Ontario Health Coalition
Submission to the Commission on the Future of Health Care in Canada
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The Ontario Health Coalition is a network of more than 150 grassroots community organizations representing virtually all areas of Ontario. Our primary goal is to empower the members of our constituent organizations to become actively engaged in the making of public

policy on matters related to health care and healthy communities. To this end, we seek to provide to member organizations and the broader public ongoing information about their health care system and its programs and services. 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 for good decision_making. We are an extremely collaborative organization, actively working with others to share resources and information. We are a non_partisan group committed to maintaining and enhancing our publicly_funded, publicly_administered health care system. We work to honour and strengthen the principles of the Canada Health Act.

Our members include local health coalitions in Algoma, Kingston, Burlington, Cornwall, Ottawa/Carleton, London, Toronto, Thunder Bay, Hamilton, Timmins, Sudbury, Durham and Windsor; local health action committees across the province; women's groups such as the National Action Committee on the Status of Women, the Older Women's Network, Immigrant Women's Health Centre, Voices of Positive Women; seniors' groups including the Ontario Coalition of Senior Citizens Organizations, Canadian Pensioners Concerned, CAW retirees, Alliance of Seniors to Protect Social Programs; low income and homeless peoples' organizations including Low Income Families Together, Food Share of Metro Toronto, Ontario Coalition Against Poverty; health sector unions such as CUPE, OPSEU, SEIU, USWA and CAW; service providers; social service organizations; workers' advocacy organizations; health professional associations; ethnic and multiracial minorities; the Ontario Federation of Labour; and other organizations such as the Canadian Council of South Asian Seniors (Ont.), the Association of Neurologically Disabled, Ontario Coalition for Social Justice, Medical Reform Group, Social Planning Council of Metro Toronto, Native Women's Resource Centre, Aids Action Now, Birth Control and Venereal Disease Centre, the Canadian Federation of Students (Ontario division), Oxfam Canada, the Ontario Nurses' Association and the Injured Workers Resource Centre, among others.

INTRODUCTION

Medicare has been and remains a defining feature of Canadian life and identity. But painful cuts, years of restructuring and the dramatic growth of the for-profit health industry have taken a serious toll on Ontarians' confidence in our Medicare system. More and more, Ontarians are finding that health services are not available or accessible when we need them. We are finding that we face escalating out-of-pocket costs when we are sick. Ontarians have become wearily familiar with critical staffing shortages, demoralized and over-stretched health care workers, confusing and seemingly endless restructuring. All too frequently Ontarians face life circumstances that make them sick – or that exacerbate ill health. For both health care workers and patients, control over the system – that is control over our care and our quality of life – is out of reach.

Despite these challenges, the foundations of Ontario's quality public Medicare system are still intact. Health care workers continue to work hard to care for patients. Agencies and organizations seek ways to try and improve accessibility of services. Patients continue to expect quality care. Public support for Medicare – its principles and goals – is unparalleled. In our experience, Ontarians remain highly motivated to protect and extend our treasured Medicare system.

It is our belief that the goal of a public Medicare system is to create the best health and health care possible for all residents. We believe that reform and revitalization of Medicare needs to stem from this premise. For too long, public policy regarding health care and the determinants of health has been based on short-term financial planning. In the meantime, closed-door negotiations have upheld old-fashioned monopolies of power and the health care reform agenda has been captured by an increasingly powerful private health care industry.

Unlike policy makers, Ontarians do not see health care as a commodity. We see it as an essential social program – an integral part of our social infrastructure. Medicare must not be seen merely as a public insurance scheme covering parts of a largely private industry. It will not be sustainable if defined this way.

The future sustainability of Medicare will depend on stable and adequate funding. It will depend on governments limiting profit-taking and resisting the commodification of health services. It will depend on the efficient utilization of resources – with a greater percentage of health spending directed to patient care rather than advertising, profit, and excess administrative costs. Medicare's future depends on restoring public confidence through building democratic decision-making, improved transparency, accountability, and public access to information. It depends on rebuilding and extending the application of the principles of universality, comprehensiveness, accessibility and public administration. It depends on modernization through progressive reform and the extension of the principles of the Canada Health Act to cover home care. It depends on control and coverage of drug and treatment costs. It depends on stable coverage of preventive services including homemaking, physiotherapy and other therapies, and access to timely treatment. It depends on a serious commitment to combat the social causes of

ill health: poverty, lack of safe and healthy housing, barriers to the access of public services and education, and unhealthy environments and workplaces.

In this submission, the Ontario Health Coalition will use data collected from our primary research and public consultations to reveal the current state of Medicare in Ontario. We will outline how the provincial government has sidestepped the Canada Health Act through moving services out from under its umbrella. We will demonstrate how this erosion of the Canada Health Act's fundamental principles (accessibility, comprehensiveness, public funding, and public administration) threatens the sustainability of Medicare. We will provide evidence of how sudden and deep cuts combined with privatization have stolen precious resources from patient care and have directed them instead to administrative costs and profit-taking. We will investigate the lack of democratic control in the system and how this has contributed to difficulty in achieving necessary progressive reform. We will outline the impact of deepening poverty and lack of attention to the determinants of health. We will conclude with recommendations for reform: reform whose goals will be to provide the best health and healthcare possible for all residents, to improve democratic control and to restore public confidence.

SECTION I.

MEDICARE IN ONTARIO: THE CURRENT SITUATION

A. Sidestepping the Canada Health Act

Federal funding cuts and ambivalence with respect to the protection of the health system's universality, comprehensiveness and accessibility, have enabled provincial governments to sidestep the Canada Health Act. Over the last half decade, the Ontario government has pursued an aggressive policy of moving services and patients out from under the umbrella of Medicare by downsizing hospitals and de-listing OHIP services. Services that used to be provided on a publicly funded basis have been cut and the burden of payment has been transferred to individuals' private purses. Sub-acute hospital services, which were previously covered by the public non-profit system have been shifted to home care, which is seriously underfunded and increasingly privatized. De-listed medical services, exemplified in the recent de-listing of audiologists' services, become out of reach for those who cannot afford user fees, thus diminishing comprehensiveness and universality. In sectors that have been privatized, such as Ontario's laboratory services, corporations have sought and found new ways to charge user fees. Medicare in Ontario is an increasingly profit- driven system controlled by a growing corporate sector.

B. The Erosion of Accessibility, Comprehensiveness and Universality

Access to a whole range of health services has been seriously compromised due to years of chipping away at health care funding compounded by the deep and sudden cuts imposed by both the federal and provincial governments in the mid-nineties. After the most recent federal government cuts and the imposition of the CHST, Ontario cut approximately $800 million from hospital budgets. Ontario Hospital Association figures showed almost 9,000 critical, acute and chronic care hospital beds cut between 1995 and 1999. A Canadian Union of Public Employees study puts the number of hospital worker and nursing positions cut during that period at 26,000. Although some provincial reinvestment followed the partial restoration of federal transfers more recently, our hospital system is still reeling. Budgets for Community Health Centres and cancer care were frozen for years. Re-investment in long term care and homecare services was delayed for years, compounding the problem. There is a wealth of data from the Ontario Hospital Association and home and long term care organizations detailing the rising complexity of care required by patients who are leaving hospitals after extremely short lengths of stay. The infrastructure to cope with these more seriously ill patients was not in place when the lengths of hospital stay were suddenly shortened and remains woefully inadequate today. According to an Ontario Alternative Budget Technical Paper by economist Bill Murnighan, a cumulative tally of the cuts reveals that Ontario has spent $355 less per person - or $4.1 billion in total - on health care, in real terms, than would have been spent if stable funding had been maintained.

The results have been an entirely predictable decline in accessibility, comprehensiveness and universality. Hospitals plunged into deficits followed by cash-flow crises from which they have not yet recovered. Patients in the most critical need – waiting in ambulances and hallways for emergency room care – have become a regular feature of life in Ontario. Senselessly and tragically, people have died while waiting for emergency hospital services. Ontario has experienced record levels of hospitals on critical care bypass and emergency redirect for years running. Chronic care hospitals have been downgraded to long term care facilities struggling to

serve the same patients while being funded at half the previous rate. Cancer patients, unable to access treatment in their communities in recommended time frames have been sent to the United States or forced to travel around the province at huge cost for treatment. Backlogs for cancer treatment are still not cleared. Thousands of Ontarians cannot access family physicians, physiotherapy, audiology, speech pathology, rehabilitation and other therapies. According to Ministry of Health and Long Term Care placement data, in December 2000 there were more than 25,000 people on waiting lists for long term care beds in this province. Thousands of Ontarians are paying for hospital beds while waiting for placement in these facilities. According to the Ontario Association of Community Care Access Centres, there were more than 11,000 people on waiting lists for homecare in 1999, many of whom were waiting for more than one service; a figure that has increased with recent budget cuts. Community Care Access Centres report unnecessary hospital admissions and avoidable illness due to their inability to provide service to those who need it. As health care jobs have become insecure and as health care workers have experienced stagnant wages and deteriorating working conditions, critical human resource shortages are reported in virtually all health care sectors. Staffing shortages have intensified the difficulty in accessing services.

C. Out-of-Pocket Costs: the Erosion of the Public Funding Principle

According to the Canadian Institute for Health Information (Report 2000), Ontarians now pay $1,012 per person per year in out-of-pocket costs, up from $860 in 1995. OHIP de-listing, high pharmaceutical costs, shortened hospital stays, poor funding of rehabilitation therapies, inadequate home and long term care have contributed to an escalating burden of out-of-pocket health care costs for Ontarians. Forty-five procedures amounting to approximately $100,000,000 in services have been de-listed from OHIP in the last seven years. With the passage of Ontario's Bill 26 in 1996, seniors and those on fixed incomes began to pay user fees for their drugs. The same legislation forces those waiting in hospitals for beds in long term care facilities to pay more than $40 per day for their hospital beds. Inadequate funding and cuts to homecare budgets have caused thousands of Ontarians to lose homemaking and homecare services if we cannot afford to pay for them. Almost three million Ontarians have inadequate drug coverage, according to a recent report commissioned by Health Canada.

The breadth of services not covered by public funding has challenged Ontarians' confidence in universal Medicare. We now pay out of pocket for a whole range of inarguably medically necessary services including blood and lab tests ordered by our GPs, hospital beds for elderly patients, home and long term care, drugs, medical supplies, treatments, therapies, and mental health services, to name just a few. In addition, critical elements of prevention are compromised as Ontarians find themselves unable to pay for homemaking services, travel for treatment, chiropody and others.

Case Examples

The following case examples were gathered as part of the Ontario Health Coalition's "Public Health Private Wealth" project and a series of hearings held in partnership with other organizations on long term care and homecare issues. Through 1999, 2000, and 2001 the OHC and our partners sponsored twenty-five public forums across the province

and ran Public Service Announcements in dozens of other communities to find out how out-of-pocket costs and health restructuring were affecting Ontarians. Over fifteen hundred people came forward to share their stories. Names of the people involved have been changed to protect their privacy. The following are just a few examples of what we heard:

Hearst, Ontario
Don has prostate cancer. His physician referred him to Thunder Bay for a four-week course of radiation therapy. This treatment was scheduled for the early part of May, and despite the fact that the Thunder Bay hospital social worker advised Don not to delay his treatment, Don decided not to go. He simply couldn't afford it. Under the northern travel allowance, Don was told his travel to Thunder Bay would be paid for and arrangements would be made for him to stay in a lodge specifically for out-of-town cancer patients. But there was no provision for meals or other living costs. Don would have to pay for these himself. Don is retired and lives on a modest pension. By his calculations, he could afford to spend $10 per day – not enough since he would have to eat all his meals in restaurants. Don calculated that he would be able to afford his treatment by the end of May when his next pension cheque was to arrive. If worse came to worst, Don figured that he would borrow the money he needed to finish his therapy. Fortunately Don did not have to cross that bridge. His co-workers took up a collection to help him with his expenses so that he could get the medical attention he needed and focus on getting well.

Barrie, Ontario
Jane's mother, Maude, has Parkinson's disease as well as Alzheimers and uses a wheelchair. This past January, Jane's family decided that Maude needed to go into a long-term care facility because her care needs had become too great for her to remain at home. The cost of the nursing home was $1000 per month. Jane's parents are both seniors and live on a modest pension. In March, Jane's father brought Maude home because he could no longer afford the nursing home fees. The CCAC has now determined that Maude is eligible for only two hours/week of homecare. Maude's condition is deteriorating and the family has asked for additional help from the CCAC, but nothing has come through yet. This is causing a great deal of stress for Jane's father and his health is now starting to be compromised.

Timmins, Ontario
Annette is 30 years old . Like many young people she works part-time because it's the only work she can find. She has multiple health issues and has been prescribed eight different medications by her doctor to deal with her high blood pressure, anemia, asthma, allergies and a thyroid condition. She is not covered by any health benefit plan and cannot afford to pay for all of these prescriptions. Annette has decided to fill only one of the prescriptions (for her thyroid), not based on any particular health priority but because it is the only one she can afford. Annette says she has no alternative but to choose which of her health conditions she can afford to take care of and which she has to leave alone and hope for the best.

Hamilton, Ontario
Carol has worked for 10 years in the mobile medical lab service run by the five Hamilton hospitals. The service provided house calls for tests, fluid samples, and other medical lab services. The mobile lab service has been replaced by a new private system that charges a direct cost to every housebound patient who needs tests or lab services. "Now not only do they face illness, but there is the stress of wondering how they'll pay the $15 required for each and every house call."

Timmins, Ontario
This spring, Sharlene's two-year-old son broke his leg on a Sunday afternoon in a small town outside Timmins. She went to the local emergency room and was told the x-ray department was closed and she should go to Timmins. At the Timmins hospital, the x-ray was taken but Sharlene was told there was no one available to read it so she would have to come back on Monday. On Monday, she returned to the hospital and it was confirmed that her son's leg was indeed broken. Because he is so young and a plaster cast so heavy, Sharlene's options were to have her son fitted with a fibreglass cast for $50 or have no cast at all and keep him off his leg. After opting to find the $50, Sharlene was told that there was no one available to fit the cast on her son and they would have to come back on Tuesday. And so, after four trips to the hospital, $50 for a cast, $15 for a shoe to go over the cast, and $8 for a tensor bandage, Sharlene's son finally had what he needed to allow his broken leg to heal. Sharlene wonders what people do who can't afford either the time or the money this episode cost her family.

Kincardine, Ontario.
Eleanor is a quiet woman in her 70s who lives alone in Kincardine. Eleanor's income is about $13,000 per year. Recently, she had surgery to remove a large portion of her intestine and she will have to use an intestinal bag which must be changed daily for the rest of her life. The cost of these materials is more than $2000 per year. The Assistive Devices Program will supplement the cost of her supplies to a maximum of $1200 per year. Eleanor has checked with local charities and churches to see if she can get some help with the remaining expenses but, so far, has had no luck. "This is a small town. They're doing the best they can," says Eleanor of these community agencies. When asked where she gets the money to buy these absolutely essential supplies, Eleanor responds that she "sometimes has to make the choice between food and medical supplies."

Cobalt, Ontario.
Stan's daughter is 22 years old, has juvenile diabetes and is just finishing school. When she turns 23 she will no longer be covered under Stan's benefit plan. The total cost of her supplies and medications is more than $3000 per year. His family does not quality for the Trillium Drug Benefit Plan and unless his daughter is able to find a job with a good benefit package, Stan doesn't know how they are going to pay for her supplies.

Huron Park, Ontario.

Esther is 54 years old and has arthritis. Her doctor has prescribed a medication to alleviate the arthritis pain but it costs $101 per month. Esther works part-time as a nurse and has no benefit plan through her employer. She earns about $14,000 per year and simply cannot afford the medication. Esther is frustrated because she feels she is caught in a "Catch-22". Because of her arthritis, she is unable to work full-time. As a part-time worker, she is ineligible for her employer's benefit plan and access to the drugs that would allow her to work full-time.

Kincardine, Ontario.

Joanne is a lab worker in the hospital. She is seeing more and more patient fees being introduced for things like Tylenol, antibiotics and inhalation masks. She says the list of lab tests no longer covered by the hospital's budget or OHIP gets longer and longer every year. Joanne says this means that patients are being charged for more than ever before.

Peterborough, Ontario.

Members of the aboriginal community have a disproportionately high incidence of diabetes in Ontario. In Peterborough, Gillian says, half of the aboriginal community has diabetes. For those living off-reserve, many of the aboriginal benefit programs do not apply so they rely on the provincial health care system. Gillian gives the example of chiropody, or foot care, as a way in which the aboriginal community is being affected by privatization. Chiropody used to be funded through the Ministry of Health's global budgets to hospitals and health centres. Funding cuts have led to the disappearance of many of these chiropody clinics. People with diabetes must pay careful attention to their feet, in particular, for signs of infection due to the circulatory difficulties associated with diabetes. Failure to properly treat these infections can lead to gangrene and amputation. Chiropody in a private clinic costs between $25 and $35 per session which, for many of the people Gillian works with, is prohibitive. "What are the long term costs if people don't get preventative treatment?"

Copper Cliff, Ontario.

Rob was injured in an accident a few years ago in which he suffered whiplash. Initially, his physician sent him for physiotherapy and chiropractic treatments 2 - 3 times per week. At each visit, Rob was charged $25-30 in addition to the amount covered by OHIP. After two months, Rob stopped his treatments because he could no longer afford them. Rob is self-employed, with a family of four and no benefits. He and his wife have not been to a dentist in years because they cannot afford it and they want to make sure their children are able to go. He worries about anyone in his family becoming seriously ill because they simply won't be able to afford to pay for the care.

Blenheim, Ontario.

For the past three and a half years, Lydia has required home oxygen for her emphysema and heart condition. She pays $18 for the actual oxygen, which lasts about three months, $30 per month for the equipment and $100 per month for her in-home and portable tanks.

Belleville, Ontario.

Irene's husband has a serious incontinence problem requiring medication that is not covered under their supplemental health insurance plan. In the past two years, they have spent more than $2000 on this medication. They have tried various government offices and organizations for help but have found nothing.

Burlington, Ontario.
Jacqueline is a former nurse who is now on a disability pension. In 1995, Jacqueline required emergency bowel surgery, which has had a profound impact on her life. She now requires continual intravenous injections for nutrition and ongoing medication for her condition. Following the surgery, she experienced frequent and serious infections, often requiring hospitalization. In fact, in one year, she had septicemia (a bacterial infection of the blood which can lead to death) three times. Each episode required a lengthy stay in hospital plus aggressive antibiotic treatment, at a cost of approximately $1600 each time. Her physician prescribed Taurolin, a drug that kills bacteria and could eliminate her repeated infections. Tuarolin is not covered by the province's drug formulary and costs $3 per day. Despite a very limited income, Jacqueline decided that this medication would improve her quality of life and has made big sacrifices in her budget in order to pay for it herself. This past October, Jacqueline was diagnosed with degenerative disc disease. Her physician prescribed physiotherapy. When she went to a local, private clinic she was told there would be a $50 fee for her initial assessment and that she would be charged $20 per visit, unless she had supplemental health benefits. This was more than she could afford to pay, so she decided to put her name on the waiting list at her local hospital for the publicly-funded physiotherapy clinic. At the time of our consultation she had been on the waiting list for nine months and was still waiting.

Scarborough, Ontario.
Theresa is a breast cancer survivor living on a disability pension. Following the treatment of her cancer, Theresa's physician ordered monthly blood tests to monitor her condition. Theresa has limited mobility and needs someone to come to her home to perform these tests but the $15 charge per visit is more than she can afford. She has asked her physician to change her test schedule to once every three months so she could avoid the $15 charge.

Timmins, Ontario.
One woman told the forum about her mother-in-law in a nursing home where she is entitled to one bath per week, having to pay for any additional baths. In forums across the province, this story was repeated over and over.

Sudbury, Ontario.
Last year, Jennifer injured her back and was prescribed physiotherapy by her physician. Jennifer lives on a limited income and could not afford to go to a private clinic, so she put her name on the list at her local hospital's publicly-funded clinic and waited. And waited. Six months later, she finally began her treatment. On her third visit, Jennifer's sciatic nerve was damaged which she feels was caused by the delay in receiving

treatment. If she had the money she probably could have avoided this additional injury. "The caring aspect of health care is gone, we're nothing but commodities," she says.

Toronto, Ontario.
Jonathan works in a laboratory in a hospital. He told the Ontario Health Coalition that men in Ontario now have to pay out-of-pocket for PSA tests. These tests, he explained, identify prostate cancer. "I cannot figure out who it benefits to have delisted these tests as early detection is so important."

Kingston, Ontario.
Anita works for a local non-profit agency that provides support for people with epilepsy. Cuts to homecare and the tightening of eligibility for benefits are leading to very real and very negative health outcomes. For example, limits on bathing in homecare leads to poor hygiene and increased infections. Many people with epilepsy cannot use stoves or ovens safely, so without meal preparation support they can only eat cold meals. Anti-seizure medications such as Dilantin cause dental problems and gum overgrowth which, if left untreated, may lead to infection. Procedures that take care of these problems are simply out of reach for people with epilepsy who are unable to work as a result of their illness.

Kingston, Ontario.
Delores is a homecare patient who is classified as quadriplegic with multiple health issues, uses a wheelchair and requires pain control medication. She reports that a staffing shortage has thrown her into crisis. Weekly, she is told that the Community Care Access Centre cannot find enough staff to cover her allotted homecare shifts. In one example, she told a forum in Kingston, her nurse who was scheduled to go to Delores' house at 8:30 a.m. was sick. The homecare provider agency could not find a replacement, and the first available person arrived at Delores' home at 2 p.m.. "I was left in my bed without medication, without my bowel routine and a lot of other very private embarrassing things. And it wasn't because the company so much failed, but the company didn't have anything to work with and that's because the nurses aren't here, because . . . they've gone south, they've gone elsewhere or they're just not going into this practice."

St. Catharines, Ontario.
A member of the Niagara District Health Council drew special attention to the desperate shortage of mental health and addiction services in the region. Lack of programs, lack of treatment beds and lack of psychiatrists are a start, she reported. She knows of people who have taken out bank loans to seek private treatment. "The eight children's mental health beds allotted to Niagara are in London, a long journey for families, provided they have the transportation to get there. Currently, under the direction of hospital restructuring, those eight beds will be moved to Hamilton."

Windsor, Ontario.

A psychiatrist reported that there is a crisis in mental health services in Windsor Essex where he reported the waiting list for children was 700-1000.

Kingston, Ontario.
At a forum, the Kingston Council on Aging addressed the problem of long waiting lists for seniors who cannot pay the rates for preferred accommodation in long term care facilities. "Under the current legislation, each long term care facility must set aside 40% of the beds for subsidized patients. The balance - or 60% of the beds - may be held for full pay patients. This results in a longer wait for placement in a long term care facility based on ability to pay rather than on need. Lower income seniors are further penalized since they cannot afford to purchase private homecare services to augment the maximum of 60 hours per month of homecare provided through the local Community Care Access Centre."
Goderich, Ontario.
A Huron County paramedic told the forum that after provincial downloading of ambulance services, the county proposed to close and move two of the six ambulance stations. "Of the six stations, five of them aren't even making a response time of 19 minutes" he reported. The proposed further cuts would only worsen the situation.

Toronto, Ontario.
Sylvia is a cancer survivor. She was told that if she hoped to get radiation therapy within the recommended 12 week timeline, she would have to leave Toronto and go to the United States. Horrified at the prospect of undergoing treatment alone in a foreign country, and appalled at the ethics of potentially replacing an American patient whose health care insurer pays lower rates than Ontario, she decided to take a risk. She waited 22 weeks for treatment in Ontario. "This is Canada: it is not a third-world country. Sending cancer patients to the U.S. for a service they should be able to get here is not an acceptable alternative. It is a disgrace. When you consider the fact that the average cost for radiation therapy in Ontario is $4000 and that the average cost of sending cancer patients to the U.S. for treatment is at least $16000, it seems that much more damaging to our health care system."

SECTION II:
MEDICARE RECLAIMED: MAKING THE SYSTEM COMPREHENSIVE

The shift of costs from public to private responsibility and the removal of services from Canada Health Act coverage contradict Ontarians' notions of what Medicare is about. Many of the people who have participated in our consultations do not understand why the Act does not cover key health services. Understandably, Ontarians find it difficult to comprehend a system in which we are able to get a diagnosis - based on a principle that access to health care is a right of citizenship and should not be contingent on income - and yet, in a growing number of cases, the same principle does not apply to our access to treatment, homecare and other health services.

The current patchwork of covered and not covered services contributes to the inefficiency of the system. Patients who cannot afford the out-of-pocket costs delay or go without preventive services, rehabilitation, treatment and medications, and end up in more expensive parts of the system with preventable illness or injury. Community Care Access Centres and hospitals in Ontario have found that if patients cannot access adequate homecare, they end up in hospital emergency rooms. This experience is further documented in a recent study by Dr. Marcus Hollander who found increased hospital admissions for seniors who did not have access to homemaking services in British Columbia.

Our experience in Ontario shows that when costs are cut from the public system, patients are forced to pay out-of-pocket for the care that we need, or we go without and eventually end up back in the public system with more acute illness. Public policy needs to reflect the interrelationship between the various health sectors. It is a more effective and sustainable use of our resources to pay for services publicly and deliver them in an integrated comprehensive Medicare system.

SECTION III:
STABLE FUNDING: A CRITICAL ELEMENT OF SUSTAINABILITY

Funding instability has not only caused deep cuts to services, it has also created new monetary and other costs. Deep cuts and restructuring have combined to create grave inefficiencies and redirection of precious resources from patient care to administration, capital costs, consulting fees, and others. Non-monetary costs such as demoralization of staff, increased stress, accidents, injuries and staffing shortages are increasing. Insecure budgets have diminished the ability of facilities to hire permanent full-time staff and to create working conditions to attract and retain personnel.

Illustrative examples are found in hospital restructuring, homecare and cancer treatment in Ontario in recent years. In this province, millions of dollars have been spent on hospital restructuring – in which we now see diminished bed and staffing levels even while operating expenditures increase. Inadequate homecare funding, cuts and lack of regulated minimum standards and levels of care have caused unnecessary hospital admissions and a diminishment of preventive services. Initial cuts in cancer care ended up in enormous costs within a very short period as patients were forced to travel great distances to access treatment.

A. Hospitals

The public record shows that $590 million has been spent on hospital restructuring in Ontario to date. While the Hospital Restructuring Commission originally estimated the cost of restructuring at $2.1 billion, the Provincial Auditor reported that the cost might reach as high as $4 billion. It is a tragic irony that multiple millions of dollars have been spent to lay off staff and decrease numbers of beds. Although a specific accounting is not publicly available, a quick analysis of the bottom lines reveals that hospital restructuring redirected vast sums of public funds from patient care to other areas. By 1999, staffing levels had *dropped* by nearly 10% while operating spending was *up* by nearly 10%. Despite a population growth of approximately 750,000, hospital and long term care staffing numbers have plummeted. In March 1995, there were 26 hospital and long term care staff for each 1,000 Ontarians. In 2000, this figure had dropped to just over 22 staff per 1000.

The costs of overworked staff have become evident. A major study by the Canadian Medical Association Journal indicates that reported errors had increased significantly between 1992 and 1997. Misadventures rose from 18 to 30 per 10,000 for in-patients and 5.2 to 11.6 for day surgeries. Complications rose from 330 to 500 per 10,000 for in-patients and from 65.2 to 95.1 per 10,000 for day surgeries. Adverse drug reactions rose from 104 to 162 per 10,000 for in-patients and from 8.1 to 10.8 for day surgeries. An Ontario Hospital Association commissioned study reported that the cut of 4,000 nurses between 1994 and 1999 resulted in reduced patient supervision and less nursing time, lower levels of cleanliness and increased staff stress.

B. Homecare

The consequences of slow redirection of resources to homecare, inadequate funding and cuts are clearly described in many reports in recent years. Ontario's Hospital Restructuring Commission in its final report stated that it remained "concerned that [the Ministry of Health's] continued slowness in the pace of reinvestments will jeopardize successful restructuring and risk the loss or diminish the gains made toward the creation of a genuine health system." In Niagara District, for example, the Health Council's Annual District Service Plan for 1999-2000 cites evidence that revised eligibility criteria due to funding shortfalls had led to increased hospital admissions, increased hospital waits for long term care placements and greater financial, physical and emotional burdens on caregivers. The report raises additional concerns about inappropriate admissions to acute care facilities due to inability to provide adequate supports in the community. The Ontario Association of Community Care Access Centres reported in July 2000 that clients in need are being denied admission, a back-up of patients in hospitals, and an inability to achieve a continuum of care across various sectors of delivery. In a sorry irony, over the last year, approximately 50% of Ontario's 43 Community Care Access Centres reported that they have been forced to create standing clinics - in some cases in hospitals - to deliver "homecare" to patients due to critical and escalating staffing shortages.

C. Cancer Treatment

Despite a projected increase in cancer patients and ensuing recommendations for enhanced services from the Ontario Cancer Treatment and Research Foundation, deep budget cuts and poor planning have contributed to personnel shortages and increased costs for travel for foreign treatment. Budget cuts in the mid 1990's froze cancer treatment budgets, delayed the construction and expansion of cancer treatment centres for years and forced the merger of Canada's only dedicated cancer hospital. In addition, the province wiped out a year of radiation therapy graduates in 1997, consequently exacerbating a shortage in radiation therapists. For the past several years, the province has been forced to pay four times the Ontario rate for treatment in order to send patients to Buffalo, Cleveland and Detroit.

SECTION IV:
FOR-PROFIT HEALTH CARE: NOT THE SOLUTION

A growing portion of Ontario's health services is controlled by private profit-seeking corporations. The outcomes of this experience provide evidence of the negative effects of privatization of health service delivery. In Ontario, as in other jurisdictions (most notably the United States where many of the same corporations are at work) the evidence is that an increase in private delivery amounts to an increase in cost and a diversion of resources away from patient care. In homecare, the introduction of so-called managed competition in 1997 attracted a flood of for-profit provider companies into the province, creating a host of concomitant ill consequences. Laboratory privatization has not reduced costs, but has diminished service levels and has had negative consequences for the remaining public providers. Privatization of cancer care and emergency triage systems have been accomplished only at a greater cost than public provision with unproven results. Drug costs have the dubious distinction of being the greatest growing provincial budget item. The net effects of privatization have been higher per-unit costs, erosion of service levels, erosion of working standards, money redirected from care to profit, higher out-of-pocket costs and inefficiencies.

A. Home care

Market instability due to public divestment, bankruptcies and changing contracts have created intolerable working conditions for workers in the sector. In public hearings organized by the Ontario Health Coalition in collaboration with other coalitions and organizations, we heard over and over from home support workers and nurses about deteriorating working conditions and increasing inability to provide the quality of care they would like. As one personal support worker in the Toronto hearing put it, "Every 30 months my company loses the contract and I lose my job. I have to start again with a new company, with no seniority and poorer wages and benefits." As the shortage has grown, remaining staff bear an increasing burden of overwork. It is no wonder, then, that no less than 11 reports have been released by Ontario's Community Care Access Centres (CCACs) over the last year detailing critical staffing shortages in homecare.

Privatized delivery of homecare through the competitive bidding model adopted by Ontario is also redirecting precious health care dollars out of patient care and into ballooning administration. Three years after its inception, Ontario's homecare system is rife with duplication, inability to use staff efficiently, excess administration and profit taking. A recent report by the Canadian Union of Public Employees uses the data that is available to estimate that these problems cost approximately $247 million per year, or 21% of the provinces CCAC budget. There is no Ministry assessment of the inefficiencies in the system they have created.

Expenses incurred by tendering requests for proposals, preparing bids, evaluating proposals and monitoring companies are all components of an unnecessary administrative cost burden. Each of Ontario's 43 Community Care Access Centres (CCACs) has often

more than ten provider agencies involved in the delivery of care. The CCAC and each of these agencies have administrations: CEOs, financial officers, human resource departments and frontline managers. Far from streamlining the process of community care governance, this model drives up administrative requirements and escalates costs.

Further costs are incurred because both the CCACs and each of the direct service provider agencies need to keep record systems to monitor the same set of patients and the same set of visits. Maintaining multiple computer systems -- with the related hardware, software and data entry costs, all performing essentially the same function – is a significant unnecessary financial drain on the system. Furthermore, with average daily visits of 1,500 to 2,000 per day per CCAC, it is inevitable that discrepancies arise between the computer records. The costs in staff time needed to reconcile discrepancies between the systems often mean hiring dedicated staff in provider agencies and thousands of additional hours of staff time in CCACs.

The common practice of using multiple agencies to provide the same service creates inefficiencies in geographical assignments and results in increased travel costs and staff time. For example, rural neighbours may be visited in the same afternoon by two separate caregivers from two separate companies, each paid for having to travel great distances -- an unnecessary duplication of costs and scarce staff time. Moreover, the multiplicity of service providers have to work through CCAC case managers to communicate, adding extra communication time requirements and the increased possibility of miscommunication, with attendant extra cost and safety concerns.

Tinkering with the competitive bidding model adopted by the province will not be enough to solve the core problems in homecare. A core component of the system's inefficiency is profit-taking. The competitive bidding system has led to an increase in for-profit companies involved in the delivery of care. Under a bidding process that is weighted in favour of opening the market to profit-seeking companies - without support for continuity of care and sound human resource practices - we have seen exponential growth in the proportion of the industry controlled by private interests. It has been estimated that $ 42 million per year of public money is currently paid out in profit to owners and shareholders of these companies. The contracting out of the therapy services by the Ottawa CCAC provides a graphic example of this system creating extra costs. In that region, the CCAC has documented that they are paying over $500,000 more per year to provide exactly the same service that would have been provided had they been allowed to keep the therapists as direct employees. If there was public access to financial and contract information across the province, more examples of this sort would likely be found.

The inherent redundancies and extra costs involved in the privatization of home care delivery detract from using our public health care dollars wisely and allowing people to receive adequate home care when they need it. This has created instability in the industry, has redirected health funds to profit and administration, has contributed to severe staffing shortages and has caused a decline in patient care.

B. Cancer Care

Recent privatization of cancer treatment at Toronto's Sunnybrook Hospital has raised further questions about the costs of for-profit health care delivery. Review of the Sunnybrook contract reveals that the privatized services are funded at a greater rate than public cancer treatment per procedure and an additional amount in "volume incentives" is being paid to the private company that has been contracted to provide the service. Additional indirect public subsidies are also being provided through the companies' free use of public facilities and cleaning services. It is not credible for supporters of privatization to argue that the private system attracts new ideas and greater innovation since the founder and CEO of the private company now contracted by Cancer Care Ontario was the Vice President of Cancer Care Ontario until his newly-formed private company won the contract for the privatized service. As has been the case in other jurisdictions, privatized delivery has simply moved personnel and resources out of the public system to provide the same services at a higher per unit cost in the private system.

C. Labs

In a report on health care privatization commissioned by the Ontario Health Coalition and written by Paul Leduc Browne of the Canadian Centre for Policy Alternatives, summarized below, an investigation of public-private partnerships for laboratory services reveals that increased private delivery has not contained costs and has created new user fees and problems for the remaining public labs.

Many years ago, Ontario's private laboratory industry was comprised of small companies funded by the private insurance industry and serving physician's offices. The consolidation of the industry has evolved to the point where three major private lab companies control 90% of the market. After a decade of 15% per year in increases in private lab expenditures through the 1980's the province negotiated an 8.9% reduction in payments over three years to bring expenditures from $456 million in 1992-93 to $415 million by 1995-96. In 1993-94, payments soared to $480 million. In 1998, the government negotiated a new cap of $425 million with scheduled increases of 1.5% for the next two years. Under a subsequent negotiation, private labs received a retroactive payment of $26.6 million for 1998-99 and a 1999-2000 global envelope of $458 million. Despite claims of private sector efficiency, a number of studies indicate that private laboratory services in fact cost more. It has been inferred from these studies that OHIP's laboratory costs could be reduced by $200-250 million a year, if the public sector were to take over the business. Not only are publicly funded costs escalating, but new user fees have also been introduced. Nursing homes and patients report that mobile-unit pick up laboratory services that used to be provided at no charge are now subject to a user fee of $15 per pick-up.

Public laboratories operate at a disadvantage. Where private labs bill OHIP on a fee-for-service basis, public labs are funded out of hospitals' block funding. They do not have the means to deal with higher volumes of services, especially out-patient work, and

they do not have the means to invest in new technology or facilities. While for-profit labs have taken the higher-volume and lower cost services, public labs must deal with more complicated, specialized, non-routine and less profitable tasks involving skilled technologists and high-cost equipment.

D. Telehealth Ontario

Like the example of privatized cancer treatment, the introduction of privatized emergency triage through Telehealth Ontario has raised questions about costs and benefits. According to an announcement in early 2000 by Ontario's Ministry of Health, newly contracted triage services through Telehealth Ontario would cost $45 million per year. They reported that the service would hire 144 nurses to provide telephone triage services – a restructuring born of emergency room backlogs. The amount of profit, subsidy for the private companies' set up, advertising and other expenses has not been revealed and a complete accounting of the costs and benefits is not evident. Emergency room backlogs have not been cleared. A straight calculation of the cost per nurse at a rate of $45 million for 144 nurses yields a figure of $300,000 per nurse. The same money, directed to hospital emergency rooms or community health centres that do not require new advertising and overhead would surely fund more than 144 nurses.

E. Drug Costs

Ironically, while our provincial government and a powerful interest groups have stepped up pressure to privatize, the province's most recent budget reveals that spending on drugs - an area dominated by transnational corporations - saw by far the largest increase in health care spending. The government has increased funding for drugs by 20% since last year, far more than other health care sectors. Indeed, since the 1998 budget public money going for the drug industry has increased 64%.

SECTION V:
DEMOCRACY: A KEY COMPONENT OF CHANGE

There are few sectors of our health system that can be described as democratically controlled with easy public access to information, public accountability and transparency. Closed-door systems of governance are the norm, exemplified in provincially appointed hospital boards, provincial health agencies, and District Health Councils; Community Care Access Centres exempted from freedom of information legislation with closed-slate board elections; and a majority of long term care facilities and homecare providers not subject to public governance as they are operated by private companies. Both federal and provincial governments have undertaken radical policy shifts with regards to health care without any public debate or consultation. Expenditures in virtually every sector are inaccessible to public scrutiny. Contracts are awarded without competition to private corporations with little or no justification or disclosure of terms. Health care workers are prohibited from criticizing their employers' practices. OHIP de-listings have been accomplished through bilateral negotiations between the provincial government and the Ontario Medical Association and publicly announced only long after decisions have been made. Primary Care Reform has been negotiated between the same two organizations to the exclusion of all other stakeholders and the people of Ontario. This overwhelming lack of democracy has perpetuated the problems in the system and is an often overlooked barrier to positive change.

A most frustrating lack of transparency and democracy exists in the lack of public access to financial information in hospitals, facilities and homecare. This has facilitated vast expenditures directed away from patient care. For example, Ontarians remain largely unaware of the vast amounts of money used in hospital restructuring to lay off staff - a devastating policy that is in no small part responsible for the critical staffing shortage we are experiencing now. Community Care Access Centres have been expressly exempted from freedom of information legislation and have inserted gag clauses into contracts. Measures of the efficiency of privatized delivery are difficult as measures of profit-taking, privatization and other key elements either do not exist or are not made public.

Bilateral and closed door negotiations have slowed progressive reform by propping up old-fashioned and self-serving power monopolies. In Ontario, primary care reform appears to be at the mercy of negotiations based on maintenance of centuries-old medical hierarchies. Reform has not included team-based approaches that utilize non-physician health professionals. While thousands of Ontarians have no family physicians, according to the Registered Nurses' Association of Ontario the province is home to between two and three hundred under or unemployed nurse practitioners. The Nurse Practitioners' Association of Ontario reports that fifty nurse practitioners live in the most underserved areas of the province and cannot find nurse practitioner jobs. While closed-door bilateral negotiations regarding primary care reform have gone on, more than eighty-six groups in sixty-seven communities are putting together proposals for community health centres that generally pay more attention to prevention issues and utilize team based approaches. Fifteen proposals have been completed and twenty-seven needs

assessments have been done. However, despite the critical need the establishment of new community health centres - even in seriously underserved areas - has been stalled.

The lack of democracy has excluded constructive criticism and complaint and has stifled innovation. Health care workers who speak out about poor practices risk discipline. Although organizations such as the private laboratory lobby note that they are achieving greater access to policy makers than ever, the majority of health care workers and patients have had no input into health policy in over seven years. Ultimately, this has contributed to the crisis of public confidence in Medicare.

SECTION VI:
PROMOTING HEALTH

The past half decade has been characterized by dismantling by both federal and provincial governments of the systems and safeguards that promoted greater equity and prevention against poor health. The federal cuts to unemployment insurance, abandonment of national standards through the removal of the Canada Assistance Plan, the introduction of the Canada Health and Social Transfer (CHST) and concomitant cuts to transfers, provided an opportunity for our provincial government to cut social assistance in Ontario by 21.6% and impose work-for-welfare. Working peoples' incomes have stagnated over the last two decades. Combined with federal and provincial abandonment of public housing, and provincial withdrawal of rent control, the effects have been disastrous.

In six years, Ontario's affordable housing deficit has ballooned to at least 74,000 units, according to the Canada Mortgage and Housing Corporation. Waiting lists for social housing run from three to ten years for many. In an Ontario Alternative Budget Technical Paper, Michael Shapcott reports that last year, more than 60,000 Ontario households faced eviction. Homelessness is on the rise in cities and smaller communities across the province. The consequent homelessness, overcrowded conditions, inadequate heating and unsafe conditions contribute to ill health and diminished life expectancy.

Cuts to environmental protection, diminished access to education and erosion of health and safety protection for workers only contribute to this grim picture of short-sighted policy and lack of attention to the determinants of health. Poverty statistics and vulnerability are considerably more acute for visible minority groups and off-reserve aboriginal people. So-called innovations such as telehealth do not touch large populations of aboriginal people, new Canadians or homeless people in cities due to language barriers and lack of telephones.

Dr. Dennis Raphael recently reported in the New Brunswick Telegraph Journal that, "The most recent estimates are that 23 percent of all premature years of life lost prior to age 75 in Canada can be attributed to income differences..." He cites a study by the Institute for Clinical Evaluative Sciences that tracked hospitalization rates for heart attack, congestive heart failure, angina, and chest pains from 1992-93 to 1196-97. The hospitalization rates for the lowest income 20 percent of neighbourhoods were 69 percent higher for heart attacks, 65 percent higher for congestive heart failure, 97 percent higher for angina, and 121 percent higher for chest pain than those in the highest income 20 percent of neighbourhoods. It is not difficult to understand how this works. Sustainable Medicare and a system that is intent on creating the best health and providing the best healthcare possible for all residents must include due attention to the social causes of ill health.

SECTION VII: RECOMMENDATIONS

1. Replace the cuts from federal transfers to the provinces for health care. Ensure stable and adequate public funding in the future.
The partial reinvestment of approximately $21 billion over 5 years as announced in September 2000 is not adequate to redress the destruction caused by cuts to transfers. The total cash transfer must be reinstated. A binding commitment must be made for funding to keep up with inflation and population growth.

2. Ensure that more public health care funding reaches patients through taking the profit motive out of health care.
Calling for a universally accessible, publicly funded healthcare system is not enough. Medicare should not be seen as a public insurance scheme to support a private for-profit industry. Profit-taking, commodification of health services and inflationary private markets risk the future sustainability of Medicare. Cost control, efficiency and sustainability depend on public non-profit service delivery.

3. Ensure greater accountability in health spending and policy.
The abandonment of geared transfers with the creation of the CHST, wasteful restructuring and profitization of the sector have contributed to confusion and the redirection of funds away from patient care. As an obvious minimum requirement, health spending should be used to provide health care. Federal transfers should be accompanied with proactive measures such as improved and clearly defined national standards as well as accountability mechanisms to measure and disclose spending on items that are not direct patient care.

Improved public governance and access to information is a critical component of improved accountability. Democratic decision-making should include an "openness" provision for health care workers to proactively seek their input about improvement of policy and "whistle-blower" protection for those who speak out about poor management practices.

4. Rebuild and modernize the comprehensiveness and accessibility of Medicare through new federal legislation to cover health care services from acute to home care.
Movement of services out from under the umbrella of Medicare into privatized home and long term care has led to unnecessary costs, confusion and declining patient care. The principles of the Canada Health Act must be enforced and extended. Physician services, hospital care and home care are inextricably related. All should be covered by the same principles of public not-for-profit administration and delivery, public funding, comprehensiveness, universality, accessibility and portability through a new Home and Community Care Act.

5. Introduce a publicly-delivered universal drug plan.
Containing the costs of and ensuring public access to medications and treatments remains a critical oversight in our public health system. Inability to access treatment is a major impediment for Ontarians. Drug costs continue to eat up ever greater portions of the provincial health budget. Controlling over-prescription and escalating drug costs are integral components to health care reform. Long promised National Pharmacare should not be delayed any longer.

6. Create good health through rebuilding and extending a commitment to the determinants of health.

Canada is the only industrialized country without a national housing strategy. The abandonment of the Canada Assistance Plan and the downloading of housing has contributed to the growth of circumstances that create ill health. Inadequate tracking of potentially occupationally or environmentally created cancers and other illnesses forestalls future prevention initiatives. Improved food safety regulatory regimes, rebuilt access to public education, and improved environmental protection are long overdue. A federal commitment to far-sighted and thoughtful policy with regards to the determinants of health and health promotion - with specific attention to the most vulnerable populations including First Nations - is a necessary aspect of sustainable public Medicare.

7. Reform the delivery of primary care and expand the role of non-physician health providers.

Primary health care is generally the first point of contact Ontarians have with the health care system. The provincial government and the Ontario Medical Association are controlling reform of this system through closed-door bilateral negotiations. This process stifles the potential of reform. Progressive and effective primary care reform requires federal government leadership and improved democractic process to ensure that reform enables Ontarians in poorly serviced areas to access critical primary health care services and to improve the range of and access to services in other areas. The Ontario Health Coalition has, in consultation with representatives from our member organizations, established a set of criteria for primary care reform. These criteria are appended.

8. Provide national leadership with respect to human resources planning, recruitment and retention.

The Commission needs to turn its attention to what it is that will enable the health sector to recruit and retain workers. Current barriers include high stress and injury rates, and unattractive working conditions. Funding cannot only be directed toward new technology - it needs to be directed towards *human* resources as well. As has been shown in Ontario, it is not realistic to believe that we can solve our human resources problems through a private delivery model. Adequate funding and improved stability will begin the process of addressing the human resources crisis in health care. Expanding the role of non-physician providers will help to alleviate Ontarian's inability to access primary care. In addition, integral to improved recruitment and retention are improved wages and working conditions, employment security, support for existing rights of healthcare workers.

APPENDIX - PRIMARY CARE REFORM

The Ontario Health Coalition is calling for immediate action to create and fund a system of primary care based on the following principles:

- ❑ Every resident must be guaranteed access to care with an entitlement to the care they need.

- ❑ Primary health care must be publicly funded, administered and delivered.

- ❑ Primary care practices must have a structure and culture that ensures they are democratically run through a Board controlled by the community with input by patients, care providers and advocates.

- ❑ Physician control of health care must end. Primary care organizations must draw on the skill of a range of health care providers: therapists, dentists, nutritionists, nurse practitioners, dental hygienists, doctors, RNs, RPNs, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, laboratory technologists, and social workers; jointly these providers will comprise the primary health care team.

- ❑ Services should be accessible 24hrs/day, 7 days/week, all year round.

- ❑ Patients should have the unfettered right to change their primary care practitioners if they feel that their health care needs are not being met. We are therefore opposed to any form of rostering that restricts the unfettered right to select or change primary care practitioners.

- ❑ Primary health care must be provided to all regardless of age or state of health -- to individuals, families, children and seniors, people living in poverty, people living in wealth, people who are ill and people who are well. There must be no preconditions for care.

- ❑ Doctors and all health care providers must be moved off the fee-for-service method of payment to salary. Salaries should be the mode of payment for all primary health care providers.

- ❑ The range of services provided must be based on the health needs of the community.

- ❑ Primary health care delivery groups must be large enough to play a meaningful role in improving the determinants of health.

- ❑ All Primary care teams must make a written commitment to patients detailing provider obligations, such as ensuring comprehensive health care, including health promotion, disease prevention, advocacy, and case management.

- ❑ Unionization of all people who work in primary care settings should be encouraged. The operators of primary care centres should be required to establish a positive climate for unionization, recognizing there is a benefit in the quality of health care if their employees are unionized.

- ❑ There must be whistle blower protection for all employees to allow them to freely and publicly identify practices in the primary care system that they find unacceptable.

- ❑ Funding must be sufficient to meet the health needs of the community being served and should be paid to the primary care center, rather than to individuals within the group. Funding also needs to be adequate to meet the collective bargaining obligations of the center to its employees.

- ❑ Primary health centers must be community controlled and accountable to the community within provincial standards ensuring that they provide the care patients need. Location, structure and methods of care delivery will vary to meet the needs of the community served and can include community controlled hospitals and hospital organizations, community controlled Health Service Organizations, Community Health Centres and CLSC-style organizations.

- ❑ Educational programs are needed to prepare practitioners to work collaboratively in a setting that focuses on the health of the community as well as the individuals who live within it. It is essential for the government to immediately engage in human resource planning, including the funding of educational programs to ensure adequate numbers of qualified practitioners.

- ❑ There needs to be improved information flow between primary care providers, ERs, hospital floors, home care and long term facilities so that patients can receive secondary and tertiary treatment and return home with minimal disruption and danger. However, adequate resources are required to put an effective system in place. While information management makes it possible for information about patients to be shared quickly and efficiently, mechanisms must be put in place to ensure privacy, security, and confidentiality. Personal information should only be shared within the health care system on a need to know basis and never revealed without consent to outside organizations, including employers, insurance companies and other businesses that may want to profit from this information.

- There should be no change in the mandate of emergency departments to see and treat anyone who chooses that as their access to health care.