

A Rural Nurse Speaks Out

Ontario's Small and Rural Hospitals Are At Risk:

**How We Can Protect & Restore the Vital Role
of Community Hospitals**

By Shirley Roebuck, R.N.

**With contributions by Dr. Ray Dawes, Fran Renoy ret'd Health Professional, Kathleen Tod, ret'd R.N.
and
Natalie Mehra, Executive Director of the Ontario Health Coalition**

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Forward

I am a retired Registered Nurse. I graduated in 1972 from the Victoria Hospital School of Nursing in London, Ontario. I have earned my living working as a nurse since that date. I have been so fortunate to experience a long and varied career, working in tertiary care hospitals, including Toronto General Hospital, St. Michael's Hospital, the Wellesley Hospital and other Toronto hospitals, before moving to Southwestern Ontario and working in a small, rural hospital in Wallaceburg, Ontario.

I have the experience and knowledge to comment on the current state of health care in this province, not only as a nurse, but as a daughter, a cousin, a friend, as well as a user of health care services.

Big city hospitals in Ontario provide exceptional health services, and are considered leaders in medicine around the world. Yet they are overcrowded, and admission wait times are longer that they should be.

Small community hospitals have seen their beds cut and their services eliminated or moved to larger centres. They are a shell of what they used to be, and are able to support larger community hospitals or big city hospitals to a much lesser degree. Thus there is a back-up of care at all levels: small rural hospitals, larger community hospitals and big city hospitals.

I am amazed at the disregard exhibited by our political leaders as well as the health care leaders in failing to plan for hospital services to meet the needs of our local communities. Years of political policy have led to bed cuts, staff cuts and service cuts around this province. Consolidation of services out of local towns when there is no capacity to take on all regional patients in one centre, lack of proper planning, and short-sighted budget cuts mean that today big city hospitals struggle to provide care, just as small hospitals do.

Remedies that are often touted as replacements community hospital care are not totally effective. The establishment of Family Health Teams and Community Health Centres that provide multi-disciplinary health services are important additions to Ontario's health care system. They are essential parts of the health care continuum and deserve attention and support of the Ministry of Health. There is no doubt that better primary care can result in fewer hospital admissions, better preventative care and early detection and treatment. But these do not provide the range of services that a local hospital provides.

Closing and cutting small local hospitals in an effort to decrease hospital admissions and cut beds more deeply than anywhere else in Canada means that Ontarians are not receiving the services or time in hospital that is needed to assure a successful discharge to the community. Repeat visits to the Emergency Department and repeat admissions are rising. People are developing more health problems while in hospital, and patient outcomes are worse.

People's health has been negatively affected by the piecemeal approach to achieving budget cuts.

The fact remains that Ontario needs its health care to be grounded in sound hospital care planning. Despite literally decades of claims by Health Ministers that care is being moved to the community, "community services" remains a vague term, and can mean different things. It can mean increased home care services, it can mean fragmented health services provided by different providers/agencies or it can mean private for profit clinics. It can mean waiting at home on a waiting list with no help at all. It almost always means less care and less publicly-funded coverage for patients.

Solutions to fixing the system lie in restoring proper hospital funding, and also restoring the role of small rural hospitals in Ontario. They also require a coordinated and effective public home and community care system that is not simply seen as a cheaper way to offload hospital patients.

Rural hospitals can become vibrant again, with basic hospital services being offered: in-patient beds for medicine and surgery; a full service Emergency Department; a variety of basic outpatient clinics, e.g. dietary health, pulmonary function testing, etc.; a full service laboratory and diagnostic imaging departments.

In-patient beds can be used to support the services offered in larger centres, and allow patients to recuperate at home, near family and friends. The outpatient clinics can triage patients that require to be sent to larger facilities, the local Emergency Department can ease the strain being felt by larger EDs and provide triage/emergent health care services for critically ill patients, by initiating the “golden hour of resuscitation”, and giving that patient a better chance at survival.

Rural specialties, for example, First Nations needs (diabetes, stress related health problems, specialized and culturally appropriate addictions services), migrant worker health issues and farming as well as hunting and fishing trauma issues can be addressed in rural communities better than in urban centres far from the patients’ homes.

Small and rural community hospitals can be better integrated with larger hospitals, with visiting specialists and surgical teams; training partnerships for residents, interns and health professionals; telemedicine and other mutually beneficial supports.

It is imperative that a laboratory, with registered laboratory technicians, is part of any small rural hospital. The trend to change to “point of care” devices, and have RNs perform these tests, leads to inaccurate results (due to hemolysis) and takes nurses away from the bedside of the patient. Registered laboratory technicians are trained to recognize nuances or mistakes and to report them. Blood test analysis is crucial to diagnosis and treatment, as is diagnostic imaging.

The cost savings of closing/downsizing rural hospitals have never been proven. As a nurse, I see every day how budget cuts have downloaded costs and stress onto patients and their families who struggle to travel further for care or go without, putting their health in jeopardy. As a nurse who has worked in the largest tertiary care hospitals in Canada and in a small community hospital, I cannot believe that it is cheaper to run services in specialist- and technology-driven large hospitals.

For these reasons and more, I believe in the importance of rural hospitals to the Ontario landscape.

We are Ontarians, urban and rural. We are citizens, taxpayers and we are voters. We deserve the same respect and dignity, and access to care, whether we live in the countryside or in a city. The benefits of Ontario’s Health Care system, and of the Canada Health Act with its principles of equity and fairness, should not be reserved only for urban dwellers.

Shirley Roebuck, R.N.

Overview

Because of Ontario's size and the location of its population, hospitals were built not only in cities, but also in small towns and rural areas. Small rural hospitals were often built through the fundraising efforts of the residents of the area. In many ways a hospital is the heart of the community. I believe this to be true whether the hospital is the Toronto General or the Sydenham District Hospital. The hospital cares for the community, not only by treating physical and mental illness, by holistically recognizing the social determinants of health, of individuals and of entire communities. In many communities it has taken decades or even generations to fundraise and build our local hospitals. Community leaders, retirees, regular citizens, farmers and women's auxiliaries have combined efforts to put resources into improving local access to care because the hospital was – and is – seen as one of the most vital public services in the community.

The job of rural hospitals is to deliver basic hospital services to the local population while triaging which patients can appropriately be treated locally and which must be transferred to larger centres. Smaller community and rural hospitals emergency departments have a crucial life-saving role in stabilizing patients. Smaller community and rural hospitals also provide complex continuing care close to loved ones for local patients with chronic illness. Patients who require more specialized services are referred to larger centres, often associated with teaching universities. Often the patients that are transferred to larger centers return to the local hospital to finish their recovery. Thus a person's experiences in the health care system begin locally, with local services providing the basis for care that is given in a larger more specialized center, and finished with a return to the patient's home area to finish his or her recuperation, surrounded by family, friends and local health care providers.

During hospital restructuring, mainly done between 1995 and 2000, small rural hospitals were put into hospital amalgamations or alliances with other larger hospitals. Later, in the 2000s, the provincial government also mandated that each hospital balance its budget, whether or not funding was sufficient to meet the local population's need. Hospitals facing deficits are now required to cut services to eliminate deficits. Both of these policies have resulted in the current situation in which many services once offered in smaller community and rural hospitals being cut, closed or moved to the larger centers, under the guise of quality care and consolidation of services.

Hospital downsizing has continued for 30 years as modes of service provision have changed. While it is true that some care has moved from hospitals to community, it is also true that workloads of hospital professionals, nurses and support staff have increased significantly as the hospital workforce has been cut. In addition, it is a fact that a whole range of services have been cut since the mid-1990s without replacement in community care or anywhere else. Inpatient medical/surgical beds and chronic care beds (now termed "complex continuing care") have been cut in half since 1990. From 1990 – 2010 almost 19,000 hospital beds were closed. Outpatient care such as chiropody and physiotherapy have been eliminated and privatized. Women's care such as mammography and birthing have been cut and moved out of town. Surgical units have been cut, ORs have been closed down, palliative care units have been dismantled and diagnostics cut. Small community and rural hospitals have disproportionately lost beds and hospital services in the periods of restructuring in the mid-late 1990s and 2008 – 2014.

The present provincial government and some health care executives now plan to further centralize health care in regional centres, severely limiting or eliminating health services which would be delivered in small town /rural settings. There is no established standard for small community and rural hospitals

that would protect any level of services for local communities. These cuts have been ongoing ever since amalgamation. In addition, for the last five years, hospital operating funding has been set lower than the rate of inflation, and for the last two years it has been frozen, resulting in ever more and deeper cuts which have disproportionately fallen on small community and rural hospitals. Moreover because of the 0% increase to hospital funding, planned for 2014, more cuts will be necessary to meet the government's mandate of balanced budgets. This will mean cuts to services in larger community hospitals and more cuts to small and rural hospitals, further decreasing the ability for both urban and rural patients to receive hospital services anywhere close to home.

The Liberal government has struck a provincial task force to determine what services an Emergency Department should deliver. Although this task force is far from finishing its' work, there is a belief that if an Emergency Department cannot deliver health services in a sustainable way, upholding current best practice medical policies, then it should not be considered an Emergency Department.

Ontario residents believe that they do receive quality emergency health care in their local hospitals and emergency departments. People are emotionally tied to their local hospitals and they wish local health care services to continue to be delivered. More than that, rural and smaller community residents understand that local hospitals provide life-saving care. It is a deeply-held public value that rural and smaller community residents are entitled to equity in health services, just as it is for those Ontarians who reside in cities.

It is a fact that some small, rural Emergency Departments have on-going problems with physician staffing and nurse staffing. It is a fact that some small Emergency Departments do not have the

access to support services that larger centers have, and thus some diagnostics are not possible before transport of a critical patient. It is a fact that some small Emergency Departments' staffs are not as educated in, up to date emergency assessment skills and procedures.

It is also a fact that the "golden hour of resuscitation" dictates that the longer a critically ill patient must wait to receive the correct critical care health services, the higher the patient's mortality percentage becomes. Thus, health care professionals speak about the "golden hour of resuscitation" and the importance of patients receiving the right care at the right place; translated this means that each emergency department must provide the correct critical emergency health care, and the patient must then receive the right care in the right critical care setting.

Negative Impacts of Cuts to Small Community and Rural Hospitals

- Longer wait times in Emergency Departments
- Longer wait times for admission to hospital
- Poorer outcomes
- Increased rates of decubitus ulcers (bedsores)
- Increased rate of nosocomial infections
- Decreased numbers of hospital "rescues"
- More return visits to Emergency Departments
- More repeat hospital admissions
- Increased and unsafe nursing staff workloads in larger centres as regional patients seek centralized care
- Hardship for patients recovering far from home
- Reduction in community's chance of attracting new industry/economic impacts
- Increased local job loss
- Decreased markers of overall health, caused by job loss, poverty and unstable access to health services
- Hardship for patients with inability to attend out-of-town appointments
- Increased long-term health care costs
- Inequity in access to health services

But it is not a fact that small emergency departments are incapable of providing life-saving care. In fact, they have done so for generations.

The issues that exist serve as challenges to the Ontario health care system, and remedies can easily be found.

Despite repeated assertions from various governments that they are in fact protecting small hospitals, this is not the case, particularly in cases wherein rural hospitals were amalgamated with larger centers. Small and rural hospitals have been decimated by successive governments' policies. Some have closed. Some have been severely downsized to the point where most of the services that were once provided are no longer available locally. Others' futures are yet to be known.

A Rural Physician Outlines the Benefits, Both Financial and for Patient Care, of Restoring the Role of Small Hospitals

We asked Dr. Ray Dawes, a rural physician who is the past chair of the Section of Rural Practice of the Ontario Medical Association to review our findings. He provided the following list of additional benefits.

There are financial reasons to restore the role of small hospitals:

- Any patient treated in a rural hospital at daily rates of \$400-500 per day, will save the system money compared with large hospitals at rates of \$1,000 -2,000 per day.
- Further, the true costs of increasing demand on helicopters and paramedics have not been fully established.

Small hospitals relieve the pressure on large hospitals during times of overload (flu outbreaks, major disasters, and other times of unexpected overload) by accepting back patients from the large hospital (I receive calls each week from city doctors, asking for my help by accepting patients back to our small hospital).

Small hospital emergency departments save lives - although paramedics do amazing things, they cannot provide urgent blood transfusions for critical accidents, they cannot carry or dispense expensive, rare antibiotics that might be necessary on an urgent basis (eg. meningitis and flesh-eating disease), and they do not have the expertise to diagnose and treat complex problems.

Small hospitals are crucial during times of adverse weather when roads are closed and helicopters do not fly - not a rare occurrence in rural Canada. Further, recent accidents involving both helicopters and land ambulances raise safety concerns, not just for patients but also for staff.

Geriatric patients do far better with treatment close to home and family since complications like delirium, unusual infections like C difficile, and the loss of that vague concept - "the will to live"- are all more likely to happen in distant large hospitals.

When small hospitals are closed (as in Niagara) many unexpected problems surface: ambulances become tied up in the larger center, waiting to unload their patients, and leaving the rural area without ambulance coverage; patients who are discharged are told to leave and find their own way home - which might mean an expensive taxi; rural relatives, who often are not financially well off, are faced with huge costs including gas and parking, which limit their ability to visit loved ones.

I could go on but perhaps the above would be of help.

Dr. Ray Dawes

A Sampling of Cuts at Small Community and Rural Hospitals

It is impossible to obtain a full list of all hospital cuts at small community and rural hospitals across Ontario. It should be surprising that there is so little actual tracking of service cuts and their consequences. This underlines the lack of accountability in hospital planning. In the early 1990s, the only hospital closure was announced publicly. It was later reversed. When the Conservative government implemented hospital restructuring in the latter half of the 1990s, there were written plans and written orders for restructuring. But community fight-backs worked to push back the cuts in some places and some plans were modified or reversed. There are few if any internet records of these periods of restructuring and hard copies of initial restructuring plans are not a reliable guide to what actually happened. In the 2000s, hospital cuts have been piecemeal, sometimes without official announcements of any sort. Again, some cuts have been pushed back due to community opposition. This list is compiled by the Ontario Health Coalition which has tried, to the best of its ability, to track hospital cuts. It is a partial list so we have called it a "sampling". There have been many more cuts stretching back to the 1990s.

Arnprior

2013 – 6 acute care beds cut (approx. 5.5% of the total hospital beds). Physiotherapy reduced along with diagnostic imaging. All personal support workers cut.

Chesley

2008 – Outpatient physiotherapy closed.

2010 – Patient food cut. Frozen “re-therm” meals introduced.

Dunnville

January 2014 – closure of outpatient physiotherapy announced along with cuts to staff in cleaning, therapy and emergency departments.

2013 – Cafeteria closed on the weekends.

Note: In 1995 the provincial government tried to close the hospital. 4,000 people protested the closure and the hospital was saved. The hospital now has 26,000 Emergency Department visits per year.

Durham

2010 – Patient food cut. Frozen “re-therm” meals introduced.

2008 – Outpatient physiotherapy closed.

Grimsby

April 2012 – the rebuild of the West Lincoln Memorial Hospital was cancelled. The community had raised \$14 million towards the \$136 million cost. The capital project had been previously approved by the provincial government and was subsequently cancelled in the 2012 budget. The future of this hospital, which was largely built in the 1940s is uncertain. A merger with the Hamilton hospitals has been proposed and would almost certainly mean cuts to local services. The hospital serves 65,000 people in West Niagara. In the immediate vicinity of the hospital, Grimsby has a population of more than 23,000 and West Lincoln has a population of approximately 14,000.

September 2010 – 10 FTE staff cut and up to 9 beds cut (approx. 13% of the hospitals' beds).

Haliburton Highlands

2009 – CE LHIN Integrated Services Plan closed birthing/maternal services.

Ingersoll

April 2014 - Alexandra Hospital to cut outpatient lab services at the beginning of July. These lab services are to be privatized. The public hospital lab sees between 65 – 80 outpatients per day.

2013 – Nine complex continuing care beds closed (out of a total of 14 complex continuing care beds, equalling a cut of 64% of the Alexandra Hospital's complex continuing care beds).

2013- Outpatient physiotherapy and occupational therapy closed.

Kincardine

Spring 2014 – The hospital announced plans to privatize outpatient physiotherapy in August. Patients will have to pay for physiotherapy.

April 2012 – Previously approved redevelopment plan for the hospital cancelled in budget.

2010 – 21 staff cut and food services cut. Patients to be served frozen “re-thermalized” meals.

2008-9 – The hospital announced plans to privatize all in- and out- patient physiotherapy. The community and physicians opposed the cuts with hundreds participating in petitions and demonstrations. Eventually the privatization was abandoned.

Leamington

2011 – Clinic on Pelee Island which provides urgent care, primary care and nursing was cut from 7 days per week to 5 days per week. 23-hour on-call service was also closed down.

2009 – The hospital announced plans to close 2 ICU beds and 6 rehab beds.

2008 – Closed 8 beds. Consolidated departments. Cut staff including Emergency Department nursing.

Niagara

2014 – Minister of Health announced that the hospitals in Welland, Fort Erie, Port Colborne, Niagara-on-the-Lake and Niagara Falls will be closed entirely. By this plan, five hospitals will close and be replaced with one hospital in Niagara Falls.

2013 -- Pediatric and maternity services closed at Welland and Niagara Falls. Inpatient mental health services closed in Welland.

2013 – Services closed in Niagara-on-the-Lake.

2013 – Some operating rooms in Welland, Niagara Falls and St. Catharines to be closed for 6 weeks due to budget shortfalls.

2009/10 – All medical/surgical beds closed at Fort Erie and Port Colbourne. Emergency Departments closed at Fort Erie and Port Colbourne. ORs and all surgeries cut and closed.

2011 – Leaked documents show plans to cut 120 more bed in Welland. Hospital claims they plan to close 75 beds.

Penetanguishene

May 27, 2014 – announcement that the Penetanguishene Hospital will close. 11 beds will close entirely. 36 of 47 beds will move to Midland over the next 3 – 5 months and the dialysis unit will be moved next year.

Perth & Smiths Falls

2012 – 12 beds closed (more than 1 of every 10 beds in the hospitals). Diagnostic imaging cuts. Day hospital cut from 5 days per week to 3 days per week. Pulmonary rehab program eliminated. Staff cuts in more than a dozen departments.

Picton

Spring 2014 – 3 beds cut (20% of all remaining hospital beds).

Spring 2013 – 6 beds cut (this represents a closure of 29% of the total hospital beds at that time).

Maternity department closed. 3,000 colonoscopies per year cut under threat of being transferred to Belleville. Outpatient laboratory closed. Outpatient physiotherapy closed. Endoscopies under threat of being moved to Belleville.

2009 – Site administrator cut. Diabetic Nurse Educator and Dietician moved to Belleville and Trenton. These services no longer provided by the Picton Hospital.

Port Perry

2002 – 6 beds closed: 4 acute care, 1 complex continuing care, 1 New Life Centre (pediatrics).

Quinte West (Trenton)

2012 - 5 inpatient beds cut (from 31 down to 26 beds, equaling a cut of 16% of the total hospital beds in this hospital). Outpatient physiotherapy eliminated. Laboratory cut. Emergency Department threatened but cuts rolled back. Cuts to long-term care and palliative care services.

Renfrew

2014 – Birthing unit to close in June. Expectant mothers will have to drive to Almonte or Pembroke to access services (both are about 60 km away from Renfrew).

Shelburne

January 2010 – Board voted to close down Shelburne Hospital. 22 chronic care beds moved to Orangeville and 4 beds eliminated.

Tillsonburg

2013—closed 6 complex continuing care beds. (This is equals a closure of 38% of the total complex continuing care beds in the Tillsonburg Hospital.)

2009 – closed 12 beds.

Walkerton

2010 – Patient food services cut. Frozen “re-therm” meals introduced.

2008 – Outpatient physiotherapy closed.

Wallaceburg

2014 – All remaining complex continuing care beds closed and removed to Chatham. All day surgery beds closed. Lab technologists axed. Emergency Department nursing staff decreased. Emergency department nurses to perform “Point of Care” testing. Only 5 medical beds left.

2012 – 10 complex continuing care beds cut. Laboratory cut and replaced by point-of-care testing by nurses. Lab techs cut.

Winchester

Spring 2014 – hospital to close 5 of 17 complex continuing care beds (29%) and 9 of 34 medical/surgical beds (26%). Elimination of 9.5 FTE staff.

Wingham

May 2014 – 30 front-line workers to be cut. Details of service impacts not yet revealed.

2012 – Capital redevelopment plan that had been previously approved was cancelled in the Ontario Budget.

2012 – previously approved redevelopment project for the hospital cancelled in the 2012 Ontario Budget.

In Our Own Words: Nurses and Health Professionals Speak Out About the Dismantling of Their Local Hospitals

Burks Falls

Kathleen A. Tod is a retired nurse, serving in a variety of rural and larger hospitals throughout her career. She helped to fundraise, develop and build the Whitestone Nursing Station and presented to the Romanow Commission on nurse practitioners and nursing stations. She has served as the past president and founder of Emergency Nurses of Niagara; an executive member of the Registered Nurses' Association of Ontario; past president of the Ontario Nurses' Association local 32. Her extensive community involvement includes the Board of Management, Eastholme Home for the Aged in East Parry Sound; Grant Review Team, Ontario Trillium Foundation; District of Parry Sound Employment Services; Magnetawan Agricultural Society; Almaguin Highlands Economic Development Committee; Algonquin Health Services; Almaguin Health Centre and many others. She is the Warden at the Parish of the Good Shepherd in Emsdale and is the founder of the Friends of the Burk's Falls and District Health Centre.

The Burks Falls Hospital was closed by the NDP government in the early 1990s, but the Conservative government reversed the decision, re-opening the 10-bed hospital. (The hospital was in the Finance Minister's riding.¹) The Burks Falls Health Centre, as it was then known, was amalgamated with the Huntsville and Bracebridge Hospitals in 2005. Over the years, it was downsized to 7-beds, an Urgent Care Centre and several diagnostic clinics.

December 2009 saw the closure of the Burk's Falls and District Health Centre, and with it all inpatient beds and the Urgent Care Centre serving 7,000 people in the North Muskoka region.

The Health Centre was replaced with a Family Health Team and some clinics. The cuts have still not stopped. In April 2014, it was announced that the x-ray clinic will be reduced from five days a week to three days per week.

Retired registered nurse and hospital administrator, Kay Tod, had this to say of the hospital's demise:

Thoughts on the Closure of a Local Hospital: Burk's Falls

by Kathleen A. Tod

The silence is heart-rending. Rooms that once offered sanctuary to the sick and halls that once resounded to the echo of busy feet are now filled with overflowing boxes and sundry equipment. The venerable Burk's Falls and District Health Centre is dead! Sixty-one years of history, care and healing is now "headed south". Literally.

Without much in the way of public consultation, close to 7,000 residents of the surrounding communities were informed by the Muskoka Algonquin Healthcare Services (Huntsville and Bracebridge Hospitals) that all lost local services could be "easily obtained" at three area hospitals

¹ Armstrong, Pat et al. *Exposing Privatization: Women and Healthcare* University of Toronto Press, January 1, 2001: 167.

--- one situated 45 minutes south, another an hour to the north and yet another an hour or more to the east on Georgian Bay.

Tell the 23% of our population over the age of 65 – many without access to transportation – and young mothers with sick babies that it “will be easy”. Convince our summer residents and the thousands of tourists who find themselves requiring medical intervention that they only have to travel an hour or so for care and medical intervention.

We, in this area, are devastated and rightfully feel that the Premier, the Minister of Health, the NELHIN, the NSMLHIN and the Muskoka Algonquin Healthcare Services have ignored and abandoned us. All this, in spite of the principle in the Canada Health Act stipulating that it will “protect, promote and restore the physical and mental well-being of Canadians and facilitate access to health services without financial or other barriers.”

We fought the good fight with dignity and passion. For a brief moment this past summer, we thought our voices had been heard when a task force was struck to develop Guidelines for Rural and Northern Healthcare. We soon learned this that it was little more than a sham.

Optimistically, we continued to demonstrate our concerns in various ways, assisted by the Ontario Health Coalition (OHC). Twice we traveled to Queen’s Park with our message. It would seem no one heard.

IN THE NEWS:

Cuts rip apart delivery of healthcare locally

Rob Learn Almaguin News January 7, 2010

BURK’S FALLS – The closure of services at the Burk’s Falls and District Health Centre was like a slow-moving train crash that no one ever managed to find the brakes to halt.

Area residents and politicians saw early on in the year that the outlook for the health centre’s urgent care clinic (UCC) and seven acute care beds was grim and took action. On April 29 a busload of people attended a rural health-care rally at Queen’s Park where they voiced their opposition to cuts in rural services.

The Burk’s Falls contingent was one of many in Toronto that day voicing displeasure with the host of cuts to services in small and outlying communities.

A few weeks later the Almaguin News was able to confirm that, indeed, Muskoka Algonquin Healthcare (MAHC) – the hospital board that operates the Burk’s Falls site along with the Huntsville and Bracebridge hospitals – was

considering closing the beds and the UCC in Burk’s Falls.

Just weeks later MAHC held an official press conference announcing its intention to go ahead with the closures that would create about a \$1.8-million savings annually for the organization. The announcement was made on Wednesday, June 17 and on Monday, June 22 MAHC held a public consultation meeting in Burk’s Falls about the decision that was effective as of the end of that month.

The UCC was closed July 1 and notices were sent to MAHC staff at the BFDHC that the beds would close as of Dec. 1. Before July was out local residents started to rally together to save the services at their hospital. A local chapter of the Ontario Health Coalition was started and plans began to develop to push the community displeasure to the forefront.

At the same time MAHC and local doctors Andrew Albert and David Apramian started to spread the

message about the potential of the Family Health Team (FHT) they were operating out of the Burk's Falls site. Benefits they touted included increased patient load and access to expanded services including a dietician and mental health supports through the team. However, community embracement of the FHT was limited because only patients of the two doctors would have access to the extra services.

In September MAHC was ordered by the regional health authority, the North Simcoe Muskoka LHIN, to conduct a third-party audit of their planned service cuts, but did not order the hospitals' board to put the cuts on hold. At the same time, however, the chairs of the LHINs for Simcoe-Muskoka and Northeast Ontario said that community consultation was paramount in any change to health services and that MAHC had to demonstrate that services were staying at the same level or improving.

Those sentiments didn't stop the beds from closing in Burk's Falls on Dec. 1. MAHC had personnel move the beds and equipment out of the locally supported facility for patients to the Bracebridge and Huntsville sites.

At the same time that MAHC was moving capital items paid for by local donations out of the area,

it announced that the remaining donated monies earmarked for the BFDHC would be pumped into renovations for the FHT, which remains a closed practice. At a public meeting MAHC said it will retain ownership of the Burk's Falls building and land with the intention of charging the FHT rent for space in the BFDHC. At the same time the preliminary findings of the third-party review are that the consultants believe it was a prudent move for MAHC to close services in Burk's Falls.

The official report is to be unveiled to media on Jan. 8, this Friday with public meetings in Huntsville and Bracebridge to come later in the month. No consultations are scheduled for the Burk's Falls area.

The closure of services at the BFDHC mean that any medical emergencies have had to go to emergency departments in Huntsville, Parry Sound or North Bay, while patients recovering from illness, undergoing observation or in palliative care have been separated from friends and family.

The North East LHIN chair Peter Vaudry has promised that his organization will review the cuts to services once the formal process with MAHC has ended. That is expected in April.

Prince Edward County

Fran Renoy has lived in Prince Edward County for 40 years. She worked as a health professional at PECMH for 30 years until her retirement.

Prince Edward County Memorial Hospital (PECMH) amalgamated with Belleville in 1998, under the name Quinte Health Care. At that time PECMH had 42 beds. Today, the hospital has 15 beds left and is facing more downsizing.

The lab has been closed and the Emergency Department staff uses Point of Care devices. A private lab does outpatient blood work. Physiotherapy has been downsized. Obstetrics has been closed, and because of that, two physicians have now left the area. There is no longer a dietician in Picton.

The use of the Operating Room is now restricted to endoscopies and that service is in jeopardy. All other surgeries have been cut.

Prince Edward County has a population of 25,000, with the population of Picton being 5,000. The population is aging. Geography has resulted in harsh winters with heavy snowfalls. This makes travel to Belleville very difficult if not impossible. Closing PECMH entirely would severely harm the population's access to timely health care.

A July 2013 blog by Fran Renoy outlined the cuts at that time²:

“About 10 years ago when I first started writing to the media, my goal was to keep the residents of the County informed about service cuts to PECMH. That goal has not changed a decade down the road. My primary concern has always been that it is cost-prohibitive for many County residents to travel to Belleville for services that are no longer available at PECMH. And now there is more to come. The following cuts are about to take place at PECMH in less than two months.

At the end of August we will lose the two maternity beds and maternity will close. In the past, 180 maternities related tests a year have been completed for women who are expecting. Hopefully, QHC will release a statement saying where these tests will now be performed. In early September, four beds will close on the medical floor. The original QHC plan was to take seven beds plus the two from maternity and reduce us from 21 beds to 12. In September they will take four beds from the medical floor and next year they will take three more. We will then be down to 12 beds.

Carolyn Corbin our Dietician at PECMH for the last 20 years will be sent to Belleville and Trenton in September. We have not been told who will look after 'In and Out Patient counseling'. The Family Health Team has a part-time dietician but I suspect that her workload is already heavy.

The Weekly Pulmonary Function Testing Clinic was discontinued this year. I suspect that these patients now have to travel to Belleville.

Urologist Dr. Jim Wilson who travelled from Kingston to Picton for 30 years to operate a clinic and perform surgery has now retired. Dr. Wilson was very well liked and will be missed. In September

the lab will close completely. There was a concern that those patients who attend clinics in Belleville such as Oncology or are having surgery would have to travel to the BGH lab for blood work. My understanding now is that QHC has worked out an agreement with Life Labs so that these patients will be able to have their lab work done in Picton.

Presently a phlebotomist at PECMH performs this work. This phlebotomist has many duties such as taking blood and doing ECGs on in-patients and then packaging the blood and sending it to BGH. The nurses will now have to perform these duties once the lab closes. There will not be any extra nursing staff provided to perform these extra duties.

The other service that has not been cut is the operating room where the only surgery performed is endoscopy. I suspect that once the new operating rooms in Belleville are completed, the scopes will move to BGH. The surgeons that are operating at PECMH are also doing the same procedures at Campbellford. I also understand that Trenton is interested in doing scopes again. I must add that the operating room at PECMH is very efficient and the surgeries performed here are less expensive than BGH. Hopefully this has been a help to you in seeing the direction that your hospital is taking. If the operating room closes next year the pillage by QHC and the bureaucrats will be complete. Please speak up for your local hospital while you can."

Fran Renoy, Picton

A March 2013 blog by Fran Renoy reveals the frustration and disappointment which many share at decisions to eradicate local control and services and the process by which these are being accomplished:

I read with sadness in the Belleville Intelligencer "Following meetings with three unions Wednesday, Quinte Healthcare management announced an overall reduction of 82 full and part-time positions across three of the networks four hospitals with 40 of those cuts affecting Belleville General Hospital. Trenton Memorial Hospital will shoulder 30 cuts and. PECM Hospital faces nine cuts."

Clearly Trenton and Picton are much smaller than Belleville hospital and are shouldering a much larger percentage of the staff cuts. This comes as no surprise to me and many others who have been following local healthcare for the last 15 years.

Make no mistake. The government has always had a plan to decimate our local hospital and many other rural and small hospitals.

In 1998, as I was about to retire after working 30 years at our local hospital, I remember a conversation with our surgeon Dr. Earle Taylor. We were both of the same minds that we had been forced into amalgamation and it was only a matter of time before Belleville would swallow us up. Sadly this prediction has come true.

In 2002 while attending a QHC board meeting, Eleanor Lindsay MacDonald and I watched in disbelief as each board member raised their hand endorsing cuts to four major services at PECM. Once again QHC had a funding shortfall. There was a huge outcry from the stakeholders so the then Minister of Health George Smitherman eventually sent in a consultant to look at the governance of QHC. I remember the consultant, the late Scott Rowland, saying that his friend the

deputy MOH had asked him to do this investigation. Hearing this I knew why PECMH had not come out in a favorable light in this report.

Just before Smitherman released the Governance report at the Crystal Palace in 2006, Rick Conroy of the Wellington Times said to me that he had just read the report and it was obvious to him that the Ministry of Health wanted our hospital to be scaled down to the level of service and capacity of North Hastings in Bancroft.

Interestingly enough, that day Smitherman said that PECMH had a very bright future. Scott Rowland called our hospital the 'Jewel in the Crown'. I think perhaps Paul Huras and the SELHIN did not receive these memos. At PECMH we eventually lost the Lab, Special Care Unit and a number of beds and the nursing that went with them. One of Rowland's recommendations was to remove the mayors from the QHC board. When amalgamation came into effect in 1998 part of the agreement was that each community was allowed to have their mayor sit on the board.

From the onset of amalgamation in 1998, QHC had a governance system in place in which stakeholders were allowed to purchase memberships. At that time you were allowed to attend the AGM and vote for individuals who were running for the QHC board. Some of us placed application forms in various locations throughout the County encouraging residents to become a member of the QHC Corporation. That year the membership rose to around 700 from about 100 the year before. Even though Prince Edward County represented approximately 20 per cent of the stakeholders the representation in the QHC Corporation was very high. The headline in the Picton Gazette in an article written by reporter Jason Parks read 74 per cent. It was obvious that the stakeholders controlled the vote at the AGM. This would certainly prove to be a problem for QHC and the Ministry of Health and would have to be dealt with at some point.

The other problem for the MOH and QHC was the presence of the mayors on the board. They of course would speak up if cuts were proposed at their respective local hospitals. This action could not be tolerated. We of course didn't have to wait long. In early 2009 then MOH David Caplan sent in supervisor Graham Scott to oversee QHC. On the day that he arrived he dismissed the volunteer QHC Board and the democratically elected membership. He chose to retain CEO Bruce Laughton at a salary of approximately \$270,000. Laughton retired the next year with a handsome payout. At a press conference held by Supervisor Scott the Times' Rick Conroy asked him if he felt that his appointment by the MOH was a conflict as it was he who formulated the QHC amalgamation back in 1998. Mr. Scott said he didn't feel conflicted.

Over the next year he replaced the QHC board with a no-elected board. That he worked for almost one year. He was able to obtain extra funding for QHC. Mr. Scott earned \$2,700 per day for this assignment.

In February 2013, on the Lorne Brooker show, Paul Huras stated that over the years, QHC got more than their fair share of funding. I don't need to remind you as taxpayers that all of these salaries came out of the public coffers. Shortly before Graham Scott left, Mary Clare Egberts was hired as the new QHC CEO in early 2010.

Fast forward to 2012/2013 QHC communicates to their stakeholders' staff, etc. that they must make cuts due to a shortfall of \$10 million (maybe more).

The final nails are now being driven into the coffins of PECM and Trenton Memorial hospitals. You

may ask why I write this article. It is to share with you that some of us who have followed local healthcare very closely knew that there was always a plan to cut our services disproportionately from PECMH and Trenton.

I will leave you with a quote that I feel very adequately describe our relationship with QHC. In his comment in the Feb 27th Wellington Times, Rick Conroy states “PECMH and TMH are not partners in QHC. They are lunch.”

-Fran Renoy

IN THE NEWS:

More Cuts to Picton Hospital

Rick Conroy Wellington Times Friday, April 4th, 2014

Quinte Healthcare Corporation has balanced its budget for the fiscal year beginning April 1—erasing a \$7 million shortfall identified last autumn. To do this, three more beds will be cut from Prince Edward County Memorial Hospital. Two more will be cut from Trenton Memorial. (Other measures were required to close the \$7 million gap—but QHC was unable to show how much each of its four hospitals contributed to funding the shortfall.)

CHIPPING AWAY When it was forced into amalgamating with QHC in 1998, PECMH had 42 beds—now it will have just 12, perhaps as few as 10 for part of the year. In the 15 years since it was amalgamated, each time QHC has struggled to balance its revenues with its expenses—the hospitals in Picton and Trenton have borne a disproportionate share of the cuts to service and capacity. The trend continues.

These cuts are even more difficult to comprehend given that the inpatient unit at PECMH was named top performing hospital in Ontario for overall care in acute inpatient care in community hospitals, and in the 90th percentile in all hospitals combined (includes all small community and academic hospitals) last November.

It was just last spring that QHC had cut six beds from the Picton hospital. Now it will cut

three more. The hospital corporation is also considering a “seasonal model” in which Picton would have 14 beds part of the year and only 10 the remaining months.

This Friday morning past, 19 people were being cared for in inpatient beds in Picton.

But patient care is better according to the board of QHC. And the budget is balanced—or very nearly so. QHC’s finance Chief Brad Harrington acknowledged that about three per cent of the corporation’s budget isn’t tied down yet.

“We should be very proud of our processes,” said QHC board chair, Steve Blakely. He added that other hospitals are “salivating” at QHC’s success at improving patient care with fewer resources.

“It speaks volumes about our people and processes,” said Blakely.

Another board member suggested that while QHC had adjusted its ways to adapt to the changing role of hospital care in the province— patients were lagging.

“We at QHC and our partners have changed our attitudes and processes,” said Karen Baker, board treasurer. “Patients need to change their attitude.”

Baker urged patients to come to the hospital “only when they need to be in the hospital”.

PROFOUNDLY DISAPPOINTING Dr. Elizabeth Christie describes QHC’s choice to cut three more beds from PECMH as “profoundly disappointing”. Christie heads the Prince Edward Family Health Team (PEFHT).

“It is hard to imagine how QHC could cut another three beds—20 per cent of the remaining beds—in the number one community hospital inpatient ward in all of Ontario,” said Dr. Christie. “The cheapest beds in the entire hospital corporation.”

Notwithstanding the latest round of cuts of capacity of PECMH, Dr. Christie and other physicians and allied healthcare professionals of the Family Health Team will continue to work through the challenges and will not allow them to reduce the quality of care for their patients.

“We will have to pursue more inventive means of helping people to get out of hospital sooner,” said Dr. Christie.

“We will have to absolutely maximize Family Health Team resources and push our partners—in particular the CCAC (Community Care Access Centre) to the limit of their resources to provide even more home-based and community-based care,” said Dr. Christie. “The question remains whether they have the resources to do it.”

CUT FIRST, MEASURE LATER The Family Health Team is also hoping that the recently announced Hospital@Home program will succeed and will alleviate pressure on PECMH beds. Yet it is a pilot program that will be evaluated after two years. It has also had mixed success in other centers. And while the CCAC received increased funding last year—it was spread across the entire southeast region, from Brockville to Bancroft to Brighton.

Cutting inpatient beds in Picton is based on assumptions that community-based support will be in place and sufficient to serve the needs of this community—assumptions that haven’t been proved. Why make the cuts to beds until those supports are in place and proven?

“I would love to be able to implement the current health system reform over a longer time frame and not reduce the beds until all the supports have been well established and proven in the community,” said Mary Clare Egberts, CEO of QHC. “But the reality is our funding is being reduced starting April 1. We must deliver our services within the funding we receive from the province. We know we’re not as efficient as peer hospitals in the province, so there is room for improvement. That being said, we will also continue to monitor quality and safety indicators and make adjustments as necessary to ensure we’re not increasing risks.”

CLOCK IS TICKING Dr. Christie says cutting PECMH to as few as 10 or 12 beds increases the urgency to establish a new hospital in Picton. An emergency department and 12 beds in a hospital built for 100 are vulnerable.

“I see that as the only way this community is going to continue to have a hospital,” said Dr. Christie. “It is pretty hard to be able justify 12 beds in that great big building for very long.”

She says a new hospital is needed with related services and capacities nearby, such as complex continuing care, services for patients with severe dementia, and other services targeted at the needs of this aging community.

She remains hopeful this may yet happen. She met with Local Health Integration, QHC officials and community representatives last week to discuss development plans.

“That entire group is absolutely committed

to the construction of a new hospital in PEC,” said Dr. Christie. “Our next push is to demand that the services that need to be provided in this community— are provided in this community.”

It’s a task that Dr. Christie says gets harder with every round of cuts to Picton’s capacity, services and beds.

Wallaceburg

Shirley Roebuck is a Registered Nurse who has worked for 42 years until recently in large community, tertiary and small community hospitals.

The following is an essay by Shirley Roebuck outlining the cuts to the Wallaceburg Hospital and the consequences for patients:

The Wallaceburg hospital was amalgamated with 2 hospitals in Chatham Ontario, in 1998. The Wallaceburg Board of Directors, led by M. Kilbride, Chair, at that time asked to be amalgamated with the Sarnia hospitals but the MOHLTC stated that the Chatham Hospitals could not survive without Wallaceburg.

At the time of amalgamation the Wallaceburg hospital was a 65-bed hospital, with a full service Operating Room, inpatient beds for Medicine and Surgery, outpatient services including Pulmonary Function testing and Cardiac Stress testing, a Day Surgery unit, Ambulatory Care unit, Obstetrics, Pediatrics, a Palliative Care unit, a 5-bed Intensive Care Unit and an Emergency Room (supported by full service Laboratory, Pathology and Diagnostic Radiology).

As of this spring, it has been reduced to an Emergency Room, with point of care blood testing by RNs and 5 inpatient beds. All other services have cut and closed or moved to the Chatham Campus.

Time after time the population of Wallaceburg and its catchment area did fundraising for this community hospital, which included maternal monitoring equipment and obstetrical needs, palliative care furnishings and beds, critical care monitors and beds as well as funding the building of a 5-bed Intensive Care Unit.

Due to the amalgamation agreement, all of this equipment was deemed to be the property of the Chatham Kent Health Alliance and was removed to the Chatham Campus.

It has turned out that the statement made by the MOHLTC representative in 1998 was correct: the Chatham hospitals could not have survived without Wallaceburg...without the dismantling of the Wallaceburg Hospital, that is.

I moved from Toronto to this area years ago, and I had a pre-conceived notion that small hospitals were behind the times, out of date, and basically inept at providing patient care. As a nurse, I remembered running cardiac arrest scenarios in Toronto: we had at least 6 nurses, an ICU resident, a medicine resident, an anesthesiologist, several interns, a respiratory technologist, an administrator to deal with the family/friends, clergy and perhaps others I have forgotten. In the small rural hospital that I worked in, we had 3 nurses, a respiratory technologist during business hours, and a doctor. Health professionals worked together, and although I cannot provide you with statistics, I know that we successfully resuscitated many people, giving them another chance at life.

I will share with you that people's health has been negatively affected by the cuts and the fragmented approach to providing health services in Chatham Kent:

- It is very difficult for some patients and families to travel to Chatham in good weather, let alone during inclement weather conditions. Recently an older woman, who was a very nervous driver, was unable to visit her husband who had been hospitalized in Chatham; this went on for several weeks. Studies have shown that patients recuperate faster in the presence of family and friends.
- The human element of health care seems to have been forgotten by those who are planning huge changes in Ontario's health care system. An elderly woman, who must have lifesaving dialysis, has just lost her 'ride' to Chatham. She has no family, and no other way of transportation to her treatment; she has no idea if she will be able to attend her treatments.
- Patients who have been admitted to hospital have much longer waits in ER due to lack of available beds to admit to. A stretcher is hardly a bed, and this is hardly quality service. Also, this lack of hospital beds ties up ER stretchers, elongating the wait times.
- The local CHC has numerous satellites, but is administered by one management group; one local satellite has lost a doctor. This in turn leaves scores of patients without any access to primary care; they will turn to the local ER, for their health care services.
- An eighty year old Wallaceburg man, with a chronic leg ulcer, was sent to a specialist in Sarnia. There, the doctor told him to go the local CCAC clinic for a dressing change. The man did so, but was told he had to go to Chatham, as he did not live in Lambton County. In total, the man had to drive from Wallaceburg to Sarnia to get specialist care, then from Sarnia, back through Wallaceburg, to Chatham to have his dressing done by the "home care" clinic, then he returned home to Wallaceburg.
- The local Geriatric Emergency Management (GEM) program is funded by the Erie St. Clair LHIN. One goal of this program is to prevent unnecessary hospital admissions to active beds. The LHIN gave the program funding for respite beds, but these beds were administered by the CCAC. When an elderly patient comes to the ER, and requires admission to one of these respite beds, CCAC must be called. CCAC works Monday to Friday during the day so when a patient arrives outside of business hours, these beds cannot be accessed.
- CCAC also controls admissions to nursing homes, so a patient who is in hospital, and is awaiting a nursing home bed, will continue to wait in hospital until CCAC returns to work on Monday; this is not efficient, and clogs up the system.
- One man was on the waiting list for admission to the in-patient psychiatric unit; he was suffering from depression. He waited a year for a bed to come available, but unfortunately, the bed came too late; he committed suicide.

Leaving all emotion out of the argument, I will assert that this is far from excellent health care and instead reeks of "empire building" at the expense of the patient and community.

All hospitals do good work for the people they serve. "Excellent Care" is not a term used by only larger community hospitals or tertiary cares hospitals. Centralization of health service creates problems for both the health care providers and for the patients they seek to serve. Options can be found to keep rural health care as vibrant as care provided in urban centers.

I believe in Ontario's health system; I believe that every Ontarian should have equal access to quality care. I believe that Ontario's small rural hospitals play a pivotal role in Ontario's health

system. They support Ontario's excellent tertiary hospitals in our cities. I believe that we pay taxes for services like this, and I believe that taxpayers should not have to prop up corporations and the wealthy.

The Erie St. Clair CEO once told me that I was not looking forward; it was as if I was driving a car, but staring out the back window at the brake lights. I think that he was in the driver's seat, and he didn't have his headlights on.

This car is headed for a cliff, if the voters -- the taxpayers -- don't make the policy makers turn on their lights, they won't realize that if we, as a society, are to uphold the Canada Health Act and ensure that people in need have access to care without the barrier of cost when they are ill or dying, then they must restore Ontario's small and rural hospitals and the vital care they provide.

Solutions

1. Create policy to set a standard for levels of care in hospitals. Ensure a basket of services are available in every hospital, including in the smallest and amalgamated or allied hospitals.

Small hospitals specialize in assessment, stabilization and transfer of critical cases, and provide basic hospital care close to home. Larger small hospitals and more remote small hospitals should include ability to perform minor surgeries, and a wider range of clinics, specialties and other services as determined by population need and the need for accessibility. Local hospital beds need to be re-opened to allow for easy admission. Re-establish nursing staff levels and mix to allow for safe patient care, early interventions for health crises, and to allow staff interaction, cooperation and professional growth. The role of the smallest hospitals, including the smaller sites of the amalgamated and allied hospitals, should be to plan to provide at minimum the baseline hospital services identified here.

Baseline services to be provided in the smallest of hospitals include:

- An emergency department and special care units/monitored beds.
- Blood services.
- Laboratory, x-ray and ultrasound.
- Ability to admit for both acute and complex continuing care in patients' home communities.
- Diabetes programs, linked with family, physicians, mental health services and rehabilitation.
- Palliative care close to home.
- Rehabilitation.
- Obstetrics close to home unless population demographics clearly indicate no need.
- Services such as mammography and other diagnostics should be provided at least as visiting services (on mobile units) to small and northern hospitals, as a public non-profit service linked to or coordinated with hospitals.
- Dialysis for stable patients and a chemotherapy/oncology program should be provided in the larger small hospitals, coordinated among hospitals where there is a cluster of nearby hospitals. In more remote areas they should be provided in every hospital.
- The provision of minor surgeries, and simple geriatrics, internal medicine and pediatrics should be organized with a focus on accessibility, in tandem with other small hospitals where there are clusters of small hospitals nearby.
- Similarly mental health services should be organized in coordination with other local hospitals, with a priority given to improving accessibility.

In the special case of northern hospitals that are more remote, surgeries, visiting surgical programs and specialties, the use of telemedicine and technological links, robust rehabilitation programs and access to allied health professionals should continue to be supported and provided along with development of improved addictions and mental health programs.

2. Create a provincial standard and a plan to provide at least baseline hospital services at optimum 20 minutes from residents' homes in average road conditions and at most 30 minutes from residents' homes in average road conditions. In the special case of the north, all existing hospitals should be maintained.

A multi-year province-wide plan to develop baseline hospital services should be created. Ambulance response times can be 30 – 45 minutes for traumas from car and farm accidents in rural areas. Thus, at optimum, baseline services should be 20 minutes from residents' homes in average road conditions, and, at most, 30 minutes from residents' homes in average road conditions. This would allow

ambulances access to a hospital emergency room within the critical “golden hour” during which the intervention provided in a local emergency department can save life and improve health outcomes.

All the northern hospitals are needed and should be maintained along with the nursing stations.

3. Amalgamation of governance and management functions should not be interpreted to mean that services are not needed and can be summarily withdrawn by hospital boards or LHINs.

There should be legislative protection against closure, including closure of vital services such as emergency departments, for rural or small hospitals. This legislative protection should extend to all small community and rural hospitals regardless of status as an amalgamated site of a larger community/urban hospital.

3. Reorganize health planning to focus on the fundamental job of a public health care system: measure population need for services and plan care services to meet the needs of the population.

The Ontario Hospital Association is calling this “capacity planning”. Ontario’s health planning system must be clearly organized to ensure that their first and only priority is to ensure excellent health care to meet the health care needs of the population in their region. Extraordinary powers to order cuts and closures, or movement of services from one community to another should be removed from the Local Health Integration Act and democratic processes should be restored. Community consultation should meet much higher standards, and those standards should be enforced.

4. Set a provincial standard to measure access and assess capacity more meaningfully.

The measure of accessibility should not measure distance simply from the door of one emergency department to the door of another. Many patients have already traveled significant distances to get to the door of the first hospital. A tool is needed that includes such factors as distance for the total catchment population of the hospital, population demographics and assessed need, transportation systems and road conditions. Further, careful attention to other local or regional hospitals’ capacities must be included in planning decisions. Hospital cuts should not proceed if there is no capacity to meet need for services under the public health care system.

4. Step up efforts to train, recruit and retain nurses, health professionals, physicians and support workers in areas that are suffering from poor access to care.

Shortages of physicians, nurses and other health professionals should not be used as an excuse to fail to plan to provide services for rural Ontarians. Where shortages imperil the ability to deliver on planned baseline services, service planning should move ahead with enhanced planning to supply and recruit health professionals to meet the service planning targets.

Severe shortages in some regions are creating a crisis in access to care and increasing costs.

- The provincial government must intervene when disagreements between hospital managements and physicians threaten the loss of emergency and hospital services for entire communities.
- Create emergency task forces for critically underserved areas first (including such localities as Shelburne, Hailybury and Minden) in partnership with municipalities, local physician recruitment committees, regional planning bodies and local hospital management. Leverage the connections, knowledge, skills and resources of these groups to create and implement meaningful plans to alleviate shortages.
- Build on the recent success at improving medical school enrollment in family medicine programs. Continue to increase space for medical school positions to meet population need for

family physicians, coupled with medical school recruitment processes to encourage rural and northern applicants and those committed to family medicine and practices in rural and northern communities.

- Continue and expand the work of Health Force Ontario and Ontario Medical Association programs that are providing better access through supporting recruitment and retention, mentorship, and locums.
- Support hospitals in developing partnerships with medical and nursing schools to bring interns, residents and nurses to small hospitals.
- Build upon the recent initiatives to improve the supply of nurses, including increasing spaces in educational institutions to meet standards of care, coupled with recruitment processes to encourage rural and northern applicants and those committed to practicing in rural and northern communities, and opportunities for clinical placements.
- Actively promote the team of health care professionals including nurse practitioners and allied health professionals working to their scopes of practice, by creating or expanding funding mechanisms and support targeted first to those areas with severe access to care issues and those at risk of declining access.
- Create clear planning targets for improving the supply of health professions.
- Continue to support the northern nursing stations and nurse practitioners.
- Recognize and celebrate the special skills and the vital contribution of rural and northern physicians, nurses and allied health professionals.
- Support family physicians to continue to provide emergency department coverage. Do not use the lack of specialized emergency physicians to justify closure of local emergency departments. Support the creation of technological innovations to advance specialized training for local emergency room physicians.
- Similarly, shortages of nurses should not be used as a justification to close hospital services. Instead planning should be undertaken to rectify shortages and maintain services.
- Restore access to outpatient rehabilitation in local hospitals.

5. Revise current practices of closing complex continuing care beds and long term care beds in hospitals and provide stable accessible services to seniors.

Care levels are inadequate to provide for chronic care patients in long term care homes. Patients end up back in emergency departments and their health can be irreversibly compromised. There are few or no dedicated complex continuing care hospitals in rural areas. Complex continuing care is a legitimate hospital service and should be appropriately funded and provided. The movement of long term care patients should only be allowed when there are adequate and appropriate placements available that are accessible to patient's communities (spouses, families and friends). Retirement homes should not be used to take hospital and long term care patients.

9. Restore proper provincial legislative decision-making powers and processes.

Decisions to remove democratic rights, such as elected hospital boards, should not be made in secret, nor in an "ad hoc" way at the local level, but must clearly be subject to debate and decision of the provincial legislature. Similarly decisions to shrink the scope of public coverage by privatizing entire categories of hospital services such as physiotherapy and complex continuing care must be subject to proper parliamentary process, including clearly- stated, publicly-accountable legislative changes, debate in the legislature, and public hearings. Canada Health Act rights must be respected by the Province of Ontario.

- Provincial legislation should embody the principles of the Canada Health Act.

- Hospitals should be required to show cause, according to provincially-set standards, for removing or cutting existing services. The provincial government must retain decision-making power to approve such cuts before they are implemented. The public should be provided notice, access to documents, an ability to be heard and an ability to appeal proposals for cuts.

12. Restore democratically-elected hospital boards.

- It is not a “best practice” in governance to remove public accountability, public access to information, open board meetings, a transparent board election process, and CEO accountability. Simply shutting out the public to force through hospital cuts is not a best practice. Ensure that hospital boards are elected and requirements for the needed mix of skills are consistent across the province and balanced with strong representation for patient and community voices. Municipalities should not be excluded from hospital boards.

13. Curb the powers and overuse of provincially-appointed hospital supervisors.

Hospital supervisors should be used in limited circumstances only, as intended by the Public Hospitals Act, to deal with serious issues of misuse of public funds and governance break-down. This also applies to cases such as take-over by groups that oppose hospital services such as abortion or choices in end-of-life care. Hospital supervisors should not be granted open-ended terms of reference by cabinet. Supervisors should not go into a town to eradicate local voting memberships in hospital corporations in perpetuity, nor to create appointed boards in perpetuity. Supervisors should not be allowed to create new provincial hospital policy without proper parliamentary process.

22. Take real measures to contain exorbitant hospital executive costs and set reasonable expectations for remuneration. This cannot be done through new bonus systems.

In many cases hospital executive salaries are in excess of ten times the average wage of the community and are increasing faster than can be justified by any measure. Executives are already handsomely recompensed for their services and do not need “bonus” systems to perform to expectations. Provincial policy makers should recognize that so-called performance measures that support cutting hospital services while giving bonuses to executives will stoke further public outrage.

23. Plan to increase hospital funding towards meeting the national average.

Ontario funds our hospitals significantly less than other provinces. Rural communities, in particular, have experienced continual service cuts and instability as a result. According to Ontario Hospital Association figures, the Ontario government funds hospitals \$194 less per person than the average hospital funding levels of other provinces. When tallied for the 13 million Ontarians, the aggregate total shortfall is \$2.5 billion.³ Ontario’s patients are suffering from the decision to continue inadequate funding to their local hospitals’ global budgets.

24. Reform home care to create a public and non-profit home care system that works closely with hospitals to provide coordinated care for patients.

³ Ontario Hospital Association slide, “The Efficiency Dividend”, November 20, 2009.

