Toward Access and Equality:
Realigning Ontario's Approach to Small and Rural Hospitals to Serve Public Values

Results of the Ontario Health Coalition hearings on small and rural hospitals held in12 communities across Ontario in March 2010 submitted by the panelists to the Ontario Health Coalition May 17, 2010

Background

During March 2010, the Ontario Health Coalition held twelve public hearings across Ontario to gain input on the future of small and rural hospitals. At the same time, written submissions from the public were solicited though widespread media advertising and publicity. The hearings were attended by more than 1,150 people. The coalition has received a total of 487 oral and written presentations including 305 written submissions and an additional 182 formal and informal oral presentations at the hearings.

Witnesses that provided testimony at the hearings included patients, mayors, municipal councilors, religious leaders, agricultural organizations, economic task forces, seniors' organizations, unions, doctors, nurses, patients' families, concerned community members, Members of Parliament, community health and social service organizations, health professionals and associations, and others.

The Ontario Health Coalition set up its own process of non-partisan public hearings after repeated requests in the summer and autumn of 2009 to the Health Minister's office to have their rural and northern panel conduct a province-wide public consultation process were ignored. The coalition was concerned about the unclear mandate of the Minister's panel and had observed, through reports from its networks, poor planning, evaluation, consultation and governance processes with regard to the future of local hospitals. As a result, the coalition decided to create their own hearings.

Summary of What We Heard

The Role of Small and Rural Hospitals

The hearings covered hospitals that ranged in size from very small to medium in communities that varied in remoteness and rurality. Governance structures covered the gamut from amalgamated corporations to alliances to stand-alone hospitals. Some hospitals are doing well and provide for their communities the range of what we will term here as "baseline" hospital services as well as clinics, specialists and surgeries. Others are being closed or were threatened with significant cuts to services. Though each community is unique, we heard some common themes that this panel believes should inform policy makers' decisions about the role of small and rural hospitals.

Smaller communities have tremendous pride in their hospitals. The long history of the development of local hospitals and the priority the public places on their continuation cannot and should not be ignored. Local hospitals play an essential role in regional heath care systems. They are vital to community social and economic development.

The passion expressed by Ontarians for their community hospitals is deeper than symbolism and sentimentality. For decades, community development, social practices, systems and infrastructure have been built around these hospitals. The location of hospitals has been a priority factor in planning travel and settlement patterns including municipal transit where it exists, ambulance systems, and seniors' retirement choices. Hospitals employ a core of professionals who, in turn, support employment in the communities' services sectors. They have stabilized and supported recruitment of nurses, health care professionals and family doctors. Every mayor and community economic development committee member will testify that access to a hospital is among the foremost priorities for industries when considering their location.

In turn, local hospitals benefit tremendously from local donations of money, equipment and services. There is natural self-policing: local communities want well-run, efficient and compassionate hospitals. They want money to go to care and not waste. They support skills on hospital boards without being to be told to do so. But they also believe that hospitals should be accountable to the people who built them and who fund them.

Small and rural hospitals specialize in assessing patients, stabilizing critical patients and transferring them to sites where they can receive optimal care. They provide humane and compassionate chronic and palliative care. They provide vital access to primary care and acute care, diagnostics, clinics and, in some cases, minor surgeries.

This panel believes that local hospitals are in danger of short-sighted cuts that will reverse decades of improvements in access to care to the detriment of both rural communities and the larger communities in the region. Because of this context, we believe that it is necessary to set a baseline level of expected hospital services for communities that will provide some protection against the current trend of arbitrary and ad hoc cutting.

This is not our preferred approach, but we believe that access to care is at such risk that it is necessary. These baseline services should not be considered a definitive list of services to be offered in all of the smallest hospitals. Because geography, accessibility and capacities of local hospitals and other health providers vary, what might comprise a range of hospital services to ensure reasonable access is also variable. Particular communities also have unique needs that must be served. Nor should this approach be taken as a substitute for the imperative that the province to comply with the Canada Health Act's requirement for reasonable and equitable access to medically necessary hospital and physician services. This committee rejects the practice, recently exemplified in Northumberland Hills of a small group voting on what to consider "core services".

This panel's recommendation is for policy to based on reasonable geographic access to baseline hospital care, measured not by distance simply from the door of one emergency department to the door of another, but by a tool that includes such factors as distance for

the total catchment area, population demographics and assessed need, transportation systems and road conditions.

Shortages of physicians and nurses should not be used as an excuse to withdraw services from entire communities. Service planning should move ahead, with enhanced plans to build or rebuild human resource and physical capacities to provide these services.

Following this criteria, a multi-year province-wide plan to develop baseline hospital services should be created. 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. In the special case of the north, all existing hospitals should be maintained.

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. Small hospitals specialize in assessment, stabilization and transfer of critical cases, and provision of 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 accessibility.

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

- An emergency department and intensive care.
- 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.
- 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.
- Palliative care close to home.
- Rehabilitation.
- Obstetrics close to home unless population demographics clearly indicate lack of need.
- 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 in tandem with other small hospitals where there are clusters of small hospitals nearby, with a focus on accessibility.
- 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, rehabilitation and access to allied health professionals should continue to be supported and provided along with development of improved addictions and mental health programs.

In conclusion, historically, local hospitals were supported and overseen by local boards who were accessible to the community. The treasurer was usually a local bank manager or accountant. Communities could ask questions and hospital boards were expected to answer them. Administration was minimal and administrators were clinicians who understood clinical needs and priorities. Hospital board and community were united with the goal of providing the hospital services that were needed by the community efficiently and effectively. Compassion and public service were practiced values. The movement away from that approach is credited with reducing access to care, increasing bureaucracy, eliminating accountability and alienating communities.

Access to Care

Some identifiable trends relating to access to care emerged across the province. But it is also evident that planning for hospital services has deteriorated and is now ad hoc, erratic and inequitable. Access to care varies greatly from locality to locality. It is not guided by principles and policy and there are few basic standards or expectations. If the provincial government is supposed to "steer" the system by providing policy and standards and the human, financial and material resources to meet policy goals, it has failed in its role. If LHINs are supposed to implement a provincial plan and coordinate services, they have not done so. If local hospitals are supposed to meet community need for hospital services, they are not meeting it. Advocacy to protect or improve access to services is discouraged in legislation and in practice by all levels of governance. This situation cannot continue.

Some small and rural communities are experiencing severe problems accessing basic medical and hospital care. Shortages of physicians, nurses and health professionals are compromising health. Shortages exist everywhere but they are at critical levels in some regions. In general, bed shortages are causing backlogs in emergency departments and compromising care practices. Public coverage for rehabilitation and seniors' care is being eradicated. The effects of hospital cuts and planning decisions on access to care is not being evaluated. In several communities, the full extent of the cuts has been obscured by hospital leadership.

This panel believes that the culture of disrespect for advocates (including municipal leaders) and, frankly, arrogance on the part of an increasing number of bureaucrats, ministerial staff, LHIN and hospital executives with key policy-making and evaluation functions has led to poor decision-making. It is not possible to oversee, coordinate and evaluate complex decision-making regarding hospital services without listening to the needs of communities. The problems of democracy and public accountability are dealt with in the following sections. The ensuing problems regarding planning and access are covered in this section.

This panel heard the worst testimony of poor access to hospital beds and emergency departments in Niagara and Wallaceburg. In Chatham-Kent, Wallaceburg, Niagara and other areas, shortages of medical/surgical beds and/or complex continuing care are causing extreme backlogs in the emergency departments. In Niagara, patients are being

treated in stretchers in hallways for days at a time. In other hospitals, patients awaiting discharge within 48 hours are moved out of inpatient units into hallways without appropriate physical supports, privacy or nursing staff. The overloaded emergency departments have created dangerous offload delays and ambulance redirect and by-pass situations in both regions. These problems have been exacerbated by the recent closures of beds. There has been no evaluation of the decisions to close beds and emergency departments despite the evidence of serious problems in quality and access to care.

Patients and health professionals described the experience of hallway medicine. Sick patients are left on uncomfortable stretchers in noisy corridors under bright lights, often with no food for entire days. There is no privacy. Staffing levels are inadequate to meet care needs and monitor intensive care patients. Patient care is compromised and human dignity is assailed.

Shortages were reported almost everywhere, but the worst accounts of poor access to family doctors were reported in Shelburne, Northern Dufferin County, Minden, and Hailybury. The almost total absence of family doctors in these areas has left thousands of people without access to care and with little hope of getting a family doctor in the future. Residents have no choice but to wait for hours in the emergency departments to get prescriptions filled. In many hearings, witnesses gave examples of residents with poor access to family physicians who put off seeking care, turned off by long waits in emergency departments. When they finally seek care, more aggressive treatment is needed or health is irreversibly compromised by the delay.

In Burk's Falls, an emerging problem of no access to primary care and urgent care will become more evident this summer as cottagers return to the area. The local hospital was closed in December. It provided the only walk-in urgent care service in the north Muskoka area serving thousands of residents all year and more than ten thousand summer residents. A family health team comprised of two doctors cannot replace the services that have been cut.

The closure of outpatient rehabilitation in local hospitals means the total loss of access to these vital services. With the closure of outpatient physiotherapy in Kincardine, the nearest publicly funded clinic is 100 km away. Closure of outpatient rehabilitation in Cobourg means that the nearest publicly funded physiotherapy is in either Peterborough or Ottawa and it is unlikely that there is capacity in those communities to take the 5,500 patient-visits from Northumberland. Information from the Ontario Association of Physiotherapists reveals that very few OHIP-covered clinics are located in rural settings and only two are in northern Ontario. While the province has priorized increased volumes of hip and knee surgeries and cardiac care, many patients return home after surgery to find rehabilitation services cut and inaccessible. Many rural residents and farmers have no private insurance, and, in any case, private insurance is inadequate for the intensive rehabilitation required for fractures, joint replacements and other injuries. The privatization of payment and provision of rehabilitation is causing hardship, violates the Canada Health Act and is compromises people's health.

Cuts to and privatization of laboratory services were the cause of complaint in three of the hearings. In Southwestern Ontario, witnesses raised concerns about late and poor

quality tests. Similarly, in Burk's Falls, witnesses testified about poor quality and lateness of tests. In Shelburne, a witness complained about long waits at the nearest private lab. Indeed, it has been the experience of the Ontario Health Coalition that privatized lab collection facilities, set up after outpatient laboratory services were cut, have decreased their hours of operation and are the frequent subject of complaints about long line ups and poor access. The laboratory system does not seem to be accountable for access, quality, patient user fees and higher costs to the public health care system.

This panel shares concerns expressed by witnesses about access to dialysis. Dialysis patients feel so awful after their dialysis and must go so often (three times a week) it is extremely difficult for those who have to travel great distances to access this service. The panel supports protecting and enhancing dialysis services for stable patients close to home.

We also share the concerns about cuts to and closures of hospital-based diabetes education programs in Shelburne and Cobourg. These programs are vital for the prevention of more serious disease, disability and death and the cuts to them are short-sighted. In both areas there is no replacement for the services that are being cut from the local hospitals.

The McGuinty government deserves credit for the recent increases in the number of positions in medical schools and the number of medical students choosing family medicine. In addition, the efforts of Health Force Ontario, the Ministry of Health and the Ontario Medical Association to provide locums, community health centres, family health teams, nurse-led clinics and physicians in underserved communities have improved access to care in some areas. But the practice of municipalities competing for scarce physicians by providing bonuses and other financial incentives drives up the cost for everyone and does not improve inequities. We recognize and credit the strides that are being made. Nonetheless, this panel believes that the provincial government must do much more to support supply and recruitment for nurses, allied health professionals and physicians.

In general, among the public there was widespread support for increasing the availability of nurse practitioners and the use of the entire team of health professionals to their scope to alleviate pressure and improve access and care. The public see this a complimentary to physicians and many called for increasing support and efforts to recruit family doctors, with many viewing mentorship programs as a need.

In many areas homecare services are facing budget deficits and severe rationing. Across the province, hospital cuts to complex continuing care, long term care and rehabilitation are happening at the same time as cuts and curtailment of access to homecare services. Many witnesses described staff shortages, poor working conditions and rationing of homecare services. In some areas, so-called "homecare" clinics to which injured and elderly patients are required to drive, is seen as both an access issue and privatization. In many hearings, witnesses conveyed that homecare is inadequate to take the patient loads cut from hospitals.

Similarly, long term care homes have long wait lists in many of the areas we visited. Hospital complex continuing care bed cuts have been made in small hospitals without replacement care in the community. Witnesses described complex and dying patients moved out of hospital into long term care homes only to end up spending the majority of their remaining lives back in the hospital emergency departments. Poor access to care and instability is believed to have shortened the lives of family members. Community members view the movement of patients out of complex continuing care, long term care and alternate level of care (ALC) hospital beds into facilities far away from their home communities as inhumane. Many questioned what is happening to patients moved out of hospital beds that are being cut. Several witnesses opposed the use of private for-profit retirement homes to take hospital patients as unsafe, inappropriate and privatization.

In general, core planning functions, such as contouring hospital capacity to meet population need, efficient use of facilities, proper costing, service coordination and evaluation have been ignored. Community care and regional hospital capacities are not taken into account when hospital cuts are being made. In every case where hospitals and emergency departments are under threat of closure, the capacity to take all the regional patients in the remaining hospital sites is dubious. While cuts and closures are moving ahead, costing and planning has not been done for renovations, staff displacement, community and other institutional care, and increased ambulance and paramedics. While clinical implications of cuts are being downplayed and misportrayed by hospital and LHIN executives, patient and clinicians' voices are being ignored. Care is increasingly fragmented. Service planning is erratic, with services built and introduced and then closed down within a few short years. Infrastructure planning and restructuring planning is inadequate and is not coordinated with service planning. Short-term and ad hoc decision-making appears to be the rule rather than the exception.

In virtually every hearing, witnesses described declining access to services in rural communities through seemingly endless restructuring. Many feel that changes are unfair and rural residents are not treated equally. Many cited a belief that rural communities disproportionately bear the burden of cuts and rural communities. Government commercials touting emergency departments, urgent care centres and walk-in clinics as "the right care", "accessible to the public" were scorned and laughed at in several hearings. Health reform regarding hospitals is not serving the needs of rural populations, nor the public interest in general.

Democracy

a. Absence of meaningful public input

At every level of governance, democratic input, public feedback and evaluation have been absent from planning and decision-making processes regarding small and rural hospitals. Where public or stakeholder meetings had been held, witnesses described the processes as manipulative or meaningless. Witnesses believe that the decisions are finalized prior to any public input and public input results in no change. The only evaluation processes regarding hospitals are performance measures that do not measure access to care. Hospital fiscal advisory committees are described as impotent. Across the

province, witnesses conveyed a deep distrust and alienation from those entrusted with oversight of local hospitals. These observations apply to every level of governance and oversight including the provincial government, the Local Health Integration Networks (LHINs) and local hospital boards.

While every level of governance formally charged with oversight of local hospitals is the subject of intense public criticism, municipal governments that do not have formal requirements to oversee hospitals are viewed much more favourably by witnesses. Many municipal leaders complained about local government carrying an increasing burden for health care and, at the same time, being ignored in planning and decision-making processes. Indeed it is this panel's observation that there is a culture of disrespect for duly elected local governments exhibited by the Ministry of Health, the LHINs, the Ontario Hospital Association, and hospital CEOs and boards. This is inappropriate and undemocratic. It squanders the talents and commitment and ideas of vital local resources and duly elected local leaders, and it should stop.

Provincial Government

Participants described a provincial government that has neither sought nor received a mandate to fundamentally change the role and services of local hospitals. The government's approach to small and rural hospitals is seen as failing to meet public need and in conflict with the values and priorities of Ontarians. The government has not evaluated the impacts of its policies on communities and has not engaged in any public feedback process.

This panel's opinion, based on the overwhelming response from the public, is that the provincial government is deeply distrusted in rural and northern communities. The government has failed to listen to community concerns. Its policies run counter to deeply-held priorities, communities' values and the public's sense of fairness. Most witnesses believed that a restoration of local control would improve services and prove more responsive.

- The government's rural and northern panel has refused to meet with local stakeholder groups and was soundly criticized by witnesses for conducting its review behind closed doors. No patient advocates, public interest groups and local community groups have been allowed to meet with the panel.
- It is universally believed that the government is "hiding behind" their appointed LHINs, has failed to take responsibility and evaluate its hospital policies.
- There is a widespread belief that the government does not understand nor plan for the unique needs of rural and northern residents. It is believed that government policies regarding smaller hospitals – particularly the notion of "centres of excellence" – are urban-centred planning ideas that are being imposed on rural areas where they do not fit the requirements of the unique population demographics and geographic conditions.
- No witnesses had been asked by the provincial government for their ideas or suggestions of reform, and no witnesses had been consulted on the current round of hospital restructuring.

- Witnesses provided copies of correspondence with the Minister of Health in which the Minister upheld decisions to withdraw services from entire communities without any evaluation of the impacts on access to care.
- Access to the Minister of Health is inappropriately curtailed. One mayor, facing the closure of his local hospital, was given 1 ½ minutes to ask the minister a question. Fourteen mayors and reeves facing the closure of their local hospital were granted less than 15 minutes with the minister's staff who informed them at the beginning of the meeting that the closure of their hospital was not up for discussion.
- The lack of access to, and public consultation by, the Ministry is particularly problematic given the LHINs' failure to understand and track hospital cuts and even closures, and the trend of both local hospital leadership and the Ontario Hospital Association to downplay the extent of cuts in access to hospital services.
- The government has failed to respond to public calls to rein in executive and LHIN salaries and excessive use of consultants and PR firms.
- There is a total consensus that provincial government-forced restructuring has harmed, not helped the health system; government-created LHINs have made things worse, not better; and every round of restructuring has removed funds from care and has created a bureaucratic, alienating and unresponsive system.

Local Health Integration Networks

LHIN consultation processes are non-existent or lack credibility. In many areas there has been an almost total absence of public consultation. In most cases, municipal leaders had never been asked for feedback or ideas. In every case, hospital staff (including nurses, health professionals, physicians and support staff) had not been asked for ideas, nor consulted on plans. Where there have been consultation processes, witnesses described them as manipulative or meaningless. In several regions, the use of PR firms by the LHINs angered the public. Witnesses feel this is a misuse of public funds.

Local Hospital Boards

Local hospital boards and executives were repeatedly criticized for ignoring or failing to seek public input. In many cases, witnesses described extremely poor governance practices, apparently created to push through service cuts. Staff are ignored and bullied. Community members are shut out. Elected municipal leaders are ignored except when money is needed. Public access to information is denied. There are no feedback and evaluation processes.

Hospital staff in every region and of varying classifications - from doctors and health professionals to nurses and support staff – described a deeply disrespectful planning environment. Staff have not been consulted about the impacts of cuts on their patients. Staff are afraid to raise concerns or speak publicly and have been subject to dismissal and retribution if they do. Staff concerns are ignored. Clinical decisions are overturned by administrators to the detriment of patients. If there is

evaluation of the consequences of planning decisions, it does not involve asking the staff about effects on or outcomes for their patients.

Community members described board meetings in which entire proceedings or key decisions are closed to public scrutiny. There is an almost total inability for the public to raise systemic and planning issues and have them dealt with. Even processes to deal with patient care complaints are slow and inadequate. Participants in the hearings provided examples of correspondence and communications that they had received from local hospital executives and board members that can only be described as arrogant.

b. Removal of elected hospital boards

A principal theme which emerged at every committee hearing was the absence of democracy in how local hospital boards of directors function. Communities now realize control of local boards has been lost to hospital CEOs without adequate checks and balances.

Many witnesses provided histories of community fundraising for building, maintaining and improving local hospitals. They conveyed the passion of community to provide modern facilities delivering hospital care while local citizens sat on the hospital board to provide ongoing oversight. Local citizens, elected by local citizens, would pose the tough questions needed to be asked for the open operation of a community hospital. The board democratically represented the community.

These same witnesses conveyed how local representation and oversight have vanished in an effective coup d'etat which is believed to have emanated from the Ministry of Health and approved by the provincial government.

When regional hospital restructuring occurred in the mid-1990s and hospital boards were amalgamated, elected boards were eliminated in the amalgamated hospital corporations. Since then, other hospitals, particularly those that have had cabinet-appointed supervisors in recent years, have followed the trend of removing voting rights for community members and eradicating elected boards.

A widespread belief was expressed in the hearings that hospital board members in these undemocratic corporations are selected by the hospital CEO. Such "cherry picking" of boards members has opened the door to director sycophancy. Board members are at the same time legal and fictitious watchdogs. CEOs are absolute rulers of hospital domains and local communities are left without any influence and without access to information at Board of Directors meetings.

In communities such as Fort Erie and Cobourg contrived hospital boards made cuts without any consideration whatsoever of local opinion and needs. In Picton a hospital supervisor appointed by the Minister of Health, after dismissing the elected board, has lectured local residents about why democracy was bad for local hospitals. In Kincardine, the community was informed that the hospital is a "private corporation" in response to

community questions about hospital finances and planning decisions. In Shelburne, access to planning options and financial information has been denied to municipal officials and the public. Hospital executives and boards ignore the fact that hospitals are funded almost entirely from public funds, operate as a non-profit community-based entities, and are governed under the Public Hospitals Act that clearly has an expectation of meaningful public memberships in hospital corporations.

Flagrant disregard of the public and its right to be represented have become a hallmark of hospital boards and others at the Ministry of Health and within the provincial government and its caucus. This committee could find no government MPP who had defended local boards from such perfidious takeovers of their functions. Hospital CEOs are the new elites who work unfettered by appropriate board oversight and public accountability.

c. The special case of amalgamated hospitals

A secondary effect of the elimination of community-elected boards is that smaller hospitals in an amalgamated corporation are most apt to be cut or closed. Local hospital advisory committees and other similar structures enjoy neither the trust nor support of local communities. They have been relatively unknown until hospital cuts and closures are planned. When their memberships are exposed, the appointed community members are believed to be hand-picked and under the control of hospital CEOs. In some cases, members do not live in the communities whose hospital they are supposed to represent. In others, members had passed away and had not been replaced. It is widely believed that several agreements made upon alliance or amalgamation have been violated.
It is evident that the smallest of the hospitals in the amalgamated hospital corporations have had services and equipment removed and have been subject to disproportionate cuts. If amalgamation was intended to capture administrative efficiencies, it has now been turned into a virtual carte-blanche for cutting and closing the smallest hospitals in the corporation while administrations have ballooned.

- In the Chatham Kent Health Alliance the smallest facility, that being Wallaceburg's Sydenham District Hospital, has been subjected to the most extensive cuts. Local fundraising efforts to purchase equipment and pay for renovations has been summarily disrespected. For example, at the request of the hospital board, the auxiliary fundraised for and opened a second palliative care suite in 2005 at an estimated cost of $100,000. Three years later, in 2008, it was closed by decision of the same hospital board that requested the auxiliary create it only a few years earlier. Intensive care, maternity, laboratory, physiotherapy, mammography, surgery, palliative care, and pediatrics have been cut from the Wallaceburg site. Despite contradictory claims by Alliance executives, Wallaceburg has disproportionately been impacted by each round of hospital cuts and budget constraints. Most recently, all acute care beds were closed (summer 2009) and the emergency department is at risk of closure. The local consensus is that the hospital has been left in disrepair and physician recruitment efforts have been unsupported by Alliance hospital executives purposefully to render the Sydenham Campus unviable so it can be closed.
- Similarly, in the Niagara Region, all acute care services in Douglas Memorial Hospital in Fort Erie and the Port Colborne hospital are being closed despite

public opinion and need, while a privatized P3 facility is built some distance away on the farthest side the larger centre of St. Catherines. Equipment and services have routinely been removed from these two communities since amalgamation. The smaller hospitals are deemed to be no longer viable. The community believes the amalgamated hospital corporation has consistently pursued a path of decisions to render these two sites less viable.

- Similarly, the Burk's Falls Health Centre, was, until it was closed at the end of 2009, the smallest site of its amalgamated hospital corporation. Budget cuts have disproportionately been levied at the expense of services in Burk's Falls since amalgamation and services have been systematically stripped from the community.
- The Shelburne Hospital has also been subject to disproportionate cuts and is now being closed entirely.

This panel fears for the continued operations of hospitals such as those located across Southwestern Ontario[1], in mid-Ontario and the near north, and on St. Joseph's Island. Without any meaningful public input, it appears that there is an unspoken policy – either forged by the hospital corporations themselves or by the provincial government – to facilitate the elimination of the small hospital sites in amalgamated hospitals.

d. Lack of public accountability

Witnesses repeatedly described a failure for hospitals to engage in normally-accepted practices of public accountability. Hospital planning and financial documents have been withheld from community scrutiny. Hospital board meetings in some communities are conducted entirely behind closed doors, with no public and media access. In other communities, boards frequently go "in camera" (in secret) to make decisions vital to the public interest. The public has limited ability to raise questions or concerns. In several cases, public meetings regarding service cuts have been held with little public notice, or after decisions are already made. In several communities, hospital spokespeople have understated or misportrayed service cuts.

Among the worst examples:

- The hospital board responsible for Shelburne's hospital considered three options before choosing to close down the Shelburne hospital entirely. It would not reveal to the public what the three options were. It would not reveal financial information, and would not answer questions about what other measures, if any, have been taken to limit administrative costs and preserve services.
- The hospital board responsible for the hospitals in Strathroy-Caradoc and Newbury holds all of its meetings entirely "in camera", closed to public and media scrutiny.
- The community's attempts to get financial reporting of the costs for the operation of the Kincardine hospital have been refused.

[1] Communities reported to be at risk for total hospital closure (including ERs and beds) include Wallaceburg, Shelburne, Fort Erie, Port Colborne, Markdale. Communities reported to be at risk for emergency department cuts or closure include: Petrolia, St. Marys, St. Joseph Island and Strathroy. Burk's Falls hospital was closed in December 2009. The emergency departments in Port Colborne and Fort Erie were closed in 2009.

- The hospital held a meeting in Burk's Falls regarding the hospital closure well after the cuts had begun. In the meeting the CEO told the assembled community that he was "there for a good time, not a long time".

Public Values and Principles of the Canada Health Act

Throughout the hearings, Ontario's communities expressed a profound attachment to their local hospitals. This province has a proud century-long history of local fundraising and effort to improve access to hospital care. Community development efforts and maintenance of vibrant local hospitals are seen as symbiotic. For many, hospitals and community are synonymous. Patients refer to dying in local hospital as dying at home. Staff in the local hospital are frequently termed family. The pride in local hospitals cannot be overstated. Generosity of community members in fundraising, donating and leaving large bequests to hospitals is expressive of this core public priority.

Witnesses described hospital cuts as violations of the principles of the Canada Health Act.

- In many communities, OHIP-covered physiotherapy, chiropody and other key hospital services have been cut. In many areas, the CCACs are cutting homecare rehabilitation services at the same time. In some areas, such as Kincardine and Cobourg, the nearest publicly-funded physiotherapy no longer exists in the entire county. In some cases, there is no service for more than 100 kms.
- In many communities, complex continuing care has been cut and downloaded to the point of de facto delisting. Inappropriate placement of heavy care patients in long term care facilities or private for-profit retirement homes without the care levels to support them has become a norm.
- Hospital patients are being discharged from inpatient units without adequate homecare. Homecare is, in turn, severely rationed and struggling with lack of staff capacity and budget deficits.
- Cuts to emergency departments and medical beds in communities such as Wallaceburg and Niagara has led to overwhelmed emergency rooms and inability to access basic hospital care. The remaining hospitals do not have capacity to take all the regional patients. Hospitals in both Niagara and Chatham experience frequent gridlock, offload delays, extraordinary waits for patients and inability to access needed hospital beds. This situation holds true for other Ontario hospitals also.

Provincial government policy of cutting, closing and reducing the scope of public hospital services runs contrary to deeply-held public priorities and values. It is both believed that hospitals are underfunded, and that hospital funding is not going to patients' priorities. The public sees front line staff and care cut while significant amounts of public money wasted on overly expensive executive salaries, bureaucracy and LHINs, and consultants. Communities believe that patient care and vital support services should be protected as a first priority. LHIN boards and hospital executives are characterized as putting human life at risk, while taking excessive salaries and priorizing functions that are not seen as useful by the public. Across the province, witnesses expressed these values,

calling for policy that puts "people before bottom line" and a stop to "putting a price on human life".

Numerous witnesses called for strong support of the ethic of non-profit and public hospitals. It is believed that current policy and planning have substituted an inhumane and corporate approach for compassion and public interest. Witnesses cited examples such as that of the Chatham hospital which announced to the local media its intention to increase its "market share". Northumberland Hills Hospital wants to increase nuclear medicine because "it is profitable" while cutting services needed by thousands of residents. The Muskoka Algonquin hospital CEO noted in a memo to all staff that certain diagnostics must become a "profit centre" or services would not be maintained. The commercial ideology evidenced in these approaches to policy and planning violates core public values of equity and access and the non-profit ethic of our health system.

Communities across Ontario have struggled for generations to build and sustain their local hospitals. To the communities involved, these hospitals are the first priority local public service. Hospitals are understood to be democratically-controlled and accountable to the people who built them, fund them and need them. They are expected to measure and try to meet local needs for services. They are expected to be respectful to their communities and staff, and be governed and overseen as a professional public non-profit service. They are expected to value and respect bequests and community donations. Both the government and the hospitals are expected to follow the basic tenets of public medicare in Canada. The fact that these priorities and values have been ignored in successive rounds of hospital cuts has resulted in widespread anger and alienation.

Local Health Integration Networks (LHINs)

Almost without exception, the public cannot see value in the Local Health Integration Networks (LHINs). In every area of the province, the LHINs lack credibility and support. In many areas, the LHINs are the object of extreme public anger. Witnesses conveyed a litany of grievances relating to poor planning, poor management and misspending, including:

- Poor service coordination and worsening gaps in access to care.
- Erratic, inconsistent and unprincipled decision-making.
- Poor public accountability and manipulative or non-existent consultation processes.
- High costs of LHINs compounded by worsening access to hospital care.
- Overuse and misuse of consultants and high cost to the public.
- Biased or inaccurate consultant reports that lack credibility.
- Failure to plan for population need and evaluate consequences of decisions.
- Failure to investigate and respond appropriately to serious complaints.
- Unqualified board members who are seen as political appointees.
- Lack of process to protect local donations and bequests from expropriation.
- Increasing privatization and total lack of democracy.

This panel found all of these observations to be supported by evidence.

The LHINs' mandate is unsupported by the public and irredeemably flawed. The size of the regions is too big for meaningful health care planning and service coordination. LHIN decision-making processes are confused and erratic. Decisions are not evaluated. There is a total lack of proper policy, processes and protections for the public interest.

This panel believes that the size of the LHINs, coupled with their mandate to permanently centralize services is inevitably damaging to the small and rural. It is not feasible to centralize hospital and community health care services across the LHIN regions. To continue to do so will mean continuing loss of local health care access for small and rural Ontario, and likely for mid-sized communities also. This will not help large hospitals that are themselves facing serious cutbacks and do not have the capacity to serve all the regional residents.

The size and geography of the LHINs do not make sense to the people that access health care services. Patient support services and social systems are not organized along the geographic boundaries of the LHINs. There are no public transport systems to facilitate travel across these vast distances and roads are often impassable in winter storms. Municipalities, who provide significant resources and support for local health care systems – including hospital capital campaigns, physician and health professional recruitment, and advocacy – and whose leaders are elected by their local populations, are ignored in these structures. In areas such as Burk's Falls and Uxbridge, local hospitals are located in different LHINs than their amalgamated partner hospitals.

The core mandate of the LHIN is to "integrate". The definition of "integration" in the LHIN legislation encompasses not only service coordination between providers, but also includes powers for LHINs and the Minister to override local hospital boards and transfer volumes of services from one provider to another, force mergers, amalgamations, and dissolve local non-profit health care providers, including hospitals. There are few, if any checks on these extraordinary powers. There are no provisions to protect those served by hospitals that were amalgamated in the hospital restructuring of the mid-1990s.

The provincial government's choice to define "integration" to include restructuring powers has spawned a trend of cuts to smaller local hospitals. Whether this was planned or not is unclear because the provincial health care plan which is supposed to guide all LHIN decisions has never been revealed to the public, if it exists. What is clear is that LHINs are required to restructure without principles, processes and policy to protect the public interest. There is no requirement to improve access to care. There are no proper consultation and evaluation systems. Draconian cuts to local hospitals are being forced through with and without the approval of the LHINs. These cuts are undoing decades of effort to build local services, improve access and attract and retain staff.

Though the LHINs have not made integration orders in most cases, they are required to approve integration proposals by local health care providers. A review of board minutes from several LHIN meetings reveals that LHIN board members are confused about what comprises an "integration", given the unusual and sometimes contradictory definition of the term in the legislation. The result has been erratic decision-making processes, made worse by the almost total absence of any plan or policy that would provide equity and protect the public interest.

- For example, in the case of the Burk's Falls Hospital, the community has been informed by the LHIN that the decision to close their local hospital and all its services rests with the amalgamated hospital corporation. According to municipal leaders, the LHIN was not aware of the decision even 1 ½ months prior to the announced closure date. The hospital, including the only urgent care for thousands of residents and more than ten-thousand cottagers and all inpatient beds, was closed without LHIN approval and without involvement of the provincial government.
- In all other communities where there are amalgamated hospitals, such as in Niagara, Shelburne, Wallaceburg and Petrolia, the LHINs are understood to be required to approve decisions to close the local emergency departments. But while an order to close an entire hospital must be made by the Minister (without any process of debate in the legislature) a voluntary decision by an amalgamated hospital board or LHIN to gut or close an amalgamated hospital is not subject to this level of approval.
- Across the province and in government commercials "urgent care centres" are touted as the new wave of care to replace emergency departments. Yet, there is no policy for a consistent funding model and set of services in an "urgent care centre". Such centres are not described in any health care legislation. In Burk's Falls and Cobourg, urgent care centres are being closed down. In Port Colborne and Fort Erie, they are slated to close in 2013.
- In some areas all rehabilitation beds are being closed down. In other areas, proposals are being made to convert local hospitals into rehabilitation sites. The variability in these decisions has nothing to do with population need.
- Hospital services have been closed in communities without any access to that care in any other care setting. Examples include diabetes care in Shelburne and Northumberland Hills, physiotherapy in numerous locations, complex continuing care, long term care, palliative care, emergency departments. There appears to be no policy to protect communities from ad hoc cuts to needed services.

In reality, LHINs mandates to enforce arbitrary budget targets and cuts seem to trump all other planning functions. Ironically, given the primacy of budget cutting, costing for restructuring that results from cutbacks is extremely poorly done if it is done at all. In some cases LHINs have approved cuts that exceed the hospitals' deficits (for example in Cobourg and Shelburne) or have approved cuts when alternate funding envelopes for services are available from the Ministry of Health (for example in Cobourg). But LHINs are also violating the requirement for balanced budgets, passing cuts to services and plans that engender more costs rather than less. In every case of major closures of hospitals, costing for restructuring is poorly done or has not been done. For example:

- Under the LHIN regime, the Niagara Health System was required to produce a "Hospital Improvement Plan" (HIP) to eradicate its budget deficit. The cuts planned in the HIP have been implemented. But more than a year into the plan, the "enablers" (transportation, access to long term care, and other) that are supposed to offset hardship for patients have not been implemented. Moreover, the HIP did not plan to eradicate the budget deficit, but rather planned for tens of millions of dollars in new capital and operational funding even while cutting services. Implausible assumptions of dramatic reductions in emergency department usage (and therefore costs) were included in the HIP. Renovations to

the closing hospital in Port Colborne were not priced in the plan; nor were new ambulance costs amounting to $3.1 million downloaded to the regional government.

- In areas such as Niagara, Muskoka-Algonquin, Shelburne-Orangeville and Chatham-Kent, new restructuring requirements for renovations to the closed hospitals, ambulances and paramedics and staff lay-offs have not been costed as part of the analysis to close services.

It is widely observed that LHINs misuse consultants at great expense to the public, in addition to having growing staff teams and high executive salaries. The public see the use of consultants as unnecessary and their costs as excessive. It is understood that they are taking scarce resources away from needed health care services. Consultants are not seen as independent and have little public credibility. In several areas consultant reports were criticized for misinformation and inaccuracies. In all cases, these reports were seen as biased or their conclusions are believed to be pre-determined by the LHIN. This panel was dismayed to learn of the volume of reports produced by exorbitantly costly and unaccountable consultants rather than by professional accountable (and reasonably paid) public servants.

LHINs have inadequately investigated and responded to serious complaints. The Central West LHIN failed to adequately investigate and respond to complaints about a patient being turned away from a hospital in a neighbouring LHIN without recourse to services in the patient's own LHIN. The patient's family believes the delay in diagnosis and treatment contributed to the patient's death. In fact, several patients submitted examples of the London hospitals refusing or cutting treatment to residents from outside their LHIN. Witnesses conveyed that LHIN board meetings do not allow delegations and do not provide an opportunity for public questions and answers. In cases where dramatic hospital cuts have taken place such as in Niagara, there has been no evaluation by the LHIN of complaints about increased costs and inability to access services.

Many witnesses were deeply disturbed by what they see as the expropriation of local donations and bequests that were meant to be used to build and support local hospital services. Local hospitals have benefited from extraordinary community generosity. Many witnesses described huge local fundraising campaigns to build palliative care units, buy equipment and renovate hospitals only to see services removed, sometimes within only a few years. When local hospitals are closed (usually in amalgamated hospitals) residents are questioning how the bequests and donations are being used. For example, in Burk's Falls community donations made expressly to support hospital services closer to home are now planned to be used to renovate the building to remove its function as a hospital and turn it into a facility that will house a family health team. Living donors have not been contacted for approval. Those that left bequests did not intend them to be used in this way. These practices violate community notions of fairness, respect and integrity.

While it is the widespread belief that the LHINs are an undemocratic political buffer, in fact, they have not succeeded in shielding the provincial government from public anger. In truth, the provincial government is blamed for creating the LHINs and is held at least equally accountable for decisions that have led to a reduction in access to needed services and the destruction of democratic governance.

This panel found no evidence that Local Health Integration Networks have improved access to care in rural and northern Ontario. Neither have they improved service coordination. At best the public considers them an expensive political buffer that lacks credibility. At worse, they are seen as corrupt and callous. It is this panel's opinion that the Local Health Integration Networks should be disbanded.

This report is submitted to the Ontario Health Coalition by the following panelists who conducted public hearings across Ontario in March 2010, investigating community perspectives on the future of small and rural hospitals.

- Dr. Claudette Chase from northwestern Ontario, has spent most of her 15 years as a family physician serving remote First Nations communities and working in small rural hospitals. She worked as an outpost nurse for 5 years before starting a medical career. She was on the founding executive for Canadian Doctors for Medicare and was president of the Ontario College of Physicians in 2003.

- Hon. Roger Gallaway holds a BA from the University of Western Ontario and an LLB from the University of Windsor. He practiced law before entering political life, initially as Mayor of Point Edward (1991) and subsequently as the Liberal Member of Parliament for Sarnia-Lambton in 1993. He was re-elected in 1997, 2000 and 2004. He served as a Committee Chair in the House of Commons, a Parliamentary Secretary and was made a Queen's Privy Councillor by the Governor-General in 2003. He now teaches and does foreign development at Sarnia's Lambton College.

- France Gelinas, MPP Nickel Belt and NDP Health Critic is the NDP Member of Provincial Parliament responsible for Health and Long Term Care, Health Promotion, Autism and Francophone Affairs. She is a licensed physiotherapist and practiced in Sudbury at Laurentian Hospital, now part of Sudbury Regional Hospital. After graduation from Laurention Univeristy with a Masters in Business Administration she worked as the Executive Director of the Community Health Centre in Sudbury. She has served as a member of the United Way's Citizen Advisory Panel, President of the Sudbury and Manitoulin District Health Council, President of the Francophone Reference Group of the Northern Ontario School of Medicine, and President of the Association of Ontario Health Centres.

- Dr. Tim McDonald came to Ontario Canada in 1968 as a decorated serviceman and surgeon from Glasgow, Scotland. His commitment to the armed forces continued in Canada, unitl he retired from his successful military career in 1994. Dr. Macdonald currently helps to run the Charlotte Eleanor Englehart E.R in Petrolia, and in the past has served as president for the Lambton County Medical Society, District 1 Representative of OMA, Coroner for the Province of Ontario, and the former Chief of Staff of Charlotte Eleanor Englehart Hospital.

- Natalie Mehra is the director of the Ontario Health Coalition where she has served for the last ten years. Prior to this she worked for five years as the executive director of the Epilepsy Association in Kingston, Brockville and area. She is the author of numerous reports on health policy, non-profit governance, disability issues and human rights. She has served as a board member for a number of disability, arts, housing, women's, crisis and anti-poverty organizations. She currently serves on the Board of the Canadian Health Coalition, dedicated to protecting and improving universal public health care in Canada.

- Barbara Proctor, RN has been a practicing registered nurse serving in administrative and mentor roles in Ontario hospitals for over 4 decades. She has worked in small, rural hospitals and larger urban facilities. She recently completed her nursing career as a visiting nurse delivering care to residents in her own community who were recovering from illness or surgery. She is the chair of the Friends of Prince Edward County Health Services, the appointed chair of the Municipal Healthcare Advisory Committee for Prince Edward County and recently appointed Municipal Advisor to the Board of Directors of Quinte Healthcare Corporation.

- Kathleen Tod, RN 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.