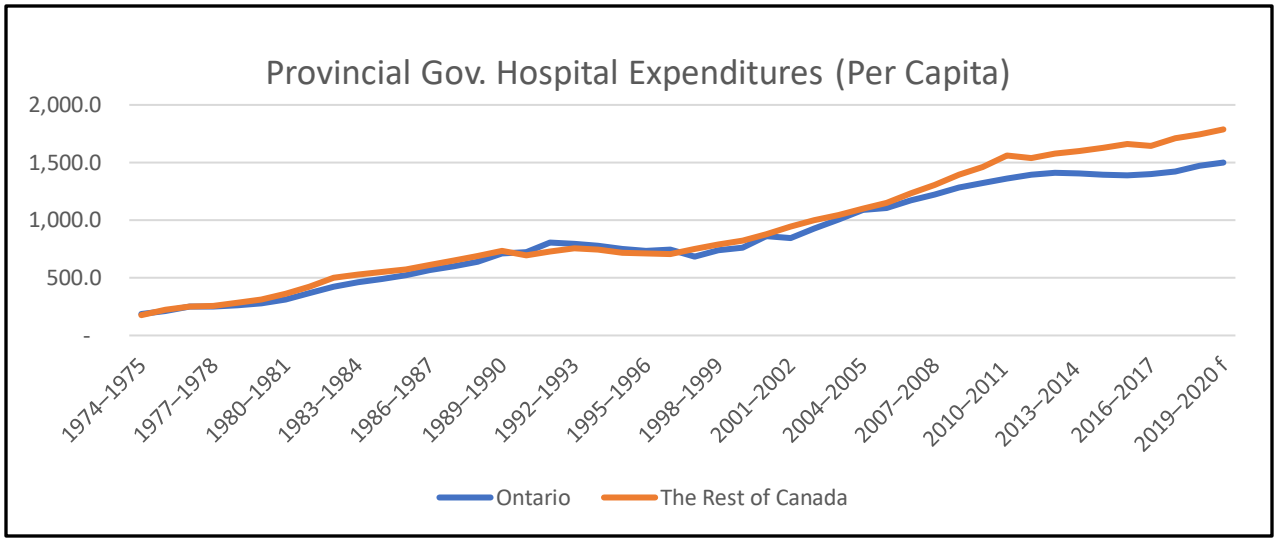
Pre-Budget Submission
to the
Standing Committee on Finance and Economic Affairs of the
Ontario Legislative Assembly
from the
Service Employees International Unions Healthcare
and the
Ontario Council of Hospital Unions/CUPE

26January2022

The Service Employees International Union (SEIU Healthcare) and the Ontario Council of Hospital Unions (OCHU/CUPE) represent 70,000 hospital employees in Ontario. As in previous rounds, we are jointly bargaining a central collective agreement with Ontario Hospitals through their representative the Ontario Hospital Association. We would like to flag two issues relevant to the Budget which are also impacting on our collective bargaining.

[1] Hospital Funding



After decades of a close relationship between provincial government hospital funding in the rest of Canada and in Ontario, Ontario began to fall behind around 2004/5.

The result of this underfunding is predictable: fewer staff, fewer beds than the rest of Canada, far fewer beds than other developed countries, extraordinarily high levels of bed occupancy, very short lengths of stay, a low level of patients treated in hospitals, higher than average levels of readmissions, dramatically rising acuity of patients receiving home care, the removal of less sick patients from home care service, and the exhaustion of unpaid family caregivers. In other words, all the factors that led to the hallway health care crisis and put Ontario in a delicate position when COVID-19 struck.

Much of the post-COVID period has been focused on preserving hospital capacity, first during the early days when residents were not transferred out of long-term care homes to hospitals, then again when ICU usage went up close to 900 per day in April and May of 2021, and now with high hospital bed usage over 4,000 during Omicron. Hundreds of thousands of surgeries and procedures have been postponed. This is one of the costs of running a hospital system near the edge – you cannot simply conjure up extra hospital capacity on command.

Given this lack of capacity, what is appropriate funding? In the past, many proposed that to *maintain* existing services funding would have to be increased to offset: [1] inflation, [2] population growth, and [3] societal aging. These factors alone require significant funding increases, but they are not completely sufficient now for several reasons:

- Even before COVID, Ontario was experiencing "hallway healthcare" due to a lack of hospital capacity, as the current government has recognized.
- COVID has further revealed the problems associated with a lack of capacity and running the system on the edge. When a surge comes (COVID or otherwise), the hospital system cracks as capacity cannot be instantly created. So simply maintaining existing capacity is not enough.
- Inflation over the last year has shot up leaving previous forecasts for its impact on hospital requirements behind. So, for example, as of December 2021, the CPI was 5.2% higher than a year earlier in Ontario. It is quite possible higher inflation will continue for some time.
- Postponed surgeries and procedures will have to be done at some point. After the first set of hospital closures, the Financial Accountability Office estimated a total cost of $1.3 billion to complete the catchup over 3.5 years. The situation is presumably more acute now, given the second round of COVID closures.
- The province appears to favour living with COVID rather than adopting COVID Zero policies. But this will come at some cost. So, for example, if 20% of the population is infected annually and one in one hundred of those individuals are hospitalized that will create an additional 30,000 hospital inpatients (mostly during the flu season). The Canadian Institute for Health Information (CIHI) reported in June of 2021, that the cost of treating a patient in hospital for COVID was $22,000. If there are 30,000 COVID inpatients per year, that would mean an additional cost of $660 million per year.

We believe a more appropriate metric would be to return Ontario hospital funding to the average of the rest of Canada.

To its credit, the government did improve funding in 2020 with a 6.4% per capita funding increase, according to CIHI data. Ontario did less well in 2021. Still, as of 2021, we are a little closer to the average funding in the rest of Canada than we were in 2019, prior to COVID.

Provincial funding of hospitals (CIHI National Health Expenditure Trends Appendix D1). Ontario and the rest of Canada (TROC)														
Province	ON	NFLD	PEI	NS	NB	Que.	Man	Sask	Alta	BC	YT	NWT	Nun	TROC Ave.
2021	1,702.78	2,528.88	2,165.71	2,352.74	2,033.71	1,757.16	1,864.21	1,900.25	1,957.26	1,802.64	2,760.29	6,696.60	7,413.26	2,040.29
Share of TROC pop.		0.022121	0.006882	0.041812	0.033362	0.367025	0.0593261	0.050885	0.1918959	0.221272	0.001802	0.001926	0.001691	1
2021 $ Contribution to TROC		55.94	14.91	98.37	67.85	644.92	110.60	96.69	375.59	398.87	4.97	12.90	12.54	1894.15
											TROC per capita hospital funding			1894.15
											TROC/Ontario hospital funding			111.24%

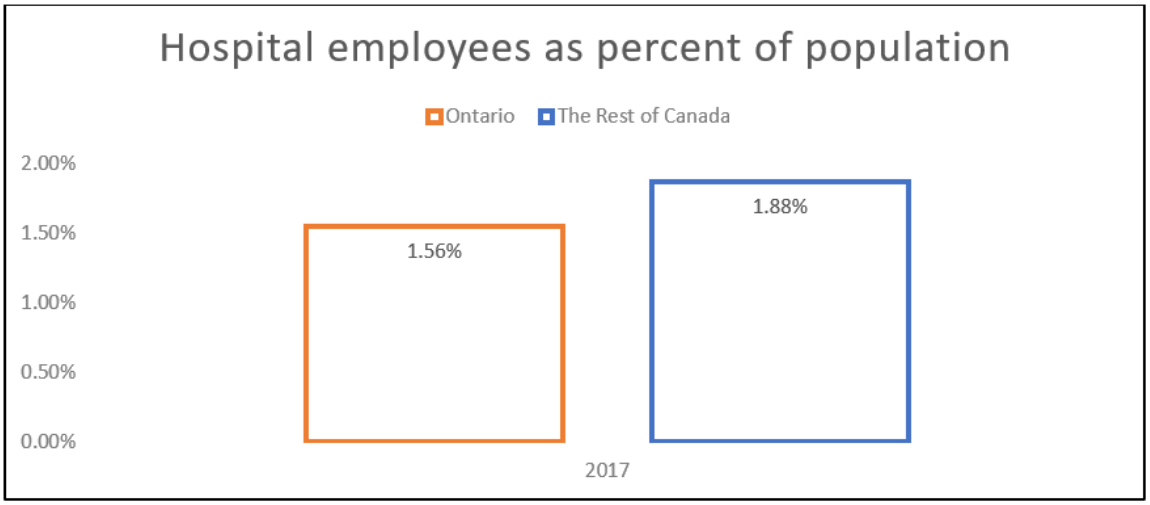
The Ontario provincial per capita funding of hospitals is $1702.78. The per capita average in the rest of Canada is $1,894.15.[1] That is 111.24% of the Ontario funding or $191.37 more per capita. For Ontario that would have required $2,853,996,495 in extra provincial hospital funding ($191.37 x 14,913,500 people).

This is a significant increase, but could be achieved over several years. Assuming other provinces increase hospital funding 4% per year, the additional 11.24% gap could be eliminated by adding an additional 3.75% funding increase each year, **for a total of a 7.75% increase in 2022-23, 2023-24, and 2024-25.**

2] Staffing and Wages

Ontario faces truly troubling health care worker staffing issues, both now and over the longer-term.

With low funding, staffing has been much lower in Ontario hospitals than in the rest of Canada, deepening the problems we have faced during COVID.



Hospitals across the rest of Canada were staffed 21% more than in Ontario. If Ontario hospitals had the same staffing as hospitals in the rest of Canada, there would have been 45,000 more hospital employees in Ontario.

Health care staffing shortages grow: Across Canada, the number of vacancies for health care positions has increased dramatically during COVID. Notably, however, this increase only exacerbates a trend since 2015, whereby the number of vacancies for health care jobs has increased.

Registered Practical Nurses: RPNs (or LPNs in provinces outside of Ontario) saw the most rapid percentage increase in the number of vacancies of any occupation reported in

[1] The average of the other 9 provinces is $2040.29

Canada over the first year of COVID, according to a recent Statistics Canada report, with vacancies increasing 94% in one year.

The 10 occupations with the largest year-over-year increases in job vacancies, first quarter of 2021

	Year-over-year change	
	level	%
Registered nurses and registered psychiatric nurses	7,230	56.2
Nurse aides, orderlies and patient service associates	5,395	45.4
Licensed practical nurses	4,005	94.0
Material handlers	3,525	50.1
Store shelf stockers, clerks and order fillers	2,845	39.8
Carpenters	2,290	51.7
Home support workers, housekeepers and related occupations	2,270	35.4
Social and community service workers	2,220	38.1
Landscaping and grounds maintenance labourers	2,000	48.7
Construction trades helpers and labourers	1,995	22.0

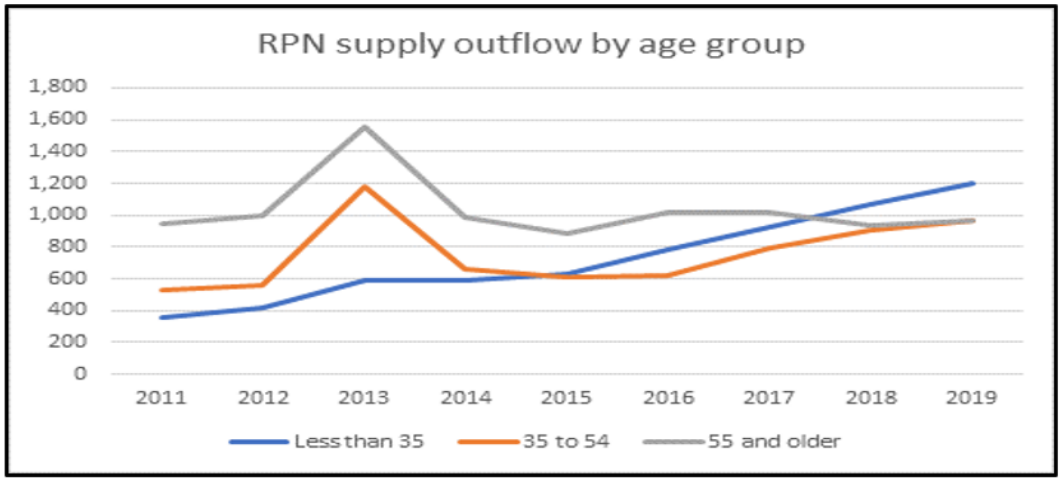
Source(s): Job Vacancy and Wage Survey (5217), table 14-10-0356-01.

RPN vacancies in Ontario increased over the same period from 1,715 to 3,700 – an increase of almost 2,000 (or 116%) in one year, while RN vacancies in Ontario saw a very significant 78% increase. In both cases, this is a more rapid increase than the reported cross-Canada increases.

While RPN vacancies have exploded during COVID, they also increased very significantly in the years leading up to COVID, gradually creeping up from less than 600 in the first quarter of 2015. In other words, RPN vacancies have increased more than six-fold since 2015. RN vacancies over the pre-COVID period also increased significantly, but not at quite so rapid a pace.

Based on data from the second quarter of 2021, there was 7.54 vacancies for every 100 RPNs in the workforce. This is similar to the level for RNs – where there are about 8.6 vacancies for every 100 RNs in the workforce.

The longer-term increase in the number of vacancies is likely exacerbated by a sharp increase in the number of RPNs who are leaving the profession that are under the age of 35.



Other health care work: There has been a significant increase in vacancies for other hospital occupations in Ontario as well as for RNs and RPNs. Statistics Canada provides details on two significant categories for service and office health care bargaining units:

> [a] "Nurse Aides, orderlies and patient service associates" saw vacancies increase from 4615 (in the first quarter of 2020) to 6915 (in the second quarter of 2021). That is a 50% increase in just over a year. Notably vacancies in these classifications were in the 2,000 area in the 2015-2017 quarters, with gradual increases to the 4000-vacancy area in the 2019 quarters. So, this area has also seen, like RPN work, a steady increase in the number of vacancies in the pre-COVID period, with vacancies now over three times the level found in 2015.
>
> [b] "Other assisting occupations in support of health services" saw an increase from roughly 395 in the first quarter of 2020 to 710 in the second quarter of 2021. That is an 80% increase in just over a year. These classifications saw roughly 250 vacancies reported per quarter in 2015, so they too have seen a very significant increase over the pre-COVID period as well.

Combining the classifications in [a] and [b] above, we can say that vacancies increased three-fold since 2015.

So:

- During COVID there was a 116% one-year increase in RPN vacancies in Ontario – 2,000 more vacancies in the quarter.
- RPN vacancies are over 6 times higher than in 2015.
- Other health care service and office occupations have also seen a significant increase in vacancies – we are currently seeing three-fold the number of vacancies in 2015.
- The increasing number of vacancies has been exacerbated by COVID, but this trend also pre-dated COVID.

Retention of PSWs within the health sector is also a very significant issue in Ontario according to the government's own LTC staffing study:

> "**PSW Retention Within The Health Care Sector**
>
> > Approximately 25% of personal support workers who have two or more years of experience leave the long-term care sector annually.

> According to Health Force Ontario, 50% of personal support workers are retained in the health care sector for fewer than 5 years, and 43% left the sector due to burnout of working short staffed.
>
> Approximately 40% of personal support workers have left the health care sector after graduating or within a year of training.
>
> The average overall job tenure of a personal support worker (in all sectors) has dropped 10 months to 85-90 months between 2015 and 2017.
>
> Turnover is highest for part-time and casual positions predominantly held by entry-level personal support workers."

Retention problems, increasing vacancies and younger staff leaving the health care workforce are signs that health care employers are having difficulties attracting and retaining staff.

Surging Demand for More Health Care Workers is Coming: The Financial Accountability Office (FAO) reports that achieving the government's post-COVID policy of four-hours care per resident per day in long-term care (LTC) will require 17,000 new full-time Personal Support Workers (PSWs), and 12,200 new full-time nursing jobs (RPN and RN), by 2024-2025.

The FAO also notes that only 40% of RNs, RPNs, and PSWs work full-time in LTC. As a result, the actual number of new nursing and personal care staff that will be needed to be trained or recruited will be more like 160% of those figures (assuming part-time staff work on average half-time). That would mean Ontario would need 27,200 new PSWs and 19,510 new RPNs and RNs, by 2024-25.

In addition, the government plans to add 30,000 long-term care beds over the decade. By 2024-25, the FAO estimates that four-hour staffing standard *and* the new LTC beds due by 2024-25 will require 37,000 RPNs, RNs, and PSWs. Given part-time work, that would require 59,200 extra RPNs, RNs, and PSWs by 2024-25. That is, roughly 25,000 extra nurses and 34,000 extra PSWs by 2024-25.

The opening of these new beds is driven by a rapidly aging population that requires more health care services. That demographic trend will also drive up the need for additional RPNs, RNs, and PSWs, and other health care staff working in hospitals, home care, community care, and other health care sub-sectors.

Another factor that will drive-up need for RPNs, RNs, and PSWs is the surgical and medical backlog occasioned by the postponements associated with COVID-19. The backlog is very significant and, according to the FAO, the backlog created before the Omicron wave will require $1.3 billion and three and a half years to resolve. Presumably, the backlog is now significantly worse with the reduction in surgeries and procedures during Omicron.

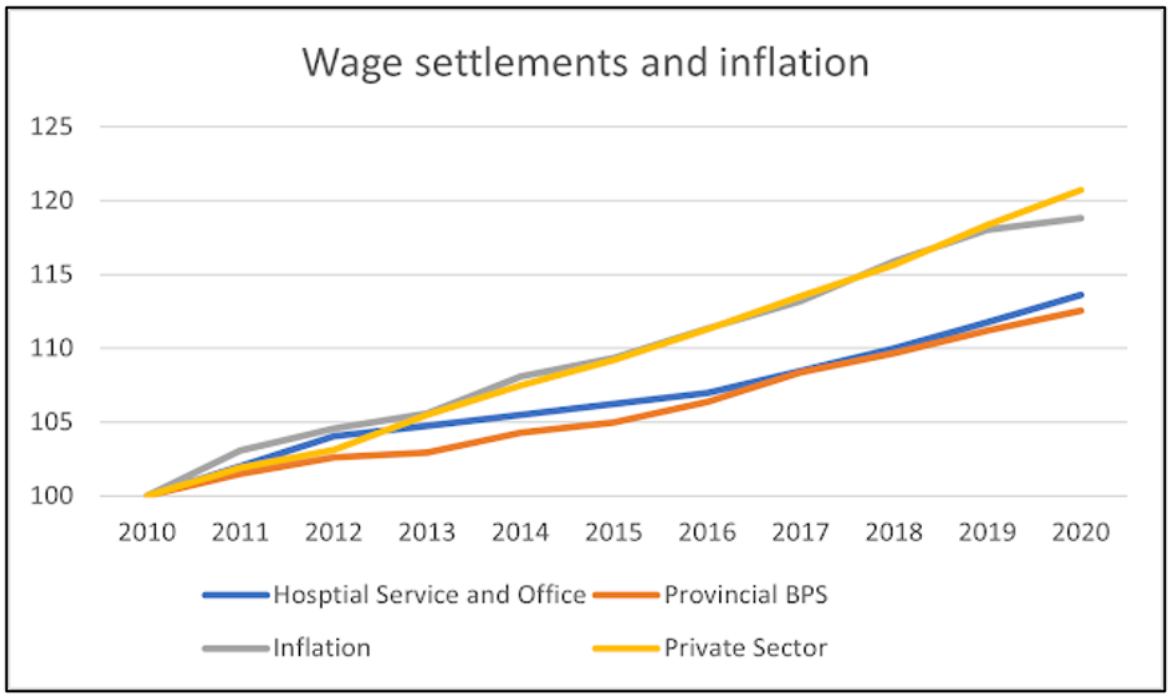
Finally, as noted in the previous section, living with COVID may well mean increased number of inpatients in our hospitals, quite possibly just when hospitals are under pressure due to the flu.

Existing Staff Shortages: These factors that will drive up demand are on top of the normal recruitment and training needed to replace existing LTC, hospital, and home care staff, as they quit or retire. Notably, Premier Ford recently estimated that there is already a 15% shortage of health care workers.

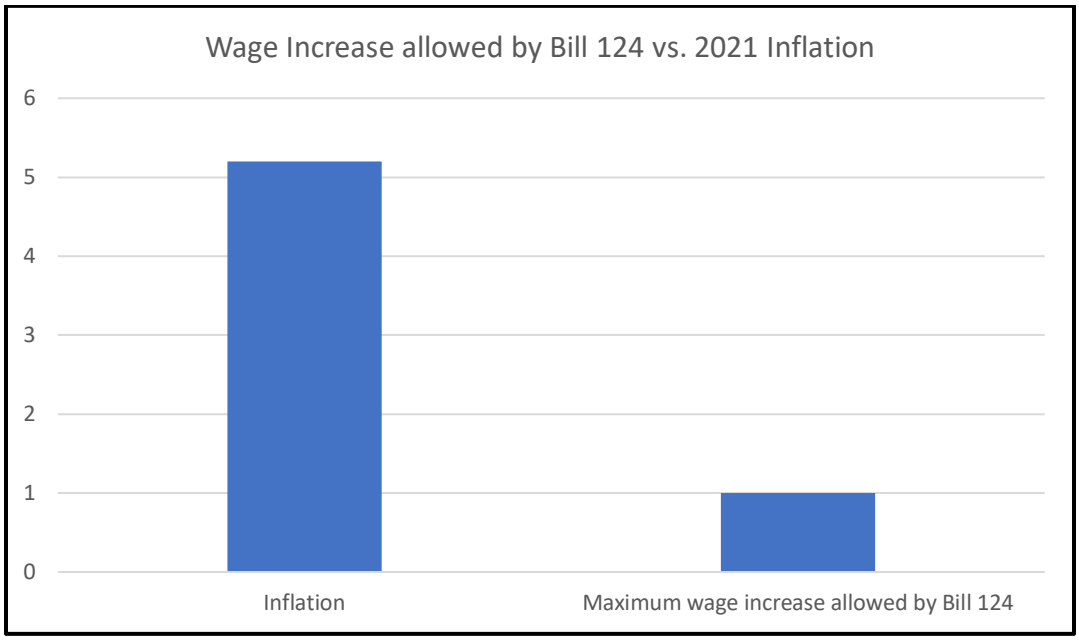
Clearly, there is a pressing need to find new ways to recruit and retain hospital staff, to make hospital work more appealing. **We are very concerned by the lack of steps that have been taken to date by the government to recruit and retain health care staff. We do not understand the lack of urgency.**

In collective bargaining we have proposed changes to allow better access to N95s and protection from airborne transmission. We proposed more full-time work, in part to help reduce staffing shortages. We have proposed improvements to reduce the widespread violent incidents in hospitals that negatively affect a primarily female workforce. We hope the government will encourage the hospitals to resolve these problems. The staffing increased that would be afforded through increased funding would also improve the attractiveness of hospitals as workplaces. But for our pre-budget submission, we would also like to flag what can be done to deal with the staffing issues regarding wages.

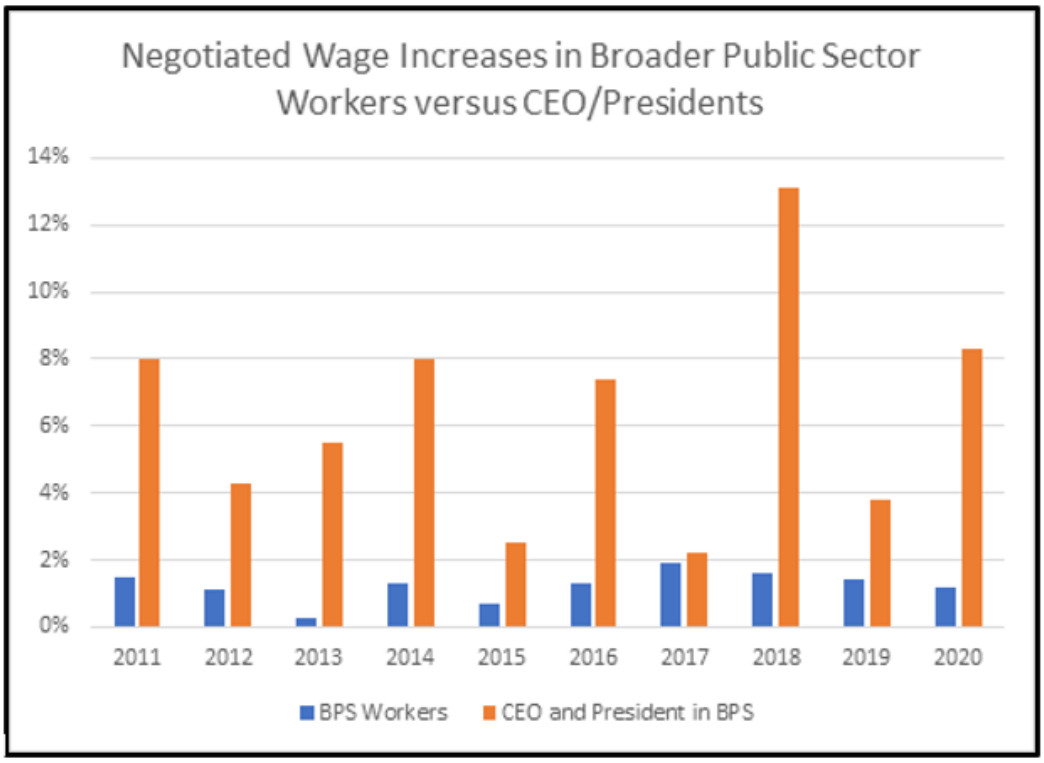
Wages have fallen behind: In Ontario health care wage settlements have fallen behind municipal and private sector settlements, as well as inflation, for more than a decade as government targeted wage settlements in the broader provincial public sector (BPS). The government plans to continue this wage suppression for hospital and health care workers for several more years through the wage restraints imposed on BPS workers under Bill 124. This has created a major problem in ongoing central negotiations for a collective agreement for the tens of thousands of workers represented by OCHU/CUPE and SEIU.



In 2021, wages are falling even further behind. Statistics Canada reports that as of December 2021, consumer inflation was 5.2% higher compared with a year earlier. With broader public sector settlements capped at 1%, that means a 4.2% reduction in real wage levels in that year alone, the first year of our hospital central agreement. This decrease is almost as much as the decrease the government (and hospitals and other BPS employers) imposed from 2011 through 2020. Notably, 2021 is just the first year of the three years of wage restraint imposed by Bill 124 for many hospital workers. This is not sustainable.



Wage suppression has applied to workers in the broader public sector (like hospital workers), but it has not applied to the presidents and CEOs of organizations in the broader public sector, where wage increases have average over 6% annually:



On behalf of 70,000 people working on the frontline of our hospital system, our unions are urging the legislature's committee on finance and economic affairs to recommend the Minister of Finance table a 2022 budget this spring with the funding commensurate with the needs of Ontario's health human resource crisis.

Ontario's government is overseeing a system that is failing families who work and receive services in our hospitals.

Below lay out our immediate, short-term, medium-term, and long-term solutions that require budget funding necessary to heal and strengthen a broken system:

- IMMEDIATE: Repeal Bill 124 and offer comprehensive mental health counseling to all health care workers who have experienced trauma during the pandemic.

- SHORT TERM: Introduce new "Stabilization Pay" of $8 per hour for all health care workers to bolster recruitment and retention efforts until the backlogs of surgeries and hospital procedures are cleared.

- MEDIUM TERM: Sectoral bargaining for the health care sector so health care jobs become good jobs with strong benefits and universal pay across all job classifications that increase wages in real terms.

- LONG TERM: Enable long-term planning with annual increases to the hospital budget for the next five years:

  - 9% in 2022
  - 8% in 2023
  - 7% in 2024
  - 6% in 2025
  - 6% in 2026

Thank you for your consideration. We are of course available for any questions or comments you may have.