THE CANADIAN HEARING SOCIETY
LA SOCIÉTÉ CANADIENNE DE L'OUÏE

HEAD OFFICE 271 Spadina Road, Toronto, Ontario M5R 2V3 Voice: (416) 928-2500
TTY: (416) 964-0023 Fax: (416) 928-2525 Website: http://www.chs.ca

SUBMISSION TO THE MINISTRY OF HEALTH: 10 YEAR STRATEGIC PLANNING EXERCISE

February 2007

Submitted by:
The Canadian Hearing Society
271 Spadina Road, Toronto, Ontario
M5R 2V3

Contact:
Kelly Duffin
President and CEO
kduffin@chs.ca

"Consider someone who has a chronic illness, lives alone, and is having trouble coping. Without any concerted effort to help them with problem-solving and adjustment to their particular circumstances, this person will probably spend a lot of time seeking medical help. When we compared a group who received counseling and support to a group who were left to cope on their own, the people with chronic illness, poor adjustment and poor problem-solving capacity who struggled with depression and loneliness on their own were half as well adjusted, and cost the health system 10 times more ($40,000 per year per person vs. $4,000)."

- *The Effectiveness and Efficiency of Health Care Promotion in Specialty Clinic Care, "Medical Care 33 (9)," Roberts et al, 1995*

"Hearing loss is the third most prevalent chronic condition in older adults and has important effects on their physical and mental health. Despite these effects, most older patients are not assessed or treated for hearing loss."

- *Journal of American Medical Association, 2003*

INTRODUCTION

The Canadian Hearing Society (CHS) is a 67-year-old non-profit organization that provides services to deaf, deafened, and hard of hearing people in 28 offices across Ontario.

We believe we share with your ministry the fundamental goal of making Ontario a healthier province. Your government has taken several initiatives that have helped and the thousands of people who we serve acknowledge these efforts. But there is more to do.

The fundamental transformation of Ontario's health care system that your government has undertaken presents a major opportunity for the Ontarians we currently serve and equally importantly, those we will serve in the future. As a provider of local health services we support your efforts to provide a more integrated, accountable approach to health care delivery. The introduction of the LHINs and the restructuring of CCACs provides an excellent opportunity to advance better health care for our clients and all Ontarians.

With any large system-wide change there is the risk that smaller but no less important opportunities can be missed. CHS is concerned that in this time of change the *important* will get overlooked by the *urgent* so we welcome this opportunity for dialogue.

Our submission comes from the perspective of the three ways we function: first, as a community health-care provider; secondly, as an agency serving people with disabilities; and thirdly, as a member of the voluntary sector.

From all perspectives, our submission will make recommendations that we believe are essential for your 10 year strategic plan.

PRIORITY #1: HEALTH CARE

Senior Population and the Need to Address Chronic Conditions – A Matter of Equity

As baby boomers age the percentage of seniors in Ontario will increase dramatically and the strains on systems including health care will be unprecedented. It is critical that Ontario plan for this demographic shift. Clearly your ten year health care strategy should form part of that planning process. In particular, investments in mitigating chronic conditions through early diagnosis and appropriate intervention could considerably reduce the financial as well as social cost of leaving such conditions unaddressed and contribute markedly to the majority of our seniors "aging well."

We understand that the first years of health care restructuring focused heavily on integrating acute care services, improving patient wait times and increasing physician and other providers supply. The fact that acute care often gets the bulk of attention and funding reflects the original health insurance programs for hospital and physician coverage that were the foundations of the Canada Health Act and most provinces' health care programs for decades.

But this is about the future and we are encouraged at the activity beginning at the regional level to tackle the less obvious but no less significant challenges of the effective management of chronic conditions especially among senior populations.

As one of the LHIN's wrote, "A chronic condition is an illness, functional limitation or cognitive impairment that lasts (or is expected to last) at least one year, limits what a person can do, and requires some ongoing level of care. Chronic Disease Management (CDM) is a proactive treatment approach that seeks to support clients in the community to manage their condition and minimize the need for acute episodic care." *(South West LHIN Preventing and Managing Chronic Illness, 2006)* The stated goal of CDM is to treat patients sooner, closer to home and earlier in their condition.

CHS applauds this perspective, but we are concerned that efforts to improve chronic disease management could end up over-emphasizing some conditions and illnesses at the expense of other conditions. We have examined many of the reports being produced by the LHIN task forces and the Ministry and not surprisingly find the chronic conditions that receive the majority of analysis are those associated with diseases that often result in acute episodes (asthma, high blood pressure, diabetes, chronic bronchitis).

From a provider perspective preventing high-cost and often repetitive acute episodes is a pressing priority. But as a community support provider we believe that the patient would expect us to balance any health care strategy by including a significant effort to address conditions like hearing loss or vision loss that may not readily lead to emergency room visits or major disease incidents but have no less significant impacts on individual health and on costs to the system as a whole. If, for instance, Mrs. Smith doesn't hear or can't see the instructions given to her about her heart condition and she does not comply and consequently gets ill, the costs to her and to the health care system can be significant in the long run.

Compounding this challenge is an increasing focus on metrics, evidence-based decision-making, and measurable outcomes. Acute situations – such as wait times and times in surgery – are relatively easy to measure and as recent reports seem to indicate, to manage and improve. The percentage of Ontarians with chronic conditions is large and growing, but their circumstances can be harder to measure. Some chronic conditions like diabetes are well studied and the Ministry has begun to develop a condition-specific care model. Unfortunately we do not yet have enough specific studies to develop a comprehensive system of metrics and map out the clinical and community interventions that would be most effective both for patients who have hearing loss and for the health care system as a whole. But based on the studies that do exist and our daily engagement with this condition we know that seniors who suffer hearing loss are equally deserving of concern and effort from the Ministry as the more "data rich" conditions.

Recommendation 1: A special effort is required to ensure that the health care system, especially LHINs and CCACs, assess all prominent chronic conditions and that where the data is lacking efforts be made to ensure that relevant information has been collected and analysed before priorities and programs are set in stone. Without such efforts the system runs the risk of being biased towards data-rich and more studied chronic conditions.

Recommendation 2: At the same time, it will be increasingly important to ensure appropriate metrics are developed around chronic conditions that have been less studied to date and that system-wide plans, procedures, and funding are in place to measure and track chronic conditions as well as acute.

The Need to Develop a Provincial Hearing Health Care Strategy

Based on the above it is clear to us that there is an urgent and pressing need to develop a condition-specific strategy for hearing loss that can be fully integrated into an effective model of chronic disease management.

There is considerable anecdotal evidence and increasing research that indicates hearing loss is a chronic condition that can exacerbate or be misdiagnosed as dementia in older Ontarians; that those with undiagnosed hearing loss admit that they often do not understand medical instructions; and that depression and other strains on the health care system are often directly attributable to untreated hearing loss in the seniors' population.

This is significant because hearing loss is the fastest growing disability in Canada and aging is the leading cause of hearing loss. While almost 25% of adults report having some hearing loss, that percentage increases dramatically in the senior population where approximately 40% of people over age 65 have hearing loss. The number of seniors who

are hard of hearing will grow rapidly with the aging population and currently there is no provincial strategy to address this looming issue.

The Canadian Hearing Society believes that in addition to general health services, attention must be given to hearing health care in particular. Detected early, successful and cost-effective interventions can take place. Seniors can get hearing aids, for instance, and have devices placed in their home to ensure their safety and independence. This is aging in place: it not only represents an increased quality of life for the senior, but a significant savings for the government relative to the high cost of long-term care, which is very often the alternative when diagnosis and intervention don't take place.

Early identification, intervention and accommodation can also prevent other costly problems associated with unrecognized hearing loss, including mental health problems resulting from isolation and frustration, and the risks of misdiagnosis and non-compliance described above.

Recommendation 3: Just as there are condition-specific provincial strategies to deal with stroke, cataracts, and Alzheimer's Disease, a provincial strategy to deal with hearing loss should be funded and developed in consultation with all stakeholders.

The Need to Value Community Health Care Providers

The Canadian Hearing Society believes that one potential benefit of Ontario's new LHINs could be the proper balancing of effort and outcome between acute and community service providers. If the LHINs enable hospitals to focus on those activities which only they can do – which tend to be acute, urgent, and high cost – and leverage community health care providers to assume increasing responsibility for other services with the potential to reduce both wait times (by reducing the burdens on hospitals) and cost (by enabling earlier interventions and better self-management of chronic conditions) we stand to make significant gains over time as the research we quote on page 2

demonstrates. As the Ministry of Health advances its transformation agenda, then, community health care partners become increasingly important, especially in dealing with chronic conditions provided there is adequate funding for this work.

Recommendation 4: Wherever health care delivery is moved from institutions to community health care providers, sufficient funding for service delivery must accompany the move.

PRIORITY #2: DISABILITY and THE RIGHT TO ACCESS

We applaud the government, indeed all parties as it received unanimous support, on the passage of the Accessibility for Ontarians with Disabilities Act (AODA) in 2005. Action on this legislation has the real potential to make society more accessible to all people with disabilities and in fact, to bring Ontario closer to equal citizenship and full human rights.

However, despite the passage of the AODA, no new funds have been announced to turn these legal tenets into social realities within the health care system. To ensure that patients with hearing loss get complete information and actively participate in their care adequate budgets directed explicitly to access and accommodation need to be included in program and ministry plans.

Deaf people use sign language interpreters. Deafened and hard of hearing people use note-takers or other supports. Devices – such as visual, not only audible, alarms – must be in place in hospitals. Critical health information should be provided on websites in sign language and in plain language. And health care centres must be accessible by TTY.

In addition, limitations of funding under ADP result in both reduced independence for Ontarians who would benefit from essential devices and increased costs for the government as a result of that reduced independence.

Recommendation 5:
Include a budget line for equitable access and accommodation in the Ministry of Health's budget. Without communication there can be no informed consent.

Recommendation 6:
Increase the ADP budget to enhance services for people with hearing loss.

PRIORITY #3: THE VOLUNTARY SECTOR

Community health care is often delivered by agencies that are voluntary sector organizations. These agencies are frequently over-stretched and their limited staff are chronically underpaid.

This historic lack of adequate resourcing must be corrected in order for community health care providers to be an effective partner in meeting the upcoming demands on the health care system.

The voluntary sector must be acknowledged and respected as an increasingly key part of the Canadian economy. A 2005 study commissioned by Imagine Canada and funded by the federal government demonstrated that the non-profit sector now employs nearly two million people – almost the job size of the manufacturing industry in this country. February 2006 Ontario Labour Force statistics reveal that one in eleven Ontarians works in the nonprofit sector.

Furthermore it is a sector that delivers incredible value. Many recent studies substantiate the claim of the Ontario Community Support Association: that for every $1 of funding, the voluntary sector delivers $1.50 worth of service.

That return on government dollars may be attractive, but it is not sustainable. While CHS has been heartened to receive some increases to our base provincial funding in the last

three fiscal years, those increases have yet to catch up with the erosion in funding in real terms that occurred in this sector over the last decade or more. That erosion is estimated to be 15% or more. *(Howarth 2003, Shaken Foundations: The Weakening of Community Building Infrastructure*).

Adding to these challenges, some ministries have begun to elevate the competition for contracts, often opting solely for the lowest cost provider. In the case of home care, this lowest common denominator approach decimated the traditional providers who had operated for decades and brought real expertise to their work. It also left clients in the lurch during a transition and with reduced, poor quality, or eliminated services afterwards. Ultimately this proved to be an ineffective solution for Ontarians who needed home care and as a result, the government has gone some way to reverse its original position. However, some of the damage done as a result of that process is irreversible. In the current drive to accountability agreements with health care providers within the LHIN and CCAC restructuring history must not repeat itself and we must ensure that cost is not the only factor considered in awarding contracts going forward.

For these and other reasons, it is critical that the 10 year strategic plan not promote further erosion to this major, under-funded, and cost-effective sector, any weakening of which threatens the health and quality of life of everyone in Ontario.

Recommendation 7: We urge the government to provide increased funding in the voluntary sector, particularly for those agencies engaged in the health care of seniors. Minimally, this increase should be in the order of 5% in the coming fiscal year and in line with the growth in the economy in years ahead. This should be a base funding increase to go some way towards remedying the erosion of capacity experienced by the sector in the last decade and help keep pace with demands for and cost of service.

CONCLUSION

As the second Annual Report of the Government's Health Results Team indicates there is a renewed momentum for change in Ontario's health care system which is beginning to achieve results. We recognize that there is new energy in the system, but that energy has not yet reached all parts of the system, especially community providers of health services.

Your efforts to consult about your "Plan for Ontario" has come at a key time. The Canadian Hearing Society stands ready to be a full and active health system partner. There is much to do to improve the current health care system for deaf, deafened, and hard of hearing Ontarians and to prepare together to improve the outcomes for the unprecedented cohort of seniors who will experience hearing loss in this province.

We hope you will consider our comments and recommendations. We would welcome the opportunity to work with you or anyone else you think would be appropriate, to develop the concepts and explore implementation.

APPENDIX A

Legal Agreements, Policies and Legislation on Duty to Accommodate

FEDERAL

- Canadian Association of the Deaf, et. al. v. Her Majesty the Queen [2006]:
  This recent Federal Court of Canada decision requires that all Federal Government programs, offices and services provide sign language interpreters "upon request." The ruling makes explicit the right to access government for Deaf Canadians and reinforces the legal precedent set by the *Eldridge* decision.
  http://decisions.fct-cf.gc.ca/en/2006/2006fc971/2006fc971.html

- No Answer II: A Review of Federally Regulated Organizations' Telephonic Communications with People Who Are Deaf, Deafened or Hard of Hearing [2006]
  The report is a review meant to test the responsiveness and effectiveness of TTY services (where available) in federally regulated organizations. The key recommendations of the study are that: all concerned entities should ensure that their services are accessible by providing appropriate assistive devices, including but not limited to, TTYs; those who have TTY service should list the TTY number wherever the telephone number is listed; effective and consistent TTY training should be provided to staff; and finally, provision of accessible telephonic services should be part of a policy that makes specific reference to the duty to accommodate as provided under the Canadian Human Rights Act (CHRA).
  http://www.chrc-ccdp.ca/proactive_initiatives/tty2_ats2/toc_tdm-en.asp

- Canadian Human Rights Commission Memorandum of Understanding with Treasury Board Secretariat [2006]:
  The MOU formalizes the consultation and collaborative process between the Treasury Board and the CHRC with respect to ensuring accessibility to Government of Canada telephone communications for all Canadians, particularly those who are Deaf, deafened, hard of hearing or have a speech impediment. The MOU is in response to the CHRC report, *No Answer: A Review of Government of Canada Telephonic Communication with People who are Deaf, Deafened, Hard of Hearing or Have a Speech Impediment* (2005).
  http://www.chrc-ccdp.ca/proactive_initiatives/tty_ats/chrc_mou_tbs-en.asp?highlight=1

  Update on the progress to-date of improving accessibility of government communications with people who are Deaf, deafened or had of hearing.
  http://www.chrc-ccdp.ca/proactive_initiatives/tty_ats/pr_rp-en.asp

- No Answer: A Review of Government of Canada Telephonic Communication with People who are Deaf, Deafened, Hard of Hearing or Have a Speech Impediment [2005]
  The report addresses the Government of Canada's failure to adequately accommodate the needs of Canadians who cannot use the regular government telephone system, particularly for Canadians who are Deaf, deafened, hard of hearing, or have a speech impediment. The report recommended that the Government of Canada develop a strategy to provide telephonic services for people with hearing loss or a speech impediment, specifically referencing the duty to accommodate as provided by the Canadian Human Rights Act. The **report also recommended that the government review other communication issues**, including the availability of American Sign Language/langue des signes quebecoise (ASL/LSQ) services, the provision of real-time captioning at federal meetings and consultations, consideration of the special needs of hard of hearing people, and captioning of federally sponsored television feeds, videos and the audio portions of websites.
  http://www.chrc-ccdp.ca/proactive_initiatives/tty_ats/toc_tdm-en.asp

- Eldridge v. British Columbia (Attorney General) [1997]:
  The responsibility of governments to provide sign language interpreters was dealt with by the Supreme Court of Canada in the leading case of Eldridge v. British Columbia (Attorney General) I51DLR (4th) 577. While Eldridge dealt specifically with the right to sign language interpreters in the health care system, the principles set out apply more generally to services provided by government, or provided by non-government organizations carrying out specific government objectives.
  http://scc.lexum.umontreal.ca/en/1997/1997rcs3-624/1997rcs3-624.html

- The Canadian Charter of Rights and Freedoms [1982]:
  The Charter is explicit in its provision for sign language interpreters during any proceeding in which Deaf Canadians are involved (see Section 14 and 15.1).
  http://laws.justice.gc.ca/en/charter/index.html

- Canadian Human Rights Act [1976/77]:
  The Act extends the laws of Canada to "give effect…to the principle that all individuals should have an opportunity equal with other individuals to make for themselves the lives that they are able and wish to have and to have their needs accommodated…without being hindered in or prevented from doing so by discriminatory practices based on…disability."
  http://laws.justice.gc.ca/en/h-6/text.html

  Duty to Accommodate Fact Sheet: a short explanation of the duty to accommodate, its requirements and restrictions
  http://www.chrc-ccdp.ca/preventing_discrimination/duty_obligation-en.asp?lang=en&url=%2Fpreventing%5Fdiscrimination%2Fduty%5Fobligation%2Den%2Easp

ONTARIO

- Accessibility for Ontarians with Disabilities Act [2005]:
  Ontario unanimously passed the Accessibility for Ontarians with Disabilities Act (AODA) in June 2005. The legislation promises to create, implement and enforce standards of accessibility with respect to goods, services, facilities, accommodation, employment, buildings, structures and premises for the 16 per cent of Ontarians with disabilities, including people who are deaf, deafened and hard of hearing.
  www.e-laws.gov.on.ca/DBLaws/Statutes/English/05a11_e.htm
  - ✓ Ministry of Community and Social Services Accessibility Plan 2005-2006
    http://www.mcss.gov.on.ca/mcss/english/ministry/accessibilityPlans/2005.htm
  - ✓ Ministry of Community and Social Services Guide to AODA
    http://www.mcss.gov.on.ca/mcss/english/pillars/accessibilityOntario/what/aoda_guide.htm

- Ontario Human Rights Commission Guidelines on Accessible Education [2004]
  These guidelines set the standard for how educational institutions can ensure compliance with the Ontario Human Rights Code as it relates to accommodation for students with a disability, allowing them to access educational services equally.
  http://www.ohrc.on.ca/english/publications/accessible-education-guide.shtml

- Ontario Human Rights Commission's Policy and Guidelines on Disability and the Duty to Accommodate [2000]
  The Ontario Human Rights Code explicitly states that everyone has the right to be free from discrimination. The Policy and Guidelines outline the details and give practical measures for workplaces, public transit, health services, restaurants, shops and housing to provide Ontarians with a disability equal treatment and barrier free access.
  http://www.ohrc.on.ca/english/publications/disability-policy.shtml

- Ontario Human Rights Code [1990]
  The Code protects Ontarians from discrimination based on disability or other characteristics (e.g. race, ancestry, family status, sexual orientation, etc.) and endeavours to create a "climate of understanding and mutual respect for the dignity and worth of each person so that each person feels a part of the community and able to contribute fully to the development and well-being of the community and the Province."
  http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90h19_e.htm