

Pushed Out of Hospital, Abandoned at Home

After Twenty Years of Budget Cuts, Ontario's Health System is Failing Patients

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Executive Summary

For nearly two decades Ontario's provincial government has purposely downsized hospitals, cutting 19,000 beds and reducing access to in-hospital restorative care and rehabilitation therapies, under the guise of shifting care from hospitals to "outpatient" services in the "community".

The report *Pushed Out of Hospital, Abandoned at Home: After Twenty Years of Budget Cuts, Ontario's Health System is Failing Patients*, chronicles the anecdotal experiences of hundreds of patients from over 30 Ontario communities who called a 1-800 patient hotline set up for a period of year by the Ontario Association of Speech-Language Pathologists and Audiologists (OSLA) and the Ontario Council of Hospital Unions (OCHU).

A key finding of the report is that rather than delivering "the right care, in the right place, at the right time," the provincial government's health reforms are failing Ontario patients on many levels. Ultimately, many people are not getting the healthcare supports they need in hospital or at home, under this outpatient community-based care model.

Most affected are the elderly, who are often pushed out of hospital when still acutely ill or in need of in-hospital restorative care and therapies for instance to help with swallowing and communication following a stroke. They are in fact being denied care that they deserve.

Since moving to this community model for care, most therapy services, including speech language pathology services, have seen decreases in referral rates through the Community Care Access Centres (CCACs), which leads to individuals not receiving the timely care they need.

In 2012-2013 speech language pathology services amounted to just .7 per cent of all home care visits through CCACs. Due to hospital funding cuts, waiting periods to access some, in-hospital services, range from two to ten months.

The report makes recommendations and offers solutions that encourage the provincial government to make alternative policy choices, these include the following:

- **Reopen chronic and alternative level of care beds** to give the frail and elderly the in-hospital restorative care and therapies they require.
- **Funds must be reinvested in hospitals** so that critical speech-language pathology services can be provided and delivered in a timely fashion.
- **Put funding into care, not profit** by moving away from private for-profit delivery of home care, long-term care and pharmaceuticals.
- **No rationing of care.** Give those who need home care, therapies and services the care hours they need, without being charged user fees.

Introduction

While over nearly 20 years, funding for hospitals has been reduced considerably, the money has not been transferred to home care and other community-based services. This has had a catastrophic impact on patient care.

Between 2004 and 2009, funding per capita for home care declined 14 per cent. Today there are over 10,000 Ontarians on a waiting list for some type of health service support at home and another 25,000 waiting for a nursing home bed.

According to readily available health data, Ontario has fewer beds to population than any other Canadian province. Bed cuts have driven hospital occupancy to untenable levels, forcing doctors to discharge patients, often too soon and still ill, before a new patient can be admitted. In Ontario, average length of stay in hospital has dropped 25 per cent — a whole two days— over the past two decades.¹ This practice is resulting in 1 in 6 patients being readmitted to hospital within 30 days of being discharged.

Data also shows Ontario patients receive 6.1 hours less nursing care than patients in other provinces.

Pushed Out of Hospital, Abandoned at Home: After Twenty Years of Budget Cuts, Ontario's Health System is Failing Patients key findings include the following:

1. Many patients, particularly the elderly are being hurt by the Ontario government's healthcare policy of downsizing hospitals, closing beds and decreasing access to restorative care and therapies, while under-resourcing care in the community.
2. Lack of hospital beds is resulting in hospitals discharging patients too soon, patients languishing in emergency departments and not getting timely care because there are no beds available to admit them.
3. There continued to be a serious decline in patient referral for most therapy services. This includes for speech-language pathology supports both in hospital and through care at-home.
4. Increased hospital re-admission rates. According the Ontario health ministry's own figures 1 in 6 patients discharged is re-admitted to hospital within 30 days.
5. Poorer patient outcomes because of a lack of timely care.
6. Increasing rates of hospital acquired infections and medical errors.
7. Understaffing of nurses and doctors.
8. Insufficient care at home or through community-based service providers.
9. 32,000 frail (mostly elderly) patients waiting for a bed in a long-term care home.
10. Increased stress on EMS services because paramedics cannot offload patients.

The Healthcare System is Failing The Elderly

"I told my husband, when these cuts happen, people are going to pay with their lives—and they have."

Two years ago, my son began having seizures. Every time, the hospital refused to admit him—they'd keep him in Emergency, run some tests, and then send him home—with no explanation as to why he was having the seizures. Eventually, they sent him to a larger hospital out of town, where he was finally diagnosed with epilepsy.

During the fourth seizure, he fell and dislocated his shoulder. At the hospital, they sedated him; the doctor said he and the paramedic were going to pop the shoulder back in. I left the room. When I returned, my son's shoulder was broken, broke right up in the ball. They broke it trying to put it back in. I never said a word. What do you say? I can't prove they broke it. So, broken shoulder—we're told to jump in our car and drive fast as we can—no painkillers, no sling, no nothing—to the larger hospital, a 4-hour drive. You know, if they're going to ask me to do that, give me a siren to put on my vehicle; there are 3-4 construction stops on the way, averaging 10-20 minutes each.

When we arrived at the hospital, my son was given Oxy and we were told to come back the next day for surgery. So we spent the night in a hotel—his shoulder broken, in pain. The next day, we got to the hospital and he was put in a room with about 40 other people, on a waiting list—priorities A, B and C. His injury wasn't life-threatening so it was a long wait. He was in such pain, literally passing out from pain. It was supposed to be outpatient surgery but they kept him overnight for pain control. A week and a half later, he had another seizure and reinjured his shoulder. So then he needed more surgery.

Then, in June last year, my son wasn't feeling good. Emergency checked him out and said everything was normal. But it wasn't. He was in pain. Two weeks later, he went back to the hospital—by this time, he'd lost 15lbs, he's having trouble breathing. And something's wrong with his platelets. The doctor told us to drive to the big hospital out of town. He said, "Get there right away. Jump in your car and drive as fast as you can." So again, we jump in our car. And again, construction—we're being stopped. My son could hardly breathe. I wanted to get out of the car. My son, down to his last breath is saying, "No, Mum, it's okay, Mum." It's absolutely appalling that twice, we've had to drive as fast as we can to another hospital. And I know other people have had to do that, too.

The hospital had a room waiting for him. They thought he was going to be flown there; that's what the nurse told me when we arrived. They gave him transfusions; he was on oxygen. Well, come to find out he's got the two different kinds of cancer—leukaemia and non-Hodgkins lymphoma. He was in hospital 54 days. The care was good, and he

was doing great. He'd go out, walk around in the evenings... Oh, he was doing well. And for all the chemo and radiation he was getting, he only threw up twice in those 54 days.

Now, we were under the impression, after speaking to the doctors, that when the big hospital released him, he was going to be transferred to our local hospital. When he was released however, he was told to stay at home – it was home care.

He should've been transferred to our hospital. Because you go from taking morphine and all your other meds via IV in hospital, to pills at home—well, that's a big difference. Like I said, he only threw up twice at the big hospital. As soon as he got home, he was throwing up 5-6 times a day. The nausea and vomiting still hasn't stopped. And he's not sleeping. When I asked around, I was told my son didn't get a bed because the hospital was looking at capacity—26 beds. Years ago, our hospital had 120 beds. Then we got cut down to 50 beds. Well, now we're at 26 beds. This isn't a 26-bed town, you know.

I work at our local hospital—Kitchen and Housekeeping—and I've seen firsthand what the cuts have done to our hospital. None of the changes have been good. I think everyone feels—I mean, you can see it—it's like everyone has just given up.

When the cuts first happened, especially cuts to nursing staff, we had patients missing. I remember being on the ward one day, and the nurses were just running. It was winter; it was freezing. They eventually found the patient outside in his wheelchair. Oh, they just went nuts looking. Of course, everything's hidden. Nothing's ever said.

I've seen patients laying on floors in the Continuing Care Unit (CCU), and it takes half an hour for someone to help them. We used to have a room in the CCU where patients could at least get out of bed and go have their meals. Now they're in bed 24/7. And you know, we've got one housekeeper for 26 beds. It's ridiculous. Talk about overworked.

I've seen and heard of stroke victims getting sent home from Emergency. The people that have been misdiagnosed and sent home and died... A man I worked with went in for heart pain; he was told he was fine and sent home, where he died. I told my husband, when these cuts happen, people are going to pay with their lives—and they have.

"The healthcare system is failing the general public."

My husband was admitted to hospital in October 2011. He was non-responsive, unable to speak, unable to swallow, and paralyzed on the right side.

On the rehab floor, speech therapy was not offered to my husband—because the speech-language pathologists were too busy with swallowing assessments. I had to hire

a private speech-language pathologist that we still have to this day. She came to the hospital twice a week to work with my husband, at a cost of \$135/session.

In December, I had a meeting with the manager of the 6th floor regarding the lack of speech therapy. She said she'd discuss the issue with her manager, flag the concern—that people prior to me had raised the same issue. I found this unacceptable. It is inexcusable for a hospital to operate in this manner. When a patient has a stroke and speech is affected, speech therapy is a vital service.

The rehab floor continued to advertise speech therapy, along with physiotherapy and occupational therapy. Still, no speech therapy was offered. I went to my MPP and was informed that OHIP is responsible for services while patients are in hospital. I then discussed the matter with the CEO of the LHIN, who in turn phoned the CEO of the hospital. The hospital CEO would not get involved. What happened to commitment and compassion? I was dismissed with no answers. The CEO needs to be accountable but he is not accessible to the public he is meant to serve.

On December 27, I noticed my husband wasn't feeling well. Numerous tests were done and the results came back negative. My husband continued to become more fragile over the next few weeks. Because the test results were negative, the rehab floor continued to push my husband to do physiotherapy. He became weaker by the day. On January 13, even though the nurse informed the therapist that my husband was too sick to get out of bed, my husband was forced to complete his routine. The end result—he had a minor heart attack. Finally, the hospital took a blood culture and determined that he had encountered a serious bacteria infection. The ICU informed me he had 2 weeks to live. Thankfully, he got well. He was discharged in August 2012, after 10 months in hospital.

Upon his discharge, CCAC were on board to provide PSW support, occupational therapy and physiotherapy. To this day, however, CCAC provides only 2 hours of home care in per day. This is not sufficient! I'm my husband's primary caregiver, and I work full-time—I'm tired on a daily basis. In order to care for my loved one, I have to care for myself—but I'm not entitled to respite hours.

For the first month, I had to hire a PSW for 6.5 hours of home care per day, 5 days/week. My husband was accepted into an adult program 3 days/week, so now I pay a PSW for 6.5 hours of home care per day, 2 days/week. I had a wheelchair ramp built for access in and out of the house. On the main floor, I had to have a wheelchair-accessible shower installed, which cost \$8500. I also had a transfer pole and grab bar installed, to assist my husband in getting up from his wheelchair. There are a myriad of additional expenses. The lack of hospital services, namely speech therapy, had an enormous impact on my husband and I. Hiring a private speech-language pathologist was a huge financial burden. After the 10-month hospital stay, our speech therapy bill was \$6765.50.

The hospital needs to hire additional speech-language pathologists to teach stroke patients how to communicate again. Rehabilitation is meant to address all areas of need that a patient has, and our hospital is failing to provide a complete and meaningful program. The healthcare system is failing the general public.

Shorter hospital stays have been hailed by some as evidence of a more advanced health system, a product of “innovation” and “efficiency.” And to be sure, the sooner a patient can safely leave hospital, the better. Yet there is increasing evidence that patient safety is being disregarded in favour of saving money.

One indication that cost pressures may be trumping patient safety is the growing phenomenon of physicians and hospitals citing cost pressures in their defence against negligence lawsuits.² But the most powerful evidence is simply the number of patients coming right back to hospital within a month of discharge because they’re still sick. In Ontario, this number is surprisingly high: 16% of patients (1 in 6) discharged from hospital come back unexpectedly within 30 days.³ Even worse, when patients are readmitted, they are often sicker than they were upon first being hospitalized.⁴

In the United States, 1 in 5 patients ends up back in hospital within a month of being discharged.⁵ This should come as no surprise—studies have shown that poor and uninsured patients end up leaving hospital early, against medical advice, simply because they cannot afford to stay.⁶ In Ontario, Canadian citizens do not have this particular problem, and yet we fare almost as poorly, despite our universal healthcare system.

Two recent U.S. studies by the University of Maryland may explain at least part of the reason for this troubling similarity. Researchers found that cost constraints were causing hospitals to discharge patients before they were well enough to leave.⁷ When hospitals got busy (over 90% occupancy), they discharged patients early, to avoid cancelling valuable surgeries.⁸ The studies found that patients discharged when the hospital was busiest were 50% more likely to return for treatment within three days.⁹

Ontario hospitals operate at 98% occupancy on average—many are regularly over 100%.¹⁰ As a result, discharging patients early is the only way to make room for new patients and avoid cancelling surgeries. Targeted funding to reduce wait times for certain surgeries—rather than proper funding for the whole hospital system—has likely made this worse.

Today we have fewer beds and fewer hospital staff than we did in the 1990s, but our population has increased, it is older, and as technology has improved, more people are seeking medical help for an ever-increasing spectrum of treatments. Supply has fallen, while demand has grown. As a result, between 2000 and 2010, hospital occupancy rates jumped 16 points.¹¹ In other words, hospitals have been trying to treat a growing number of patients with fewer and fewer resources. What choice do under-resourced hospitals have but to try and free up staff and beds

as fast as possible for the ever-growing queue of critically ill patients waiting in corridors, utility closets and parked ambulances?

The government brags that it is shifting resources from hospitals to community care, but community care is drowning under the strain. Between 2004 and 2009 (both years when the Auditor General of Ontario reviewed home care), funding increased about 5% per year while clients served increased more than twice as fast, at over 11% per year.¹² The result was that funding per home care client actually declined from \$3,486 to \$3,001 over this period.¹³ Filling the growing gap between the care patients need and what they get falls to family and friends (invariably women), causing emotional and economic hardship. And when even they cannot fill the gap, patients end up back in hospital.

Despite the Minister of Health's rhetoric about moving care from hospitals into the community, the 2012 budget only provided a 4% increase to funding, while demand is as high as ever. In fact, at last estimate, there were over 10,000 people wait-listed for home care,¹⁴ and 32,000 people wait-listed for long-term care (of the 32,000 wait-listed for a long-term care bed, 19,000 were waiting at home or in hospital, and 13,000 were waiting to transfer from one long-term care facility to another).¹⁵ Meanwhile, hospital funding is being cut, forcing further bed closures.¹⁶

Where do patients go? If there is no home care, and/or there are no long-term care beds, they wait in hospitals, known officially as Alternate Level of Care (ALC), or disparagingly, as "bed-blockers." Hospitals have levied hefty fees—as much as \$1,800/day—to force them out of much-needed acute care beds, but with nowhere to go, these patients are increasingly ending up back in hospital—now sick enough to have "earned" back the very hospital bed they were recently kicked out of.¹⁷

Sicker and Quicker

LENGTH OF STAY

“I was out at the prescribed time... The very next day, I ended up in emergency.”

I had a hip replacement done on a Thursday. I was to start physio on the Saturday. I was actually to be moved to the rehab wing. So I got all packed up. But it got postponed. “No, there are no beds,” I was told. On Sunday, the same thing: no beds in rehab, no physio. That night, a friend visited to see how I was managing, was I comfortable going home. Because I was to be discharged the next morning. Well, I was just in tears. I said, “No, I haven’t had anybody show me how to do anything.” I didn’t know how to get in and out of a car; I didn’t know how to use the bath; I didn’t know how to do anything.

I was to be discharged at 10am on Monday. At 9am, two physiotherapists came. They rushed me through, how to use the bath and... Everything was a blur. The nurse in the background kept saying, “You have to be outta here by 10 o’clock.” She was quite adamant; she said it more than once. While I was being rushed through all this physio, my daughters packed my things. And then I was out of there. I was out of there at the prescribed time, very foggy about what I was supposed to do. The very next day, I ended up in emergency. My blood pressure had dropped dramatically.

I was rushed out of hospital. I wasn’t properly prepared by the physiotherapists on how to handle myself when I got out of hospital, and I’m on blood pressure medication—I suspect they weren’t paying proper attention to my blood pressure levels, or why would I have run into such difficulty? I wasn’t carefully monitored. In fact, I had to make several visits to the hospital after my surgery, because I was also having difficulty with my INR levels, and they couldn’t get them up. They kept increasing my dosage of Coumadin but the levels wouldn’t budge. Every day, I had to leave the house for blood tests. You know, I’m trying to recover from a surgery. And here I’m being shovelled out of the house every day for tests. And of course I had to have somebody drive me. It was very stressful.

Anyone who has hip surgery needs to be given fair opportunity to learn, through physio, what to do for basic mobility issues. Thursday surgeries are very disadvantageous, because your stay runs into the weekend when there’s no staff. So the rehab wing, for example, has very limited personnel; they just haven’t the capacity to deal with any more people than they already have. The hospital either needs to have proper staffing so that patients are given proper physio before they’re discharged, or the hospital needs to keep patients an extra day so there’s enough time to give them proper physio.

Discharging hospital patients too early increases their chance of readmission. A 2012 study by the Canadian Institute for Health Information (CIHI) found that when patients’ length of stay was

more than a day below the expected length of stay for their particular illness, their risk of readmission increased 40%.¹⁸

Ontario has the shortest length of stay of any province in Canada at just 6.4 days—more than a full day shorter than the national average of 7.7 days—and more than two days shorter than Ontario’s average length of stay in 1989/90.¹⁹ The McGuinty government claims, like the Harris and Eves governments before it, that this permits patients to recover from surgery/illness in the comfort of their own homes. However, while care in hospital is guaranteed and free, home care is covered only partially and sporadically by public funds, with many patients forced to rely on unpaid care by family and friends, and/or out-of-pocket private care, or to forgo needed medical and custodial care.

READMISSION

“When she returned to the hospital, they didn’t expect her to last the night.”

My mother had been in the hospital and she is on drugs, but while she was in the hospital, they started giving her several drugs that were contraindicated. And then they literally booted her out, and she was visibly ill.

It was our pharmacist who caught the error—he called and said that these drugs could cause death; they were not to be used together; they were giving her drugs that were very dangerous. He said, “You better see your family doctor because these drugs could kill her.” So actually, when Mom came home from the hospital, on having those drugs, she was four days home, but she was delirious almost, she was just very, very ill, she had a bladder infection, they were giving her way too much potassium, plus these drugs.

And she went into a seizure. We had to call the ambulance and they took her back to the hospital. So when she came home for those four days, she was very ill, and when she returned to the hospital, they didn’t expect her to last the night. She was going to die. She was that ill. She should never have been taken out of the hospital. But she was also on bad drugs. So that was a very negative experience for my whole family.

According to the Ministry of Health and Long-Term Care’s own figures, 16% of patients (1 in 6) discharged from Ontario hospitals is readmitted unexpectedly within 30 days.²⁰ In his 2010 Annual Report, the Auditor General of Ontario suggests readmission rates are likely to be even higher than reported, due to inaccurate reporting by hospital staff.²¹ Unplanned readmissions within 30 days are widely understood to be a result either of premature discharge (the patient was still sick and should not have been discharged) or lack of adequate post-hospital supports (insufficient care at home or in long-term care).²² In Ontario, cuts to the health system have worsened both of these factors.

In the case of premature discharge, a 2006 study of multiple Canadian hospitals found evidence that insufficient beds and hospital staff were resulting in premature discharges from intensive care units (ICUs).²³ According to researchers, 10% of discharges from the ICU occurred at night, between 9pm—7am.²⁴ Canadian ICUs generally do not discharge patients at night, except as a result of bed and staffing shortages.²⁵ Night-time discharges were found to be much more likely to result in readmission within 48 hours, a measure commonly associated with inappropriate discharge from the ICU.²⁶

In the case of inadequate community supports, a 2012 study by the Canadian Institute for Health Information (CIHI) found that Canadian readmission rates were higher among rural patients than urban ones, and significantly higher for poorer patients than for richer patients.²⁷ Curiously, the CIHI report makes no attempt to explain this finding. Given that neither long-term care or home care are free in Ontario (long-term care costs between \$55-75 per day,²⁸ and while some home care is provided free in Ontario, the funding is capped so patients are often forced to supplement it with private care), it is not surprising that poorer patients would be less able to afford to keep themselves out of hospital. Further illustrating the culpability of underfunded community supports, CIHI found that 28% of patients returning to the emergency department within seven days of discharge were treated for non-urgent conditions; in other words, return to the emergency department could well have been prevented by adequate access to home care and/or primary care upon discharge.²⁹ Low-income patients were also more likely than high income patients to return to Emergency within seven days of discharge.³⁰

INCREASED MORTALITY

“The paramedics couldn’t believe she’d been sent home.”

My mother was 86 and she had osteoporosis. In April, she fell. She was taken to hospital by ambulance. They kept her five hours, then sent her home—no pain medication, no x-rays. That night, she couldn’t breathe and she was in a lot of pain. So in the morning, I got her to a clinic near the house. The doctor ordered x-rays and found out she had a cracked rib, and a major problem with her lungs, which was caused by the osteoporosis.

The hospital sent a nurse. Without checking Mom’s lungs or anything, the nurse started her on lung exercises. What was happening was the osteoporosis was pushing down, Mom’s spine was curving, and her stomach and her diaphragm were coming up—so it was crushing the lungs. One day when the nurse arrived, Mom had another fall. She was trying to let the nurse in through the front door—she had her walker, and she fell.

Again, she went to hospital by ambulance. This was around 3pm. I said to the ER doctor, “She’s been to the clinic and had an x-ray; she has a broken rib.” He said, “She doesn’t have a broken rib. She wouldn’t be able to tolerate me poking at her.” That was his answer. At 3am, they finally decided to admit her for the night. In the morning, they did a CAT scan. They said, “We’re going to send your mother home. We’re going to set her

up with oxygen at home and a portable to get her home.” Then they gave her an enema, and I thought, well, they’ll keep her for the rest of the day. No. Wasn’t an hour after they gave her the enema, they sent her home.

And you know, she couldn’t walk after that second fall. There was a woman in Mom’s room, about Mom’s age, maybe a bit younger—and she had to show the staff that she could walk before she could leave the hospital. With Mom, they didn’t do that. They had made her lay there so long in ER, and they hadn’t done anything for her; they hadn’t even give her Tylenol. Then they just put her in a wheelchair and rolled her out. The porter and I had trouble getting her into the car. We had to pick her up and kind of push.

I drove her home. Of course, the enema’s starting to work. And then I couldn’t get her out of the car. I had to call my brothers to help me carry her into the house. That night was awful. She was in such pain. There was no way we could lay her; she just couldn’t get comfortable. It was unbelievable. And she couldn’t breathe.

At midnight, I called an ambulance. The paramedics couldn’t believe she’d been sent home. They put oxygen on her right away. We found out that the oxygen she’d been sent home with hadn’t been set up properly—the hospital hadn’t arranged for enough oxygen. We were in ER all night. No one gave her any pain medication. They just let her lay there. Mom kept saying to me, “Oh, well, I’m old, they don’t want to do anything for me. They don’t want to spend any money on me.” I felt so bad for her. I kept asking them to look at her wrist. It was 7am before anyone actually did anything—and they found out her wrist was broken. Around 8am, someone came in and put a bandage around her wrist. Then we waited for the doctor. Then finally, “Okay, we’re going to admit her.”

After five days, they gave her a bone scan. They found out that she had 17 fractures in her ribs, a broken collarbone, two breaks in her pelvis, a broken knee and broken wrists. And they still hadn’t been giving her pain medication all that time! They kept her a month and a half, then said we needed to find a nursing home, because her condition was no longer considered critical, and in the meantime, they were going to start charging us \$400/day. But by that time, Mom was too weak, and her lungs weren’t cooperating. She never did walk again. She never left that hospital. She died there at the end of June.

One consequence of under-resourcing hospitals is increased mortality. Overcrowding, understaffing, insufficient community supports, and other effects of healthcare spending cuts can directly and indirectly result in increased mortality. For example, night-time discharges—unusual except when necessitated due to insufficient beds or staff³¹—were found, by studies conducted in Canada,³² Finland³³ and Australia,³⁴ to increase mortality. In the Finnish study, risk of death increased during “out-of-office” hours; mortality was higher among patients admitted on weekends, and discharged in the afternoon and at night, all times when staffing tends to be

lower.³⁵ The Australian study mirrored the findings of the Canadian study, namely that patients discharged from ICU at night were more likely to die.³⁶ What we can infer from these studies is that understaffing and premature discharge are causing avoidable harm, including death, to patients.

Increased mortality resulting from short-staffing and other hospital cuts is not limited to ICU patients. A growing number of suicides by discharged mental health patients in Australia has been blamed on hospital funding cuts—wherein hospitals have prematurely released patients in order to free up beds.³⁷

Two suicides by discharged mental health patients in Windsor have raised concerns that cost pressures could be having similar effects here in Ontario—hospitals prematurely releasing patients in order to free up beds. In 2011/2012, two mental health patients at Hotel-Dieu Grace Hospital committed suicide within weeks of each other; in both cases, the patients killed themselves shortly after being sent home by the hospital.³⁸

Gutting Hospitals, Abandoning Patients

Ontario has fewer healthcare workers than the rest of Canada. According to Statistics Canada, Ontario has approximately four fewer healthcare workers per 1,000 residents, or 47,000 total fewer healthcare workers, than the rest of Canada.³⁹ The decline in healthcare workers has been particularly harsh in hospitals. Between 1991 and 2011, the number of hospital staff in Ontario per 1,000 people declined by 20%—the most dramatic decline of any province after Alberta.⁴⁰

Declining hospital support budgets and outsourcing account for much of this decline. In both cases, since labour accounts for over 90% of support staff costs, any “efficiencies” in these areas translate directly to layoffs.⁴¹ Below, we examine the impact of overcrowding and understaffing on patient well-being.

OVERCROWDING

“I was on a cot in Emergency for six days.”

I took ill while visiting my mother at the nursing home, so I asked my brother to give me a ride home. On the way home, I said to my brother, “I think you better take me to the hospital ‘cause there’s something wrong.” So he took me to the hospital. They kept me there for six days, did a bunch of tests, and diagnosed me with follicular b-cell lymphoma, which is cancer.

I had no place to stay while I was there. I was on a cot in Emergency for six days. Just in the corridor. I was in a robe and that. I didn’t have access to the washroom because I was hooked up to an IV and everything. While I was in there, I had an accident. I defecated in my underwear. They took the underwear off me but didn’t clean them—they put them in a bag and they put the bag underneath the rest of my clothes that I had there. And I was wondering what the smell was. When I went to get my clothes, I found the bag with the underwear. I don’t see why they couldn’t get me a room. They said they didn’t have any room, but there were people coming in and out all the time. It was terrible.

“While he was in surgery, they gave away his bed.”

My father-in-law was admitted to the hospital for bleeding ulcers. He was initially on the floor. He complained that he was passing blood in his stool, and the nurse said to him, “If it happens again, let us know,” sort of thing. And he grew very weak, and within two days, he was transferred to ICU. There wasn’t enough hospital care on the ward; there weren’t enough nurses to go around. Had there been, I don’t think he would have gotten as bad as he did; it wouldn’t have taken them so long to figure out there was a serious issue.

In ICU, he was given blood transfusions. The care was exceptional. Then we received a call—it was a Saturday or a Sunday, about 7:30am. They said, “We’re taking him into surgery because we can’t get the bleeding to stop—he’s had 17 units of blood; he’s had twice as much as a gunshot victim.” So we went up to surgery. Three hours passed. Then the doctor came out. He said, “I think we’ve got the bleeder stopped, but there’s a problem: there’s no bed to put him back in ICU.”

So while he was in surgery, they gave away his bed! We were in unbelievable disbelief. The doctor was as exasperated as we were. But his demeanour didn’t come across as really being on our side; it was more, “Hey, I’m not the bad guy here; this is just what’s happened. If you don’t like it, talk to your MPP.” Then he said, “We need to transfer him to another hospital; he’s serious enough.”

But it was 10:30pm before he was actually transferred to another hospital. He sat on a gurney in a hallway. They had no room in ER, so we were on the second floor, the surgical unit. That’s where we waited. Now, they said that they left him in the hallway till 10:30pm because he wasn’t stable enough to transport, but we were listening to the conversations back and forth, and they’d put a call out for a bed—and they were saying, “When a bed becomes available, God knows where he’s going to end up. If it’s Hamilton, we’ll airlift him.” So he sat in that hallway because there were no beds.

He made the ambulance ride with a doctor and a nurse, and a bag of blood sitting on his lap. And then the other hospital turned around and said, “There’s nothing we can do for him. He can’t stay here.” They said, “There’s a surgery that can be done. Why it wasn’t done, we don’t know.” With the surgery that had been done, they said, what was happening was they were injecting epinephrine into the bleeds, which is all they were capable of doing at a small hospital. And the epinephrine started causing heart issues, so they’d had to stop. At a bigger facility, they explained, there would be little clips that would go onto the bleeds. So the bleeding was still happening, so basically they kept pumping him full of blood, and eventually he would stop bleeding.

Two days later he was shipped back to the hospital he’d come from because an ICU bed had come available. And in that time he was tested for MRSA and came back positive. At that point, we basically threw a fit. We insisted he not be discharged until the bleeding stopped. We started insisting on how things were going to be done. And as soon as you start insisting and pushing, they start taking the situation more seriously.

In hindsight, I think they should have transferred him way sooner to a different hospital—because they were way beyond their capabilities of actually treating him. I think it could have turned out a lot worse, and I think they expected it to turn out a lot worse. I was honestly left with the feeling that when they took him into surgery, they didn’t expect him to live—they thought he was going to die—so they gave up his bed.

My own father... I kind of hold us responsible for this now, because we didn't push it, but... I took my father to the hospital because he was having excruciating pain in his back. They said, "Well, arthritis in the back is very painful"—that was his own family doctor. And back and forth to the hospital, nothing. Finally, he drove himself to the hospital and was admitted—he had lung cancer. He died 32 days later. So we've learned a lot over the years. Of what you need to push for.

In 1988, I had a malignant melanoma. I called my family doctor and was in to see her same day. She had me to a dermatologist on a Tuesday. On Thursday, my pathology came back; it was malignant. By the following Tuesday, I was on the operating table—and while I was still under, pathology was being done to see if the margins were clean. And the follow-up was great. But nowadays—it's just unbelievable what's happening.

In 1990, Ontario had 50,000 hospital beds staffed and in operation, but throughout the 1990s and 2000s, provincial governments steadily slashed beds, leaving just 30,000 beds today.⁴² That's a cumulative cut of 38% in twenty years. Over the same period, Ontario's population has grown by 28%.⁴³ Today, Ontario has just 2.3 beds per 1,000 residents—the fewest hospital beds per person of any province in Canada, and down from 4.8 beds per 1,000 residents in 1990.⁴⁴

Internationally, Canada ranks near the bottom of the OECD (Organisation for Economic Co-operation and Development) Health Data list, which compares 34 of the world's wealthiest countries.⁴⁵ At just 3.3 beds per 1,000 residents, Canada is sixth-worst among reporting member countries.⁴⁶ When just acute-care beds are considered, Canada has fewer beds than any country save Mexico.⁴⁷

Quebec has almost as many hospital beds as Ontario, despite having 4 million fewer people.⁴⁸ That's because Ontario currently spends \$320 less per person on hospitals than the rest of Canada spends.⁴⁹ It would require \$4.3 billion in additional annual funding for hospitals to bring Ontario to the level of the Canadian average—still far below international standards.⁵⁰

Without enough beds to care for patients safely, hospital occupancy rates have exploded. In Ontario, occupancy rates have jumped 16 points since 2000. Canada currently has the second-worst occupancy rate of all OECD countries, at 93%.⁵¹ Ontario is even worse, with an occupancy rate of 98%—far worse than any OECD comparator!⁵²

Such high occupancy means there are no available beds to admit patients until an existing patient is discharged. This creates pressure on hospitals to reduce lengths of stay, despite evidence that this can have negative health consequences, and can in fact cost the hospital and the health system more in the long run, as prematurely released patients are highly likely to return. High occupancy rates also increase patients' risk of acquiring diseases from other patients: a 2008 study found increased rates of hospital-acquired infections when occupancy rates climbed above 82%.⁵³

UNDERSTAFFED CLEANERS

"She went into the hospital with pneumonia... they discharged her ten weeks later with pneumonia and the ESBL superbug."

My mum was in hospital ten weeks in 2010, and then ten weeks in 2011. The first stay, she was rehabbed and back to the retirement home. That instance was okay; she had a fantastic doctor. It took them ten weeks to figure out what was wrong with her, but at least she made it. But the second stay—she went in with pneumonia—was just brutal.

If I wasn't there, things didn't get done. If I didn't go in at dinnertime, for example, she didn't eat. She didn't want to eat, so you had to encourage her. The nurses were just too busy for that. And the call bell—we'd ring it and no one would ever come. The doctor Mum was assigned was never around.

And then Mum got the ESBL superbug off a dirty toilet seat—from someone who was admitted during the night who was mobile, could use the bathroom, which they did, and infected the toilet seat—and then Mum and another woman in the same room got ESBL. So then Mum was quarantined and we had five weeks of going in with masks and gloves.

The hospital started charging us a month into Mum's stay. One bill was \$1,000; another bill was \$600 and something. My brother and I fought the charges for the longest time, saying: "We can't even speak to a doctor, so how can you say she's ready to be discharged? We don't know if her pneumonia's cleared up, we don't know what's going on with this ESBL superbug." We could never get any information. Because we were threatening to cause a stink, the doctor finally called my brother and said that as of February 17th the pneumonia was clear, and now it's just this ESBL—so the hospital could start charging from that day forward.

They asked us to choose ten nursing homes, but told us Mum would be placed within our top five. So we did. On the Thursday morning, they said Mum's name was in the placement register. And that afternoon, we got a call saying a spot had been found—it was our #8 choice. I said, "No. You told me Mum would be placed in our top five." And they said, "Well, things have changed." It was all fixed. We could see it a mile away. They needed Mum's bed, so they changed the rules.

I went up Thursday night to talk to Mum and tell her the news, and she was all crackly. I said to the nurse, "She sounds chesty again. I would like you to check for pneumonia." The nurse said, "Oh, that takes a few days and she's getting discharged on Monday." I said, "I know, but I don't want her discharged if she's got pneumonia." And she said, "Well, I'll talk to the doctor." Of course, on Friday, there are no doctors to request a pneumonia test, and there are no doctors available over the weekend, and there are no

labs to check the test results. They discharged her Monday morning at 9am. They just washed their hands of her.

At the nursing home when the doctor came in to welcome her, I said, "Would you do me a favour and check for pneumonia?" They brought in the x-ray machine and yes, she had pneumonia. She went into the hospital with pneumonia and they discharged her ten weeks later with pneumonia and the ESBL superbug.

Studies have established that infectious agents can survive in the hospital environment,⁵⁴ that these infectious agents can be transferred from the environment to hands,⁵⁵ and that environmental cleaning can reduce the risk of infection.⁵⁶ Yet, hospital cleaners are often treated as though their work is unrelated to patient care, and are thus an "efficiency" to be exploited for cost savings either through layoffs or outsourcing.

Between 2000 and 2009, the proportion of Canadian hospital budgets going to cleaning declined 25%.⁵⁷ In Ontario, outsourcing of hospital cleaners has increased nearly tenfold in the past decade.⁵⁸ In British Columbia, the proportion of cleaning budgets that have been outsourced has jumped from 3% in 2003 to 60% today.⁵⁹

Over 90% of hospital cleaning budgets go to staffing (as opposed to materials), so cuts to cleaning mean fewer cleaners and lower wages.⁶⁰ Privatization nearly halved wages for B.C. hospital cleaners, rolling them back to pre-1968 levels.⁶¹ Those working for private contractors are now the lowest paid health services support workers in all of Canada, earning 26% below the national average.⁶²

In one study of B.C. contract hospital cleaners, 75% of participants reported having been understaffed in the previous month.⁶³ Over one-third of surveyed cleaners regularly performed work for which they were not trained.⁶⁴ Some reported being limited to one pair of disposable gloves per shift.⁶⁵ The results of such dire understaffing are entirely predictable.

A deadly outbreak at Nanaimo General Regional Hospital (NGRH) in 2008 led investigators from the British Columbia Centre for Disease Control to discover that the private cleaning company over-diluted the bleach (1:1000 instead of 1:10), making it too weak to kill the *C. difficile* bacterium, "clearly a contributing factor to the propagation of the outbreak."⁶⁶

Sadly, NGRH is not an isolated case. Since surveillance for Methicillin-Resistant *Staphylococcus aureus* (MRSA) infections began in 1997, the highest single-year increase comes in the Western provinces in 2004/05, immediately after British Columbia's move to privatization, when MRSA rates nearly doubled (the Canadian Nosocomial Infection Surveillance Program (CNISP)—the arm of the Public Health Agency of Canada responsible for monitoring hospital-acquired infections—does not provide separate MRSA figures for British Columbia, Alberta, Saskatchewan or Manitoba).⁶⁷ Since 2003, MRSA rates in the West have rivalled Ontario and Quebec, historically the epicentres of the disease.⁶⁸ Similarly, though Ontario had much higher

rates of *C. difficile* than British Columbia/Alberta from the start of surveillance to 2005, since then British Columbia/Alberta has overtaken Ontario and, in 2008, British Columbia had the highest rates of *C. difficile* in the country.⁶⁹

Of course, not everyone is blindly cutting hospital services without regard for public safety. Scotland has demonstrated the success of adequate cleaning resources in combatting hospital-acquired outbreaks. While rates continue to rise in Canada and elsewhere, Scotland recently announced they have the lowest levels of MRSA and *C. difficile* ever recorded, after having invested £50 million in hospital cleaning.⁷⁰

HOSPITAL-ACQUIRED INFECTION (HAI)

According to studies by the Public Health Agency of Canada (PHAC), 10.5% of patients (1 in 10) acquire an infection in hospital.⁷¹ That's about 330,000 Canadians infected in hospitals every year. Based on mortality rates for HAIs, we estimate between 12,000-18,000 Canadians die each year, making HAIs the third leading cause of death, behind only heart disease and cancer.⁷² Extrapolating U.S. cost estimates to Canada suggest HAIs cost the medical system anywhere from \$3-5 billion per year.⁷³

In Ontario, an estimated 120,000 patients experienced an HAI in 2009/10, resulting in between 4,500-7,000 deaths.⁷⁴ And it's getting worse: superbugs like Methicillin-Resistant *Staphylococcus aureus* (MRSA) increased threefold between 2001 and 2009, and Vancomycin-Resistant *Enterococci* (VRE) increased tenfold in the same period, while mortality resulting from *C. difficile* quadrupled between 1997 and 2005.⁷⁵

UNDERSTAFFED DOCTORS

"The diagnosis kept changing. And the doctor was never around."

My father passed away because of bad care. He went into the hospital in February 2010. He and my mother were living in a retirement home. He didn't want to go to the hospital; he said he felt fine. But the nurse at the retirement home said the oxygen level in his blood was low, and because the doctor at the retirement home was never on duty, she said, "Just to be on the safe side, go to the hospital and get checked out." And within two weeks, he was dead.

Every time we talked to someone, we got a different story: one minute my dad had pneumonia; the next minute he didn't. The diagnosis kept changing. And the doctor was never around. We kept asking to see him. We left messages daily. He would not return our calls; he would not come and see us. No updates, absolutely nothing.

When my dad fell into unconsciousness, we still didn't have a diagnosis. Just, you know, "He's old. He's sick." Well, yes, but he wasn't that sick when he went in! He got sicker when he went in—it was just complete lack of care.

On the Monday night, I said to the nurses, "He hasn't eaten now since Friday. What are you going to do about it?" They said, "Oh, well, you need to talk to the doctor." I said, "Well, the doctor won't talk to us. But my dad needs a feeding tube or something; we need to get him nutrients." And the next morning, he was dead.

What really sent me over the edge was after my dad died, the hospital sent a letter saying, "We're doing a survey and we want to know how the frontline staff dealt with you, knowing that your dad was dying." And I sent back a three-page letter saying, "He wasn't supposed to die, so no one actually talked to us about imminent death. He died because of poor care and lack of care. You didn't feed him for four days. What did you expect?" And all I got back from them was, "Oh, we're not the people you need to complain to." I just felt... What's the point? They cover each other's butts. It's an old boys' network.

Ontario suffers from a shortage of doctors, despite paying doctors more than any other province. 1.3 million Ontarians—more than 10% of the twelve-and-over population—are without family physicians.⁷⁶ Since 2003, the percentage of Ontarians without a medical doctor has grown slightly, despite declared efforts by the Ministry of Health to solve the problem.⁷⁷ There are just 1.89 doctors per 1,000 Ontarians.⁷⁸ Canada-wide, there are currently just 2 doctors per 1,000 people, one of the lowest doctor-to-population ratios of any OECD country.⁷⁹

And it looks like Canada will continue to have a doctor shortage for years to come: in 2009, Canada had the fourth-fewest medical graduates of OECD countries, at just seven grads per 100,000 Canadians.⁸⁰ Meanwhile, the percentage of internationally-trained physicians has actually declined steadily since 1978, the earliest year for which data is available. From a high of over 30% of practicing physicians in the late 1970s, internationally-trained physicians now account for between 22-25%.⁸¹ Among the reasons for this decline—the significant barriers preventing foreign-trained doctors from getting accredited to practice in Canada. Just 55% of foreign-trained doctors are able to find work in Canada as doctors, compared with 92% of Canadian-trained doctors.⁸²

While bad for the 1.3 million Ontarians without a family doctor, this restricted supply has increased demand, and increased physicians' bargaining power. As a result, physician fees are the fastest growing category of health spending in Canada.⁸³ Despite having fewer doctors than the rest of Canada (or perhaps, because of it), Ontario spends almost \$200 more per person on doctors than other provinces.⁸⁴ From 1998 to 2008, physician remuneration grew, on average, 6.8% per year.⁸⁵ Half of this growth was due entirely to increases in physician fees.⁸⁶ Physician remuneration grew faster than the rate of inflation, and faster than wages for other healthcare workers.⁸⁷

UNDERSTAFFED NURSES

"She kept ringing for the bell... and nobody came."

My mom had cirrhosis of the liver. She started to go downhill three years ago, and over that time, she was in and out of hospital probably once a week. She often needed blood transfusions. We'd call an ambulance when we needed to take her to hospital, because even though we still had to wait for hours and hours—in the ER hallway—it was faster than waiting eight hours in the waiting room. Her being terminally ill, I felt very strongly that no, my mom's not waiting for eight hours; she needs to be looked at right away.

Mom wore Depends. I had to change her because the nurses were too busy with other patients. If I didn't change her, Mom would sit in her poop. What are you going to do? You're going to change her, or you're going to let her sit in her poop. Also, she often got bladder infections. She'd have a really high fever and be sweating. The nurses wouldn't do anything. "Can you give her something for pain?" I'd ask. "Oh, no, we have to have the doctor," they'd say. "Well, how long is it going to take for the doctor to get here? How long does she have to suffer in deep sweats and fever?" And it was hours and hours.

One day I went in to visit Mom on the ward. Another patient called me over. She said, "Your mom sat on the toilet for over an hour. She kept ringing the bell for someone to come get her off the toilet. And nobody came." I flipped out. I talked to the supervisor at the hospital. My mom should not be ringing for help for over an hour. "Well, we were short-staffed." My mom sat on the toilet for over an hour because they were short-staffed.

At one point, Mom had a severe heart attack. The hospital kept her a week, and then wanted her to go to palliative care. But you have to pay for that yourself. What about the fact that my mom has bills to pay? She can't afford palliative care. That's a minimum of \$1,000/month out of your own pocket—and if you get Canada Pension and Old Age, you're only getting \$1,500/month. So how are you supposed to manage to pay for your rent and your other bills if you have to pay \$1,000/month for palliative care? So I said, "No, she's coming home." I had quit my job four years ago so that I could take care of Mom, so I felt I could continue to take care of her. But it had only been a week since the heart attack—and Mom wasn't really well enough to go home. She was sleeping all the time. She couldn't stand on her own two feet. She wasn't eating. She was vomiting everything that she tried to put down her throat. Despite Mom's condition, the weekend doctor put in the release papers and they discharged Mom on Monday morning.

We managed to get her in the car. She slept the whole way home. We had to lift her, my sister and I, put her in the wheelchair, get her up to the apartment. Very, very hard. You

know, Mom's the same weight as me. She was sleeping and she was throwing up. She wasn't well enough to go home. So we called the ambulance again. Back to the hospital.

When the ER doctor found out Mom had just been released, he contacted the doctor who released her—and this doctor said he had no idea Mom was vomiting, that if he'd known, he wouldn't have released her. How did he have no idea Mom was vomiting? Isn't it written on her chart? You know, it just it blows my mind. I mean, you've got to be 100% positive that when patients—especially seniors—go home, they're going to be okay. They send these people home with problems, and then these people come back—and you know what? Now these people may or may not make it.

With Mom—she continued being unable to keep anything down, and she passed away a week and a half later. The night before she passed away, I was at the hospital from 5-9pm. When I arrived, she was in a lot of pain. Her stomach hurt so bad she couldn't take it. And they hadn't given her any pain medicine. I asked a nurse to call a doctor for pain medicine. She tried for hours to reach a doctor, but nobody called back. So Mom suffered with unbearable stomach pain on her last day, because the nurse couldn't reach a doctor to get pain medicine. Finally, around 11pm, a doctor prescribed Tylenol. But it was too late. So this is the way our healthcare system works. I have no respect for our healthcare system anymore. How do you treat a terminally ill woman with such neglect and disrespect? Especially in her last days. What if it was your parent? You would not want this. You would absolutely not want this for your parent.

"This unit my mother was in—where patients are waiting for nursing home placement—it's just a holding tank."

It was an emergency that took my mother to the hospital. She was living in a long-term care residence, and she had a stroke. And when she had the stroke, she had a fall. She was on the floor overnight. The staff did not find her until morning. So in addition to the stroke, she had a number of injuries, because she'd been on the floor for so long, calling for help and trying to get up.

So she was admitted to hospital. She had an injured left wrist but the hospital x-rayed her right wrist. So that was a mistake to start with.

But then they sent her to the stroke rehab program at the hospital's sister branch. And the stroke rehab program was excellent—the recreation staff, the physio staff, the nursing staff. She started being able to eat with one hand, she was speaking—she was improving. But just when she was starting to make some progress, we were told—with less than 24 hours notice—that they were sending her back to the other hospital branch. Now, they had told us she would stay in the stroke rehab program until she got a nursing home placement. Then all of a sudden, out of the blue, they said, "We're moving her back. We've got a bed at the other branch, where she can wait for long-term

care. She has to go.” We didn’t have a choice. If she’d stayed in the stroke rehab program, she might still be alive. But that’s another story.

And at that point her health deteriorated significantly. She wasn’t getting stroke care, physio. She wasn’t getting any individualized care. She lost her speech, she stopped eating and drinking. And she had a DNR order; I guess she decided she wasn’t going to have any more of this, and checked out.

The nurses weren’t doing anything with Mom—they were understaffed, and I didn’t feel they really cared about their patients. Mom couldn’t feed herself, and the nurses weren’t feeding her. If we didn’t go up at mealtimes, Mom didn’t get fed. So we hired a private nurse to go in every day and feed Mom and look after her, because we weren’t satisfied with the care at the hospital. And the three of us couldn’t be there 24 hours a day. Also, there were restraint practices that concerned us. Mom couldn’t move so they had her in a lift and they had her in a wheelchair all day. Imagine an 89-year-old who’s had a stroke sitting in a wheelchair all day. And in the halls, all of these people sitting in wheelchairs; we’d see them when we arrived to visit Mom, and hours later, they’d still be sitting in the same spot. It was horrible.

When a nursing home bed came available, we took it. We knew she was dying but we took it anyway, because we didn’t want her to die in the hospital. So they sent her to the home on a Friday, and she died on the Tuesday.

And after a certain number of days, you start to get billed. Fortunately, my mother could afford to pay. It was about \$3,000 for all of this over the few months that she was in the hospital. And then they lost her hearing aid the week before she died. We managed to get \$500 deducted from the final hospital bill because of the lost hearing aid.

This unit my mother was in—where patients are waiting for nursing home placement—it’s just a holding tank. It’s not a nice setting. It’s not a comfortable setting. Most everyone is in wheelchairs or in beds. And there’s not enough staff. They should reduce the number of patients allowed in these units, and provide more stimulation for them. I was appalled, and so were my brother and sister. And we weren’t the only people with parents in there who were shocked by the lack of attention, the lack of care, the low level of staffing and just, leaving patients in dirty diapers and all of these things.

The long-term care physician didn’t come in unless somebody died or the nurse called. In fact, the whole time my mother was in the long-term care unit, we never had a consult with the physician. The nurses did everything, because the doctor was never around.

And if you don’t have the ear of the nurses... At one point, my brother and sister took my mother upstairs to the emergency room to get an IV drip, because she was basically starving to death. She was dehydrated and starving and the physician told them that. He

put her on an IV and sent her back downstairs to the unit. This is not an acceptable level of care for human beings. It's ridiculous. It has to change.

Ontario has fewer nurses per capita than the Canadian average—90 fewer nurses per 100,000 residents (around 14,000 fewer nurses total); this figure includes both Registered Practical Nurses (RPNs) and Registered Nurses (RNs).⁸⁸ As a result of cutbacks beginning in 1993, the number of nurses in Canada and in Ontario actually declined for over a decade, despite increases to the general population, aging, and increased healthcare utilization during this period.⁸⁹ As a result, the ratio of nurses to population has never recovered to levels attained in the early 1990s.⁹⁰ This deficit is likely to get worse as more and more nurses reach retirement age. In 2010, 15% of Ontario RNs were over 60, and nearly 30% were over 55.⁹¹

The implications for patient safety are concerning: studies have shown that higher patient loads for nurses result in higher mortality. A study in *The Journal of the American Medical Association* found that for every additional patient in the average hospital nurse's workload, the odds of patient mortality increase by 7%.⁹² The study shows that when patient load is increased from 4 to 6 patients per nurse, mortality is driven up by 14%—when patient load is increased from 4 to 8 patients per nurse, mortality is driven up by 31%.⁹³

A study by The Joint Commission, the main healthcare accreditation organization in the United States, found that inadequate nurse staffing levels were a factor in 24% of reported sentinel events (unanticipated events resulting in death or serious injury).⁹⁴ A study in the *New England Journal of Medicine* found more hours of nursing care per patient to be significantly associated with shorter lengths of stay, fewer urinary tract infections, lower rates of pneumonia, shock or cardiac arrest, and fewer occurrences of "failure to rescue," in which patients died from pneumonia, shock, cardiac arrest, internal bleeding, sepsis, or deep venous thrombosis.⁹⁵

To protect patients, nurses in California fought for and won mandatory staffing ratios.⁹⁶ In 2006, two years after these ratios went into effect, a study compared California's nurse staffing and nurse/patient outcomes with those of New Jersey and Pennsylvania—and found that if New Jersey and Pennsylvania had the same mandatory minimum staffing ratios as California, they could prevent 14% and 11% of surgical deaths, respectively.⁹⁷ No province in Canada has mandatory staffing ratios.

MEDICAL ERROR

"This man's going to die if you don't treat him."

My father called me and said he was short of breath. When I got to him, he was in severe distress. In fact, I felt he was in pulmonary edema, congestive heart failure, and I had the ambulance come and take him. He was gray, almost semi-comatose. He was really, really bad. The paramedics gave him a Ventolin treatment and it improved his breathing a bit, enough that he was getting some air in.

At the hospital, the doctor gave Dad another Ventolin treatment and said he was going to send Dad home. I said, "Oh my god. Do you not hear this man's drowning? I'm sure he's in failure. He's in pulmonary edema. He can't breathe." The doctor said, "No, he's improved." My father was about 89 at the time. And I think they just felt with his age, just out you go. So I said, "You took a chest x-ray. Have you looked at it?" He said, "No, I haven't had time." I said, "Well, I think it's important. The man can't breathe. You'd better look at his x-ray—or do you not read x-rays?" He said, "No, you can take him home." I said, "I'm not taking him home. I'm taking him to another hospital. This man's going to die if you don't treat him. I'm taking him where he's going to be treated." So he said, "Well, if you feel that way, we'll put him in intensive care overnight." So they took Dad to ICU. They just got through the doors and the nurses looked at Dad, and said, "Oh my god, this man's in failure." And they immediately started to give him the oxygen, the morphine and anyway, they treated him.

And then, when he was 94, he was having problems swallowing, so I suggested they have a scope, a gastropathy to see why he was having trouble, because he was losing weight. He'd lost about 15lb. The surgeon agreed. I said, "At Dad's age, you're not going to ram that scope down there and perforate. Are you going stretch the esophagus first to see?" He said, "Oh, yeah, I always do that." Well, he didn't. When they came out of the day surgery, they said, "You can take your dad home now." I looked at my father; he said, "Why am I having this sharp pain in my chest here on the left side?" I said, "Well, Dad, you shouldn't. That's not normal."

I said to the nurse, "I don't feel comfortable taking him home; I think there's something wrong. Do you suppose the doctor perforated?" She said, "Oh, no. He's fine." And I said, "Well, I'm not comfortable taking him like this. This is not right. This is not normal." I reluctantly took him home, gave him sips of clear fluid, but the pain was getting worse.

The next morning, he was really, really bad. I took him back to the hospital. In Emergency, they said, "Oh, he's just dehydrated." I said, "No, I'm pretty sure they perforated him." I asked to x-ray, to check for perforation. They didn't do it. And of course it was the weekend and many hospitals in small areas seem to stop until Monday.

I wasn't happy with the care. And I think it was because of his age. "Well, you do know his age. Why don't you just let him go?" He didn't want to die. His mother lived till she was 96. He had two aunts. One was 100, one 103. And he wanted to live to 100. I think because of his age, they just kept pushing him out, just not wanting to deal with him. They definitely wanted to get my father out.

Finally, he ended up going to a larger hospital, but it was too late. The endothoracic surgeon asked me if I wanted an autopsy. I said, "No, it's too late. I mean, he's dead, it's

too late.” And he said, “Well, I want one done. This was poor medicine. You diagnosed your father within three minutes of seeing him. Why did it take them a week to do it?”

Medical errors, also known as adverse events, are “unintended injuries or complications that are caused by health care management, rather than by the patient’s underlying disease, and that lead to death, disability at the time of discharge or prolonged hospital stays.”⁹⁸ Very little data exists on medical errors and hospital-acquired infections in Canada, due to a lack of mandatory reporting from hospitals, and/or funding for detailed research.

According to the only comprehensive study of medical errors in Canada that exists, 7.5% of patients (1 in 13) experience a medical error while in hospital.⁹⁹ With over 3 million hospital admissions across Canada in 2009/10, an estimated 235,095 Canadian patients experienced medical errors, and 49,000 died as a result.¹⁰⁰ In Ontario, an estimated 90,395 patients experienced medical errors, from whom 18,792 died as a result.¹⁰¹ Medical errors, including hospital-acquired infections, adverse drug reactions, misdiagnosis, surgical error and others, are estimated to be costing the Ontario health system between \$2-2.5 billion per year.¹⁰² Despite the extreme human and financial cost, the Ontario government has failed to require hospital reporting of deaths resulting from medical errors and hospital-acquired infections, and has failed to address the root causes of both: hospital overcrowding and understaffing.

Quebec recently began requiring all healthcare facilities to report adverse events—the only Canadian jurisdiction to do so—and has so far published results for one six-month period (April-September 2011).¹⁰³ During this period, there were 116,657 medical errors, not including hospital-acquired infections (which is one of the most common types of medical errors, but was excluded from the report on the basis that HAI data are reported elsewhere).¹⁰⁴ One third of Quebec healthcare facilities did not report fully or at all, despite being legally required to do so.¹⁰⁵ The legislation depends on healthcare facilities to self-report. One U.S. study estimated the percentage of medical errors that actually get reported using self-reporting systems at just 5%.¹⁰⁶

Studies of medical errors have demonstrated a link between hospital overcrowding and understaffing, and increased rates of medical errors.¹⁰⁷ Reflecting this widespread understanding, even physicians and institutions being sued for negligence as a result of medical errors have begun citing cost pressures in their defence.¹⁰⁸

Discontinuity of Care

NO COMMUNITY SUPPORT

"They can't send me home yet. I can't walk."

In 2005, my father had a stroke. He was in hospital three months. They gave him physiotherapy and he actually recouped most of the functioning that he had lost. And he came home. In 2007, he had a far more devastating stroke. It left him bedridden, incontinent. He could speak and feed himself—that was it.

He was in hospital for just five weeks. And what happened was, he was getting physio, but sporadically. I know this because I went there every single day. And his mind was sharp; he knew when he'd had physio and when he hadn't. And I would ask him, "Did you have physio today?" And he'd say, "No," or, "Yes." So I would argue with them: "Why isn't he getting regular physio?" I couldn't understand why they weren't giving him regular physio. And after five weeks, the hospital decided – because, I guess they figured, the really scary stage of his stroke was over—to send him home.

I can't even describe how stunned I was when they told me they were releasing him. I was shocked. So I argued with them about that. And they said—and this was from their lips to my ears— "Well, if you want to pay us \$300 per day, we'll keep him. Otherwise, we need the beds for other people." And I'm thinking, If you need the beds for other people who are in acute condition, why would you then offer to keep him for \$300 a day? I said, "Well, he's covered by Ford Motor Company. Aren't they paying you that already? What's going on? I don't understand." And then finally, she said, "No, over and above."

I said to my brother after, "We should have paid it." Because maybe if we had paid it, he would have walked again. Maybe not. I don't know. That's the big question. But as it was, I said, "Wait a minute. He had a stroke in 2005 as you're well aware; you're the case manager. It was a far milder stroke and you kept him three months, gave him full physio, and he came home walking and mobile. Two years later, he has a major, devastating stroke and you're keeping him five weeks, and the physio is one day, yes, then two days, no... And if I hadn't complained, would he have gotten physio at all?" I was screaming at her. I was so mad. I could have picked her up and choked her. Of course, it's not her decision; it comes from the top. She's frontline; she's got to do what she's told.

Just before he was discharged, he said to me, "They can't send me home yet. I can't walk. What am I going to do? How am I going to do anything?" And when he was home, he said, "If I could just get up and walk to the washroom"—which was right across the

hall from his bedroom. Had he been able to walk, he would've been spared the indignity of having that constant...having to be washed, having to be changed. He wouldn't have had any problems with bed sores. He would have had so much better a chance, and a better quality of life.

We had no special equipment at home, so the hospital arranged for a hospital bed, a mattress, and a lift. The lift looked like it came out of a World War II veterans' hospital. And it was hard having Dad home—my mom was elderly like him, and both my brother and sister worked. We had CCAC coming in twice a day, thank god—I called them my angels of mercy. Because I was in the middle. I had to do all the rest. I was the frontline at home.

We got private physiotherapy for Dad. But it was \$100 every time they came out, and it was costing \$800 to \$1000 a month. And after about three or four months, he wasn't showing significant improvement, so he said, "I don't want to do this anymore." So that stopped. And so, there he stayed until the day he died in 2009.

My father was an old European guy. They're very independent; they don't like to rely on anyone for anything. And I believe—had the hospital progressed with his treatment, especially the physiotherapy—I mean, he could still stand then; he was standing—my dad would have walked. And had he walked, the outcome would've been hugely different. As it was, he became depressed. And he gave up. Before he passed away, he said to his brother, "God forgot about me."

We used to pay for OHIP. It was automatically deducted from our paycheques. It wasn't a lot, but if you take that from every working person in the country, it's going to yield a good chunk of change. Why don't we do that again? People could afford that. It wasn't a ton of money even back then. I mean, why are they not... My personal opinion is that they want to privatize. They're making up all this bologna and they're making us go through hell and back because they want to privatize. And then we'll be like the States: you get sick, you get a serious illness, you're going to lose everything – your savings, your house, your life.

"The abrupt exit from hospital had negative effects on my husband's health."

In April last year, my husband was admitted to hospital following a massive stroke. The stroke resulted in right-side paralysis, loss of speech, and incontinence; in addition, he had to be fed by a PEG tube.

The care in hospital was acceptable most of the time. The cleanliness of his room wasn't always 100%. And personal care could've been better: shaving and hair-washing was only done if a male nurse was on duty. Also, on a couple occasions, the staff forgot to put up my husband's bed rail—as a result, my husband tried to get out of bed and fell.

In mid-May, my husband was transferred from acute care to the rehab floor. In mid-July, we were informed that the maximum time allotted for rehab was two months, and that my husband would have to leave the hospital by the end July. At this point, his medical health had stabilized—but he required 24-hour care, long-term care. We were told that he wouldn't be able to go on a crisis waiting list for emergency long-term care placement unless he was discharged from the hospital. The alternative, we were told, was to transfer him to the second floor of the hospital, which is a lock-down floor; he'd receive no further therapy; he'd be put on the regular waiting list for long-term care placement (1-2 years). Hospital personnel advised against this option. And so my husband was discharged the first week of August.

After just a couple days of my husband being discharged, I was expected to do his PEG feed, his meds, operate the lift, and give injections—which was very frightening initially.

CCAC supplied home care but it wasn't sufficient—8 hours care/day for someone needing 24 hours care/day. After many phone calls made on our behalf by an agency under contract to CCAC, they gave us 16 hours care/day. Though this was positive, 41 different PSWs were sent over the 10-week period—which caused great distress for my husband, and stress for the entire family. Some of the PSWs were excellent, but many weren't knowledgeable enough on personal care or the English language.

The abrupt exit from hospital had negative effects on my husband's health. Over the 10-week period, my husband only had 4 physiotherapy visits—that's all that was allowed by CCAC. Due to the lack of physiotherapy, the gains that he'd made in hospital—stand and transfer, walk with help—diminished. Also, the bathroom in our apartment wasn't accessible. In hospital, he'd learned to transfer, with help, from bed to chair, but this wasn't possible at home. So all bowel movements had to be done in bed using a lift to transfer—which caused him great stress and anger, and raised his blood pressure.

And after the first month, the rental cost of the hospital bed, lift and sling was our responsibility, in addition to some supplies and prescriptions.

There are several things hospitals should be doing differently. If a patient needs to be on a crisis list for long-term care placement, the hospital should allow the patient to be put on the crisis list while still in hospital—not force the patient to leave the hospital first. Also, the hospital should give CCAC an accurate condition of the patient, so that CCAC can properly plan home care. Furthermore, the hospital should offer speech therapy for stroke victims who are on the rehab floor.

The Canada Health Act does not cover care in the "community," except with respect to primary care. Home care and long-term care are not guaranteed, entitlement-based programs, like acute or primary care. The health consequences of aging, then, affect Ontarians differently,

according to their means. In Ontario, residents may qualify for a limited amount of free home care, but it is not based on their need, and it is often insufficient.¹⁰⁹ This forces patients to depend on unpaid labour from family and friends, to pay out-of-pocket for extra care if they can afford it, or to suffer the consequences of insufficient care in the form of injury, death, rehospitalisation and institutionalization. Long-term care is subsidized by the Ministry of Health and Long-Term Care, but only partially. Residents of long-term care homes are generally required to pay approximately \$1,600 per month for basic accommodation.¹¹⁰ Wealthier residents can pay extra for private accommodation (which is also safer, since it includes a private washroom), or out-of-pocket for equivalent care at home or in retirement homes.

Local Health Integration Networks (LHINs) and Community Care Access Centres (CCACs) are the regional bodies responsible for coordinating patient care in their jurisdictions. In his 2010 review of hospital discharge practices, however, the Auditor General of Ontario notes: "At the time of our audit, no one, such as the Local Health Integration Networks (LHINs), the CCACs, or the hospitals, was ensuring that community-based services, including Home Care and Long-Term Care, were available when patients were ready to be discharged from hospital."¹¹¹ According to the Auditor General's report, there is no standard procedure for communicating a patient's discharge information with their subsequent care providers, either primary care, home care or long-term care.¹¹² This glaring hole in the health system likely results in many thousands of unnecessary readmissions to hospital.

In 2009, over 50,000 patients deemed Alternate Level of Care (ALC) waited in hospital due to delays in arranging post-discharge care, accounting for 16% of total patient days in all Ontario hospitals.¹¹³ Total days ALC patients were hospitalized increased by 75% between 2005/06 and 2009/10, while total hospital patient days increased by only 7%—reflecting the crisis in home care and long-term care.¹¹⁴

HOME CARE

"There was no primary nurse assigned to her, so what she was getting was like a revolving door."

My mother was admitted to the hospital September 1st 2010. She had a minor cut on her foot, like a paper cut. She'd gone to her family doctor who said, "It's incidental, don't worry about it." That night, she took off the bandage and blood started gushing out everywhere. She called to me from the bathroom: "Call 911, it's an emergency."

911 came and—I found out later—she'd lost two liters of blood. They took her to the hospital. She was there 48 hours. And then she was pushed out, without knowing what had happened. It was very, very rushed. Even though she'd lost two liters of blood—they had to give her a blood transfusion—there was no information. Was it a vein that burst? Was it an artery that burst? The answer to everything was: "Don't worry. Home care will come in; you'll get a home care nurse; the home care nurse will help with everything."

I found it really frustrating, this disconnect, this rhetoric—"Oh, don't worry, everything will be okay"—you know, this idea that we have a seamless system where you go straight from hospital to home care. It actually took from—I think it was September 4—was the earliest we got a home care nurse to come.

And when home care finally came in, they didn't have any information whatsoever, and my mom had to explain everything. There was no primary nurse assigned to her, so what she was getting was like a revolving door: one day, she would get one nurse, and then the next day, she'd get a different nurse, and then the third day, a third nurse—so none of the nurses really knew anything. And we couldn't plan anything. One day, the nurse came at 6:40am. The next day they nurse came at 11pm. And trying to find out what time the nurse was going to come each day—I was told, "Oh, don't worry about it, the nurse will give you a call 20 minutes beforehand." And we found that we just couldn't plan anything that way.

You know, to have such a traumatic event—to not even know what really happened—and then come home and have home care nurses who don't even know what happened either—I think that impacted upon the care that was received. My mother finally went to her family doctor afterwards, and asked, "Do you know what happened? Do you have any reports or anything at all?" And he had no idea that she'd even been in the hospital.

Before people are discharged, instead of saying, "Oh, don't worry, you'll get a call from a home care nurse," I think it would be really helpful if things were actually coordinated. For the CCAC coordinator to say, "Okay, here's the name of the agency," whatever the agency is, "and this is the primary nurse that's going to be coming; we've sent all the information so they know."

There are just too many layers. I mean, you're in hospital, so you're dealing with everything there, and then you have to deal with CCAC, and then they contract out their services. I find that frustrating, because not only do you have to deal with CCAC, whoever your case manager is, but also the external agency. They actually should be CCAC employees, because that way there's a bit more accountability. The way it is now with CCAC, you have one agency for personal care, another agency for nursing, another agency for PT or OT. It's just too much bureaucracy and too many layers to go through.

"They said that Mom was going to go home with all kinds of help. But within two weeks they wanted to cut back her hours."

My mom was admitted to hospital on May 24. She'd had a stroke and she went blind with the stroke. And within three days, the hospital wanted to send her home.

I hear stories all the time about the pressure that hospitals put on families, especially elderly people—and we felt the pressure. Every single day, they were calling us because they wanted to have another bloody meeting to try and find a solution, what to do with Mom. The first thing they wanted to do was to send Mom home with family. And we fought back. So they kept mom for about six, seven weeks.

We actually had to pay a co-payment. Now, Mom's on a fixed income—so her co-payment was a lot less than what some people are paying in hospital. I think it's disgusting that they're charging people. They said the reason they were charging Mom was that she was medically stable. Well, she wasn't medically stable—she had been having TIAs, and they were having problems with her blood pressure.

I just can't believe the pressure families are dealing with from the hospital—pushing families out, pushing elderly people out. It's like the hospital doesn't want them there. It felt like Mom being in hospital was a big burden to the hospital.

It was just pressure, pressure, pressure, to get Mom out. At one meeting, they said, "Look, we have to come up with another solution." And of course, their solution was a retirement home. Well, my mom is beyond a retirement home. And of course the home was for-profit, so we would've had to pay a lot of money for it—plus pay for private care on top of that—which is money my family doesn't have. And then, within two days of that meeting, they were calling my sister and I at home, saying, "Have you made a decision?" We got so upset with them. It was just pressure, pressure, pressure. The hospital put us under a great deal of stress. Finally, we couldn't take it anymore—my sister decided to move Mom in with her while we wait for a long-term care bed.

Now, we were told that Mom would go home with a lot of care through the Home First program—over and above 8 hours a day. We asked them to put it in writing. They would not put it in writing. And then, at another meeting, we were told, "No, your Mom will be getting 8 hours of care per day." And within two weeks of Mom getting the home care, they wanted to cut back her hours. And they wanted to do that over the phone! They didn't even want to come and do an assessment of Mom. The whole Home First program should be abolished. They promised all this help, said that Mom was going to go home with all kinds of help. But within two weeks they wanted to cut back her hours.

Home care services are designed to assist people in staying at home while ill or living with a disability as an alternative to going to hospital or a long-term care (LTC) facility. Increasingly, it is also used to assist patients recovering from surgery to do so at home, rather than in hospital. Home care is provided by personal support workers (PSWs), nurses, therapists and other health practitioners, through private for-profit and not-for-profit agencies. It is not covered by the Canada Health Act. However, most provinces provide some publicly insured home care. The distinction means that it is not entitlement-based—unlike walking into a hospital with an injury or illness where you are guaranteed to receive medical care (barring errors or violations of the

Canada Health Act), demonstrated need for home care does not equal receipt of that care. In Ontario, home care is coordinated by Community Care Access Centres (CCACs). CCACs determine eligibility for care based on several criteria, including whether family, friends, volunteers, domestic cleaners, grocery delivery services or others are able to provide care, and are forced to ration due to high demand that far outstrips CCAC funding.¹¹⁵ In 2010, in an attempt to force CCACs to implement cuts that would bring their expenditures into line with the deliberately inadequate funding, the Liberal government introduced Bill 46—the Broader Public Sector Accountability Act—making it an offence in law for CCACs to operate at a deficit. As a result, CCACs across the province have cut thousands of Ontarians’ key preventative healthcare and home support services.

In 2009, the most recent date for which information is available, there were 10,000 Ontarians on waiting lists for home care.¹¹⁶ Since 2004, per client spending has decreased from \$3,486 to \$3,001.¹¹⁷ This is because spending increases by the Ministry of Health have failed to keep pace with the demand for services. The result is that more clients now receive fewer free community health services.¹¹⁸ The 2012 budget allotted a 4% increase to home care funding, which is not enough to prevent per client funding from being further eroded, as the number of Ontarians requiring home care continues to grow much faster, at around 11% per year.¹¹⁹

In the 1990s, the Harris government instituted a competitive-bidding process in which private profit-seeking corporations were invited to compete for contracts against the non-profit service providers, and CCACs were prohibited from providing any services directly. The competitive-bidding system has been suspended since 2005 after charges that it favoured for-profit providers to the detriment of quality of care.¹²⁰ But for-profit companies abound—at present, the largest provider of CCAC-funded home care services is Paramed, a U.S.-based for-profit enterprise (Paramed is owned by Milwaukee-based Extencicare Inc.).¹²¹ After the introduction of competitive-bidding, and contrary to all government rhetoric to the contrary, home care costs actually increased substantially. One study found costs have increased by 75%, while service levels have decreased sharply.¹²²

LONG-TERM CARE

“It’s as though being a senior is a disease.”

My mother was admitted to Emergency on a Friday, for what appeared symptoms of a stroke. She was neglected in ER, left for three hours. We waited. Nobody did anything—no blood, no ECG, no nothing. When they finally did start doing stuff, they realized she had gone into cardiac arrest and that they’d lost three hours. She was taken into ICU. Now, she was 87 years old, and I had requested that I be called if there were any concerns about her. Instead, they chose to chemically and physically restrain her—and then two medications were contraindicated, and she went into a stroke, and we did not think she would make it.

Then, the hospital wanted her out. She had been living in a long-term care facility, and they wanted her sent back there within the first week. I refused. I mean, she was in no condition at that point—she couldn't walk, she couldn't swallow, she couldn't do anything.

"Your mother's not a priority." I was told that numerous times. Or, "Your mother's going to block the system, clog the system." That's why they immediately wanted her returned to the long-term care facility. And I said, "Absolutely not. Her level of care has changed, and I want her closer to me." But all they wanted—they wanted her out, they wanted her room. At one point, they threatened to charge \$1000/day if I didn't take her out.

She was in acute care for not even a month. And then she was bounced around to various hospital sites. And then she was transferred to a smaller site, where it becomes chronic care or alternate level of care, whatever they want to call it. We've been in this system for seven months. She's just recently gotten into a long-term care facility, but she just had another heart attack last night, so it's just an ongoing drama.

She was discriminated against because she came from long-term care. I was told that the reason she did not receive care in ER was because she'd come from a long-term care facility and had a DNR. She did not have a DNR. I had the paperwork with me. So there are some discrimination issues for seniors who are in long-term care; they're viewed differently. That has been my experience.

The way they treat seniors—it's as though being a senior is a disease in and of itself. She was denied access to services. She was denied access to a rehab program for her stroke. When I wanted rehab—when I wanted anything—I was told that my mother was not a priority. And I just said over and over, "She's a priority to me." And, I mean—with a stroke, you should get intervention immediately. But she was left in bed really, for five, six months, with very minimal care.

And so you become an advocate. And in turn, the hospital attacks you—they do. They discredit you. I mean, I have all of my mother's charts, and there's more in her charts about me than there is about her. I've done nothing wrong. I know my rights, and I exercise my rights. And they don't like people like me.

Long-term care doesn't offer much but I don't have any options. My mom doesn't walk now; she needs total care. I can't care for her at my home; I have a disabled daughter I care for. And having to make a decision between my mother and my daughter—it's literally been devastating, life-changing. My life will never be the same. I've lost so much.

"I think it was complete neglect."

My mother was admitted to the hospital with a chest infection. They kept her only two days, then sent her back to the nursing home. But she was still sick.

And then at the home, there was an outbreak of sickness; they said that we couldn't come to see her. And that was over a week or more. And by the time we were able to see her, she was still sick. And she just got worse.

Finally, she was rushed back to the hospital. Her sugar was out of whack; she had a really bad fever; her face was beet-red; she was yelling; she was all out of sorts. I met the doctor at Emergency. I said, "Oh my god. She's so sick." And he said, "Oh yeah." And I said, "Well, what's happening here?" And he said, "Well, it doesn't look good." And I said, "Really? I mean, what is happening here?!?" She lasted nine days. She didn't move; she didn't talk; she wasn't coherent. And then she died, of acute pneumonia. It was awful.

I blame the hospital and the home. To send her home after two days – she was 86 years old, chest full of infection – she wasn't anywhere near better.

And the nursing home... I think it was complete neglect. I don't think they gave her the antibiotics, or made sure she was getting liquids. She was so sick. And she was so dehydrated. On her tongue was all dried skin. I thought it was food on her tongue; it was a big hunk of dryness. It was horrible. And I said, "Oh my god. Nobody took care of her at the home." I mean, she was so sick. And the home was keeping her like that – so sick. It was horrible.

At first in the hospital, they were giving her the mask, the oxygen up the nose. And then the second and third day, they weren't. The nurses didn't even move her. You know, when you have pneumonia, you have to be put on your side so you can breath better. My mother, not once was on her side. She didn't even look like she changed positions for nine days. It was terrible.

Her last words were, "I can't breath." That really got me mad. Especially when here she is, in a hospital. My mother had nine children and 27 grandchildren. And she didn't deserve that. No, she didn't.

As of March 2012, there were about 32,000 Ontarians waiting for a long-term care (LTC) bed, including 19,000 not in a home and 13,000 who were already in an LTC facility but were waiting for a preferred facility (even this number of people waiting was reduced from a still higher number after the government simply narrowed those eligible for LTC through the new Long-Term Care Homes Act).¹²³

Long-term care is for elderly and disabled Ontarians for whom the other "caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to

meet the person's requirements."¹²⁴ Like home care, long-term care is not entitlement-based. There are a limited number of beds in private for-profit, not-for-profit and public institutions, with a wide spectrum of conditions and amenities, all requiring co-payments. Daily charges range from \$55-75 for basic to private accommodation.¹²⁵

As Jane Meadus, lawyer and institutional advocate at the Advocacy Centre for the Elderly (ACE) notes: "Hospitals often have policies requiring applicants to make one of the following so-called 'choices': accept the first available bed in any long-term care home; return home to wait for their home of choice; go to a retirement home to await their home of choice; or pay the 'daily rate' for the hospital bed."¹²⁶ All of these choices are income-dependent except the first one: accepting the first available bed, forcing low-income seniors to accept placement in the lowest-quality (highest vacancy) long-term care homes.

Ontario spends \$121 dollars less per person—or \$1.6 billion less gross—on long-term care than the rest of Canada, and it shows.¹²⁷ A 2001 study by PricewaterhouseCoopers found that residents in Ontario LTC facilities receive less nursing, aide and therapy care than in the majority of comparators (including other jurisdictions in Canada, the United States, and Europe).¹²⁸ The same study found that only 10% of residents of Ontario LTC facilities who could benefit from rehabilitation actually received it.¹²⁹ A far higher proportion of Ontario LTC residents—60%—were considered to have behaviour problems versus comparators, with the majority of other jurisdictions well below 50%.¹³⁰ Ontario LTC and Complex Continuing Care (CCC) facilities have relatively high rates of use of restraints.¹³¹ Ontario LTC facilities have the fewest nursing hours per resident per day (2.04) of any jurisdiction examined, far behind residents of Saskatchewan (3.06), Mississippi (4.2) and Maine (4.4).¹³²

In 2009/10, 46% of LTC homes in Ontario were for-profit, but for-profit facilities accounted for 53% of all LTC beds.¹³³ This has increased steadily over the past two decades, from a low of 43% in 1990/91.¹³⁴ Ontario's proportion of residents living in for-profit facilities is much higher than the Canadian average (40%) and is in fact more than any other province with the exception of Newfoundland (56%).¹³⁵ Long-term care facilities in Ontario have become the most expensive in the country, costing nearly twice as much as long-term care in Alberta, British Columbia, Manitoba, Saskatchewan and Quebec.¹³⁶

In Ontario, for-profit nursing homes receive 1.5 to 2.5 times more complaints than public and not-for-profit nursing homes.¹³⁷ A study in BMJ found that on average, not-for-profit homes deliver higher quality care than for-profit homes.¹³⁸ For-profit homes had higher patient-to-staff ratios than not-for-profit homes, resulting in a higher incidence of pressure ulcers (bed sores).¹³⁹ They estimated that if all long-term care homes were not-for-profit, there would be 42,000 more hours of nursing care and 600 fewer bed sores in Canada per year.¹⁴⁰

ALTERNATE LEVEL OF CARE (ALC)

"The hospital and the nursing home charged for the very same day."

My brother-in-law had a brain tumour. He had it operated on about a year and a half ago. Well, he was having falls and everything. So he was taken into hospital on the 14th of May. And on the 18th, the doctor signed the papers for him to go home the next day with palliative care.

But my sister couldn't have him home. She lives in a small one-bedroom apartment. She uses a walker. And his falls put him in a wheelchair. So there was just no room. On top of that, he was in no condition to come home. In fact, not a week after the doctor said he could come home, his condition was upgraded to two-person help, where they were to use a lift.

And the care while he was in hospital... He had a couple of falls while he was in there. They told her that. He was never dressed even though his clothes were there. His hind end was really sore from laying and not being turned. And my sister asked that his food be cut because he was paralyzed on the right side. They didn't do that half the time. And within only a couple of weeks, he ended up—he could hardly speak. At one point, my sister asked if she could have the nurse's report, to know what was going on. They told her it would cost \$100. She asked if he could go to the rehab wing, and they said no, that wasn't an option.

Because the doctor said he could come home, the hospital started charging him. They charged him from May 19th to June 21st, which is the day he went into the nursing home. It was a total of \$1809.82, which is not paid yet. She's in turmoil, money-wise—she can't afford it. She says, "If I don't pay my rent, they're going to put me out."

And then the nursing home also charged him from the day he went in—June 21st—so both the hospital and nursing home charged for the very same day.

"Most of them could walk before they were sent down to this floor—and now they're all bedridden."

I took my father to Emergency because his foot was really infected. They sent him home. But he could hardly walk on his foot. So when I was bringing him into the house, I was holding his arm, but he fell over and smashed his head on the front porch. I had to call the ambulance. They took him back to the hospital, and the hospital stitched up his head and then sent him home again.

I had nurses coming to the house to check on Dad's foot. It was one of the nurses who finally phoned our family doctor. I had been taking Dad to the doctor once a week for the foot infection; the doctor was just giving Dad antibiotics which weren't doing anything. So finally, after the nurse phoned our doctor, Dad was admitted into hospital—ten days after our initial visit to Emergency and Dad's fall. He was admitted to

the hospital, but he was stuck in Emergency for about five days before they could get a bed for him.

It turned into a ten-month hospital stay. He passed away in there; he never came home.

Ten days after he was admitted, they sent him for a CT angiogram which showed that he had a blockage in his veins so there was no blood flow going through to his foot. Then, it took another week before they could get a specialist to operate. After the operation, Dad's big toe was still infected, and two other toes turned black. They finally brought in an orthopaedic surgeon, who amputated the two black toes—but left the big toe which was still infected, and which should have been removed.

After that, he was sent down to a floor where it's more like a nursing home. The care on that floor is very poor; the patients get no care. They're just totally neglected. Most of the patients had been receiving physiotherapy and such, before they got sent down to this floor—and when they get sent to this floor, they're just left in their beds, no physical activity at all. Most of them could walk before they were sent down to this floor—and now they're all bedridden. That's what happened to my father. After his operation, nobody ever got him out of bed. I know; I was there seven hours a day, seven days a week.

And as soon as Dad got sent down to that floor, the hospital started charging him. But we have no money. In the end, the hospital sent us a bill for \$7,000. We still haven't paid it; we don't have the money to pay it.

Dad should never have been sent down to that floor. He had five operations while he was in there! All the other patients on that floor were just waiting to go into nursing homes; Dad was supposed to come home. I kept asking, trying to find out who it is that gives the order to have somebody sent from one floor to another. I got the run-around. No one would give me a straight answer. I phoned the Ministry of Health and they said they had no regulations over what happened on that floor, because it was not an acute-care floor. There were two nurses for the whole floor and most of the people have to be fed and stuff. So there just wasn't enough help on this floor.

Every single day, I was asking about his foot. Because after the two black toes were amputated, his big toe went from bad to worse—to the point where the tendon was showing, then the bone. It took me four months to get a doctor to look at it. Finally, they removed the big toe. His foot looked like it was bruised on both sides just below the toes. The doctor said, "I'm going to leave it for a week and see how it heals."

But the bruising part was actually turning black. So then they had to amputate his leg just above the knee. And then he was okay for a few months. And then he just passed

away in September. He was walking when he went into the hospital; he had an infected foot but he was otherwise okay. The hospital let his condition go on too long.

On July 1, 2009, all acute and post-acute hospitals in Ontario began using a standardized Provincial Alternate Level of Care (ALC) Definition: "When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate."¹⁴¹ These patients are also disparagingly known as "bed-blockers," as if it's their fault that they are in hospital with nowhere to go.

With 32,000 patients waiting for long-term care beds,¹⁴² and 10,000 waiting for home care,¹⁴³ patients whose conditions are no longer acute but who still require some level of care have no choice but to wait in hospital. Instead of increasing access to long-term care and home care in Ontario, which would immediately resolve the ALC problem, the Health Ministry has instead authorized hospitals to penalize ALC patients. For every day a patient spends in hospital under an ALC designation, they are to be charged the maximum basic daily rate for long-term care accommodation.¹⁴⁴ When patients refuse to be transferred to the first available LTC bed—no matter if it's located far from loved ones or spouses or if it has a horrible quality rating—hospitals have tried to charge patients outrageous amounts, ranging up to \$1,800/day in some cases.¹⁴⁵ Only when public anger boiled over did the government make some efforts to limit the charges to the maximum allowed by law (up to \$55.04 per day), but there are still reports of abuse.¹⁴⁶

In 2009, over 50,000 ALC patients waited in hospital due to delays in arranging post-discharge care, accounting for 16% of total patient days in all Ontario hospitals.¹⁴⁷ Total days ALC patients were hospitalized increased by 75% between 2005/06 and 2009/10, while total hospital patient days increased only 7%—reflecting the crisis in home care and long-term care.¹⁴⁸

The Auditor General of Ontario's 2010 review of hospital discharge practices revealed that ALC patients often resist placement in the first available long-term care beds.¹⁴⁹ According to the report, patients refuse placement in higher vacancy institutions for reasons of:

- Distance: patients prefer to be in long-term care homes in or near their own communities to facilitate visits by elderly spouses and other loved ones.¹⁵⁰
- Quality: of all institutions refused by patients on wait-lists, almost all were older facilities where basic accommodations meant four-to-a-room/shared bathroom, as opposed to two-to-a-room/bathroom in newer facilities (crowding four patients to a room with only one bathroom is a known risk factor for transmission of superbugs like *C. difficile*, which can be deadly).¹⁵¹
- Performance: 60% of rejected vacancies were in homes that had failed five or more provincial standards (double the provincial average rate of failure).¹⁵²

As the number of quality long-term care beds per population shrinks and the number of ALC patients increases, so do the risks for these patients. A study in *Open Medicine* found that a high proportion of ALC patients were at especially high risk of readmission.¹⁵³ In addition, the study found that for ALC patients, the frequency of death during readmission was 18%!¹⁵⁴ In other words, being designated ALC could actually kill you.

MENTAL HEALTH: DIAGNOSTIC INFLATION, SOARING PROFITS

“We have the facility, but we don’t have the people to staff it.”

My granddaughter has a mental illness. She’s been in a series of residential homes since she was twelve years old. And, you know, lived in a family unit there, with support workers and other kids. So for the last six years, she’s been sort of protected. Well, she just turned eighteen; she lives in her own apartment.

Recently, she was in crisis. She wasn’t eating; she wasn’t taking care of herself. She was in a really bad way. My daughter said, “Mom, I think if she’d been there another day or two, she’d be dead.”

Well, the hospital—they just get them back on their medication. My granddaughter hadn’t been taking her meds. So the hospital gets you back on your meds—you know, three or four doses or whatever, a day’s worth of medication. They give you three meals and, you know, a shower. And then they say, “You’re good to go home.”

Well, no, I don’t think so. Imagine you’re desperately ill, with pneumonia or whatever—so ill that someone says, “There’s no doubt in my mind that had you been left in that state another day or two, you would have been dead”—and then the hospital keeps you just 24 hours? It’s not good. It’s not right.

On top of that, we’d asked the hospital to call us before her release, so that we could bring her to our house until she was stable, or in the very least, have someone check on her. But the hospital didn’t do that. They got her a taxi and she was sent home to her apartment by herself. In fact, I called the hospital and they said, “Oh, she’s not here. She’s been discharged.” I said, “Pardon?” No one was advised. That’s not right. My granddaughter functions like a twelve-year-old child. And at the time, she was definitely not well. The hospital should have notified us before she was discharged. I’m not happy. I’m not happy with the way things went.

The mental health unit has been up and running for just awhile—they have the beds, but they don’t have the staff. And so any time my granddaughter has had a crisis, we’ve had to go to the larger hospital a few cities over. I don’t think that’s fair, when we’re paying the tax dollars and you know, they’re looking for support locally. We have the facility, but we don’t have people to staff it. It’s not acceptable for the people who really need care.

I work for City Police doing dispatch. We spend many hours at the hospital with people who have mental illness. We pick them up for whatever reason. They're formed and arrested under the Mental Health Act and taken to hospital. And you know what happens.

They need to modernize the way they handle mentally ill people. There has to be more money coming into the system. There has to be a better protocol. And certainly, how much effort does it take to raise the telephone, dial a number, and inform family that someone is being discharged?

"The pharmaceutical corporations—not the patients—get the priority treatment."

I went to the hospital of my own volition due to health concerns. I was labelled with psychiatric problems when in fact, I had a physical problem. Because of this misdiagnosis, I was given treatments that I didn't need—including years of drugs, pharmaceutical drugs, psychiatric drugs—and I have had to deal with a number of labels and a lot of abuse from physicians.

When I questioned what they were doing, I was made to feel very unwelcome. I said, "I've been coming here since the early 1990s. It's now fifteen years later and you still don't have my medical records right, and you still haven't made a correct diagnosis. What are you doing?" I said, "You kept me sick and on medications I didn't need and kept me from good health. I almost lost my life because of you." No one said, "We're so sorry. We will put you right after all these years." Instead, I was told to talk to patient relations. And patient relations said, "If you want to talk to us, you'll need to bring a lawyer. If you have a complaint, we will have our lawyers here."

There's no accountability and the level of care is extremely poor. What happened to me wouldn't have happened in a veterinarian's office. If I brought a pet bird to my vet and said, "Here are the problems my pet is having," the vet would say, "Hmm, this problem, this problem"—not, "Oh, your pet has a psychiatric problem and needs psychiatric drugs." Part of my body was missing. A part that was about as big as my thumb in my throat. It was missing. And because the doctors missed it, they did untold damage to me. A veterinarian would have said, "Oh my goodness. Your bird is missing part of her body. That's why she's cold all the time. She's molting her feathers. She's depressed. Here's a remedy." A remedy that is so simple. Instead, these smart doctors wasted not only my life but hundreds of thousands of tax payers' dollars on doctors salaries for services through OHIP that were inappropriate, for medical tests that weren't needed, for a brain scan. A brain scan! The problem was not in my brain. I think it was in somebody else's. We have a medical system that knows nothing about health, and arrogant doctors who know nothing about diagnosis.

This entire experience has been hideous, disastrous. It cost me my career. I was completely disabled because of their care. Meanwhile, they're collecting multi-million dollar grants for projects funded by big pharmaceutical corporations, and the pharmaceutical corporations—not the patients—get the priority treatment. The pharmaceutical companies with the money are important, not the patient. So I had to say, "If you're not going to pay attention to your patients, why do you have a hospital at all?"

Allen Frances edited the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (known as the DSM-IV)—the standard classification of mental disorders used by mental health practitioners in the United States. He has since become a vocal critic of what he and others have called "diagnostic inflation"—the exponential growth of people being diagnosed with mental illness, and the corresponding explosion in prescription of psychotropic drugs.¹⁵⁵ Frances cites studies showing that the number of Americans who experienced at least one episode of a DSM-defined disorder during their lifetime jumped from 32% in the 1980s to nearly 50% in 2003.¹⁵⁶ Frances claims that this enormous expansion of mental health diagnoses is due in large part to "the aggressive marketing strategies of drug companies."¹⁵⁷

Looking at drug sales in Canada and Ontario would appear to bear out Frances' concerns. Neurological drugs have been growing at record rates in Canada. Spending on anti-psych drugs in Canada grew on average 12% per year between 1998 and 2007 after adjusting for inflation and population.¹⁵⁸ In Ontario, spending on anti-psych drugs grew even faster, at 14% per year over the same period.¹⁵⁹ The volume of anti-psych drugs purchased in Ontario over this period grew faster (7.3% per year) than any other province.¹⁶⁰

Antidepressants grew more slowly (3.4% per year) over this period, which suggests that the market for antidepressants is saturated after explosive growth in the preceding two decades—from 1980 to 2000 antidepressants grew 353%, or 17% per year on average.¹⁶¹ By 2005, nearly 6% of all Canadians were taking antidepressants, according to a University of Calgary study.¹⁶²

With the adult antidepressant market at near-saturation, drug companies are focussing more and more on child neurological drugs, such as Risperidone. Manufactured by Johnson & Johnson, Risperidone is prescribed for child bipolar disorder. In 2008, Dr. Joseph Biederman—widely considered the U.S. expert on childhood bipolar disorder—was accused of conflict of interest after publication of an internal memo in which Dr. Biederman agreed to "move forward the commercial goals of J&J."¹⁶³

The elderly represent another growth market for drug companies. Without money for adequate staffing in long-term care facilities, drugs are becoming almost the only form of therapy employed. A 2001 study by PricewaterhouseCoopers commissioned by the Ministry of Health found that "less than 6% of Ontario LTC residents had any intervention related to evaluation of 'talk' therapies while 31% received an antipsychotic or restraint."¹⁶⁴ According to the study, the highest rate of use of chemical restraints was in Ontario.¹⁶⁵ Cholinesterase inhibitors, used to

treat symptoms of dementia, increased 26% per year in Ontario between 1998-2007.¹⁶⁶ Increase in the volume of prescriptions accounted almost entirely for this rapid expansion.¹⁶⁷ The growth in the volume of sales for these drugs was higher in Ontario than any other province.¹⁶⁸

Drugs are a for-profit wild west within the Canadian healthcare system. Most Canadians must pay for their drugs either through private insurance, or out-of-pocket. But even when government pays, it pays through the nose—fuelling enormous profits for pharmaceutical companies. In 2011, while we were being told that healthcare spending is unsustainable and cleaners and nurses had better take wage cuts, the two highest paid CEOs in the United States were from the pharmaceutical industry, making \$145.3 million (McKesson Corporation) and \$98.3 million (Omnicare), respectively.¹⁶⁹ If either the Harper or McGuinty governments were seriously concerned about reigning in healthcare spending, they would do more to slow drug costs. Canada has the second-highest per capita drug expenditure of any OECD country, second only to the United States, and Ontario spends another \$60 more per person on drugs than the rest of Canada.¹⁷⁰ Canada has the third-most expensive patented drug prices in the world (behind only the United States and Germany), and the second-most expensive generics (twice as much as in the United States, on average).¹⁷¹ Between 1998 and 2008, drug spending grew 10.1% per year, while general inflation was just 2.6%, and in spite of the fact that overall drug prices actually declined 2.7% (as a result of expired patents).¹⁷²

Canadians rely on private funding for drugs (out-of-pocket or private insurance) more so than citizens of any other OECD country save the United States.¹⁷³ Ontarians rely on private funding for drugs more so than the Canadian average.¹⁷⁴ Between 1985 and 2009, the share of drugs in Ontario's total health expenditure jumped from 10.3% to 16.2%.¹⁷⁵ A universal national Pharmacare plan in Canada could save \$10.7 billion annually, by removing tax subsidies to employers who cover their employees privately, lowering Canadian drug prices for patented and generic drugs, and with savings from increased efficiency.¹⁷⁶ This efficiency would come largely from eliminating the unnecessary and costly overhead from private drug plans (by eliminating the need for private plans). Canadian public drug plans have 1.3% overhead, compared with 13% overhead for private insurance plans.¹⁷⁷ Despite all of the chicken-little talk of the healthcare sustainability crisis, Pharmacare is not even on the political agenda.

Not only are Canadians, and Ontarians in particular, lining the pockets of Big Pharma, we are potentially being exposed to unsafe treatments in the interest of protecting profits. Two 2012 investigations by the Toronto Star revealed that Health Canada has been gutted of the capacity to do one of its most important jobs: regulate the drug industry. The first Star investigation discovered that ADHD drugs have been linked to horrific side-effects—including suicide—in children as young as six years of age.¹⁷⁸ The second Star investigation uncovered a disturbing pattern of suicides among otherwise healthy individuals taking the smoking-cessation drug Champix.¹⁷⁹ In both cases, Health Canada appears to have sat on adverse-event reports filed by nurses, physicians and pharmacists—putting Canadians at continued risk from these drugs.

Create a Problem to Fit the Solution

Finance ministers habitually cry wolf about healthcare expenditures. Take, for example, Jim Flaherty from the 2002 budget: "When we look ahead five short years, we could see health care consuming 60 cents of every dollar we are spending on programs."¹⁸⁰ Five years later, healthcare accounted for 41% of program spending.¹⁸¹ And here's Dwight Duncan from the 2011 budget: "Just 20 years ago, 32 cents of every dollar spent on government programs were spent on healthcare. Today, it is 46 cents. In 12 years, if we don't take action, it could be 70 cents."¹⁸² As Toronto Star columnist Carol Goar pointed out at the height of the health-care-sustainability hysteria in the lead-up to the 2012 budget, however, healthcare as a percentage of total government spending had actually decreased since Duncan's doomsday speech, from 46% to 42%.¹⁸³

TAX CUTS

What's the real "pac-man" eating up the budget? Over the past three decades, the federal and provincial governments have slashed taxes, especially for corporations and the very rich. Ontario's richest are now taxed less than at any time since before the Great Depression.¹⁸⁴ As a result, the richest 1% of Ontarians doubled their incomes over the past 30 years, while the incomes of middle-class Ontarians have not changed at all, and poor Ontarians are more than 20% poorer.¹⁸⁵ This represents a direct transfer of over \$30 billion since 1982 from the poorest Ontarians to the richest 1%.¹⁸⁶

Economist Hugh Mackenzie estimates that Ontario's annual tax revenue has been depleted by over \$16 billion as a result of tax cuts in the 1990s and 2000s by the Harris, Eves and McGuinty governments.¹⁸⁷ Without these tax cuts, Ontario would have no deficit, and would in fact have billions of dollars in surplus to spend on improving social programs and services every year. A December 2011 Angus Reid poll revealed that 82% of Ontarians support increasing taxes on incomes over \$300,000.¹⁸⁸ An extra 5% tax on the incomes of the richest 5% of Ontarians, and a 15% tax on the incomes of the richest 1% of Ontarians, would generate approximately \$10 billion per year in new revenue.¹⁸⁹ The 2% surtax on the 23,000 Ontarians with incomes over \$500,000 added by the NDP in the 2012 Liberal budget generates just \$470 million.¹⁹⁰

PRIVATIZATION

Rather than tackle the private for-profit causes of soaring healthcare costs—drugs, equipment and doctors' fees—the McGuinty government is instead moving to expand the role of for-profit players in the province's healthcare system. Despite the scandals of privatized health delivery (ORNGE) and data collection (E-Health), the Liberal government has remained committed to privatization.

One of the biggest ways that healthcare is being privatized in Ontario is also one of the stealthiest (and fuzzy-sounding): moving care from hospital into “the community.”¹⁹¹ “Community-care” most often refers to home care and long-term care, neither of which are entitlement-based, and both of which include private funding (out-of-pocket and private insurance) and private delivery (for-profit nursing homes, for-profit home care providers).

Privatization increases costs and reduces quality of care. Those who seek to profit from the privatization of healthcare in Canada claim there is no other choice, because healthcare spending has become unsustainable.¹⁹² In fact, the reverse is true: privatization has damaged the sustainability of healthcare by driving up costs, much of which goes towards the profits of private firms, while reducing quality.

Privatizers advocate for increasing private delivery of healthcare, while maintaining (for now) public funding. Popular perceptions to the contrary, the United States represents an excellent case-study of a publicly funded, privately delivered healthcare system. The United States has the highest public per capita healthcare spending in the OECD.¹⁹³ There, 60% of healthcare spending is public—just 10% less than Canada—yet a high proportion of care in the United States is delivered by for-profit private firms.¹⁹⁴ The experience of the United Kingdom is also relevant to Canada, as the United Kingdom has a national entitlement-based healthcare system with steadily increasing for-profit delivery.

The result is more expensive and less effective care. Private for-profit hospitals in the United States are 19% more expensive than not-for-profit hospitals.¹⁹⁵ Australian private for-profit hospitals are 9% more expensive than public hospitals.¹⁹⁶ Private health providers in the United Kingdom cost 12% more than public providers.¹⁹⁷ Administrative costs consume 31% of healthcare spending in the United States, compared to 16.7% in Canada.¹⁹⁸ U.S. Medicare patients whose care has been outsourced to for-profit health maintenance organizations (HMOs) cost 12% more than comparable patients served by Medicare.¹⁹⁹ Privatization in England has caused administrative costs to double, and they are projected to more than double again as the private market share of healthcare increases.²⁰⁰ Private surgery clinics in the United Kingdom are paid for thousands of operations they never provide, costing the taxpayers between £200-927 million.²⁰¹ Since the privatization of long-term care facilities in Ontario, these facilities have become the most expensive in the country, costing nearly twice as much as long-term care in Alberta, British Columbia, Manitoba, Saskatchewan and Quebec.²⁰² Private laboratories are significantly more expensive than public and not-for-profit hospital labs. Vitamin D tests cost over \$90 at private labs in British Columbia, \$52 at private labs in Ontario, \$32 in Ontario hospitals, and just \$17 at Saskatchewan’s government lab.²⁰³ After contracting-out community lab services to for-profit companies, for-profit labs were paid 75% more for the same tests that had previously been provided by the Hospitals In-Common Laboratory for the preceding 30 years.²⁰⁴ After privatization, home care costs have increased substantially—in one reported case, by 75%—while service levels have decreased sharply.²⁰⁵ Why are private firms so much less efficient? They are diverting billions of dollars to profit: in 2010, four of the ten highest paid CEOs in the United States were from the healthcare industry.²⁰⁶

In addition to costing taxpayers more money, for-profit care is also lower quality. In Ontario, for-profit nursing homes receive 1.5 to 2.5 times more complaints than public and not-for-profit nursing homes.²⁰⁷ In the United States, hemodialysis patients at for-profit centres have 8% higher mortality rates than those at not-for-profit centres, while for-profit hospitals have 2% higher mortality than not-for-profit hospitals.²⁰⁸ Increasing privatization in the United Kingdom's National Health Service (NHS) has escalated wait times by 40%.²⁰⁹ As a result of privatization, competing clinics have the perverse incentive to increase wait times as a cost saving measure, because the longer patients wait, the more likely they will "remove themselves" from the waiting list, either by dying or paying out-of-pocket at private clinics outside the NHS.²¹⁰ Since privatization of long-term care under the Harris government, Ontario residents of long-term care facilities receive less nursing care, substantially less physical therapy, are more frequently physically restrained, and are more depressed than major comparators (including Saskatchewan, Manitoba, Michigan, Mississippi, Maine, South Dakota, Sweden, Finland, and the Netherlands).²¹¹ Home care services have deteriorated substantially in quality, quantity and continuity.²¹²

Solutions for a Better Healthcare System:

- **Give the frail and elderly the in-hospital care and therapies they require.** Reopen chronic and alternative level of care beds in hospitals so that frail patients with chronic conditions, those who need convalescent care, or who have suffered a stroke get the in-hospital restorative care and therapy they need.
- **Funds must be reinvested in hospitals so that critical speech-language pathology services can be provided to patients** and delivered in a timely fashion before they leave hospital.
- **Improve access to speech language pathologist services in home care.** This would ensure that patients who are discharged from hospitals, but who require rehabilitation type supports get them. Currently, most therapy services, including speech language pathology services, have seen decreases in referral rates through the Community Care Access Centres (CCACs)
- **Funding for healthcare should grow in real terms and keep pace with population growth.** This could be achieved by establishing a reasonable expectation for hospital productivity improvements (e.g. 0.75% efficiency improvements per year) and then funding hospitals based on the required efficiency improvements along with funding for population growth, aging, inflation, and increased utilization. In the current situation, this will lead to significantly more funding than is currently provided, but will also prevent the current decline in healthcare from deepening.
- **Put funding into care, not profit** by moving away from private for-profit delivery of home care, long-term care and pharmaceuticals. End competitive bidding in home care and return to a not-for-profit system. Today 75 per cent of home care service providers are for-profit. Since competition and for-profit were introduced in the late 1990's, billions of dollars in public funding has been siphoned into profit and away from care.
- **No rationing of care.** Give those who need home care, therapies and services in the community the care hours they need, without being charged user fees.
- **Improve the quality of home care supports.** To ensure continuity of care, standardize care quality and stabilize high staff turnover rates; personal support workers (PSWs) should be paid at institutional wage rates, have guaranteed hours of work and receive benefits and pensions.
- **Develop community hospitals as a hub for a range of healthcare services.** This includes acute care, outpatient care, rehabilitation, complex continuing care, primary care, and long-term care services. A hospital hub model of care will promote the

true integration of our healthcare system, allow economies of scale to be achieved, and ensure that community hospitals are able to attract the range of human expertise required.

- **Reduce hospital bed occupancy to 80% or less as is the case in other countries.** This will reduce (a) hospital “crisis designations,” (b) the cancellation of surgeries, (c) back-ups in the emergency rooms, (d) ambulance offload delays and “code reds,” and (e) extra EMS costs for municipalities. This will also improve community access to long-term care homes and limit re-admission to hospital.
- **Assess and restore beds in hospitals should be increased.** These less costly post-acute beds are designed to allow patients to recover enough so that they can return home (with the assistance of adequate home care). In contrast, long-term care facilities are *residences* where people live permanently; they are not curative facilities designed to transition people back to home.
- **Increase the development of new not-for-profit long-term care beds so frail and elderly people who need 24-7 residential care, receive it at a nursing home.** The increase in long-term care bed capacity would not be a permanent, on-going need. Rather this increase in beds would be finite in order to deal with the care needs of ageing baby boomers.
- **Increase hospital restorative/rehabilitation professions and nursing care staffing levels to Canada-wide standards.** Data shows Ontario patients receive 6.1 hours less care than patients in other Canadian provinces.
- **Make hospitals safer for patients by reducing infection.** Hospital acquired infections cost more to treat than they do to prevent. Investing in increased cleaning and individual patient bathrooms would save lives, curb infections from spreading and save the health system money.

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⁸ Ibid.

⁹ Ibid.

¹⁰ Calculation by authors based on data from: Ontario Hospital Association (OHA). (n. d.). Average Number of Inpatients on Any Given Day, Ontario, 2010. *Health System Facts*. Available at http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Average+Number+of+Inpatients+on+Any+Given+Day+Ontario; Ontario Hospital Association (OHA). (n. d.). Beds Staffed and in Operation, Ontario, 1990 to 2010. *Health System Facts*. Available at http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large

¹¹ Calculation by authors based on data request to Ontario Ministry of Health and Long-Term Care, Health Analytics Branch.

¹² Auditor General of Ontario. (2010). Home Care Services. In *2010 Annual Report of the Office of the Auditor General of Ontario* (chapter 3, section 3.04, 113-31), 113. Retrieved from http://www.auditor.on.ca/en/reports_en/en10/304en10.pdf

¹³ Ibid.

¹⁴ Ibid., 122.

¹⁵ Auditor General of Ontario. (2012). Long-Term-Care Home Placement Process. In *2012 Annual Report of the Office of the Auditor General of Ontario* (chapter 3, section 3.08, 185-204), 191. Retrieved from http://www.auditor.on.ca/en/reports_en/en12/308en12.pdf

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