Association of Ontario Health Centres
Community-governed primary health care

Association des centres de santé de l'Ontario
Soins de santé primaires gérés par la communauté

2014 Ontario Budget Submission from the Association of Ontario Health Centres

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Contact:
Jacquie Maund, Policy and Government Relations Lead
Association of Ontario Health Centres (AOHC) /
Association des Centres de Santé de l'Ontario (ACSO)
Tel: 416.236.2539 x 234
jacquie@aohc.org

Summary of Recommendations for 2014 Ontario Budget

Recommendations to strengthen primary health care:

1. **Recommendation:** Confirm the government's commitment to increase overall funding for home and community health care services by an average of over 5% annually over the next three years. Ensure that part of the 5% health funding increase for the community health sector – community governed primary health care organizations, mental health and addictions and community support agencies-- be made available to address operating pressures and cost of living adjustments.

2. **Recommendation:** Allocate $52.9 million in capital funding to maximize the proven effectiveness of the Community Health Centre (CHC) and Aboriginal Health Access Centre (AHAC) model of health care.

Recommendations to eliminate systemic barriers to health care:

3. **Recommendation:** Make a down payment on Ontario's next Poverty Reduction Strategy with targeted investments which improve health outcomes and save healthcare system costs in the long term:

    a. Extend public oral health programs to low-income adults.
    b. Increase the minimum wage to ensure that full time minimum wage workers have earnings above the poverty line.
    c. Increase social assistance rates.
    d. Invest in affordable housing, with a focus on more supportive housing for people with mental health and addictions challenges.

4. **Recommendation:** Ensure access to health care for new immigrants to Ontario by removing the 3 month wait for OHIP.

Community governed Primary Health: Preventing illness to save health care spending

The Association of Ontario Health Centres (AOHC) is the voice of community-governed primary health care in Ontario. Our vision is the best possible health and wellbeing for everyone.

Recommendations in this submission are based on the frontline experience of our 108 member centres who are working to achieve this vision: Community Health Centres (CHC), Aboriginal Health Access Centres (AHAC), Community Family Health Teams (CFHT), and Nurse Practitioner-Led Clinics (NPLC). As they deliver Primary Health Care throughout the province, health providers in these centres see how strategic investments in community health and poverty reduction can improve health outcomes and also ease financial burdens on the health care system.

CHCs presently serve about 4% of the Ontario population equivalent to about 500,000 people. The mandate of CHCs and Aboriginal Health Access Centres is to serve vulnerable populations who face barriers to accessing health care services. This includes people living in poverty, people in rural or northern communities, immigrants, Francophones, LGBT communities, Aboriginal People, people with disabilities, and people without health insurance.

We have two sets of recommendations for the 2014 Ontario Budget:

- Recommendations to strengthen primary healthcare as the foundation of our health care system and improve the effectiveness of community based health care.
- Recommendations to eliminate systemic barriers to health through healthy public policy.

Recommendations to strengthen primary health care

1. **Recommendation: Confirm the government's commitment to increase overall funding for home and community health care services by an average of over 5% annually over the next three years. Ensure that part of the 5% health funding increase for the community health sector – community governed primary health care organizations, mental health and addictions and community support agencies– be made available to address operating pressures and cost of living adjustments**.

   Rationale: In the 2012 Ontario Budget the Province made a commitment to increasing investment in home and community care services by an average of 4% per year. The government built on this commitment in the 2013 budget by providing an additional 1% per year to increase overall funding for home and community care services by an average of over 5% annually over the next five years.

   AOHC strongly supports the government decision to shift healthcare resources from the hospital to the community health sector. We appreciate the 2013 Ontario budget

commitment to increase funding to the community health sector and call on the government to confirm this funding increase in the 2014 budget.

The community health sector includes community governed primary health care organizations (Community Health Centres, Aboriginal Health Access Centres, Community Family Health Teams, and Nurse Practitioner-Led Clinics), mental health and addictions agencies and not-for-profit home and community support agencies. A strong primary health care sector must serve as the foundation of Ontario's health care system. By ensuring adequate resources in primary health care to prevent/treat illness and promote good health we can keep people out of the more costly hospital system.

In order to reduce high cost hospital and long term care use, particularly for those with the highest health needs, Ontario needs a strong community health sector offering better integrated services as people move out of hospitals into community-based services and as more seniors remain at home.

All of our members are experiencing increased operating costs including utilities, staffing and information management services. But we are restricted by Ministry of Finance policies to using the new funding only for new programming, and cannot apply it to operating expense increases. The community health sector is requesting that our members be allowed to use our portion of the 5% funding increase to address operating pressures and cost of living increases.

Without this flexibility we fear the government's plan to ensure that people receive the right care in the right setting at the right time will be compromised. Programs cannot be moved out of hospitals to community-based services if those providers are shrinking their services because they cannot cover operating costs.

2. **Recommendation: Allocate $52.9 million in capital funding to MOHLTC Capital Investment Branch to cover the capital requirements of Community Health Centres and Aboriginal Health Access Centres.**

Rationale: A growing body of evidence demonstrates that the Community Health Centre model of health and wellbeing which focuses on health promotion and illness prevention is delivering superior services compared to other primary care models. The Institute for Clinical Evaluative Sciences (ICES) recently found that even though CHCs serve people with more complex needs, they do a significantly better job than other models keeping these people out of hospital emergency departments[i]. This follows studies by the Élisabeth Bruyère Institute which show CHCs do a better job than other primary health care models promoting health, preventing and managing chronic disease and orienting services to community needs[ii].

In 2004 and 2005 the provincial government promised to significantly expanded access to CHCs with the decision to invest in 49 new sites across Ontario. Capital funding for 9 of these new CHC sites was announced early in 2013, for which AOHC is very

appreciative. However, 7 CHC sites have still not received the $29.5 million in funding required to secure permanent sites from which to deliver services. As a result many people with complex needs who are high users of the hospital system cannot access the health services they have been promised.

There is also a backlog of capital requests at MOHLTC for funding for three Aboriginal Health Access Centres totaling $7.5million, and two older CHCs in London and Hamilton totaling $15.9 million. At the AHACs, cramped conditions greatly limit the providers' ability to operate efficiently and recruit and retain staff. At the London Intercommunity Health Centre they cannot accommodate any more providers, and the crumbling condition of the building housing the Hamilton Urban Core CHC means they cannot fill vacant physician positions.

The full list of CHCs and AHACs requiring capital funding is provided in Appendix One.

Recommendations to eliminate systemic barriers to health through healthy public policy

3. **Recommendation: Make a down payment on Ontario's next Poverty Reduction Strategy with targeted investments which improve health outcomes and save healthcare system costs in the long term.**

   Rationale: The World Health Organization, the Canadian Medical Association, the Ontario Medical Association, Ontario College of Family Physicians, Public Health Agency of Canada, Registered Nurses Association of Ontario, Toronto Public Health and many other healthcare organizations have identified poverty as the leading cause of poor health and health inequity.

   Community Health Centres and Aboriginal Health Access Centres are mandated by government to serve vulnerable populations and witness on a daily basis the impact of low income on health. Our members provide healthcare services to low income people who often cannot afford healthy food and extended health coverage, including prescription medication and dental care. Research has found that people whose incomes are below the poverty line experience increased rates of chronic illnesses such as diabetes, heart disease, migraines and bronchitis, compared to people with decent incomes. These factors can lead to unnecessary health complications, increased emergency department utilization, and compounding of healthcare costs.

   Targeted investments to increase low incomes would lead to improved health outcomes and cost savings over the longer term. A study by the Wellesley Institute demonstrated that an annual income increase of $1,000 for the poorest 20% of Canadians would lead to nearly 10,000 fewer chronic health conditions[iii].

According to a 2008 economic study done for the Ontario Association of Food Banks, if the poorest 20% of Ontario workers earned as much as those one step higher on the income ladder the savings to Ontario's healthcare system would amount to $2.9 billion[iv].

AOHC supports Ontario's Poverty Reduction Strategy which has helped reduce child poverty by almost 10% between 2008 and 2011. Many of our members participated in community consultations last summer and look forward to release of Ontario's next Poverty Reduction Strategy, 2014-2018. We urge the government to make a down payment on the new Strategy with priority investments in the 2014 budget in the following areas:

a. Extend public oral health programs to low-income adults.

Rationale: Across Ontario in 2012 there were almost 58,000 visits to hospital Emergency Rooms (ER) for oral health problems. This is evidence that many people are using costly acute care ER for dental problems because they cannot afford dental treatment.

Public Health Ontario reports that 1 in every 5 Ontarians does not visit a dentist because they cannot afford the cost. However, at the ER people can only get pain control so many return to ER. This is a costly and inappropriate use of hospital ER. Ontarians should be able to receive affordable preventative dental care in their communities. At a minimum cost of $513/visit, the total estimated cost for dental visits to ER in Ontario was at least $30 million in 2012.

The Ontario government should re-direct the $30million (minimum estimate) spent on acute care for oral health in ERs to a pilot program to provide public oral health care for low income adults. CHCs and AHACs are well positioned to deliver these services given their experience working with marginalized and vulnerable people.

b. Increase the minimum wage to ensure that full time minimum wage workers have earnings above the poverty line.

The $10.25/hour minimum wage has been frozen for four years. A full time minimum wage worker earns $18,655, which leaves him/her with earnings that are 19% below Ontario's Low Income Measure. Increasing the minimum wage to lift minimum wage workers above the poverty line will mean they have more resources to cover the cost of healthy food, prescription drugs, and dental care. Increased incomes would improve health outcomes leading to healthcare cost savings.

c. Increase social assistance rates providing an additional $100/month for all people receiving OW and ODSP. Fully index rates to inflation.

Many advocates have recommended increasing benefits by $100/month which the Commission for the Review of Social Assistance recommended for single people on OW.

We support increasing rates for all people receiving social assistance by $100/month to begin to bring rates up to an adequate level.

d. Invest in affordable housing

Make permanent the $42 million in transition funding provided last year for critically important housing and homelessness funds administered by municipalities under the Community Homelessness Prevention Initiative. This will help municipalities deal with the loss of the Community Start Up and Maintenance Benefit (CSUMB) for people on social assistance.

In support of Ontario's Mental Health and Addictions Strategy, allocate funding for supportive housing including capital, rent supplements and support services. Numerous studies have demonstrated the importance of ensuring housing with supports for the recovery of people living with mental health and addictions issues. Research shows that supportive housing along with community mental health services reduces hospitalization up to 89%, and that for the cost of one psychiatric hospital twenty people could be accommodated in supportive housing. Once homeless people were accommodated in housing City of Toronto research found there was a 68% reduction in jail admittances[v].

4. Recommendation: Ensure access to health care for new immigrants by eliminating the 3 month wait for OHIP for newcomers to Ontario

Rationale: Continuing the practice of applying a three month wait for newcomers to receive OHIP undermines Ontario's competitive advantage in attracting and recruiting immigrants. Ontario, BC and Quebec are the only provinces where landed immigrants with permanent resident status have to wait three months before they can receive public health care services. The three month wait is contributing to a loss of competitive advantage which Ontario once had in attracting new immigration which supports provincial economic growth.

Immigrants in the three month wait period who delay seeking health care for chronic and acute care issues may drive up the cost of health care delivery. Illnesses that could have been prevented or managed could become acute which puts pressure on the health care system.

Newcomers start paying taxes as soon as they arrive in Ontario. It is not fair that they cannot access for three months the health services into which they pay.

It is estimated that the cost would be approximately $60 million annually to eliminate the three month wait[vi].

Conclusion

AOHC recognizes that these measures require new investment during a period of deficit in Ontario's public finances. The Ontario government has committed to improving transportation infrastructure in the GTA and to identifying new revenue sources to fund this priority. We urge the government to similarly pursue revenue raising measures within the context of a progressive tax system to ensure adequate public revenues to fund our recommended investments in Ontario's social infrastructure.

Research by the Ontario Centre for Policy Alternatives has found that Ontario loses $17 billion/year in tax revenue as a result of tax cuts made since the mid-1990s. Their work has identified a number of options for government to pursue to raise public revenue[vii].

Appendix One: List of CHCs & AHACs with unmet requests for funds for permanent sites

The complete list of sites requiring capital funds and approximate capital project costs are as follows:

A total of $29.5 million is required to complete capital the 2005 unannounced projects at CHC sites for which funding is still not announced.

1. Kawartha Lakes - $7.0 for a health and social service hub (multi-agency funding)
2. Bramalea (mainsite) - $7.5 million
3. Chatham (main site)-$3.5 million
4. Chatham (Wallaceburg)- $2.0 million
5. Kingston (Street Health) – $1.5 million
6. Central (St. Thomas) - $5.0 million
7. South East Grey - $3.0 million

AHACs with outstanding capital requests:

1. Anishnawbe Mushkiki – $170,600
2. N'Mninoeyaa Aboriginal Health Access Centre - $322,912
3. Shkagamik-Kwe Health Centre – $7 million

Additional CHCs requiring capital with requests prior to 2005

1. London Intercommunity Health Centre – $7.9 million
2. Hamilton Urban Core Community Health Centre – $8 million

[i] Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10, by Glazier RH, Zagorski BM, Rayner J. March 2012 http://www.ices.on.ca/webpage.cfm?site_id=1&org_id=32&morg_id=0&gsec_id=7345&item_id=7345&category_id=53

[ii] See http://www.cachc.ca/?page_id=95&category=6

[iii] Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario, Produced by the Community Social Planning Council of Toronto, the University of Toronto's Social Assistance in the New Economy Project and the Wellesley Institute. February 2009 http://socialplanningtoronto.org/wp-content/uploads/2009/02/sick-and-tired-for-web.pdf

[iv] Hunger Report 2013, Ontario Association of Food Banks. 2013 http://www.oafb.ca/tiny_mce/plugins/filemanager/pics_cms/55/255/Hunger_Report_-_Final.pdf

[v] A Doorway to Success: Housing and Supports, Ontario Federation of Community Mental Health and Addictions Programs http://www.ofcmhap.on.ca/sites/ofcmhap.on.ca/files/A%20Doorway%20to%20Success.pdf

[vi] Investing in Health, Economic, Settlement and Integration Outcomes: A Business Case for Eliminating the Three-Month Wait for New Ontario Residents. January 31, 2011 http://accessalliance.ca/sites/accessalliance/files/Business_Case_3monthwait.pdf

[vii] See http://www.policyalternatives.ca/offices/Ontario