The Hospital Crisis:

No Capacity, No Plan, No End

Stratford

OCHU

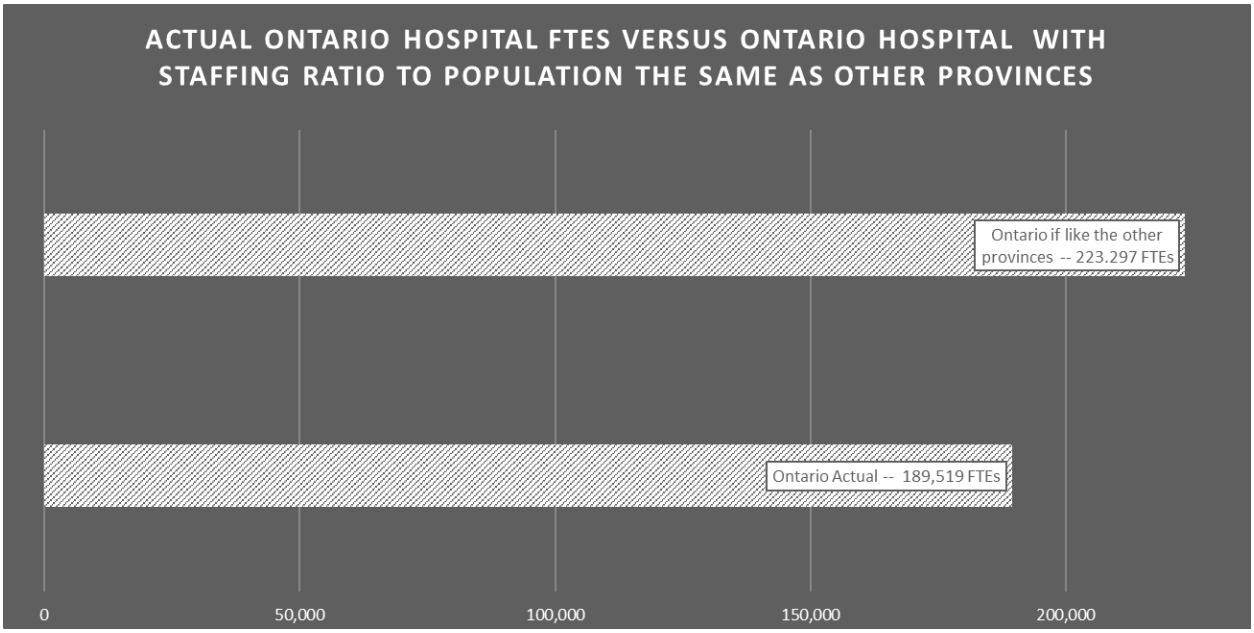
ONTARIO COUNCIL OF HOSPITAL UNIONS

CUPE

Community groups and hospital workers have campaigned for more capacity and improved staffing in the Ontario hospital system for decades. Gradually, this issue became more widely recognised as a major problem. The current government ran in 2018 on a promise of ending hospital hallway healthcare. When COVID hit, the focus became preserving limited hospital capacity. Now we have a near constant stream of Emergency Room closures in rural areas, long waits in backed up urban Emergency Rooms, a record level of hospital hallway healthcare, and many other problems. This report reviews the features of the capacity and staffing problem, shows current government plans will cut capacity, privatize services and make the problem worse. We will also propose how we can end the capacity crisis and build a better public health care system that meets the needs of all.

1] The nature of the crisis

A] Inadequate Staffing. Hospitals in provinces other than Ontario have 18 percent more staff per capita than hospitals in Ontario. Much, but not all of this is due to low levels of inpatient staffing in Ontario. Overall, if Ontario had the same staffing capacity as the other provinces and territories, we would have another 33,778 full time staff working in Ontario hospitals.[1]

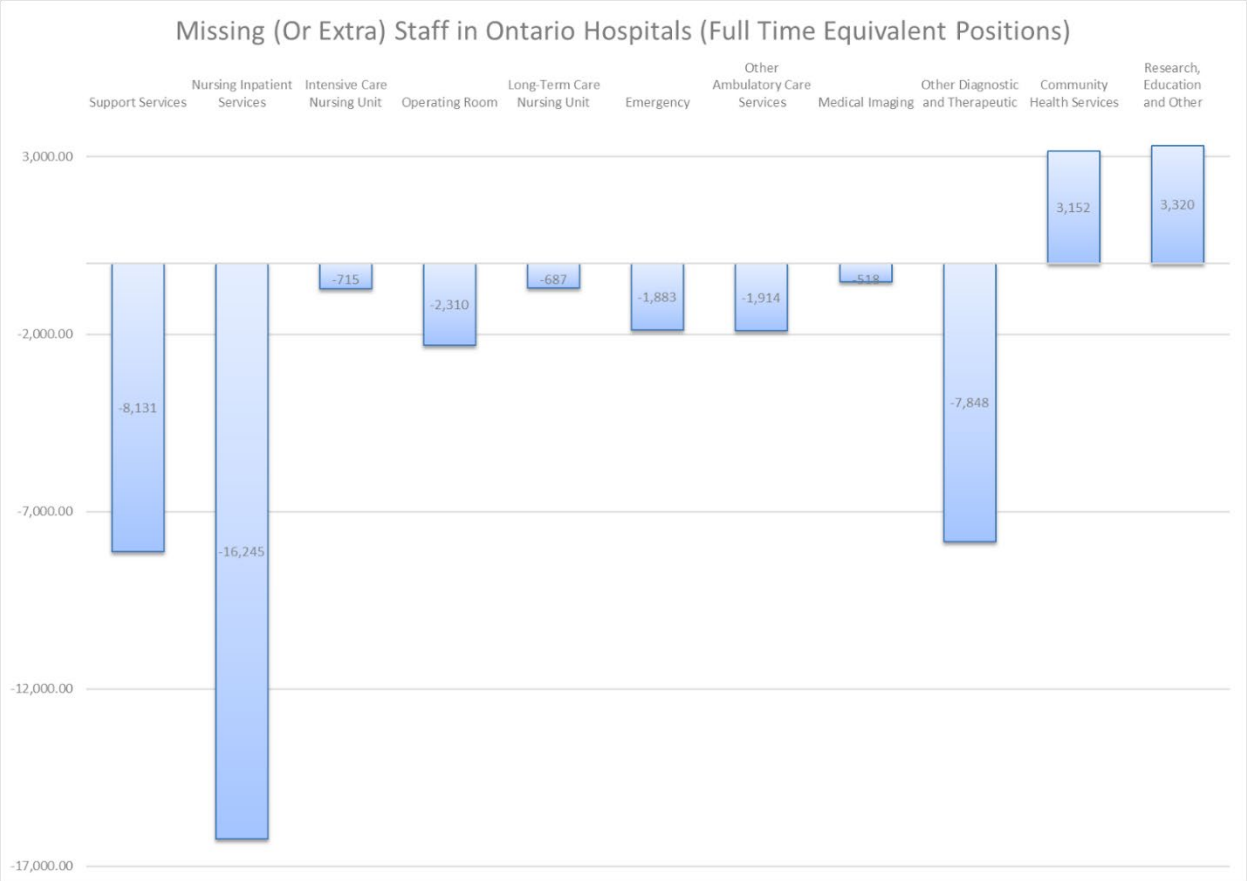


Date sources: Statistics Canada on population and CIHI, "Trends in Hospital Spending, 2009–2010 to 2020–2021 — Data Tables — Series E: Hospital Calculated Full-Time Equivalents by Service Area"

[1] Sources: Statistics Canada on population and on hospital full time equivalent staff, CIHI, "Trends in Hospital Spending, 2009–2010 to 2020–2021 — Data Tables — Series E: Hospital Calculated Full-Time Equivalents by Service Area"

Ontario hospitals have far fewer staff than other parts of Canada despite having an outsized role in two areas that go beyond traditional hospital services. Ontario hospitals employ 6,500 extra employees in research and education (as one might expect in the largest province) and (less expectedly) in community health services. In the more traditional areas of hospital work – inpatient care, emergency care, diagnostic services, medical imaging, ambulatory care, support services, operating rooms, and intensive care – Ontario is understaffed.

If Ontario had the same ratio of support and administrative staff in hospitals to population as in the other provinces, there would be another 8,130 staff. That staff would support the cleaning, food, maintenance, administration, IT, and supplies, needed for more inpatient and outpatient capacity.[2]



Sources: Statistics Canada population and CIHI, "Trends in Hospital Spending, 2009–2010 to 2020–2021 — Data Tables — Series E: Hospital Calculated Full-Time Equivalents by Service Area"

There are deficits in other parts of Ontario hospitals: 715 missing FTEs in Intensive Care Units, 2,310 missing full-time staff in Operating Rooms, 687 in Chronic Care, 1,883 in

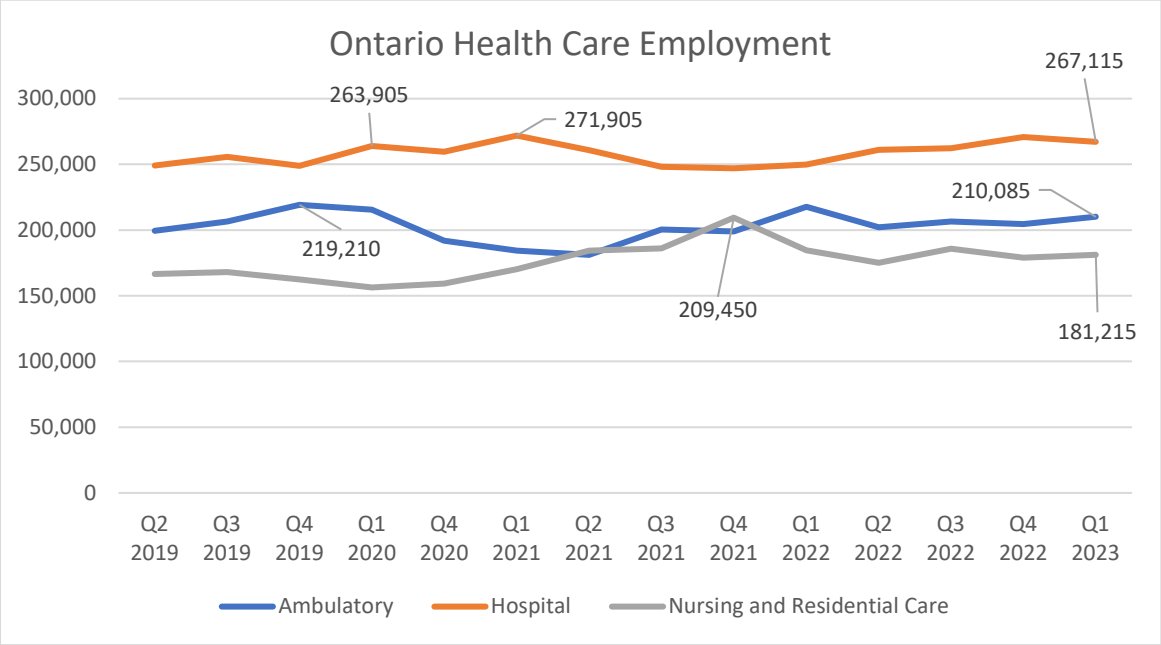
[2] Ibid.

Emergency Departments, 1,914 in ambulatory services, 518 in medical imaging, and 7,848 in other diagnostic and therapeutic services.

The largest part of the staff deficit for Ontario however is in **nursing and inpatient services** – Ontario has 0.285 FTE workers per 100 population in inpatient services versus 0.395 in other provinces across Canada – fully 38.7 percent more. If Ontario had the same ratio of inpatient health care workers, there would be another 16,201 full-time inpatient jobs in our hospitals. That would allow a lot more hospital beds and inpatients and would help solve the capacity crisis we are currently experiencing.

B] Staffing levels are getting worse: Statistics Canada data on health care employment[3] suggests that there has not been a real staffing improvement over this government's tenure, despite the COVID crisis.

Currently, all three (3) health care subsectors are down from previous highs in employment.



Source: Statistics Canada, "Job vacancies, payroll employees, job vacancy rate, and average offered hourly wage by industry sector, quarterly, unadjusted for seasonality," Table: 14-10-0326-01 (formerly CANSIM 285- 0002)

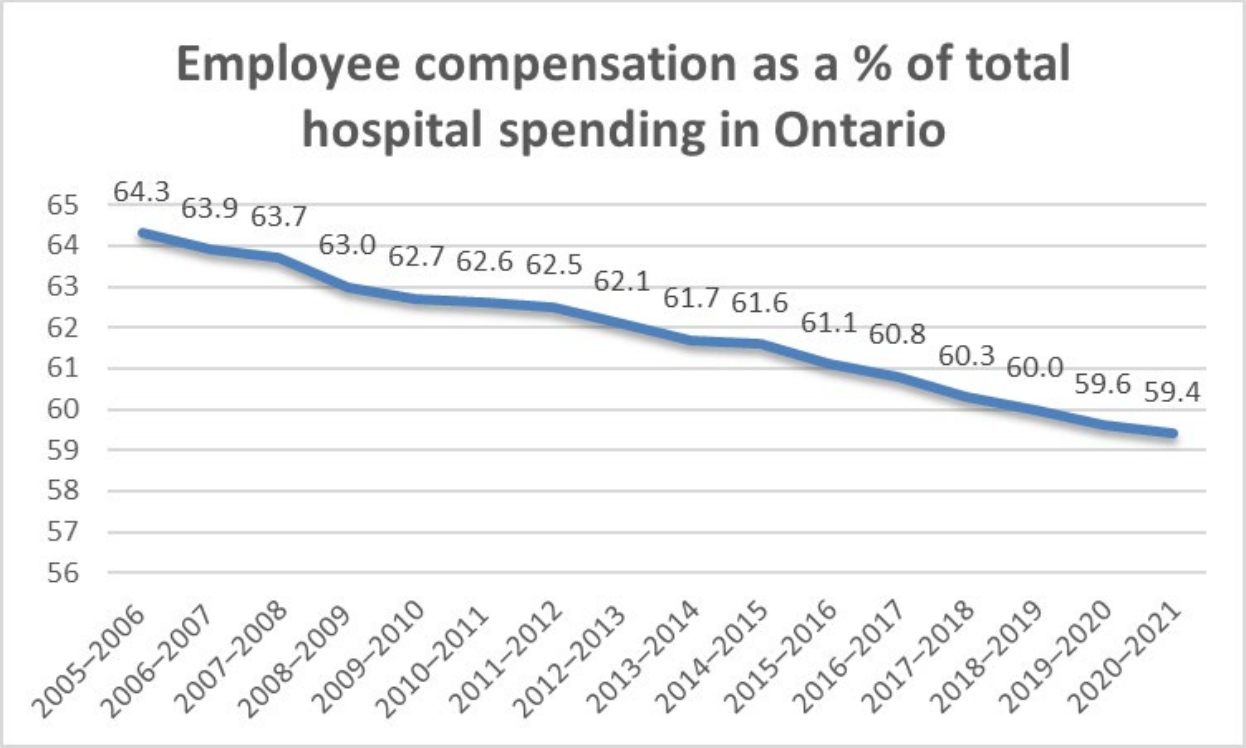
In hospitals, employment has increased by 3,210 since the onset of COVID three years ago in the first quarter of 2020. **That is an increase of 1.2%, or 0.4% per year. This is a shockingly small increase** considering the burden COVID and long-COVID have placed on

[3] Note: this report on "employment" is a slightly different report than the report by CIHI on full time equivalent staff.

health care. COVID aside, the need for hospital care due to population growth and aging has expanded at a much faster rate, as we shall see.

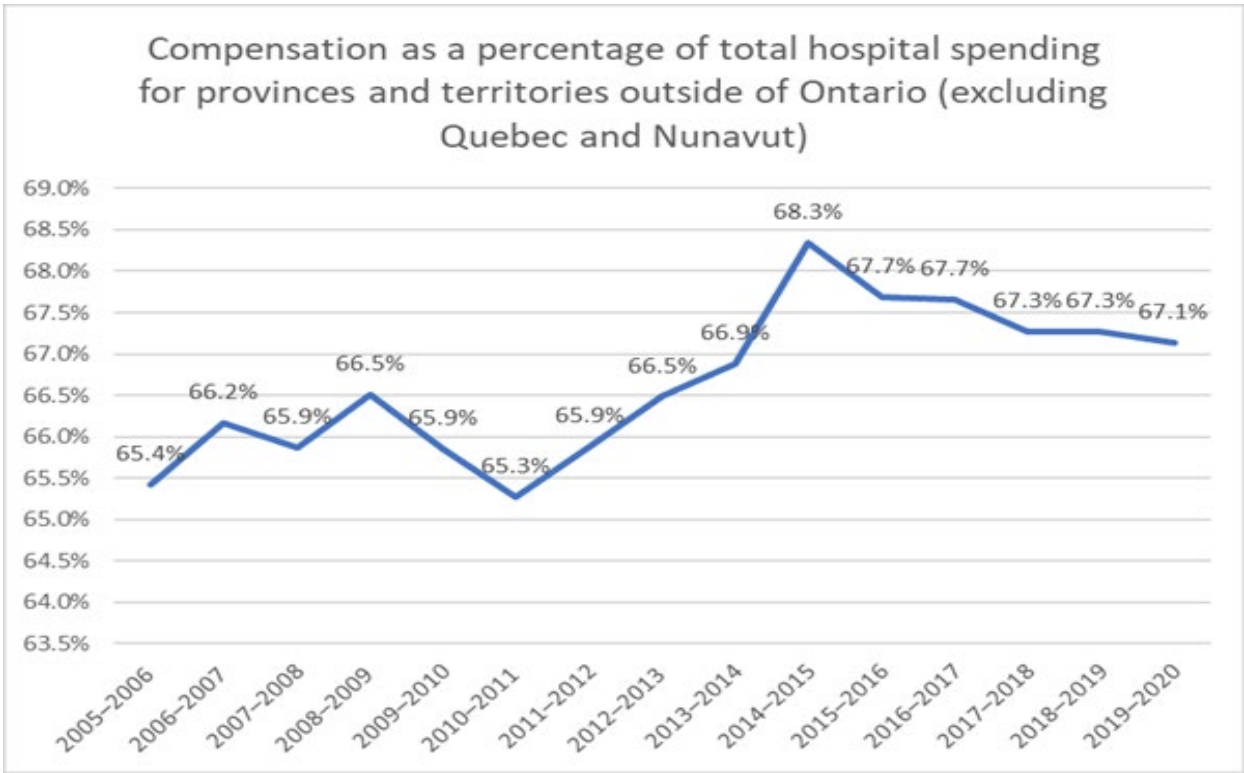
It is also noteworthy that there has been a decline in employment in the health sub-sector "nursing and residential care." This is troubling as after the COVID disaster that occurred in long-term care, the provincial government promised to increase the number of care hours per resident by 50% by 2024/5. It also promised to add thousands of new LTC beds. Yet there has been a decline in staffing in this sector. Health care staffing is in crisis.

C] The long-term decline in spending on hospital staff. Spending by hospitals on employee compensation has declined as a percentage of total spending, falling from 64 percent in 2005-06 to 59 percent in 2020-21 in Ontario.



Source: CIHI, Hospital Spending, September 15, Data Table

In other provinces, compensation has not shrunk as a proportion of hospital spending. Instead, it has increased from 65.4% to 67.1%.



Source: CIHI, Hospital Spending, September 15, Data Table

D] The shortage of hospital workers: Hospital job vacancies have grown dramatically.

Hospital data indicates a sharp increase in hospital service[4] job vacancies for the year ended September 20, 2022, with over **5,161 service job vacancies** at reporting hospitals, bringing the vacancy rate for service classifications up to 10.02 percent. In March of 2018, just before the current government was elected, the service job vacancy rate was 3.93% (see chart below). Since the current government was elected the percentage of service job vacancies has more than doubled.

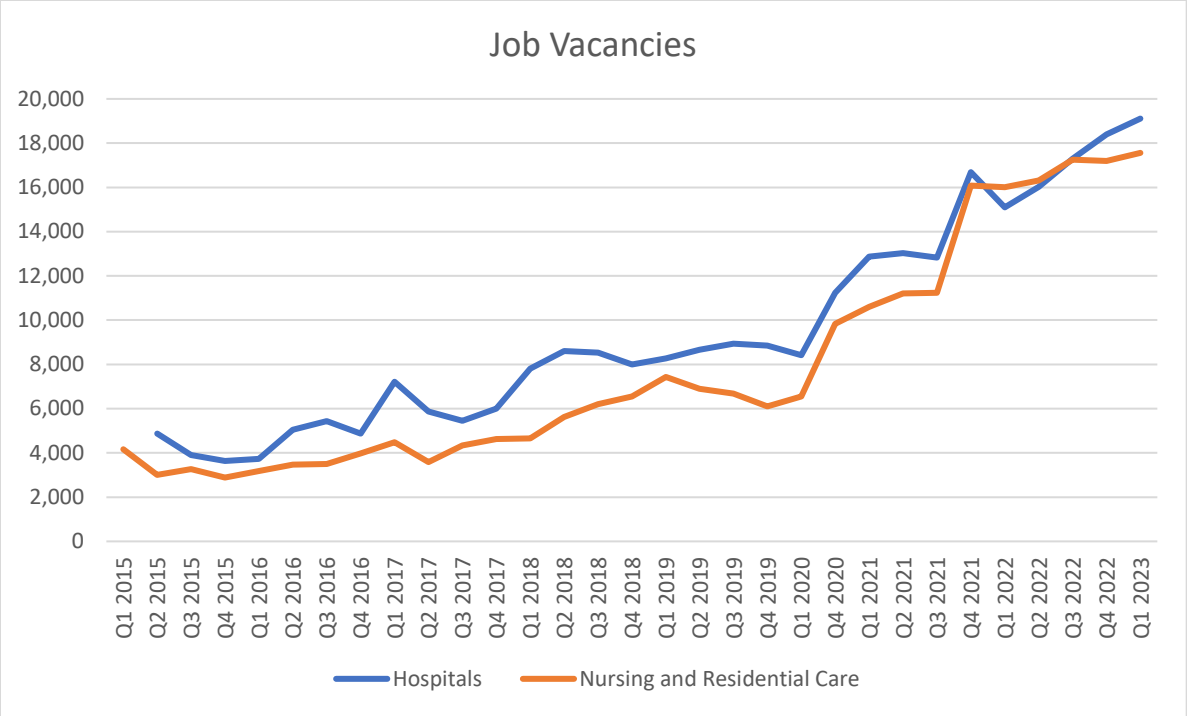
[4] Service employees include PSWs, porters, housekeepers, dietary workers, RPNs, stores and warehouse workers, trades workers, ward clerks, administrative workers, etc.

Vacancy Rate (FT & PT Permanent Positions)	on Mar 31, 2017*	on Mar 31, 2018*	on Mar 31, 2019*	on Mar 31, 2020*	on Mar 31, 2021*	on Oct 20, 2021**	on Mar 1, 2022**
All Hospital	5.57%	3.93%	3.70%	4.24%	5.57%	8.09%	8.84%
RN & RN-Specialty (Total)	6.89%	4.90%	4.81%	4.85%	7.50%	11.73%	12.63%
Service (Total)	6.25%	3.93%	3.81%	4.56%	6.00%	7.94%	8.35%
Registered Practical Nurse	6.75%	4.71%	4.40%	5.13%	6.89%	9.76%	10.24%
Personal Support Worker	5.53%	4.90%	4.95%	6.05%	4.67%	9.31%	9.36%
Paramedical (Total)	3.69%	2.74%	2.78%	3.33%	4.11%	5.01%	6.14%

*Annual OHA HR Benchmarking Survey
**HHR Workforce Survey conducted in October 2021 and March 2022.

All permanent Registered Practical Nurse (RPN) positions had a vacancy rate of 11.89 percent for October 1, 2022. This is up from 4.71 percent just before the current government was elected. Fully 2,355 hospital RPN positions were vacant on October 1, 2022.

Statistics Canada data also indicates job vacancies in the hospital sector continue to increase. There are over **three times** the number of hospital job vacancies in the first quarter of 2023 than in 2015.



Source: Statistics Canada. Table 14-10-0326-01 Job vacancies, payroll employees, job vacancy rate, and average offered hourly wage by industry sector, quarterly, unadjusted for seasonality

Over the last year, hospital job vacancies increased by 4,015, an increase of **19.3%.** This has occurred even as job vacancies in the overall Ontario economy fell by 57,035 vacancies – or by 18%.

D] Low Bed Capacity. Consistent with the low level of hospital staffing, bed capacity in Ontario is also very low. According to the most recent CIHI data[5], Canada as a whole (including Ontario) has 7.7% more hospital beds per capita than Ontario. Ontario also has a much lower number of beds than almost any other developed nation. The result is very high hospital bed occupancy, cancelled surgeries, and inpatients being treated via hallway healthcare.

[5] Canadian Institute for Health information, Trends in Hospital Spending, 2009–2010 to 2020–2021 — Data Tables — Series D: Beds Staffed and In Operation by Functional Centre.

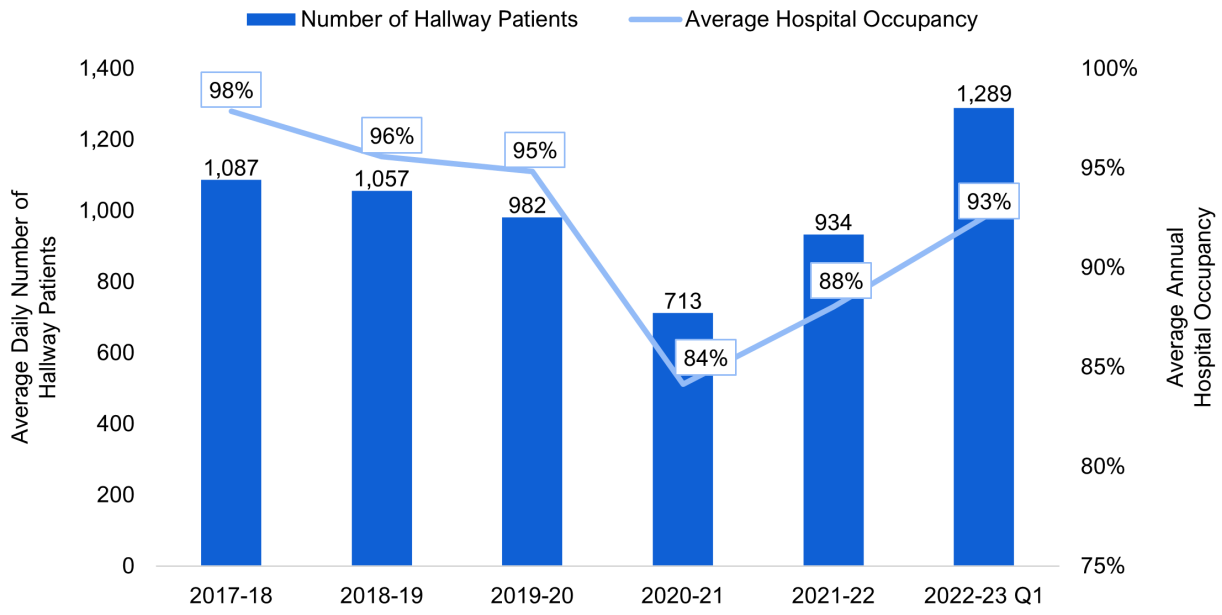
2] Consequences of the Staffing and Capacity Crisis

Ontario is experiencing an unprecedented hospital staffing crisis that has seriously compromised hospital care. Attracting and retaining hospital staff has become much more important for the health of our hospitals.

What has limited staff meant for Ontario hospitals? According to the Financial Accountability Office (FAO), Emergency Rooms (ERs) were closed at least 145 times in 2022. The FAO had found only one other unplanned ER closed since 2006. These closures continue in 2023, with local media reporting ER closures in Carleton Place, Hawkesbury, Walkerton, Arnprior, Listowel, St. Mary's, Clinton, Durham, Almonte, Seaforth, Mount Forest, and Chesley (which is also experiencing an ongoing daily closure from 5 pm to 7 am). Wingham Hospital has closed its ER four times (at least) so far in 2023.

The Minden Hospital ER closed permanently on June 1, 2023, with the Hospital CEO citing staffing issues. Residents will have to drive twenty-five (25) kilometers to Haliburton. In vain, the Minden Mayor pleaded for a delay to allow the community to save the ER. Tens of thousands signed a petition opposing the closure. Prior to the announcement of the permanent closure, the hospital CEO said that between 40 and 50 per cent of the total nursing hours at Minden and Haliburton were covered by private agency staff.

In 2018, the Progressive Conservatives ran on a promise of ending hospital hallway healthcare. In fact, the problem has gotten worse. The number of inpatients being cared for in hallways has hit 1,289 per day an all-time high, **22% higher than when the government was elected** in June 2018. After the hospital crisis and the cancellation of tens of thousands of surgeries with COVID, hospital bed occupancy has already returned to 93 percent, a dangerously high level, even as the number of surgeries has not returned to pre-COVID levels. Demand for staffed beds will increase further when hospitals are able to bring surgeries back to the number of surgeries performed in 2019.



Source: FAO

In the early months of 2022, hospitals, including children's hospitals, had to pause elective surgeries as demand for hospital services outstripped staffing capacity. In 2022, Ontario hospitals performed 93,812 fewer surgeries than in 2019, according to the FAO. That is a 14 percent reduction.

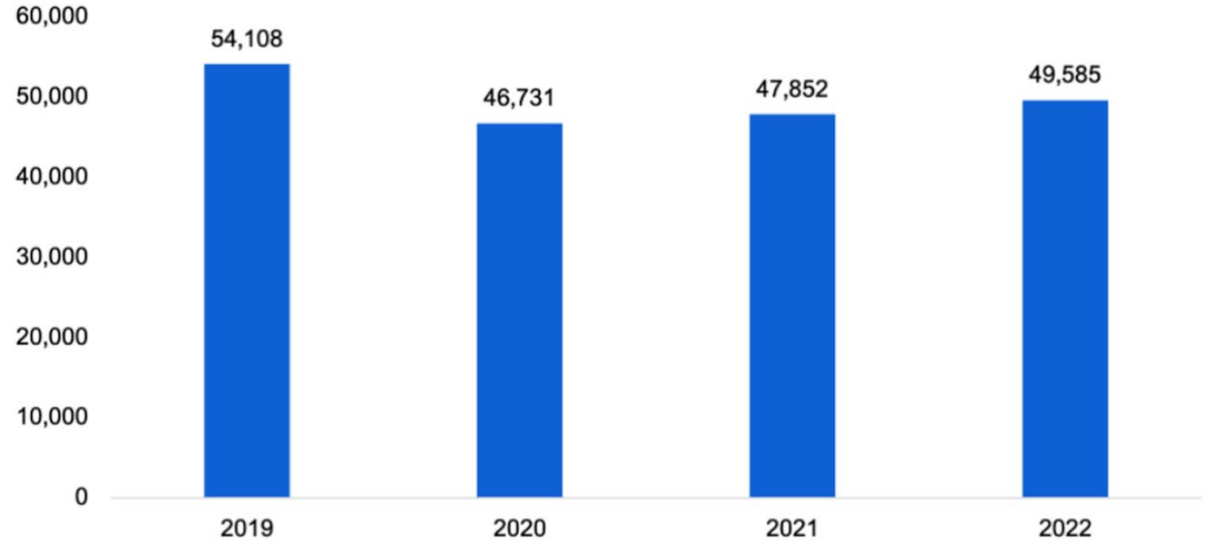
Reduction in surgeries performed compared to 2019

	2019	2020	2021	2022	2020 to 2022 Average
Surgeries Performed	649,299	461,785	532,241	555,487	516,504
Change from 2019 (Number of Surgeries)		-187,514	-117,058	-93,812	-132,795
Change from 2019 (%)		*-29%*	*-18%*	*-14%*	*-20%*

Source: FAO based on data provided by Ontario Health.

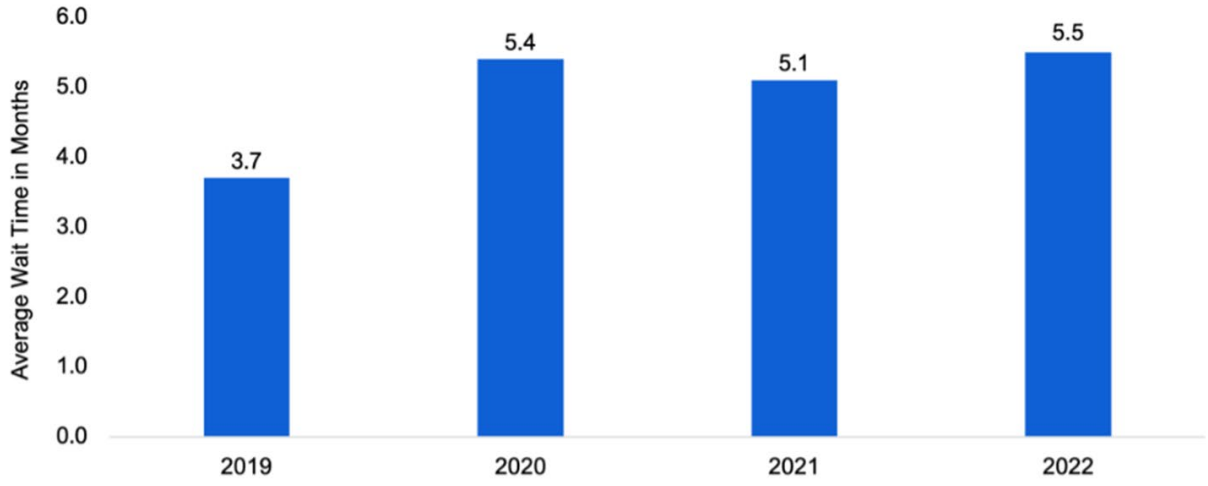
But even for the months later in the year when the pause on elective surgeries ceased, the FAO reports that hospitals performed **4,523 fewer surgeries per month than in 2019**. Annualized that would be a cut of 54,276 surgeries, **8.4 percent fewer** than in 2019. Surgical wait times in 2022 were 49 percent longer than 2019.

Average monthly surgeries performed, excluding months with elective surgery pauses, 2019 to 2022



Note: 2020 monthly average excludes the pre-pandemic period. 2022 monthly average excludes incomplete data from October onwards.
Source: FAO based on data provided by Ontario Health

FAO estimated average surgical wait time in months by year



Note: Wait times are estimated based on the waitlist and surgeries performed. For example, in 2019 there was an average of 200,000 patients on the waitlist and 649,000 surgeries were performed, implying that patients waited an average of 3.7 months. For the methodological rationale, see Karl Sigman, Notes on Little's Law.
Source: FAO based on data provided by Ontario Health.

The FAO reports that 107,000 patients are waiting longer than the maximum clinical guidelines for their surgeries, an all-time high. The (unacceptably high) pre-pandemic level was 38,000. The FAO notes a reduction in the "long-waiters" list will not occur without additional measures:

> With respect to patients on the surgery waitlist who are classified as long-waiters, the Province has yet to record any sustained reduction in the number of these patients waiting for surgery. As of September 2022, the surgery waitlist had 107,000 long-waiters, which was the highest number recorded since the start of the pandemic. Consequently, without additional measures, the Province will not achieve its goal of reducing the number of patients on the surgery waitlist classified as long-waiters to the pre-pandemic level of 38,000.

3] The Government's plan is inadequate

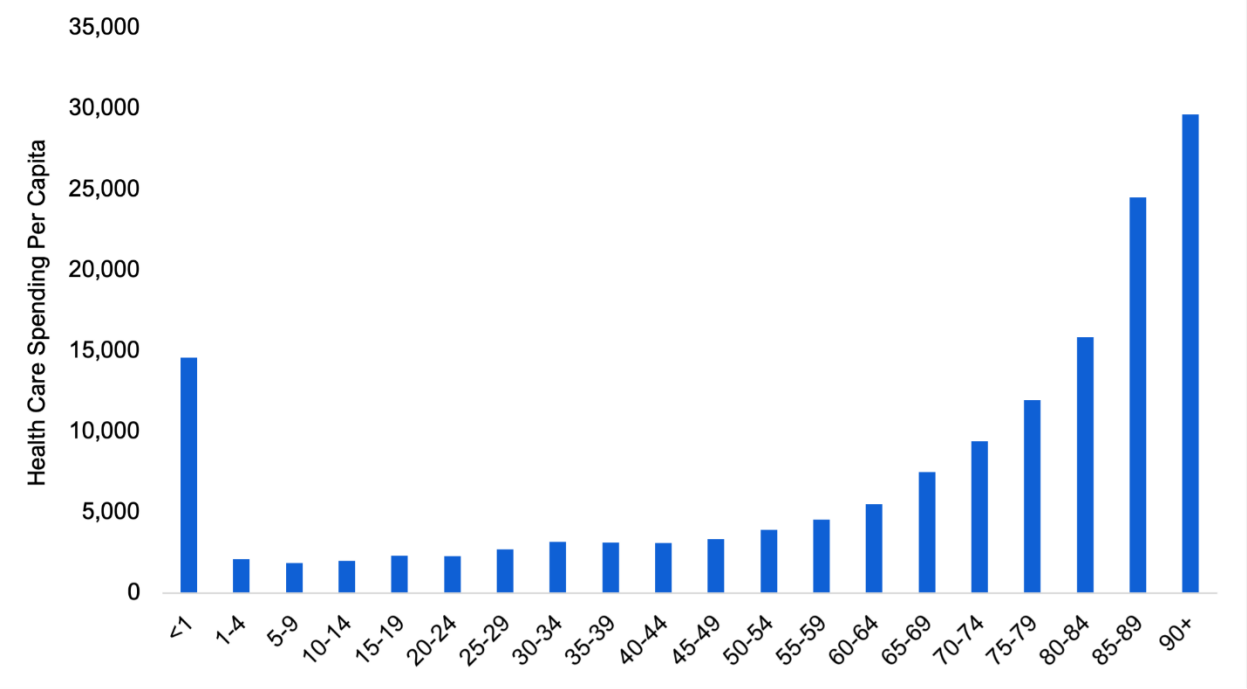
The government plans 3,000 new hospital beds over the next decade.[6] That's about an 8.4% increase in nominal capacity, or 0.79% per year. This is roughly comparable to the very modest increase in staffing since COVID. It falls far short of need and will continue to deepen the crisis unless improved.

Measured against need, **this will mean a sharp decrease in service levels**. The public wants improved service levels, but the opposite is planned.

That nominal increase won't come even close to covering off increasing demand for services due to population growth, which according to provincial government projections, will be about 15%. The demands on health care will be much more than this, however, due to a rapidly aging population.

Health care needs are very sensitive to age.

[6] Financial Accountability Office, Ontario Health Sector: 2023 Budget Spending Plan Review, 31 May 2023. https://www.fao-on.org/en/Blog/Publications/health-update-2023



Source: FAO

People 65 years of age or older use most of our hospital bed days -- 59.5% hospital bed days in 2021/22.[7]

The population of the 65+ age group is currently growing according to Ontario Ministry of Finance data by more than 3% a year, twice the rate of the overall population. We will have about a third more people aged 65+ in a decade. The oldest parts of the 65+ age group (the 75+ age group and especially the 90+ age group) are projected to grow the fastest. The total 65+ age group is projected to grow by 63 percent by 2046 (from 2.7 million to 4.4 million), but the oldest sections of that group will grow *much* more rapidly:

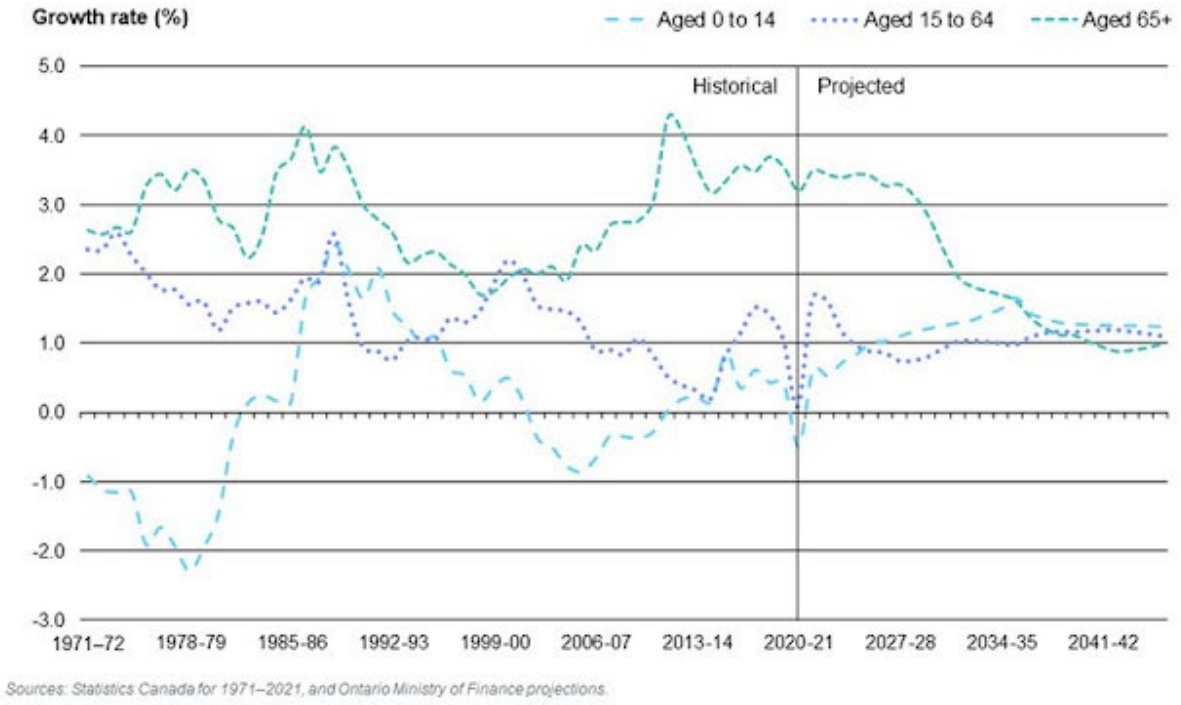
> The older age groups will experience the fastest growth among seniors. The number of people aged 75 and over is projected to rise from 1.2 million in 2021 to almost 2.7

[7] Data source: Canadian Institute for Health Information, "Hospital Stays in Canada" (February 23, 2023) . With fewer numbers, this age group accounted for 50.8 percent of hospital bed days in 1995/96 in Ontario. The number of hospital bed days for the 65+ age group increased from 3,828,378 in 1995/6 to 4,640,810 in 2021/2.

million by 2046. The 90+ group will more than triple in size, from 137,000 to 430,000. [8]

This compounds the need for more hospital capacity due to aging. As indicted in the graph above, older elders require, on average, much more health care.

Chart 6: Pace of growth of population age groups 0–14, 15–64 and 65+ in Ontario, 1971 to 2046



Sources: Statistics Canada for 1971–2021, and Ontario Ministry of Finance projections.

The plans for the years immediately ahead are even worse. The FAO estimates that only 1,000 new beds will be added in the next four years, less than a 3% increase. That four-year increase is enough for about two years of population growth, with nothing to offset aging, much less improve service levels to deal with the capacity crisis.

The rapid growth in the number of elders is driving up the need for hospital beds (and the hospital workers to staff them) by more than triple the planned increase in staffed beds.

[8] See the Ministry of Finance Ontario Population Projections (2022)

Aging is a long-term trend and should have been planned for decades ago. Capacity was not adjusted with the number of beds remaining in the same range for many years despite significant population growth and aging. This resulted in the hospital capacity crisis. After several years of intense crisis, however, this problem should, at the very least, be responded to now.

The plan, however, is to double down on long-term cuts in hospital service levels. Amid a hospital capacity crisis, the plan is to reduce hospital capacity relative to need.

Is there relief coming from home care and long-term care? Both of these sectors are dominated by for-profit providers, and the Ford government has made no bones about providing significant funding increases for these providers. While public hospitals and other primarily not-for-profit providers received less than a 1% funding increase in the 2023/24 Budget Estimates, home care and long-term care were budgeted to get 9.3% and 16.2% increases respectively this year.[9] But government plans for these sectors will not resolve the hospital capacity crisis. Indeed, overall, they will make it worse.

Home care: The government trumpets new money for home care - -but (with aging and population growth) the FAO projects a decline in the number of nursing and personal support hours per Ontarian aged 65 and over, from 20.6 hours in 2019-20 to 19.4 hours in 2025-26. That is down 5.8% -- almost 1% per year. Unless this improves there will be no relief of the pressure on health care through home care - - in fact just the opposite.

Long-Term Care: The FAO now sees a *slight* improvement in the ratio of long-term care bed to elders 75 years of age and over -- from 71.3 beds per 1,000 in 2019-20 to 72.1 in 2027-28. The increase amounts to a 1.1% increase over 8 years. That's an increase of 0.1% per year.

[9] Data Source: Budget Estimates 2023/24 MOH and MLTC.

This tiny increase is the plan when almost 40,000 elders are on the LTC wait list and the government has just passed legislation to require hospital patients to move into long-term care more quickly.

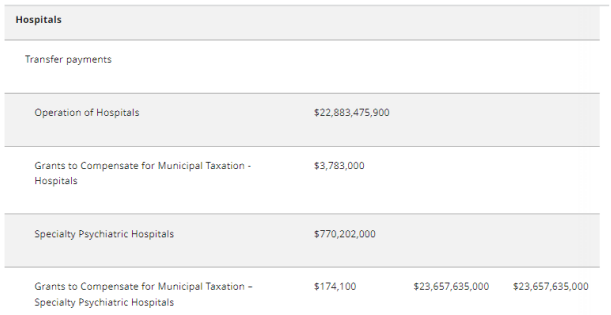
Even with this very modest increase, we are still far short of the 90 beds per 1000 elders 75+ in 2010/11 -- 20% less.

As with home care, there is no relief coming for the capacity crisis from the current plan for LTC development.

4] The Fake Solution: For-Profit Care

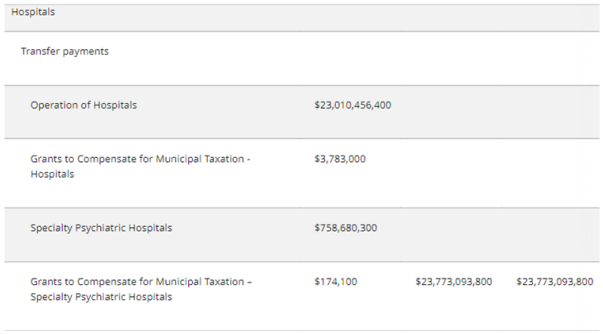
The increase for public hospitals in the 2023/24 Budget Estimates is 0.5% compared to last year's Budget Estimates.

1] 2022/23



Hospitals			
Transfer payments			
Operation of Hospitals	$22,883,475,900		
Grants to Compensate for Municipal Taxation - Hospitals	$3,783,000		
Specialty Psychiatric Hospitals	$770,202,000		
Grants to Compensate for Municipal Taxation – Specialty Psychiatric Hospitals	$174,100	$23,657,635,000	$23,657,635,000

2] 2023/24



Hospitals			
Transfer payments			
Operation of Hospitals	$23,010,456,400		
Grants to Compensate for Municipal Taxation - Hospitals	$3,783,000		
Specialty Psychiatric Hospitals	$758,680,300		
Grants to Compensate for Municipal Taxation – Specialty Psychiatric Hospitals	$174,100	$23,773,093,800	$23,773,093,800

In contrast, so called "Independent Health Facilities" (i.e., private, for-profit surgical and diagnostic facilities) are budgeted to get a **212%** increase from last year's Budget Estimates. It is a boom for private profits, even as the government implements harsh austerity for public hospitals.

While the government touts this privatization as a cure, this will, in fact, add little capacity. The increase budgeted (from $38.7 million to $120.7 million) sounds significant, but the private facilities are too small to significantly add capacity in the short or medium term.

Even a huge percentage funding increase for private facilities will not make a significant difference in the face of a $75 billion health budget. The private facilities, even after being budgeted to receive a historic funding windfall, are tiny players in the health care system (receiving less than 2-tenths of 1% of public health care funding). They cannot make a significant difference any time soon. Yet this is where the government has chosen to focus its energies in the midst of a severe capacity crisis. This initiative is sold by government as a way to solve the capacity crisis but it is, at best, an attempt at a diversion from the need to develop more capacity.[10] True solutions lie elsewhere.

5] A real solution

We need to grow the facilities that can add the capacity needed, we need to grow public hospital capacity.

A] To maintain services over the next four years

1. Deal with the growing elder population.
   36,500 existing beds x 59% (for the elder population) = 21,535 beds for the 65 and older. 3% growth = 646 beds added in the first year (with proportionate increases thereafter).

2. Deal with the growth in the under 65 population
   36,500 x 41% (for the population 64 and under) = 14,965 beds for 64 and under. 1% population growth = 150 beds in first year

[10] Other than their inability to solve the capacity crisis, there are many other problems with for-profit care: extra-billing for patients, higher costs to the public purse, diversion of public money to private profits, quality of oversight, etc. Unions and community groups will be campaigning and exploring these other issues in other reports and venues.

3. Total: 646+150 = 796 beds in the first year, a 2.18% increase. The compounded total increase needed over 4 years: 3,288 beds or 9% growth.[11]

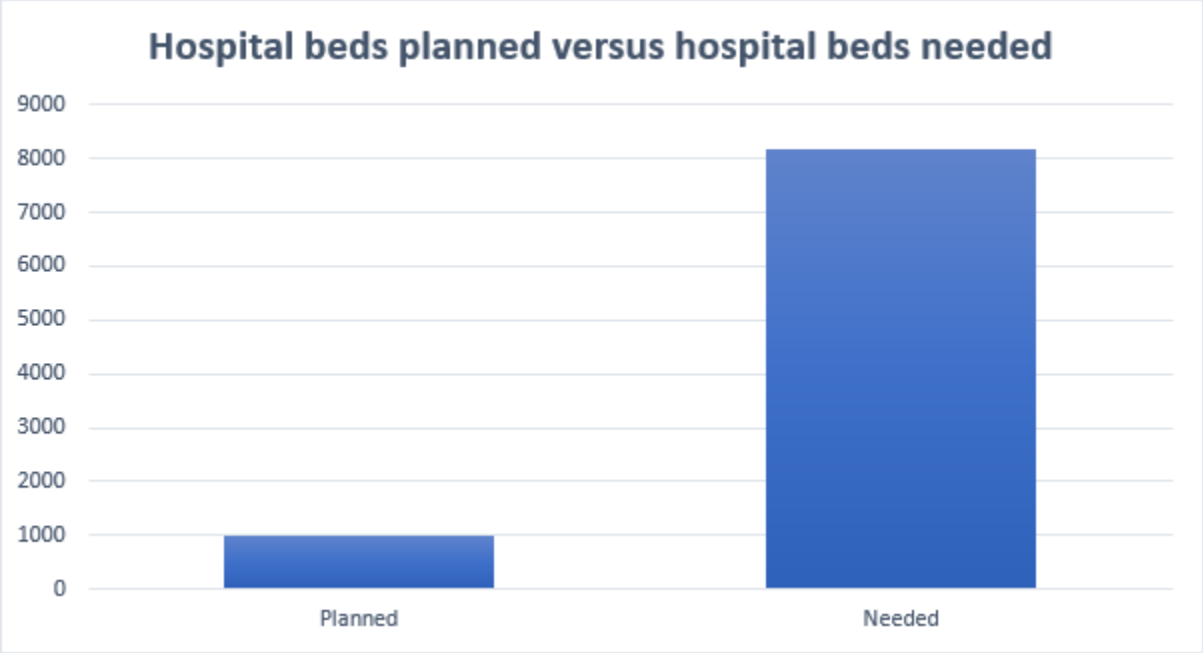
Just to **maintain** existing service levels we have to plan for over **3 times** the 1,000-bed increase planned by the Ford government.

B] To alleviate the existing capacity crisis

Given the states of preparedness by the current government, we recognise this cannot all be done at once, so we assume just under a 3% improvement in capacity per year. With the allocation to offset the growing and aging population, we need a total 5.18% increase per year, and a compounded increase of 22.39% over four years.

This means we need to add 1,891 beds in the year and 8,170 added beds over four years, far more than planned.

[11] For comparison, the FAO estimates that need for hospital services will increase by 21% over the eight years from 2019/20 through 2027/28.



C] Extra Staff needed

To be of any meaning, the new beds have to be staffed. We assume a proportionate increase in hospital staff as in bed capacity.

A 5.18% annual increase in staff means 13,986 extra staff added in the first year. (Assuming we start with 270,000 hospital staff). This would mean 60,000 extra hospital staff over 4 years (a 22.39% increase). This is *not* the number of staff that needed to be *recruited*, this is the number of extra staff needed to be *added* to the existing complement.

What this means for the Stratford and area hospitals in St. Marys, Seaforth, and Clinton:

For Stratford and area hospitals this means we must grow hospital capacity by 42 extra beds and 246 extra staff over the next four years.

Staffing solutions

As illustrated in this report, capacity is constrained by a lack of staff. In many ways the government has exacerbated this problem -- most notably by its pursuit of wage and

compensation reductions and its refusal to deal with the widespread violence against hospital staff. OCHU/CUPE has proposed the following solutions to the government:

- Reach out to the thousands of nurses, PSW, paramedical, service and other staff who are no longer working and recruit them back to work. Over 15,000 nurses are licensed and not practicing. Many thousands of PSW and support staff have left the sector. It's time for an aggressive plan to entice these workers back into the hospital workforce.
- Enable all staff work to their full scope of practice. Despite significant advances in training and licensed competency for many health care professionals, they cannot contribute to their full scope of practice at the hospital. This waste of human talent could ameliorate current pressures.
- Ban the use of nursing agency staff. These agencies charge 2x and 3x what hospitals pay their own staff, and they bleed away resources from round the clock and weekend staffing, worsening morale and weakening the continuity of care.
- Real wages must increase. In any other labour market with skill shortages, wages would increase to retain and recruit. But real wages are being cut for Ontario's health care workers and this policy is leading to an exodus of staff and to demoralization.
- Drop the appeal of Bill 124 and work with unions and employers to bring about improvements acceptable to all parties. A "successful" appeal would cut hospital wages and compensation even more dramatically and threatens to seriously destabilise the hospital workforce, possibly even clawing back hard-won wage increases. We cannot understand how the current government can pursue this policy in good conscience.
- Put in place financial incentives. Develop meaningful financial incentives in consultation with health care workers and employers to bolster short-term hiring efforts for all health care workers.

- Work with unions and employers to increase the amount of full-time work. Over half of the CUPE health care membership work part-time or casual. Turning these workers in to full time employees will significantly increase health care capacity and create a more tempting work environment.
- Work with unions and employers to reduce workplace violence in healthcare. Our research indicates that workplace violence in health care is widespread and is a significant factor discouraging healthcare retention.

To date we have yet to receive a reply and the staffing shortage continues. Urgent action, however, is required.

Government must act urgently. We have described the beds and staff needed in the hospital sector to del with low capacity, population growth and aging - - but the same dynamic is at play in long-term care and home care. Government must not tinker, it must act quickly and strongly to end the health care capacity crisis.

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