Out of patience: it's time to save public health care

A pre-budget submission of the Health Care Divisional Council, Ontario Public Service Employees Union, to the Standing Committee on Finance & Economic Affairs

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About the Ontario Public Service Employees Union

The Ontario Public Service Employees Union (OPSEU) is a trade union representing 130,000 Ontarians working in every corner of Ontario and most areas of the provincial public sector, including the municipal sector. In health care, OPSEU represents approximately 45,000 frontline workers in these areas: ambulance services; long-term care; mental health care; hospital professional services; hospital support services; community health care; and Canadian Blood Services and diagnostics.

Introduction

Ask Ontarians, and the vast majority will agree: public health care is not only part of the Canadian identity, it is a top priority for voters, regardless of their party affiliation. Public medicare is based on the principle that as citizens, we ought to receive health care based on our need, not our ability to pay. The principles of equity, compassion and fairness are what make us proud of our health care system.

But for the better part of the last decade, the services and infrastructure that make up the foundation of this system have been chipped away at during an Age of Austerity in Ontario. During this period, funding for public services has been cut back sharply while regular Ontarians suffer and profiteers line their pockets. Needless to say, inequality is growing and the working conditions of health care workers are deteriorating.

This is of particular concern to OPSEU and its members. OPSEU members not only use the public services that are funded and delivered by the province; we also deliver the services and are the public face of the system. At the bedside and behind the scenes, we are on the frontlines of health care.

Create a crisis, then privatize

Ontario's hospitals are in a crisis, one that has been systematically created through relentless cuts that have lasted nearly a decade. Since 2008, the province has set hospital global funding increases below the rate of inflation. This means real-dollar cuts. From year to year, Ontarians have seen services and staff cuts deepen. Entire community hospitals have been put on the chopping block. This is the longest period of sustained hospital cuts in Ontario's history.

While Ontarians continue to hear the rhetoric about "transforming" our health care system, and that transition can be painful, they've come to see this as code for the cuts to and privatization of our health care system. By a host of key measures, Ontario now ranks at the bottom of comparable jurisdictions on hospital care levels: Ontario has the fewest hospital beds per capita of any Canadian province; Ontario has the fewest nurses per patient in Canada (RNs and RPNs); and Ontario ranks near the bottom for funding of our public hospitals (both by population and as a percentage of GDP).

After nearly a decade of cuts, patients are suffering.

The government's formula has been to create a crisis through cuts, then offer privatization as a solution. But in reality, privatization creates investment opportunities for private companies *at the expense of* the public medicare system and those who depend upon it. When we consider that the main bidders on home care contracts, or on the contracts for cleaning, food services and portering in hospitals, are often multinational consortia, one must question the argument that there is no money for health care. Millions of dollars are being siphoned from the public purse into private hands annually.

In their recent analysis, Ontario's Financial Accountability Office (FAO) stated that, "If the current level of health care quality and service are to be maintained, health expenditures will require 5.3 per cent annual increases from this year to 2020." According to the FAO however, the government plans to *limit* growth this year through to 2018-19 to 1.7 per cent. This plan will not even cover the basic rate of inflation, let alone population growth, the demands of an aging population, and the higher rates of inflation typically seen in health care, e.g., for pharmaceutical drugs. It will invariably result in deeper and deeper cuts.[1]

Perhaps even more distressingly, the FAO estimates that the cost of the currently planned health programs will surpass the government's budget projections, which will require further program cuts. The only way to meet the province's 2016 budget health sector expense targets is through cuts to health spending on the order of $2.8 billion, according to the FAO.[2]

It is OPSEU's view that Ontarians have suffered enough. It's time for the province to restore financial stability and fund safe levels of hospital service.

Restructuring and the state of Ontario's hospitals

In her November 2016 report, Ontario's Auditor General Bonnie Lysyk described a bleak outlook for Ontario's large community hospitals. The report describes a state of severe overcrowding in the hospitals visited by the audit team.

> At the hospitals we visited, we saw patients placed on uncomfortable stretchers or gurneys in hallways and other high-traffic areas that were never designed for patient care [and] these waits can last as long as 28 hours for a minority of patients. Overcrowded emergency rooms also make it difficult to control infections. The first Canadian to die in the 2003 SARS outbreak, for example, was infected after spending one night in a hospital emergency room.[3]

The OECD has reported that 85 per cent bed occupancy is broadly considered to be a safe occupancy level in the United Kingdom, Australia and Ireland.[4] According to the Auditor General's report, during 2015, 60 per cent of all medical wards in Ontario's large community hospitals had occupancy rates greater than 85 per cent.[5] The majority of large community hospitals are dangerously overcrowded.

The Auditor's report also highlights long waits for in-patient beds and surgery at Ontario's large hospitals. As mentioned previously, Ontario has the fewest hospital beds per capita of any province, and that number is declining. We also now rank at the bottom of international data on hospital beds by population. Compared to 33 countries of the OECD, Ontario is third last in hospital beds per capita, followed only by Mexico and Turkey. The Ontario government has cut more than 18,500 hospital beds since 1990, and still the cuts continue.[6] High bed occupancy rates have also led to higher levels of hospital-acquired infections. It is no wonder that there are huge wait times for in-patient beds and surgeries: we have the fewest beds available.

Across Ontario, reports have emerged of severe overcrowding and a lack of beds, which have been associated with flu season. At Lakeridge Health in Oshawa, an emergency command centre was set up to deal with record patient volumes in the emergency department. While the most vulnerable populations may require hospitalization as a result of the flu, this does not fully explain the crisis experienced in emergency departments across Ontario. These crises are the result of chronic and severe underfunding and ongoing bed cuts. Already overstretched hospitals have little capacity to deal with any surge in need, and even illnesses we anticipate and plan for each year throw hospitals into mayhem. This is no way to run a health care system.

The Auditor's report also addressed the fact that there are thousands of people taking up hospital beds that actually require long-term care or home care (Alternate Level of Care). Despite the rhetoric around "transition in our health care system," home care funding per patient has actually decreased over the past decade. This is because so many people are pushed out of our hospitals quicker and sicker and into home care. There have been more than 20,000 people on wait lists for long-term care home spaces for more than a decade. The funding for home and long-term care is not keeping pace with population need, and the entire system is backlogged as a result.

The Ontario government has created a crisis through cuts, and privatization has been offered as the solution. Patients and their families are increasingly forced to pay out-of-pocket fees for home care services or long-term care because they cannot access publicly funded care in a timely fashion. The province has downloaded this responsibility onto patients – often the elderly, who are sick, frail and dying. Services in hospitals are cut and hived off to private, for-profit clinics.

Quite shockingly, the Ministry of Health and Long-Term Care does not require hospitals to run at safe occupancy levels. There is no set benchmark. The ministry has prioritized the rationing of care, not planning for community need. There has been no provincial capacity planning since 2000.[7] It is not surprising, therefore, that there is such a disconnect between community need and the levels of service and staff being funded.

This problem is being exacerbated by the latest wave of mega-mergers and service consolidations sweeping the province. There is a major cost associated with mergers, whose purpose is to consolidate services, place more power in fewer hands, and – ultimately – facilitate more cuts. The most recent example is the forced merger of the Durham and Scarborough hospitals, a plan projected to cost more

than $50 million. In Niagara, five entire community hospitals are on the chopping block, with the promise of one new hospital to be built, sometime down the road. Two hospitals in Hamilton are expected to be replaced by one. In Windsor, plans are in place to close all hospitals and replace them with one. Already overstretched hospitals are forced to pay for restructuring out of their own operating budgets. This comes at a heavy cost to patients and to our communities, especially at a time when we are told there is no money to fund needed public services.

Each of the new hospitals is a privately financed public-private partnership hospital. Typically, these hospitals are built with fewer beds than the hospitals they replace, and at a much higher price than if they had been financed publicly. Ontarians are paying through the nose to get less. This just doesn't make sense.

The consolidation of services and resulting cuts have been particularly hard hitting in rural and northern communities where patients are forced to travel further for the care they need. Often in regions with particularly bad weather, traveling for needed health care can be a risky endeavour.

It's important to understand that the evidence does not support restructuring as a cost saving measure. Ontario needs look no further than its own history. In the fall of 1995, the Ontario government announced large cuts to hospital funding and the creation of the Health Services Restructuring Commission (HRSC); budget cuts were to occur over a three year period with $365 million cut in 1996/97, $435 million in 1997/98, and $507 million in 1998/99.[8] The establishment of the HSRC was an effort to reduce costs further. After two years of cuts, the third year was cancelled because of the impact more cuts would have had in forcing reduced service volumes.[9] In total, from 1996-1998, the province cut $800 million from the health care budget, and as it turns out, the restructuring of the health care system which which was meant to help reduce costs actually ended up *costing* $880 million (double what was projected).[10] The provincial government spent more money on restructuring than was "saved" through cuts to needed services and staff.

Today, Ontario's hospitals have already been cut to the bone. Since 1998, the number of hospital beds has remained virtually constant at approximately 31,000, but the population has grown by more than 16 per cent.[11] Yet we see history repeating itself in the last nine years.

OPSEU is calling for the Ontario government to restore financial stability and safe levels of hospital service. OPSEU is calling for the funding to go directly to hands-on care and vital patient support services, not to more bureaucracy and administration. We believe this is a priority for all Ontarians.

Privatization: the malady, not the remedy

"Privatization is a like a poison that has entered the bloodstream of our health care system. It's public medicine that will fix it."

-- Warren (Smokey) Thomas, President, OPSEU

Privatization has become embedded in our health care system. It is being used as a method to download costs onto individual patients, often the frail, sick and elderly who can least afford to pay. This is true in Ontario's home care system, which is rife with privatization, where the majority of provider agencies are private, for-profit entities competing for bids to provide services and seek profits. OPSEU is calling for an end to contracting-out and the delivery of home care by private operators, which sees public money siphoned into the hands of private profiteers.

While OPSEU is very concerned about Bill 41, the *Patients First Act,* and has pointed out that the Government of Ontario is taking no action to end the contracting out of home care services, we remain hopeful that the legislation, which does remove the structural barriers to allow the Local Health Integration Networks (LHINs) to assume responsibility for the management and direct delivery of home and community care, will be used to do so. The ministry ought to explore its options for termination or non-renewal of all contracts with current provider agencies. Patients must have enshrined rights to access the care they need along the entire continuum of care. This legislation could be an important step toward a fully public, non-profit home care system in Ontario and we encourage the provincial government to initiate that transition.

According to the Auditor General's 2015 report, there are 160 third-party providers currently contracted by the province's Community Care Access Centres (CCACs) to provide home and community health care services. Many of these are for-profit. The Auditor General found that for every dollar spent by a CCAC, only 61 per cent is spent on the actual face-to-face treatment of patients.[12] Much of the remaining 39 per cent goes to managerial salaries and profits of the for-profit companies.[13] The exact amount, of course, is unknown because the private sector service providers have no obligation to open their books to public scrutiny. In order to make investments that will improve our health care system, we need every dollar going to provide care, not into the pockets of the for-profit home care agencies. This is especially important at time when Ontarians are being told to tighten their belts because there is not enough money to go around.

While Bill 41 offers an opportunity for positive system-level change, it is important to note that the LHINs, to-date and in their current form, are not accountable to the public. They are appointed by Cabinet and accountable upwards. Local communities have virtually no meaningful input, and while Bill 41 gives the LHINs more power, it does not make them more accountable. OPSEU is calling for the establishment of democratically-elected LHIN boards of directors that are accountable to their communities and representative of diversity.

Furthermore, LHINs are not required to consult meaningfully with the public or the health care workforce. There must be a legislated requirement for meaningful public consultation, including a system for redress. There must be formalized relationships between each LHIN and its key stakeholders and an open and transparent consultation process that empowers these stakeholders, including the health professionals' advisory committees.

Unfortunately, home care is not the only health care sector affected by privatization. The privatization of medical laboratories, the expansion of private clinics providing services previously offered in hospital, the contracting-out of hospital support services including cleaning, food services and portering, the privatization of infrastructure through P3s, and the use of Social Impact Bonds, currently being piloted in Ontario, are just some of the ways in which the profit motive is infiltrating our health care system, to the detriment of frontline care. We review a few of our key concerns below.

Contracting-out of hospital support services

As outlined in the OPSEU Hospital Support Division's submission to the Standing Committee on Finance and Economic Affairs in February 2016, it is housekeeping staff and sterilization technicians (CSR) that are the hospital's first defense in infection control.[14] Hospitals have rigorous inspection mechanisms that minimize the risk of infection. When these services are contracted out, the profit motive incentivizes for-profit companies to cut corners. Yet the correlation between cleanliness and health is unmistakable. A study published in the *Journal of Hospital Infection* offers an insightful example; it was found that a stubborn MRSA outbreak at a hospital in Britain was only contained after cleaners doubled the time spent on the ward.[15] All factors considered, the contracting-out of cleaning services does not save money in the long run. It puts patients and staff at risk, and it puts the most vulnerable at even greater risk of death.

Concerns around contracting out are only made worse by the current state of overcrowding in Ontario's hospitals. When hospitals are running at over 85 per cent capacity, this leads to higher rates of potentially fatal hospital-acquired infections. A study published in the *American Journal of Infection Control*, by Dr. Dick Zoutman, confirmed that overcrowding raises the risk of infection. Researchers found that with each new roommate, a patient's risk of acquiring an infection in hospital was raised by approximately 10 per cent.[16] It is for this reason that OPSEU is calling on the province to end the contracting-out of hospital support services. The health and safety of Ontarians must be prioritized.

Privatized plasma collection a growing concern for Ontarians

OPSEU is very concerned about the red flags of privatization that are emerging within Canadian Blood Services (CBS). CBS has been impacted by staffing cuts in much the same way as the rest of the health care system, where full-time positions are being replaced with precarious part-time employment, the number of mobile blood collection units has been reduced (which creates a more frustrating experience for voluntary blood donors), and clinic hours have been shortened (particularly for donor recruitment).

This is especially troubling in the current Canadian context. In 2016, a private blood plasma collection company that pays donors was permitted to set up shop in Saskatchewan. Canadian Plasma Resources, the for-profit company responsible, is looking to secure licenses to operate in other provinces.

It is important to note that our blood system in Ontario is safe because it is public. Allowing private plasma collection would impact CBS's donor base which relies on volunteers and will, in effect, set up competition for blood and blood products. CBS and Hema Québec already have the facilities and abilities to collect plasma.

In the 1980s, blood tainted with the HIV virus and Hepatitis C led to the worst public health tragedy in Canadian history, claiming more than 1,000 lives. The disaster led to the establishment of a commission of inquiry, known as the Krever Commission, to study how the blood system became contaminated and to make recommendations to the federal government.

Among the key findings of the commission:

- Blood is a public resource.
- Donors should not be paid.
- Canada should become self-sufficient in blood products.
- Access to blood products should be free and universal.
- Safety of the blood system is paramount.

The Ontario government must ensure proper staffing levels are met and that reasonable clinic hours and mobile units are maintained to provide donors ample opportunities to donate blood and to support our public, non-profit blood collection service. The province must support Public Health Ontario as a public entity and ensure the funding needed to support the services and specialized testing done by PHO laboratories.

Social Impact Bonds (SIBs): an innovation only in profit-making

It was recently reported in the Toronto Star that Toronto and Vancouver will be home to the first health-related Social Impact Bond model in Canada, and the largest of its kind in the world. The Heart and Stroke Foundation of Canada will run the program and the MaRS Centre for Impact Investing has found 11 investors, including businesses and wealthy individuals, to put up the money.[17] This is cause for concern, and according to David MacDonald of the Canadian Centre for Policy Alternatives, "There's no need for us to put a middle man in between what traditionally was a relationship between governments and social service agencies."

The truth is that this is yet another form of privatization. Whereas P3s are used to finance public infrastructure projects, SIBs are used to fund preventive interventions for social programs upfront, with the promise of financial return to investors if the program meets its goals. SIBs are a kind of "P3 for

people – a P4."[18] SIBs marketize health and social services. They provide an opportunity for private investors to make money off the sick. In this case, investors are expected to see a minimum return of 6.7 per cent profit – if the three-year prevention initiative succeeds at stalling the development of hypertension in participants over 60 with high-normal blood pressure – and upwards of 8.8 per cent profit if the program "over-shoots this target and blood pressure among participants goes down."[19] The very design of the program ensures that targets will be easily achievable.

The pay-for-success nature of the scheme does not foster innovation, or support the case that government dollars can be "more focused on outcomes" as the director of the MaRS Centre has stated. The government, which can borrow money at the lowest interest rate possible, could design, fund and implement the exact same program at a much lower cost. Investors, set on making a return on investment, are unlikely to experiment with initiatives that will not work, and governments are not sheltered from risk because they will always end up paying more. With an entire industry of middle men (lawyers to review contracts, consultants etc.), SIBs invariably cost more money.

OPSEU is calling on the Ontario government to reject any future Social Impact Bond proposals at the provincial level. In a time of fiscal restraint, there is absolutely no justification for money being siphoned away from public services and into the hands of profiteers.

The fire-medic model: a waste of valuable resources

A new model proposed by the Ontario Professional Fire Fighters Association (OPFFA) is calling for firefighters to perform more medical interventions. The OPFFA has argued that increased demand for pre-hospital care, combined with budgetary pressures, has placed a drag on paramedic response times and therefore a new class of fire-medics is the solution.[20] This is a highly flawed and incorrect assumption. Not only are response times measured differently between firefighters and paramedics, making comparisons difficult; it is long wait times for hospital beds that have actually tied up ambulances delivering patients to emergency rooms. The hospital bed crisis in this province has had a system-wide domino effect. Improved hospital funding, and hospital occupancy standards, would allow paramedics to move in and out of hospital much more quickly.

Furthermore, there is no medical evidence to support increased fire involvement under the proposed fire-medic model. There is no Ontario-relevant evidence to show there will be any improvement in patient outcomes. Increased fire involvement does not negate the need for timely patient transport and treatment at appropriate facilities. Where an ambulance is required, it is a waste of resources and a duplication of costs to send both paramedics and firefighters. The cost of expanded fire response is an increased cost placed on already-overstretched municipalities, who bear 100 per cent of the cost of providing fire services. Furthermore, expanded fire involvement does not fix any of the issues that exist with the current dispatch system, hospital offload delays, or rising community demands. The provincial government should focus its attention on improvements in these areas.

OPSEU is committed to improving pre-hospital care for the citizens of Ontario and strongly advocate changing the current dispatch process to the Medical Priority Dispatch System (MPDS), which will reduce the urgency of approximately ten per cent of the calls, thereby reducing stresses on the system.

OPSEU is advocating for an Automated External Defibrillator (AED) registry to allow Ambulance Communications Officers (ACOs) to identify the location of AEDs at the time of a 911 call. OPSEU advocates and supports the expansion to the Public Access Defibrillator (PAD) program and citizen CPR. While the Ministry of Health and Long Term Care has recognized the changing demographic needs by piloting the Community Paramedic Program, OPSEU strongly supports the formalization and appropriate funding of all these programs.

Health and safety in Ontario's mental health system

Across Ontario, workers in the mental health sector are facing increasing exposure to violent assaults, including recent assaults on staff members at the Waypoint Centre for Mental Health Care in Penetanguishene, the Centre for Addiction and Mental Health in Toronto, the Royal Ottawa Mental Health Centre, the Brockville Mental Health Centre, and other facilities. Frontline workers and their unions continue to report that many employers are not doing enough to control workplace violence. Often they are failing to perform adequate risk assessments and failing to put procedures in place that prevent violence.

Workers have the right to be safe at work and to be free from assault while doing their jobs. No one should go to work afraid for their well-being or for their life. The Ministry of Health ought to mandate immediate measures to help ease the high risk faced by workers in mental health facilities, such as: increased staffing; better risk assessment procedures; improved communication systems; heightened security; and more training for staff. If staff are not safe, neither are patients.

Like so many other sectors in the health care system, decisions are no longer being made on the basis of clinical rationale and patient need, but rather, decisions are made on the basis of budgets. This is putting workers' and patients' lives at risk. Managers and decision-makers used to be clinicians that adhered to standards of professional practice, but more and more these decision-makers have been replaced by non-clinicians – the proverbial bean counters.

The Ministry of Health and the Ministry of Labour ought to implement the system-wide use of the *Violence, Aggression and Response Behaviours Tools (VARB)* for assessing security, conducting organizational risk assessments and assessing individual client behaviour.

Long-term care

In 2008, the government-commissioned Sharkey Report on long-term care made a host of recommendations for strengthening Ontario's long-term care system and the residents living in long-

term care. Among them, the report recommended a target of four hours of direct care per resident per day and that this target ought to be reached by 2012.

But as of the 2015-16 Ontario Budget, very little progress has been made in reaching this target. It is Ontario's seniors and those in need of long-term care that are suffering the consequences.

> Currently, based on the Ministry of Health and Long-Term Care's data and its formula to calculate hours of direct care, long term care residents are receiving an average of 3.4 hours a day. The Association calculated that the gap of just over half an hour per resident per day could be closed with an investment of $385 million and recommended that this be phased in over three years in recognition of the fiscal situation.[21]

According to the Ontario Association of Non-Profit Homes and Services for Seniors, the minimal increases offered in the 2015-16 provincial budget helped to maintain existing staffing levels but did not go far enough in closing the care gap. The fact remains that despite modest investments in community care, "the government can't ignore the fact that some seniors will reach the stage where their care needs can't be met at home, and we must make sure that our long-term care homes have the staff and resources to provide the level of care they need."[22]

Research compiled from around the world has shown that strong staffing levels, good working conditions, secure jobs, proper levels of public funding, full-service kitchens with in-house food service staff, and sensible standards lead to excellent care for residents. According to an international research project led by Pat Armstrong and Donna Baines entitled, "Promising Practices in Long Term Care," non-profit nursing homes with adequate public funding were more likely to have better working conditions.[23] The links between good working conditions and strong care relationships with residents are obvious[24]:

- Adequate staffing levels ensure that staff have time to interact with residents.
- Permanent, secure jobs with stable work schedules help residents get to know regular staff who care for them at predictable times.
- Paid sick leave allows staff to rest when sick and avoid infecting residents at work.
- Good wages, hours of work, benefits and pensions reduce staff turnover, ensuring continuity of care.
- De-emphasizing excessive paperwork and charting allows staff more time to interact and socialize with residents.
- Offering staff continuing education increases their ability to provide quality care for residents.
- Having all services provided by in-house staff instead of contracting them out (e.g., food service, cleaning, laundry) results in better quality and more personalized care for residents.

Of course, creating an environment within long-term care homes that fosters relationships rather than bureaucracy requires a high ratio of staff to residents. But in Ontario, there are no regulations for minimum staffing levels. This is troublesome, considering that acuity is rising as residents entering long-

term care increasingly have much more complex needs. People entering nursing homes today are often older, frailer, and more likely to suffer from dementia and behavioural problems. Care levels in long-term care homes have not increased to meet the heavier and more complex needs of these residents, placing residents and staff at higher risk.

In 2005, a coroner's jury recommended sweeping changes in the operation of Ontario's long-term care homes after the deaths of two residents at the hands of another in the Casa Verde home. These recommendations included minimum care standards, improved staffing levels, mandatory specialized units for residents who pose a risk to themselves and others, and better admission and assessment protocols. Yet today, Ontario's government still has not implemented these recommendations.

According to the Ontario Health Coalition, 62 per cent of residents in long-term care live with Alzheimer's disease or other dementias (nearly one-third have severe cognitive impairment); 46 per cent of residents exhibit some level of aggressive behavior (between 2010 and 2012 alone, there was a 14 per cent increase in moderately aggressive behavior); 40 per cent of residents have a psychiatric diagnosis such as anxiety, depression, bipolar disorder or schizophrenia; dual diagnosis (e.g., dementia coupled with a psychiatric diagnosis) is increasing at 11 per cent per year; and 97 per cent of residents have two or more chronic diseases.[25]

While improved staffing ratios and minimum care standards are crucial to the well-being of residents in long-term care, the ownership of long-term care homes also matters. A study published in the *Journal of Post-Acute and Long-Term Care Medicine* found that for-profit nursing homes in Ontario have 16 per cent higher death rates and 33 per cent higher hospitalization rates than non-profit facilities. For-profit homes also have higher rates of falls, incontinence, and use of restraints.[26]

Access to publicly-funded, non-profit long-term care beds remains an ongoing concern. In Ontario, the median wait time for long-term care is 83 days. The wait list for long-stay beds as of May 2015 was at 23,443 and waitlists have numbered 20-30,000 since the 1990s.[27] Only 24 per cent of beds are non-profit/charitable, while 17 per cent are municipal and 57 per cent are privately owned. The Ontario government needs to invest in public, non-profit long-term care and ensure that the needs of Ontarians are being met.

Conclusion

The health care system is just that, a system; an interconnected continuum, a living thing with moving parts. When one part of the system is deprived, starved and suffering, the entire system suffers. While the rhetoric has been relentless – that Ontario is in a time of transition, where we are moving away from our focus on hospitals and investing more in home and community care – patients, their family members, workers, and experts all see and experience something vastly different. The divide between reality and this government's policy choices has never been starker.

For nine years now, Ontario's hospitals have been cut to the bone, unable to keep up even with basic inflation. Real-dollar cuts have meant that patients are discharged quicker and sicker and pushed into other parts of the health care system. Home care and long-term care have been overwhelmed and are not keeping pace with demand. Privatization is so deeply embedded in both, that patients are increasingly forced to pay out of pocket for the care they need, while private, for-profit companies continue to line their pockets with public monies. Ontario's government is, apparently, proud that per capita funding for public services in Ontario is lower than in any other province, but meanwhile, while regular Ontarians are suffering. Workers in the health care system are increasingly faced with precarious and dangerous work where they risk being assaulted and injured.

Across the board, the health care priorities of Ontarians are second fiddle to the interest of the provincial government to slash budgets, keep taxes low for the wealthiest, and provide investment opportunities for those looking to make a profit off the sick and elderly. Ownership matters: services provided publicly are of higher quality, safer, and more cost-effective. It's time the Government of Ontario heeded the calls that supporters of our public health care have been making for nearly ten years.

Summary of OPSEU's recommendations

1. Restore financial stability and safe levels of hospital service, beds and staffing. Stop the cuts that are starving the system and putting patients last. The provincial government must conduct capacity planning to properly plan and provide adequate funding based on community need, rather than arbitrary budget choices. The provincial government must restore funding that raises Ontario to at least to the average of Canadian provinces when it comes to hospital funding.

2. Stop the endless health care restructuring that only facilitates more cuts. This is not what Ontarians voted for.

3. End contracting out and fund a fully public, non-profit home care system. Reform the LHINs to ensure they have democratically-elected boards of directors that are accountable to their communities and require meaningful consultation with the public and workforce. Mandate the LHINs to hire staff directly under the public model.

4. Stop the outsourcing and privatization of public health care services.

    a. Stop outsourcing hospital support services such as cleaning, food service and portering. Privatization puts public money into private hands and threatens the safety of our communities.
    b. Bring privatized hospital services like diagnostic imaging, laboratories, surgeries and procedures, etc. back into the public sector.

5. Implement minimum care standards in long-term care and improve access to public, non-profit long-term care beds.

6. Ensure that proper staffing levels and reasonable clinic hours are maintained at Canadian Blood Services. Protect our public, non-profit blood collection and diagnostic services.

7. Reject any future proposals for Social Impact Bonds. There is no justification for money to be siphoned away from public services and into the hands of profiteers on the backs of the sick and elderly.

8. Make the necessary changes to improve pre-hospital care, including changing the current dispatch process to the Medical Priority Dispatch System (MPDS). Establish an Automated External Defibrillator (AED) registry and expand the Public Access Defibrillator (PAD) program and citizen CPR. Do not implement the fire-medic model.

9. Mandate immediate measures to help ease the high risk faced by workers in mental health facilities, including increased staffing, better risk assessment procedures, improved communication systems, heightened security, and more training for staff. Implement the system-wide use of the *Violence, Aggression and Response Behaviours Tools (VARB)* for assessing security, conducting organizational risk assessments and assessing individual client behaviour.

Notes

[1] "Expense Trends and Medium-Term Outlook Analysis," Financial Accountability Office, Ontario Health Sector, Winter 2017.
[2] Ibid.
[3] *2016 Annual Report of the Office of the Auditor General of Ontario*, page 446.
[4] *OECD Reviews of Health Care Quality*: Israel, 14 October 2012.
[5] *2016 Annual Report of the Office of the Auditor General of Ontario*, page 431.
[6] Ontario Health Coalition
[7] OHA Position Statement on Funding and Capacity Planning for Ontario's Health System and Hospitals, October 2011.
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] *2015 Annual Report of the Office of the Auditor General of Ontario*.
[13] Ibid.
[14] Submission to the Standing Committee on Finance & Economic Affairs, OPSEU Hospital Support Division, February 2, 2016, https://opseu.org/information/hospital-support-members-budget-committee-stop-cuts
[15] "How hospitals are on the front lines in a new era of germ warfare." The Globe and Mail. http://www.theglobeandmail.com/life/health-and-fitness/health/the-hospital/in-new-era-of-germ-warfare-hospitals-best-weapon-is-good-housekeeping/article16633960/?page=all
[16] "Sharing a hospital room raises risk of superbugs." Queen's University Gazette, January 5, 2010.
[17] "Groundbreaking MaRS funding initiative takes aim at high blood pressure, Toronto Star, October 28, 2016.
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