Time to Rebuild

Health Care Platform for the 2018 Ontario General Election

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Ontario Health Coalition
Protecting public healthcare for all.

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 representing more than half-a-million Ontarians and a network of Local Health Coalitions. 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.

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.

It's Time to Rebuild

If there is one message that Ontarians need to communicate to politicians regarding health care in our province leading into the 2018 general election it is this: it is time to rebuild. After almost four decades of public hospital downsizing and restructuring, broken only by a brief respite (2000-2005), after longstanding and increasingly severe rationing of long-term care even while our population is growing and aging, the pressing need to restore care cannot be ignored. The Ontario Health Coalition's platform – our body of ideas and recommendations for the provincial election – centres around this urgent need for reinvestment, rebuilding of capacity and revitalization of our health care services and institutions.

Given the gravity of the service cuts, Ontarians must be wary of simplistic pledges to find more "efficiencies", to "lean", or to "transform" health care. While everyone supports the idea that funding must go first and foremost to care, too often "efficiencies" have meant cuts to needed local and front-line services. While most embrace the idea that the elderly should be supported to age in place, too often "transformation" has been window dressing for devastating cuts to local hospitals' services that are not transferable to home or long-term care.

It has come down to this: the core health care policy of Ontario can no longer be endless downsizing of our local public hospitals without regard for population need. Further, it is unconscionable to leave aging and those with chronic illness to their own devices after they have paid all their lives in their taxes for a public health care system that is supposed to provide for them. When an Ontarian in a mental health crisis waits for 6 days in an emergency department; when a sick man is left on a stretcher for 13 days wedged up against a toilet; when there is no longer enough surge capacity to deal with a flu or incoming trauma –we must insist that urgent action be taken to resolve the crisis. While no single government can be blamed for how we got here, there is no question that cuts and rationing have gone too far.

Compassion and equity are deeply rooted values in our province and Ontarians rightfully expect that these principles guide planning for our health care system. To do this, the next Ontario government must turn the corner on hospital cuts and rationing of long-term care and act urgently to rebuild services. It must have a fiscal plan that is realistic and thoughtful, including a revenue plan to provide for the services that are needed, and the candidates must talk about these budget choices honestly with voters. Ontarians also expect that our public services be managed and provided efficiently and be responsive to our communities' needs. This means that meaningful measures must be taken to improve access to care as a priority, to direct funding to care, and put the public interest in improving health care for all at the centre of policy.

Recommendations to Rebuild and Improve Public Health Care in Ontario

Stop the cuts and rebuild capacity in our local public hospitals

- **Hospital funding must be set at a rate that will protect service levels and stop cuts.**

To do this, the best evidence shows that Ontarians need a 5.3 percent hospital funding increase per year for the next four years: approx. 2.3 percent inflation; 1 percent population growth; 1 percent aging; 1 percent increased utilization. This is not an outlandish recommendation. Ontario currently funds its hospitals at the lowest rate in Canada. There is considerable distance to go even to meet the average of the rest of the provinces. Furthermore, there is precedent for significant reinvestment. In the late 1990s to the early 2000s when the Harris/Eves government began to restore funding after the deep cuts of the mid-late 1990s, hospital funding increases varied dramatically, running to 12.8 per cent per year, as needed, to address the crisis that had emerged.

- **A capacity plan must be developed and implemented, based on evidence of actual population need, to reopen closed hospital wards and floors, reopen closed Operating Rooms and restore needed services that have been cut.**

The new Brampton Civic Hospital was opened just ten years ago. In a growing community it should have extra capacity to last for a generation. But last fall, hospital documents revealed that in the most recent year measured, more than 4,300 patients stayed on stretchers in hospital corridors for significant lengths of time, often waiting 40 – 70 hours for a bed, as the hospital grappled with “Code Gridlock” for 65 days.

Health Coalition advocates, concerned about reports that the London hospitals were operating at alarming rates of overcrowding in September, asked their local MPPs to look into the issue. The numbers revealed are unheard of among developed nations. Starting in May 2017, the psychiatric unit has been running at between 130 and 165 percent occupancy, with the latest numbers showing 151 percent. The medicine beds for acute care patients have been at more than 100 percent occupancy for the majority of the time, with levels as high as 115 percent. Surgical beds have also been running at very high rates of occupancy.

These examples are just the tip of the iceberg. Hospitals in every medium-to-large sized town in Ontario report that they are full, often operating at dangerous levels of overcrowding amounting to 100 percent capacity (every single bed full) or even higher. In towns all across Ontario patients are treated in sunrooms, broom closets and on stretchers in hallways, sometimes for days, waiting for a hospital bed to open up. Local ambulance services report that the number of days in which they are operating at Code Zero – that is there are no ambulances available because all are held up at overcrowded emergency rooms waiting to offload patients – have reached record levels.

Yet there is an almost-total consensus among governments and health policy leaders internationally that levels of crowding exceeding 85 percent capacity lead to bottlenecks and blocked emergency departments, cause dangerous ambulance offload delays, increase incidence of hospital-acquired infections, worsen violence rates, and are unsafe. It is also irrefutable that overcrowded emergency departments lead to higher rates of patient mortality. A capacity plan to reopen closed wards and operating rooms must be urgently developed to restore public hospital capacity to safe levels.

- **Closed and privatized outpatient services must be reopened and restored in our local public hospitals to meet population need, including but not limited to outpatient physiotherapy, labs, day clinics and others.**

In 2013, the Scarborough Hospital closed its outpatient rheumatology (arthritis) clinic as a result of a $17 million budget deficit and in so doing cut services for 2,000 patient visits per year. At the same time, the Ottawa Hospital had a $31 million budget shortfall. To offset its deficit, the Riverside endoscopy unit was closed and 1,600 cataract surgeries per year were chopped. As a result thousands of procedures were cut and privatized; this occurring even after revelations of serious quality and sterilization breaches in the private clinics. After the hospital clinic closures, a local investigative media report revealed patients being charged user fees to patients unlawfully in area private clinics. The year prior, Northumberland Hills Hospital closed its outpatient diabetes clinic that provided vital preventative care and support to more than a thousand patients per year.

All across Ontario, these experiences have been replicated. As outpatient physiotherapy has been systematically closed, patients have been forced to pay hundreds of dollars per week for needed rehabilitation. Stroke and accident victims are now often compelled to drive to another town to access services. As outpatient labs have been similarly closed and privatized, patients complain that the private companies have reduced local lab operating hours and centralized testing sites, lengthening waits for results, forcing patients to travel further and reducing quality.

The evidence, from two decades of these experiments with privatization is that care has become fragmented and is often moved further away; costs for patients and governments has escalated; and quality protections for patients are far fewer. Integration of inpatient clinical services with outpatient care is helpful for clinicians seeking diagnostics, consultations with health professionals and on-site referrals, and for patients trying to navigate and often complex health system. Indeed, access to care has become a serious problem as privatization has expanded. For decades, municipal public transit systems and non-profit supportive agencies have located to facilitate ease of access to local hospital clinics. There are often no public transportation options for patients who now have to find their way to centralized private services. The evidence shows that privatization has neither served the public interest in accessible quality care, nor is it less expensive. It is time to restore and rebuild integrated outpatient services that operate in the public interest.

- **Patients must be protected from extra-billing and user-fees in private clinics. Canada's and Ontario's Medicare laws must be protected, strengthened and upheld.**

As public hospitals have cut and shed services, a new industry of private for-profit clinics has emerged. In three separate studies over 10-years the Ontario Health Coalition has called all of the private clinics we could find in Ontario, including boutique physician clinics, MRI/CT clinics, colonoscopy and endoscopy clinics and cataract surgery clinics. We found that the majority of the clinics are billing OHIP and charging patients extra user fees on top, amounting to hundreds or even thousands of dollars. Sometimes fees are charged for medically-needed care and sometimes for add-ons and services that are upsold to patients by clinic operators. We also surveyed 250 patients who had been charged for services and found that many reported manipulative pressure tactics used to compel them to pay extra user fees for things such as extra eye measurement tests without patients being informed that such extras are medically unnecessary. Patients, many of them elderly and on fixed incomes, reported that they suffered financial hardship as a result of the user fees; going without groceries, forgoing other bills and borrowing money to pay medical costs.

Medically needed hospital and physician care are covered under public health care and paid through our taxes to protect against financial hardship when patients are in need. These practices by private clinic operators are unlawful in many cases, and in all cases violate the spirit and intent of our medicare laws. The government must roll services back into public hospitals that have better quality regimes and operate in the public interest. Extra-billing and user fees by private clinic operators must be stopped and patients must be protected against manipulative tactics used to enhance profits at human expense.

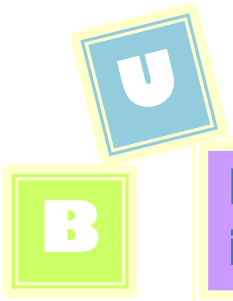
- **An immediate moratorium must be declared to stop the closures of local hospitals, consolidation of local services and the mega-mergers of our local public hospitals.**

Already Ontario's hospital cuts and consolidation have been more extreme than anywhere else in Canada. Ontario underwent the largest-scale hospital amalgamation and closures in Canada's history in the 1990s. Billed initially as a plan to achieve administrative savings, the reality has been quite the opposite. In the ensuing years, smaller sites of amalgamated hospitals have seen their local democracy eradicated and their services gutted, and at huge cost. In fact, the price has been tallied by Ontario's Auditor General. From 1995-1997 $800 million was cut from hospital budgets. But the costs of amalgamations, closures and movement of services were far greater. In 1999 and 2001, the annual reports of the Ontario Auditor General revealed that costs had escalated to $3.9 billion (up from the projected $2.1 billion) an increase of $1.8 billion over expectations. Billions of dollars were spent cutting beds, forcing mergers, closing hospitals and laying off staff, after which hundreds of millions were spent re-opening needed beds and recruiting staff to restore stability. The high costs of restructuring and merging were never recouped.

The body of evidence regarding the costs and quality-of-care consequences for mergers is substantial and stretches across two-and-a-half decades. The Canadian Health Services Research Foundation published a 2002 essay that took issue with the myth that "bigger is better". They found that during the 1990s the number of Canadian hospitals declined from 1,231 to 929 – a drop of 25 per cent, largely due to mergers. The CHSRF said evidence on cost savings from mergers is largely anecdotal and inconclusive, finding that a number of mergers increased the cost of management and administration. They reported that larger hospital mergers tend to be less responsive to the patient, disadvantage low income patients, do not necessarily improve recruitment and retention and often lead to issues around staff morale and trust. The essay concluded that "the urge to merge is an astounding, run-away phenomenon given the weak research base to support it, and those who champion mergers should be called upon to prove their case." These findings are supported by recent studies, both international and Canadian.

Despite the evidence and without regard for massive community opposition, the closures and consolidations are still happening. In 2016, the hospital for Ajax-Pickering, a hospital that serves more than 150,000 people, was amalgamated with Lakeridge Health in a double merger that by the hospital's own documents was slated to cost $47.8 million. The Ajax-Pickering/Lakeridge merger, according to the hospital documents, would take more than 62 years to pay off, threatening further consolidation and local closures of care services. Currently, a proposal has been floated to close one or both of the remaining hospitals in Muskoka and merge them onto one site. This comes after the Burk's Falls hospital was already shuttered in recent years. Another planned merger between Lindsay and Peterborough has just been made public. In Windsor the proposal is to close virtually all hospital services in the downtown area and move services ranging from emergency to acute and chronic care out to one hospital site past the airport, a $70 round-trip taxi ride from the poorest neighbourhoods of the city.

These mergers and amalgamations are not in the public interest. They are extremely expensive, taking vital resources away from care, and they lead to the centralization of services further away for many residents.



Build capacity and improve levels of care in long-term care

- **Levels of care in Ontario's long-term care homes must be improved by instituting a minimum care standard of 4-hours of daily hands-on direct nursing and personal support per resident to provide care and protect from harm.**

  With an aging population, escalating care needs, offloading of more complex hospital patients and increasing incidence of dementia, the need for safe and appropriate care in Ontario is growing; yet there is no current plan to meet these requirements. Today, the vast majority (84%) of those admitted to long-term care homes are assessed as having high and very high needs. Those who require residential long-term care, but whose needs are not ranked at the highest levels are simply not getting in. While every day tremendous compassion is demonstrated in long-term care homes across our province, as the long-term care sector takes on more and more complex patients, serious problems have emerged, including: systemic inadequacy of care levels; homes working short-staffed; insufficient training and support to provide care for those with behavioural issues, and; unacceptable levels of fatal violence.

  Care relationships in long-term care are central to treating long-term care residents, staff and families with dignity and respect. This means understanding that the conditions of work in long-term care homes are also the conditions of care. It means recognizing that Ontario's overburdened long-term care system is not meeting the current needs of residents, their families, and staff and needs to be properly resourced and organized to do so.

  Improving care means adequate staff and an appropriate staff mix, providing enough time to care for and support residents, providing a stable work environment that encourages staff retention and care relationships, providing the training and education support needed to meet the needs of the increasing complexity of long-term care residents, and providing specialized behavioural supports in long-term care homes.

  Daily hands-on care staffing levels should be set at an average of at least 4 hours of care per resident per day to promote health and protect from harm. This staffing standard should apply to direct daily hands-on care hours provided by RN, RPN and PSW/Aides and should not include Administrators, Directors of Care, Nurse Practitioners and others, and it must be measurable and enforceable.

- **A plan must be developed and implemented to build capacity to meet the need for long-term care beds now, not a decade down the road, and this capacity should be built in public and non-profit homes that are operated for the public good.**

  Ontario's long-term care homes have the longest wait-lists in the country, high levels of occupancy, and increasing levels of acuity or complexity among residents. According to Ontario government data, wait lists now number more than 34,000. Ontario's current plan to build 30,000 long-term care spaces over the next 10 years, including 5,000 in the next 4 years, is inadequate and leaves tens of thousands of people without the care they need. The evidence shows that non-profit and public long-term care homes provide higher staffing levels, better resident care outcomes, and are preferred by Ontarians. Ontario needs at least 30,000 long-term care beds which should be built in public and non-profit long-term care homes that are preferred by Ontarians and operate in the public interest.

Integrate Home Care into a public non-profit service, establish a clear right to access care, eliminate redundancies and move funding to front-line care

- **A clear right to access care in home care must be established and upheld.**

  When patients are moved out of hospital, they are moved out from under the Canada Health Act which requires that care be provided without extra user fees for patients with medical need. Public Medicare was established when hospitals cared for the ill and homecare for the frail. This has changed dramatically over the last thirty years, with much more clinical care provided at home as well as a growing number of frail elderly and the disabled requiring support at home. At the same time, governments have failed to create and enforce clear standards for accessible home care as patients are moved to the community. In effect, the continual failure to establish a clear right to access medically necessary home care amounts to an erosion in the scope of our public health coverage.

  For decades Ontario governments have focused attention and PR activities on increasing funding for home care. However, the steep hospital cuts and severe rationing in long-term care have swelled home care rolls dramatically. In truth, funding has barely kept up (and at times it has not kept up) with the increase in need for care. At the same time, care needs of home care clients are more complex as patients with greater clinical needs are offloaded from hospitals and long-term care wait lists.

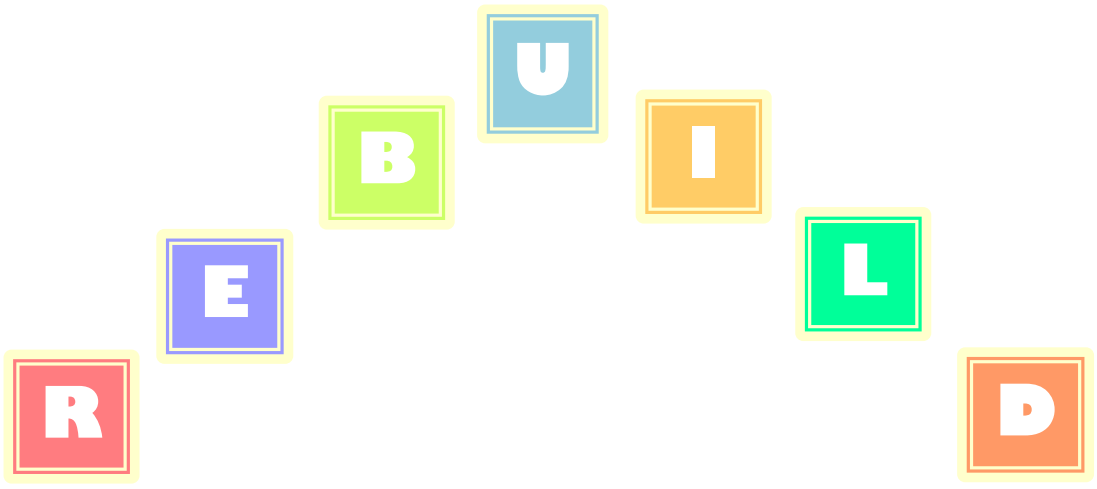
  Home care funding per client has improved slightly (according to Ontario's Auditor General's office it was $3,486 per client in 2002/03; dropped to $3,003 in 2008/08, and has increased to $3,504 in 2015). In the most recent report by the Auditor General, wait lists for personal support and therapies still number up to 2,000 in different health regions, with significant inequities in access to care. In a number of health regions, patients with assessed needs that are moderate or less do not even make it onto wait lists and have no ability to access needed care. To restore and rebuild an effective and compassionate continuum of care, Ontario needs clear standards that are upheld to ensure access to home care for those in need.

- **An integrated public non-profit home care system must be created and administrative savings should be redirected to improving care.**

  Ontario's home care system is rife with duplication and excess administration. Approximately 160 provider companies are contracted through more than a thousand varied contracts with differing billing rates. The administrative requirements are enormous and, despite this, successive Auditors' reports over a decade-and-a-half repeatedly note that contracts are not well monitored even for such basics as whether or not the contracted care visit ever happened. For clients in home care, missed visits mean missed care, leaving patients stranded in bed, without their most fundamental needs met. Yet managing Ontario's overly complex home care system redirects

hundreds of millions of dollars that do not go to care, but rather to profit mark-ups, redundant offices and administrations, billing systems, redundant scheduling systems and so on.

Ontario has the most privatized home care system in Canada. To reduce the fragmentation and inefficiency of home care, the next Ontario government should reform home care to create a public non-profit home care system, based on the same principles of equity and compassion that underlie the Canada Health Act with clear standards for access to care. Such a system would clear out significant administration and redundancies that do not add value or improve care levels and move public funding to the front-lines and vital care coordination services that matter most to the quality of life and care of home care patients.

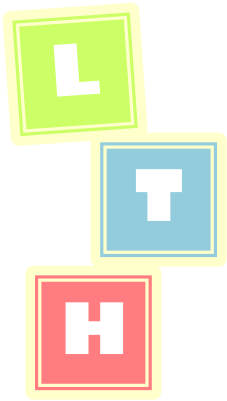


Support and expand public, community governed comprehensive primary health care

- **Funding and access to public non-profit primary care must be improved and corporate-owned and private clinics should be stopped.**

  Primary health care is the front door of medicine and access to comprehensive primary health care through community governed comprehensive primary care teams, such as Community Health Centres, Aboriginal Health Access Centres and Nurse-led Clinics, can help bridge inequities in access to needed care. But 1 in 5 Ontarians still face barriers to accessing nearby primary health care. Indigenous peoples, racialized groups, people with disabilities and mental health challenges, recent immigrants and refugees, people who are LGBTQ, and people living in rural and remote areas face the biggest barriers to health care. Community Health Centres use team-based approaches to provide comprehensive preventative and health care and the evidence shows that they serve a higher proportion of people with social and economic complexities that create barriers to accessing care.

  For many years, advocates have pushed for primary care reform, including the full range of health professionals (from physiotherapists and social workers to nurse practitioners and others) in the health care team; public and non-profit governance; and a move away from fee-for-service payment. The Ontario Health Coalition supports the expansion and support of public community primary care models such as Community and Aboriginal Health Centres.



Build new hospitals using public financing and improved public oversight; Stop P3 privatization and use the savings to enhance public capacity and access to care based on population need.

- **New hospitals must be financed using public borrowing rather than exorbitantly expensive P3 privatization, with sound management and public oversight. The substantial savings generated from this can be used to rebuild public capacity and improve access to care.**

  In the last two decades, Ontario has built our new hospitals using a privatized “P3” private-public partnership model. In these schemes, private multinational consortia fund and build our hospitals. The costs are much higher than if our hospitals were publicly funded, and P3 hospitals are often located on greenfield sites far from local town transportation systems. In fact, Ontario’s Auditor General reports that $8 billion could have been saved if our hospitals and other public infrastructure projects were built using traditional public finance and sound management. Today, P3 hospitals are so expensive that 2 or 3 or more existing community hospitals are closed down to build one new one, too small to meet the needs of local communities for the next generation. Billions have been taken away for care and local access as a result. Infrastructure Ontario should be reformed to be governed by public interest experts and focus on sound management and public oversight of a publicly-financed infrastructure program.

Rebuild accountable democratic governance structures and improve responsiveness to patients and communities

- **Our public hospitals and health services must be governed democratically in the public interest by Board of Directors that reflect the diversity of our communities.**

Undemocratic boards have neither improved quality of care nor planning. Too often, they can be controlled by CEOs without proper accountability and public oversight. Both hospital and Local Health Integration Network Boards of Directors should be elected, publicly accountable and should be required to reflect the diversities of our communities. New long-term care capacity should be built in public and non-profit long-term care homes, operated democratically in the public interest.

- **Services must be transparent, accountable and responsive to patients and communities. Staff should be protected when they advocate for quality and access issues in the public interest.**

Public health care services are just that – public. They are funded by the public and rely on public funding. They should be operated in transparent and accountably ways. Health care staff who whistleblow must be protected from retribution. Gag orders have no place in contracts for public services, such as our local public hospitals. Patients should have access to quality of care information and their own records. Independent patient advocates should be re-established and empowered to help patients obtain meaningful responses to complaints and improve access to care. Planning for health care must be responsive to community values and needs.

Take concrete steps to build public confidence and move funding more directly to care

- **Take concrete steps to move public funding away from activities that do not add value and are not improving care.**

Each round of health care restructuring has entailed systems to administer the cuts. This has led to the emergence of an entire class of technocrats and consultants, administrators, public relations experts and the like to manage the endless "system change", cuts, pricing, and measurements. Too often, to facilitate decisions regarding cuts that have already been made, consulting firms are commissioned to write redundant reports and provide "expert" testimony, or to form public relations messages to sell service cuts to communities, alienating and angering the public. Moving funding to care in our view does not mean adopting processes from manufacturing, such as Lean, which has been tried over two decades, has run its course and is widely criticized by front-line workers as a cover for cuts . It means curtailing unnecessary and unhelpful administrative activities, market mechanisms and excessive and redundant systems used to justify cuts and manage public reaction.

- **Curtail exorbitant executive salaries and the use of PR firms, unnecessary advertising and consultants.**

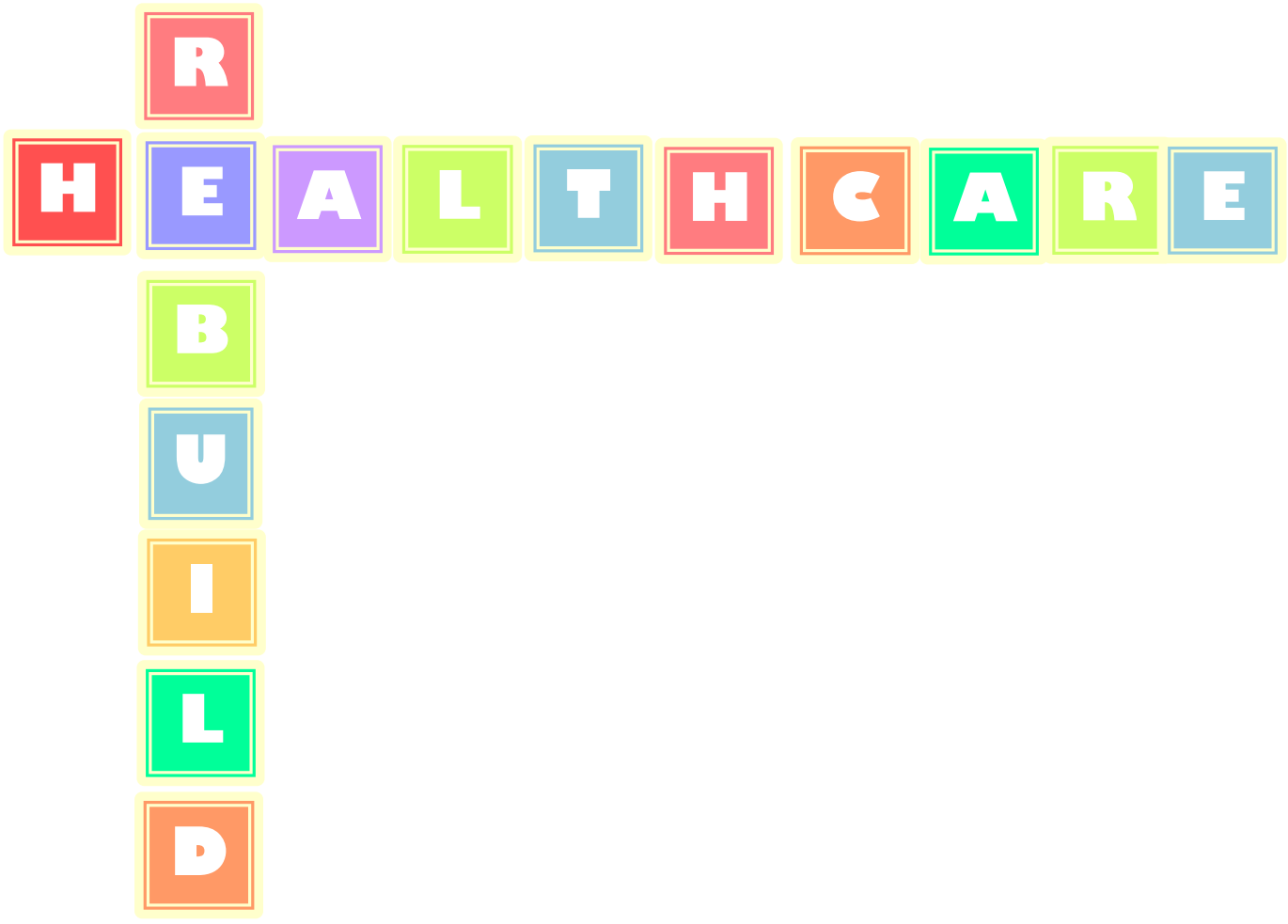
A hospital cannot run without the cleaners, food preparation, patient records and transcription, porters, maintenance, nursing care, diagnostic testing, rehabilitation, and clinical care. But these services have been routinely cut while CEO salaries have risen, and the use of contracted consultants and the number of administrators have increased. The public is angry and alienated by these decisions and wants care to be the priority-- including the vital support services that ensure our hospitals are clean, the quality of life in them is of a high standard, and patient care is safe. While the savings that would accrue from curtailing these costs has been oversold and is not sufficient to provide needed funding, taking concrete measures to move funding to care and patient support are nonetheless important to build public confidence and conform to our communities' values and priorities.

- **Cease the practices of shadow-billing and price-based procedures in hospital clinical care.**

Such practices take time away from vital patient care to administration that does not improve access or quality of care. These practices are criticized by clinicians and patient advocates as arbitrary paper-based exercises that take a great deal of time without adding value. In fact, clinicians routinely report that they do not fit the unique needs of patients and the unique requirements of public hospital care, redirect resources away from care and remove services from local communities. Local hospitals are not, in the public's view, in competition for a "market" of "customers", but are vital public services that should provide needed care for their communities. Funding should be based on assessed community need, not price competition and market mechanisms.

- **Amend legislation to ensure that contracts with private companies that are receiving government funding are open for public scrutiny.**

Today, virtually all contracts in the health care system with private companies are made in secrecy, shielded from public scrutiny by commercial clauses in legislation. This is not in the public interest. It facilitates corruption and overly expensive contracts, and hides information about the use of public monies from the public that pays for the contracts.



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