CUPE Ambulance Committee of Ontario
Submission to the
Emergency Health Services
Modernization Consultation

April 2020

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1. Introduction

The Canadian Union for Public Employees (CUPE) in Ontario and the CUPE Ambulance Committee of Ontario (CACO) are committed to ensuring high quality emergency health services (EHS) for communities across the province.

Our submission regarding this proposed restructuring is sent to you while we are all coping with the COVID-19 pandemic in Ontario. In light of all this entails for paramedics, our first position on the proposed restructuring is that you should not be proceeding with any overhaul to the administration or funding model for paramedic services.

The pandemic highlights all the breaking points in the system: public health workers and paramedics operating without the personal protective equipment (PPE) we need, mass diagnoses of our paramedic members that then create staff shortages, skyrocketing call volume, and job-related illness and injury.

Through it all, CUPE members continue to report to work and deliver this vital public service. The idea that this restructuring is proceeding apace behind the scenes when no one has the ability to fully evaluate options makes no sense to us. All the consultations were cancelled (appropriately) in light of the pandemic. We ask that you hit pause on this entire process while the whole province is working together to stop the pandemic, and that we then come together at some time in the future to re-evaluate how to consult properly, and whether or not this proposed restructuring should even be taking place.

The COVID-19 crisis has made it clearer than ever that paramedic services must be properly and consistently funded. There will be time for collective post-mortems when the global pandemic recedes, and we'd wager that no one will suggest that underfunding or cuts to funding will help anyone prepare for, prevent, or cope with a future pandemic.

We hope you will consider our submission, largely prepared in advance of the COVID outbreak, in light of our overarching view that the entire restructuring process should be completely halted until the global pandemic has receded, and until we have had a chance to collectively make plans for how best to meaningfully consult going forward.

CUPE is by far the largest union in both Canada and Ontario and has members in practically every city, town, village, and unorganized territory in Ontario. CUPE represents over 5,500 Paramedics and Ambulance Communications Officers in Ontario. CUPE members work in 22 municipal land ambulance services in Ontario (including most of the largest services), two hospital-based services and one First Nations service in the province. We represent

Ambulance Communication Officers ("Dispatchers") at the communication centres in Toronto, Ottawa, Niagara, North Bay, and Kenora. Our members include Primary Care Paramedics (PCPs), Advance Care Paramedics (ACPs), Logistics Support/Schedulers and approximately 300 Ambulance Communication Officers (ACOs).

Given that CUPE represents the majority of paramedics in Ontario, as well as an important number of ACOs, we have a keen interest in the consultation process that the Ministry of Health (MOH) has launched on emergency health services modernization.

CUPE and CACO welcome the stated objective of the consultation process, and in particular the expressed desire to start with a "blank slate" and do a "reset". The troubling and unhelpful policy proposals related to emergency health services that circulated in April of 2019 created enormous concern among paramedics and ACOs. The threat of regionalization, collapsing the 52 land ambulance services and the 22 dispatch centres to 10 regional units each, created much upheaval and was particularly unhelpful.

The budget freeze announced by the Provincial Government for ambulance services that followed in May 2019 only aggravated the situation. This, in the context of a core service review that has pressured municipalities to reduce their budgets by 4%, bodes badly for the quality and quantity of life-saving services provided by paramedics and dispatchers. The COVID-19 pandemic only makes this more apparent.

Ontario Health Minister Christine Elliott's announcement at the August 2019 AMO conference, which maintained in-year cost sharing and lifted the budget freeze, was a welcome development. Moreover, a 4% increase for land ambulance services was announced for 2019/20, and there was some commitment for continued growth in 2020/21. However, the information has been far from transparent and details of exactly what this means for individual paramedic programs and municipalities have been scarce. Very importantly, there are no clear commitments with respect to budgets for ambulance services for 2021 and beyond. Unpredictable funding from the province for these life-saving services, which are already experiencing significant capacity shortfalls, is a recipe for further turmoil and failure.

CACO members concur that there are some aspects of the current system that would benefit from modernization, but we are concerned that the consultation discussion paper omits some key issues that must be part of a serious discussion of the modernization of paramedic services, namely the need to increase the capacity of paramedic services across the province to respond to growing needs, and the urgent need to better resource hospitals so that ambulance offload delays are shortened and paramedics are allowed to attend to other emergencies. This submission therefore emphasizes those missing pieces, which we consider essential to the discussion.

2. The Key Challenges in EHS: Lack of Resources

The discussion paper that informs this consultation identifies 5 key challenges in EHS: outdated dispatch technologies; lengthy ambulance offload times and delays transporting medically stable patients; lack of coordination among EHS system partners; a need for innovative models that improve care; and health equity. The paper does not, however, identify what for us is a central key challenge: insufficient resources for paramedic services and for the hospital system across the province.

2.1 Paramedics and Ambulances

More funding is urgently required for ambulances, paramedics and dispatchers.

For your background information, we are attaching a CUPE study which details that lack of capacity for paramedic services in Ontario. But, to summarize, the report shows that the total volume of emergency calls in Ontario is rising, with the highest rate of growth taking place in the category of calls that demand the most urgent response. However, the number of scheduled hours for ambulances is not keeping pace with the increasing demand.

Paramedics are also experiencing increasing delays when it comes to transferring patients to the care of hospitals. Both the number of incidents of offload delay and the amount of time that ambulances are waiting is increasing.

As a result of these two pressures, there are far too many occasions where very few ambulances – or even no ambulances – are available within a service region to respond to emergency calls.

Across Ontario, demand is surging faster than the growth in population. From 2016 to 2017, the total volume of calls in Ontario grew 6.1% compared to population growth of 1.4%. From 2017 to 2018, the volume of calls in Ontario increased 4.1% compared to population growth of 1.8%. When looking at call volume by priority level, we see a clear trend. The increase in calls is occurring in the most urgent categories of Priority 3 and Priority 4, while call volume is actually declining in the less urgent categories of Priority 1 and Priority 2. In fact, call volume for Priority 3 calls increased 6.5% from 2016 to 2017 and another 7.2% from 2017 to 2018, while call volume for Priority 4 calls increased 7.2% in 2017 and another 5.3% in 2018. Excluding calls for an ambulance to stand by (not all services provided information on these calls), Priority 4 calls made up 72% of calls for emergency medical services in 2018.

The number of scheduled hours for ambulances, meanwhile, is not keeping pace with the increasing call volume. Among those services for whom three years of data was available, scheduled hours remained roughly the same, despite the significant increase in calls.

Four services reported statistics on the number of offload incidents between 2016 and 2018. Between 2016 and 2017, the number of incidents increased 9.3%; between 2017 and 2018, they increased another 5.6%.

Seven services reported to CUPE the total amount of time lost by ambulances and paramedics to offload delays – calculated as the amount of time spent waiting at a hospital after 30 minutes had passed. The amount of time lost to such incidents has increased dramatically: a 67.8% increase from 2016 to 2017 and another 16.3% increase from 2017 to 2018. At just these seven services, nearly 58,000 hours are being lost annually because ambulances cannot transfer patients into hospital care.

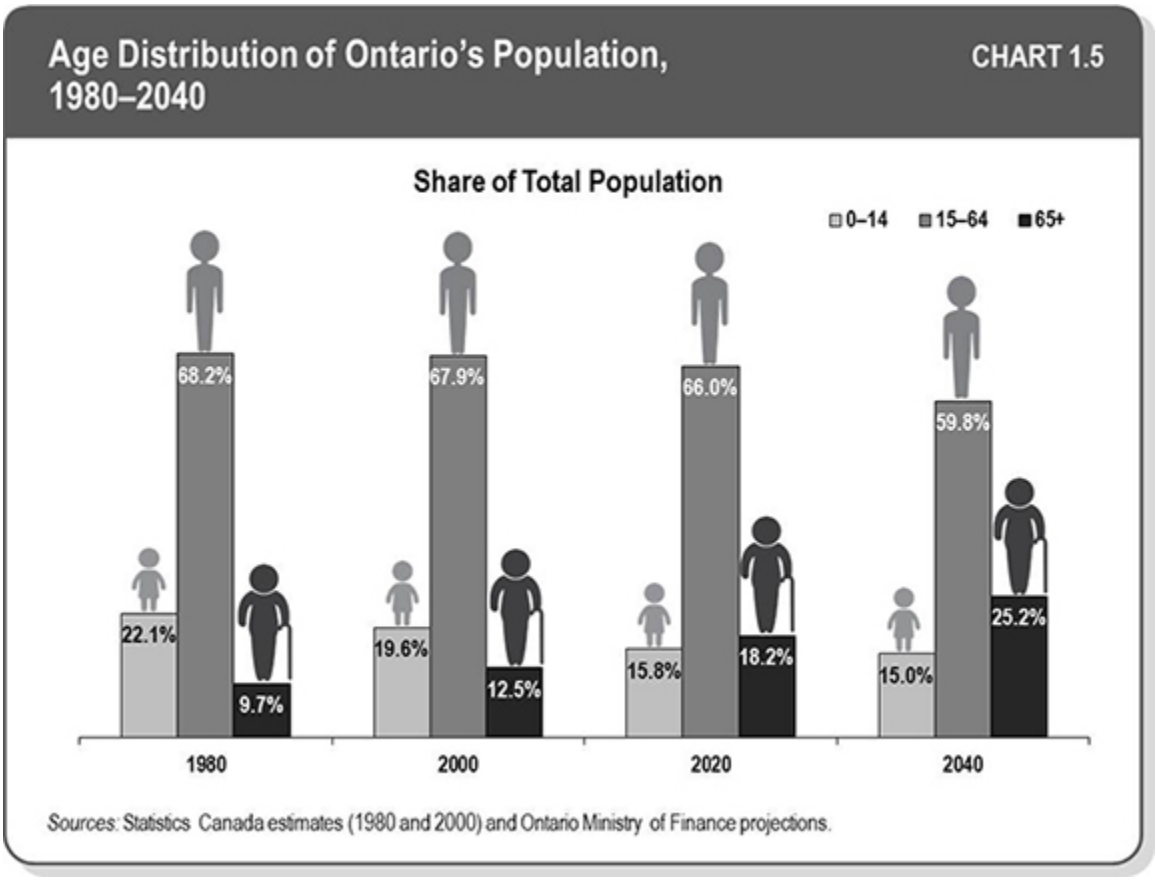
In 2018, among the six services that provided information to CUPE, there were 2,409 reported occasions when ambulance coverage was critical. Of these, 1,062 were instances of highly critical levels of coverage – with one or no ambulances available in a service region.

The amount of time with highly critical levels of coverage is increasing. Among the four services that provided data over three years, the total number of hours of highly critical coverage increased 21.7% from 2016 to 2017 and another 42% from 2017 to 2018.

The twin pressures of increasing call volume and offload delays are also having a major impact on the workload of paramedics. The amount of overtime required of paramedics is rising annually. Paramedics are also increasingly being expected to miss breaks in order to provide service. The detrimental impacts of these developments are felt by the paramedics themselves and of course by the communities they serve.

Our members indicate that short staffing is having a similar negative impact on Ambulance Communication Officers.

Population growth and, especially, population aging are having a serious impact on emergency health services. Aging is now slipping into high gear.



Source: Ontario Ministry of Finance, Ontario's Long-Term Report on the Economy, 2017
https://www.fin.gov.on.ca/en/economy/ltr/2017/ch1.html#s4

The government-funded Financial Accountability Office estimates that aging will require 70,000 new long-term care beds by 2033 just to moderate the growth in the wait list for LTC.[1] That is a 90% increase in capacity. We expect similar consequences of aging for emergency health services.

Unfortunately, recognition of these realities by authorities is lacking.

Instead of predictably increasing resources for paramedic services, which are funded 50% or more by the province, the current government announced a funding freeze for 2019/20. This would have represented cuts of approximately $40 to $50 million dollars for municipalities in Ontario. This announcement was made once budgets had already been developed and approved, resulting in the downloading of $40-$50 million to municipal budgets, that are already very stretched for resources.

Given a very strong response to these announced cuts from communities, workers and municipal councils, the freeze was reversed in August of 2019. However, the 4% increase

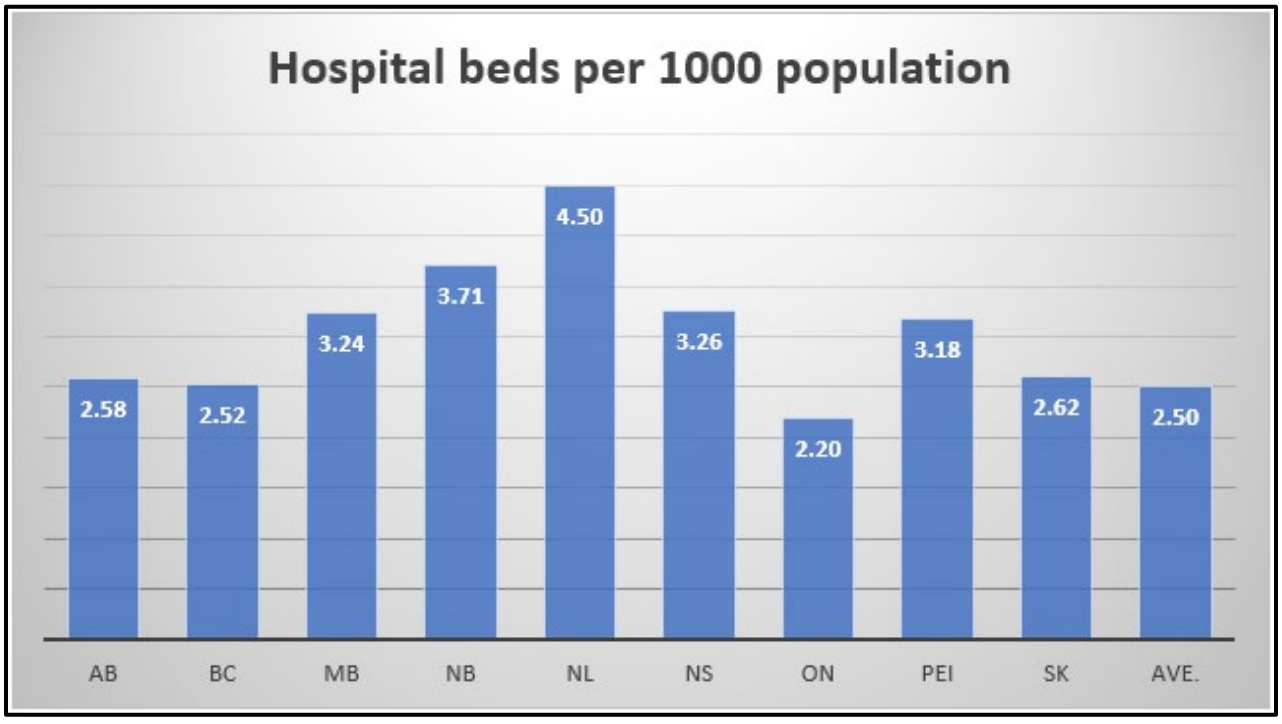
[1] FAO, Long-Term Care Homes Program, 2019. https://fao-on.org/en/Blog/Publications/LTBO-2019

announced then, only maintains the status quo and does not address the growing resource gap in paramedic services. The Association of Municipalities of Ontario (AMO) estimates that demand for EMS has been growing at 3.5% per year.[2] As a result, a 4% increase does not protect against inflation and so, barring impressive gains in productivity, this will result in a further deterioration of service.

Paramedics, dispatchers and ambulances are under-resourced across the province. The impact on quality services for communities is the first concern, and is augmented by undue stress places on paramedics and dispatchers to keep up with growing demand in the face of budgets that are shrinking in real terms.

2.2 Hospital Beds and Services

The other dimension of this key challenge of lack of resources, which is having a severely detrimental impact on EHS, is the reduction of hospital capacity. Ontario has less hospital funding, fewer hospital staff, and fewer hospital beds than the rest of Canada — by a considerable margin. Although Canada has a very low bed capacity compared to the rest of the developed world, Ontario is lower still.

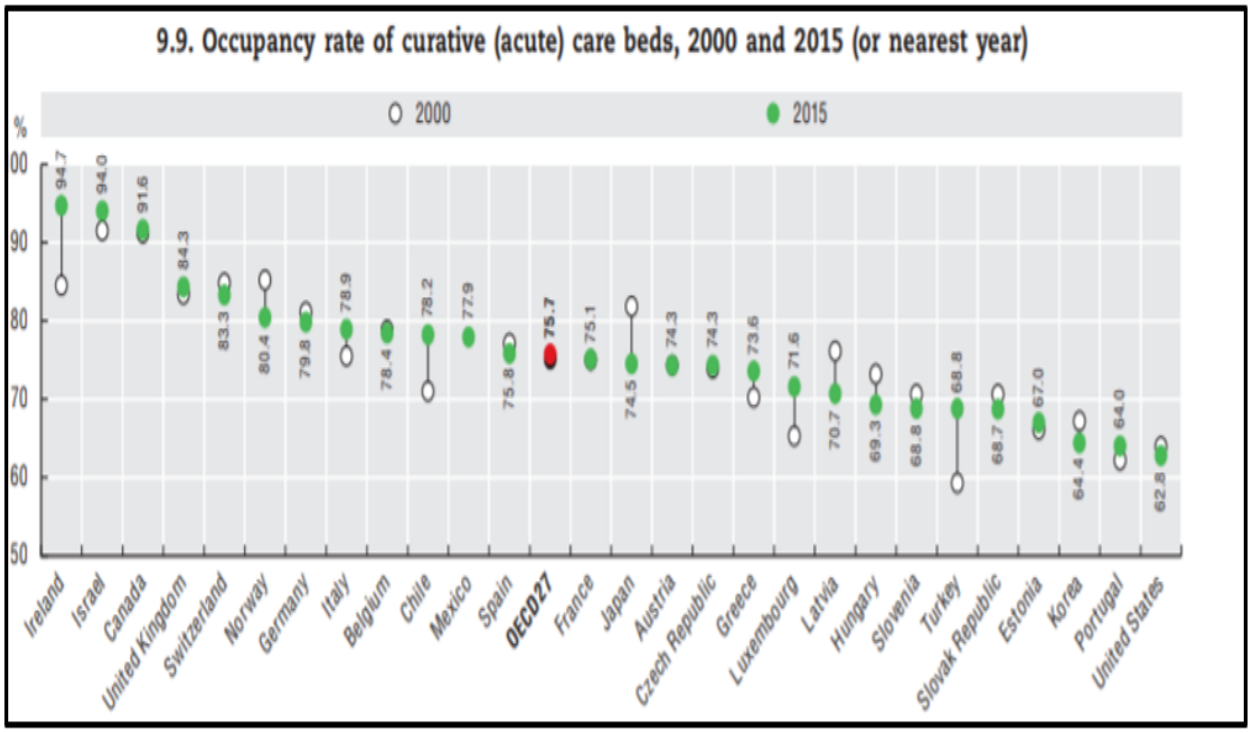


All types of hospital beds are included — e.g. rehabilitation, acute, mental health, CCC.

[2] https://www.amo.on.ca/AMO-PDFs/Reports/2016/ExpandingMedicalResponsesDiscussionPaperMOHLTCNov2.aspx

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

Notably, even Canada as a whole has a 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.

Notably, 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.

Reduced capacity has increased pressure on emergency health services and contributes directly to lengthy ambulance offload times. Recent reports in the media have illustrated the alarming

state of hospital beds in the province.[3] A growing and aging province will significantly increase demand for hospital services.[4]

Though some attempts have been made to address this challenge, much more needs to be done. In addition to funding hospital and LTC beds to reduce offload delays, special beds reserved for ambulance patients need to be funded. The accountability around the use of these beds needs to be tightened. In Peterborough, for example, 4 dedicated offload beds at the hospital are funded by the Province and a RN (also funded by the Province) does the triage. Given the hospital's bed shortage, however, it was decided to put other patients in these beds and offload delays were not addressed. Most hospitals do not have offload beds, thus more are needed. Oshawa has some, and Ajax and Toronto used to, but they no longer exist.

Cuts to hospitals have other impacts on the delivery of emergency health services. Hospitals are eliminating certain health services, creating pressure on neighbouring hospitals and further contributing to shortage of beds, long wait periods at emergency, and lengthy offload times. Bowmanville, for example, has recently lost pediatrics and obstetrics due to budget cuts. It never had a crisis unit. Some neighbouring hospitals have stopped offering labour and delivery services too, and so all patients are being diverted to the bigger hospitals in the region. These big hospitals, however, have not seen increases in their budgets with respect to when the diversion started, and so they become overstretched and greater contributors to hallway medicine.

While we support initiatives to reduce offload delay, we believe it is important to note that offload delays often allow paramedics to recover from the physical and mental stress they experience dealing with the horrors that inevitably come with the paramedic profession. Accordingly, if offload delays are reduced, some steps must also be taken to ensure that the stress on paramedics does not become too much. We suggest a sharing of the benefits to ensure paramedics are not overwhelmed.

2.3 Community Paramedicine

One of the recent innovations, and an important part of the solution to many challenges faced in the sector, is community paramedicine. The different pilots have proven that it works.[5] Paramedicine is the most patient-centered and effective way to address low acuity cases that divert scarce and stretched EHS services. More widespread and efficient community

[3] https://www.cbc.ca/news/canada/toronto/ontario-hospital-hallway-medicine-healthcare-beyond-capacity-1.5420434

[4] The Financial Accountability Office has ably demonstrated that the government's proposed increase in LTC beds will not stem the increase in the wait list for those services. Much more needs to be done.

[5] The Toronto pilot resulted in a dramatic reduction in calls with up to 20% of calls being diverted to paramedics. Renfrew County has a good paramedicine program which can serve as a model for others.

paramedicine will provide a solution to the many low acuity patients that call 911 for ambulances because they do not have any viable or reliable alternatives. Patients who regularly make use of EHS, could benefit from high quality health services without having to go to the emergency or be transported in an ambulance. Community paramedics are qualified paramedics and can provide a range of health services to patients, as well as link them up with other relevant health services as needed. Community paramedicine could also be one and the same with home palliative care services, an area of growing demand as the population ages.

Another advantage of community paramedicine is that it would provide opportunities for paramedics on modified duties and pregnancy. The duty to accommodate, in keeping with collective agreement language and requirements, could be well served by community paramedicine programs.

More funding is urgently needed for community paramedicine – it needs to be system-wide and standardized. There is a need to expand this program in a consistent manner with adequate and predictable funding. Funding needs to be guaranteed in the long-term so that municipalities across the province can take this on without risking setting up a service that they will not be able to afford in the future. Community paramedicine directly addresses the need for provincially funded services such as hospital care and so should remain 100% provincially funded and have a clearly defined structure of what can and cannot be done. Since community paramedicine does not fall under the base hospital jurisdiction, it needs consistent oversight. Legislation is needed to make community paramedicine a permanent and regulated feature of emergency health services.

We understand that Medavie has become interested in providing community care. We object to this in the strongest terms possible. This would fragment paramedic services and introduce private interests into the provision of health care. Privatization has been introduced into paramedics services through Ornge. This led to disaster — privatization was used to obscure public accountability (indeed the Ornge scandal was first revealed when Ornge used privatization to thwart the Auditor General's investigations) exorbitant management salaries, and bad decision-making.

3. Outdated Dispatch Technologies

In our understanding of the challenges that EHS faces today, upgrading the dispatch centre systems to improve coordination and efficiency is paramount. In fact, we are convinced that none of the other attempts at modernization can be successful without first updating dispatch technologies. This will require major investments in equipment, software and training. Progress to date has been very slow and bumpy, with only three of the 22 CACCs having

implemented MPDS. At this rate it is hard to envision when all dispatch centres in the province would be equipped to contribute to a modernized EHS system. Greater priority and investment must be given to upgrading dispatch technologies.

Paramedics need to be able to communicate effectively across units – using the same language. There is also a pressing need for common dispatch protocols and rules to facilitate cross-border dispatches. And to avoid double-dispatch in bordering regions.

It is important to note that standardization of service delivery requires equal resources and funding across the province. Downloading of EHS to the municipal level generated local level purchasing and so there are now differences in the equipment and supplies for paramedics. This makes cross-border collaboration difficult.

However, it is also important to recognize that different regions have different needs. Demographics are different and they present different challenges. Some regions have high concentration of retirees (Durham for example). Others have a population that speaks more than 80 languages (Toronto). Each region needs to bring the different stakeholders together in roundtables to find solutions for the particular challenges that they face. A balance between standardized service delivery and catering to specific local needs must be struck to enhance efficiency.

Where it makes sense, consideration should be given to bringing dispatch services in-house with paramedic services. Advantages of this approach include:

- It will create a team environment making it easier to attain mutual understanding between the paramedics and the dispatchers.
- The team will have common management for paramedics and dispatchers which will help to address challenges and find win-win solutions.
- Greater trust can be established by the two teams.
- Policy and procedures for dispatch and paramedics will be aligned.
- Internal agreements will be easier to interpret.
- Schedules of paramedics and dispatchers will be easier to align.
- Shared health and safety concerns can be addressed jointly.
- Information can be shared more efficiently.

Bringing dispatch in house may facilitate the adoption of the Medical Priority Dispatch System (MPDS).

4. Lengthy Ambulance Offload Times

We all know that hospitals and emergency rooms are operating at overcapacity, creating offload delays for paramedics, and delays for patients. Hospital, paramedic ambulance, and ER systems are underfunded and lack capacity. That is apparent from recent news stories which have documented the crisis of capacity that CUPE has been raising for years.[6]

The MOH's discussion paper states that, "when paramedics must wait to transfer patients in emergency departments to the care of the hospital, it contributes to hallway health care". This statement focuses on the symptom and not the cause. Clearly, as discussed above, hallway health care is caused by lack of sufficient beds in the hospital and in emergency rooms. This needs to be addressed with increased investments to keep up with growing population and demographics.

5. Delay in Patient Transfers

Hospitals are the appropriate destination for most patients — they have the range of diagnostic equipment, expertise, and staff to diagnose and treat patients. Paramedics provide emergency medical services and emergency transport — they do not provide detailed diagnosis. Diversion can only be appropriate where the patient explicitly consents, and when it is abundantly clear that no risk to the patient is involved. Disaster and death will occur if patients are wrongly transferred to limited facilities only to find later that they did in fact need emergency transport to a hospital.

In any case, low acuity patients are not clogging up emergency rooms. The Canadian Association of Emergency Physicians' policy paper on ER over-crowding states:

> "Contrary to popular perceptions, ED overcrowding is not caused by inappropriate use of ED's, or by high numbers of lower acuity patients presenting to the ED; the inability of admitted patients to access in-patient beds from the ED is the most significant factor causing EDOC in Canadian hospitals."[7]

What is needed, is better funding for hospital, paramedic ambulance, and ER services. Public hospitals, community health centres and other public providers should be funded to provide a diversified range of clinical services. Current systems which divert patients to other hospitals,

[6] https://www.thestar.com/politics/provincial/2019/09/04/worst-june-on-record-for-hallway-medicine-at-ontario-hospitals.html

[7] https://caep.ca/wp-content/uploads/2016/03/cjem_2013_overcrowding_and_access_block.pdf

or other parts of the hospital (e.g. stemi, stroke, and trauma patients) as well as the expansion of community paramedicine programs need more support.

Non-urgent patient transfer services should be brought back in-house. Some years ago, the CBC reported the following regarding the for-profit transfer industry:

- Workers within this industry who express concern to their dispatch operators about their patients' safety are routinely suspended or fired.
- In interviews, workers have recounted such experiences as trucks catching on fire and lug nuts shearing off wheels. In both of those cases, patients were aboard the trucks. One worker said she was ordered by her dispatcher to drop off a homeless patient in a back alley of Toronto. Workers also recalled cases in which patients who required oxygen during transit were denied it, either because a dispatcher ordered the transfer despite the attendant's protests that the tanks were empty, or the attendants didn't know the patient required oxygen.
- Regulated ambulances that transport infectious patients are taken out of service after each transport to go through a deep clean, whereby all equipment, surfaces and stretchers are disinfected. There are no such requirements for private companies. Patients are frequently exposed to infectious patients transported alongside them inside these vehicles, by staff who have no training in infection control precautions.

The Ontario Ombudsman followed up the CBC documentary with its own report on this industry. It was equally scathing.

- Ontario residents would be better off taking a taxi to a hospital than one of the privately owned vehicles used to transfer hundreds of thousands of non-critical patients each year, provincial watchdog Andre Marin told the Canadian Press.
- The Ombudsman said he was "blown away" by the stories he heard while investigating non-emergency medical transfers. "Of all the cases that I've done since I've been ombudsman, this is a case where I've rarely seen such incontrovertible and conclusive and convincing evidence early on, that was really not in dispute," he said. Marin said he received more than 60 complaints about private companies providing medical transfer services.
- It's allowed private companies to charge hundreds of dollars per patient for transports in old, beat-up ambulances operated by "kids" with no medical training, he said.
- "They place people's lives in serious jeopardy," Marin said. "These vehicles - that for all intents and purposes are ambulances - are completely without any rules" Marin said. "It's astounding." There have been other complaints about lack of infection controls, and even parts falling off unsafe vehicles. Marin said complaints had been circulating for at least 10 years, but fell on deaf ears until now.
- Marin, who launched his investigation in January 2011, said what he found was so compelling that he halted the probe and asked Premier Dalton McGuinty directly for immediate action. "Of all the cases that I've done since I've been ombudsman, this is a

case where I've rarely seen such incontrovertible and conclusive and convincing evidence early on, that was really not in dispute," he said.

As far as we know, there has been no significant change to this private industry since these reports other than some extremely minor legislation

Bringing this work in-house can be done at cost recovery (no profit margin). From a human resource perspective, this could be achieved by introducing an EMA wage level (attendant) or by making it an entry level job for fully trained paramedics. Patient transfers could use non-emergency vehicles. If the stability of a patient changes during transfer, the paramedic can respond as needed while patient transfer services cannot. And important added advantage of this model would be to allow for surge capacity which is sorely lacking in the system. Once patient transfer services are brought in-house, dispatch services can do the triage all in one place, increasing the efficient use of available resources. In order for this to happen, we would need to enhance the dispatching protocols as was discussed in section 3 above.

Patient user fees should not be contemplated for non-urgent patient transfers. Downloading cost of health care to individuals is privatization and must be avoided at all cost, a policy we also advocate for all paramedic services.

6. Lack of Coordination

Restructuring is not a panacea. The last major restructuring of health care services was a mixed bag at best. The download of EHS to municipalities is the best example of success.

Emergency health services have improved since downloading to municipalities – local control and local autonomy have made services more responsive to specific needs of each municipality. Municipal government are close to their local communities and municipal control, has facilitated public accountability and appropriate democratic control. It has become clear that there is no cookie cutter formula and that municipalities need flexibility to respond to their specific and evolving circumstances.

However, even this success only came after vigorous campaigning by CUPE and others to prevent the Harris government from privatizing EHS.

Other aspects of the health care restructuring of that era were not so successful — notably the mergers, closures and restructuring of hospital services. The Auditor General revealed, that hospital restructuring actually cost the province $3.2 billion dollars. Despite hopes that these mergers would help them cut spending, the Harris government quietly recognized reality, starting in 1998, three years after it was first elected. By 2000, they silently completed a U-turn on hospital funding, increasing funding 12.6% in one year.

Between 1998 and 2003 (when the PC government was defeated), hospital funding increased on average 7.5% per year. The Health Services Restructuring Commission completed its work and shut down in March 2000. So, arguably, the fruits of its work might be expected to have been gained in the five following years (including the first full year of Liberal governance). But funding increases averaged 8.7% for the 2000-2004 period. Whichever way you slice it, this is not strong evidence that the restructuring did anything to reduce costs. They did, however, cost the PC government considerable political capital. Wrecking the current system of municipal responsibility may have similar consequences.

In previous sections we have noted, that modernizing dispatch technologies and bringing dispatch services in-house to the municipalities would have a significant impact on the capacity to coordinate between paramedics and dispatchers, making EHS much more effective and efficient.

Enhancing community paramedicine will also improve coordination with other health services, and with other community services.

Crisis teams in urban settings should also include paramedics. This would allow for comprehensive and integrated care of patients who frequently use EHS and currently require significant EHS resources. Currently there is limited communication between different components of the health system for these patients. Many homeless and precarious citizens do not have an individual action plan, and there is limited transmission of health care information between different health services. This can be improved by adding paramedics to crisis teams.

Another area where improved coordination is badly needed to improve emergency response is with the municipal fire departments. A tiered response protocol for all local fire services is needed to reduce waste and redundancy. Firefighters currently respond to almost all non-fire calls. Yet firefighters are usually only required in 1% of medical calls. Since 100% of fire services are paid by municipalities, this translates into a huge resource drain which impacts lower-tier municipalities most. These are resources that could be used to enhance much needed paramedic services instead. The government should require a standardized tier-response agreement for municipalities across the province.

The modernization of dispatch services should include the capacity to direct calls to the appropriate services – fire, police, or paramedics. At present, paramedics are required to respond to all 911 “unknowns” (calls that come in but are not completed) even when often it might be Bell working on the lines and triggering unwanted calls. Often these calls are due to technical glitches.

7. Innovative Care Models

Innovative care models in EHS are already being piloted in Ontario and recently the MOH has consulted on amendments to regulation 247 to this effect. CACO and CUPE are particularly concerned with the increased levels of liability that these proposed changes convey, as well as the additional levels of training required to responsibly undertake expanded roles for paramedics and other care professionals. We also see the proposed new care models as facilitating privatization of emergency service delivery, which we know would be costly and inefficient. We do not believe that the proposed changes will adequately address the current challenges faced in emergency care (hallway medicine). To effectively address the overburdened system, greater resources need to be invested in ambulances and hospital and health care staffing.

We therefore want to ensure that any new patient care models consider these key issues and prioritize the highest levels of patient care in emergency situations above all else. We believe that for this to be the case, paramedics must be consulted at all stages of the process. The Niagara pilot project has not been a good example in integrating the experience and expertise of front-line workers, and this needs to be corrected moving forward in order for the new models to reflect the true needs of the communities served.

CUPE and CACO support the practice of paramedics treating and referring patients in the appropriate circumstances. CACO endorses the expansion of the current practice of paramedics to allow for paramedics to treat and refer (divert) patients to other than emergency rooms in hospitals in the following circumstances:

- Diversion from emergency rooms in hospitals should be only to public, not-for-profit facilities,
- Diversion from emergency rooms in hospitals would be only with patient agreement,
- Diversion from emergency rooms in hospitals would be only for patients with low acuity,
- Continuation of diversion systems which move patients to other parts of hospitals (e.g. stemi, stroke, and trauma patients) would continue,
- The expansion of community paramedicine programs would continue,
- Paramedics must not be pressured to treat and refer patients inappropriately due to lack of funding for Ambulance Service or Ambulance Service capacity issues,

• Paramedics and dispatchers must be protected from any additional liability that may arise from the Government's changes to allow diversion away from emergency rooms in hospitals, and

• Decisions to not transport patients or to divert them from Emergency Rooms should be made only on scene and not through dispatch protocols.

In addition to the above, in the case of a patient that has had a delegated act performed on them, that patient has to be taken to an emergency room and cannot be subject of referral or diversion. These CACO principles should be a starting point for any process contemplating, treat and refer, or treat and defer.

8. Equity

For many years paramedics (including predecessor classifications) bargained to achieve wage parity for paramedics across the province. Significant success in this regard was achieved, with arbitrators often adjusting wages to achieve near-province-wide parity. This however has seriously eroded since the last restructuring of paramedic services at the end of the 1990s. The result is that wage may vary by as much as $10 per hour. In contrast, other health care professionals have achieved wage parity across the province. RNs have parity at hospitals across the province, as have hospital paramedical professions. Similarly, hospital RPNs have significantly narrowed the wage gap.

First Nation paramedics are particularly affected by the paramedic wage gap. In CUPE's original First Nation paramedic bargaining unit, wages are $4 behind the CUPE paramedics in the adjoining municipality. But small town, francophone, and northern paramedics are also negatively affected by the lack of wage parity for a single profession.

In some communities, wages disparity is not even the biggest problem. Paramedics in small communities with limited service may be required to work "standby" for a very modest stipend — in at least one case with a requirement to physically be within five minutes of the ambulance base.

All of this makes these communities unappealing workplaces to some paramedics, limiting the ability of these communities to provide top quality service. Wage parity at the top rate will solve this inequity.

9. Privatization of EHS

One of the key concerns with the proposed modernization process is that it will pave the way for the privatization of emergency health care services. First, we want to reiterate that our understanding of public services is that they must be publicly funded *and publicly delivered*. We are reassured to have heard the Minister of Health, Christine Elliott, state clearly that the government has no plans to privatize land ambulance services, as stated at the 2019 AMO conference and repeated several times afterwards by herself and her staff. However, we know there are private operators who interpret that commitment as meaning that ambulance services will continue to be publicly funded but not necessarily publicly delivered.

There is ample evidence that privatization of health care services, including emergency health services, is done at the detriment of cost, efficiency and quality of services. There are an endless number of documented cases that illustrate how ineffective and costly privatization of health services can be — from the exorbitant cost of hospital P3 projects, to the excessive hiring of consultants in eHealth, payment of inflated executive salaries in ORNGE air ambulance, repeated problems regulating private clinics, unsupported bills to the public purse from for-profit physiotherapy clinics, and attempts by private plasma clinics to force their way into Ontario despite objections from the government.[8]

9.1 The case of Medavie

In a case directly on point, we are concerned with the ambitions of Medavie to manage the entirety of land ambulance services in Ontario as a result of regionalization of EHS. Medavie is a conglomerate of not-for-profit and for-profit companies that has been providing health-related services in New Brunswick, Nova Scotia, Prince Edward Island, Alberta, Saskatchewan and Ontario. It currently provides services in health insurance, air and ground ambulance, dispatch, paramedic training, medical communications, remote and home-health care.

Started as Maritime Medical Care in 1940's, Medavie has evolved into a three-pronged organizational structure with Medavie Blue Cross (the insurance wing), Medavie Health Services (with 11 subsidiaries), and Medavie Health Foundation (philanthropic/charitable wing). It also delivers ambulance services in Massachusetts with subsidiary registered in Delaware (a state known as a tax haven).

Medavie Health Services employs or manages 4,300 health care professionals in six provinces across Canada. In Ontario, Medavie manages land ambulance services in Elgin County and the Municipality of Chatham Kent with approximately 200 paramedics and management staff.

[8] For a review of some of the problems with health care privatization in Ontario see, "The long series of failures of private clinics in Ontario, https://ochuleftwords.blogspot.com/2015/09/the-long-series-of-failures-of-private.html

It also executes the Community Paramedics Improving Patients Outcome Program in Chatham-Kent. More recently, Medavie assumed transitional paramedic leadership support in Perth County, and has now secured a five year contract to continue providing that service.

Medavie's advocacy efforts have intensified in Ontario in the wake of the current Provincial Government's expressed interest in modernizing EHS. Principles of Grosso McCarthy Inc., that co-authored a 2019 report to MOHLTC on restructuring the Health Care system in Ontario, are registered lobbyists for Medavie. The leaked report clearly sets the frame for regionalization and privatization that Medavie is promoting in its public presentations at conferences such as AMO and ROMA. And early this year, Medavie announced that key members of its executive team will be relocating to the Toronto office, in support of their growth objective and Medavie Ontario Initiative. This move to Ontario positions Medavie for continued expansion in Ontario.

Medavie's record in Ontario though has not been problem free. The land ambulance service in the Municipal District of Muskoka was brought back in-house, following a 10-year contracting out of land ambulance services to Medavie. The municipal council voted to reintegrate the service to the municipal delivery model following an exhaustive analysis which demonstrated that the private delivery model was more costly and less efficient.[9]

The main factors that led to the 2016 Muskoka council vote were: cost savings (high management fees, loss in sales taxes, high WSIB assessments, and lack of oversight); increased transparency; improved accountability; better management of liability (not reduced with contracting-out but more complex); greater efficiency (government is not restricted by contract and can adapt more quickly, leveraging of other services without a 3rd party); and the direct employment relationship with paramedics.

A very important consideration was the lack of accountability that contracting out paramedic services to Medavie resulted in. Medavie has a 12 member self-appointed board that is only accountable to itself, creating secrecy around decision-making on key public services. This results in lack of public control and limited public information about operations and finances. Medavie, as a private entity, may not be subject to FOI legislation and therefore is not required to share documents on its use of public monies. Repeated FOIs in New Brunswick, were Medavie is very active in the EHS system, have been blocked and only heavily redacted contracts have been released, if at all.

Furthermore, there is the concern that public funds are being used for private profit, for though Medavie presents itself as a not-for-profit it is a conglomerate that includes numerous for-profit companies that are directly delivering EHS in the different regions where they intervene.

[9] Ambulance Service Delivery Report, The District Municipality of Muskoka, December 14, 2015

Related to this, there is the risk that innovations for improving EHS systems become the intellectual property of private operator, depriving the municipalities and the EHS public system of these advances.

9.2 Private patient transfer companies

MOHLTC must ensure that elements of Bill 160 (and in particular amendments to the Ambulance Act section 20.0.1 on holding out) come into force as planned on April 1 to further guarantee title protection for paramedics. The fact that this has not been done over two years after Bill 160 received Royal Assent, combined with some of the proposed changes to regulation 257 to allow for new models of care, raise concern about an agenda for privatization. If patient transfer services use the term "paramedic", the concern of privatization of land ambulance services will remain. This is a dangerous path that must be avoided.

It is imperative that transfer of 911 patients to health facilities, including non-hospital facilities, only be done by properly trained and accredited paramedics and ambulances, and not by private sector patient transfer companies. There have been repeated instances of private transfer companies claiming to deliver "paramedic" services. Private patient transfer services are largely unregulated and lack the appropriate oversight to ensure that patients and the public are well protected. These private companies are not accountable to the public, and there is no recourse to the MOH in the case that something goes wrong. This is dangerous and detrimental to the public trust in paramedic services.

10. Conclusion

CUPE and CACO are concerned that the current consultation on modernization of EHS will result in regionalization, amalgamation and privatization of land ambulance and dispatch services. We are convinced that none of these measures will address the "hallway health care" challenges identified by the MOHLTC. Greater investments in paramedics, ambulances and related health services are necessary to overcome the challenges faced in the sector and municipal responsibility for paramedic services must be maintained.

We are concerned that the consultation process is not giving enough space to hear from front-line workers, be it directly or through their elected representatives. Hearing from front-line workers is essential for finding durable solutions to the growing and changing needs of the communities they serve.

In this submission we have addressed the key issue of lack of resources, for paramedics, for ambulances, for dispatchers, for community paramedicine, and for hospital and other related health services. To end "hallway medicine" more investments are needed in all these fields.

With respect to other improvements for EHS, we respectfully recommend the following:

- increase the provision of ambulance services across the province to respond to growing needs, as documented in growing call volumes;
- urgently increase resource hospitals so that ambulance download delays are shortened and paramedic resources liberated to attend to other emergencies;
- provide more funding for ambulances, paramedics and dispatchers;
- in addition to funding hospital beds to reduce offload delays, fund special beds reserved for ambulance patients;
- stop cuts to hospital programs that have negative impacts on the delivery of emergency health services (pediatrics, obstetrics, labour and delivery, crisis, etc.);
- expand community paramedicine in a consistent manner and with adequate and predictable funding;
- ensure that community paramedicine remain 100% provincially funded and have a clearly defined structure;
- ensure consistent oversight for community paramedicine since it does not yet fall under the base hospital jurisdiction. Legislation is needed to make community paramedicine a permanent and regulated feature of emergency health services;
- give greater priority and investment to upgrading dispatch technologies;
- support development of common dispatch protocols and rules to facilitate cross-border dispatches;
- acknowledge that standardization of service delivery requires equal resources and funding across the province;
- support regions to bring different stakeholders together in roundtables to find solutions for the particular challenges that they face;
- consider, where appropriate, bringing dispatch centres in Ontario in-house;
- provide more support to current diversion systems which divert patients to other hospitals, or other parts of the hospital (e.g. stemi, stroke, and trauma patients);
- bring non-urgent patient transfer services brought back in-house;
- Eliminate user fees for paramedic services and do not allow new user fees for non-urgent patient transfers;
- support crisis teams in urban settings, including paramedics;
- Require all providers to develop appropriate standardized tiered response protocols for the fire-fighting industry to reduce waste and redundancy and ensure savings are directed to the needed expansion of paramedic services;
- include in the modernization of dispatch services the capacity to direct calls to the appropriate services – fire, police, or paramedics;

- create clear and transparent instances for timely and meaningful input from paramedics as new patient care models are designed, tested and assessed;
- only expand current “treat and refer” practices to facilities other than hospital emergency rooms as detailed in this brief by CACO;
- Do not allow modernization to be used to privatize emergency health services;
- Public services must be publicly funded *and publicly delivered and EHS must not be turned over to private companies such as Medavie;*
- Ensure that the recently proclaimed elements of Bill 160 (and amendments to the Ambulance Act section 20.0.1 on holding out) come into force as planned to guarantee title protection for paramedics;
- ensure that the transfer of patients to health facilities or homes, be done by properly trained and accredited paramedics, and not by private sector patient transfer companies;
- Maintain municipal responsibility for paramedic services and reject the restructuring proposals floated in 2019.

Thank you for considering our submission.

Under Pressure:

A Statistical Report on Paramedic Services in Ontario

By Chandra Pasma, Senior Research Officer
Canadian Union of Public Employees
March 2020

ACKNOWLEDGEMENTS

Thank you to the many Freedom of Information coordinators who assisted CUPE in obtaining this data. Thank you as well to Simon Collins, Dana Kaminski, Lisa Peldiak, Tammy Emond, Alison Davidson, Andrea Addario, Suzanne Chamseddine and Jocelyn Renaud of CUPE for their assistance in collecting the data and preparing this report.

ABOUT CUPE

The Canadian Union of Public Employees is Canada's largest union, with 700,000 members. CUPE workers take great pride in delivering quality public services in communities across Canada through their work in municipalities, health care, social services, schools, universities, and many other sectors. Nearly 10,000 CUPE members are in the emergency medical services sector, including 5,500 paramedics in Ontario.

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EXECUTIVE SUMMARY

Paramedic services in Ontario are under serious pressure. Demand for land ambulances is rising and there are growing delays caused by the inability to offload patients at hospitals. As a result, too often, ambulance coverage in Ontario is critically low, putting the health and safety of Ontario residents at risk. Because of funding pressures, municipalities have not responded by increasing scheduled hours for ambulances. Instead, workers are being called upon to miss breaks and work increasing rates of overtime in order to provide desperately needed services.

In 2019, the Canadian Union of Public Employees submitted requests under the Municipal Freedom of Information and Protection of Privacy Act to all 22 local governments in municipalities or regions where CUPE represents ambulance workers. We also submitted a Freedom of Information request to the Ministry of Health and Long-Term Care and looked at publicly available data from the Ministry and from the Ontario Association of Paramedic Chiefs.

The resulting statistical portrait is cause for deep concern. The total volume of emergency calls in Ontario is rising, with the highest rate of growth taking place in the category of calls that demand the most urgent response. The number of times that services are being called on to help each other is also increasing. The number of scheduled hours for ambulances, meanwhile, is not keeping pace with the increasing call volume.

Paramedics are also experiencing increasing delays when it comes to transferring patients to the care of hospitals. Both the number of incidents of offload delay and the amount of time that ambulances are waiting is increasing.

As a result of these two pressures, there are far too many occasions where very few ambulances – or even no ambulances – are available within a service region to respond to emergency calls.

The twin pressures of increasing call volume and offload delays are also having a major impact on the workload of paramedics. The amount of overtime required of paramedics is rising annually. Paramedics are also increasingly being expected to miss breaks in order to provide service.

While paramedics continue to do an amazing job of providing care to Ontarians in challenging circumstances, the situation is clearly taking a toll. There are nearly 2,700 claims for workplace illnesses or injuries annually, and the cost of Workplace Safety and Insurance Board claims is skyrocketing.

It is time for the Ontario government and municipal governments to take this crisis seriously and take immediate steps to ensure that emergency medical services are there when people need them, without making our paramedics ill or injured through overwork. We recommend four actions:

1. The provincial government should increase funding for emergency medical services.
2. The provincial government should increase funding for hospitals and public health programs.
3. Municipal governments should take a strategic approach to planning emergency medical services.
4. The provincial government should require municipalities to collect and provide regular disclosure of information on emergency medical services.

INTRODUCTION

Paramedic services in Ontario are under serious pressure. Demand for land ambulances is rising and there are growing delays caused by the inability to offload patients at hospitals. The result is that too often, ambulance coverage in Ontario is critically low, putting the health and safety of Ontario residents at risk. Because of funding pressures, municipalities have not responded by increasing scheduled hours for ambulances. Instead, workers are being called upon to miss breaks and work increasing rates of overtime in order to provide desperately needed services. The toll on workers can clearly be seen in rates of workplace illness and injuries.

Emergency medical services in Ontario are a system in crisis. But this crisis is not occurring alone. It reflects government cuts throughout the health care system, including cuts to hospitals and public health programs. The provincial government and municipal governments need to step up and provide the funding and the leadership that are required to ensure that Ontarians get the level of health care they need and deserve.

The Canadian Union of Public Employees (CUPE) represents paramedics at 22 of the 59 land ambulance services in Ontario, representing more than two-thirds of Ontario paramedics.[1] CUPE paramedics have been raising red flags for years that the system is under enormous pressure. To provide a comprehensive statistical portrait of what is happening in this sector, CUPE submitted requests under the Municipal Freedom of Information and Protection of Privacy Act to all 22 local governments where CUPE represents ambulance workers. We also submitted a Freedom of Information request to the Ministry of Health and Long-Term Care and looked at publicly available data on Key Performance Indicators relating to land ambulances on the Ministry website and Service Area Profiles available through the Ontario Association of Paramedic Chiefs.

Our Freedom of Information requests asked for data on a variety of indicators over a three-year period from 2016 to 2018. Only one service – Kenora – denied our request. Another service, Cochrane, partially denied our request. Appeals have been filed with the Information and Privacy Commissioner of Ontario regarding both requests. Other services had gaps in the data that they were able to provide, based on which statistics they actually track.[2]

This report looks at the statistics globally, across the services. For most issues, only services that could provide three full years of data are included for the sake of providing a fair comparison over time.

The picture painted by these statistics is deeply concerning. A growing demand for services that is not being met with additional resources is leading to worrisome trends, including a growing number of occasions when emergency medical services are simply not available. The Ontario government cannot manage its way out of this problem simply by merging services. Emergency medical services need adequate funding or the pressure on the system will increase until it reaches a breaking point.

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1 For more information on the services represented by CUPE, see Appendix A. Note that for reasons of space, throughout the report we refer to each service by its location rather than using the service's full title.

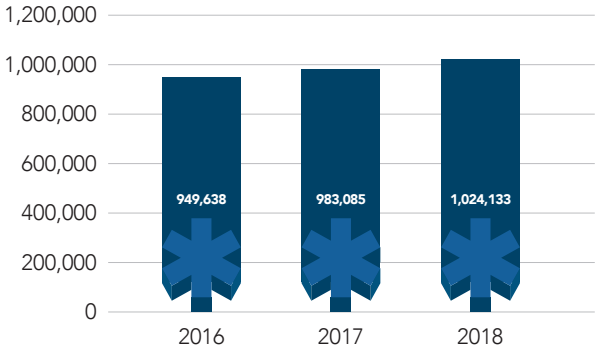
2 For more information on the questions asked and the data provided in response by each service, see Appendices B and C.

1. CALL VOLUME

Demand for emergency services is steadily increasing. In the local service regions we examined, the demand is increasing at a rate faster than the growth of population. From 2016 to 2017, the volume of calls increased 3.5%, compared to population growth of 1.4%. From 2017 to 2018, meanwhile, the volume of calls increased 4.2% compared to population growth of 1.2%.[3]

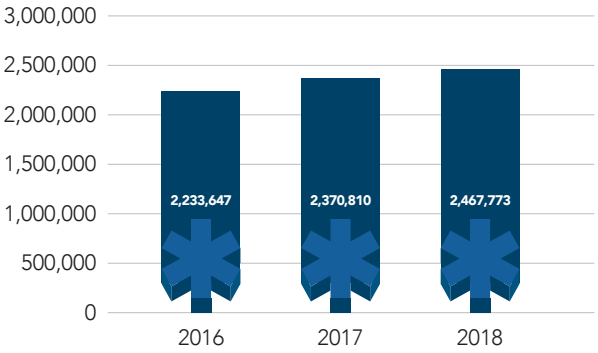
This trend is not unique to these local service regions. Data from the Ministry of Health and Long-Term Care demonstrate that across Ontario, demand is surging faster than the growth in population. From 2016 to 2017, the total volume of calls in Ontario grew 6.1% compared to population growth of 1.4%. From 2017 to 2018, the volume of calls in Ontario increased 4.1% compared to population growth of 1.8%.[5]

Figure 1: Total Call Volume in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests.[4]

Figure 2: Total Call Volume in Ontario, 2016-2018



Source: Data received through Freedom of Information requests.[6]

3 Data received through Freedom of Information requests from Algoma, Cochrane, Cornwall Stormont-Dundas-Glengarry, Durham, Essex-Windsor, Haliburton, Hastings-Quinte, Huron, Lanark, Leeds Grenville, Niagara, Ottawa, Perth, Peterborough, Prescott-Russell, Renfrew, Sudbury, Toronto, Waterloo, and York; and Ontario Ministry of Health and Long-Term Care, "Emergency Health Services: Land Ambulance Key Performance Indicators," http://www.health.gov.on.ca/en/pro/programs/emergency_health/land/default.aspx.

4 Data included from: Algoma, Cochrane, Cornwall Stormont-Dundas-Glengarry, Durham, Essex-Windsor, Haliburton, Hastings-Quinte, Huron, Leeds Grenville, Lanark, Niagara, Ottawa, Perth, Peterborough, Prescott-Russell, Renfrew, Sudbury, Toronto, Waterloo, and York.

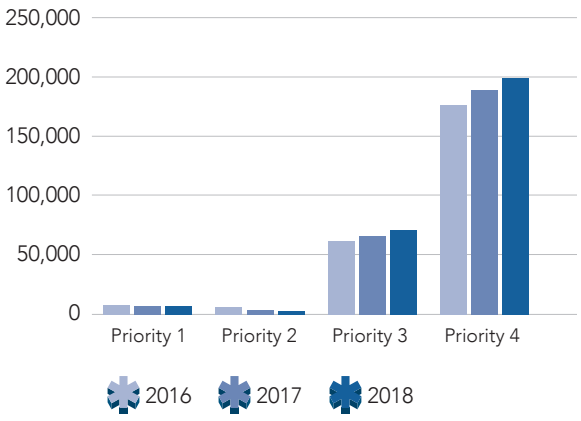
5 Data received through a Freedom of Information request to the Ministry of Health and Long-Term Care; Statistics Canada, "Table 17-10-0005-01, Population Estimates on July 1st, by Age and Sex," https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1710000501.

6 Data included from: Ministry of Health and Long-Term Care.

When calls for emergency services come in, they are assigned a priority level by dispatchers. Priority 4 calls are the most urgent – the kinds of calls that require lights and sirens as an ambulance rushes a patient to the nearest hospital. As the Ministry of Health and Long-Term Care manual says, "The patient is life, limb or function threatened, in immediate danger and time is crucial."[7] Priority 1 calls are considered "deferrable calls": calls that may receive a delayed response without endangering the patient.

When looking at call volume by priority level, we see a clear trend. The increase in calls is occurring in the most urgent categories of Priority 3 and Priority 4, while call volume is actually declining in the less urgent categories of Priority 1 and Priority 2. In fact, call volume for Priority 3 calls increased 6.5% from 2016 to 2017 and another 7.2% from 2017 to 2018, while call volume for Priority 4 calls increased 7.2% in 2017 and another 5.3% in 2018. Excluding calls for an ambulance to stand by (not all services provided information on these calls), Priority 4 calls made up 72% of calls for emergency medical services in 2018.

Figure 3: Call Volume by Priority Level in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests.[8]

Once paramedics have had an opportunity to assess the patient, calls are also assigned a Prehospital Canadian Triage & Acuity Scale code, or CTAS code. These codes designate what type of medical emergency has occurred. For instance, the code SCA refers to Sudden Cardiac Arrest. When a patient is assessed as an SCA, ambulance services are expected to respond very quickly, generally within 6 minutes or less. CTAS Level 1 covers situations where a patient needs resuscitation, or rapid and aggressive intervention, and also requires an urgent response. On the other hand, CTAS Level 5 represents non-urgent calls, such as patients with chronic conditions or patients with minor physical trauma, and services generally have a much longer expected response time, such as 25 minutes, to respond.

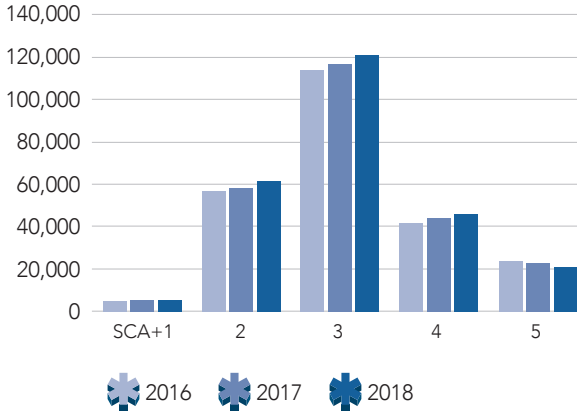
Looking at calls by CTAS codes, we see a very similar pattern: the greatest increase in calls is occurring in the categories that require the most urgent response.

In the local service regions represented by CUPE, calls for Sudden Cardiac Arrests and for CTAS Level 1s increased by 5.9% in 2017, and then increased again by another 2.5% in 2018. Calls for CTAS Level 2s increased by 2.2% in 2017 and by 5.6% in 2018. On the other hand, calls for CTAS Level 5s – the least urgent calls – are actually declining annually.

7 Emergency Health Services Branch, Ministry of Health and Long-Term Care, Ambulance Call Report Completion Manual, Version 3.0, entered into force on April 1, 2017, http://www.health.gov.on.ca/en/pro/programs/emergency_health/docs/ehs_acr_completion_man_v3_en.pdf.

8 Data included from: Cochrane, Cornwall Stormont-Dundas-Glengarry, Durham, Haliburton, Huron, Lanark, Leeds Grenville, Perth, Peterborough, Renfrew, and York.

Figure 4: Call Volume by CTAS Code in Regions Represented by CUPE, 2016-2018

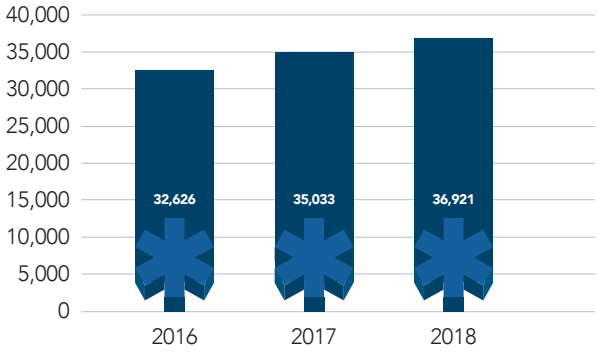


Source: Data received through Freedom of Information requests.[9]

Occasions when services are being called on to help each other are also increasing. The number of times an ambulance from a service CUPE represents was dispatched to a neighbouring service region increased 7.4% from 2016 to 2017 and another 5.4% from 2017 to 2018.

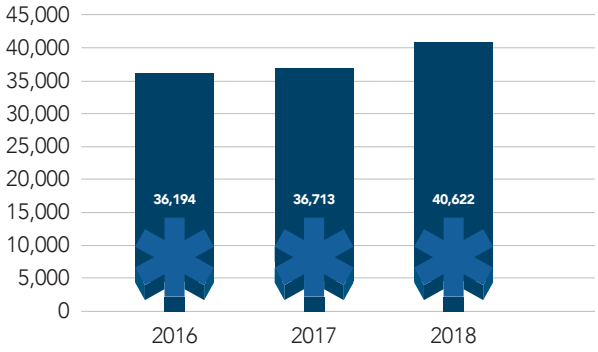
Meanwhile, the number of times that an ambulance had to be dispatched from a neighbouring service region to respond to a call within a CUPE-represented service region increased by 1.4% in 2017 and another 10.7% in 2018.

Figure 5: Ambulances Dispatched from Regions Represented by CUPE to Calls from Other Services, 2016-2018



Source: Data received through Freedom of Information requests.[10]

Figure 6: Ambulances Dispatched from Neighbouring Services to Regions Represented by CUPE, 2016-2018



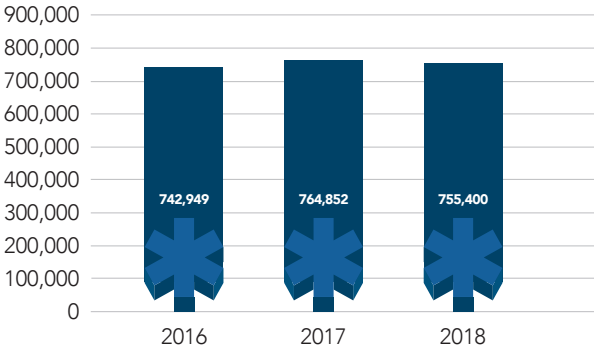
Source: Data received through Freedom of Information requests.[11]

9 Data included from: Algoma, Cochrane, Cornwall Stormont-Dundas-Glengarry, Essex-Windsor, Haliburton, Huron, Leeds Grenville, Ottawa, Prescott-Russell, Rainy River, Sudbury, and Waterloo.
10 Data received from the Ministry of Health and Long-Term care. Data includes all CUPE-represented services.
11 Data received from the Ministry of Health and Long-Term care. Data includes all CUPE-represented services.

2. SCHEDULED HOURS

The number of scheduled hours for ambulances, meanwhile, is not keeping pace with the increasing call volume. Among those services for whom three years of data was available, scheduled hours remained roughly the same, despite the significant increase in calls.

Figure 7: Total Scheduled Hours for Emergency Response Vehicles in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests; Ontario Association of Paramedic Chiefs.[12]

12 Data from Freedom of Information requests included from: Durham, Ottawa, and Waterloo. Data for Leeds Grenville from Ontario Association of Paramedic Chiefs, "Service Area Profile," https://www.oapc.ca/service-profile/.

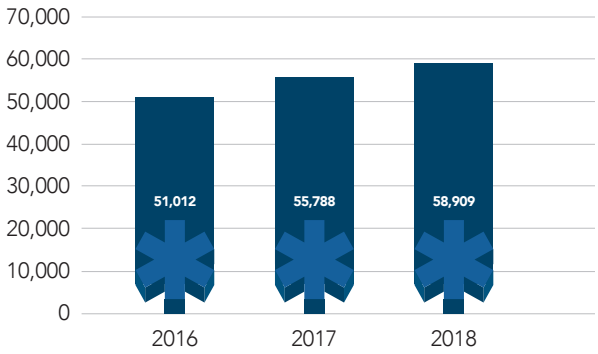
3. OFFLOAD DELAYS

The pressure on emergency medical services is not just coming from an increased volume in calls; it is also coming from an increase in offload delays. An ambulance offload delay occurs when paramedics are unable to hand over care of a patient to hospital staff, usually because hospital staff are busy dealing with an overcrowded Emergency Department.

Four services reported statistics on the number of offload incidents between 2016 and 2018. Between 2016 and 2017, the number of incidents increased 9.3%; between 2017 and 2018, they increased another 5.6%.

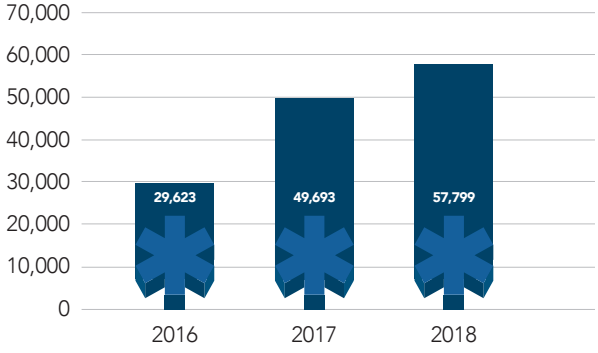
Seven services reported the total amount of time lost by ambulances and paramedics to offload delays – calculated as the amount of time spent waiting at a hospital after 30 minutes had passed. The amount of time lost to such incidents has increased dramatically: a 67.8% increase from 2016 to 2017 and another 16.3% increase from 2017 to 2018. At just these seven services, nearly 58,000 hours are being lost annually because ambulances can't transfer patients into hospital care.

Figure 8: Total Offload Delay Incidents in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests.[13]

Figure 9: Total Time Lost (Hours) to Offload Delays in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests.[14]

13 Data included from: Essex-Windsor, Leeds Grenville, Perth, and Waterloo.
14 Data included from: Algoma, Essex-Windsor, Haliburton, Niagara, Perth, Peterborough, and Waterloo.

4. AMBULANCE COVERAGE

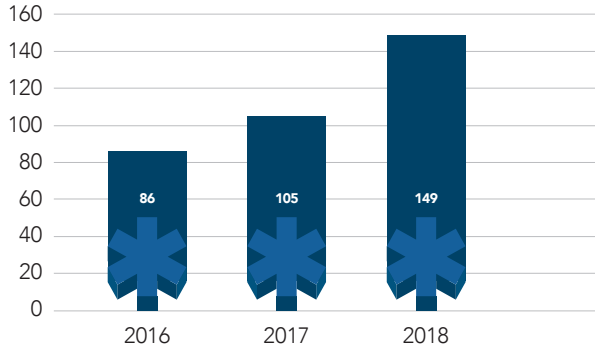
Between the competing pressures of a rising volume of calls and the increase in offload delays at hospitals, ambulance coverage is becoming a serious concern.

Instances when ambulance availability reaches critically low levels are known by different terms across the sector. Sometimes they are called Code Yellow (for significantly reduced availability) and Code Red or Code Black (depending on the service, no ambulance or one ambulance available). Other times they are known as Code Zero or Level Zero (no ambulances available). But what is clear is that by any name, there are far too many instances to fully ensure the health and safety of Ontarians.

In 2018, among the six services that provided information, there were 2,409 reported occasions when ambulance coverage was critical. Of these, 1,062 were instances of highly critical levels of coverage – with one or no ambulances available in a service region. However, this figure underestimates the total number of incidents, as two services only reported on part of the year and one service only reported on ambulance coverage at night.[15]

The amount of time with highly critical levels of coverage is increasing. Among the four services that provided data over three years, the total number of hours of highly critical coverage increased 21.7% from 2016 to 2017 and another 42% from 2017 to 2018.

Figure 10: Total Time (Hours) with Highly Critical Levels of Ambulance Coverage in Regions Represented by CUPE, 2016-2018



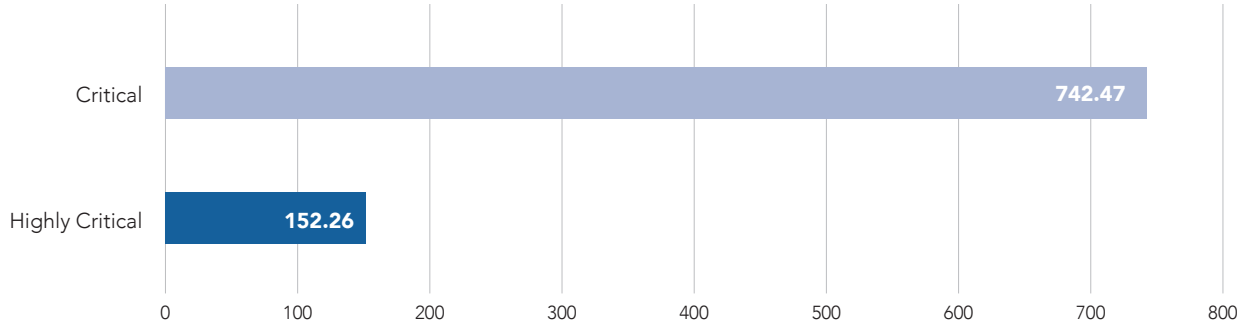
Source: Data received through Freedom of Information requests.[16]

Overall, among the five services that provided us data on the amount of time when a Code relating to critical levels of coverage was in place in 2018, there was a total of 742 hours and 47 minutes when coverage was critical, which is the equivalent of 30 days and 22 hours in total.

15 Data included from: Haliburton, Huron, Lanark, Perth, Sudbury, and Waterloo.
16 Data included from: Algoma, Huron, Peterborough, and Waterloo.

Of this, there were 152 hours and 26 minutes where coverage was highly critical, with only one or, in some cases, no ambulances available in a service region. That works out to more than 6 days in total that some part of Ontario had extremely critical levels of ambulance coverage. And this is just for five services out of 59. The real total is likely much higher, based on media coverage of Code Zeros in other service regions.

Figure 11: Total Time (Hours) with Critical Levels of Ambulance Coverage in Regions Represented by CUPE, 2018



Source: Data received through Freedom of Information requests.[17]

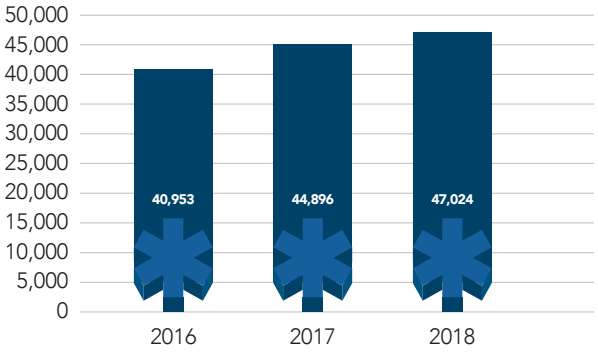
17 Data included from: Algoma, Huron, Peterborough, Waterloo, and Sudbury.

5. WORKLOAD

The twin pressures of increasing call volume and offload delays are also having a major impact on the workload of paramedics.

The amount of overtime required of paramedics is increasing. From 2016 to 2017, the number of overtime hours worked by paramedics at just five services increased 9.6%. From 2017 to 2018, it increased another 4.7%.

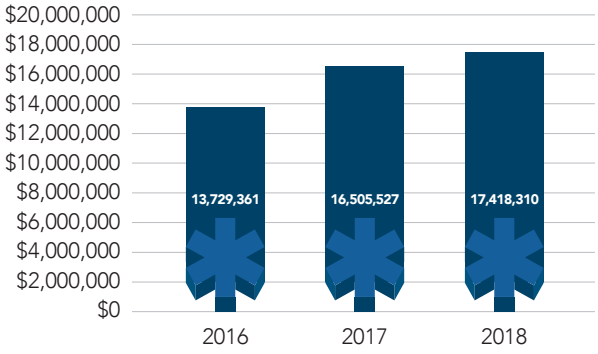
Figure 12: Total Overtime (Hours) in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests.[18]

Overall, the increase in overtime can be seen in the cost of overtime to the local ambulance services, which was $17.4 million in 2018. This was an increase of 5.5% compared to 2017. Between 2016 and 2017, the cost of overtime increased 20.2%.

Figure 13: Total Overtime Cost in Regions Represented by CUPE, 2016-2018

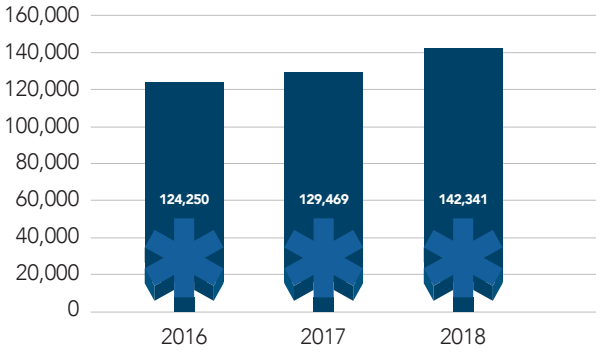


Source: Data received through Freedom of Information requests.[19]

18 Data included from: Perth, Rainy River, Renfrew, Sudbury, and Waterloo.
19 Data included from: Algoma, Cochrane, Cornwall Stormont-Dundas-Glengarry, Durham, Essex-Windsor, Haliburton, Hastings-Quinte, Huron, Lanark, Leeds Grenville, Niagara, Ottawa, Peterborough, Prescott-Russell, Rainy River, Sudbury, Toronto, Waterloo, and York.

Paramedics are also increasingly being expected to miss breaks in order to provide service, whether it's waiting at a hospital to offload a patient or rushing off to respond to another call immediately after finishing one. At just ten services, there were nearly 143,000 instances of missed breaks in 2018, an increase of 9.9% compared to 2017.

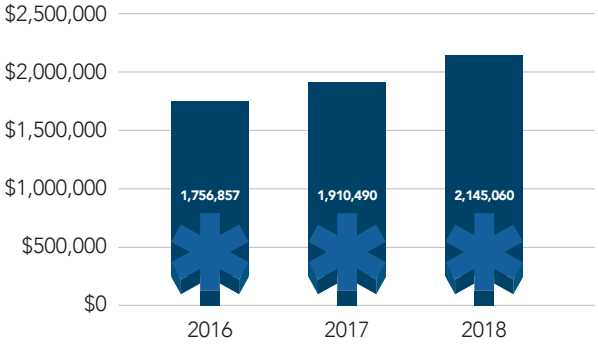
Figure 14: Total Missed Meal Breaks (Occurrences) in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests.[20]

The growing number of missed breaks can also be seen in the cost to services, which end up reimbursing paramedics for the missed break. The cost of missed meal breaks increased by 8.7% from 2016 to 2017 and by 12.3% between 2017 and 2018, reaching more than $2.1 million at 12 services.

Figure 15: Total Cost of Missed Meal Breaks in Regions Represented by CUPE, 2016-2018



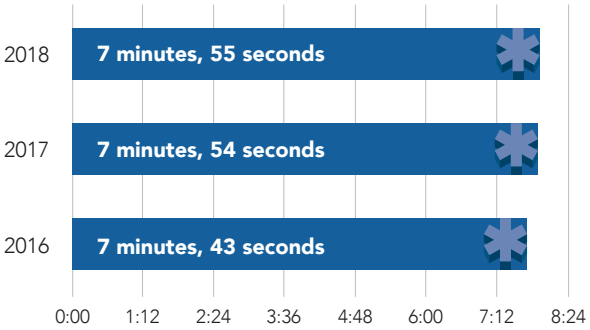
Source: Data received through Freedom of Information requests.[21]

20 Data included from: Algoma, Essex-Windsor, Haliburton, Leeds Grenville, Niagara, Renfrew, Sudbury, Toronto, Waterloo, and York.
21 Data included from: Algoma, Cornwall Stormont-Dundas-Glengarry, Essex-Windsor, Haliburton, Lanark, Leeds Grenville, Niagara, Renfrew, Sudbury, Toronto, Waterloo, and York.

6. THE IMPACT ON WORKERS

In very difficult circumstances, paramedics continue to do an amazing job of providing care to Ontarians. Despite the increase in call volume and the increase in incidents of critical coverage, the average response time to emergency calls has only increased by 12 seconds over the past three years. Meanwhile, the number of instances where performance targets have been missed remains low and has actually declined since 2016.[22]

Figure 16: Average Call Response Time in Regions Represented by CUPE, 2016-2018



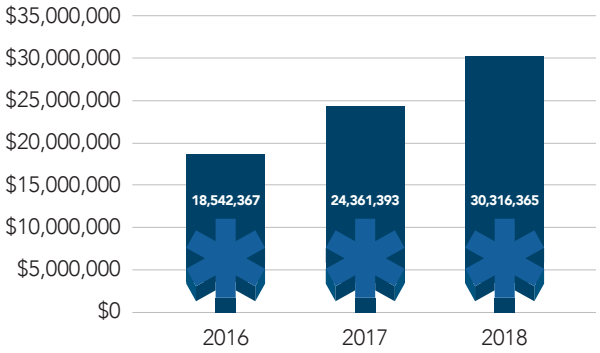
Source: Ministry of Health and Long Term Care, Key Performance Indicators for Ambulances.[23]

But the impact on workers of meeting these targets and responding to this volume of calls, while dealing with an increase in the urgency of calls and a rise in the number of offload delays, and also working a growing number of overtime hours while missing work breaks is very clear.

The number of Workplace Safety and Insurance Board claims, addressing workplace accidents and work-related injuries and illnesses, is very high among paramedics. At just 16 services, there are nearly 2,700 WSIB claims annually.[24] The toll can be clearly seen in the amount services are paying for WSIB (claims and administration), which is skyrocketing, increasing 31.4% in 2017 and another 24.4% in 2018. The total cost for WSIB in 2018 for just 16 services was more than $30.3 million.

22 Ontario Ministry of Health and Long-Term Care, "Emergency Health Services: Land Ambulance Key Performance Indicators," http://www.health.gov.on.ca/en/pro/programs/emergency_health/land/default.aspx. Data includes all CUPE-represented services.
23 Ontario Ministry of Health and Long-Term Care, "Emergency Health Services: Land Ambulance Key Performance Indicators," http://www.health.gov.on.ca/en/pro/programs/emergency_health/land/default.aspx. Data includes all CUPE-represented services.
24 Data included from; Algoma, Cornwall Stormont-Dundas-Glengarry, Durham, Essex-Windsor, Haliburton, Hastings-Quinte, Huron, Lanark, Leeds Grenville, Niagara, Ottawa, Peterborough, Rainy River, Renfrew, Toronto, and Waterloo.
25 Data included from: Algoma, Cornwall Stormont-Dundas-Glengarry, Durham, Essex-Windsor, Hastings-Quinte, Huron, Leeds Grenville, Niagara, Ottawa, Peterborough, Prescott-Russell, Rainy River, Sudbury, Toronto, Waterloo, and York.

Figure 17: Annual WSIB Cost in Regions Represented by CUPE, 2016-2018



Source: Data received through Freedom of Information requests.[25]

Paramedics describe situations where they are forced to rush to provide patient care, causing strain or physical injury, as well as the toll taken on mental health by long hours and difficult scenarios. For instance, paramedics in Ottawa told CBC News of a recent incident where it took three hours to be able to free up an ambulance to respond to a call from a cancer patient who had spiked a fever. By the time paramedics arrived, the patient was septic and "barely lucid." They still don't know whether the delay cost the patient his life.[26]

26 Laura Osman, "'People are dying: Life and death at level zero," CBC News, October 21, 2019, https://www.cbc.ca/news/canada/ottawa/level-zero-paramedic-1.5316802.

CONCLUSION

It is clear that the situation cannot continue. Emergency medical services in Ontario are under enormous pressure, putting public safety at risk, and compromising the health and safety of paramedics. The system is strained to the breaking point.

The Ontario government and municipal governments need to take this crisis seriously and take immediate steps to ensure that emergency medical services are there when people need them, without making our paramedics ill or injured through overwork.

The population of Ontario is growing and it is aging. The number of emergency calls is increasing every year, and it is the most urgent calls that are rising the fastest. It is unreasonable to think that the same number of ambulances, the same number of paramedics, and the same level of funding, even if it is adjusted for inflation, is going to provide adequate service year after year.

The provincial government has backed down on their initial threat to freeze paramedic budgets this year, but a 4% increase is still not enough to deal with a system in crisis. Simply amalgamating paramedic services, as was hinted at in the provincial budget, will do nothing to address the real problem of inadequate resources and won't take the pressure off a system that is strained to the breaking point.

Provincial cuts in other areas are also having an impact on emergency services and will continue to drive the system deeper into crisis. One of the reasons for the growth in critically low levels of ambulance coverage is the inability to offload patients at hospitals. But the delay in offloading patients is increasing because Emergency Departments are packed and Emergency Departments are packed because hospitals are packed. Failure to adequately fund one part of the health care system has a downstream effect on other parts of the health care system. And without appropriate levels of hospital funding, paramedics will keep waiting to offload patients at hospitals, keeping ambulances that could be returning to service sitting and waiting.

The Ontario government is also cutting funding for public health and important programs like children's nutrition programs, vaccination programs, and water quality testing.[27] These cuts could lead to a situation where timely health care is not being provided before an illness or injury becomes an emergency, as well as increasing the risk that pandemics are not quickly identified and contained, thereby creating more situations where emergency medical services are required.

26 Mike Crawley, "Ford government to merge ambulance services across Ontario," CBC News, April 16, 2019, https://www.cbc.ca/news/canada/toronto/doug-ford-ambulance-paramedic-merger-emergency-health-1.5099773.

27 CBC News, "Critics call it 'shortsighted' and 'wrong', but Ontario government moving forward with municipal funding cuts," August 19, 2019, https://www.cbc.ca/news/canada/toronto/ont-municipal-funding-1.5251772.

Municipalities also need to take a leadership role in approaching emergency medical services strategically, rather than leaving paramedics racing from one emergency to the next. Municipalities should be working to expand community paramedicine to defer calls and address offload delay issues. They also need to fully assess the demand for services and ensure there are adequate vehicles and teams on the road to address the volume of emergencies.

These are important and necessary steps that should be taken immediately to improve services to Ontarians and ensure that the emergency medical care they need is available when they need it. But there remain significant gaps in what we know. Many of the services replied to our Freedom of Information requests by saying that they don't collect statistics in these areas. But when information isn't being collected and tracked, then how do we know when there is a problem and how can we identify what needs to change?

Among services who track instances of critically low coverage, do we know what the outcomes are for patients? For the remaining services, if they're not tracking levels of coverage, then how can they know if they are endangering lives with a lack of emergency medical services? If we don't know how long ambulances are waiting at hospitals to offload patients, then how can we know what the appropriate solution is to address low levels of coverage? If we don't know how often ambulances are being sent to calls outside of their service region, then how do we know what the real demands for a service are and what the real availability of ambulances is?

We need mandatory collection and disclosure of data so that Ontarians can truly understand what is happening with the system and hold their governments accountable.

RECOMMENDATIONS:

1. **The provincial government should increase funding for emergency medical services**. Funding needs to keep pace with the growing demand for emergency medical services and with the reality that the highest growth is taking place in the category of the most urgent calls.

2. **The provincial government should increase funding for hospitals and public health programs**. Funding cuts to other parts of the health care system are driving the need for emergency medical services and making it more difficult for paramedics to provide timely care. The provincial government should recognize our health care system as an interconnected system and adequately invest in all parts of the system to stop creating crises across the system.

3. **Municipal governments should take a strategic approach to planning emergency medical services.** Expecting paramedics to simply run from emergency to emergency as demand grows, public health programs are cut, and hospitals are overcrowded, is simply not realistic. Municipal governments should expand prevention services such as community paramedicine programs, address offload delays at local hospitals, and provide the resources required to meet growing demand for emergency medical services.

4. **The provincial government should require municipalities to collect and provide regular disclosure of information on emergency medical services, including call volume, calls from neighbouring services, scheduled hours of operation, actual hours of operation, offload delays, and critical levels of coverage.** Having accurate data is essential to ensuring that the system is providing the best possible care to Ontarians, while protecting the health and safety of workers in the sector. It would also allow local residents to hold governments accountable for the state of emergency medical services in their region.

APPENDIX A:

PARAMEDIC SERVICES IN ONTARIO REPRESENTED BY CUPE

CUPE Local	Employer	MFIPPA Request Respondent
3631	Algoma District Paramedic Services	Algoma District Services Administration Board
4705	City of Greater Sudbury Paramedic Services	City of Greater Sudbury
1484	Cochrane District Emergency Medical Services	Cochrane District Social Services Administration Board
5734	Cornwall Stormont-Dundas-Glengarry Paramedic Services	City of Cornwall
2974	Essex-Windsor Emergency Medical Services	County of Essex
4698	County of Renfrew Paramedic Service	County of Renfrew
4435	Haliburton County Paramedic Service	Haliburton County Paramedic Service
1842	Hastings-Quinte Paramedic Service	Hastings County
4513	Huron County Paramedic Services	Huron County
5911	Kenora District Services Board, North West Emergency Medical Services	Kenora District Services Board
4480	Lanark County Paramedic Services	Almonte General Hospital
4440	Leeds Grenville Paramedic Service	United Counties of Leeds and Grenville
911	Niagara Emergency Medical Services	Regional Municipality of Niagara
503	Ottawa Paramedic Service	City of Ottawa
4514	Perth County Paramedic Services	Perth County Department of Corporate Services
4911	Peterborough County-City Paramedics	Peterborough County-City Paramedics
7911	Prescott-Russell Paramedic Service	United Counties of Prescott & Russell
4807	Rainy River District Paramedic Services	Rainy River District Social Services Administration Board
1764	Region of Durham Paramedic Services	Regional Municipality of Durham
5191	Region of Waterloo Paramedic Services	Regional Municipality of Waterloo
416	Toronto Paramedic Services	City of Toronto
905	York Region Paramedic Services	Regional Municipality of York

APPENDIX B:

FREEDOM OF INFORMATION QUESTIONS

A request for data in the following areas was submitted using the *Municipal Freedom of Information Act* to all EMS services represented by CUPE in Ontario. All data was requested for the years 2016-2018.
1.a. Total call volume
1.b. Call volume disaggregated by severity (for example CTAS 1, CTAS 2, CTAS 3, and CTAS 4).
2.a. Total number of vehicles available.
2.b. Hours of use for available vehicles.
3. The maintenance schedule for vehicles.
4. Data on standby or offload delay to hospital.
5. Data on how often ambulances are not available for calls or the service is at a critical level.
6. Data on missed meal breaks, by number of incidents and by dollar amount the service has paid out for missed meals.
7. The annual costs of overtime.
8. The number of annual WSIB claims and related costs to the service.
9. Data on calls dispatched to neighbouring paramedic services.
10. Data on number of patients served by community paramedicine programs, the number of staff assigned, hours worked, and any available patient demographic and health data.
In addition the following data regarding Central Ambulance Communications Centres was requested from the Ministry of Health and Long-Term Care. The data was requested for the years 2016-2018.
1.a. Total call volume
1.b. Call volume disaggregated by severity (for example CTAS 1, CTAS 2, CTAS 3, and CTAS 4).
2. Data on standby or offload delay to hospital.
3. Data on how often ambulances are not available for calls or the service is at a critical level.
4. Data on calls dispatched to neighbouring paramedic services.
5. Data on number of patients served by community paramedicine programs, the number of staff assigned, hours worked, and any available patient demographic and health data.
6. Emergency Room National Ambulatory Reporting System Initiative (ERNI) data on emergency room wait times.

APPENDIX C:

DATA RECEIVED IN RESPONSE TO FREEDOM OF INFORMATION REQUESTS

Paramedic Service	Q1a	Q1b	Q2a	Q2b	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Algoma	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cochrane	Yes	Yes	Yes	No	Yes	No	No	No	Yes	No	No	No
Cornwall Stormont-Dundas-Glengarry	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Durham	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	n/a
Essex-Windsor	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Haliburton	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Hastings-Quinte	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Huron	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No
Kenora	No	No	No	No	No	No	No	No	No	No	No	No
Lanark	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Leeds Grenville	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Niagara	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No	Yes
Ottawa	Yes	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Perth	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	n/a
Peterborough	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a
Prescott-Russell	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Rainy River	No	Yes	Yes	No	Yes	No	No	No	Yes	Yes	No	Yes
Renfrew	Yes	No	Yes	No	Yes	No	No	Yes	Yes	Yes	No	Yes
Sudbury	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Toronto	Yes	No	Yes	No	No	No	No	Yes	Yes	Yes	No	No
Waterloo	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
York Region	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes

*Note: Services may have provided a response that was not usable for this project because it was not comparable to other services or because it did not cover the full time period requested. For more information on which data was analyzed on each topic, see Footnotes.

	Q1a	Q1b	Q2	Q3	Q4	Q5	Q6
Ministry of Health and Long-Term Care	Yes	Yes	Yes	No	Yes	No	No


CUPE
DISPATCHERS
ONTARIO