Ontario Health Coalition
Analysis of the Peterborough Hospital Peer Review & Hospital "Improvement" Plan (HIP)

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Summary of Key Findings

The Peterborough Regional Health Centre (PRHC) Hospital Improvement Plan (HIP) recommends draconian cuts to staffing levels at PRHC. In addition, it proposes significant cuts to hospital beds and services, though it does not reveal the extent of these service reductions because it continues to list unstaffed (and therefore unusable beds) as open beds. The reduction in public hospital services for the Peterborough community and surrounding region proposed in the so-called Hospital Improvement Plan is based on the findings of the Peer Review relating to key performance indicators and financial data. In our analysis of the two documents - the HIP and the Peer Review – we have found that the financial "crisis" is overstated and key financial information has not been provided and the methodology used to determine the PRHC's status in key performance indicators is deeply flawed.

We are particularly concerned with the targets proposed by the PRHC to reduce cost per weighted case to significantly below the provincial average and to achieve what they term "top" quartile performance.[1] This is a race to the bottom. It means that Peterborough Hospital Board has agreed to join in a competition in which hospitals across Ontario compete to reduce patients' length of stay (how quickly a hospital can force a patient out), reduce staffing, and reduce beds. As everyone tries to get into the top (read: cheapest) quartile, access to care and quality of care declines. There is no proposed end to this competition. The consequences for patients are as follows:

- Patients are forced out of hospital when they are too sick, with resulting compromise to their health.
- Patients are forced out of hospital to long term care homes far from their home communities.
- Patients are forced out of hospital into inappropriate venues where there is not enough care. For example, complex patients are forced into long term care homes or, in the worst cases, retirement homes without care levels to support their needs. Patients are forced to go home with inadequate or non-existent homecare.
- Public and non-profit services are privatized to for-profit companies and costs downloaded to patients.
- Occupancy rates for hospital beds soar beyond evidence-based international best practices. Beds are turned over too quickly and infection rates for hospital-acquired infections rise.
- Housekeeping staff are cut and/or privatized worsening hospital cleaning and increasing hospital-acquired infections.
- Beds become overloaded forcing patients into hospital corridors on stretchers and backing up the hospital through to the emergency department. This forces cancelled surgeries, long emergency department waits, and ambulance off-load delays.
- User fees increase to the point that they are cause financial hardship for patients.

[1] Tremblay, Ken, President & CEO. Draft Hospital Improvement Plan. For plan to reach "top" quartile in efficiency see "HIP Goal" slide #4. For cost per weighted case goal see "PRHC At-a-glance" slide #47.

These problems are already happening in hospitals across Ontario. The evidence is that the Peterborough hospital's HIP plan to move to the lowest cost per patient, the lowest staffing and the lowest number of beds is not good health care and is not in the public interest.

Key Findings:

1. Hospital revenue and expenditure trends have been misleadingly reported to the community to overstate the case for cuts. In fact, the evidence shows that PRHC's spending has not been 10% per year. PRHC's spending has been in line or less than provincial hospital spending for most of the years covered in the Peer Review up until the year that the hospital moved when expenditures were predictably (and reasonably) higher than usual. We have asked, but have not received an answer from PRHC as to whether one-time post-construction funding which should not be included in the analysis of financial trends, were included in the figures for the year of the move.

2. The core justification for cuts is based on comparisons between the Peterborough hospitals' and peer hospitals' performance in key efficiency indicators. However, reviewers used inconsistent pools of peer hospitals in each comparison (sometimes 5 hospitals, sometimes 6, sometimes 7, sometimes 8 and sometimes 21) without explaining why, raising questions regarding "cherry picking" data to suit pre-determined conclusions.

3. There are other serious problems with the data used. Reviewers used data encompassing exceedingly narrow periods of time -- sometimes as little as one quarter or two quarters. Often the data comes from the unusual year in which the hospital moved. This data cannot be said to constitute a trend with any accuracy. Furthermore, inconsistent time periods are used throughout the Peer Report without any explanation. Again, this raises questions about "cherry picking" data to suit pre-determined conclusions.

3. PRHC's cost per weighted case is not 20% above average. The Peer Review and HIP fail to provide evidence to support cutting the cost per weighted case to significantly below the provincial average. Neither document assesses the impact on quality of care and access to care that would result from such a dramatic cut.

4. The "peer" hospitals chosen by reviewers for the key performance measures are all in deficit or have been in deficit throughout the time period covered in the review. This was not disclosed by peer reviewers. In fact, Ontario's hospitals are significantly underfunded compared to other provinces' ($2.3 billion less than the national average). This raises the question of whether all of these peer hospitals are underfunded.

5. Neither the peer review nor the HIP assess the impact of the proposed cuts on quality of care and access to care. Waiting lists for long term care beds in this community are excessive and there are not enough resources to provide homecare to meet existing community need before the proposed hospital cuts. The hospital has no power over these inadequacies in service; they are the responsibility of the provincial government. The hospital cuts proposed will lead to increased workloads for remaining staff, downloaded

costs to patients and significantly increased hospital occupancy. The Peer Review fails entirely to consider risks to patients and staff as a result of their proposed cuts. The HIP only superficially identifies risks in one sentence for each hospital department and fails to address them in any substantive way.

6. While the HIP proposes fewer bed cuts than the Peer Review, it proposes more staffing cuts. It also notes that the remaining beds may not be staffed. This is misleading. An unstaffed bed is a bed that cannot be used. Thus, to date, the hospital has not provided full information to the public on how many bed cuts it is proposing.

Overview of Data and Methodological Flaws

We cannot support the methodology used in the Peterborough Regional Health Centre (PRHC) Peer Review. Perhaps the most serious omission is the failure of the reviewers to assess the impacts of their recommended cuts on access to care or quality of care for the people of the community and the region. Key clinical staff in the Peterborough hospital were not been consulted about the potential impact of the recommended cuts on their patients. The rationale for cuts is based on a simple comparison of numbers between "peer" hospitals. However, it was not revealed in the Peer Review that the "peer" hospitals are facing serious deficits themselves. In fact, a number of these comparator hospitals are making serious service cuts. At no point were quality, wait times and access issues in the "peer hospitals" assessed by reviewers to ensure that the peer hospitals' numbers provide for safe and quality care. Moreover, the peer reviewers selected different and inconsistent pools of peer hospitals for each measure, without explaining why. This raises questions about "cherry picking" data to suit pre-determined conclusions. For a number of indicators, peer reviewers provide no evidence to support their conclusions. For some key indicators, recommended cuts are based on conjecture. Throughout their report, reviewers used inconsistent timelines and often used data from very narrow periods of time, often during the year of the hospital's move – a year in which expenditures were unusually (and predictably) high. There are a number of inaccuracies in the report borne of an apparent lack of information about the hospital and its physical space and a failure to fully research the viability of their recommendations.

In one of the most egregious examples of lack of concern for quality care, the peer reviewers recommend caring for patients on stretchers in the hallways or in procedure rooms if all the remaining hospital beds (after the cuts) are full.[2] The reviewers refer to this "model" of care being used "successfully" in other hospitals to, among other things, "ensure that patients receive care in an appropriate venue, and facilitate the shortening of

[2]Peterborough Regional Health Centre Peer Review, Final Report. April 14, 2010. Page 45.

length of stay".[3] We cannot support - nor is their any evidence to support - the notion that a stretcher in a hallway is an appropriate venue for care, nor is it an appropriate method to empty hospital beds to facilitate cuts. Furthermore, forcing shorter lengths of stay is a goal that might save money, but the evidence from other hospitals shows that it is a false economy, downloading costs to patients when they are sick and elderly and therefore least able to pay. Moreover such "savings" would likely be achieved only at the expense of deleterious impacts on patients' health.

The draft Hospital Improvement Plan (HIP) is heavily influenced by the recommendations in the Peer Review. The HIP bases its case - centred on sharp reductions to average length of stay – on the same cost per weighted case conjecture that appears in the Peer Review. It proposes significant bed cuts and notes that an unnumbered proportion of the remaining beds will be unstaffed (and therefore not useable), making the reductions in bed cuts compared to the Peer Review potentially misleading. Further, it proposes turning one medical unit (36 beds) into beds that are likely to be closed in the near future. The HIP proposes the same, and in some cases deeper, staffing cuts as the Peer Review.

Overall, it appears that the peer review and HIP are very ideological documents. Many proposed cuts are based on assumptions and extrapolations without real measure of impact on quality and access to care. Where data has been collected, it usually covers a very narrow period of time, or uses inconsistent peer comparisons and comparisons without full disclosure of pertinent information, and often covers the period of time in the year of the hospital's move – undeniably a period of major change for the hospital. It is very unlikely that data from this period constitutes a trend. In virtually every case in which data would favour the performance of the Peterborough hospital in terms of efficiency or patient acuity, or where data is incomplete or subjective, peer reviewers and authors of the HIP opt to cast doubt or ignore the evidence. Both the HIP and the Peer Review overstate hospital spending trends. The HIP undoubtedly understates the number of real bed cuts, reductions in services and impacts on quality and access to care. It would not be unreasonable to conclude that there is a drive to "create a crisis" in order to facilitate unpalatable cuts to services.

1. Claims Regarding Increases in Costs are Misleading

The Peer Review states Peterborough Hospital funding has been increasing at 10% per year for past 5 years. This would imply a trend of funding increases that are greater than the provincial average. In addition, reviewers claim that the hospital has been in deficit for 13 years. These claims are simply not true.

- In fact, funding increases have been in line with or less than the provincial average for the first several years of this period up until the year leading into and including the hospital move[4]. Increases, based on the revenue data provided on page 5 of the

[3] Ibid.

[4] The hospital moved during the weeks from May 20, 2008 to June 8, 2008.

Peer Review were as follows: 6 per cent in 2004/05 - 05/06; 6 per cent in 2005/06 - 06/07; and 7 per cent in 2006/07 - 07/08. The comparison to provincial increases is shown below.

- It was only in 2007/08 - 08/09 that revenues increased by 17%. Then, according to the Peer Review, the projected increase for 08/09-09/10 drops back down to 3.5%. The hospital moved in May - June 2008. Inexplicably, there is no measure of the impact of the move on operational revenues or expenditures in the Peer Review.
- In early May after the Peer Review was released, we have contacted the hospital to find out if post-construction operating funding (special funding given to new hospitals and not part of the general budget increase) was included in the revenue numbers in the Peer Review covering the months leading into and following the move in 2008. It would be inappropriate to include this revenue as it does not in any way provide evidence of overspending, nor does it constitute a financial trend. A hospital official has told us that this special post-construction funding (totaling approx. $11 million) is included somewhere in the peer review but could not be specific as to the amount and whether it is included in the revenue chart on page 5. We were told the hospital would provide an answer to our question. However, as of June 21, we are still waiting for further information.

Chart 1. Comparison of Provincial Hospital Funding Increases to Provincial Hospital Funding Increases

Year	Provincial Hospitals Funding Increase[5]	PRHC Funding Increase[6]
2004/05-05/06	6%	6%
2005/06-06/07	9.4%	6%
2006/07 - 07/08	No data[7]	7%
2008/09 - 09/10	No data	17%
2009/10 - 20/11	No data	3.5% (projected)

[5]The available data is calculated from Ministry of Health and Long Term Care Financial Statements for the years in question.

[6]Calculated from the financial data in the Peer Review, pp 5.

[7]The provincial government changed how it reported spending as of 2007-08 when it moved funding to the LHINs. Aggregate hospital operating spending is no longer separated out from other programs on government financial statements making comparisons difficult.

2. "Peer" Hospitals Used as Comparators are Inconsistent, in Deficit

The use of "peer" hospitals in the review is inconsistent and it is not clear how the peers were determined. Furthermore, it is not clear why some "peer" hospitals were dropped in some comparisons of data. For example, in the charts on pages 10 and 11, sets of five and six hospitals are used for comparison of weighted case data. In the charts on pages 12, seven hospitals are used as peer hospitals. In Appendix A, two lists of "peer" hospitals are provided, one containing eight hospitals and one with twenty-one hospitals. Why were some hospitals dropped from some comparisons? Since all hospitals are required to report on this data, there is no question that it was available to reviewers. This inconsistency is not explained and raises questions about reviewers "cherry picking" data to suit pre-determined conclusions.

The Peer Reviewers use data from 2004 - 2009 from a number of hospitals to make the case that Peterborough Hospital is over-funded or inefficient. However, in the report, the reviewers do not note that the peer hospitals used in these comparisons are all in deficit. There is no assessment of whether any or all of these hospitals might be underfunded.

In the comparisons of core efficiency data, the reviewers use York Central Hospital, Markham Stouffville Hospital, Quinte Healthcare Corporation and the Queensway Carleton Hospital as comparators. York Central Hospital has a $12. 5 million deficit this year. Markham Stouffville has closed all "non-urgent" patient care for 10 days in the last year to eliminate its deficit, reported at $6.7 million in October 2009. Quinte Healthcare Corporation was just given a "bail out" and increase to its base funding by the provincial government. It has been running annual deficits up to $10 million or more for all years in the period covered by the Peer Review. As of February 2010, Queensway Carleton Hospital was projecting $7.7 million deficit. See the chart below.

Chart 2. Comparator "Peer" Hospitals in the Peer Review Deficits

Name of "Peer" Hospital Used in Comparison of Core Efficiency Data in Peer Review	**Amount of Hospital Deficit Publicly Disclosed**
York Central Hospital	$12.5 million deficit reported at beginning of 2010
Markham Stouffville Hospital	Approx. $7 million deficit reported in 2009
Quinte Healthcare Corporation	Deficits ranging from $8 million to a projected $15 million over the period studied in the peer review.
Queensway Carleton Hospital	Approx. $8 million deficit reported at the beginning of 2010.

2a. Cost Per Weighted Case & Resource Intensity Weighting Conclusions Dubious

In the Peer Review, reviewers suggest that the Peterborough Regional Health Centre's adjusted average weight per case is overstated. This would lead to extra funding per case for the hospital. The reviewers give Southlake Regional Health Centre as an example of a hospital with higher acuity services than PRHC, stating that unlike PRHC it provides open heart surgery and level 1 thoracic surgery. It is not clear whether the reviewers are aware that throughout the period studied here (2004 - 2009), Peterborough Hospital provided thoracic surgery. It was only moved out under the service consolidation plan of the LHIN in 2009.

In addition, the reviewers suggest that PRHC's true weighted case profile might be more similar to York Central Hospital. What the reviewers do not reveal is that York Central Hospital is in a serious deficit and is implementing cuts of its own. In fact, in December, York Central hospital officials stated that they will enter 2010 with a $12.5 million deficit.[8] It is possible that York Central is under-funded, rather than Peterborough Hospital being over-funded. Without any real assessment of patient needs, simply comparing numbers and choosing the lower ones among "peer" hospitals could put all hospitals into an under-funding position.

The local MPP and hospital executives have claimed that PRHC's cost per weighted case is 20% above average.[9] However, in the five years of data covered in the peer review, the cost per weighted case was below average for two years, between 5 and 6.5% above average for two years and was 19.4% above average only in the year of the hospital's move. Moreover, using the other comparator data in the report - meant to compare like hospitals - when PRHC is compared to the peer hospitals selected in the peer review, we could not come up with a figure for cost per weighted case as high as 20% above the peers, no matter what configuration of peers we included in the calculations.

Furthermore, peer reviewers note that PRHC challenged the Ministry of Health's calculation of its actual Cost Per Weighted Case for 2008/09, claiming that $20 million should be removed from the total expenditures. The peer reviewers dismiss this claim without independently reviewing the hospital's case.

Similarly, we have concerns about peer reviewers reference to "inappropriate coding" of data that may lead to an overstatement of Resource Intensity Weight (RIW) in the

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[8]McLean, Adam. "Hospital Battling Deficit Cuts and Wait Times" , Richmond Hill Liberal. March 13, 2010.

[9]In the latest version of the HIP, this claim is corrected to state that the Cost Per Weighted Case is above "expected". The calculation of expected CPWC is not in keeping with the numbers for the selected "peer" hospitals in this section, nor is it explained.

Peterborough hospital.[10] The reviewers, without evidence, state that they have doubts regarding the validity of the reported RIW.[11] In fact, the hospital conducted a coding audit in January 2010 with a consultant from Med EKS. This audit, according to staff, found the coding practices at PRC to be appropriate. The Peer Reviewers did not mention this consultants' report in their review and provided no evidence to support a conclusion that the resource intensity of the patients is miscalculated.

3. Quality of Care, Democracy and Accessibility of Care Not Appropriately Considered

In the recommendations in the sections of the Peer Review regarding governance and clinical services, the reviewers attempt to force the hospital corporation to make financial targets paramount, even at the expense of quality of care and access to care. In addition, we are concerned that the recommendation to move to a "skills based board"[12] is a euphemism used by hospital executives to denote eradicating the elected board. Throughout these sections, data is inconsistent and uses differing time periods and changing groups of comparator hospitals. Throughout these sections, reviewers fail to assess impacts of proposed cuts on quality of care and access to care.

One of the most serious recommendations made by reviewers is to cut the number of inpatient days by cutting all of the days associated with physician reasons (such as a patient receiving therapy, waiting for a specialist, under observation) and half of all inpatient days associated with hospital and community reasons (ie. waiting for placement in a long term care home, or social reasons).[13] This, the reviewers state, could result in cutting 55 beds. These cuts are totally implausible. The reviewers suggest that the hospital should be working more closely with the Community Care Access Centre (CCAC - the agency in charge of homecare) to move patients out more quickly. The reviewers seem to be unaware that the CCAC reported to the LHIN in January 2010 that it was facing a deficit and was severely restricting access to its services. The reviewers recommend that the hospital use discharge planners/CCAC Placement Coordinators. It appears that the reviewers are unaware that the hospital already has these. In addition, there is a very long wait for long term care homes in this area. There is nowhere safe and appropriate for patients to go, even if it was appropriate to discharge them.

The reviewers' data on length of stay appears to be inconsistent.[14] In one chart, they state that Quarter 1 of 2008/09 and Quarter 2 of 2008/09 average lengths of stay was 10.1 days and 8.6 days respectively. In the next chart, the reviewers state that the actual length of stay

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[10]Peer Review, page 11.

[11] Ibid, page 41.

[12]Ibid, page 21.

[13]Ibid, pages 30, 31.

[14]Ibid, page 27.

is 7.0 days for the same two quarters of 2008/09. It is not clear why differing time periods and, yet another different comparator group of hospitals is used in this section.

Further, it should be noted that the reviewers have stated that in general the average length of stay in Ontario is one day less than the average experienced in most other provinces. They have lowered the national comparative number accordingly. Yet this shorter length of stay is not based on quality or accessibility, but is rather more likely a result of the significantly less funding Ontario's hospitals receive compared to other provinces. Moving patients out of hospital too quickly can have a host of negative health impacts, including hospital readmission and higher emergency department utilization. (These are not measured in this Peer Review.) If the reviewers had not lowered the national average length of stay by one day, Peterborough Regional Hospital would be in line with the national average.

The reviewers chose a very narrow and inconsistent time periods to measure rates of infectious disease.[15] The narrow time period is not explained. It is questionable to extrapolate a trend in PRHC's performance from three months of data, particularly since data available on the PRHC and Ontario websites show that incidence rates for these infections varies every month reported.

The reviewers state that the number of Alternate Level of Care (ALC) patient days in PRHC is overstated.[16] Yet, the reviewers also state that the high number of ALC patient days implies that acuity is lower than the hospital has reported.[17] These two statements are contradictory and the contradiction raises questions about the veracity of peer reviewers' conjecture that acuity is lower than actually reported.

In fact, there is data in the report that could equally be used to make the case that acuity is high. For example, PRHC has the third lowest percentage of emergency department visits that result in admission out of the 21 peer hospitals in the review. Furthermore, the rate of admissions for the most serious emergency cases (CTAS levels I & II) is also the third lowest of the longest lists of peer hospitals used in the report.[18] This indicates that there is a very low (or non-existent) rate of avoidable hospital admissions, which would imply higher acuity, not lower acuity. The ICU and Surgery programs have very low average lengths of stay compared to peer hospitals. In the Appendix, the reviewers provide a chart giving the five-year trend for ambulatory care visits, showing a reduction of visits over the period studied (2004 - 2009). This would imply that these patients are being cared for in the community through family health teams and other services, leading to a conclusion of

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[15] Peer review, page 19.

[16] Ibid, page 30.

[17] Ibid, page 28.

[18] Ibid, page 38.

higher, not lower, acuity.

Ironically, peer reviewers found that the ICU has a very low average length of stay compared to peers. Yet, instead of concluding that the ICU is efficient, reviewers raise questions about whether these patients should be in ICU and whether the beds should be cut. Throughout the section pertaining to the ICU, data from differing periods of time were used. In some cases, data from only one quarter of one year was used. In others, two quarters were used. In others, data dating back to 2006-07 was used. There is no explanation provided by reviewers for cherry-picking the data in this way. Contradictory conclusions are drawn in this section and in other sections of the report based on similar rankings among peer hospitals for average length of stay. At one point, reviewers note that the ICU has a 90% occupancy rate.[19] In another, they state that based upon length-of-stay data, five of the 20 ICU beds could be cut (reducing the beds to 75% of the current cohort).[20] In fact, most of the section on the ICU is conjecture and reviewers provided no evidence that patient safety and quality of care could be maintained if their proposed cuts to the ICU were to be implemented.

The reviewers also recommend closing all the Medical Constant Care (MCC) beds without any concrete evidence. They further recommend the reduction of Step Down beds to four. Finally, they recommend considering the closure of half of the telemetry beds. For the latter three recommendations, there is no actual review of the services in PRC and no assessment of the impacts on quality or accessibility of care.

The reviewers make several recommendations pertaining to governance that are troublesome. They recommend that the Board of directors amend its by laws to include an article requiring the Board of Directors to ensure that the organization lives within its financial means.[21] They fail to note that in the last two years 50 - 80% of Ontario's hospitals have been in deficit, and provincial funding has failed to meet the rate of inflation for hospitals resulting in widespread deficits. If patients will suffer as a result of under-funding, it is at least equally important, if not more important, that the members of the organization and the provincial government be apprised that funding is inadequate and will result in harm. In addition, the peer reviewers recommend that the board move to a "skills-based Board".[22] In Ontario, among hospital CEOs and policy elites, "skills based board" is a euphemism for eradicating elected local boards and voting community members, replacing them with self-appointing Boards. This is not a "best practice". It reduces community accountability and increases CEO unaccountability. It is profoundly undemocratic and at odds with fundamental political values of our society.

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[19]Ibid, page 41.

[20]Ibid, page 42.

[21]Ibid, page 18.

[22]Ibid, page 21.

4. HIP Cuts[23] Compared to Peer Review

The Draft HIP proposes $23.3 million in cuts and $3.7 million in increased revenues (including $2.6 million from the Ministry of Health and $1.1 million in user fees and other non-governmental revenues). The Peer Review recommended $25.7 million in cuts and $1 million in increased user fees and other non-governmental revenues. The HIP has a slightly smaller dollar cut, but this is offset as it includes fewer unidentified cuts ($2.4 million in the HIP versus $3.7 million in the Peer Review). Thus, the cuts are virtually the same.

Dollar Cuts in the HIP Compared to the Peer Review		
	Identified Cuts	**Unidentified Cuts**
HIP	$20.9 million	$2.4 million
Peer Review	$22 million	$3.7 million

Front-line staffing cuts are virtually the same with the HIP proposing to cut approximately 150 FTE (full-time equivalent) positions and the Peer Review recommending a cut to 151 FTEs.

- While the HIP currently proposes cutting 124.6 FTE "clinical" positions versus 131 FTE clinical positions proposed to be cut in the Peer Review, this is because they have not yet made a decision about medical telemetry. Under the Peer Review, 9 telemetry FTEs and 10 telemetry beds were to be cut. The HIP indicates that they will determine what to do with telemetry later.
- The HIP plan is to increase the cuts to housekeeping from 9.5 FTEs recommended in the Peer Review to 11.3 proposed in the HIP (an 18.9% increase) and in dietary from 11.0 to 16.5 FTEs (50% increase).

[23]For this section we are using the draft HIP by Ken Trembly, President & CEO PRHC dated May 31, 2010. At time of finalizing this report, we received an updated version dated June 8, 2010. However, the staffing figures in the updated version are contradictory. Page 13 shows a proposed cut of 138.2 staff positions and page 14 shows a proposed cut of 153.8 staff positions. We will seek to reconcile the new HIP with the May 31 version in the coming days but time constraints prevent further research prior to the release of this report.

Staffing Cuts in the HIP Compared to the Peer Review		
	HIP	**Peer Review**
Total Front Line Staff	"approximately" 150 FTE (full time equivalent) positions. (Note: the numbers provided actually add up to 152.4 FTEs with the possibility of an additional 9 FTEs cut if they cut telemetry.)	151 FTE positions
"Clinical" Staff	124.6 FTE (with a decision to be made later about an additional cut to up to 9 telemetry FTEs)	131 FTE positions
Housekeeping Staff	11.3 FTE positions	9.5 FTE positions
Dietary Staff	16.5 FTE positions	11 FTE positions

The HIP proposes to cut 36 medical beds and create 32 "sub-acute" beds (ie. Interim Long Term Care, Long Term Care, transitional, Alternate Level of Care and Complex Continuing Care beds). It appears, then, that the plan is to transition the community into the full cuts proposed in the Peer Review. These sub-acute beds are the targets of cuts all across Ontario. It is very likely that they will be cut in the very near future as the hospital moves patients out and reduces its length of stay as per its stated targets.

In addition, the HIP proposes to cut 8 MCC beds (including consolidating 4 into the ICU); restrict surgeries; close 4 beds in the Women's and Children's Unit and restrict admissions; reduce diagnostic tests; and, change staffing mixes in a number of departments. The HIP also notes that fewer beds will be staffed[24], but does not provide numbers of staffed beds. Thus, the reduced number of bed cuts in the HIP compared to the Peer Review are likely illusory as the staff cuts are the same or worse.

5. Proposed Increases in User Fees Contrary to Canada Health Act

Peer reviewers recommend increase in non-Ministry of Health revenues by $1 million through increasing the number of private and semi-private beds for which patients must pay user fees and through other fees.[25] The HIP proposes increasing the number of patients charged for semi-private and private beds as a way of increasing its revenues through increased user fees. It has already increased its parking fees. This is in keeping with the Peer Review's recommendation to increase user fees. These recommendations run counter

[24]Ibid, Slide 9.

[25]Ibid, page 66.

to the Canada Health Act and the basic tenets of medicare. Hospital care should be accessible to all as a publicly-funded service. Already patient user fees (such as parking fees and rental fees) across Ontario are causing hardship for patients. The use of benchmarking against peer hospitals simply continues to raise user fees on an ongoing basis for everyone. This practice, far from being recommended by peer reviewers must be rolled back. It places particular hardship on those least able to pay – seniors and those with chronic illnesses who require frequent hospital care.

Conclusion

The Peterborough Regional Health Centre Peer Review document, upon which the Hospital Improvement Plan is based, relies heavily on misleading statements about cost increases and conjecture regarding acuity to support drastic cuts to length of stay and hospital beds and staff. The report is rife with methodological inconsistencies. There is a surprising lack of evidence provided to support most of the largest cuts proposed. Perhaps most importantly, the reviewers demonstrated an almost total failure to consider risk to the patients, quality of care and access to care.

In the HIP the hospital reports that its Board has passed a motion to "operate at the top quartile of Ontario hospitals". This would require PRHC to endlessly reduce its average length of stay (ie. how fast it moves patients out of hospital) and reduce its costs per case, its staffing levels and its number of beds on an ongoing basis, in competition with other Ontario hospitals. Such a motion is irresponsible. The result is a race to the bottom in which hospitals cut beds, staff and services regularly in a competition to have the lowest statistics without proper regard for patient safety, access, and quality of care. The weakness of this approach is evidenced in the lack of fulsome information and evidence in the Peer Review pertaining to key indicators such as cost per weighted case, admission and discharge data for several departments and the reasons for length of stay in medical beds. Moreover, there exists in Peterborough both a deficit and severe constraints on services provided through homecare (CCAC) and an extraordinary wait list for long term care beds. Both of these are outside of the hospital's powers to rectify. In order to accomplish operating in the "top" quartile, the hospital would have to move patients out without anywhere appropriate for them to go.

Most seriously, we believe that both the peer reviewers and the authors of the Hospital Improvement Plan have based the majority of their proposed bed and service cuts on an assumption of lower acuity and an ability to move a significant number of patients out of the hospital, without providing evidence to support these contentions. Overall, the evidence provided does not support the notion that the deep bed, service and staffing cuts recommended can be sustained without causing a serious shortage of medical and other beds resulting in backlogs throughout the ICU and cancelled surgeries, inappropriate discharge, reduced quality of care, downloaded costs and poorer health outcomes for patients.