Submission to the Standing Committee on Finance & Economic Affairs
Ontario Pre-Budget Hearings

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Ontario Health Coalition
Protecting public healthcare for all.

Mission and Mandate

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

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

Who We Are

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

Introduction:

After almost four decades of public hospital downsizing and restructuring, broken only by a brief respite (2000-2005), after longstanding rationing of long-term care even while our population is growing and aging, the pressing need to restore care cannot be ignored. 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; when current wait lists for long-term care far exceed the number of beds planned to be built over the next 10-years – 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 Ontario government must turn the corner on hospital cuts and rationing of long-term care and act urgently to rebuild services. It must develop a fiscal plan that is realistic and thoughtful, including a revenue plan, to provide for the services that are needed. 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 (not private for-profit interests) and the goal of improving health care for all at the centre of policy.

Priority Recommendations:

1. Health Care Funding must be improved and proper capacity planning restored to provide services based on need and stop rationing, cuts and downsizing.

- **Health care funding must be set at a rate that will improve public health care service levels and stop cuts.**

The evidence is clear that Ontarians are suffering from poor access to care, and in particular, access to hospital care and long-term care. The Ontario Health Coalition hears from tens of thousands of Ontarians each year about their experiences with health care. We are witnessing the same trend that other patient advocacy organizations report. The most common complaint we receive is from family members of patients who are unable to be admitted to hospitals and long-term care homes or are being pushed out of hospitals without anywhere appropriate to go.
Patients who are being pushed into discharge without anywhere to go:

Hospital and political leaders have characterized many of these patients as "ALC" or Alternate Level of Care and repeatedly claim that they ought not to be in hospital. However, assessments are subjective

and are trend-driven. The acuity of patients being pushed out of hospitals today is much higher than it was a decade ago and that was much higher than it was a decade prior. Coercive tactics to force patients to move to places that are not appropriate are common. Increasingly, the use of private for-profit unregulated retirement homes, which are not health care facilities, and other unregulated entities, often at high cost to the patient, is being used to move out patients to clear beds. "ALC" has taken the place of the term "bed blocker" but patients continue to be treated as though they are in the way and unwanted.

Patients who cannot get access to care:

We hear repeatedly from patients and families who have gone to emergency only to be sent home repeatedly, even as their health fails. In some cases, people have died. Others who contact us have waited interminable time on stretchers in hallways, sunrooms, bathrooms, closets and places that have been termed by the media as "unconventional". In truth they are beyond unconventional: they are unacceptable and shameful. We also hear repeatedly from patients who cannot get appointments for surgeries or needed treatments or who are waiting in pain or other suffering for care. We hear from many patients whose surgeries are cancelled at the last minute, leaving them to wait again for needed care.

This is inhumane. Capacity across the continuum of hospital and inpatient care -- in complex continuing care, rehabilitation, acute care, operating rooms, emergency care, palliative care, convalescent care, diagnostic testing and others -- needs to be rebuilt to meet population need for care.

Promise broken:

The current government promised to end "hallway medicine" and improve access to long-term care. Yet the fiscal policy of the government is completely at odds with these commitments. Today, wait lists for long-term care in Ontario number over 36,200 (Source: Ministry of Health, July 2019). Ontario has the second fewest long-term care beds of any province. Ontario has the fewest hospital beds, extraordinarily long wait times for an array of hospital care, increasing readmission rates, the least amount of nursing care per patient, the shortest hospital stays meaning patients are moved out sicker and quicker than anywhere in the country.

Fiscal policy and a failure to plan for population need are central factors in these bottom-tier rankings. The data is irrefutable. By our governments' own figures, Ontario ranks at the bottom of Canada in public health funding. Chart I below shows public health spending per person in each province. Ontario ranks second last. We are $728 per person below the average of the rest of Canada. Per capita spending measures comparable resources put into health care by our provincial governments. Spending as a proportion of our provincial GDP (economic output) measures economic sustainability. Chart II shows public health care funding in Ontario as a proportion of provincial GDP compared to other provinces. We have a long way to go before our health care spending could be considered to be unsustainable. We are second last in Canada by this measure and far below the average of the other provinces.

This data underlines the fact that this fiscal policy is a choice, not a necessity. Virtually all other provinces fund their health care at a significantly higher rate than does Ontario.

Chart I.

Public Sector Health Funding Per Capita 2017	
Newfoundland & Labrador	$6,018.93
Saskatchewan	$5,535.74
Manitoba	$5,434.79
Alberta	$5,428.19
Prince Edward Island	$5,052.36
Nova Scotia	$5,043.89
New Brunswick	$4,805.27
Quebec	$4,547.07
Ontario	$4,409.85
British Columbia	$4,373.16
Average of other provinces	$5,137.71

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2019*

Chart 2.

Public Sector Health Expenditure as a % of Provincial GDP 2017	
Prince Edward Island	11.44%
Nova Scotia	11.23%
Manitoba	10.22%
New Brunswick	10.21%
Newfoundland & Labrador	9.62%
Quebec	9.04%
Saskatchewan	8.01%
British Columbia	7.63%
Ontario	7.51%
Alberta	6.94%
Average of other provinces	9.37%

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2019*

2. Stop devastating hospital cuts & rebuild capacity in our public hospitals to meet Ontarians' needs

- **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.**

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.

Hospital global funding increases were set below the rate of inflation from 2006 – 2016 and were frozen from 2012/13 to 2016/17. In 2018/19 global funding again was set below the rate of inflation. Global hospital budgets have been cut in real dollar terms (inflation-adjusted dollars) for more than a decade with only two years of slight recovery around the last election. By virtually every measure, Ontario now ranks at the bottom of comparable jurisdictions in hospital care and capacity levels.

As a result, hospitals large and small in every geographic region of Ontario have cut services, closed operating rooms, reduced bed and staff numbers, even while wait lists and wait times for services have increased significantly. Hospitals are now at dangerous levels of overcrowding, staffing levels have dropped precipitously, and patients are suffering as they are forced to wait longer and drive further to access care and are discharged before they are stable.

“Ending Hallway Medicine” The Facts About Ontario’s Hospital Overload

Warnings about hospital overcrowding have been repeatedly provided to Ontario’s government. The following backgrounder contains recent reports and warnings about the problem from Ontario’s Auditor General, Health Quality Ontario, and the Canadian Association of Emergency Physicians. It also contains data from the Canadian Institute for Health Information comparing hospital bed capacity across Canada and the OECD, comparative hospital nurse staffing levels and public hospital funding. The evidence is irrefutable. Ontario has cut more hospital beds and staff than any virtually all peer jurisdictions. Ontario has dropped to the bottom of the country in public hospital funding. The resulting hospital bed shortage and serious overcrowding situation compromises patient and staff safety. Ontario’s government must urgently reopen hospital beds and restore capacity to safe levels.

The Coalition called on the Ontario government to take responsibility for planning for hospital services in our province, as is required under the Canada Health Act, including:

- Recognize that the emergency department crisis reported by hospital executives is a symptom of a systemic shortage of hospital beds that must be urgently rectified.
- Fund public hospitals to meet evidence-based measures of population need and ensuring that the funding goes to care.
- Reduce Ontario’s hospital overcrowding to meet the 85% occupancy benchmark that is the internationally-accepted indicator for the safe level of crowding.
- Commit to ensuring that no patient will be left on a stretcher in a hallway or public area overnight or for days waiting for a hospital bed.

Myth-buster:

- Government and hospital spokespeople routinely mischaracterize Alternate Level of Care (ALC) patients as the cause of hospital backlogs. In fact, according to the Ontario Hospital Association’s June 30, 2016 update, approx. 2,700 of ALC patients are in acute care beds. Of these patients, one-third are waiting to be transferred to another type of hospital bed (palliative, complex continuing care, convalescent care, mental health, rehabilitation); one-third are waiting for a long-term care bed; ten percent are unknown; and the rest are waiting to be discharged to various types of home or community care. To characterize ALC patients as though they are inappropriately in hospital is erroneous. This information is being mischaracterized to cover up the shortage of hospital beds. (The OHA’s ALC survey results for June 30, 2016 are here: https://www.oha.com/CurrentIssues/Issues/HSFR/Documents/ALC%20Update%20June%202016.pdf)

- Misuse of emergency departments by patients is not the cause of hospital overcrowding. People who are frightened and sick should be able to go to their local hospital for help. Patients lying on stretchers waiting for admission to hospital beds are, without question, acutely ill and are not malingering. Patients that are not acutely ill are not admitted to hospitals. (See myth buster from the Canadian Institute for Health Research: http://www.cfhi-fcass.ca/sf-docs/default-source/mythbusters/Myth-Emergency-Rm-Overcrowding-EN.pdf?sfvrsn=0)

Findings of Ontario's Auditor General

Ontario's Auditor General describes the situation in Ontario's large community hospitals in her most recent report, released on November 30, 2016. Her findings support the evidence that the Ontario Health Coalition has brought to the government repeatedly in recent years. Among the Auditor General's findings:

(Page references for the 2016 Ontario Auditor General's Report are included here.)

- The audit team describes a state of severe overcrowding in the hospitals they visited. Patients are waiting on stretchers or gurneys in hallways and other public areas, sometimes for days (page 446).
- Bed occupancy rates of greater than 85 per cent are unsafe and contribute to infections (beds are too crowded and turn over is too fast). During 2015, 60 per cent of all medicine wards in Ontario's large community hospitals have occupancy rates of greater than 85 per cent (page 431).
- The Canadian Institute for Health Information reports that Ontario hospital patients have the 2nd highest rate of potentially fatal sepsis infections in Canada (page 431).

The Auditor General describes the consequences of chronic underfunding and the failure to plan to meet population need for care:

- 1 in 10 patients requiring admission to hospital are waiting too long in emergency departments. The provincial government's target is 8 hours from triage (90 per cent of patients are supposed to be transferred to a bed withing 8 hours). But in the hospitals the audit team visited it took 23 hours for 90 per cent of the patients to be transferred to the ICU and 37 hours for transfers to other acute care wards (page 429).
- The audit team described a situation across Ontario's large community hospitals in which there are frequent and planned operating room closures. 45 per cent of large hospitals have one or more O/R closed due to funding constraints (page 450).
- There has been no improvement in wait lists for elective surgeries for the 5 years leading into this audit (pages 430-431).
- 58 per cent of hospitals ran out of money for some types of surgeries and had to defer them to the next fiscal year (page 444).
- Patients with traumatic brain injury and acute appendicitis are waiting 20 hours or more for emergency surgery (page 430).
- Wait time targets are not being met for the following types of surgeries: neurosurgery, oral and dental, thoracic, vascular, orthopedic, gynecologic, ophthalmic, cancer (page 451).

Warning from the Ontario Health Quality Council

Even Health Quality Ontario, though it studiously continues to refuse to mention Ontario's shortage of hospital beds, regardless of the evidence, included a warning about how close the system is to critical in its November 2016 report on emergency departments:

> "Patients are already lying in hallways and being seen by doctors in waiting rooms. Under current conditions, the ability of Ontario's emergency departments to care properly for patients could be seriously compromised by an occurrence as predictable as a bad flu season or as unpredictable as a SARS outbreak or a major weather event." page 3.

Position Paper from the Canadian Association of Emergency Physicians

The Canadian Association of Emergency Physicians has repeatedly warned about dangerous levels of emergency department overcrowding. Among the key causes they cite is the Canada-wide shortage of hospital beds, a situation that is more severe in Ontario than other provinces. Here is a description of the situation from their position paper on emergency department overcrowding:

> "With the shortage of hospital beds and recurring issues with acute care capacity, hospitals increasingly face a situation where more patients require admission than there are beds to accommodate them. The current approach to dealing with Access Block due to hospital crowding involves delaying the outflow of admitted patients into appropriate inpatient areas; resulting in an excessive and unsafe use of EDs to inappropriately ''warehouse'' admitted patients, both stable and unstable, for long periods of time. This ''boarding'' of admitted patients within the ED results in EDOC and thus creates delays in seeing new patients presenting to the ED. Surveys have shown that patients attempt multiple other options prior to accessing the ED. Moreover, patients of lower acuity and urgency do not occupy acute care stretchers, require little nursing care, and typically have brief treatment times. The myth of ''inappropriate use'' should be permanently dispelled, and administrators and politicians should be encouraged to avoid attributing EDOC to ambulatory patient ED health services access…. The lack of acute care beds in Canada means that most hospitals frequently operate at unsustainable occupancy rates of higher than 95%, a level at which regular bed shortages, periodic bed crises, and hospital overcrowding are inevitable. Functioning at capacities above 95% occupancy does not allow for flexibility in the system to accommodate the natural peaks in patient volumes and admissions that will periodically occur."
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> Affleck et al., CMAJ 2013, Pages 362-363.

By the Numbers: Comparative Data Shows Ontario Ranks at the Bottom in Key Indicators of Hospital Care Levels

The evidence is indisputable that Ontario's government has cut hospital care to the lowest levels of all provinces in Canada. As illustrated in Chart 3, Ontario has the fewest hospital beds left per capita of any province, and that number is declining. In 2008-09, Ontario had 2.5 hospital beds per 1000 population, according to Canadian Institute for Health Information (CIHI) data. Today that number has dropped to 2.2 hospital beds per 1000 population. The other provinces average 3.2 hospital beds per 1000 people. The difference of 1 bed per 1000 people is vast. On an aggregate per capita basis Ontario now has 14,320 less hospital beds than the average. In fact, Ontario's government has cut more than 18,000 hospital beds since 1990, and yet, still this year, needed hospital beds are being cut and closed.

Chart 3.

Hospital Beds Per 1000 (population) By Province 2017-18	
Newfoundland & Labrador	4.5
New Brunswick	3.7
Manitoba	3.3
Nova Scotia	3.3
Prince Edward Island	3.3
Saskatchewan	2.7
Alberta	2.7
British Columbia	2.5
Ontario	2.2
Average other provinces	3.2

Ontario Health Coalition calculations from: Canadian Institute for Health Information, *Data Table: Hospital Beds Staffed and in Operation 2017-18*. Population statistics from Canadian Institute for Health Information, *National Health Expenditures Database 2019*.

Not only has Ontario cut more hospital beds than any other province in Canada, we also now rank at the bottom of international data on hospital beds per population. Compared to 35 other countries of the OECD, Ontario is third last in hospital beds per capita, followed only by Mexico and Chile. (See Chart 4.)

Chart 4.

OECD Hospital Beds Per 1000 Population 2017	
Japan	13.1
Korea	12.3
Germany	8.0
Austria	7.4
Hungary	7.0
Czech Republic	6.6
Poland	6.6
Lithuania	6.6
France	6.0
Slovak Republic	5.8
Belgium	5.7
Latvia	5.6
Estonia	4.7
Luxemburg	4.7
Switzerland	4.5
Slovenia	4.5
Greece	4.2
Australia	3.8*
Norway	3.6
Portugal	3.4
Netherlands	3.3
Finland	3.3
Italy	3.2
Iceland	3.1
Israel	3.0
Spain	3.0
Ireland	3.0
Turkey	2.8
United States	2.8*
New Zealand	2.7
Denmark	2.6
United Kingdom	2.5
Canada	2.5
Sweden	2.2
Ontario	2.2**
Chile	2.11
Mexico	1.38
OECD Average	4.7

Source: OECD, *Health Statistics 2017* at https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC
* this data is from 2016, the most recent year available
** Data calculated from CIHI, *Hospital Beds Staffed and in Operation 2017 - 18*

As hospital beds continue to be cut and closed down, nurses, health professionals and support staff have also been cut dramatically. Ontario has dropped to the bottom of the country in nurse to patient ratios. Data from the Canadian Institute for Health Information shows that Ontario now has the least hours of nursing care per hospital patient. Yet nurse staffing levels continue to be cut.

Chart 5.

	Nursing Inpatient Services **Total Worked Hours per Weighted Case**				
	2007-2008	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**
NFLD	52.2	53.26	54.48	55.9	52.9
PEI	83.48	N/R	62.19	62.46	61.66
N. S.	56.79	57.34	U	U	54.95
N.B.	54.98	55.46	56.26	57.29	58.13
Quebec	49.73	50.06	50.82	50.73	52.47
Ontario	**44.98**	**44.76**	**43.71**	**42.81**	**42.88**
Manitoba	54.41	54.27	53.87	53.06	53.97
Saskatchewan	49.37	51.42	51.28	52.95	54.18
Alberta	54.12	54.65	54.52	54.24	54.36
B.C.	44.24	45.27	45.03	45.87	46.27
NWT	U	83.05	88.51	69.48	N/R
Yukon	48.84	48.97	50.25	56.31	54.51
Weighted Average	**48.59**	**48.8**	**48.36**	**48.2**	**48.98**

Source: Canadian Institute for Health Information, 2013.

Across Canada, according to the most recent data we have accessed, patients receive 14.2 per cent more nursing care than do patients in Ontario's hospitals. Chart 5 illustrates the growing gap between Ontario and the rest of Canada in nursing hours per patient (ie. per weighted case). In 2007 – 08 Ontario's nurse staffing hours were 3.61 hours below the average of Canada per weighted case. By 2011-12, Ontario's nurse staffing hours were 6.1 hours below the average of the country. That is a 69 per cent increase in the differential in just four years. As the hospital cuts have continued and escalated since 2011-12, we can expect that gap to be even wider when more recent data becomes available.

A Decade of Real-Dollar Cuts Mean Ontario Has Dropped to the Bottom of the Country in Hospital Funding

The above data gives a statistical overview of some key indicators of hospital service levels in Ontario compared to other jurisdictions in Canada and internationally. The following section measures hospital funding compared to other provinces in Canada. As noted above, Ontario's government has set global hospital operating funding increases below the rate of inflation for 10 of the last 12 years – the longest period of hospital cuts in our province's history. Today, by all measures, Ontario has dropped far below the other provinces in hospital funding.

Measured on a per capita basis, the most recent data from the Canadian Institute for Health Information National Health Expenditures Database shows that Ontario ranks last in hospital funding. We are significantly below the national average. In fact, Ontario's government funds our public hospitals $480 less per person than the average of the other provinces.

Chart 6.

Public Hospital Funding Per Person, 2017 Current $	
Newfoundland & Labrador	$2,406.94
Prince Edward Island	$2,120.01
Nova Scotia	$2,093.86
Alberta	$2,008.35
New Brunswick	$1,953.07
Manitoba	$1,915.96
Saskatchewan	$1,802.32
British Columbia	$1,594.39
Quebec	$1,480.48
Ontario	$1,450.75
Average of the other provinces	$1,930.59
Difference between Ontario and the average of the other provinces	Ontario funds hospitals at $479.84 per person less

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2019*

Hospital spending per person is a clear comparison of how many resources our government is allocating to these services. To measure economic sustainability or affordability, GDP (which measures economic output) is used as the comparator. As measured as a percentage of provincial GDP, the results are the same. Ontario is last in Canada. This measure shows that Ontario has room to improve hospital funding while keeping funding at sustainable levels, as long as funding goes to improving services.

Chart 7.

Public Hospital Funding as % of Provincial GDP 2017	
PEI	4.80 %
Nova Scotia	4.66 %
New Brunswick	4.15 %
Newfoundland & Labrador	3.85 %
Manitoba	3.60 %
Quebec	2.94 %
British Columbia	2.78 %
Saskatchewan	2.61 %
Alberta	2.57 %
Ontario	2.47 %
Average of the other provinces	3.55 %

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2019*

Sustainability can also be measured in terms of expenditure as a proportion of the provincial budget. Ontario funds all of its social programs at the lowest rate in Canada. In Ontario, hospital funding as a share of the provincial budget has been declining for decades. The most recent data show that we are third last among Canadian provinces for hospital spending as a proportion of total program spending (spending on all social programs). The data shows that we are considerably lower than the average of the other provinces and there is significant room to improve hospital funding to stop the cuts and restore service levels to meet population need.

Chart 8.

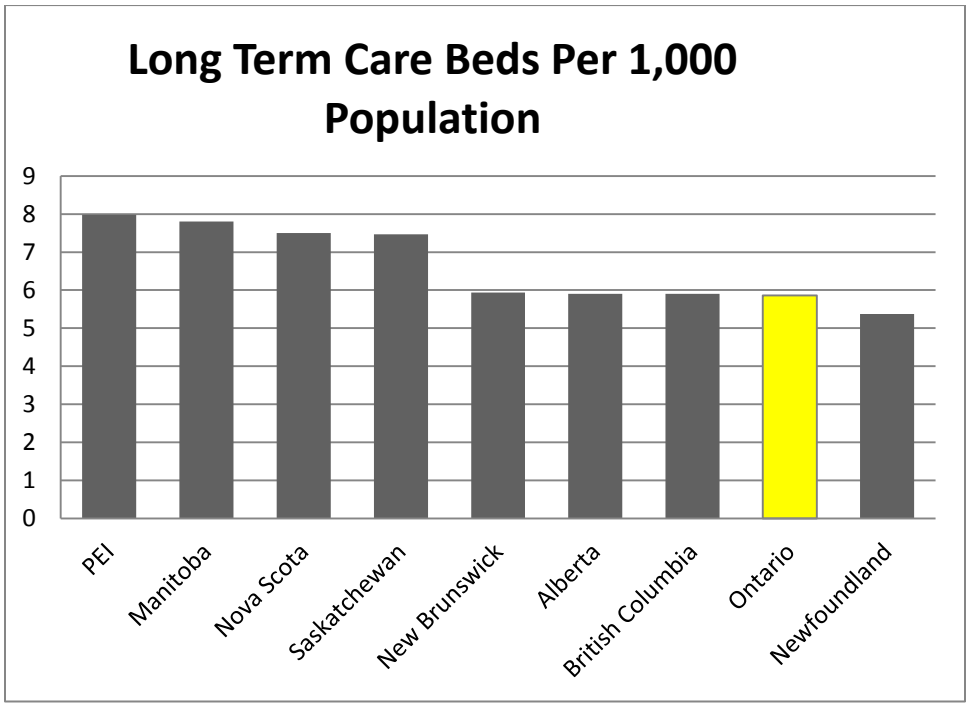
Public Hospital Funding as % of All Provincial Program Funding 2017	
Nova Scotia	16.98%
Prince Edward Island	16.85%
Newfoundland & Labrador	15.48%
Manitoba	15.37%
British Columbia	14.95%
Alberta	14.67%
New Brunswick	14.60%
Ontario	14.00%
Saskatchewan	12.86%
Quebec	12.19%
Average of other provinces	14.88 %

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2019*

3. Improve funding for long-term care homes and require a minimum level of 4-hours of hands on daily care per resident, provide enhanced funding to improve wages and working conditions for PSWs and provide reduced tuition, grants and access to daycare for PSW courses. Create a sound fiscal plan to fund the expansion of long-term care to meet population need.

The current government promised to build 15,000 new long-term care beds over 5-years and 30,000 beds over 10-years during the last election campaign. However, nearly two-years into their mandate, virtually no new beds have been built yet. Still, wait lists for long-term care continue to mount. As of July 2019, the number of Ontarians waiting for long-term care spaces had increased to more than 36,200 according to Ministry of Health data. In its recent report, the Fiscal Accountability Office projected that the 15,000 new beds would not decrease wait lists and that by the time they are on stream there will be 37,000 people waiting for long-term care. Ontario currently has the second fewest long-term care beds per capita of all provinces.

Chart 9.

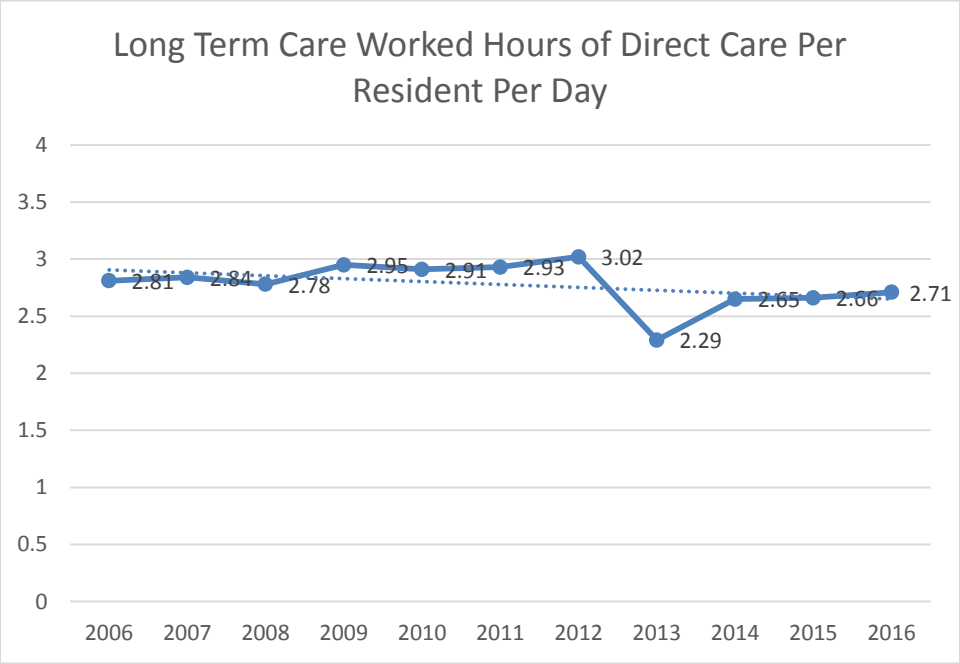


Ontario Health Coalition calculations based on data gathered from provincial websites and Statistics Canada *2016 Population Census data.*

In addition, care levels within existing long-term care homes are not adequate to meet the acuity of the residents. By every measure, the complexity and heaviness of residents' care needs have increased. Yet, according to the government's own staffing data, daily care levels per resident have actually dropped. There have been warning signs for many years that Ontario's long-term care system is failing. There have been numerous individual reports of neglect, and insufficient care, and violence, and homicide; and even, as reported by the Ontario Coroner, aggregations of mounting incidents and homicides that point to serious systemic issues. Injury rates for long-term care staff are, by Ontario government data, the highest of any sector in our economy. Our latest research shows that the poor conditions for PSWs in long-term care have now resulted in a province-wide shortage that is leaving nursing homes with unacceptable staffing shortages virtually every shift every single day. Residents and staff alike are suffering as a result of inadequate funding and too-high acuity for the homes to provide safe care. There is no possible way to staff the new beds in the current context.

Yet funding for daily hands on care in this year's provincial budget was set at less than the rate of inflation, meaning real dollar cuts. Two special funds – the High Wage Transition Fund and the Structural Compliance Fund were threatened with elimination. The elimination of those two funds has been delayed but not stopped entirely. Given the homicides, extraordinary injury rates, staffing shortages and the irrefutable evidence of increased acuity, there is no possible justification for these cuts.

Chart 10.



Ontario Health Coalition's calculation based on Ministry of Health and Long-Term Care Staffing Database: *Ontario Long-Term Care Homes Staffing Data 2009-2016*.

Conclusion

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

Provincial governments are expected to uphold the principles of Public Medicare for all, as enshrined in the Canada Health Act. But when public hospital services are cut, and services are offloaded from public hospitals, services are inequitable, subject to user fees, ad hoc and almost always privatized. Patients are faced with burgeoning user fees and costs that cause hardship, just when people are least able to bear them. As care and costs are privatized, Ontarians are suffering as a result. The evidence shows that ownership matters. Cuts to public hospital services are resulting in for-profit privatization of needed care, and private clinic operators are eroding the first principle of Public Medicare in Canada, that care must be provided equally, based on need not wealth. Cuts to hospitals and rationing of long-term care mean that provincial legislation that provides for access to long-term care is routinely ignored. Decades of work in the public interest to regulate care, improve equity, provide safe access and quality is being discarded as increasing numbers of patients are moved into entirely unregulated, private, costly and unsafe places with inadequate care levels.

The long trend of downsizing and rationing of Ontario's vital health care services must end. Our health care system was founded on principles of equity and compassion. Driven by fiscal policy that has given tax cuts that have overwhelmingly benefitted the highest income earners and corporations, access to health care has been gravely compromised. The same suffering that led to the creation of public health care in the first place has re-emerged. All the data shows that Ontario has fallen to the bottom of the country in virtually every measure of public hospital and long-term care capacity and funding, and that care levels lag far below need. Our province must turn the corner on these failed policies without further delay. It is time to rebuild our public health care, to re-establish sound planning, to build capacity, and to restore compassion.