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

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London Health Coalition

A Proud Chapter of the

Ontario Health Coalition
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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 nonpartisan 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 London Health Coalition is one of more than 400 member organizations comprising 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. 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. 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 endless hospital cuts and rationing of long-term care and act urgently to

rebuild services with a realistic concern for public 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 health care policy.

For over a decade, the Ontario Health Coalition and local health coalitions like London's, have born witness to the devastating effects of real dollar cuts to hospital funding. Year after painful year, the Ontario Health Coalition has documented for the Members of this Standing Committee, Ontario's descent to the bottom of the country on key capacity indicators in our hospitals –

- 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. 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. Ontario's government funds our public hospitals $480 less per person than the average of the other provinces.
- As measured as a percentage of provincial GDP, Ontario, possibly the wealthiest province in Confederation, spends the least on public hospital services
- Ontario has the fewest beds per person left in the country
- Ontario has the fewest nurses per patient in Canada (both RN and RPN)

Today, yet again, we want to bring you up to date on the state of our province's public hospitals and the impact of the government's fiscal (budget) policy on them.

A Humanitarian Crisis is Unfolding in Ontario's Public Hospitals

London is a regional medical hub with 2 teaching hospitals comprising a combined $1.5 billion operating budget. Such a sum of hospital dollars taken on its own, without the benefit of historical context, would seemingly paint a picture of a well-resourced medical centre of excellence. However, it must be understood, that over the past 2 decades of London hospital restructuring, which came with the hefty price tag of $1 billion, the city has lost incalculable health care assets.

Londoners have witnessed the closure of the London Psychiatric Hospital and the loss of a vital Emergency Department and Intensive Care Unit at St. Joseph's Hospital. Losing the ICU and CCU effectively downgraded St. Joseph's Grosvenor campus from serving the community with the most medical beds in the city to that of an ambulatory care centre. Adding insult to injury, since 2012, London Health Sciences Centre and St. Joseph's Health Care have both been forced to make accumulative cuts of almost $200 million, entailing the loss of some 384 health care positions.

Such an enormous shift of health care dollars out of the public hospital system has had unfathomable consequences for hospital stability and the ability to provide access to quality patient care. Over 18,500 public hospital

beds have been closed provincially. Over 2,000 acute care beds have disappeared from service in the City of London since 1990.

Approximately 80 percent of Middlesex-Elgin's psychiatric beds have been permanently shuttered. Mentally ill patients in the community are increasingly forced to wait days for admission while languishing in hallways or empty rooms, or worse, living on the streets. In St. Thomas, where psychiatric patients once received much needed care, Apple TV is preparing to shoot a television series set in a dystopian future on the grounds of the former St. Thomas Psychiatric Hospital. A once vital component of regional health care has been reduced to little more than a movie set.

Although housing approximately 1000 beds, the LHSC is chronically registering over 100 percent patient occupancy. Often "Code Gridlock" emerges, a troubling scenario with more patients than available beds and a situation that is neither acceptable nor safe. Inpatient Daily Metrics and freedom of information requests, reveal staggering occupancy rates. The London Health Sciences Centre's psychiatric unit can run over 165% occupancy. Medicine beds for acute care patients and Surgical beds run at more than 100% occupancy for the majority of the time. By comparison, the OECD reports an average occupancy rate for acute care beds of 75%. Most often cited in the academic literature, a target hospital occupancy rate to reduce access blockages and improve outcomes is 85%.

Like so many other hospitals in the province, London's emergency departments are chronically filled to bursting. This is not because patients are inappropriately accessing care for influenza and other viruses, but rather, due to a systemic shortage of hospital beds. It is not uncommon for patients

seeking treatment at University Hospital's ER to wait 13.1 hours for complex conditions and up to 5.5 hours for minor/uncomplicated conditions. This is well above the provincial norm. The Victoria Hospital site is little better, registering waits of 12 hours for complex conditions and 5.5 hours for relatively minor ones. It has been reported that patients have sometimes waited days at a time before being admitted (reported in the London Free Press, March 31, 2017). Since overcrowded conditions in emergency departments are known to lead to higher rates of patient mortality, it is of the utmost urgency that a capacity plan to reopen closed wards and operating rooms be developed so as to restore public hospital capacity to safe levels.

Code Zero (that is, there are no ambulances available because all are held up at overcrowded emergency rooms waiting to offload patients) and ambulance crew offload delays at LHSC are spiraling upwards, with over 10,800 instances recorded in 2017 (Jonathan Sher, "Paramedics Stranded in Overcrowded ERs Demand Changes", The London Free Press, May 7, 2018).

In a desperate attempt to deal with the severe lack of capacity to meet population need in the system, LHSC officials pioneered hallway medicine protocols, "fit to sit" measures for patients arriving by ambulance and conference room care.

Replacing two defunct City emergency departments are two Urgent Care Centres, one private, the other publicly administered through St. Joseph's Health Care. Neither is able to relieve the pressure on the remaining two ERs.

St. Joseph's Urgent Care Centre is routinely overwhelmed with patients awaiting treatment and cannot afford to remain open to the public beyond

6PM. Since December 2017, Urgent Care physicians have routinely taken to rationing care based upon doctor to patient ratios without regard for acuity. The fewer the doctors on duty, the less patients treated and the earlier the department is closed to the public, sometimes as early as 1PM.

Monday to Friday
If 5 doctors working cap is 160 patients.
If 4 doctors working cap is 150 patients.
Sat Sun holidays
If 4 doctors working 125 is cap
If 3 doctors working 115 is cap.

Other consequences of budgetary shortfalls in London hospitals include:

Budget cuts at London Health Sciences have led to the recent announcement of the departure of a renowned cardiologist to the US, closure and privatization of the Cardiac Functions Fitness Institute, moth balling of 14 burn unit beds, plus loss of another 49 beds in yet to be determined services. Palliative care, mental health, intensive care, oncology, perioperative services and stroke rehabilitation have all been impacted.

Adding insult to injury, striving to plug a pernicious $25 million budgetary hole, the hospital is throwing untold public dollars at private consulting firm KPMG in order to develop a plan to further streamline and even divest itself of public hospital services. While losing valuable hospital beds, public money is being squandered on private interests so as to sacrifice more publicly funded health care services!

As well, due to previous budget cuts, St. Joseph's Health Care can no longer bear the burden of unfunded Transitional Care Unit (TCU) beds at Parkwood Institute, costing LHSC a crucial pressure valve for dealing with patient surges in an already overcrowded hospital system.

Hundreds of elective surgeries are routinely cancelled. It is common place at all hospital sites to have multiple annual OR closures or slow down periods so as to conserve fiscal resources. Due to severe staffing shortages, surgeries are frequently delayed at SJHC so as to accommodate overworked staff who require much needed break periods.

Reduction across the board of Operating Room hours, is exacerbating already stubbornly long surgical wait times. At least one surgical suite a day remains idle due to budgetary constraints at St. Joseph's Hospital.
Hospital administration has been forced to resort to dedicated OR time for non and partial OHIP covered surgery as an additional revenue stream to make up for lost government dollars. Some surgeons, seizing upon the diminished opportunity for hospital OR time, moonlight in private for-profit clinics, catering to those who can afford to pay to jump the que while exacerbating the lengthening public wait-time list.

The dwindling bed stock at the once most robust hospital bed site in the city, is now down to a mere 21 inpatient beds. The shell of an inpatient unit, as a further cost cutting measure, is vacated every weekend, and any unfortunate patients unable to be discharged are ferried to the Post Anesthetic Care Unit, where they are housed from Saturday through Sunday and then returned to the floor on Monday morning. Inadequate staffing may result in patients

enduring extended stays in PACU. There is no further staffing cushion available to absorb any surprise patient occupancy surges.

Because St. Joseph's Grosvenor site now lacks a CCU or ICU, any complication during surgery can evolve into a life-threatening situation, requiring the transfer of the unfortunate patient via ambulance to London Health Sciences Centre. Having to transfer a patient from one medical facility to another adds another unacceptable level of risk to the patient's well-being.

This is not a picture of a healthy community public hospital system, but one of a manufactured humanitarian crisis.

LONG TERM CARE Is Not the Solution:

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. The London region has approximately 5000 citizens waiting for a long-term care bed with a 2 year wait not unheard of for a bed at the municipally owned Dearness Home.

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.

With the closure of chronic care and psychogeriatric hospitals in the late 1990s, long-term care homes became the less expensive default for all chronic care patients. Long-term care homes were not built to address the increased acuity, complexity and heaviness of current residents' care needs.

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.

The poor working 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, and daily care levels per resident have actually dropped. 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.

Stop devastating hospital cuts & rebuild capacity in our public hospitals

The Ontario Hospital Association has requested close to one billion dollars of reinvestment in public hospitals, but the best evidence shows that Ontario hospitals need an even greater cash infusion. We 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 and indeed is aligned with the provincial government's own request for increased health funding transfers from the federal government.

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.

Getting Funding to Care:

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.

The current generation of Londoners deserves accessible quality care available in public hospitals close to home. There is no excuse for a community that has almost doubled in population to offer less hospital services than existed 25 years ago. This requires genuine democratic reform in health care decision making and independent bed counts based upon projections of community needs and not rationing of dollars to meet arbitrary and reckless austerity measures which most certainly will play into the hands of the forces seeking to dismantle Canada's Medicare system.

At the bare minimum, the evidence demonstrates the need to restore public hospital funding to the average of the rest of Canada and to rebuild capacity, including reopening acute and complex continuing care hospital beds,

reopening Operating Rooms as soon as possible and developing a real evidence-based capacity plan to meet population need for hospital care.

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. It is the duty of the provincial government, self-proclaimed as "For the People", to uphold the principles of Public Medicare for all.

Respectfully submitted by,

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Co-Chair,

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~ Protecting Public Medicare for All ~

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