Oxford Coalition for Social Justice -

Presentation to the Ontario Legislature’s Standing Committee on Finance and Economic Affairs

Ontario Pre-Budget Hearings

January 20, 2017



**Introduction**

Good morning, and thanks to the committee for inviting us to attend and to speak today. I am Bryan Smith, Chair of the Oxford Coalition for Social Justice, and with me is Alma Martin, a spokeswoman for our group, and valued member of our community. We are here to do four things, and thank you for the opportunity to

* Set the context for our remarks by brushing a portrait provincially
* Detail what impact financial decisions you will assist in has on rural health, specifically in Oxford County
* Tell the story of how those decisions have affected Alma and her family
* Answer any questions you might have in the time remaining.

The Oxford Coalition for Social Justice is a broad group with individual members as well as people who by dint of their paid or volunteer jobs engage a lot of Oxford people in conversation, popular education and advocacy. Beyond our borders, we are also in contact with some provincial groups and associations whose support and analysis is vital to our understanding of the impacts decisions are having and will have on residents of Oxford and all of Ontario.

**Across the Province**

At a recent Ontario Health Coalition conference, where provincial organizations from other provinces helped provide a national focus, it was revealed (again) that

* Ontario has the fewest hospital beds per person left in the country
* Ontario has the fewest nurses per patient in Canada (both RN and RPN)
* Ontario is in the bottom rungs for funding of our public hospitals by every reasonable way of measuring funding (by population, as % of GDP)
* Ontario has a long-term care crisis now and worse looming.

Government’s fiscal policy, budget, has major impact on health care in Ontario. Health Care, in the view of the Oxford Coalition for Social Justice, needs to the number one task of government, the number one priority for all members of the Legislature and the most significant investment to be made by the Province. Yet, public hospitals are still being cut – services removed, privatized, and whole hospitals closed.

Public Hospital Funding in the 2016 Ontario Budget has shrunk the real dollars available to support the health of Ontario residents. An increase of less than 1 per cent is below the consumer rate of inflation which is reported as 2.1 percent for October 2015 – October 2016 by Stats Canada. **(Source:**Statistics Canada, CANSIM, table [326-0020](http://www5.statcan.gc.ca/cansim/search-recherche?lang=eng&searchTypeByBalue=1&pattern=326-0020&p2=37) and Catalogue nos. [62-001-X](http://www.statcan.gc.ca/bsolc/english/bsolc?catno=62-001-X) and [62-010-X](http://www.statcan.gc.ca/bsolc/english/bsolc?catno=62-010-X). Last modified: 2016-11-18.)   This follows four years of 0 per cent funding increases or the ninth consecutive year of real-dollar hospital cuts, meaning that hospital global funding increases have not even met the rate of inflation for almost a decade. The planned and purposeful underfunding forces local hospitals to cut ever more services.

Despite claims that make it look like all hospitals are getting an overall 2 per cent increase, the fact is that only a minority of hospitals – usually larger hospitals and those that have highly specialized services like provincial children’s hospitals or those that do organ transplants – got the 2.1 per cent funding increase in this year’s budget. Even so, neither this rate nor the fall 2016 announcement of some additional funds is enough to meet population growth, the effects of an aging boomer generation and inflationary costs. To be clear though, we are not advocating reducing money to children’s hospitals or to those in large centres. We are, however, arguing for the saving of lives over the saving of dollars, and for the continuance of effective local care over obliging patients and their families to travel long and dangerous distances for hospital care. The Financial Accountability Office of Ontario has calculated that to meet inflation, aging and population growth, health spending requires a 5.2% escalator.

Ontario’s large hospitals are in a state of dangerous overcrowding with lengthy, sometimes catastrophic, waits for needed care. Ontario’s rural populations are suffering due to the reduction in the services and even the number of rural hospitals.

Ontario’s Auditor General describes the situation in Ontario’s large community hospitals in her recent report.

(Page references for the 2016 Ontario Auditor General’s Report are included here.)

* The audit team describes a state of severe overcrowding in the hospitals they visited. Patients are waiting on stretchers or gurneys in hallways and other public areas, sometimes for days (page 446).
* Bed occupancy rates of greater than 85 per cent are unsafe and contribute to infections (beds are too crowded and turn-over is too fast). During 2015, 60 per cent of all medicine wards in Ontario’s large community hospitals have occupancy rates of greater than 85 per cent (page 431). This means that the majority of large community hospitals are running at dangerous rates of overcrowding.
* The Canadian Institute for Health Information reports that Ontario hospital patients have the 2nd highest rate of potentially fatal sepsis infections in Canada (page 431).

The Auditor General describes the consequences of chronic underfunding and the failure to plan to meet population need for care:

* 1 in 10 patients requiring admission to hospital are waiting too long in emergency departments. The provincial government’s target is 8 hours from triage (90 per cent of patients are supposed to be transferred to a bed within 8 hours). But in the hospitals the audit team visited it took 23 hours for 90 per cent of the patients to be transferred to the Intensive Care Unit and 37 hours for transfers to other acute care wards (page 429).
* The audit team described a situation across Ontario’s large community hospitals in which there are frequent and planned operating room closures. 45 per cent of large hospitals have one or more O/R closed due to funding constraints (page 450).
* There has been no improvement in wait lists for elective surgeries for the 5 years leading into this audit (pages 430-431).
* 58 per cent of hospitals ran out of money for some types of surgeries and had to defer them to the next fiscal year (page 444).
* Patients with traumatic brain injury and acute appendicitis are waiting 20 hours or more for emergency surgery (page 430).
* Wait time targets are not being met for the following types of surgeries: neurosurgery, oral and dental, thoracic, vascular, orthopedic, gynecologic, ophthalmic, cancer (page 451).

Imagine waiting 20 hours or more, in agony, for emergency appendicitis surgery. Or imagine, the parents of a child in Oxford, whose appendix burst while waiting, or the woman who says “I shouldn’t be here” when recalling her own burst appendix and hours to wait for treatment to prevent full infection of her body cavity.

**Health Care in Oxford**

The situation described by the Auditor General is a crisis brought on by a decade of planned and purposeful funding constraints, geared toward making local hospitals cut services. In Oxford, that means that for the three community hospitals which have seen donations by many individuals amounting to millions of dollars, arbitrary decisions are made which are contrary to the intentions of the donors, contrary to the public’s needs and wishes as witnessed by over 2300 recorded comments in a recent poll we conducted, contrary to the good health planning and contrary to common sense.

Woodstock General Hospital is a relatively new site. The old building in the city core has been knocked down now that a new one has been built close to the 401 to serve not only local people, but those foolish enough to drive that stretch of highway. Despite the massive investment in Woodstock General Hospital and the region’s hope for it, 23 complex care beds were eliminated, and hip surgeries in 2015 were postponed for at least a year, immobilizing people and trapping them in their homes. In Ingersoll, however, the hospital has seen not only the loss of 9 critical care beds but also the loss of lab services for out-patients, meaning that a private health clinic is now taking profit from taxpayers instead of a more cost-effective public health service. Further, if you need a colonoscopy (and I hope you don’t), you will be instructed to drive to Tillsonburg and drive home afterwards. Tillsonburg’s residents, however, if they require eye surgery are instructed to drive to Ingersoll. This would appear to be a rationalization of services, unless you are driving on Highway 19 either for these services or at the same time as people needing these services. The distance is a barrier for many who do not drive, and for family or friends to accompany them. Further, in Tillsonburg, 16 complex care beds have been removed. I can assure you that Tillsonburg, like the rest of Oxford, is not getting less complex. Rationing might be a kind term for the reduction of services, but when you hear over and over in Oxford from people whose eye or joint surgeries have been postponed, or offered at fees of up to $2000 at private clinics, you know that you are no longer dealing with a rational solution to health.

“Health Status and Health Care Access of Farm and Rural Populations”, [commissioned by U.S. Department of Health and Human Services] states that "both farm and rural populations experience lower access to health care along the dimensions of affordability, proximity, and quality, compared with their nonfarm and urban counterparts." Further, it reports that “Nonmetropolitan households report that the cost of healthcare limits their ability to receive medical care. In more remote counties, patients have to travel long distances for specialized treatment. These patients may substitute local primary care providers for specialists or they may decide to postpone or forego care from a specialist due to the burdens of cost and long travel times”. While Oxford County is not remote in the way that Attiwapiskat may be, time is a factor; distance is a barrier; travel is costly for many. There is no public transportation between urban areas in Oxford, nor to London for access to the specialized care in its hospitals. The facts are clear that proximity is vital in healing. I have not mentioned the research on the curative effects of visits from family and friends, provided they sanitize their hands often and well.

But the costs associated with distance and the time to travel are not the only costs. Health care delayed results in health emergencies. “According to the 2014 report, Access to Rural Health Care - A Literature Review and New Synthesis, barriers to healthcare result in unmet healthcare needs including lack of preventive and screening services, treatment of illnesses, and preventing patients from needing costly hospital care. A vital rural community is dependent on the health of its population. Access to medical care does not guarantee good health; however, access to healthcare is critical for a population’s well-being and optimal health”.

Subsequent to a cut of 30 staff ordered in 2009, Woodstock General Hospital struggles to maintain services. Those remaining comment as follows: “The hardest part of the job is dealing with cut backs and still expected to do the job of 3 people”.( <https://ca.indeed.com/cmp/Woodstock-General-Hospital/reviews>). “Fast-paced” comes up repeatedly in remarks by nurses. Cleaning staff, now private, do not have paid hours enough to adequately clean public or patient areas of the hospital. Though not a medical practitioner, I’d describe that “fast pace as a pre-condition to burn-out and the lack of cleaning as a recipe for C-difficile. Long-term costs far outweigh short-term savings.

For Tillsonburg and Ingersoll, the situation is dire as a result of cuts in 2013. “Oxford County will be losing 15 Complex Continuing Care beds. The South West Local Health Integration Network (LHIN) voted in favour of the recommendation Wednesday to cut 6 beds at Tillsonburg District Memorial Hospital and 9 at Alexandra Hospital in Ingersoll”. Further, the mayor of Tillsonburg identified those complex care beds as doing double duty, providing emergency beds when the emergency department is overflowing. (<http://www.heartfm.ca/news/local-news/lhin-vote-in-favour-of-bed-cuts-in-oxford>). The cuts in Oxford County mean that residents of our area, like others, are referred to London’s understaffed, over-occupied hospitals. You’ll hear more on that from Londoners, I’m sure.

In the last major round of hospital restructuring, the government did actually track and fund restructuring costs. In 1999 and 2001, the reports of the Provincial Auditor revealed the costs of hospital restructuring under the Harris government. While estimated costs for hospital restructuring under the Health Services Restructuring Commission (HSRC) were originally set at $2.1 billion. The auditor revealed that costs had reached $3.9 billion; an increase of $1.8 billion over expectations. It is hard to make a fiscal argument for hospital restructuring, and fatal to enforce it.

 **Alma’s Story**

Alma is here today with me, and has asked that her story and the story of Bill, her late husband be told. Until a few months ago, I only knew them slightly, as members of our community working to stop a dump from affecting environmental and human health. At an event in the Fall, Bill, and active Kiwanian already, was seated at a table collecting signatures from the public on an environmental question, because, he told me, he was awaiting knee surgery and couldn’t help lift and carry. He had been waiting for two years.

When that surgery was finally to happen, Bill and Alma travelled to London’s University hospital, because Woodstock doesn’t have the cardiology back-up needed. Knee surgery these days is routine. Bill’s was anything but routine. Bill needed anti-coagulants as regular medication but was instructed to stop taking them three days in anticipation of the surgery according to the surgeon but 5 days according to the anaesthetist. That made for a risk of blood clots. The risk, Bill and Alma were told, was acceptable. Nothing that happened thereafter was acceptable. Bill was in a room with a dementia patient, where recovery was difficult because of the other man’s sufferings. When he was discharged by a fourth year medical student (!), he was sick. Alma though was hopeful that being home would help him. She also could spend more time with him, rather than driving back and forth daily. He got worse at home, and was taken by ambulance to Ingersoll’s Alexandra Hospital. It appeared he had pneumonia. His kidney was malfunctioning. Creatine levels were too high. He didn’t get better. The infection from University Hospital was resistant to antibiotics. He was sent again to London. There he found himself again in a ward where rest was difficult. Alma begged – that’s her expression – begged that Bill be moved to a private room, sitting empty in the same hall. She was told that the hospital was not allowed to use that room unless he required isolation for a drug-resistant infection. He had one, contracted in the hospital, but it was undiagnosed. After intervention, he was moved from the ward to a semi-private room but again less than acceptable. He was placed in with another dementia patient who was out of his clothes, who was yelling at the top of his lungs, who struck the nurse and whom it took three security people to secure. The bed beside Bill was then occupied by a man with a staph infection so serious that doctors and nurses wore gowns, masks and gloves. Bill didn’t have any protection from these germs other than the curtain between the beds. He didn’t get better. He did get shuttled back to Ingersoll in a transport without medical support whose staff said that if anything went wrong on route, they’d call and ambulance. The infection was not only in his lungs, but on his skin. He didn’t get better. There is more to this troubling story, but I’ll leave it to you to imagine or to ask Alma. Alma is still in grief.

Many Ontarians lived through the last round of restructuring and know clearly what the consequences have been. We saw services at our local hospitals cut. We saw increasingly overcrowded hospitals in larger towns get dirtier and dirtier. Patients and their care-givers, many of them elderly, all of them sick, are forced to drive from town-to-town to access care. This is neither in keeping with the values and priorities of Ontarians, nor is there any evidence that it is cheaper. Indeed, the increasing body of international literature in the field suggests that mergers cost more and reduce quality of care, particularly mergers of the size that are being contemplated in our province today. In Ontario’s history, the evidence shows that the costs of restructuring have never been recouped, and local services have continued to be dangerously eroded. It has cost Alma her husband.

For most communities, a new hospital will be built only once in almost a hundred years. In Oxford County, people have been fundraising, donating and volunteering in an effort to bring services closer to home, for almost a century or longer.  It is imperative that a real democratic process be created so that the people of Ontario – who fund our public hospitals and rely on them from birth to death -- have meaningful input on the future of our vital local hospital services before more communities lose services that it took generations to build. It is also imperative that your committee impress on all your colleagues at Queen’s Park the necessity of properly funded public health care in Ontario. It is the most important service you can render to the people of Ontario. It’s a matter of life or death.

Alma has told me that she didn’t think she could get through the telling of the story I have shared with her permission, but that if you have any questions, she’ll try to answer. Because I’ve talked for most of this time which you have kindly allotted us, I’d ask you again to be so kind as to talk first to Alma.

**Questions**