Submission to the Standing Committee on Finance & Economic Affairs

A submission to the Ontario Ministry of Labour Standing Committee on Finance and Economic Affairs, from the Ontario Public Service Employees Union, Hospital Professionals Division

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Introduction: Hospital professionals facilitate healing

OPSEU represents approximately 24,000 health professionals that provide diagnostic, therapeutic and rehabilitative services in over 75 hospitals in Ontario.

Health professionals play a critical role in the delivery of health services, providing paramedical services such as lab tests, ultrasounds, CT scans, and MRI scans. Without accurate and timely medical testing, doctors would not be able to perform their duties. Paramedical workers that provide on-site hospital testing get faster results and reduce patient travel. This ensures greater efficiency and helps to reduce wait times.

Our members also provide therapeutic and rehabilitative services that facilitate the healing process in areas like social work, physiotherapy, occupational therapy and nutrition. Health professionals play a key role in ensuring that patients successfully transition out of hospital and are not re-admitted shortly after being discharged.

Since the implementation of the new funding formula in 2012, hospitals in smaller communities have lost programs and health care jobs. The hospital system has been destabilized, and overcrowding has become a fact of life. Hospitals are constrained to spending levels as set out by the Ministry of Health and Long Term Care or they face budget cuts. Under this regime they have meted out sustained cuts which have often targeted hospital professionals and paramedical staff who are not considered to be as essential to the delivery of hospital services. This has happened to the detriment of patients.

Communities that have drawn attention to the consequences of the loss of hospital services have had some success at preventing wholesale program closures. Citizens should not have to defend services that are enshrined under the Canada Health Act.

Chronic hospital underfunding

The under-funding and overcrowding in Ontario hospitals continues to place tremendous pressure on hospitals to find savings which often target the less visible but critical aspects of the hospital workforce.

Most recently, the CEO of the Ontario Hospital Association, Anthony Dale, said that, “after four years without an increase in base operating funding, hospitals are now at a turning point. Hospitals are facing extremely challenging budget decisions aimed at containing costs while meeting the increasing service needs of patients.”[1]

In 2015, the Ontario Health Coalition published *"Code Red: Ontario's Hospital Cuts Crisis,"* warning that Ontario's hospitals are living in a permanent state of crisis, having been pushed by years of cuts into levels of overcrowding that are dangerous for patients and staff. The report identified 51 hospital sites slated for significant hospital cuts or the threat of closure.[2]

In 2015-16 the Ontario health budget rose by just 1.2 per cent, well below the rate of inflation. Health spending per capita has not recovered in Canada since the 2008 recession, unlike in other comparable countries where it has rebounded. Hospital spending has had the lowest rate of growth since the late 1990s.[3]

The Canadian Institute for Health Information reported that hospital spending will grow by an estimated 0.9 per cent in 2015, reaching $1,804 per person. This is the lowest rate of growth since the late 1990s. From 2011-15, total health expenditure has declined by an annual average rate of 0.6 per cent as governments focus on balancing budgetary deficits.[4]

Hospital health in Ontario:

- Base operating funding for Ontario's 149 public hospitals has been frozen for the fourth year in a row;
- Ontario ranks last in public hospital funding per person, tied with Quebec, and ranks 8th of 10 provinces in hospital funding as a percentage of provincial GDP;[5]
- Ontario has among the lowest per capita bed numbers in Canada and across peer countries at a rate of 1.4 acute care hospital beds per 1,000 residents, the lowest level of all province's except British Columbia, which has 1.3 beds per 1,000 population (Nationally, the average is 1.7 beds per 1,000 population);[6]
- The lack of availability of acute care beds on hospital wards and in Intensive Care Units has produced overcrowding in hospitals. The Canadian Association of Emergency Physicians (CAEP) identified that hospital overcrowding has been escalating. CAEP recommends "that governments sufficiently increase the number of functional acute care beds to achieve regular hospital occupancy rates that do not exceed 85 per cent;[7]
- More than 14 per cent of hospital beds are occupied by patients that are waiting for beds in a long term care home. The hospital sector is shrinking and there is enormous pressure to discharge patients faster than ever;
- The median wait times for Long Term Care (LTC) beds have almost tripled, from 36 days in 2004-05 to 98 days in 2011-12. An increase in the number of LTC beds of three per cent during that period has not kept pace with the rising demand from an aging population. According to Statistics Canada, between 2012 and 2021, the number of Ontarians aged 75 and older is expected to increase by almost 30 per cent. This trend will likely increase the demand for long-term care.[8]

Private for-profit labs don't deliver on accessibility and cost

Doctors rely on laboratory tests to inform more than 80 per cent of medical decisions. Sixty per cent of all medical tests in the community are provided by seven private companies and the rest are completed in hospitals and by public health officials. Ontario pays $700 million per year for medical testing to private labs.[9]

Ontario is the only province not to permit hospitals to conduct laboratory tests for outpatients, posing a significant challenge to many smaller and rural communities underserved by Ontario's current lab providers. Reduced access to laboratory testing sites and timely delivery of quality service has been identified as problematic by doctors, patients, and service providers, and similarly identified in two Auditor General Reports.

Ontario now has the fewest lab centres per capita of any province**.** Since 2008, the number of community laboratory patient care centres dropped by 25 per cent, while the population has grown nearly 20 per cent. Over the past five years, nearly 100 such locations in Ontario have closed.[10]

The Ontario government has serious challenges to address regarding outpatient laboratory testing. The per-test fees haven't substantially been updated in over a decade, despite cost savings brought about by rapidly evolving technology. Private lab companies appear to have little incentive to provide more accessible service to Ontario patients, and hospitals are sometimes picking up the slack without adequate compensation. A review of private laboratory spending, involving auditing firms Deloitte and KPMG, has been ongoing since 2010. The government confirmed a review is ongoing but said the audit reports are not public due to their "sensitive nature."[11]

The Ontario Medical Association (OMA) conducted a survey of doctors in 2010. In the survey, 61 per cent of doctors reported that their practice had been affected by closures and reduced hours of service; 81 per cent reported patients who had to travel increased distances due to lab closures; 71 per cent had patients experiencing longer wait times; and 45 per cent had patients not going for prescribed testing at all due to excessive waits times.[12]

In its 2015 final report, the Expert Panel on Laboratory Services acknowledged that outpatient testing is not advantageous in small, rural communities and Northern communities. And yet, rather than strengthen the existing hospital provision of services, the panel recommends that "full cost benefit of this practice should be assessed, and guidelines should be introduced to support this practice over time."[13] The insistence on imposing a practice that will not work in a

particular community smacks of an ideological approach to health planning – to offload services at all costs even when the evidence does not support it.

Downloading to community for-profit clinics (Independent Health Facilities)

In 2014, Ontario brought in regulations making it easier to outsource community hospital services to private Independent Health Facilities (IHFs) with an initial focus on providing low-risk cataract and colonoscopy services. Government has indicated that in the future, additional procedures that do not require overnight stays in a hospital will be eligible to be performed in these clinics. The introduction of the profit-motive in health care will undoubtedly impact on quality as 97 per cent of IHFs are run by for-profit companies.

For-profit corporations are not required to disclose financial information. There is a clear conflict of interest when physicians open up private clinics and then self-refer for medical services while also working in hospitals. This form of double dipping is not in the interest of patients or citizens. The Auditor General noted that the Ministry estimates that about 50 per cent of facilities are controlled by physicians and that while it has not analyzed the patterns of physicians referring patients to their own facilities, the Ministry estimates that 20 per cent of facility-fee tests are likely inappropriate. In the absence of full disclosure this number is most likely grossly underestimated.[14]

The Auditor General identified significant problems around billing practices and poor rates of inspections in its review of IHFs:

- The College of Physicians and Surgeons is the regulator of IHFs. However, as of March 2012, about 12 per cent of facilities had not been assessed within the last five years. Even for the assessed facilities, the College assessors did not review the work of all physicians working at each assessed facility;
- The Ministry's X-ray Inspection Services Unit had not inspected almost 60 per cent of facilities as frequently as required to ensure that radiation-producing equipment—for example, x-ray equipment—was appropriately shielded to prevent staff and patients from being exposed to excessive radiation levels;
- 25 per cent of clinics had irregular billing practices for facility-fee payments for diagnostic services, amounting to increases of 130 per cent in one instance for ultrasounds charged per limb;
- Billing rates went up from $2.9 million in 2007 to $7.5 million in 2011;

- As of March 2012, almost 60 per cent of the IHFs had not been assessed within the prescribed time frames. Furthermore, the Ministry could not determine how many of these facilities were new or how many had been rated as "bad" in their last inspection.[15]

There should no place for private, for-profit care in Medicare. The Auditor General identified troubling problems inherent in private clinics and yet the province moved to further enshrine regulations that will facilitate the expansion of IHFs in 2014.

Physiotherapy services not meeting demand

Rehabilitation services will become more critical as our population continues to age. And yet the Auditor General noted that hospitals have closed many outpatient programs over the last 10 years and that there has been a reduction in publicly-funded outpatient services. Wait times for outpatient programs range from immediate access, to a few days, to a couple of years.

The Auditor General's Report noted that 50 per cent of Ontario hospital sites responding to a survey said they had reduced outpatient rehabilitation services over the past two years; 16 per cent indicated that even more reductions were planned for the following year. This report also noted that the availability of outpatient programs was inconsistent across the LHINs and that there is little information on the demand for services, service capacity and service accessibility.[16]

The Auditor General's report highlights several reports highlighting that availability of in-patient services has also been compromised. The Ontario Stroke Network in its report, *The Impact of Moving to Stroke Best Practices in Ontario*, suggests that many patients are unable to access the rehabilitation services they need. The best available estimates suggest that approximately 40 per cent of stroke patients are candidates for inpatient rehabilitation when discharged from acute care, yet less than 25 per cent were discharged to inpatient rehabilitation in the 2010-11.[17]

The Ontario Hospital Association indicated that about 2,300 Alternate Level of Care (ALC) patients occupied acute-care beds in the province as of March 2013. Of these, 16 per cent were waiting for a regular rehabilitation bed and 9 per cent for a Continuing Complex Care bed (CCC beds include restorative rehabilitation beds).

Greater frequency and access to in-patient rehabilitation shortens hospital time. A 2010 report resulting from a round-table discussion between the MHLTC, the LHINs, and the Ontario

Hospital Association noted that providing more in patient therapy is less expensive than having patients spend more time in the hospital.[18]

Recommendations:

Chronic underfunding of hospitals will not improve the delivery of acute care services. Hospitals face impossible decisions in deciding which hospital service will be cut, to the detriment of all Ontarians. Hospital professionals are key players in maximizing patient recovery, and when their services are cut the entire system is weakened. Hospital funding must be restored to the average of the other provinces in Canada and funding must go to restoring and improving service levels to meet population need.

OPSEU calls on the government of Ontario to:

1) Stop the implementation of cuts and program closures on the sole basis of cost cutting. Healthcare policies must be motivated by more than "doing more with less." Patients that are discharged too soon return to hospital for longer stays and cost us more for healthcare.
2) Restore bed capacity to meet local needs, increase the number of acute care hospital beds, and create more long-term and chronic care beds within the hospital and/or in the community.
3) Expand in-patient and out-patient physiotherapy services across all hospitals in Ontario. The demand is exceeding the service and the consensus is that greater access to physiotherapy reduces time spent in hospital.
4) Bring privatized lab testing and diagnostic testing (lab x-ray nuclear medicine, MRI) back into our hospitals as a public service. The benefits of providing more immediate results to physicians, quality inspection control, and reducing patient travel far outweigh the fictional savings that have produced a private parallel system that is actually costing Ontarians more.
5) Stop the growth of Independent Health Facilities. These facilities charge user fees, provide inappropriate testing and ultimately are financially unaccountable as private companies operating in a public health care system.

Notes

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[3] Canadian Institute for Health Information. (2014). "National Health Expenditure Trends 1975-2014." Available at https://www.cihi.ca/en/spending-and-health-workforce/spending/national-health-expenditure-trends
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[6] Canadian Institute for Health Information. (2014). "National Health Expenditure Trends 1975-2014." Available at https://www.cihi.ca/en/spending-and-health-workforce/spending/national-health-expenditure-trends
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[13] Laboratory Services Expert Panel Review. (2015). Ministry of Health and Long Term Care.
[14] Auditor General Annual Report. (2012). Section 3.06, Independent Health Facilities.
[15] Auditor General Annual Report. (2012). Section 3.06, Independent Health Facilities.
[16] Auditor General Annual Report. (2013). Section 308, Rehabilitation Services at Hospitals.
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[18] Auditor General Annual Report. (2013). Section 308, Rehabilitation Services at Hospitals.

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