Pre-Budget Submission from the Ontario Council of Hospital Unions (OCHU/CUPE) to the Standing Committee on Finance and Economic Affairs of the Ontario Legislative Assembly

19 January 2022

The Ontario Council of Hospital Unions / CUPE represents 40,000 workers in hospitals (and some long-term care homes) in communities across the province. We represent dietary workers, housekeepers, maintenance staff, IT staff, stores and warehousing workers, Personal Support Workers, Registered Practical Nurses, pharmacy and laboratory workers, Porters, and many others.

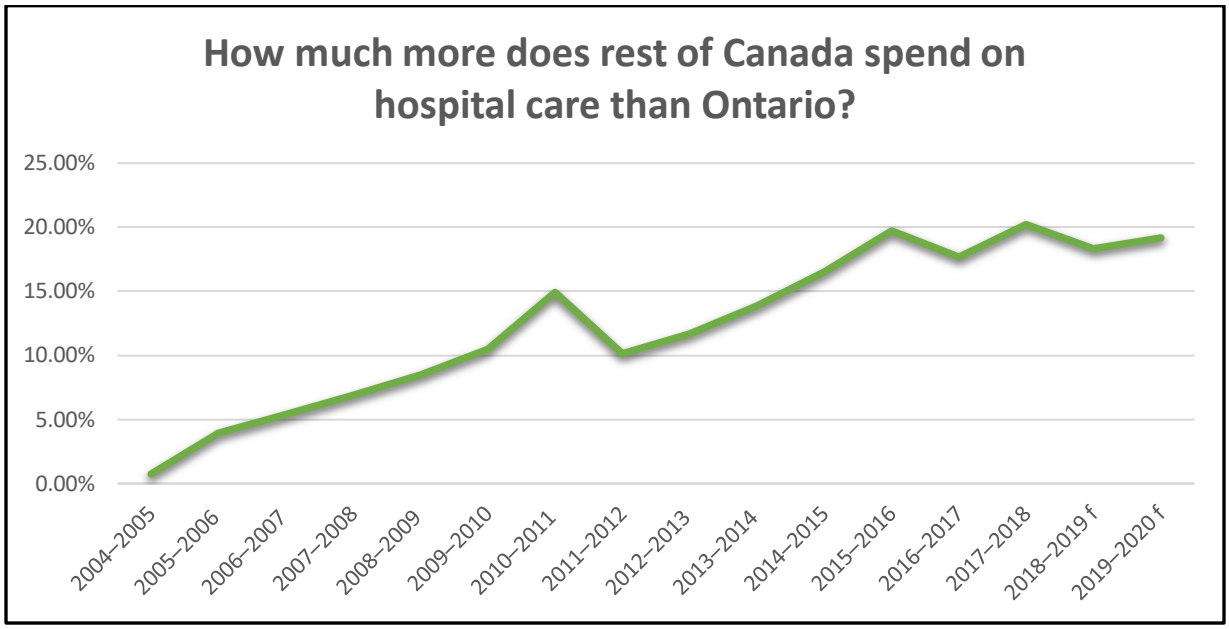
OCHU has appeared before this committee for many years noting the problems of underfunding and understaffing. These problems have become even more clear with COVID. Despite temporary, emergency funding increases, understaffing has come home to roost and is now on full display in hospitals and long-term care.

We will: [1] review the underfunding and the associated understaffing situation prior to COVID that set us up for the current problems; [2] discuss how COVID exacerbated these problems; [3] note how existing plans fall short, and [4] indicate how plans must be improved.

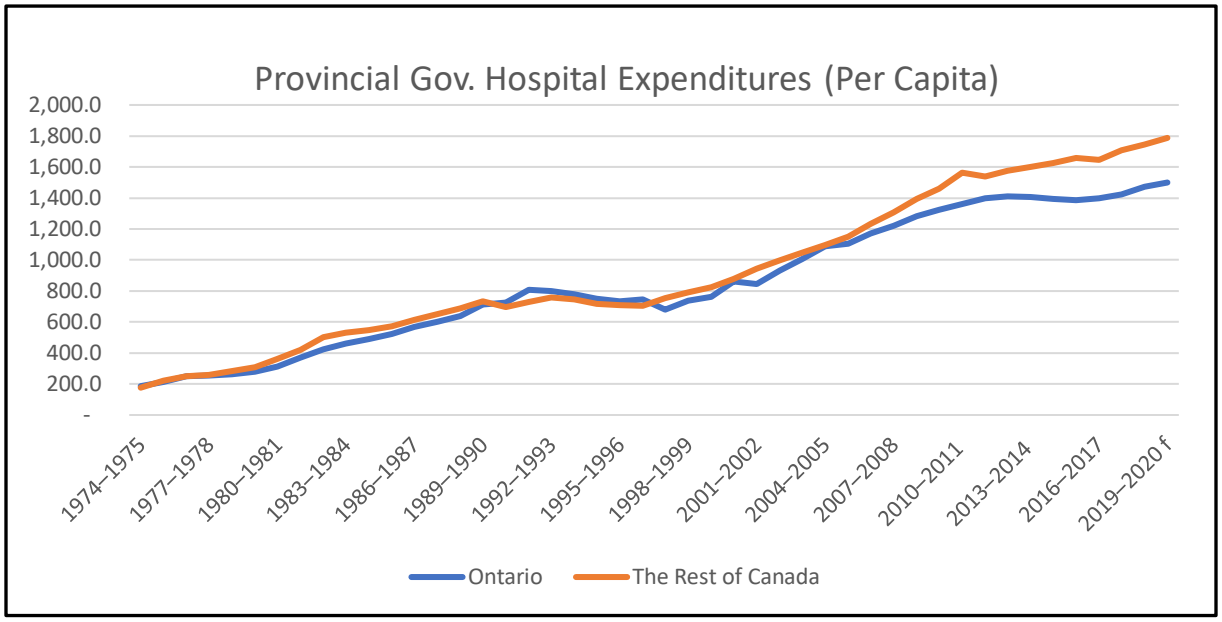
[1] The long-term problems

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.

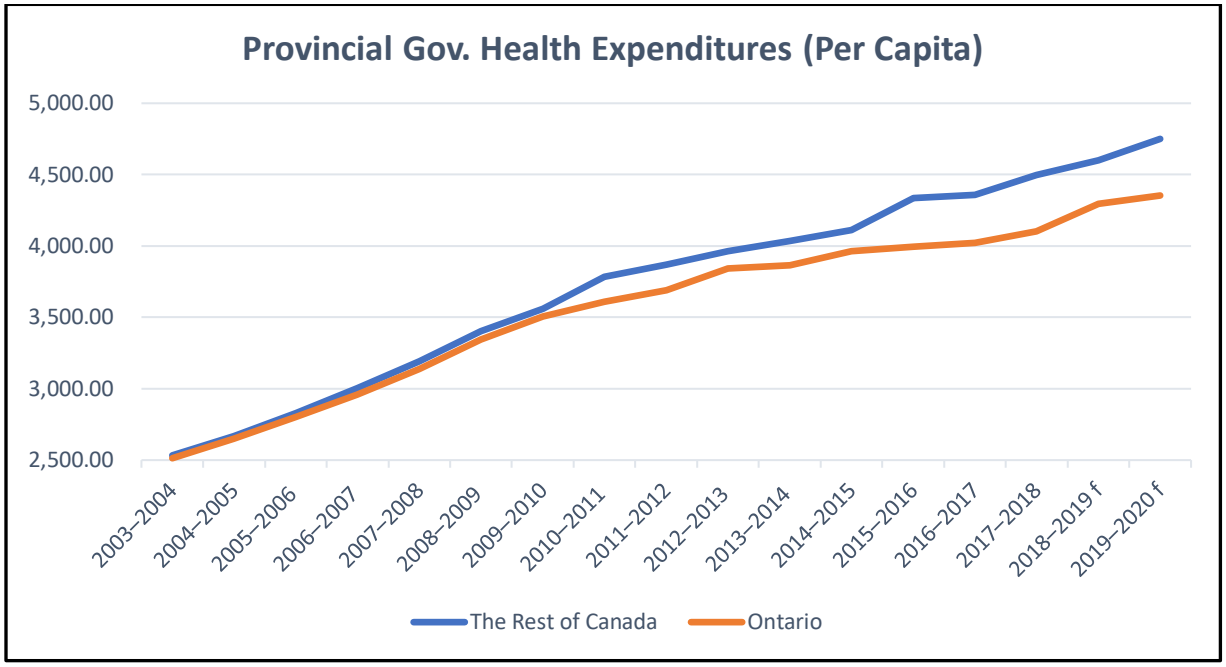
Ontario provides much less funding per capita to hospitals than other provinces and territories:



The gap between Ontario and the rest of Canada is a relatively new phenomenon. For decades we were in lockstep with the rest of Canada. We have fallen far behind since 2004-2005.[1]



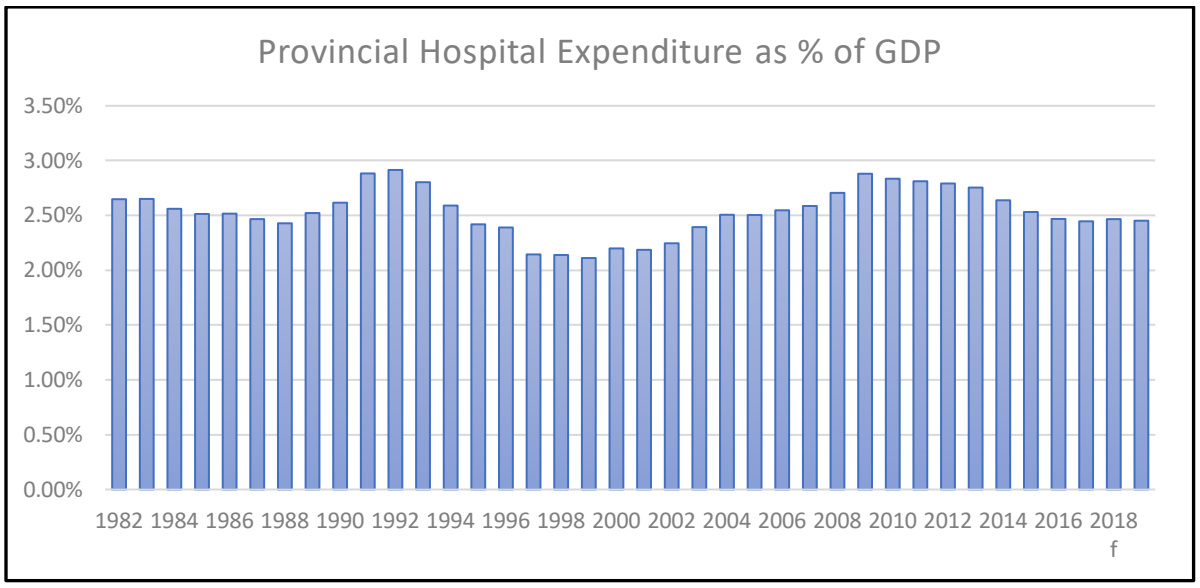
A similar trend is seen for provincial government expenditures on all forms of health care. Notably, hospital underfunding accounted for 72.5% of health care underfunding in Ontario compared to the rest of Canada.



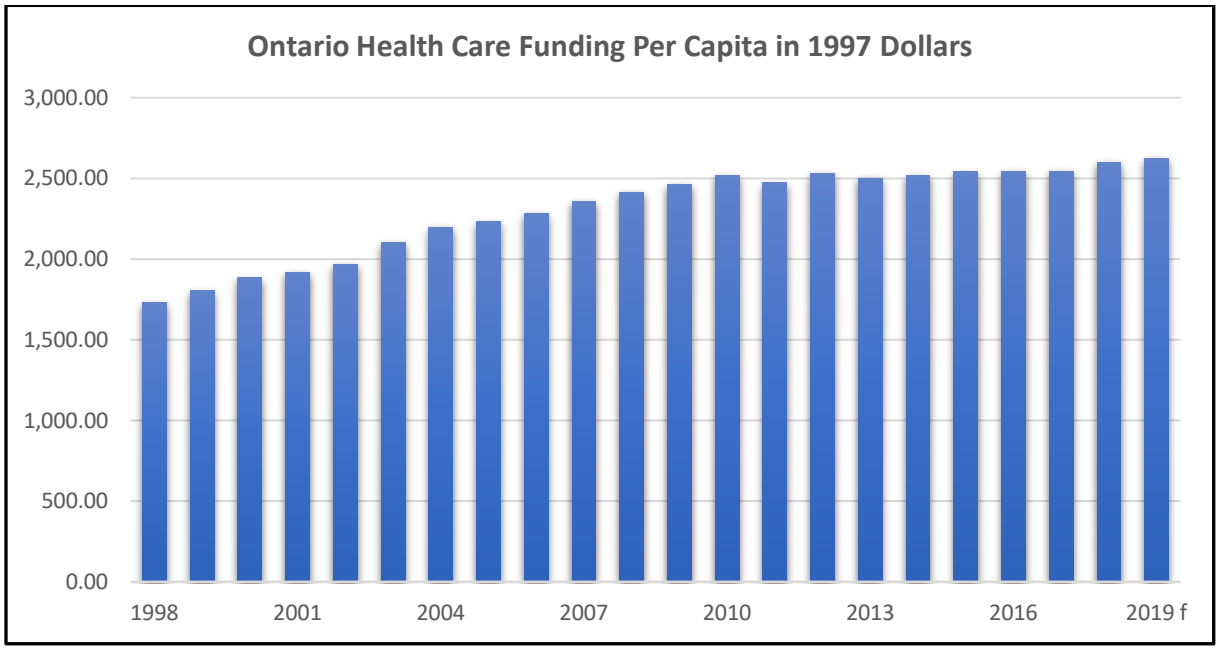
[1] The historical funding data in this brief comes from the Canadian Institute of Health Information data set associated with its National Health Expenditure Trends, 1975-2019.

Aging: This underfunding occurred while the population was rapidly aging. The median age in Ontario has increased from 30.0 years in 1980 to 40.4 years in 2020 according to Statistics Canada.

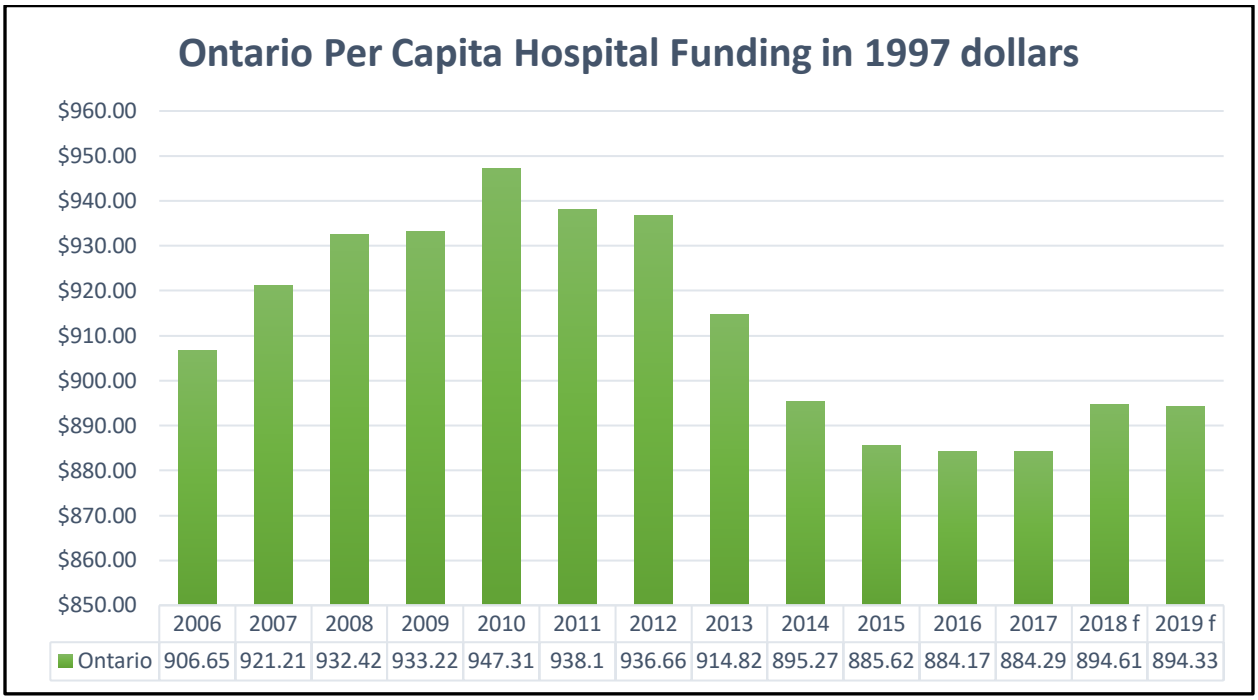
Despite aging of the population, provincial expenditures on hospitals have remained flat for at least 39 years at about 2.5% of GDP. In 2019, expenditures were just below that level.



Ontario health care funding per capita in real terms remained almost constant between 2010 and 2019.

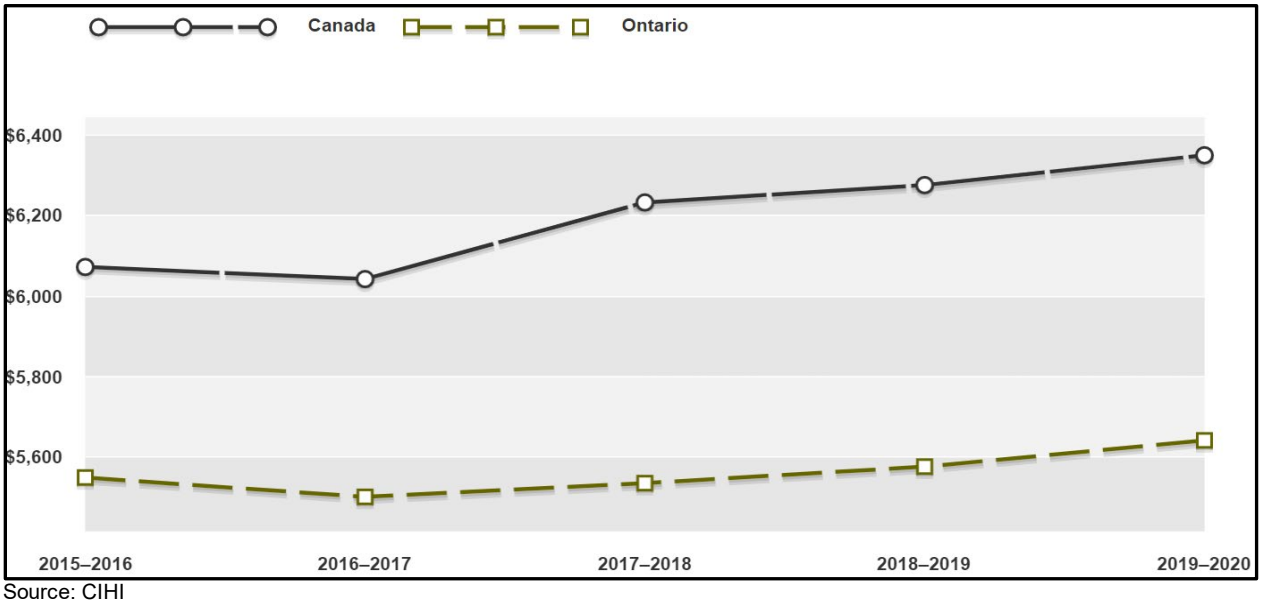


Real hospital funding per capita went down 5.4%. In contrast, the economy grew over 20% between 2010 and 2019.



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

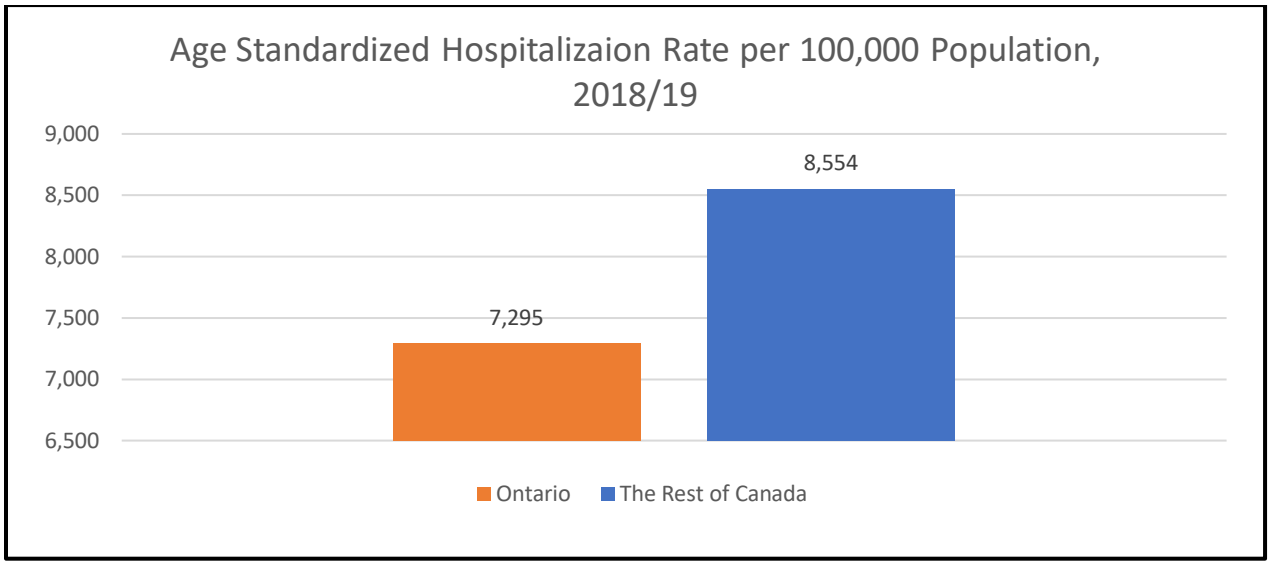
With austerity, the cost for an average hospital stay in Ontario fell further and further behind the Canadian average. By 2019-20, gap had grown to over $700 per inpatient. That was up from $540 only three years earlier.



Source: CIHI

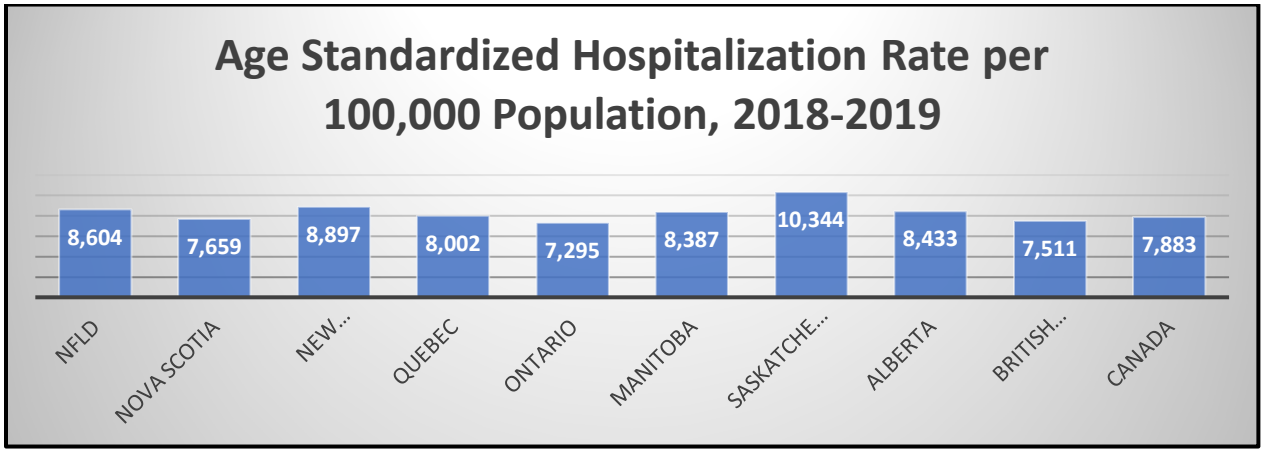
The Consequences: The result of this underfunding is predictable: fewer staff, fewer beds than the rest of Canada, far fewer beds than other developed countries, extraordinarily high levels of bed occupancy, very short lengths of stay, a low level of patients treated in hospitals, higher than average (and rising) levels of readmissions, 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.

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 18.2% more discharges per 100,000 population in the rest of Canada (TROC) than in Ontario:

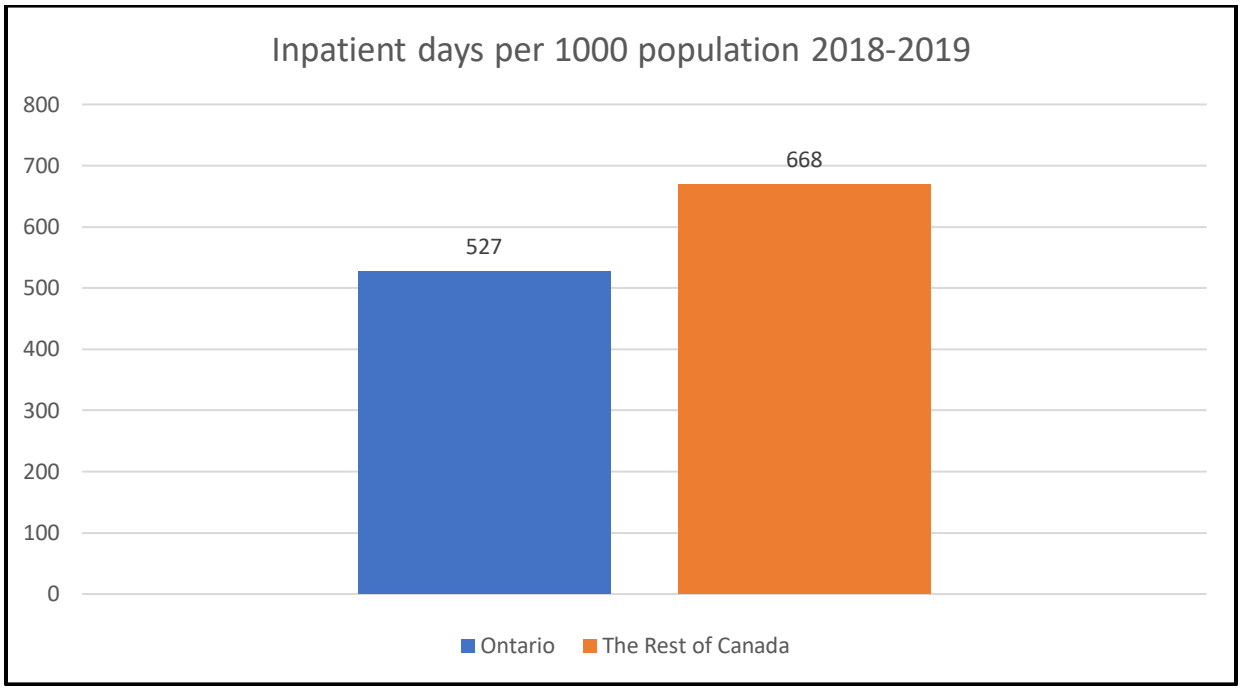


Source: CIHI data, Report name: "Inpatient Hospitalizations: Volumes, Length of Stay and Standardized Rates" and Statistics Canada population report

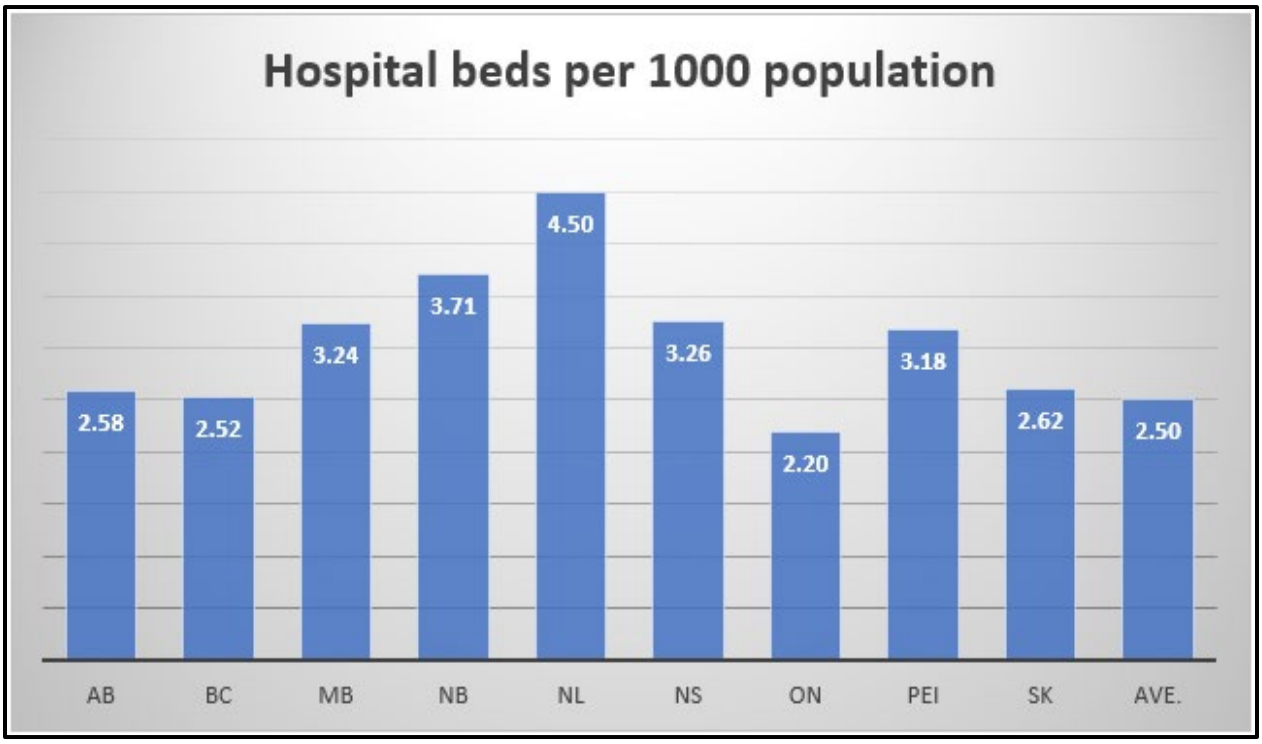
Ontario has the lowest hospitalization rate of any province in Canada.



As a result, the rest of Canada has ***27%*** 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.

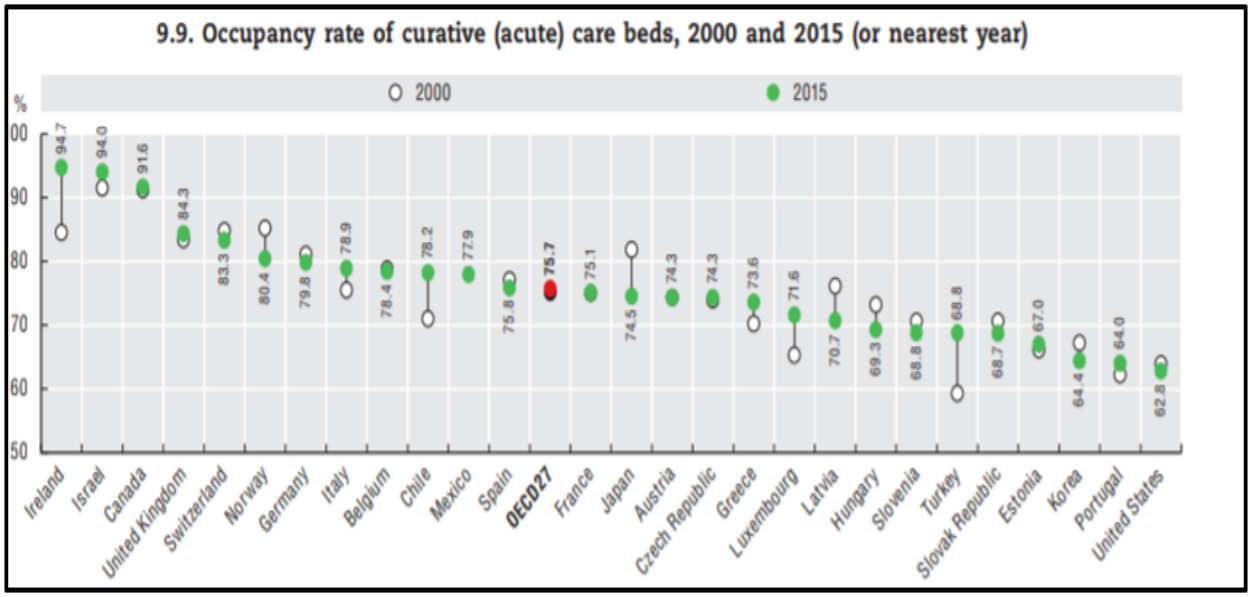


For Ontario to meet the average for provinces outside of Ontario (2.81 beds per 1,000) we needed another 8,793 beds. This in large part explains the very high bed occupancy and hallway health care often reported by Ontario media.

Accordingly, the Financial Accountability Office (FAO) reports:

> The average occupancy rate of both acute care beds and total hospital beds was 96 per cent in 2018-19, which included approximately 28 hospitals where the average occupancy rate for the year was over 100 per cent. Due to the lack of beds compared to patients, some hospitals have relied on placing patients in emergency rooms, in unconventional spaces (such as hallways) or on stretchers. On average, hospitals reported that 1,057 patients received care in these unconventional settings each day in 2018-2019. Overall, in comparison to other countries, Ontario's rate of total hospital beds per 1,000 people is among the lowest in the Organisation for Economic Co-operation and Development (OECD) and Ontario's occupancy rate of 96 per cent is the highest.[2]

Notably, Canada as a whole has 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:



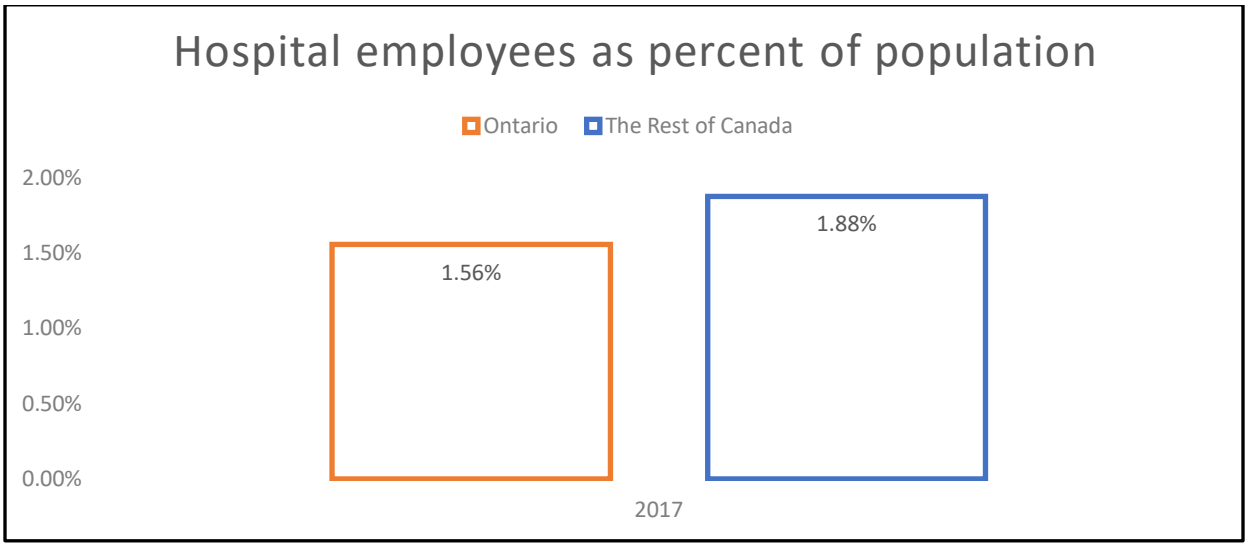
Under the OECD definition, "curative" hospital beds excludes rehabilitative and long-term care beds. Source: Eurostat, "Health care resource statistics – beds," 2016, http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_resource_statistics_-_beds

[2] The FAO, The Ontario Health Sector, April 28, 2020, https://www.fao-on.org/en/Blog/Publications/health-2020 .

Also notable, 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.[3]

Low levels of staffing: 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.



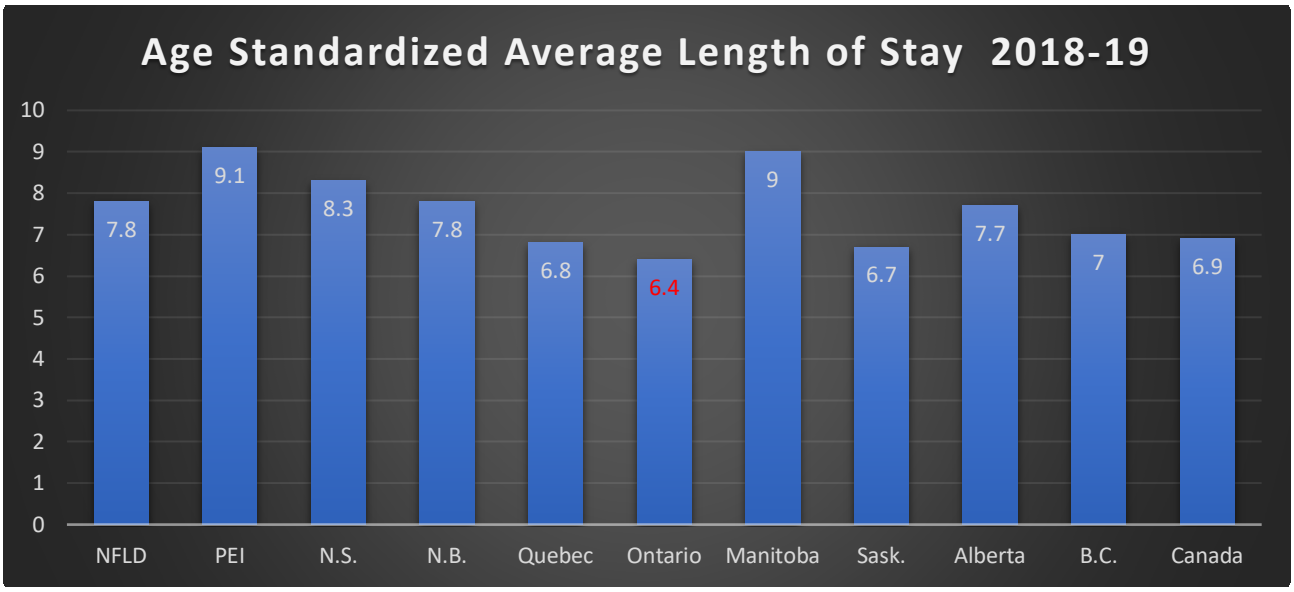
Hospitals across the rest of Canada are already staffed 21% more than in Ontario. If Ontario hospitals had the same staffing as hospitals in the rest of Canada, there would be **45,000 more hospital employees in Ontario**.

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 7.8% longer in Canada as a whole than in Ontario[4]:

---

[3] The Auditor General Office, *Annual Report 2019*, https://www.auditor.on.ca/en/content/annualreports/arreports/en19/2019AR_v1_en_web.pdf

[4] CIHI, Report Name: Inpatient Hospitalizations: Volumes, Length of Stay and Standardized Rates Report ID: HAS5, 2020 Canadian Institute for Health Information



[2] Things become worse during COVID

Ontario has run its hospital and long-term care system with inadequate funding and staffing for many years. This became particularly apparent during COVID when the extra pressure of COVID caused chaos and death in long-term care. Government was forced to promise to increase the staffing standard that OCHU, CUPE, the Ontario Health Coalition, and many others had demanded for many years.

The crisis in LTC in 2020 was likely driven in part by a recognition in government that hospitals lacked capacity to deal with a surge in patients. This lack of capacity is evident again with the current crisis in hospitals. Even with the government's Hail Mary (and often temporary) increases in health care funding after COVID, capacity cannot simply be conjured up. As a result, a staffing crisis is now rampaging through hospitals, long-term care and home care, and hundreds of thousands of surgeries and procedures have been cancelled or postponed.

Health care staffing shortages grow: Across Canada, the number of vacancies for health care positions has increased dramatically during COVID. Notably, however, this increase only exacerbates a trend since 2015, whereby the number of vacancies for health care jobs has increased.

Registered Practical Nurses: RPNs (or LPNs in provinces outside of Ontario) saw the most rapid percentage increase in the number of vacancies of any occupation reported in Canada over the first year of COVID, according to a recent Statistics Canada report, with vacancies increasing 94% in one year.

The 10 occupations with the largest year-over-year increases in job vacancies, first quarter of 2021

	Year-over-year change	
	level	%
Registered nurses and registered psychiatric nurses	7,230	56.2
Nurse aides, orderlies and patient service associates	5,395	45.4
Licensed practical nurses	4,005	94.0
Material handlers	3,525	50.1
Store shelf stockers, clerks and order fillers	2,845	39.8
Carpenters	2,290	51.7
Home support workers, housekeepers and related occupations	2,270	35.4
Social and community service workers	2,220	38.1
Landscaping and grounds maintenance labourers	2,000	48.7
Construction trades helpers and labourers	1,995	22.0

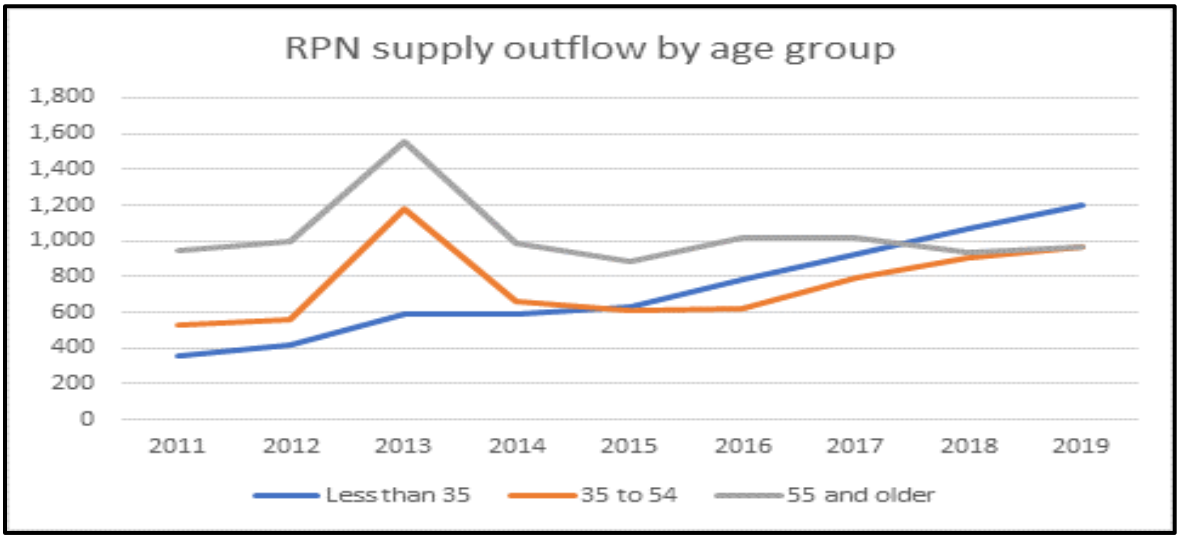
Source(s): Job Vacancy and Wage Survey (5217), table 14-10-0356-01.

RPN vacancies in Ontario increased over the same period from 1,715 to 3,700 – an increase of almost **2,000** or **116% in one year**, while RN vacancies in Ontario saw a very significant 78% increase. In both cases, this is a more rapid increase than the reported cross-Canada increases.

While RPN vacancies have exploded during COVID, they also increased very significantly in the years leading up to COVID, gradually creeping up from less than 600 in the first quarter of 2015. In other words, RPN vacancies have increased more than six-fold since 2015. RN vacancies over the pre-COVID period also increased significantly, but not at quite so rapid a pace.

Based on data from the second quarter of 2021, there was 7.54 vacancies for every 100 RPNs in the workforce. This is similar to the level for RNs – where there are about 8.6 vacancies for every 100 RNs in the workforce.

The longer-term increase in the number of vacancies is likely exacerbated by a sharp increase in the number of RPNs who are leaving the profession that are under the age of 35.



Other health care work: There has been a significant increase in vacancies for other hospital occupations in Ontario as well as for RNs and RPNs. Statistics Canada provides details on two significant categories for service and office health care bargaining units:

> [a] "Nurse Aides, orderlies and patient service associates" saw vacancies increase from 4615 (in the first quarter of 2020) to 6915 (in the second quarter of 2021). That is a 50% increase in just over a year. Notably vacancies in these classifications were in the 2,000 area in 2015-2017 quarters, with gradual increases to the 4000 vacancy area in 2019. So, this area has also seen, like RPN work, a steady increase in the number of vacancies in the pre-COVID period, with vacancies now over three times the level found in 2015.
>
> [b] "Other assisting occupations in support of health services" saw an increase from roughly 395 in the first quarter of 2020 to 710 in the second quarter of 2021. That is an 80% increase in just over a year. These classifications saw roughly 250 vacancies reported per quarter in 2015, so they too have seen a very significant increase over the pre-COVID period as well.

Combining the classifications in [a] and [b] above, we can say that vacancies increased three-fold since 2015.

So:

- During COVID there was a 116% one-year increase in RPN vacancies in Ontario – 2,000 *more* vacancies in the quarter.
- RPN vacancies are over 6 times higher than in 2015.
- Other health care service and office occupations have also seen a significant increase in vacancies – we are currently seeing three-fold the number of vacancies in 2015.
- The increasing number of vacancies has been exacerbated by COVID, but this trend also pre-dated COVID.

Increasing vacancies and younger staff leaving the health care workforce are signs that health care employers are having difficulties attracting staff. While there have been some attempts to increase the number of people trained for health care work, this will be overwhelmed by the need to recruit tens of thousands of *extra* staff to deal with an aging population. Given plans to increase LTC beds and staffing hours, improving recruitment and retention, should be an urgent issue for government and health care employers.

To date, however, there is little sign of any urgency to improve wages and working conditions. Indeed, for almost all health care occupations, the *plan is to decrease real wages* significantly through Bill 124's three years of wage restraint. The Ford government needs to change direction and improve health care working conditions. It must make hospitals and health care an attractive place to work.

Surging Demand for More Health Care Workers is Coming: The Financial Accountability Office (FAO) reports that achieving the government's post-COVID policy of four-hours care per resident per day in long-term care (LTC) will require 17,000 new full-time Personal Support Workers (PSWs), and 12,200 new full-time nursing jobs (RPN and RN), by 2024-2025.

The FAO also notes that only 40% of RNs, RPNs, and PSWs work full-time in LTC. As a result, the actual number of new nursing and personal care staff that will be needed to be trained or recruited will be more like 160% of those figures (assuming part-time staff work on average half-time). That would mean Ontario would need 27,200 new PSWs and *19,510* new RPNs and RNs, by 2024-25.

In addition, the government plans to add 30,000 long-term care beds over the decade. By 2024-25, the FAO estimates that four-hour staffing standard *and* the new LTC beds due by 2024-25 will require 37,000 RPNs, RNs, and PSWs. Given part-time work, that would **require 59,200 extra RPNs, RNs, and PSWs by 2024-25**. That is, roughly 25,000 extra nurses and 34,000 extra PSWs by 2024-25.[5]

The opening of these new beds is driven by a rapidly aging population that requires more health care services. That demographic trend will also drive up the need for additional RPNs, RNs, and PSWs, working in hospitals, home care, community care, and other health care sub-sectors.

Another factor that will drive-up need for RPNs, RNs, and PSWs is the surgical and medical backlog occasioned by the postponements associated with COVID-19. The backlog is very significant and, according to the FAO, the backlog created *before* the omicron wave will require $1.3 billion and three and a half years to resolve. Presumably, the backlog is now significantly worse with the reduction in surgeries and procedures during omicron.

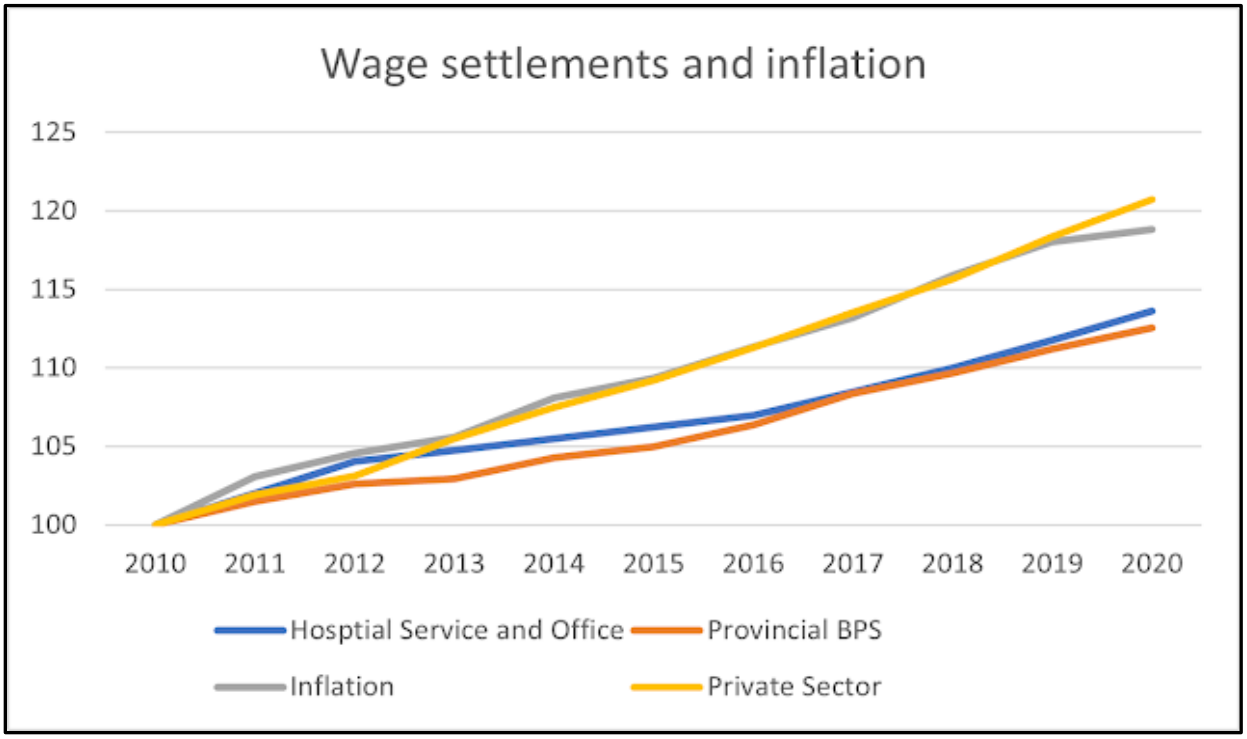
[5] As may LTC beds will be opened after 2024-25, the new staff needed will continue to grow through the decade. By our estimate, 30,000 new beds will require over the course of the full decade an additional 25,000 full time employees (or 40,000 working RPNs, RNs, and PSWs, given part-time work). This will continue to drive expansion of the health care workforce through the decade.

Existing Staff Shortages: These factors that will drive up demand are *on top* of the normal recruitment and training needed to replace existing LTC, hospital, and home care staff, as they quit or retire. Notably, premier Ford recently estimated that there is already a 15% shortage of health care workers.

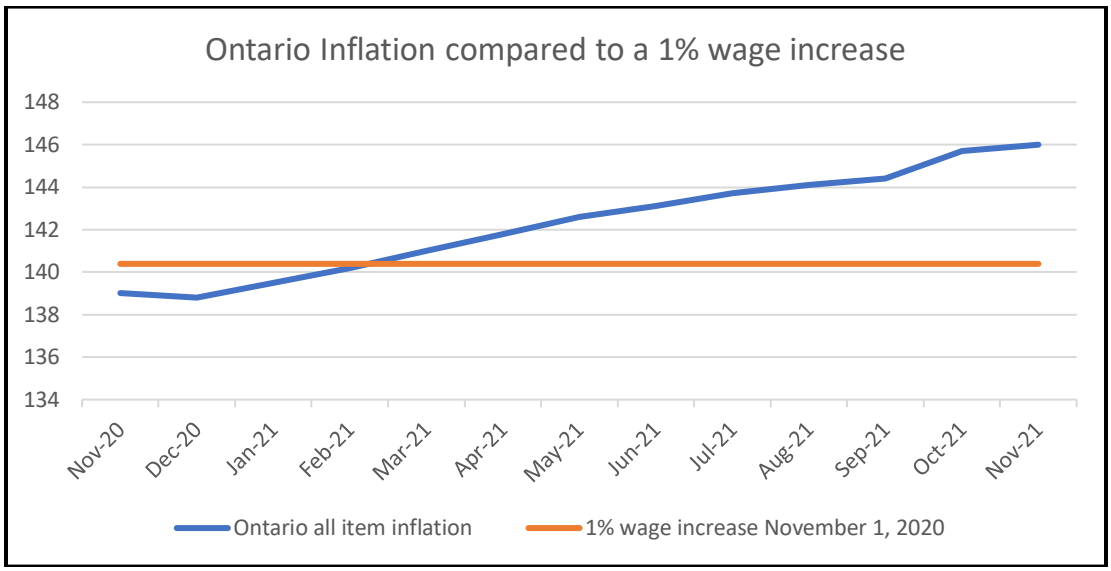
Is there a plan? To date the government's publicly announced plans to deal with staff shortages and surging demand for RPNs, RNs, and PSWs, are very modest relative to need.

Quebec has taken much quicker and larger steps to deal with the staffing shortage by increasing training spots and wages for their equivalent of PSWs. It has also moved to offer significant incentives for nurses to move from part-time work to full-time work and move from private agencies to the public system. The government also plans to hire thousands of administrative workers to relieve nurses from some of their paperwork.

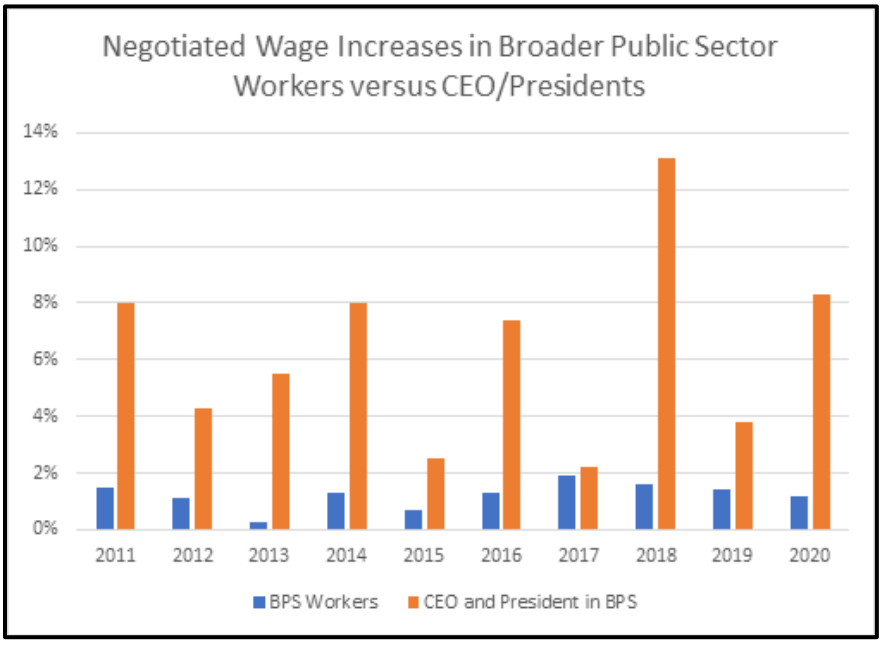
Wage Suppression: In Ontario health care wage settlements have fallen behind municipal and private sector settlements, as well as inflation, for more than a decade as government targeted wage settlements in the broader provincial public sector (BPS). The government plans to continue this wage suppression for hospital and health care workers for several more years through the wage restraints imposed on BPS workers under Bill 124. This has created a major problem in ongoing central negotiations for a collective agreement for the tens of thousands of workers represented by OCHU.



In 2021, wages are falling even further behind. Statistics Canada reports that as of November 2021, consumer inflation was 5.0% higher compared with a year earlier. With broader public sector settlements capped at 1%, **that means a 4% reduction in real wage levels in that year alone,** almost as much as the decrease the government imposed from 2011 through 2020. This is not sustainable. Below is a chart that Ontario inflation over November 2020 through November 2021 compared to an annual 1% wage "increase" achieved November 1, 2020.



Wage suppression has applied to workers in the broader public sector (like hospital workers), but it has not applied to the presidents and CEOs of organizations in the broader public sector, where wage increases have average over 6% annually:



Plan to reduce part-time work: Similarly, Ontario hospitals have strongly opposed union attempts to reduce part-time work and increase full-time work. There is no sign that the government is attempting to change this approach in any way. There is also no evidence to date that the government is attempting to reduce privatized agency work, nor help health care employers hire administrative workers to alleviate RN paperwork.

Take action on COVID and violence: Hospitals and government have also failed to protect hospital workers from airborne spread of COVID-19 and widespread violence against the predominantly female staff. During COVID, we have consistently raised these issues in public campaigns and in central hospital bargaining – all to no avail. Even today, despite the extremely strong evidence of airborne transmission, we cannot get clear direction from government, hospitals, or long-term care facilities that all health care workers should wear N-95s or equivalent respirators.

We believe the experience of patients, residents, and health workers would have been very different if governments, hospitals, and long-term care employers had not fought us so hard to prevent proper protection from airborne transmission.

Injuries and outbreaks under omicron: During the week of January 1 to 8, 2022, Public Health Ontario reported 1,302 health care workers were infected with COVID, up from 812 the previous week. A total of 28,336 healthcare workers have been reported as infected by January 8.

As of 16 January 2022, there are 236 ongoing COVID outbreaks in Ontario hospitals, over 1.5 per hospital corporation: far more than ever before. Many new hospital outbreaks are declared every day. In long-term care, 426 outbreaks are ongoing.

The Workplace Safety and Insurance Board has reported some of the consequences for the first year of COVID, 2020. Lost time injury (LTI) claims for health care support workers increased from 4,271 claims in 2019 to 7,850 claims in 2020. **That is an 84% one-year increase in LTI claims.** As a share of all LTI claims, health care support workers accounted for 6.5% of all claims in 2019, but 13% in 2020.

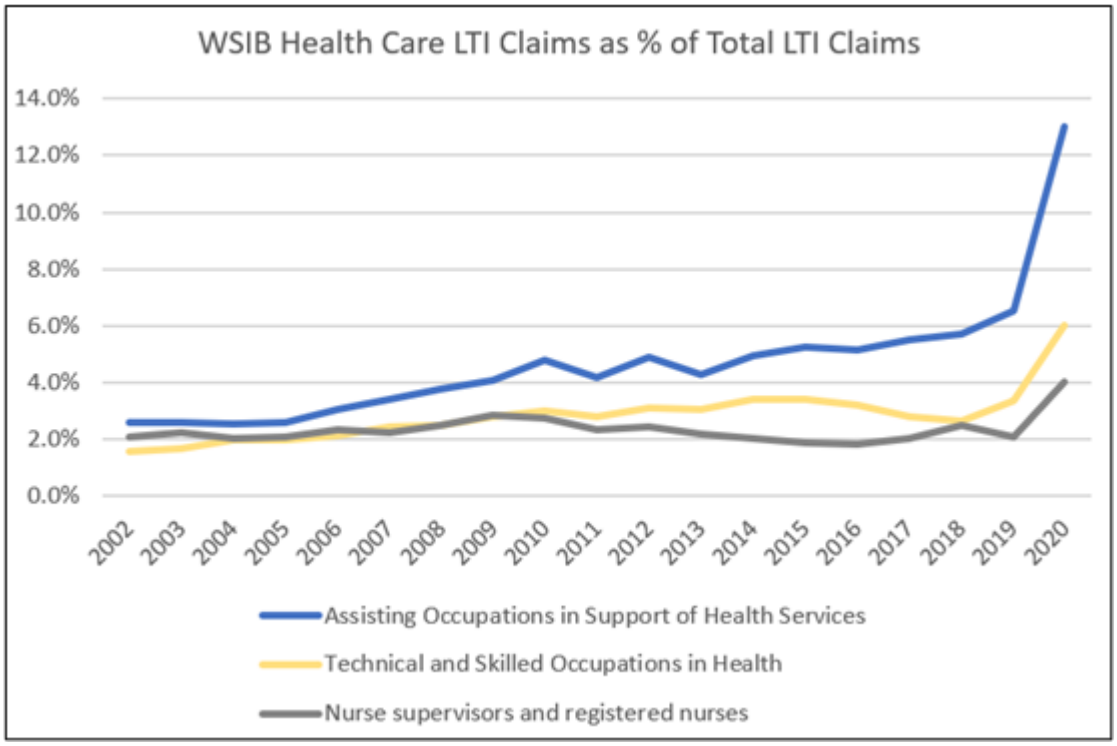
The number of LTI claims by health care support workers was by far the highest of any other occupation reported in 2020 – well more than double the occupation with the second highest number of LTI claims.

The other major categories of health care occupations also saw a major increase in LTI claims in 2020, with RN (and nurse supervisor) LTI claims increasing from

1,378 to 2,433. That is a 76.5% increase, not quite as big as the increase in health care support worker LTI claims but quite remarkable, nonetheless. “Technical and skilled” occupations in health care increased from 2,198 claims to 3,630 claims, a 65% increase.

While health care worker claims increased the overall number of LTI claims for all occupations decreased 8.3% in 2020 – from 65,644 to 60,248. This is another illustration of how hard COVID-19 has been on health care workers.

The increase in health care worker claims in 2020 was driven, of course, by COVID-19. WSIB reports 12,768 COVID-19 LTI claims in 2020, fully 21.2% of all LTI claims.



Bottom line: Heavy workloads, widespread part-time or casual work, violence in the workplace, inadequate protection against COVID-19, and a long-term policy of wage suppression have made hospitals and health care organizations unpleasant places to work. All of this is directed against a largely female workforce. Health care staffing shortages have been building for at least six years and have spiked during COVID-19. The staffing shortages will be compounded by an urgent need to increase staffing by large amounts due to the COVID backlog, unmet needs, and a rapidly aging population. Despite this, there

is very little sign that hospitals or government are taking strong steps to make working as a hospital worker more tempting. Quite the reverse.

[3] The plan ahead

The Financial Accountability Office reported that in the Budget Estimates there is a planned decrease of $4.8 billion in the Operation of Hospitals transfer payment this year. The government believes this will be partially offset by a hoped-for increase of $1.0 billion (to be achieved, apparently, through increased private payments to hospitals for things like parking and semi-private accommodation). These cuts were related to the (*then* hoped for) easing of the pandemic and the government's plan to eliminate its special COVID funding. Since that plan, we, of course, have fallen back into another very bad wave of COVID.

Separate from the elimination of special COVID funding, the Financial Accountability Office (FAO) reported that the nominal health care funding increases planned by the Ford PC government in its last Budget for the years between 2019/20 to 2029-30 fall well short of the nominal increases over the previous nine years (2010/11-2019/20, the period of public sector austerity that followed the last recession).

Indeed, as the increase planned on a go-forward basis (between this year, 2021-22, and 2029/30) amounts to only 2% annually**, we are looking at significantly harsher austerity than the 2010/11-2019/20 period**, where funding increased 3.2% annually.[6]

As the FAO notes, the health care austerity imposed over 2010-20 "included a number of significant spending restraint measures, including: freezing base operating funding for hospitals from 2012-13 to 2015-16; reducing physician payment rates in 2013 and 2015; and limiting investments in new long-term care beds, with only 611 new beds created between 2011 and 2018."

The FAO estimated a $5.7 billion gap between the health sector funding plan and required spending over the next two years, with most of the spending gap in the hospitals program area.

The FAO notes that if the government does implement its plans through 2029-30 "then annual real per capita health sector spending will have declined by $490 per person (or 10.2 per cent) since 2011-12."

[6] Since the FAO review of the Estimates, the government has promised to add $1.5 billion to the health sector for two years. Increases for the health sector for 2022-3 and 2023-4 are now estimated at 2.4% and 2.2% respectively. This will presumably reduce the $5.7 billion funding gap noted by the FAO over the next two years by $1.5 billion.

Reports that the government plans to increase hospital beds in the years ahead are incorrect. As the FAO notes, “the ministry’s spending plan for the hospitals sector implies that the 3,522 surge hospital beds will not be maintained after the pandemic ends”. As a result, the planned “addition” of 324 beds annually will leave us with 1,095 fewer hospital beds by 2029-30. Ontario has very low bed capacity so the surge beds should not be removed, and we should build capacity from there.

Clearly, government plans must be revised.

[4] What should be done?

There are many very helpful things that government can do. In October, we wrote to premier Ford asking for discussion on the following proposals:

• Increase staffing levels to reduce workloads and work to create a working environment where time off is possible and where work is safer.

• Repeal Bill 124 and allow wages to increase in real terms and strongly encourage the creation of full-time employment with benefits and pensions, as Quebec has done.

• Immediately and aggressively require the provision of proper protection against airborne transmission of COVID-19, including N95 respirators for all hospital and LTC workers.

• Take decisive steps to reduce violence in the hospital sector by investing significantly in safety measures. Encourage amendments to the Canadian Criminal Code to enhance protections for health care workers. Encourage the prosecution of offenders.

• Stop hospitals from using private agencies, which actually compete with them for employees.

We would now like to suggest the government convene an urgent summit of health care stakeholders, including unions, to discuss an effective plan to retain existing staff and to recruit tens of thousands of additional staff. Quebec was able to act decisively and add 10,000 staff last year. We can certainly match that with the application of our collective experience and with sufficient resources.

For some years we have suggested that to at least maintain hospital and health care services at their current levels funding must be adjusted with population growth, inflation, and, very importantly, the aging of the population. While in the

past, we have estimated this at 5.3%, inflation is now much higher and so we suggest a bigger increase is necessary to maintain services.

For the longer run, the government must change its plan to cut real funding for hospital and health care services, as outlined by the FAO. The government should at least return to its former long-term funding parity with the other Canadian provinces.

We agree that the federal government should increase the Canadian Health Transfer to the provinces, including to Ontario. We must ensure, however, that all this funding increases provincial health care funding and is used for public delivery of health care services.

Thank you for your consideration.