



June 9, 2004

POSITION STATEMENT

Re: Access to Publicly Funded Physiotherapy

Background

Over the past decade, many public hospitals in Ontario closed or downsized their rehabilitation clinics as cost-saving measures. At the same time, hospitals were discharging their patients with unprecedented levels of acuity. Those patients required more rehabilitation than ever before. These twin factors put enormous pressure on the non-hospital rehabilitation delivery models.

In 2000, the previous Ontario government delisted OHIP code G. 467, the physicians' code under which physician-supervised physiotherapy was provided in the community. The money saved was supposed to have been reallocated to hospital and community-based physiotherapy, but never was. This put increased pressure on the declining physiotherapy resources available through the publicly-funded system.

Physiotherapy is a mandated service for Community Care Access Centers (CCAC's) to provide under the *Long-Term Care Act*. However, resources allocated to physiotherapy by CCACs is far short of demand, requiring many CCAC's to ration and "prioritize" physiotherapy treatment visits. This has resulted in long waiting lists for physiotherapy and has also resulted in many going without. Some homecare patients circumvent the CCAC's by obtaining treatment through OHIP Schedule Five.

In the long-term care facilities sector, the per diem allocated to the personal services envelope (through which physiotherapy could be provided) is inadequate to address the needs of most long-term care residents. As a result, an increasing number of long-term care facilities obtained physiotherapy for their residents through OHIP Schedule Five. In fiscal year 2003-2004, approximately half of total expenditures in the OHIP Schedule Five pool (i.e. \$32.5 million dollars) was billed for treatments in long-term care facilities and in homecare.

On May 18th, as part of its Budget Statement, the Ontario Government announced that OHIP Schedule Five would be delisted, along with OHIP coverage for chiropractic



(complete) and optometry (partial). ¹The delisting is effective at the end of the current fiscal year, namely March 31, 2005.

Several public hospitals have indicated to their employees their intention to stop providing rehabilitation services to hospital out-patients. This latest round of downsizing appears to be based on a misunderstanding of the government's May 18th delisting announcement, because the delisting of OHIP Schedule Five does not extend to hospital physiotherapy services that are provided under each hospital's global budget. Nor does it imply that physiotherapy services are not necessary in the community. The government has indicated it will put additional funding into long-term care and homecare to replace billings in those sectors through OHIP Schedule Five.

The OPA Position

Over the last four years, through the delisting of OHIP Schedule Five and G Code 467, about a *quarter of a billion dollars in government funding for community-based physiotherapy has been withdrawn*. Persons requiring publicly-funded physiotherapy in the community may now access it only through long-term care facilities, in homecare through CCAC's and through the declining number of out-patient clinics in hospitals. Each of these delivery models is facing severe resource challenges. The supply of community-based physiotherapy, therefore, has fallen and continues to fall substantially behind demand. This situation will be exacerbated by increasing the numbers of cardiac surgeries, joint replacements and so on as promised in the May 18th budget. These patients will have enormous difficulty accessing the publicly-funded rehabilitation services that they require.

Limiting access to publicly-funded physiotherapy will end up costing the health-care system more. It will force patients to rely more and for longer periods on more expensive physician and hospital services. It will increase reliance on expensive pharmaceuticals. It will delay recovery times and return to work. It will increase the incidence of chronicity. It will redirect patients who can afford it to the privately-funded system, thereby expanding two-tier healthcare.

The Ontario Physiotherapy Association fully acknowledges that OHIP Schedule Five had developed fundamental structural flaws. The OPA has indicated many times to the Ministry and to successive Ministers of Health that it wants to enter into a dialogue with the government to enhance access to publicly funded and cost-effective community-based physiotherapy through alternate delivery and remuneration models (e.g. primary care networks, independent health facilities, CHCs, capitation, block fees and so on).

¹ " OHIP Schedule Five " refers to OHIP coverage for community-based physiotherapy provided in 91 registered clinics (Part I) and through home visits by 29 registered practitioners (Part II).



Physiotherapy services provided to hospital in-patients or out-patients, as defined under section 2 ("hospital services" subsection (h) and (i)), are insured services under the *Canada Health Act*. The closure of hospital facilities that provide physiotherapy services to out-patients that are necessary for maintaining health, preventing disease, or diagnosing or treating an injury, illness or disability, therefore, contravenes the *Canada Health Act*. Downsizing those hospital facilities to the point where hospital in-patients or out-patients are unable to access those services on a reasonable basis also contravenes the *Canada Health Act* and amounts to privatization of health-care by stealth.

The delisting of OHIP Schedule Five will substantially reduce access to already-limited publicly-funded, community-based physiotherapy. This will impact particularly on seniors, low-income individuals and those who have limited or do not have private health insurance or who cannot afford to pay for treatment out of their own pockets. The closure or downsizing of out-patient rehabilitation clinics will compound that access problem by further reducing the availability of physiotherapy in the publicly-funded health-care system.

Hospital out-patient rehabilitation services allow earlier discharge of hospital patients and thereby reduce patients' length of stay in hospitals. The Ontario Government claims that it will provide an additional 36,000 cardiac procedures per year by 2007-08, an additional 2,300 joint replacements each year, also by 2007-08. Where will these people go for the rehabilitation services these procedures require?

The closure or downsizing of hospital-based rehabilitation clinics will mean that cardiac and stroke patients, hip, other surgery and other patients who require physiotherapy treatments will have three options:

- i) They will have to stay in hospital longer, which will cost the health-care system more. (The cost of one hospital bed per day averages \$420.00. The cost of a physiotherapy treatment in a hospital out-patient facility is a fraction of that amount.);
- ii) They will have to obtain treatment from private physiotherapy clinics. This will impose an intolerable expense on many patients, who do not have private insurance and cannot afford to pay out of their own pockets. They may elect to defer, or delay, treatment, which could detract from recovery and increase the likelihood of chronicity, thereby adding costs for the health-care system later on.
- iii) They will have to rely on publicly-funded homecare services provided through Community Care Access Centers. CCAC's are already facing their own challenges and waiting lists for care are already very long (nine weeks in some locales).



Actions

The Government of Ontario must clearly communicate to hospitals that the delisting of OHIP Schedule Five does not mean that the government will not continue to fund hospitals' out-patient services.

Hospitals must recognize that closing their out-patient services is not only contrary to the *Canada Health Act*, but will add to their costs in the long run and erode the health status of the communities they serve.

The federal government must require that Ontario abide by the *Canada Health Act*.

The Government of Ontario, in consultation with the OPA and other stakeholders, must find ways of providing publicly-funded cost-effective, rehabilitation services in the community.

F:\data\word\documents\Hospitals & Sched 5.rtf