Pre-Budget Submission by the Ontario Council of Hospital Unions / CUPE to the Standing Committee on Finance and Economic Affairs of the Ontario Legislature

OCHU / CUPE

ONTARIO COUNCIL OF HOSPITAL UNIONS / CANADIAN UNION OF PUBLIC EMPLOYEES

January 17, 2019

The Ontario Council of Hospital Unions / CUPE represents 42,000 hospital and long-term care workers across the province. Our members provide nursing and personal care, maintenance, housekeeping and infection control, food, stores and warehousing, administration, pharmacy, laboratory, information technology, and many other services. We are part of the largest union of workers in both Canada and Ontario, and the largest union of health care workers in Canada and Ontario. CUPE has members in almost every city, town, village, municipality, and unorganized territory in Ontario.

The problem: Ontario has the lowest revenue of any province, despite its relative wealth, making the provision of adequate public hospital, long-term care, and home care services impossible. The government can either deal with this reality or pretend to deal with it through other means.

The latter option has been consistently taken, bringing us to the current situation with extraordinarily high hospital bed occupancy, long waiting lists for long-term care, a dramatic increase in the sickness of patients treated through home care, the removal of home care services from other sorts of patients (who previously received home care), and a crisis for unpaid, mostly female, caregivers facing depression, exhaustion and burnout.

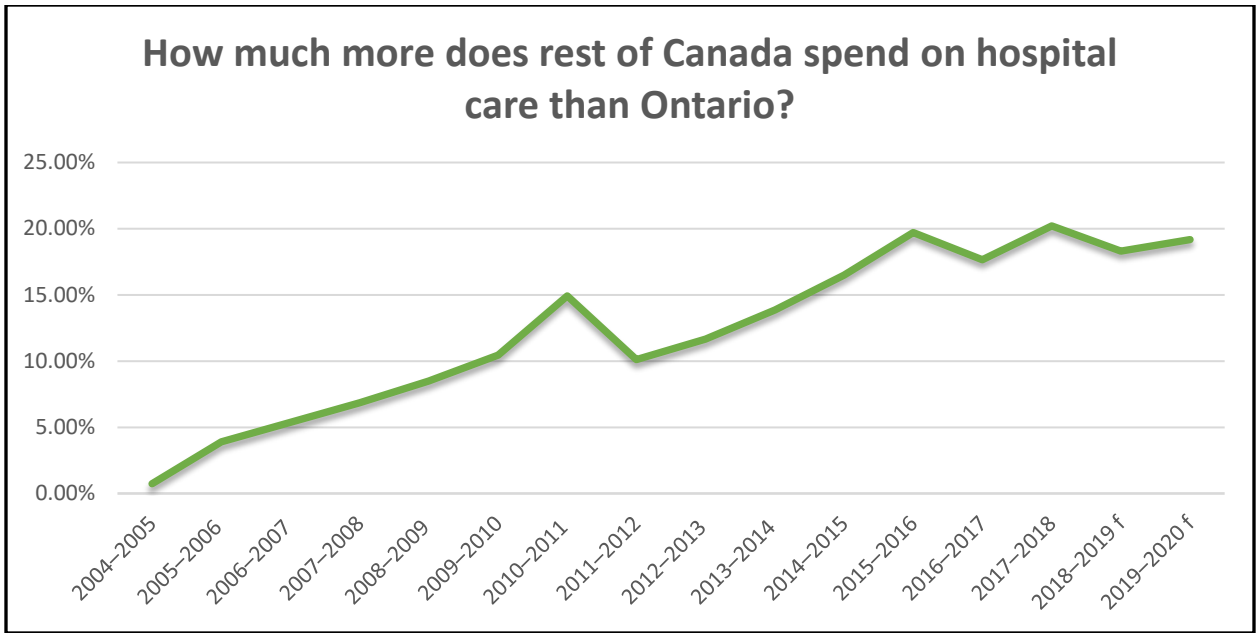
Ontario faces unprecedented challenges of hospital underfunding and lack of capacity. For decades governments have pretended to try to address this problem by *claiming* to improve home and community care. Yet, today the result has been an overwhelmed home care system that has seen a staggering increase in the sickness of the patients it is trying to treat, long LTC wait lists, and a hospital system reduced to treating over-capacity patients in hallways. Funding improvements are needed in all these three sectors.

The new government has promised to end hallway medicine, yet their fiscal plans will make the situation worse and their focus on more fiddling with the structure of health care services will only divert more time and treasure away from actually solving the basic capacity problems of health care.

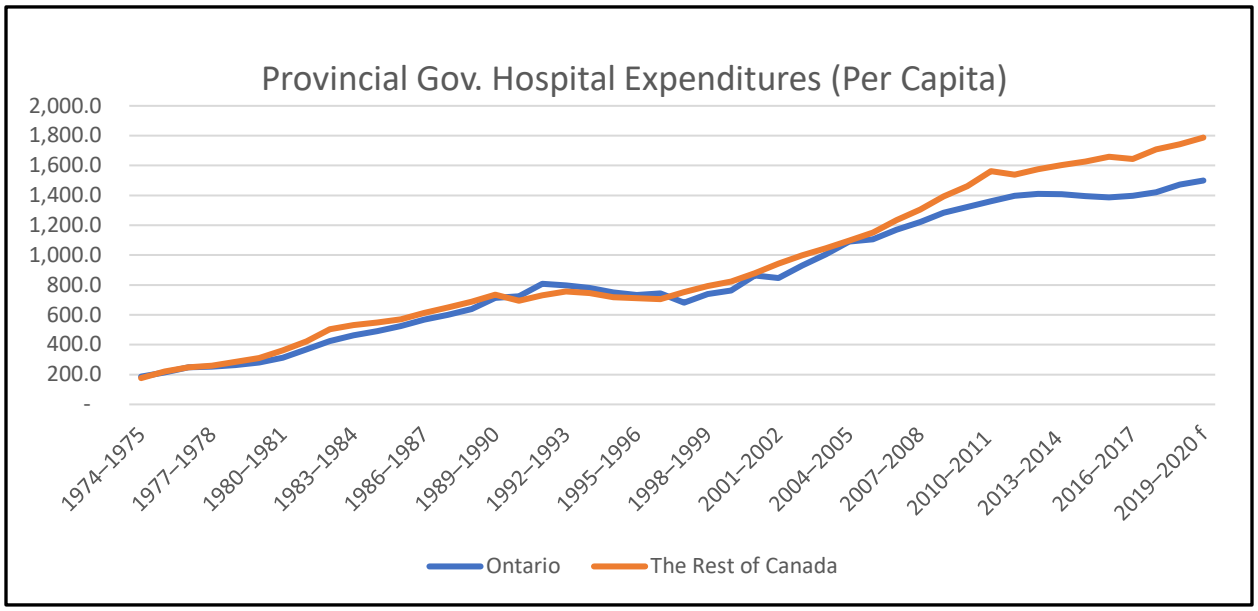
The basic hospital problems in Ontario

Hospitals typically benchmark against each other to determine care levels and efficiency. But when Ontario hospitals are benchmarked against hospitals in other provinces, a pattern clearly emerges – underfunding and under-capacity.

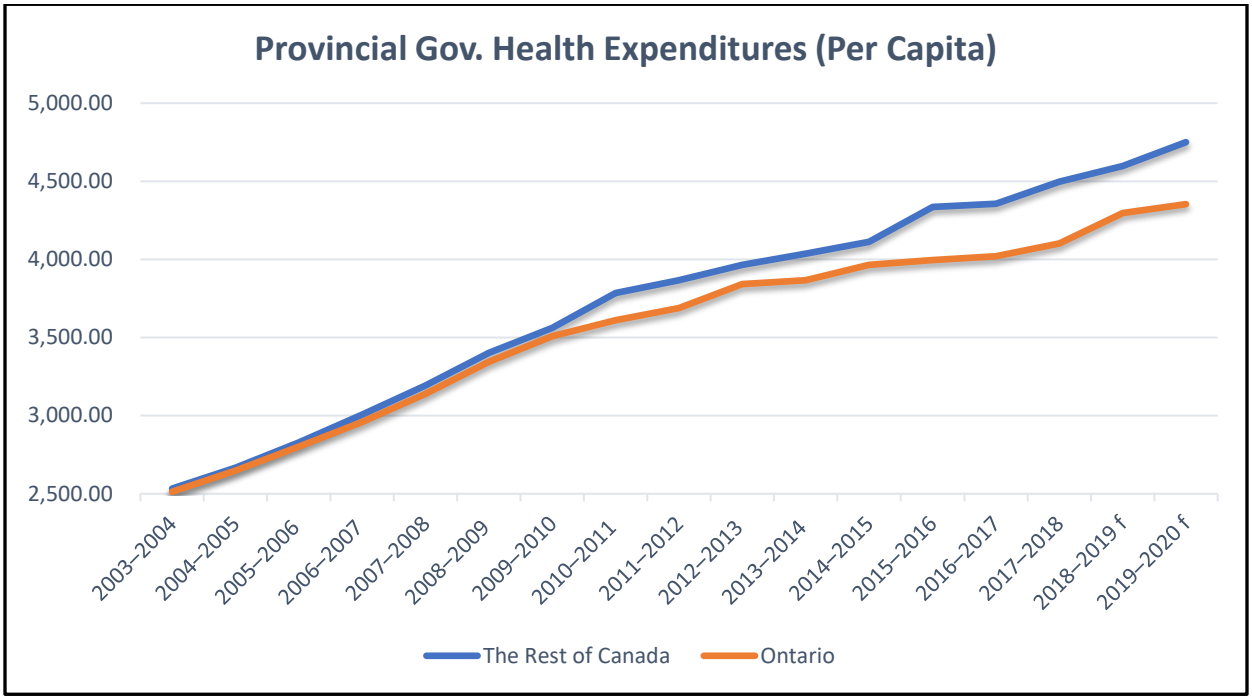
Ontario provides much less funding per capita to hospitals than other provinces and territories:



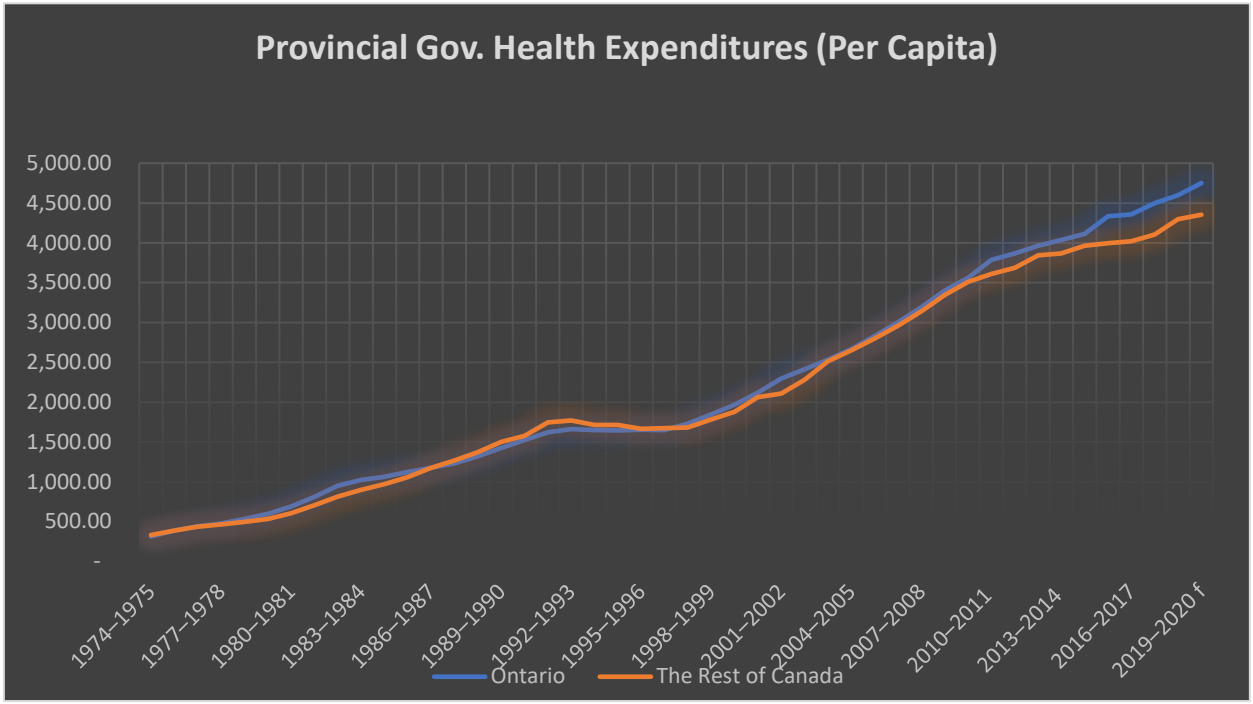
The gap between Ontario and the rest of Canada is a relatively new phenomenon. For decades we were in lock-step with the rest of Canada. We have fallen far behind since 2004-2005.



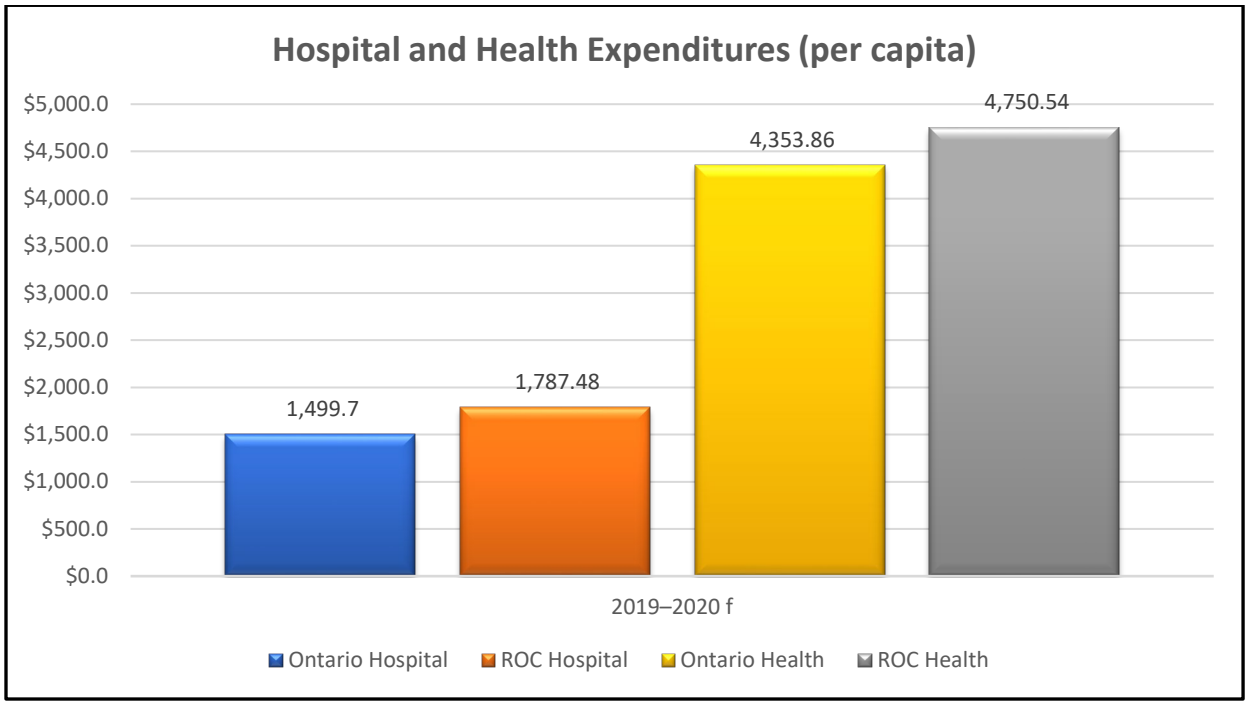
A similar trend is seen for provincial government expenditures on all forms of health care. Notably, hospital underfunding accounts for 72.5% of health care underfunding in Ontario compared to the rest of Canada.



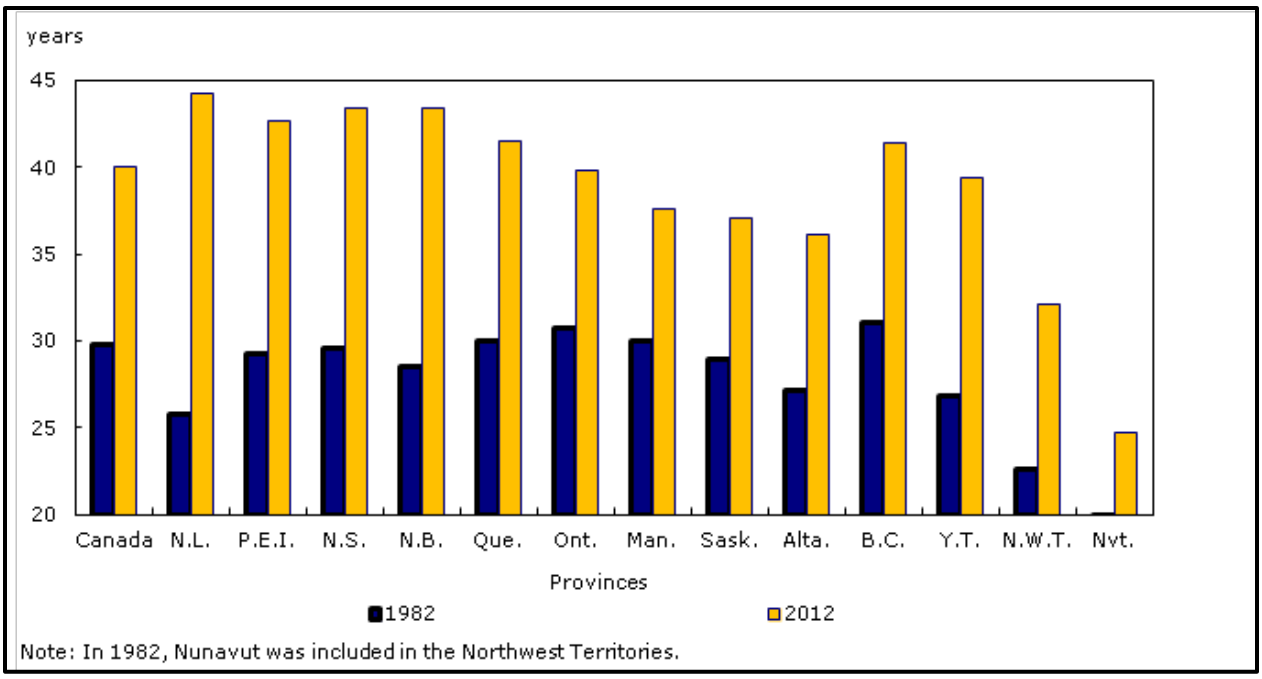
Accordingly, the gap between Ontario health expenditures and expenditures in the rest of Canada also exploded when the same occurred for hospital expenditures, after decades of almost identical expenditures:



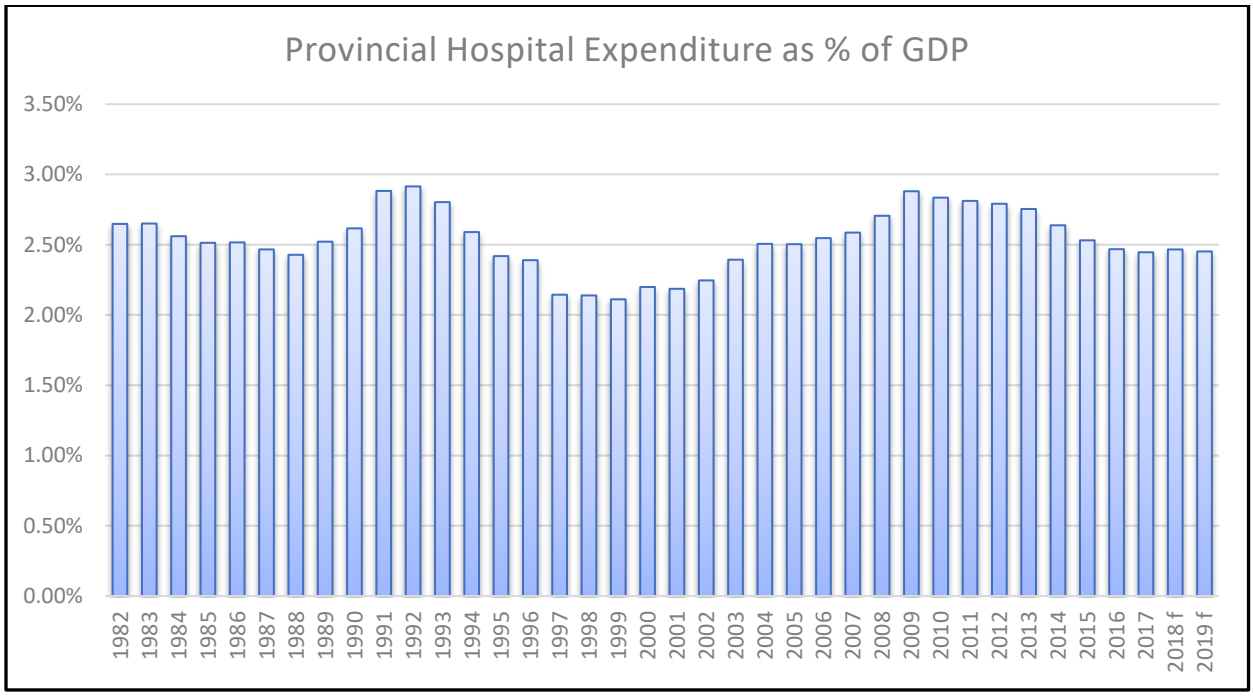
Here is how provincial expenditures in Ontario and the rest of Canada (ROC) compare in the current year, according to ther latest Canadian Institute for Health Information (CIHI) data:



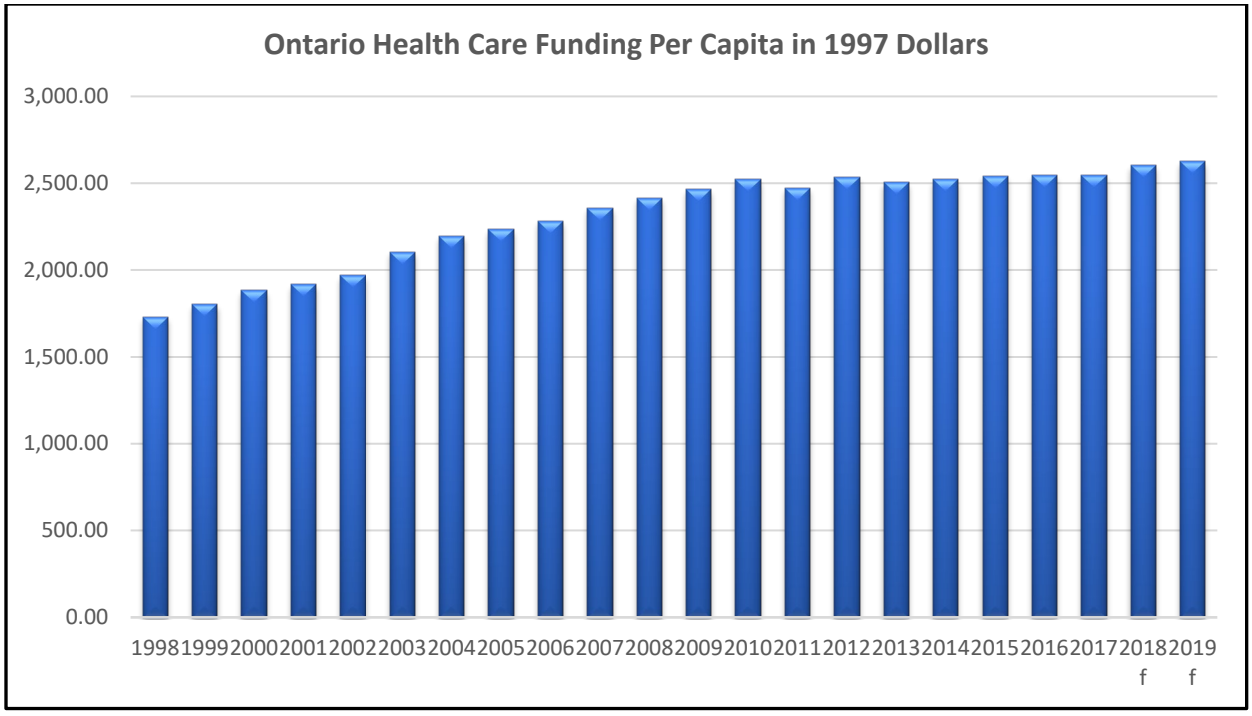
There has been significant aging in Ontario over the last four decades. Here, for example, is the change in median age since between 1982 and 2012:



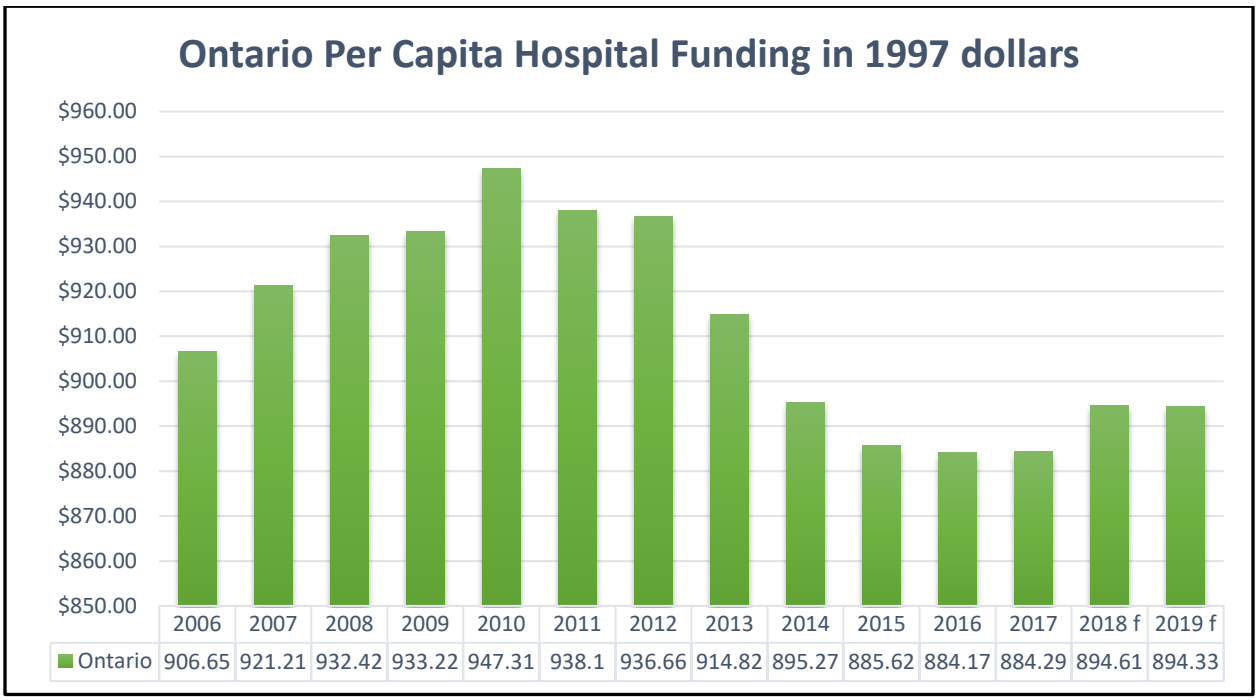
Despite aging of the population, provincial expenditures on hospitals have remained flat for at least 39 years at about 2.5% of GDP. Currently they are just below that level.



Ontario health care funding per capita in real terms has remained almost constant since 2010.

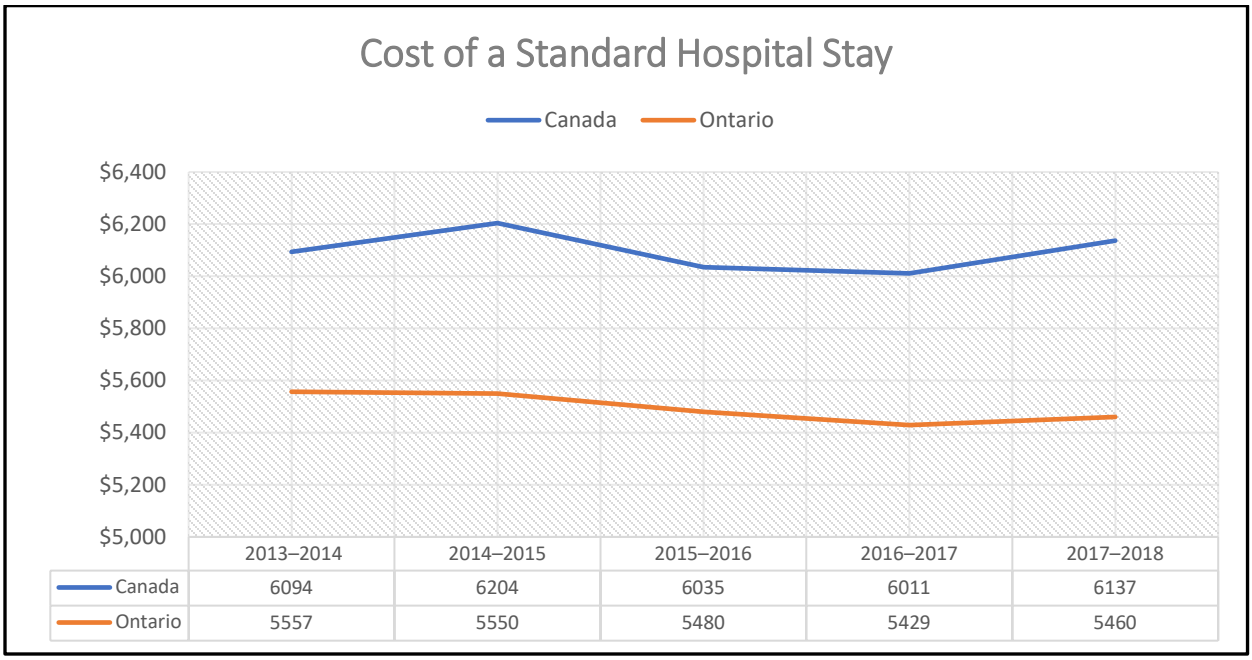


Real hospital funding per capita has actually gone down 5.4%. The economy has grown over 20% since 2010.

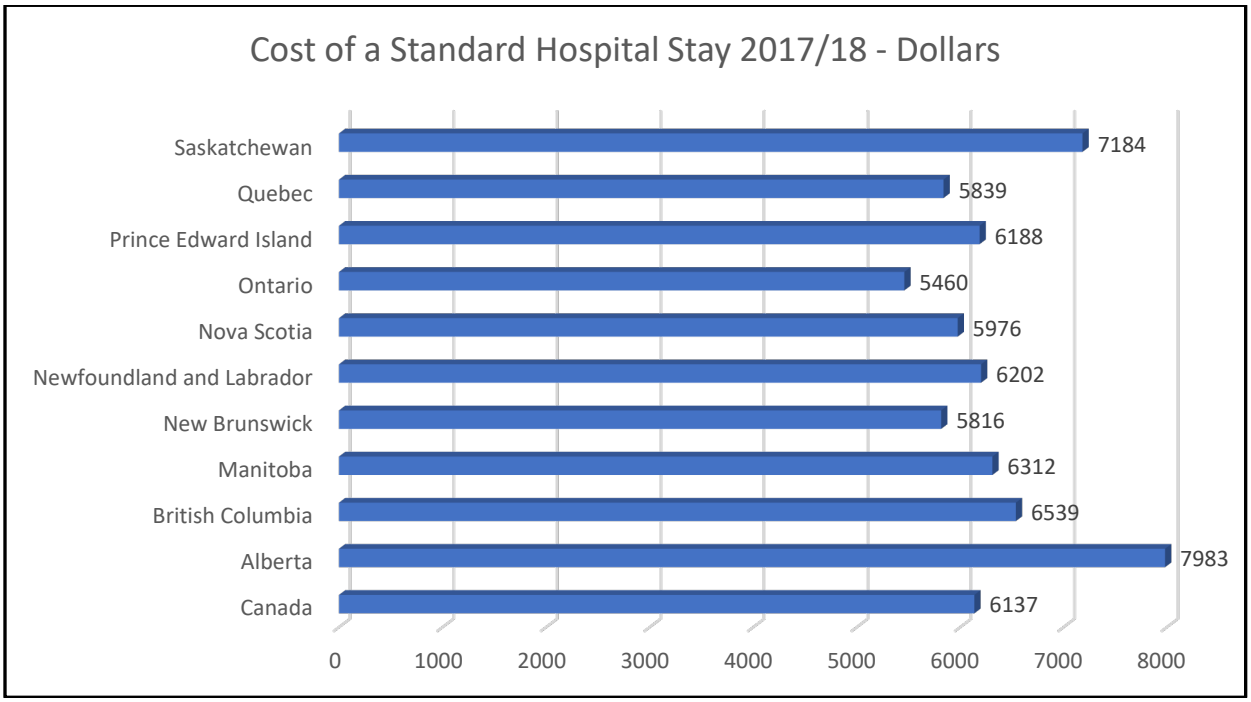


That is a cut of $53 per person per year in constant 1997 dollars, or $88 per person in 2019 dollars.

Hospital costs per patient have also gone down in Ontario



In the four years from 2013-14 to 2017-18, standardized costs for a hospital stay (adjusted for differences in the types of patients) fell 1.75% in Ontario. Ontario has the lowest cost for a standardized hospital stay of any province.

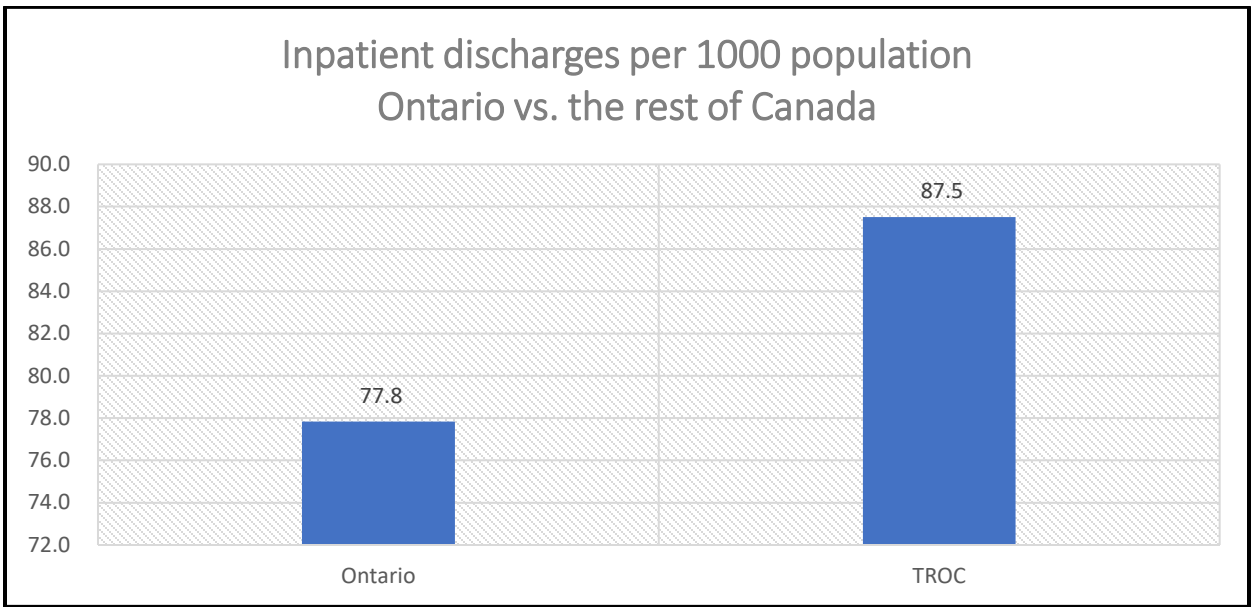


The cost of a standard hospital stay in Canada as a whole is $677 more than the cost in Ontario – that is 12.4% more than Canada and the gap between Canada and Ontario has increased $45 more than the previous year.[1] The province with the second least cost for a standard stay (New Brunswick) is still $356 more than Ontario.

The result of this underfunding is predictable: fewer beds than the rest of Canada, far fewer beds than other developed countries, extraordinarily high levels of bed occupancy, very short lengths of stay, a low level of patients treated in hospitals, higher than average (and rising) levels of readmissions, enormous wait lists for long-term care, dramatically rising acuity of patients receiving home care, the removal of less sick patients from home care service, and exhaustion for unpaid family caregivers. In other words, all the factors that led to the hallway health care crisis. We will review a few of these points below.

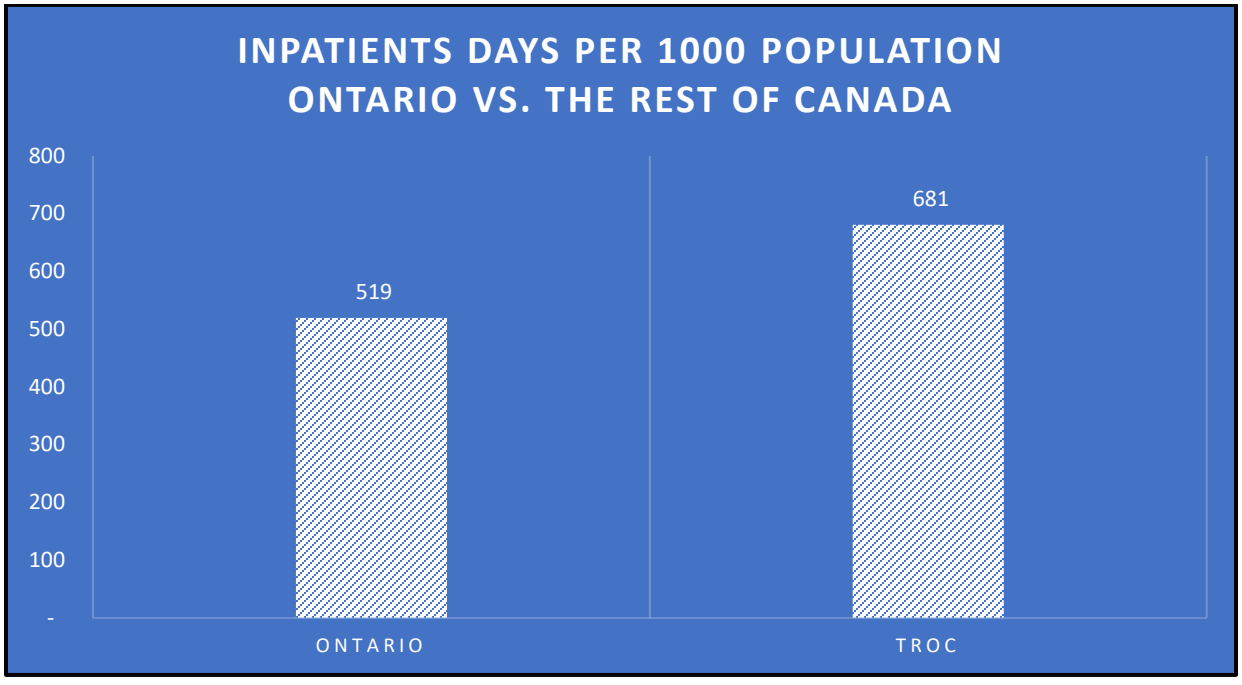
[1] This underestimates the difference between Ontario and the *rest* of Canada. If figures for Canada excluding Ontario were available, the gap would be considerably larger.

Hospital Capacity, Beds, and Staffing: Given the low level of funding, fewer patients are admitted into a hospital in Ontario than in the rest of Canada. There are 12.5% more discharges per 1000 population in the rest of Canada (TROC) than in Ontario:

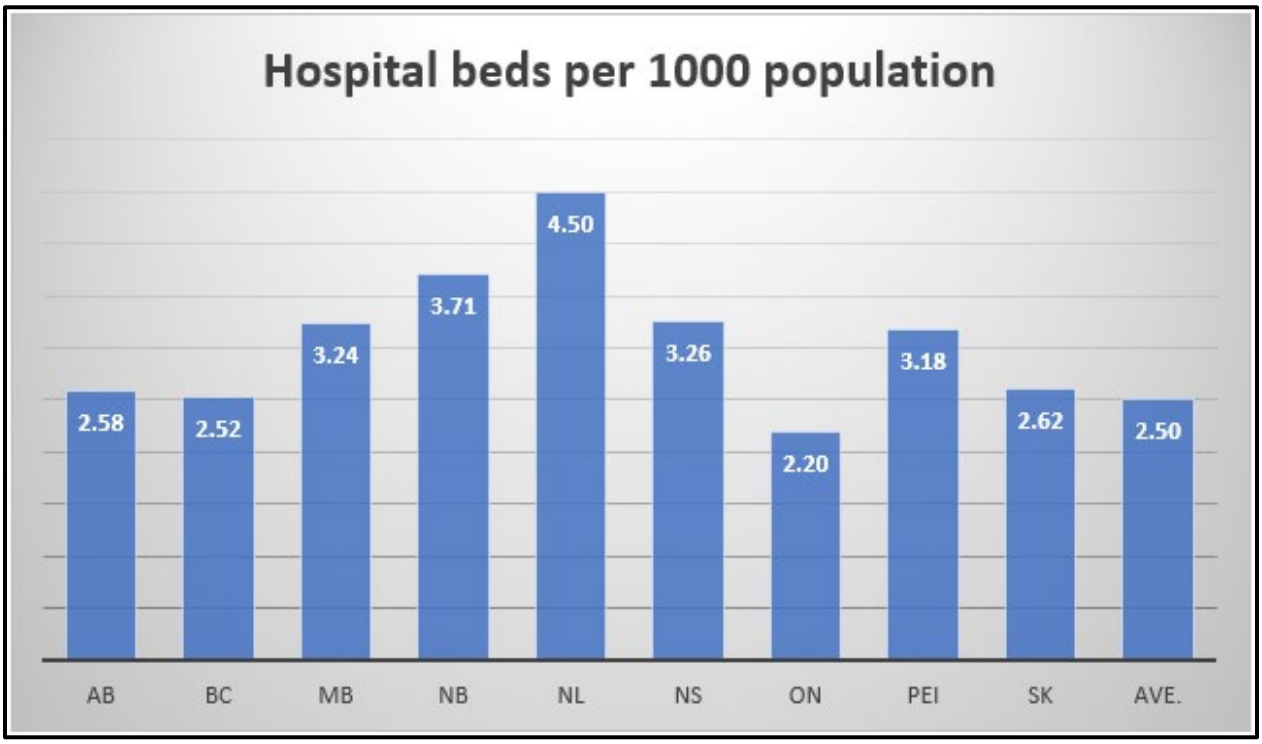


Source: CIHI, Report name: "Inpatient Hospitalizations: Volumes, Length of Stay and Standardized Rates"

As a result, the rest of Canada has ***31.2%*** more inpatient days per 1000 population than Ontario.



Another key result of low funding is a very low number of beds per capita, both in comparison to other provinces and in comparison, to other developed countries.

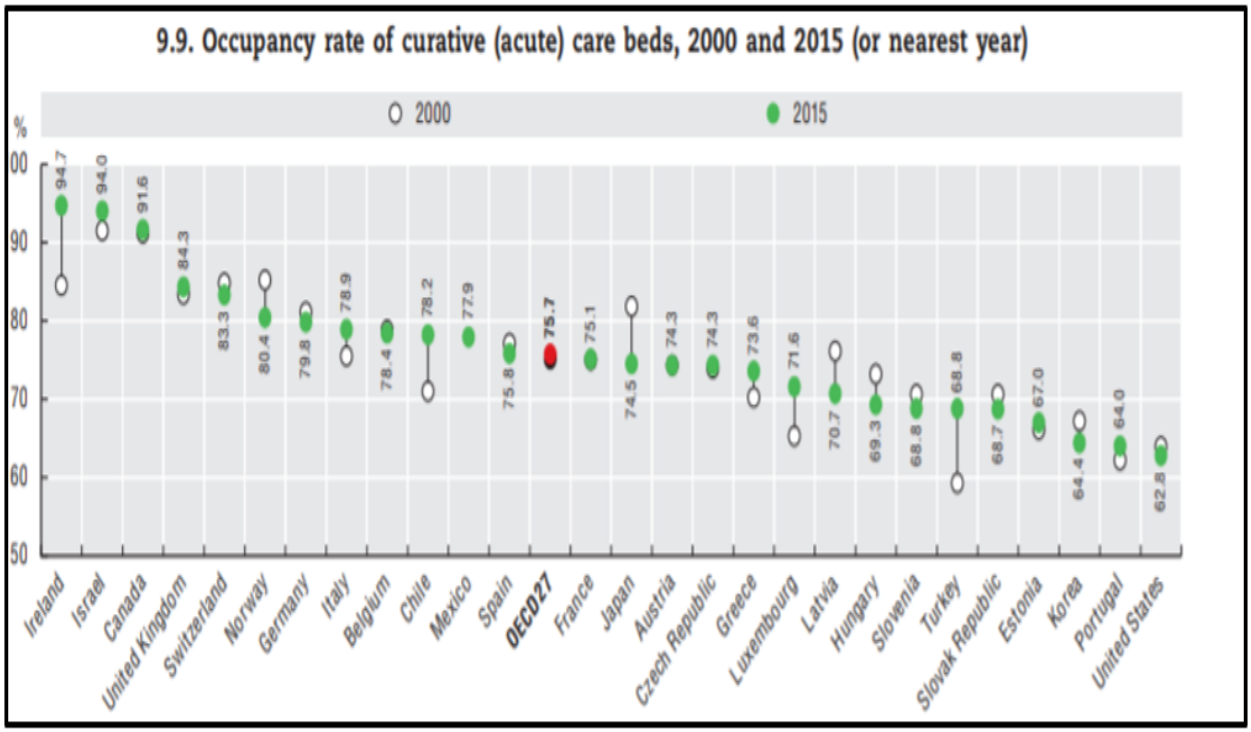


All types of hospital beds included - e.g. Rehabilitation, Acute, Mental Health, CCC

Ontario would need another 4,352 beds to meet the Canada-wide average (including Ontario) of 2.5 beds per 1,000 population. To meet the average for provinces outside of Ontario (2.81 beds per 1,000) we would need another 8,793 beds. This in large part explains the very high bed occupancy and hallway health care often reported by Ontario media.

Notably, even Canada as a whole has a high hospital bed occupancy compared to other nations. In other developed nations bed occupancy averages 76%,

significantly below the 80% or 85% levels often identified as maximums for safe patient care:

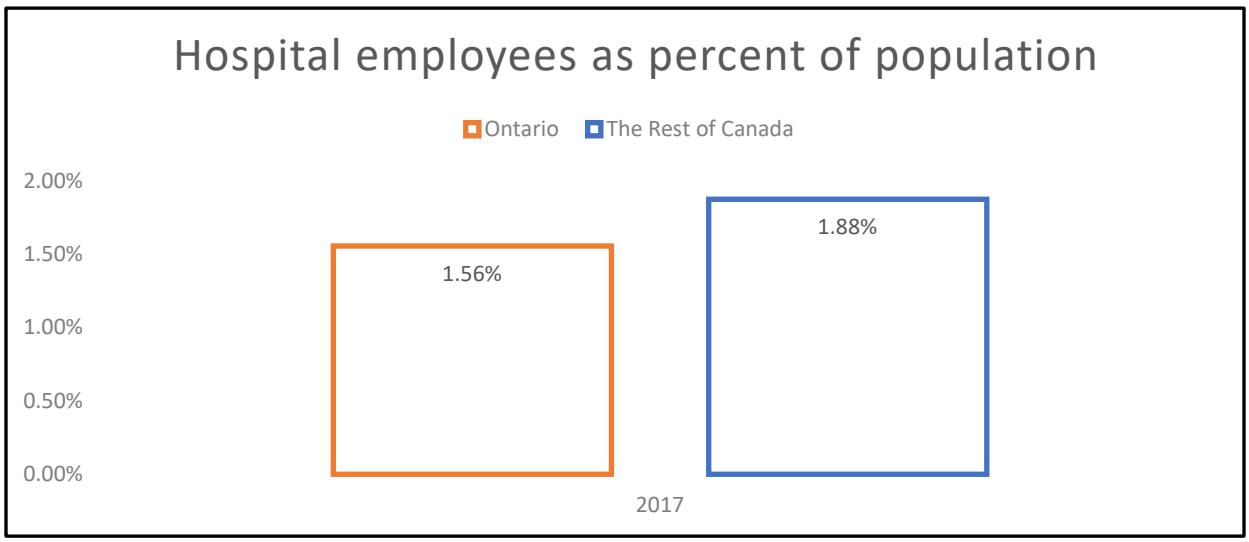


Under the OECD definition, "curative" hospital beds excludes rehabilitative and long-term care beds. Source: Eurostat, "Health care resource statistics – beds," 2016, http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_resource_statistics_-_beds

Notably, the Ontario Auditor General reports,

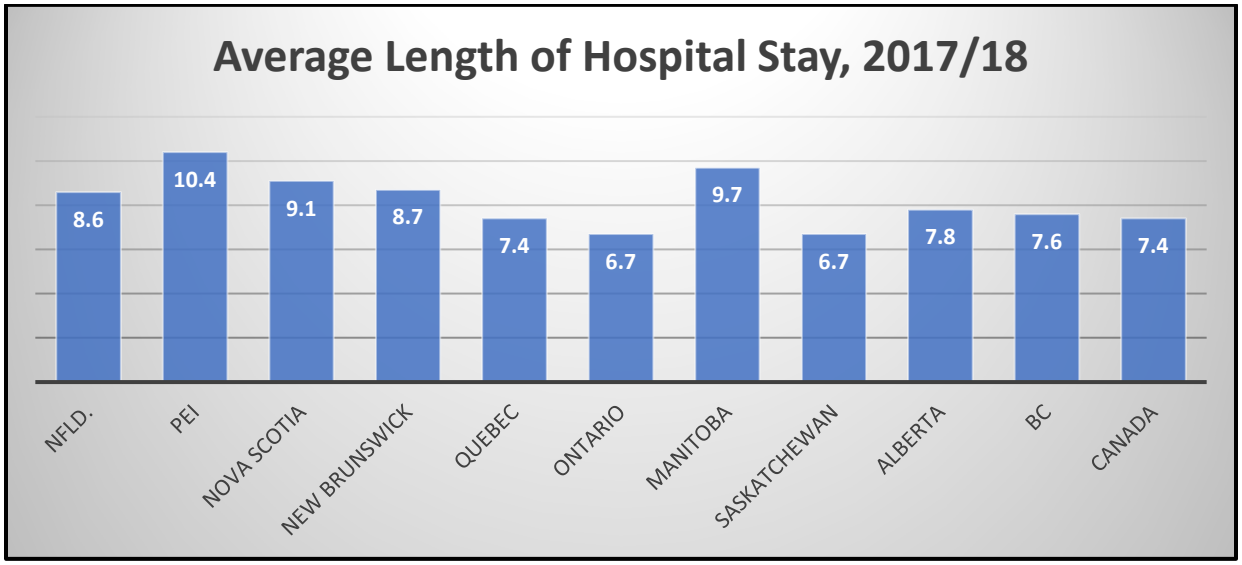
> between April 2003 and the end of March 2018, according to Statistics Canada and Ministry data, the number of acute-care hospital beds in Ontario decreased from 1.5 beds to 1.3 beds per 1,000 people. We obtained data from the Ministry for the 25 acute-care hospitals with the highest overcrowding over the 12-month period ending February 2019. Over the year, these hospitals were at 110% of capacity on average, while on some days in winter months one hospital exceeded 120% of capacity.

Hospital beds however are simply a marker for hospital staffing levels. Accordingly, staffing in Ontario hospitals is also much lower than the rest of Canada.



Hospitals across the rest of Canada are already staffed 21% more than in Ontario. If Ontario hospitals had the same staffing as hospitals in the rest of Canada, there would be **45,000 more hospital employees in Ontario**.

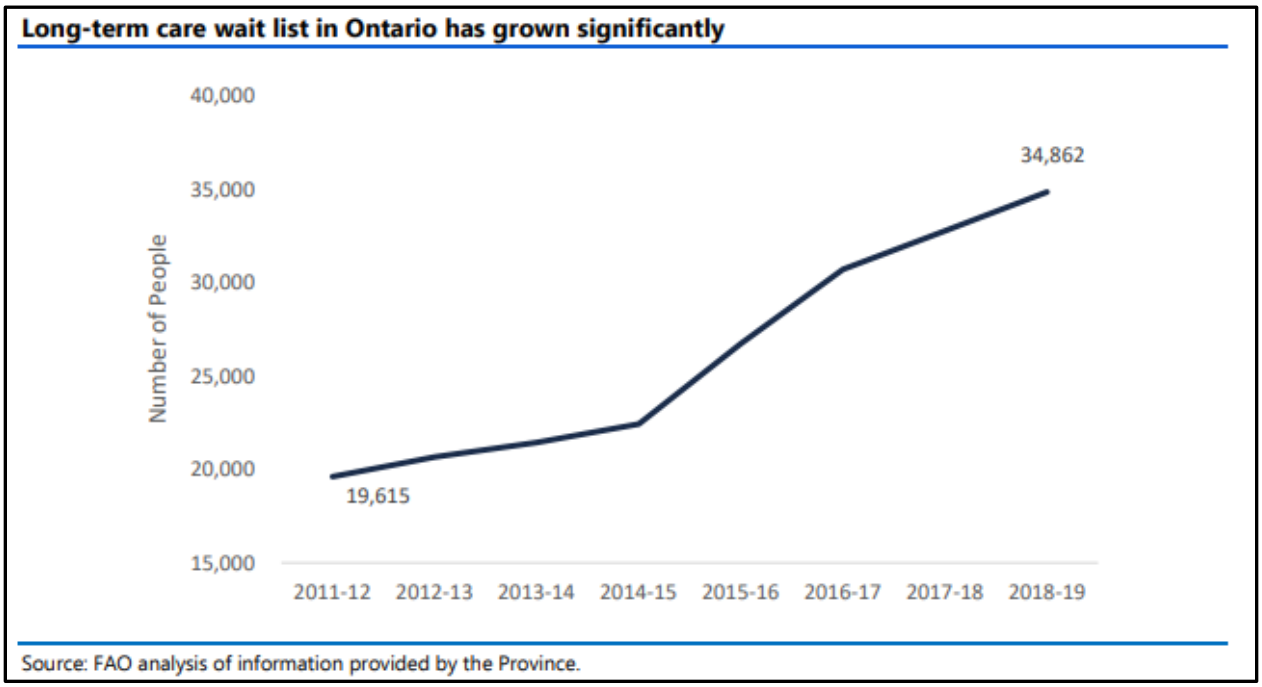
Length of Stay: Low hospital funding and few beds means that hospital patients must be discharged more quickly. Ontario has the shortest length of stay in Canada and the average length of stay is 10.4% longer in Canada as a whole than in Ontario:



Re-admissions: Hospital re-admissions continue to increase. In 2012-13, 30-day hospital re-admissions were 8.9 per 1000 patients, but rose to 9.6 in 2018-19 according to CIHI. This is a 7.6% increase in six years. The Ontario re-admission rate is 2.1% higher than the Canadian average.

The in-hospital sepsis rate is 17.9% higher in Ontario hospitals than the Canadian average.

Long-Term Care (LTC) faltering supply: Since 2004, the 85 and older population has grown roughly *twenty times* quicker than the number of new LTC beds. With few new beds, wait lists grew rapidly.

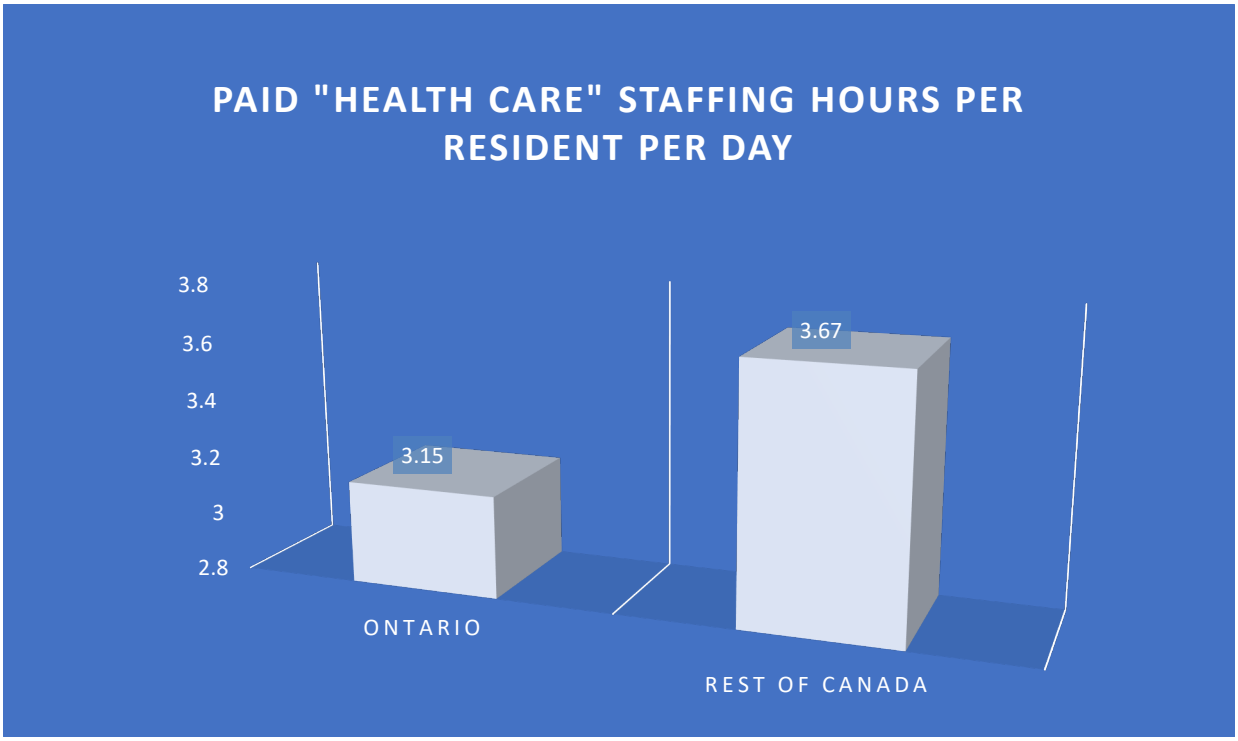


The government's initial response at the beginning of the past decade was to restrict access to the wait list. Only the sickest are even being allowed to wait for a LTC bed. Bed occupancy is at very high levels, 98.7% in February 2019.

The lack of new capacity means that LTC residents that are getting into a home are much sicker and require much more care. Residents with heart disease are growing at a rate of 4.5% per year, those with renal failure are growing at a rate of 3.7% per year. Residents with six or more formal diagnoses are growing at a rate of 4.8% per year. Growth in care that is labour intensive is growing at an

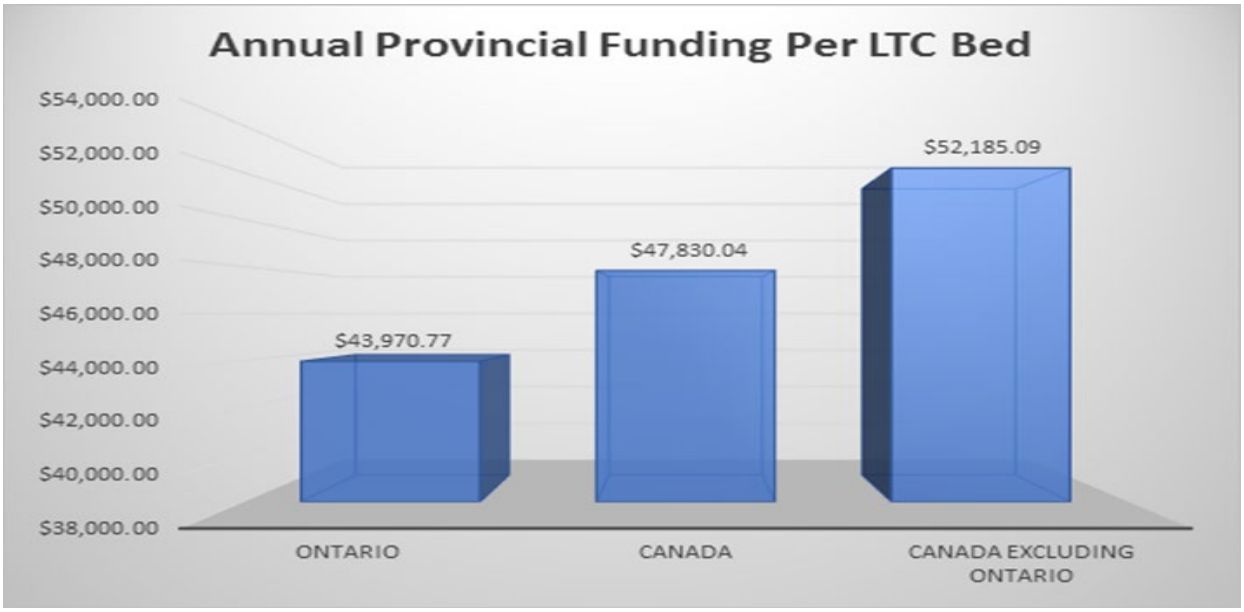
alarming annual rate: 5.2% for oxygen therapy, 9.7% for the administration of IV medications, 8.3% for the monitoring on input and output.

Making matters worse, the average hours of care per resident per day was *reduced* during the period of austerity during the last decade. LTC hours of care per resident per day in Ontario fall far behind the hours provided in the rest of Canada.

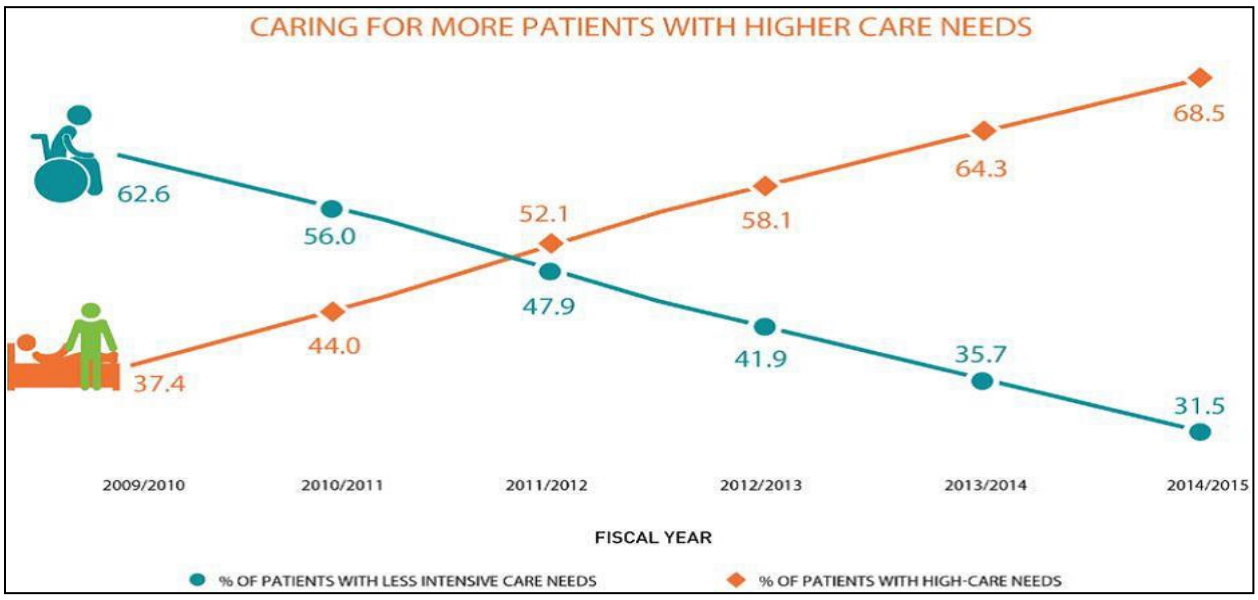


CUPE LTC members want better: 91% of CUPE LTC focus group members do not feel satisfied with level of care provided; 97% feel there is not enough staff. Staff believe they are forced to make unsafe choices: “Either you follow the rules or you help this resident.” Compromised care is reported in a whole number of areas: resident cleanliness, eating, dressings, forcing residents into incontinence, and insufficient infection control. Sadly, staff report a lack of time to provide the emotional care to residents, who are often at their most vulnerable and in the final stages of life.

Provincial funding is also much less in Ontario than the rest of Canada.



Home care acuity way up: The restrictions placed on LTC beds and hospital care has also dramatically driven up the acuity of home care patients overseen by Community Care Access Centres (CCACs — now merged into Local Health Integration Networks or LHINs).



In just five years, the percentage of patients with CCACs who have higher care needs increased from 37% to 68% and lower need patients declining from 63% to 32%. The province has removed some lower need patients from the LHIN home care altogether. For almost three decades governments have advocated reducing hospital capacity by claiming increased home care – they did not mention that

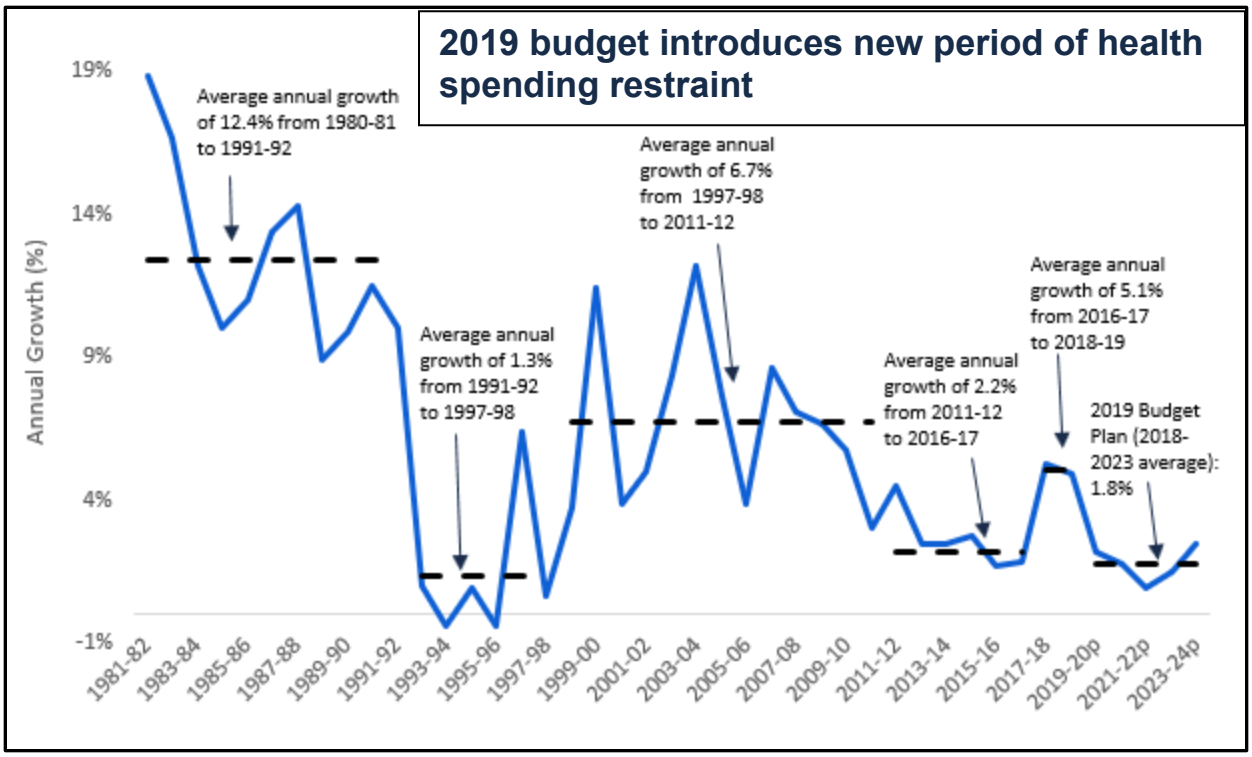
they would also remove patients from home care, but that is what has happened. While increased home care is desperately required, it cannot in this situation replace hospital care. That excuse can no longer stand.

Unpaid caregivers in Distress: A research study reveals that one-third of long-term home care patients had unpaid caregivers who experienced distress, anger or depression in relation to their caregiving role, or who were unable to continue in that role. That rate of distress even in 2013-14 had more than doubled from 15.6% just four years earlier. Over the same period, the proportion of patients with caregivers who were not able to continue looking after them also more than doubled, to 13.8% from 6.6%. Despite this impact on unpaid caregivers, they are now being asked to take on responsibility for sicker and sicker family members and friends.

The emerging funding crisis under the new government

While the new government has promised to end hallway health care, the funding plan it announced in the last Budget will make things much worse.

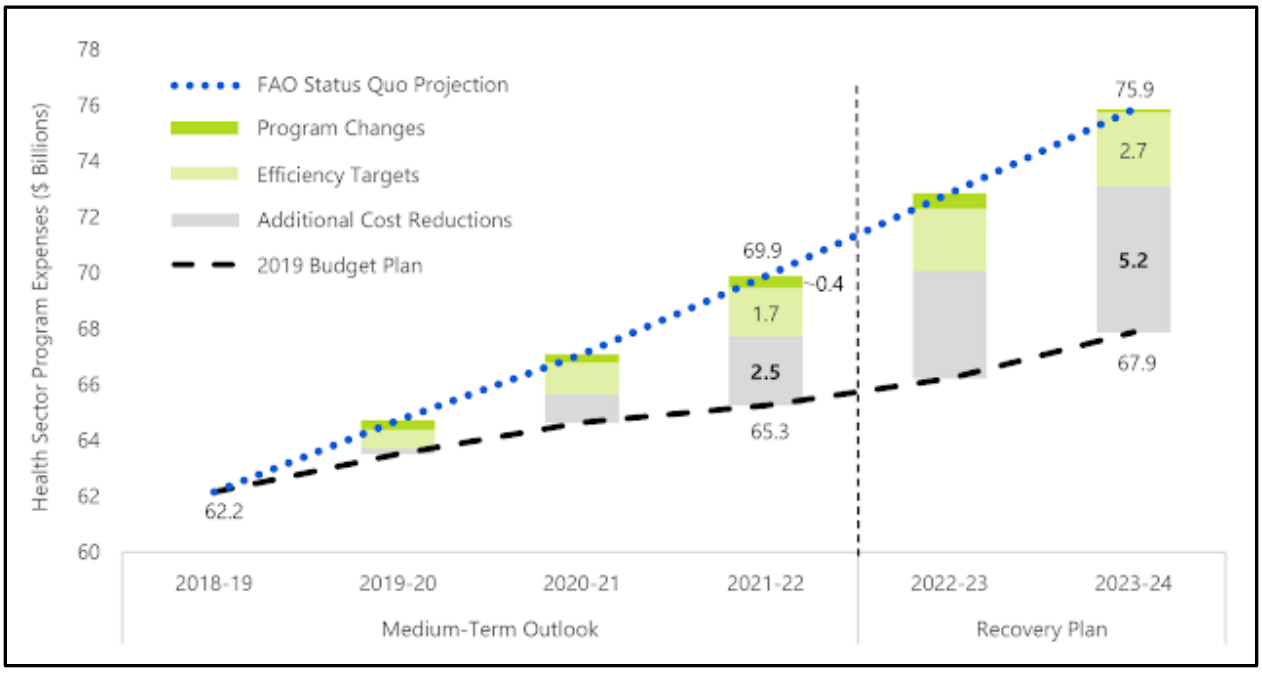
The Financial Accountability Office (FAO) reports a new period of health care funding restraint under the 2019-20 Budget plan:



The Financial Accountability Office (FAO) estimates that 43 per cent of the annual average increase of 1.8% over the next five years will go to the OHIP (physicians and practitioners) program area. For hospitals and other parts of health care, that means very small increases – an average funding increase of 1.1% for the next five years. This is well below inflationary cost pressures, never mind cost pressures arising from aging, population growth, and increase utilization.

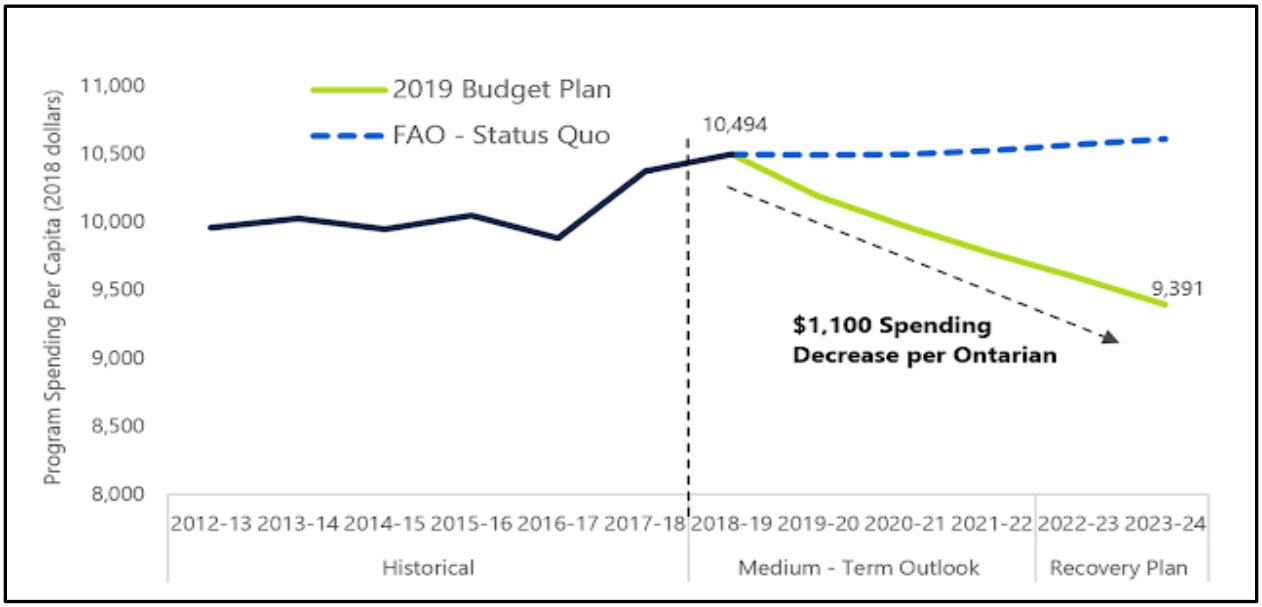
For hospitals the FAO concludes that "to achieve the health ministry spending restraint outlined in the 2019 budget, the Province will be required to restrict base hospital operating funding growth ***to less than one per cent annually*** over five years." (Our emphasis)

This means that by 2023-24, cuts to current health care ***will amount to $8 billion annually,*** with the bulk of the cuts hitting areas outside of physician OHIP fees. While the government has identified how they hope to make some of these cuts, the great bulk of these cuts – $5.2 billion – have neither been identified nor announced. Here is a graph from the FAO:

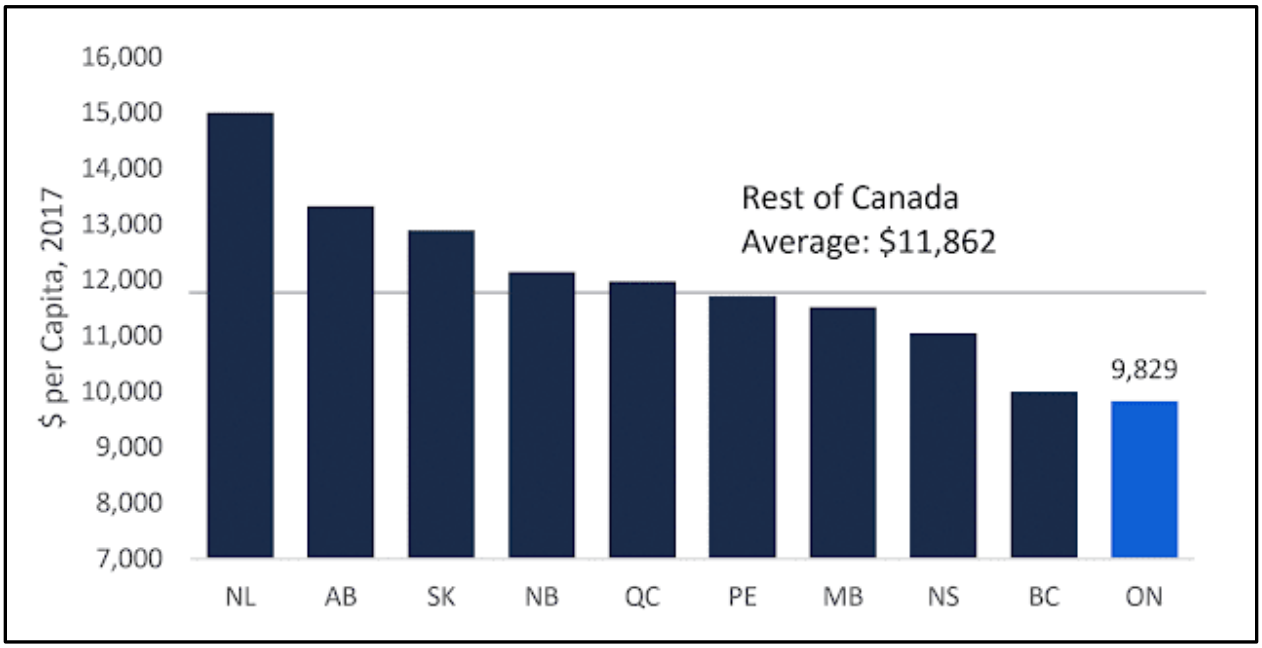


Even though the cuts identified to date have been major and painful, $8 billion is many times more than the cuts announced and implemented to date, as can be seen from this graph.

The FAO notes the government's overall program cuts are [a] similar to the level of cuts in the 1990s, and [b] equal to about 10% in real terms for all program spending – about a $1,100 per person cut (in constant dollars) for all program spending.

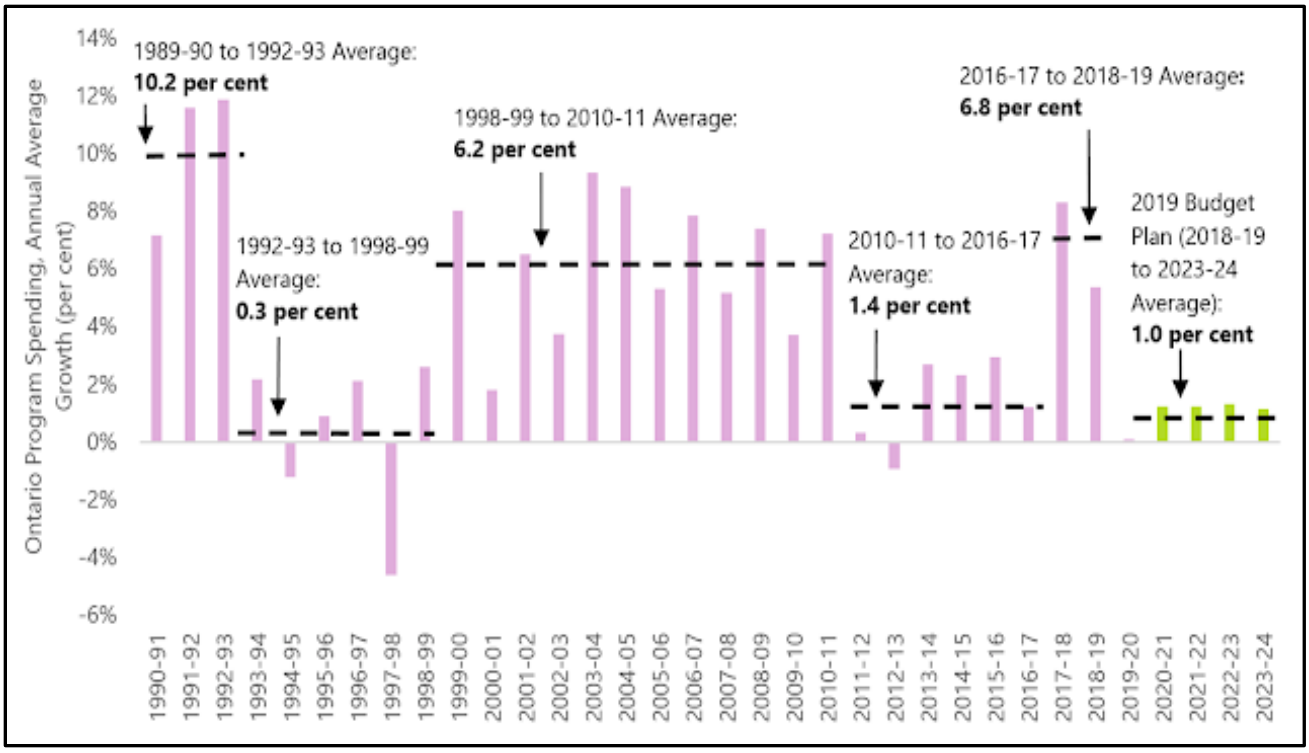


Ontario already has the lowest provincial government program spending, over $2,000 less per person than the Canadian average:



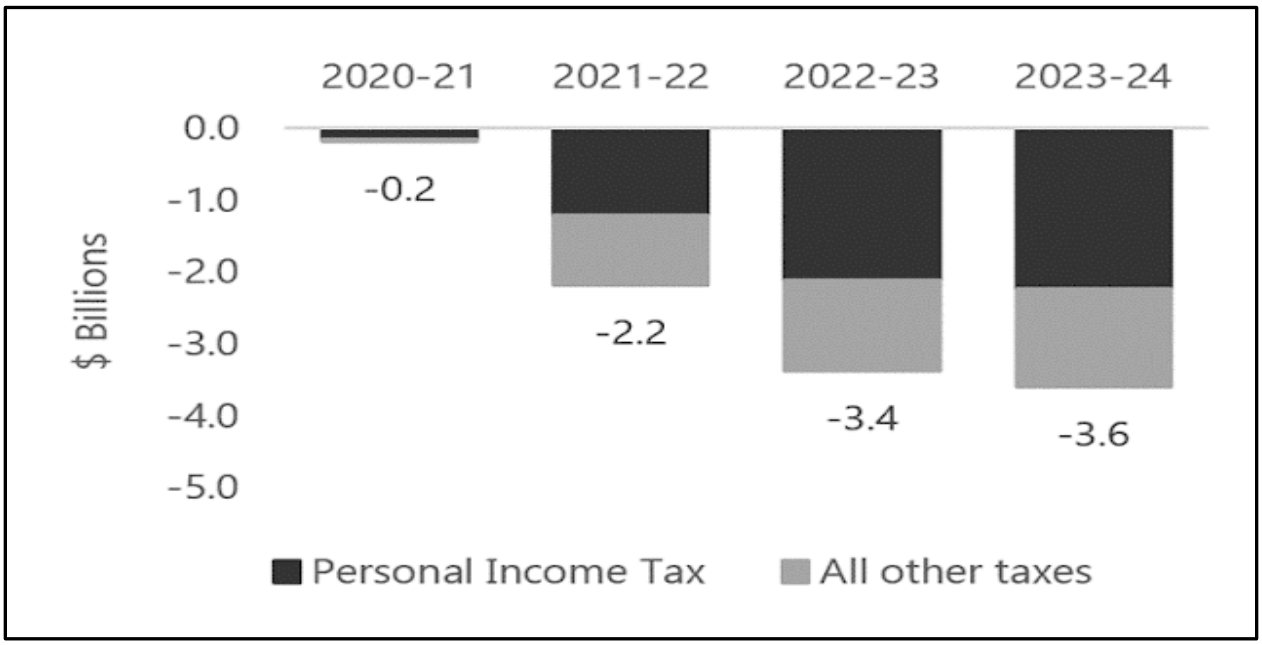
Source: FAO, February 2019, Comparing Ontario's Fiscal Position with Other Provinces

While the cuts imposed by the Mike Harris Progressive Conservative government were particularly painful in its first Budget, they lasted only a couple of years before that government was required to reverse its policy in its third year, when it recognised reality and increased program spending by 8%. The new Progressive Conservative government plans *at least* five years of austerity (there are no reports from the government yet about what it plans to do in years six and beyond).



The FAO also reveals that the government's plan also has some ***unannounced tax*** changes that will reduce revenue by $0.2 billion in 2020-21, and by $3.6 billion in 2023-24. So, not only has the PC government introduced billions in tax cuts this year, we will also get more, as yet unannounced, tax cuts in the years ahead. These revenue cuts delay the achievement of a balanced budget, deepen the provincial debt, and require more cuts to social programs. And these tax cuts are planned even as the government continues to claim – with shameless hypocrisy – that the program cuts it is imposing are required by the province's fiscal situation.

Revenue Impact of Unannounced Tax Policy Changes



Bottom line – The government must identify and implement very major cuts for health care (and all social programs) over the next five years if it keeps to its Budget plan.

What does this mean for health care services? Unless corrected, this means very serious cuts. While the cuts to date are only a tiny fraction of what is planned, here are some examples of what has happened.

LHINs and Ontario Health: The first Progressive Conservative Budget claims that by 2021-22 the merger creating Ontario Health will save $350 million annually (page 276):

> Establishing a new, single health agency to provide health care oversight and reduce health care bureaucracy and regional administration duplication, resulting in annual savings of more than $350 million by 2021–22;

To give a sense of the scale of the cuts involved here consider that *part* of this was done through the layoff and elimination of 815 positions at Ontario Health earlier this year.

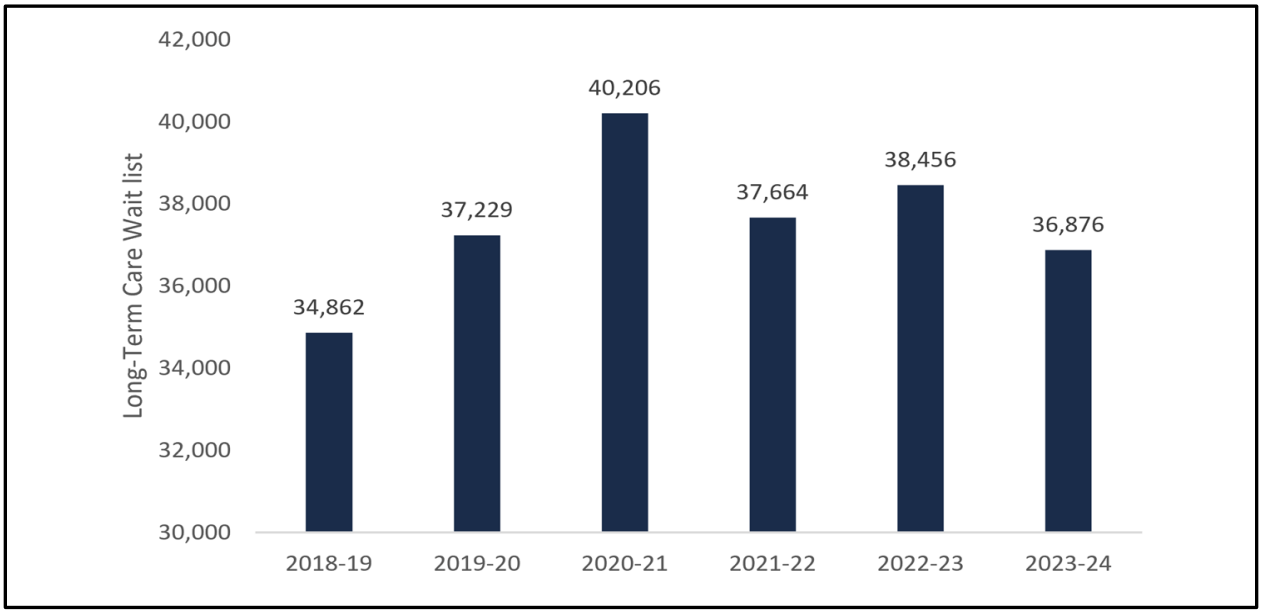
However, even if we estimate a well-above average total cost for those 815 jobs – say $100,000 per annum – the savings would only amount to $81.5 million (815 x 100,000), i.e. less than a quarter of the $350 million cut that the government says they will cut. Even with 815 job cuts at least another $268.5 million is needed to meet the government's plan.

There's more to come, unfortunately – we just don't know where, ***yet***.

LTC: The government has pointed to their plan to increase long-term care beds when asked how they will end hallway health care. But even here their plans will only make things worse.

The FAO reviewed the government's plans and concluded that the LTC wait list will actually *increase* under the government's plan:

> Despite the significant increase in the number of long-term care beds, the FAO projects that the wait list for long-term care will increase by about 2,000 Ontarians over the next five years, from 34,900 in 2018-19 to approximately 36,900 Ontarians in 2023-24. The FAO projects that the wait list will peak at 40,200 Ontarians in 2020-21, an increase of about 5,300 from 2018-19, and will be reduced to 36,900 by 2023-24 as the new beds come into service.
>
> **LTC wait list projected to increase to 36,900 Ontarians by 2023-24**
>
> The reason that the wait list for an LTC bed is projected to increase over the next five years, even with 15,000 new long-term care beds, is that the growth rate in the number of Ontarians aged 75 and over is projected to outpace the growth rate in LTC beds.



What's more, the FAO notes, "[a]fter 2023-24, in order to maintain the projected wait list at approximately 36,900 Ontarians, the Province would need to create an additional 55,000 new long-term care beds by 2033-34.

For health care, given population growth and aging, capacity has to rapidly expand just to maintain services at existing levels.

The funding just to meet the promised 15,000 LTC beds far outstrips the Budget plan for the next several years. The FAO estimates that LTC funding must increase an average of 5.4% per year just to meet the promise of the new beds. Notably, funding was Budgeted to increase 1.5% this year.

Hospitals: For hospitals, the cuts are already happening. Here is a sampling of some since the election of the new government:

- Plan to cut 22 hospital beds and 176 positions from Sudbury Health Sciences North over a five-year span (July 2019).
- Plan to cut 31 beds at North Bay Regional Health Centre. These cuts must be reversed.
- Cut 46 RN positions from Grand River Hospital in Kitchener – Waterloo (July 2019).

- Cut 80 staff from Windsor Regional Hospital (WRH) mostly in housekeeping and food services departments (April 2019).
- Privatized routine outpatient blood tests and lab tests at St. Michael's hospital to for-profit laboratories (April 2019).
- Cut 14 full-time registered nurses at Orillia Soldiers' Memorial Hospital (May 2019).
- Cut at least 50 clerical staff at St. Michael's Hospital, St. Joseph's and Providence Health Centre in Toronto (May 2019).
- Cut 165 full-time equivalent staff positions from London Health Sciences Centre (June 2019).
- Closed the Maternal Fetal Medicine Clinic at Windsor Regional Hospital (June 2019).

Since the election of the new government in June 2018 emergency room wait times for patients admitted to hospital increased 2.2 hours (to 16.6 hours) by November 2019. ***That is a 15.3% increase.*** Over the same period, the percentage of patients admitted within the provincial target declined from 38.7% to 33.5%. These are important metrics as capacity issues back up into the emergency room. Hospital capacity issues discussed earlier in this brief appear to be getting worse, not better.

Conclusion

During this fiscal year, the government was forced to recognise reality and modestly promised to increase health care funding compared to the Budget plan.

While these changes are an improvement, they fall far short of altering the problems noted above, and do not change the longer-term plan. The new Budget must make plans for significant health care funding increases, for the coming year and beyond to deal with an aging and growing population. We recommend:

- A 5.3% increase in hospital funding along with comparable (or greater) increases for long-term care and home care

In the longer run, Ontario must make progress towards returning to the average funding in other provinces. We are not a poor province and we should not be asked to accept below-par health care.