demonstrating unnecessary high costs and exorbitant profit-taking in P3 hospitals has grown every year that the Ontario government has continued to expand the P3 policy.

A 2012 study by University of Toronto researchers that reviewed 28 Ontario P3 projects worth more than $7 billion found that the P3s cost on average of 16 per cent more than if the projects were built publicly.[17]

A recent British study of more than 154 P3 projects found "astronomical" profits, averaging more than 50 per cent, and that P3 consortia involved in large hospital projects saw the biggest profits averaging more than 66.7%.

All of Ontario's P3/AFP hospitals have experienced significant cost overruns. None have been compared to the publicly-procured hospital project in Peterborough, where the auditor found that cost overruns warrant a 5% risk transfer, unlike the 13% found in the Brampton P3 accounting. The more recent P3 hospitals have included even more gargantuan claims of risk transfer (closer to 30%) in order to ske the financial reporting to make the P3s look like they make financial sense without any evidence – in fact, when the evidence clearly shows that such claims are not supported by the actual costs of public hospital procurement.

The opportunity cost for P3 privatization amounts to a loss of billions of dollars that could have gone to improving patient care and other public services. In Ontario the communities where large P3 hospitals have been built are suffering among the worst hospital cuts – Niagara, Sault Ste. Marie and North Bay – as billions in public money is siphoned away from care to pay multinational consortia and consultants.

The Ontario Health Coalition is calling upon the provincial government to stop the P3 privatization of Ontario's hospitals and direct the savings to needed health care services.

[17] McKenna, Barry "The Hidden Costs of Public Private Partnerships" Globe and Mail, October 14, 2012. References study by Matti Siemiatycki and Naeem Farooqi