Ontario Health Coalition Submission

Regarding the Rural and Northern Framework/Plan Stage 1 Report

of the Ontario Ministry of Health and Long Term Care

March 8, 2011

I. Introduction

The Ontario Health Coalition welcomes this opportunity to provide input into the creation of a rural and northern health care framework and to respond to the Rural and Northern Panel's Stage 1 Report. We strongly support the stated focus on access to care for people who live in rural and northern communities. We support the primary recommendation of the report that the Ministry of Health and Long Term Care must consider access to care when pursuing other quality of care initiatives. We also support the focus on geography and proximity to services. Among the other recommendations that we support are the following:

- The creation of a framework, strategic directions and guidelines to guide health care planning for rural and northern Ontario.
- The recognition that rural residents, health providers and other stakeholders must be active participants in health care planning for their communities.
- The inclusion of transportation, ambulance and patient transfers in the recommendations.
- The recommendation to create one point of accountability within the Ministry of Health focused on the needs of rural and northern Ontarians.
- The recognition of the need to address health human resource shortages in rural and northern communities.
- The tentative steps towards embracing local flexibility and control guided by provincial standards, and we encourage a stronger acceptance of these general approaches.

We do, however, have a number of concerns. The most serious of these relate to how the Panel's recommendations may impact rural access to care, particularly across southern and mid-Ontario. Our chief concerns are as follows:

1. The focus on access outlined at the beginning of the report, including geographic proximity, does not carry through the report. It cannot be found in the recommended principles, and it does not flow through into concrete recommendations for many aspects of health care.
2. The recommended definition of "rural" adds to the confusion surrounding the future of the hospitals in many communities as it excludes dozens of local hospitals, including those at most risk for closure and serious service cutbacks.

3. The distance to care recommendations lack definitions and have added to our confusion and concern. There is no mention of the problems patients in rural and northern communities face in accessing chronic care, rehabilitative care, home care and long-term care in facilities and there are no standards proposed for these.
4. We do not support the recommendations that would assign to LHINs the responsibility for setting standards for access to care, defining performance goals, and creating funding models. These are policy decisions that are the responsibility of the provincial government.
5. More concrete recommendations are needed to alleviate health care human resource shortages.
6. The recommendations regarding creating "local hub" models of planning, and referral networks and pathways are unclear. Clear recommendations regarding this must be consulted upon before they are adopted.
7. Community engagement should be replaced with transparency, democracy and public accountability. Recommendations pertaining to roles and responsibilities for improving access need to be clarified and improved.

We have outlined these issues and have made concrete recommendations pertaining to them in the sections that follow.

Last spring the Ontario Health Coalition conducted our own hearings into the future of small, rural and northern hospitals. More than 1, 150 people attended our consultations and we received almost 500 written and oral submissions. We have provided our full report and recommendations to the Minister. A number of the key issues and recommendations we made are not contained in the Ministry's Stage 1 report and where relevant we have included our recommendations under the appropriate sections.

Response to the recommendations in the Ministry of Health's Stage 1 Report

ISSUE 1 The goal and vision of the Rural and Northern Framework needs to be clarified and aligned with the principles, strategic directions and guidelines in the framework.

- On page 7 the panel report states that it is focused on access to care.
- On page 11 the panel's proposed vision is:
  "A health care system that promotes appropriate access and achieves equitable outcomes for rural, remote and northern Ontarians".
- On page 11 the panel also states that their principles are in keeping with the province's broad vision for health care that is:
  "Help people stay healthy. Deliver quality care when and where they need it. Ensure sustainability for future generations".

- On page 11 the panel goes on to elaborate its proposed Guiding Principles as:
  Community engagement
  Flexible local planning and delivery
  Culturally and linguistically responsive
  Value
  Integration
  Innovation
  Connected and coordinated
  Evidence-based
  Sustainable

There needs to be more alignment between the vision, goal and principles.[1] The principles proposed in the report (listed above) are particularly problematic. Though "access" and "equitable health outcomes" are central to the vision, accessibility and equity are not listed nor captured in the principles. The privatization of needed health services, such as cuts to publicly-funded outpatient physiotherapy and chronic care across rural Ontario have created severe problems in access to care. These are not recognized anywhere in the report nor in the recommendations. In fact, most of the proposed principles reflect the point-of-view of providers, not patients. Most of them are health-management buzzwords, not principles. Further, the proposed principles exclude the fundamental principles that underlie our public health system including comprehensiveness, portability, accessibility, universality; nor do they reflect the requirement for publicly-funded, publicly-administered medically necessary health care. The founding goals of our public health system – compassion, equity and public interest -- are not reflected in this part of the report.

Finally, some of the stated principles have become value-laden terms that are not positive and are not supported by Ontarians. For example, "community engagement" is a buzzword that has been used to cover undemocratic or manipulative practices by various LHINs. It does not mean

democratic, transparent or accountable. In the words of Ontario Ombudsman, Andre Marin, "the reality of "community engagement" is that its in a wishy-washy grey zone" and this has been used to render it "meaningless".[2] "Integration" has been used to close down rural health services rather than to coordinate them. As has been noted by former Liberal Health Minister Ujjal Dosanjh, "sustainable" is a code-word used by the advocates of privatization to undermine public medicare, and it too has been used to rationalize the dismantling of small community hospitals in Niagara and Shelburne. Some of the other terms listed under "principles" are so conceptually broad as to be meaningless or potentially damaging to access in the context of rural and northern health care. These include terms such as "value" or "innovation".

If guiding principles are to set a tone and frame policy-making, it would serve residents of rural and northern communities better to adopt a set of guiding principles that clearly reflect the public interest and the values and priorities of these communities, that are definitively progressive, and that support the public non-profit health system.

Recommendation

We recommend clarifying and unifying a goal, vision and principles as follows:

Goal: Improved equity and access to public non-profit health care services for rural, remote and northern communities.

Vision: "A health care system that promotes access and achieves equitable outcomes for residents in rural, remote and northern Ontarians".

Guiding Principles:
Accessible
Universal and equitable
Comprehensive and coordinated
Portable
Compassionate
Public and non-profit
Culturally and linguistically responsive
Transparent and accountable
Democratic
Reflective of unique local contexts
Guided by equitable provincial standards

Note: We support the Ontario Medical Association's Section on Rural Practice in its recommendation that "Compassionate care close to home must be available, particularly for the elderly, those in need of palliative care, and those with chronic illness." We have included this under #3 below but would also support its inclusion in guiding principles.

[2] Andre Marin "The LHIN Spin" *Ombudsman's Remarks* August 2010.

ISSUE 2 The definition of "rural" in the Stage 1 Report is problematic. We are concerned that it could imperil dozens of hospitals across southern and mid-Ontario.

The panel defines rural as an area with population <30,000 more than 30 minutes drive from a centre with >30,000 population. It further defines distance as driving distance in good weather.

The panel's definition of rural is problematic when applied to planning for hospitals as it excludes many or most small community hospitals across southern and mid-Ontario. These hospitals provide vital access to health care for dozens of communities. A number of them have been, in recent years, most at risk for service cutbacks and even total closure. Thus, while LHINs and local communities have been waiting for clarity regarding the future of their local hospitals in Petrolia, St. Marys, Wallaceburg and other towns, this report does not provide any assurances as to the future viability of these important health care services. Nor does it address the serious problems that have occurred as a result of the closures in Niagara, North Muskoka and Shelburne.

In the most recent report on this subject by the Joint Policy and Planning Committee of the OHA and the MOHLTC, small, as well as rural, remote and northern hospitals were discussed as a group and definitions were based on numbers of weighted cases.[3] The panel's report provides no explanation for their choice to define "rural" in a way that excludes small community hospitals. It is not clear how this definition is to work with existing health care services – particularly hospital services – across Ontario. Communities that consider themselves "rural" because they are characterized by agricultural production as well as industry all across southern Ontario do not fit into the panel's recommended definition. Community agencies and local transportation systems (including EMS) have long-established approaches to providing care based on existing local hospitals' catchment areas, local history and social cultures etc. In a number of situations that have arisen in the last three years, small hospitals have lost vital services when there is inadequate capacity in larger community hospitals or regional tertiary hospitals to take the additional patient load. The distance measures are problematic because they do not take into account these factors. Nor do they take into account weather conditions that change driving times dramatically from summer to winter when a 30 minute drive may be routinely impassable or may take double that time or more. It is not clear if the panel intends for those communities to have no assurance about the future of their hospitals or other existing health services in their areas.

Further, the report is unclear about whether the definition of rural is to be meaningful or not. On page 8, the panel recommends that LHINs determine the rurality of communities within their regions, and use the panel's guidelines for planning purposes. Is a "guideline" policy or not? Though we strongly support the aim of establishing a framework that contains planning guidelines that take into account proximity to care as an important factor in access to care, and though we accept that no guideline is going to be perfect, it is not acceptable to have 14

[3] The Ontario Joint Policy and Planning Committee (JPPC) Multi-Site Small Hospitals Advisory Group *The Core Service Role of Small Hospitals in Ontario* Summary Report to the Minister of Health and Long-Term Care December 18, 2006: pp 1.

different standards for health planning. The LHINs are not trusted by the public, they are not accountable and they lack the skills to make these crucial determinations.

Ultimately, guidelines establishing goals for proximity to care should be adopted. But this is a political question with significant implications that should be informed by the values and priorities of Ontarians and determined in a publicly-accountable way. To determine these in an undefined manner by each LHIN is to continue the ad hoc and short-sighted decision-making that has led to the closure of needed hospital services in the southern tier of Niagara, Burk's Falls and Shelburne, and the threats to other community hospitals.

Recommendation

2A) The definition of "rural" should reflect the reality of existing small community hospitals in Ontario or the framework should be expanded to include "small" as well as "rural" and "northern" hospitals with a definition for small hospitals that captures the existing small community hospitals in Ontario.

The Minsitry's health planning processes need to take into account that the amalgamation or alliance of some hospitals' governance and not others' has little basis. Allied and amalgamated hospitals range from medium-sized to very small. Their proximity to larger centres varies. Their local contexts and histories are unique. Amalgamation and alliance were purportedly meant to capture administrative savings, not to be taken as approval of continual removal of service and/or eventual closure of hospitals that serve entire communities.

The continual erosion of the services in the small sites of amalgamated and allied hospitals through removal of equipment, failure to plan for needed staff, removal of services and reductions in funding has compromised access to care for thousands of Ontarians. Hospital boards and executives cannot be allowed to make decisions that rob thousands of people of services with no policy to guide them, no recourse for patients, and no public accountability.

For planning of service levels, allied and amalgamated sites of larger hospital corporations should be treated as discrete entities and approval processes for levels of service should follow the same guidelines as those in stand-alone small and rural hospitals. This needs to be made a clear policy that is communicated to hospital leadership across the province. The framework needs to address the problem of planning and sustaining these hospitals that are most at risk in concrete ways.

Recommendation

2B) The framework should clarify the role of small hospitals, appropriate to their rurality or remoteness, including those that are amalgamated or allied. This is how patients experience access to care, regardless of amalgamation or alliance in governance.

The role of the smallest hospitals, including the smaller sites of the amalgamated and allied

hospitals needs to be clarified. The report contains confusing language about local hubs and pathways that could be interpreted in many different ways. The planning guidelines for these hospitals should be to provide, at minimum, the baseline hospital services identified here. Small hospitals specialize in assessment, stabilization and transfer of critical cases, and provide basic hospital care close to home. Larger small hospitals and more remote small hospitals should include ability to perform minor surgeries, and a wider range of clinics, specialties and other services as determined by population need and the need for accessibility.

Recommendation

2C) A clear baseline of services should be available in every hospital, including in the smallest and amalgamated or allied hospitals.

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

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

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

We support the panel's recommendation that further work be done to guide a framework that is specific to the unique needs of remote communities.

<u>ISSUE 3</u> The proposed distance-to-care guidelines in the Stage 1 Report are unclear and potentially imperil existing access for thousands of Ontarians.

In the Stage 1 report, the panel proposes standards and planning guides, then give the caveat that these are to be considered "visionary" and not guidelines in the sense of rules that would set minimum standards or guide service and infrastructure planning.[4] They are:

- 90% of people in a community or local hub shall receive primary care within 30 minutes of their residence (measured by driving time)
- 90% of people in a community or local hub shall receive emergency services within 30 minutes of their residence
- 90% of people in a community or local hub shall receive inpatient care within 1 hour of their residence
- 90% of people in a community or local hub shall receive specialty inpatient care and tertiary diagnostics within 4 hours of their residence

Again, clarity is needed regarding what is a guideline and what is not. On one hand, the caveat in the preamble seems to render this list meaningless. On the other, we support establishing planning guidelines that guide and set goals for Ministry planning for health care services. But these guidelines, if used to allow closure of services closer to home than the distances outlined, could result in the closure of dozens of local hospitals. To date, distances from one emergency room to another have been used to justify proposals to close some hospitals' acute care services and emergency departments without taking into account many factors that impact access. In general, we are concerned because it is not clear how the list of planning guidelines above is to be used.

We consulted with local health coalition and community hospital advocates across Ontario, who identified the following questions and concerns about these recommendations:

- It is not clear why a planning goal would be for 90% rather than 100% of the population.
- The recommendation that inpatient care (undefined) should be within 1 hour driving time of peoples' residences could endanger the future of rural hospitals all across mid-and southern-Ontario
- Is emergency care defined as a hospital emergency department or EMS? Does the recommendation mean that ambulance response time should be 30 minutes or less, or that emergency departments should be located within 30 minutes driving distance from residents' homes?
- The recommendation that tertiary diagnostics and specialty inpatient care be located 4 hours from residents could mean that large hospitals in Windsor, Toronto, Ottawa, North Bay, Sudbury, Sault Ste. Marie and Thunder Bay are all that are planned for, in addition to services for remote areas in the north.
- What is the four-hour guideline based upon?

[4] There are two notable caveats in this report in which the caveat partially or wholly negates the panel's recommendation. This is one of them. The other is in the preamble to recommendation #9 of the panel's Stage 1 report which calls for improved community consultation and ownership.

- The same problems regarding the measurements of driving time as were outlined in the previous section apply here.
- Note: We have reviewed the ICES report that measures distance to care in 30, 60 and 240 minute increments.[5] While this descriptive report is interesting, it does not follow that these distance measures should be prescriptive. Moreover, the ICES report does not measure capacity – ie. it does not measure whether tertiary hospitals are overcrowded or whether physicians are accepting patients. Thus, it does not actually measure access to care.

The planning guidelines in the Stage 1 Report comprise too blunt an instrument to assess population need and access to services. Clear definitions of what is meant by inpatient services, emergency services, tertiary and specialty services are needed. Wait times and lack of capacity in larger hospitals must be taken into account in planning and decision-making, as should infectious disease control. It is not clear how these guidelines – or whatever they are – are supposed to impact existing hospitals or whether they are meant for planning new hospitals. Additional care services such as chronic and rehabilitative care require guidelines for planning.

Recommendation

3A) Set a provincial standard to measure access and assess capacity more meaningfully.
A tool is needed that includes such factors as proximity to care for the total catchment population of the hospital, population demographics and assessed need, transportation systems and road conditions. Further, careful attention to regional hospitals' and other health services capacities must be included in planning decisions. Hospital cuts should not proceed if there is no capacity to meet need for services under the public health care system.

Recommendation

3B) Create a provincial standard and a plan to provide at least baseline hospital services at optimum 20 minutes from residents' homes in average road conditions and at most 30 minutes from residents' homes in average road conditions. In the special case of the north, all existing hospitals should be maintained.
A multi-year province-wide plan should be created to develop baseline hospital services outlined in recommendation "c" under Section 2 above. In the Ontario Health Coalition hearings, we heard testimony that ambulance response times can be 30 – 45 minutes for traumas from car and farm accidents in rural areas. Thus, at optimum, baseline services should be 20 minutes from residents' homes in average road conditions, and, at most 30 minutes from residents' homes in average road conditions. This would allow ambulances access to a hospital emergency room within the critical "golden hour" during which the intervention provided in a local emergency department can save life and improve health outcomes. All the northern hospitals are needed and should be maintained along with the nursing stations. The medical centre on Pelee Island should be maintained.

[5] Glazier RH, Gozdyra P, Yeritsyan N. *Geographic Access to Primary Care and Hospital Services for Rural and Northern Communities: Report to the Ontario Ministry of Health and Long-Term Care*. Toronto: Institute for Clinical Evaluative Sciences; 2011.

Note: we accept the use of driving distance but do not accept the measure if it is used only when driving conditions are optimal. If a reasonable assessment is that a hospital is 20 minutes away in optimal conditions, but 40 minutes away when roads are icy or snowy, it is reasonable to estimate that the average driving condition might be 30 minutes. While imperfect, this estimation leans in favour of access and, generally accords with the existing travel distances for most small hospitals across southern Ontario. In a few areas, it would lead to a need to plan enhanced access to hospital services. This is reflective of real population need for services.

Recommendation

3C) Create provincial standards and a plan to provide chronic, rehabilitative and palliative care close to home. The goal should be to ensure compassionate access to care close to support networks particularly for seniors and those with chronic illnesses.

This plan should include measuring and planning to meet community need for publicly-funded chronic, rehabilitative and palliative care across the continuum of public non-profit hospital beds, outpatient services, long term care facilities and home care.

Recommendation

3D) Revise current practices of closing complex continuing care beds and long term care beds in hospitals, and create a provincial plan to provide stable accessible services for seniors.

Care levels are inadequate to provide for chronic care patients in long term care homes. Patients, moved out of hospital too quickly, end up back in emergency departments and their health can be irreversibly compromised as a result. There are no dedicated complex continuing care hospitals in rural areas. Complex continuing care is a legitimate hospital service and should be appropriately funded and provided. Small, rural and northern hospitals should have the ability to provide this care close to home.

The movement of long term care patients should only be allowed when there are adequate and appropriate placements available that are close to patients' home communities. Retirement homes should not be used to download hospital and long term care patients.

<u>ISSUE 4:</u> The strategies in the sub-recommendations under Governance and Accountability (page 54 – 55) are unclear and potentially lead to 14 different sets of standards for access to care.

While we support the overarching recommendation of the Minister's panel under Governance and Accountability to create a point of accountability within the MOLTC leadership focused on rural, remote and northern health, we have concerns about the sub-recommendations. In particular, R1.12 states that definitions and performance goals for standards for access would be developed in collaboration with LHINs and local communities. This would counter attempts to clarify policy goals and strategic directions and could lead to no standards for planning and measurement of progress or different standards for 14 LHINs. In combination with R1.20 which calls for "flexible funding models that support integration [undefined] at the local level across existing funding silos" and that are unique to local circumstances, we are concerned that there would be no provincial planning standard and continued ad hoc decision-making. The consequence is evident in decision-making to date which has, for example, deprived some communities of access to acute care hospital services close to home particularly where hospitals were amalgamated or allied in the mid-1990s, while others have robust local hospitals. Another example can be found in home care where the provincial auditor has repeatedly criticized the lack of provincial standards for access to care.

<u>Recommendation</u>

Our response to this is covered in recommendations 2 & 3 above. We do not support different funding models and different levels of service in each LHIN. There is plenty of room for local flexibility and sensitivity to unique contexts while establishing, at the provincial level, basic expectations for access to care for all Ontarians.

<u>ISSUE 5</u> In general, we support all the recommendations under the heading of Health Human Resources but they are insufficient to deal with the problems experienced in communities that currently have very poor access to primary care and crises in recruitment of health professionals and physicians for primary care and local hospitals.

In particular, we support the recommendations aimed at bolstering inter-professional care and team-based approaches such as community health centres and family health teams. We further support the expanded utilization of nurse practitioners and allied health professionals including physiotherapists, and midwives. The recommendations regarding mentorship and on-site educational experiences for training health professionals in small, rural and northern hospitals echo our own recommendations from our hearings last spring and we support these.

We must note, however, that family health teams are not equivalent to access to acute care services in local small hospitals and should not be used as such. Funding for family health teams should not create a disincentive for family physicians to work in emergency departments overnight or to support their local hospitals. Moreover, 24-7 coverage by family health teams should not comprise an answering service that tells patients to call back in the morning. Further, the opinion espoused by some LHIN staff and board members that paramedics can replace emergency departments is not true and should not be used to close local emergency departments.

In addition, in the OHC hearings we traveled to communities such as Minden, Hailybury and Shelburne where access to primary care was reported to be extremely poor. This is not captured in the ICES report and the recommendations in the Stage 1 Report are insufficient to address the crisis in access to care for residents in communities such as these.

One problem that we have witnessed is that responsibility for recruitment addressing severe shortages is not clear. The LHINs do not cover physicians. In some communities, local physicians have taken the responsibility for recruitment upon themselves. In others, there are community committees or the municipal government is involved. In some communities the hospital leadership in the dominant larger community hospital in the region has taken no responsibility for recruitment, in part, because they seem to support the closure of the smaller hospital sites. The provincial government must step in to avert crisis-level shortages and to solve them when they occur. Shortages cannot lead decision-making or planning on access to care, they must be actively addressed by the level of governance that has the ability to effectively address them.

<u>Recommendations</u>

5A) The provincial government must intervene when disagreements between hospital managements and physicians threaten the loss of emergency and hospital services for communities. These instances must be reported to the leadership of the Ministry of Health and immediate intervention to preserve access to care must follow.

5B) Create emergency task forces for critically underserved areas first. The ICES report should not be used as a basis for this since it did not measure whether physicians (or other primary care providers) are accepting patients. These task forces should levy the connections, knowledge, skills, resources and goodwill of municipalities, local physician recruitment committees, regional planning bodies and local hospital management to coordinate efforts and create meaningful plans to alleviate shortages.

5C) Continue and expand the work of Health Force Ontario and Ontario Medical Association programs that are providing better access through supporting recruitment and retention, mentorship and locums.

5D) Support hospitals to develop partnerships with nursing and medical schools to bring interns, residents and nurses to small hospitals.

5E) Build upon the recent initiatives to improve the supply of nurses, including increasing spaces in educational institutions to meet standards of care, coupled with recruitment processes to encourage rural and northern applicants and those committed to practicing in rural and northern communities, and opportunities for clinical placements.

5F) Actively promote the team of health care professionals including nurse practitioners and allied health professionals working to their scope of practice, by creating or expanding funding mechanisms and support. Target areas with severe access to care issues and those at risk of declining access first.

5G) Create clear planning targets for improving the supply of health professions.

5H) Continue to support the northern nursing stations and nurse practitioners.

5I) Restore access to publicly-funded outpatient rehabilitation in local hospitals.

5J) Support the creation of technical innovations to advance specialized training for local emergency room physicians. Do not use the lack of specialized emergency physicians to justify the closure of local emergency departments.

5K) Recognize the special skills and the vital contribution of rural and northern physicians, nurses and allied health professionals.

<u>ISSUE 6:</u> Under the heading "Integration" the Minister's panel makes a number of unclear recommendations regarding a "local hub" model of health planning and referral networks and pathways.

It is not clear what is intended by these recommendations. If the intention is to provide a public non-profit multi-service agency that integrates home and community care and/or public-non-profit integration of hospital and home care, we are supportive. In addition, we are supportive of ambulatory care centres that provide a range of public non-profit health care services. However, if the intention is to replace the acute care role of small hospitals with something else, we cannot support this.

An additional problem is that in this section responsibility is assigned to LHINs that cover regions that are far from local or even regional, have no transportation or any other social, political and health care infrastructure that fits their boundaries, and operate under legislation that defines integration in a way that promotes perpetual centralization of health care providers.

<u>Recommendation</u>

New recommendations that clearly state the intention and role of "local hubs" and referral networks and pathways should be consulted upon.

ISSUE 7: The recommendations under the section "Integration: Local Community Engagement and Planning" (page 57) are inadequate.

While we support the goals of improving the assessment of community health care access needs at the local level and improve capacity to apply for provincial funding, there is nothing concrete in the recommendations that would accomplish these things. The responsibility for setting standards for local "community engagement" and planning is improperly assigned to the LHINs and local health care provider organizations when it is the responsibility of the provincial government to establish governance structures and lines of accountability in the health system. Moreover, "community engagement" is an unclear term that has been misused. Too often, the LHINs only consult meaningfully with provider groups. In a number of instances, community members or users of services have been subjected to manipulative "PR" processes called "community engagement". The principles that underlie our political structures are democracy, transparency and public accountability. Community engagement is nebulous, but it is clearly less than these principles.

A meaningful framework for improving access and equity in rural and northern communities needs to establish clear roles and responsibilities, including what should be guided by provincial standards (equity) and what should be determined locally to be sensitive to unique conditions. The panel's Stage 1 Report starts off strongly, with a vision and apparent goal to improve equity and access, but the recommendations are inadequate to fulfill these.

Recommendations

7A) Clarify roles and responsibilities as follows:

- **There should be provincial standards for access to hospital care, primary care, long term care facilities and home care. LHINs should be required to measure and report on access to these services. Where access falls short of meeting measured needs for care, publicly-accessible plans to address shortfalls should be made.**
- **LHINs should be required to consult the public on their experience with access including gaps in service and problems in moving along the continuum of care. This consultation should be publicly-accountable, recorded and reports based on these consultations must be available to the public.**
- **The public should be able to access information including board meeting minutes and financial reports for publicly funded health care providers, statistics on wait lists and service levels, information about service planning including accountability agreements and other documents.**
- **"Community engagement" should be replaced with transparency, democracy and public accountability. Health care policy should provide the public with the tools that comprise democracy – access to information and the ability to ask questions and have them answered, consultation and input, responsiveness to complaints, and representation on governing bodies.**
- **Hospitals should be required to show cause, according to provincially-set standards, for removing or cutting existing services. The provincial government must retain**

decision-making power to approve such cuts before they are implemented. The public should be provided notice, access to documents, an ability to be heard and ask questions, and an ability to appeal proposals for cuts.

- **The provincial government should release its secret 10-year plan for the health system to the public of Ontario to whom it is accountable.**

Recommendation

7B) Performance measures for health care providers, such as hospital performance measures and CCAC performance measures, must reflect the primacy of access to care and quality of care. Such measures cannot be set locally by the LHINs and health service providers. They are clearly the responsibility of the provincial government.

Measures that help to protect and promote access to services and quality of care need to be created. These should be considered at least as important as efficiencies and funding targets. Many hospital reports, peer reviews and LHIN reports, hospital performance measures neither adequately measure efficiency, nor do they protect the public interest in access to care, quality of care, sound governance and management practices. For example, simply measuring "throughput" and "average length of stay" can work against access and quality. The requirement that hospitals continually bump up their standings relative to each other in these measures can mean a continually declining standard of care and a shortage of hospital beds and staff across all hospitals. The frenzy to continually cut patient length of stay – without any real assessment of the consequences – must be tempered. Cutting budgets for "poor performers" hurts patients and cannot replace enforcement of clear provincial standards.

Similarly, the provincial auditor has repeatedly criticized the lack of equitable clear standards for access to care in CCACs. Patients with similar levels of need may have no problem accessing care, may be placed on a wait list, or may not be able to access care at all, depending which CCAC's region they live in. This is unacceptable.

Additional Recommendations

7C) Patient and staff complaints should be measured and monitored. The provincial government should consult on the creation of an independent patient advocate and/or oversight of hospitals by the ombudsman.

7E) Restore democratic governance of hospitals. Promote non-profit governance structures for primary, home and long term care.

7F) Build processes that respect and involve staff in decision-making.

Fiscal advisory committees with staff representatives should be functioning in all hospitals. Physician leadership positions must not be left vacant for years. The provincial government must ban the practice of imposing gag orders on hospital, long term care and home care staff, and work to create a culture of respect for staff input and opinions. Such debate may be uncomfortable at time, but it is necessary for sound decision-making and public accountability.