REGIONAL MUNICIPALITY OF OTTAWA CARLETON — REPORT

MUNICIPALITÉ RÉGIONALE D'OTTAWA CARLETON — RAPPORT

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TO/DEST. Co-ordinator
Community Services Committee

FROM/EXP. Medical Officer of Health
Commissioner, Homes for the Aged

SUBJECT/OBJET **RESPONSE TO THE HEALTH SERVICES RESTRUCTURING COMMISSION'S OTTAWA-CARLETON PLANS**

DEPARTMENTAL RECOMMENDATION

That Community Services Committee recommend Council approve the following report as its response to the Health Services Restructuring Commission's Ottawa-Carleton Plans.

PURPOSE

The purpose of this report is to update Regional Council on the Ontario Hospital Restructuring Commission's Ottawa-Carleton plans which were made public on February 24, 1997 and to reiterate Council's existing positions on health care restructuring as a response to the Commission's plans. Responses are required within forty-three days (thirty days plus a thirteen day extension) i.e. by April 8, 1997.

BACKGROUND

The reconfiguration process for the Health Care System in Ottawa-Carleton was begun in 1994 by the District Health Council. The District Health Council produced its final report Commitment to Change: Building an Integrated and Affordable Health Services System. This report recommended no hospital closures but significant budget reductions and changes in governance in the hospital sector accompanied by reinvestment and reallocation of resources into the community and preventive sectors. Regional council has taken a position on these issues based on Community Services Committee Report RMOC Response to the District Health Council Health Services Reconfiguration Project of Dec. 15, 1995 and a joint submission with the Community Health Centres to the Health Services Restructuring Commission.

The consistent approach of Council has been to not take a position on the details of hospital services but to argue strongly and consistently in favour of reconfiguration of the system towards preventive and community services and the implementation of these services in a timely fashion and co-ordinated with the hospital downsizing.

In January 1997, The Health Services Restructuring Commission produced the report A Vision of Ontario's Health Services System The Vision document proposes a health care system which has among other things: shared goals, a focus on population health and a balance between health care and population health. It also proposes a system which is based on a rostered population not a hospital, and has a more integrated organizational structure.

On February 24, 1997, the Ontario Health Services Restructuring Commission made public its Ottawa-Carleton plans. The report proposed changes in hospital care in Ottawa-Carleton. Highlights of these recommendations include:

Hospital Services

- Consolidation of all acute hospital services at four sites: the Ottawa General, Ottawa Civic, Queensway-Carleton and CHEO sites.
- Decommissioning of the Montfort Hospital (June 1999), Riverside Hospital (June 1998), and Salvation Army Grace Hospital (June 1998) sites.
- Merging the governance structures of the Ottawa General, Ottawa Civic, Montfort and Riverside Hospitals into a single amalgamated hospital.
- Closure of the Brockville Psychiatric Hospital.
- Consolidation of all chronic psychiatric services (except for children) at the Royal Ottawa Hospital..
- Consolidation of chronic care services with the Sisters of Charity of Ottawa.

Governance

- Governance of hospital services will be under five boards: Amalgamated Hospital, CHEO, Queensway-Carleton, Royal Ottawa and Sisters of Charity.
- CHEO will also lead development of a network for children's services.
- Ottawa-Carleton is to move toward an integrated Delivery system of unspecified nature and with no timeframe

Reinvestment/Reallocation

- significant investment in long term care to be specified by late March
- an investment of $3.8 million in home care
- Capital investment of $106 million to facilitate restructuring.

DISCUSSION

Governance

The report of the Restructuring Commission speaks only to Hospital governance. There is no direction or timetable to move the system to a more integrated governance. Yet, it is clear that any significant reconfiguration and restructuring of the overall system in the direction that Council would like will only occur in an integrated system with a clear mandate and accountability to achieve population health objectives. The Commission's report will, at best, streamline hospital services but will do nothing to address the inherent structural imbalances in the existing system. The one partial exception to this observation is the mandate to CHEO to develop a network of community children's services. While, as currently phrased, this could be limited to the co-ordination of services, it does present an opportunity to involve partners in both health and non-health sectors to look at the population needs of children and establish goals accordingly.

Reinvestment/Reallocation

Prevention/Promotion and Community Services

The report is silent on this area. There is grave concern that there will be none. It would appear that if there is to be any reinvestment, it will be done by the provincial Ministry and will, by definition, not be based on local priorities and not be driven by local population health objectives. This should be addressed by amending the interim report to incorporate the principles and recommendations of A Vision of Ontario's Health Care System and the Reinvestment and Reallocation sections of Commitment to Change: Building an Integrated and Affordable Health Services System. Such amendments should include clear endpoints and timeframes. This will begin to move Ottawa-Carleton towards a more balanced and prevention-oriented health care system. In addition, the funding and implementation of these services should be clearly defined as a crucial component of the proposed restructuring. Of particular concern in the short term is the funding of community mental health services to address current problems as well as the probable exacerbation brought on by the proposed reductions in psychiatric beds.

Long Term Care

Home Care even without restructuring has experienced a 61% caseload growth in the past three years. Given the magnitude of the changes being proposed in hospital services, we feel that estimates of a 15% caseload growth and a 15% increase in services per client due to increased acuity are very conservative. Budget calculations based on these estimates leads to an estimated budget increase of $16 million for the Home Care program. (Home Care Director's Brief to the Hospital Restructuring Commission). The $3.8 million reinvestment in Home Care announced by the Commission will not approach the increased demand for Home Care Services.

The Restructuring Commission has noted that an additional 2100 long term care beds would be required by the year 2003 to meet the provincial average. It is unclear whether this includes transitional beds. Traditionally the District Health Council has recognized the close relationship between long term care beds and chronic care beds and projected the need for additional resources on that basis. It is unclear how the Commission viewed this relationship when developing the projections.

The Region has supported the District Health Council in its request for new beds to meet the needs of the growing elderly population. Similarly the replacement of chronic care beds with long term care beds has been supported as an appropriate direction, as was the case with the Perley Hospital, now Perley Rideau Health Centre. As the Region will now be responsible for sharing in the operating funding of any new beds, the Region needs to participate in system development. Using rough estimates, it will cost approximately $20,000 per bed annually in operating subsidies. Addition of 2000 beds by the year 2003 would cost $40 million annually of which $20 million would come from the property tax base under the new cost-sharing formula. It would make political and economic sense that any reinvestments by the Commission in long term care and capital improvements should be fully funded from savings elsewhere in the health care system and not funded from the property tax base.

Capital Costs

The Restructuring Commssion has stated that the $106 million in capital improvements arising from restructuring would require at least 25% local contribution. We have also heard that a capital funding formula requiring a 50% local contribution is being considered. Historically, the RMOC has contributed to the building of health care facilities but has no current reserves set aside for this purpose. Thus the size of the local contribution and how it would be collected remains uncertain. The RMOC will likely be asked to contribute to this funding but is currently not under any obligation to do so.

FINANCIAL IMPLICATIONS

The report of the Restructuring Commission if implemented would result in an increase of an estimated $22 million in annual operating costs to RMOC by the year 2003 under the new proposed cost sharing formula. In addition, there are $106 million in hospital capital costs and an undetermined amount of capital costs in long term care facilities in which RMOC may be requested to contribute a portion.

PUBLIC CONSULTATION

Due to the short turnaround time for response, there has not been the opportunity to fully consult the public on this issue. However, this report primarily reiterates existing Council positions on this issue as well as detailing the financial implications for the Region.

CONCLUSION

This report restates existing Regional Council positions on health care restructuring and details the implications of the report for the region.. The report continues to insist on the importance of restructuring the health care system to emphasize prevention, promotion and community services. It also reiterates the importance of a greater investment in alternative community services, especially home care, long term care beds and community mental health as a crucial component of the proposed restructuring. Finally, the report outlines the financial implications for the Region.

Approved by
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