Submission to the Standing Committee on Finance & Economic Affairs

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Kingston Health Coalition

93 Hillcrest Avenue
Kingston ON K7K 4L7

613-542-5834

As an affiliate of the Ontario Health Coalition (OHC), we are familiar with the statistical data provided by our parent organization documenting the inadequacy of funding of health care services in Ontario. We will provide some local data consistent with the provincial numbers provided by the OHC. However, we believe that you are going to be satiated with numbers. This presentation will try to put a human face to the numbers.

Recently we organized a Kingston media conference on the OHC report: "Situation Critical: the Crisis of Violence in Long Term Care". In preparation for that event we heard numerous accounts of the situation in our long term care facilities. We learned of the long waiting list for access to beds. (Health Quality Ontario reports the number of days wait to be admitted to long term care. Averaging the five facilities in Kingston, the wait time from the community is 218 days and from the hospital it is 253 days.) We learned of staff working short shifted because management didn't replace absent workers. We heard of staff accepting violence and assaults as routine because of lack of time to submit reports.

How does this play out for patient care? A resident is sitting in the dining area. In front of him is a glass of juice. He does not help himself to drink it. No one comes over to see if he wishes to drink it. Meal time is over and staff come over and clear the table. His care plan included adequate hydration.

Residents in long term care should not fall. Proper assessment, care plan and staff attention is vital to fall prevention. Staff often find themselves in a situation where they are carrying out a care plan for a patient, including assisting them to a toilet when another patient rings for help. All back up staff are similarly already occupied. Without sufficient resources the unattended resident manages to get out of their chair and stumbles on the way to the washroom. The person ends up in hospital and upon return to the long term care facility, languishes and dies. A fall is more than a physical accident, it is a social and psychological trauma. But it is also a traumatic experience for the staff. They experience guilt and public embarrassment. (Health Quality Ontario reported that, averaging the five facilities in Kingston, 20.7% of patients fell.)

And even if the calling resident doesn't fall, often they soil themselves because they can't get to the washroom. How embarrassing is that and how often is skin irritation and infection risk a consequence?

Of course, lack of availability of a long term care bed often results in falls in the home, violence in the home, and the victim of dementia wandering off. These events should be counted as a failure of the long term care system, but they are hidden from statistics. For the family member, this is grossly unfair. The family member faces the guilt and shame. There is a heavy 24 hour per day burden on families (especially women) trying to look after a relative who has been determined to need the ongoing care of a long term care facility. Remember, this is likely after the family has already engaged in many months of supportive care. Having families (often an elderly spouse) overwhelmed with accelerating care needs wait almost a year is unjust and inhumane.

Recently, one of our participants met an individual living the reality of caring for a family member in the home. This woman (and it is usually a woman) has been taking care of her father for two years. To do so, she had to withdraw from the work force. She is the caregiver 24/7 with limited home care assistance. Her father is housebound and seriously mobility challenged. Respite care is very limited and she can't afford $20 to $60 per hour for help. (The amount could be much higher if nursing care

was required.) Socially isolated and facing burn out she had limited access to respite; She had not had a day off in a years time. She did not complain about her sacrifice; she just felt forgotten and lonely. Nevertheless, she noted, society didn't compensate her for her work and the social value of her work.

Our hospital is often operating at or over 100% of bed capacity. The long wait times for long term care beds is a factor in this situation. The excess of in-patient bed utilization is exacerbated by the insufficiency of alternative care beds and lack of family support in the patients' homes. If you examine the Kingston Health Sciences Centre's 2018-2019 Management Discussion you will find the following information.

"A key cost driver for the organization is the volume of patient activity provided. Inpatient occupancy rates exceeded 100 percent throughout several months of the fiscal year... "

"Although initiatives were actioned during the year to reduce the number of patients in the hospital awaiting access to non-acute care facilities, the number of non-acute patients increased by 20% from prior year. "

As also asserted in the same report, a driving factor also is the growing acuity of patients entering the hospital.
"The overall total inpatient days increased approximately 4 per cent over the previous year. Total acute care activity increased 3.8 per cent (5990 inpatient days) and adult mental health activity increased 4.8 per cent from the prior year (613 inpatient days). **Acute average length of stay:** KHSC is 0.10 of a day "

This is similarly reflected in the ER situation
"...the Emergency Department was regularly at capacity in part due to the longer inpatient stays in the Emergency Department as a result of overall high bed occupancy in the hospital. Also, there was an 8% increase for the high acuity non-admitted patients and these more complex cases length of stay is longer."

Imagine arriving at the ER in Kingston General Hospital and sitting for four hours suffering from pneumonia and not being seen. When finally seen you are determined to be in need of oxygen and antibiotics and admitted to the hospital. There are no beds, so you are kept in ER for 3 days. Imagine being in severe pain from a fall, but not being seen promptly because you are not critically ill. Imagine sitting for hours with a child in the crowded waiting room and trying to keep the child occupied. (The average wait time to be seen is reported to be 1.6 hours with an average stay of 4 hours for acute care. However, patients admitted spent on average 18 hours in ER at Kingsto General Hospital – data reported by Health Quality Ontario).

We have seen people placed in sun rooms and in waiting rooms until a regular room becomes available. Worse, we have seen someone on a makeshift bed in a hallway surrounded by partitions, no access to a washroom, waiting for a regular bed to be available.

You also need to be cognizant of the serious risk of having hospitals operating at 100% of capacity. Once again a corona virus is circulating. Are we ready to handle an epidemic of hundreds of seriously ill people? Where are we going to put them? What resources do hospitals have to respond to such demands if this is a lengthy crisis? The Minister was quoted recently as saying the government recognizes the reality of hallway medicine and is taking steps to address the situation, but it will take years to see the results. As Keynes said,"We will all be dead in the long term."

Increasing acuity of patients admitted is an ongoing trend. The increase in the number of elderly in our population, the diversion of the sick to home care and other factors means that people are sicker by the time they reach the hospital. This trend is made worse by the failure to fund health maintenance resources in the community. We have reports of diabetics not being able to provide themselves with sufficient supplies because of reductions in funding these supplies. For example, the number of test strips allowed is inadequate and lower income people without insurance plans lose control of their blood sugar levels. We also note the large number of patients sent home from hospital on home care plans who end up back in the hospital. Relapsing patients are sicker when they return. (Health Quality Ontario reports that over 11% of patients sent home from ER return within 30 days in the South East Region.)

Not unusual is the complaint of patients sent home from surgeries, such as orthopaedic surgeries, without caregivers in the home or into living quarters that have accessibility challenges. Having to climb stairs is an example. In the majority of cases people adapt, However, the anxiety and insecurity is palpable. Occasional adverse outcomes contribute to the burden on the health care system. We don't measure suffering in the costs of such practices. We only count the immediate goal, such as "unblocking beds". Inadequate funding promotes such a short term perspective that is system focused and that has individual and long term costs.

The situation in Kingston is aggravated by the shortage of family doctors. Primary care provides the early intervention and coordination that helps people manage their health. (In a news report by Global News in February of 2019 a datum of the Health Experience Survey indicated that15,000 individuals in Kingston did not have primary care physician.)

Cutting of public funding for such services as physiotherapy is penny-wise and pound-foolish. Consider a patient who has suffered a herniated disc. Usually a professionally managed exercise plan will result in a better outcome in the long term than surgical intervention, and the cost is less. What is the waiting time to receive public physiotherapy services at Providence Care Hospital? We know of patients who waited so long they don't remember for which issue they were referred.

Adding to the challenge of remaining functional with a health condition is the shortage of various specialties in Kingston. Shortages in neurologists was well documented in the past. Currently, we have observed long wait times for dermatologists and access to pain clinics. Put yourself in the position of a Kingstonian who had to wait a year to be seen at a pain clinic. The person was referred by her physician because the condition was chronic and attempts to manage it by the family medicine clinic had been insufficient. Consider the implications of this situation. Sleep deprivation and dependence on large doses of pain medication are harmful to the health of the person. A person in pain suffers psychological stress and social dysfunction. Maintaining employment is difficult. Of course, it is inhumane to leave a person in severe and even agonizing pain. Loss of income and, ultimately, development of further health complications impact our society financially. More complex care costs more to all.

What does this mean for the expenditure plan of the province? Let's take a page out of the history of mental health care. With the development of psychiatric medications in the mid 20th century it was

possible to control symptoms and to allow people to live in the community. The governments readily responded to the social movement for patients' rights to decrease hospitalization. There was a promise to use the financial savings to provide community support services. This promise was not fulfilled. The living situation of the ex-patient tended to be substandard. Inadequate housing, insufficient counselling and lack of respite spaces led to increased incarceration rates, increased homelessness, increased addiction rates and lack of employment opportunities.

In its time in office, the current government has made things worse. It was recognized that mental health services were severely underfunded. When the current government took office there was a plan to invest 2 billion dollars in mental health services over a period of two years. The government then reduced that amount to $1.9 billion over ten years. It is easy to target the psychiatric challenged folk. They have fewer resources to resist. They are not well-organized. They face stigma and fear in the general population. And when they deteriorate through lack of services they become more vulnerable and more subject to arrest. The situaton of autistic children is similar. We know of parents of autistic children who have now quit work and mortgaged their houses. We have been informed that parents have contracted for private services (unregulated) which have not been delivered or were inadequate.

A copy of a letter sent to the Honourable Minister of Health Christine Elliott was shared with us. Here is an excerpt from the letter which further illustrates what we are advocating.

"...My friend Meghan (has) two sons (ages 5 and 3) both have Epilepsy. The older son has Dravel Syndrome (a life-threatening form of Epilepsy). They are otherwise happy and sweet boys. Caring for them constantly, takes it's toll on their parents. We need to provide the social support that they need to ensure a strong family. The societal needs in question are not only physical, but social and emotional as well. We need a system in place who supports families, not burdens them until they break. The impact of that is life-lasting."

"Children with special needs, like Clive and Hobbs, also need support in classrooms. Proper classroom support is essential to the well-being of **all** students. I have a 5 year old in SK in a school with a lot of high-needs children. The other kids can be really negatively impacted when the special needs kids are not getting the care they need. I have been very grateful for the Educational Assistants in my sons class in the past. They have provided quality support, but also modelled and demonstrated kindness, graciousness and empathy to the other students."

Health is addressed beyond the realm of clinical services, and the budget needs to take this into account.

This is very apparent in Kingston. Lack of adequate addiction services and safe injection sites result in larger numbers of emergency room visits for mental health reasons and homelessness. Being a centre for federal corrections, Kingston's prisons have a large number of offenders who need psychiatric care.

Cutting services and resources in the community can lead to much greater costs, financially and socially, than what was saved. The elimination of post hospitalization housing assistance for patients released from the psychiatric unit of Providence Care Hospital has had detrimental outcomes. (Note that these were not unforeseen effects; staff were dismayed at the cuts.) It has led to released patients moving into situations that reinforce their symptoms and, in cases of dual diagnoses, relapse is triggered by being placed in close association with dealers and users.

It is critical that the government address the medical care challenge (for many a crisis) by adequately funding health care. The increasing acuity of patients, the growing demand for long term care beds and the growing mental health crisis require funding above the rate of inflation. The Ontario Health Coalition has made the case for avoiding the trap of moving people out of hospital with inadequate home care resources or into long term care as a cheap substitute for chronic care and rehabilitative care. We have seen mentally alert and competent individuals moved into long term care facilities that do not have required physiotherapy and occupational therapy resources to help them live fulfilling lives. Imagine being surrounded by people with dementia who absorb much staff time and who have limited sophisticated social functionality, with no prospect for improvement.

There may be legitimacy in the argument that home care and suitable alternative care options could reduce acute hospital bed occupancy. However, the lesson from mental hospital closures is this cannot be done on the cheap. FIRST, there must be adequate and proven alternatives. For example, home care must be adequately funded. This includes resources so that people living alone are looked after and not left isolated. Families must also be adequately resourced. Not only with medical knowledge and skills, but with the capacity to maintain their life and careeer trajectories.

Turning to home care as a low cost solution to reducing the cost of health care may well be a -pipe-dream. Humane and quality home care services may lack the advantage of lower marginal costs. Grouping people together to receive care may be more efficient than trying to deliver care in a scattered way. There are many advantages to helping people remain in their homes, but saving money may not be one of them,

Kingston, like the rest of Ontario, has fewer hospital beds per capita than the rest of Canada. We need more beds and more staff until a quality alternative exists. Long term care facilities ARE NOT that alternative as they currently function. It is apparent to us that the private for-profit model has made things worse. We need a guaranteed four hour direct care minimum per resident per day standard. That means that more acute patients need even more hours. It has been proven in the Scandanavian countries that such a standard reduces falls and violence and other indicators of poor care. The private sector has asked for more money while resisting the minimum care standard. Also to reiterate, an alternative to acute hospitals is often specialized longer term care, not hiding people away in warehouses.

What we are asking is that funding be increased significantly, not decreased. We are asking that clear performance standards be mandated for the money spent. We are asking that a tried and true program of alternatives to acute hospital care be developed through demonstration program and pilot projects and rational methods, rather than putting the power into a hatchet operation that lacks an evidentiary base. We are urging the government to discard the ideologically driven idea that profit will cure the health care crisis. It has made the laboratory system worse, the long term care system worse, the home care system worse. (If you want evidence on the home care system being broken, consider how hard it is to keep PSW's motivated to remain in the field.)