

**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 in 12 communities across Ontario in March 2010**

Submitted by the panelists to the Ontario Health Coalition

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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.

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Ontario Health Coalition

Mission and Mandate

The Coalition's primary goal is to protect and improve our public health care system. They work to honour and strengthen the principles of the Canada Health Act. They are led by a shared commitment to core values of equality, democracy, social inclusion and social justice, and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. They are a non-partisan public interest activist coalition and network.

To this end, the coalition empowers the members of its constituent organizations to become actively engaged in the making of public policy on matters related to the public health care system and healthy communities. They seek to provide to member organizations and the broader public ongoing information about the health care system and its programs and services, and to protect the public health system from threats such as cuts, delisting and privatization. Through public education and support for public debate, the coalition contributes to the maintenance and extension of a system of checks and balances that is essential to good decision-making. They are an extremely collaborative organization, actively working with others to share resources and information.

The Ontario Health Coalition is comprised of a board of directors, committees of the board as approved in the Coalition's annual Action Plan, local coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than 400 member organizations, a network of 70 local health coalitions and many individual members. Their members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

“We can never accept the notion of limited access to health care for the one-third of Canadians who live in rural and remote Canada. Geography cannot become an excuse for inequity.”

Honourable Allan Rock, Minister of Health, Canada, at 132nd Annual General Meeting of the Canadian Medical Association, August 23rd 1999.¹

¹ The Rural News Vol.3 Issue 6, March 14, 2001.

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Introduction

It has been a privilege for this panel to travel across Ontario and hear from hundreds of community members about their local hospitals. It is evident to us that communities welcomed the opportunity to be heard, finally, on an issue about which they feel passionately. We appreciate the warm welcome and the support we received from municipalities, local media and the more than 1,150 residents who came out to the hearings. We have been moved by the testimony of family members and friends who shared their pain, grief and anger with us. Out of respect for the time and preparation many people put into their submissions we have tried to include as much of the testimony we received as possible. In the copies of this report that have been sent to the Minister of Health, the Premier and the opposition Health Critics, we have attached copies of all written submissions and transcripts of the oral presentations.

There is remarkable consensus in the 487 submissions we received. Across Ontario, a disturbing lack of proper planning, policy, and evaluation processes for changes in hospital services is in evidence. Similarly, public opposition to the LHINs and the erosion of democratic principles in hospital boards and public policy is universal. Continual instability has taken its toll on the workforce. Witness after witness testified to the urgent need to address the crisis levels of shortages, the decline in local hospital services and the cuts to publicly-funded care.

If there is one overarching theme, it is a plea for equity. Though a few communities are doing relatively well, in general, communities are facing severe challenges. Overall, rural residents feel that they are treated unfairly; that they are treated as lesser than their urban counterparts. Across Ontario people are calling for someone to intervene; to recognize the vital role that small hospitals play in their communities, to credit the decades of work that local governments and residents have put in to trying to improve access to care, and to restore compassion, equity and a principled approach in policy making.

In our recommendations and in our account of what we heard we have tried to stay true to the spirit and intent of the input we received. While we do not have every answer to the complex and often overwhelming challenges facing those who govern Ontario's health care system, we have put together what we believe is a truly democratic contribution to the policy discussion.

We have made a number of recommendations. In particular, we determined that the LHINs are so lacking in public confidence, so flawed in their size and confused in their mandate, that we have recommended that the province change direction and create new accountable regional planning bodies closer to home with a principled and clear mandate. We also determined that hospital planning is so erratic, so short-term and short-sighted, that the risk of closure of needed services in small and rural hospitals is now very high. As a result, we have heeded the many calls from communities to recommend that the province set standards for hospital services and distance to care. We hope that our recommendations to set required baseline services and distances serve as an opening for much-needed debate and we welcome feedback on these proposals. We have also proposed improving hospital funding in Ontario to be in line with the national average. There are many more recommendations, many equally important to these.

We hope that this report serves to bring important injustices to light. We hope to amplify the most important voice that has not been heeded by the provincial government and key policy makers to date – the voice of the people of Ontario.

Public Hearings Process

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 through 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.

Background

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.

The coalition selected panelists to hear from local citizens based on the following criteria:

- Panelists had to represent active members of all three major political parties in Ontario.
- They had to represent each of the geographic regions of the province – east, west, near north and north.
- They needed to include clinical experience as well as the point of view of community members and patients.

The panel includes physicians, retired nurses and a physiotherapist. Panelists represent every region and have embraced a non-partisan approach.

The panel held hearings in 12 communities across the province. Meetings were publicized through local media, advertising, posters and leaflets. In the publicity, community members were asked to bring their experiences of service gaps, their concerns, their vision of the role of their local hospital, and their recommendations. All hearings were open to everyone and all who requested time to present were given the opportunity to do so.

Recommendations

I. ACCESS TO CARE

Set baseline requirements for access to hospital services and build upon efforts already underway to address nurse, physician and health professional shortages. Investigate, evaluate and rectify severe problems in access to care as a result of hospital cuts.

1. Create policy to ensure a basket of services are available in every hospital, including in the smallest and amalgamated or allied hospitals.

The role of the smallest hospitals, including the smaller sites of the amalgamated and allied hospitals, should be to plan to provide at minimum the baseline hospital services identified here. Amalgamation of governance and management functions should not be interpreted to mean that services are not needed and can be summarily withdrawn by hospital boards or LHINs. 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.

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

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

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

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

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

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

A multi-year province-wide plan to develop baseline hospital services should be created. The panel heard 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.

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

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

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

- The provincial government must intervene when disagreements between hospital managements and physicians threaten the loss of emergency and hospital services for entire communities.
- Create emergency task forces for critically underserved areas first (including such localities as Shelburne, Hailybury and Minden) in partnership with municipalities, local physician recruitment committees, regional planning bodies and local hospital

management. Leverage the connections, knowledge, skills and resources of these groups to create and implement meaningful plans to alleviate shortages.

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

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

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

I a. ACCESS TO CARE – LOCAL RECOMMENDATIONS

6. The provincial government must send an investigator under the provisions of the Public Hospitals Act to investigate serious complaints and unresolved issues in the Niagara Health System.

- Issues regarding finances, human resources, management, quality and access to care in Niagara are among the most serious that we witnessed in Ontario. This panel supports the requests of the nurses, physicians, municipalities and MPPs who have called for a provincial investigator.
- In addition to investigating the serious clinical, management and financial issues that have been raised, the investigator should conduct or set a process for the immediate review and evaluation of the impact of the service cuts and closures in Niagara. This review should include meaningful and accessible public input. A clear plan to improve access to emergency care, intensive care, and acute care should be established, with timelines for implementation. The process should be open and transparent. The proposals put forward by the municipalities deserve an answer.

7. The provincial government must intervene to restore urgent care and walk-in access to services in northern Muskoka (Burk's Falls and area) as an immediate priority. A review of the needs for continuing and palliative care should be undertaken.

The Ministry should convene a meeting with the municipalities, the two LHINs, and the hospital to resolve questions of ownership of the facility and to forge a plan to restore access to care in this region.

8. The provincial government should immediately ensure that the hospital cuts in Cobourg are stopped.

The hospital and LHIN should be directed to present a plan to resume the diabetes education clinic, outpatient rehabilitation and the hospital beds. This panel recognizes that the hospital is comparatively "efficient" and the issue is one of funding. The hospital should be directed to come up with a funding proposal to maintain services.

8. The provincial government must place a moratorium on closures of emergency departments .

Local Health Integration Networks should be directed to stop the closures of local emergency departments, including those proposed for amalgamated hospitals. There is no appropriate assessment of capacity and policy to ensure reasonable access to urgent and emergent care in these regions and restructuring costs have not been assessed or approved. There is poor alignment of planning for capital redevelopment and proposed changes to services. Provincial policy and planning to meet baseline service targets and other safeguards for public access must precede further hospital restructuring.

II. GOVERNANCE

Rebuild democratic, accountable governance with a realignment of accountability and responsibilities and improved oversight.

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

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

- Provincial legislation should embody the principles of the Canada Health Act.
- Hospitals should be required to show cause, according to provincially-set standards, for removing or cutting existing services. The provincial government must retain decision-making power to approve such cuts before they are implemented. The public should be provided notice, access to documents, an ability to be heard and an ability to appeal proposals for cuts.
- Proposed changes to the Public Hospitals Act should be preceded by broad public consultation including all stakeholders and communities in all regions of the province.

10. Phase out the LHINs within three years.

At best the public considers LHINs to be expensive political buffer that lacks credibility. At worse, they are seen as corrupt or callous. This committee could find no evidence that the LHINs have improved access to care or coordination of care. The size and mandate of the LHINs are deeply flawed and LHINs have proven by their actions to be damaging to the small and rural.

11. Realign governance roles and responsibilities and restore political accountability for significant policy changes.

- Replace LHINs with elected local planning bodies and regional ministry offices with regions smaller than the current LHINs. The mandate of these new planning bodies should be focused on improving access to care, improving service coordination, improving communications and facilitating linkages between health service providers, and building a continuum of care. Their mandate must include adherence to the principles of the Canada Health Act and clear provincial standards for access to and quality of care and transparency. They should measure and make recommendations to meet population need – including assessing population need for hospital beds and services - and have a strong mandate to support non-profit providers. They should share information on innovations and best practices with each other, the Ministry and the public. These democratic organizations should

make recommendations pertaining to their mandate to regional Ministry offices. They should be transparent with full public access to information.

- Clearly separate provincial responsibilities and requirements from local planning body responsibilities and requirements. A publicly-accessible vision of health reform must be a responsibility and requirement of the provincial government. The responsibility for appropriate funding levels and final approval of service cuts should be held by the same level of governance. Since hospital funding flows from the provincial budget, it should remain the accountable responsibility of the provincial government. Improved provincial standards for access to care and planning processes should be developed. Similarly, nurse, physician and health professional supply issues are not locally-controlled and are necessarily a responsibility of the provincial government. Final approvals for cuts to or withdrawal of services must be made by the provincial government.
- The current definition of “integration” in the LHIN legislation that includes centralization of services and forced amalgamations and dissolution of local non-profit health care providers must be abandoned. “Integration” should refer to improved service coordination, requirements to share information among providers and improve communication, improved continuity of care and the creation of a comprehensive continuum of care.
- Decisions to close down local hospitals (including amalgamated and allied hospitals) should require cabinet approval.
- Wholesale hospital restructuring – including multiple transfers of services, changes in the scope of services provided across regions and the province, and multiple closures of hospitals - should require provincial legislation with a clear mandate and clear powers and debate in the legislature, public hearings, a timeline, a process, financial accountability, and funding and support for restructuring costs.

12. Restore democratically-elected hospital boards.

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

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

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

14. Re-assess and reform hospital performance measures to restore the primacy of access to care and quality of care.

Measures that help to protect access to services and quality of care need to be created. These should be considered at least as important as efficiencies and funding targets. Patient and staff complaints should be measured and monitored.

In hospital reports, peer reviews and LHIN reports, many 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” (how fast a hospital gets patients in and out) can work against access and quality. The requirement for hospitals to continually bump up their standings (for example, lower average length of stay or numbers of beds) can mean a continually declining standard of care and a shortage of beds across all hospitals. This is neither efficient, nor a good measure of performance. Cutting budgets for “poor performers” hurts patients and cannot replace enforcement of clear provincial standards for quality care and sound management practices.

15. Consider and consult on the creation of an independent patient advocate or oversight of hospitals by the ombudsman.

Many witnesses called for an independent body with the power to investigate patient and community complaints about hospitals. Several noted that the ombudsman should be free from political interference. Consideration should be given to the creation of an independent body or extension of the ombudsman’s mandate with appropriate powers and resources to investigate and ensure responsiveness to patient and community complaints.

16. Align the infrastructure planning and hospital service planning oversight functions of the Ministry of Health.

Costing for renovations entailed in restructuring must be done prior to movement of services. Significantly improved stability in services is required for efficient use of infrastructure and a stop to erratic and wasteful decisions.

17. 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. Ban the practice of imposing gag orders on hospital staff and work to create a culture of tolerance and respect for staff input and opinions. Such debate may be uncomfortable at times, but it is necessary for sound decision-making and public accountability.

III. FUNDING:

Control administrative costs and focus funding and resources on providing care.

18. Impose a hiring freeze on the use of consultants by the LHINs and curtail the use of consultants by the Ministry of Health.

Create a plan, started prior to the next election to plan for and restore the capacity of the professional civil service to conduct planning and evaluation functions in an accountable way.

19. Place a moratorium on hiring PR firms and curb the use of communications programs in the LHINs.

Health care dollars should not be used for political purposes. Communications programs should be limited to functions necessary to inform communities about services and gather public input for planning and evaluation purposes only.

20. Create policy that sets out clear expectations for transparency and public release of information.

Hospital financial data and planning documents should not be withheld from the public who have built, paid for, and need our local hospitals.

21. Contracts involving public funds should not be veiled in secrecy and must be exempted from “commercial confidentiality” provisions.

If the public cannot scrutinize the use of public money based on a notion of “commercial confidentiality” then private companies should not be involved in the sector.

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

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

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

Ontario funds our hospitals significantly less than other provinces. Rural communities, in particular, have experienced continual service cuts and instability as a result. According to Ontario Hospital Association figures, the Ontario government funds hospitals \$194 less per person than the average hospital funding levels of other provinces. When tallied for the 13 million Ontarians, the aggregate total shortfall is \$2.5 billion.² Ontario’s patients are suffering from the decision to continue inadequate funding to their local hospitals’ global budgets.

² Ontario Hospital Association slide, “The Efficiency Dividend”, November 20, 2009.

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 health 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 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 be 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 prioritized 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'état 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-blanc 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 Ontario³, 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 misrepresented 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.
- 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

³ 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.

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 prioritizing 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-Orangetown 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.

Summaries of Local Hearings

Southwestern Ontario Hearing

Wallaceburg, March 4, 2010

Access to Care/Quality of Care

Overall

Witnesses described the health system as not being focused on patients, only on endless change and budget cuts. Policy towards small and rural hospitals is seen as inequitable. There is a deep resentment that rural residents are treated as “second class”. While there is consensus that local hospitals are not expected to provide tertiary care, the removal of what witnesses described as “basic” hospital services such as beds, diagnostics and emergency departments is seen as wrong and a risk to the lives and health of residents.

Witnesses conveyed a vital role for rural emergency departments:

- Rural emergency departments specialize in assessing patients, stabilizing critical patients, and taking them to where they can receive optimal treatment to reverse the effects of their illness.
- Emergency departments are seen as an essential service. Their services are not replaced by urgent care centres.
- According to the most recent figures available, usage for the emergency department in Petrolia is 15,000 and in Wallaceburg is more than 21,000 annually. There is no capacity in Chatham and Sarnia to take these patients.

It was widely described as unfair that those who live in larger centres are the only ones with the right to access timely emergency care. Many witnesses noted that rural residents pay the same taxes and should have the same rights to access basic hospital care.

There is a consensus that shortages of hospital beds is the problem causing emergency department overcrowding, offload delays and other problems.

There is total consensus that local hospitals are not expected to provide tertiary care. The public wants protections for basic hospital care, including emergency departments with the ability to stabilize and transfer patients, inpatient beds, chronic care close to home communities, birthing, and palliative care.

Several witnesses opposed the use of private for-profit retirement homes to take hospital patients. It is deemed inappropriate to move patients there.

Some witnesses described wait times of up to two months for an appointment with a GP. Many witnesses support the expansion of the scope of practice of other health professionals (including nurse practitioners) to help relieve pressure.

The shortage of doctors and long waits in emergency departments has contributed to several witnesses failing to seek timely care.

- One witness lost his wife to cancer. Without a family doctor, she put off going to the emergency department where she knew she would have to wait for hours to be seen. Eventually, three months later, her pain was so severe that she went to the emergency department and waited for 5 ½ hours. She was diagnosed with cancer, too late for treatment to save her.

Witnesses called for appropriate funding. Debt should not be eliminated at the expense of patients.

- If money needs to be cut, witnesses called upon the government to, “Look at the money the LHINs spend. Look at the executive salaries. Look at the cost of consultants. Front line health care should be last, not first to be cut”.

Witnesses spoke against privatization of health care.

Many witnesses called for expanded mentoring programs to bring in younger physicians and the use of technology to provide continuing education and support for physicians.

Southern Lambton County, Wallaceburg, Walpole Island, Chatham

The medical beds in the Wallaceburg Hospital (Sydenham site) were closed in the summer of 2009. The emergency department has been threatened with closure.

Witnesses repeatedly expressed fears that the greater distances and time involved in getting to the emergency department in Chatham would lead to poorer health outcomes and mortality.

- Sydenham campus in Wallaceburg has a large rural catchment area servicing south Lambton County, the First Nations Walpole Island community, and northern Kent County.
- Witnesses conveyed concern about the “golden hour” and time to get patients to an ER to improve chances of survival and to improve health outcomes.
- There is widespread community concern that the emergency department in Chatham is further away and has long waits.
- Many witnesses have personal stories of the emergency department in Wallaceburg saving their lives or the lives of their family members.
- Witnesses representing the vast agricultural communities and the chemical industry require the emergency department in Wallaceburg and Petrolia to stay open to deal with industrial accidents and injuries.

It was repeatedly noted that Chatham does not have the resources to take all the patients now seen in Wallaceburg, neither in the emergency department nor in their acute care beds.

- There have been numerous situations since the medical beds closed in 2009 when the need for beds has outweighed the number of beds available in Chatham. Now patients are required to sleep on stretchers in emergency department because there are not enough beds.
- Since the closure of medical beds in Wallaceburg there is a severe lack of beds at Chatham leading to admissions of active patients into beds in Wallaceburg (there are 5 beds left there). This unit does not hold the correct staffing mix or numbers to take on the patient loads with unsure patient outcomes.
- The Chatham emergency department has gone on by-pass 33 times since September 2009, (in 6 months) according to health professionals. The only public figures released by the hospital reported in local news stated that on average the Chatham ER has been on time consideration 3 times per month, or 36 times per year. This understates the problem considerably.
- Chatham continues to redirect ambulances to Wallaceburg. One witness, representing hospital workers, cited a recent 3 hour period in which 6 ambulances were redirected to Sydenham Hospital in Wallaceburg.
- One witness described a situation in which an elderly woman moved from Chatham to Wallaceburg to clear her hospital bed and her family were not told. Her husband told she was “gone” – and thought she was dead. He had no means of transport, even after he established that she was transferred. She passed away on January 8, 2009 alone. He was not able to get to her in time.

The recent cuts to inpatient beds in Wallaceburg have compromised care.

- Since closure of medical beds in Wallaceburg, nurses report they have had to transfer admissions to other centres. Longer waits are occurring in the Wallaceburg emergency department as a result of bed shortages.

Sydenham District Hospital in Wallaceburg is not a low volume hospital.

- The emergency department sees more than 21,000 visits annually.
- Rankings for triage levels: CTAS 1 volume is ranked 6th in Ontario; CTAS 2 ranked 2nd; CTAS 3 & 4 ranked 6th.

The emergency department in Wallaceburg was declared unsustainable – without any attempts to make it sustainable.

- In correspondence from the hospital CEO appended to several submissions, the CEO did not take any responsibility for physician recruitment to Wallaceburg.

Since amalgamation the hospital in Wallaceburg has continually lost programs and services. This follows decades of community efforts to improve services closer to home.

- Sydenham District Hospital (SDH) opened doors for patients in 1956. Centennial year saw expansion by doubling floor space. Laboratory, Radiology, Physiotherapy and Intensive Coronary Care Unit were added. In 1991 the birthing centre was

opened. In 1994 there were renovations and enlargement of emergency department, purchase of mammogram machine etc.

- Services and equipment moved out of SDH include ICU, maternity department, laboratory, physiotherapy, mammography, surgery, medicine/acute beds, pediatrics and the phone system.

The closure of emergency department services in Wallaceburg will increase costs and problems for community support agencies.

- Community Living staff must often attend hospital and physician appointments with clients. With wait times and travel distance to Chatham, costs will increase and ability to provide this vital support will be compromised.

Patients are already being required to drive from town to town for services. Services are poorly coordinated.

- In one example, a witness' father has an open wound on his foot. He is required to drive from Wallaceburg to Sarnia for treatment, then to drive to Chatham to get his foot bandaged, then home again to Wallaceburg. He doesn't understand why two sets of people have to look at his foot, nor why he can't just have it bandaged in Sarnia or Wallaceburg. (He used to have it done in Wallaceburg.) He misses work every time he has to do this (once per month).

The removal of hospital beds from Wallaceburg has disrupted continuity of care and clinical decisions have been taken away from clinicians.

- In one example a witness' mother who had lived her entire life on Walpole Island, was moved out of Wallaceburg hospital on Friday, July 24, just prior to the medical beds closing on Monday July 27. She saw her family doctor on July 27 and he determined that she required hospitalization. He called SDH and was told to drive her to Chatham. He sent her in an ambulance to Chatham. Her family doctor does not have hospital privileges in Chatham and could not provide care for her there. She was discharged again a week later and died a week after that on August 15.

Lambton County, Petrolia, Strathroy, Middlesex, Sarnia

London Hospitals are supposed to be regional tertiary care centre but they are also facing cuts and are turning away regional patients.

- Recent lay offs (35 FT RNs laid off).
- Hospital has reduced outpatient services without consideration of ramifications for patients. – egs. include units capping the number of patients to be seen per day or closing for one or two days per week.
- Patients' treatment plans arbitrarily changed by unit coordinators who do not have clinical background and only oversee their "financial piece of the pie".
- LHSC sending patients back to their home communities even when care is unavailable for them there.
- Patients were told to go to London when breast screening clinic was closed in Strathroy but St. Joseph's in London also cut staff from their breast screening clinic.

The Strathroy Middlesex Hospital has sustained serious cuts compromising access to care.

- Strathroy Middlesex Hospital serves second-fastest growing township in Ontario. (Currently 35,000 people). Four Counties Hospital serves approx. 23,000. They are in an alliance. There is no public transportation to the cities of Sarnia and London.
- The fourth floor of Strathroy hospital was closed. It provided chronic, long term, rehabilitation and palliative care. Some patients have been moved one hour away or more.
- Two nurses from the Strathroy Breast Screening Clinic were given notice. The patients were told they could go to St. Joseph's Hospital in London. But St. Joseph's is cutting also. There are now 7 nurses at St. Joseph's Breast Screening Clinic in London that are presently identified to lose their positions.
- The outpatient physiotherapy department has been cut. The government has now privatized a service that was available through the public health care system. Patients must pay or go without physiotherapy.
- The position of nurse educator was eliminated. Hands-on care has been decreased.
- The obstetrics unit was closed and obstetrics moved to the second floor (medical floor). Palliative care is also there. Patients are now dying in rooms next to new mothers. This is not therapeutic. There are no longer any designated palliative care beds.
- At one of the nursing homes in Strathroy there is a wait list of 69 people.

There are concerns in Petrolia that the hospital is not being maintained properly and that the threatened closure of the emergency department will worsen access and compromise recruitment of physicians.

- Witnesses provided a resolution from the Town of Petrolia rejecting the emergency department study as flawed and inaccurate.
- There is not enough capacity in Sarnia to take the patients now seen in Petrolia.
- Sarnia already sends its overflow of patients to Petrolia to relieve pressure.
- The community is worried about the instability caused by the threatened closure of the emergency department stunting physician recruitment efforts.
- There were complaints about the quality and timeliness of lab tests sent out of town for processing.

St. Clair Township has a shortage of family physicians, difficulty accessing care and a need for the maintenance of the two emergency departments in Petrolia and Wallaceburg.

- St. Clair Township has the second largest population in Lambton County and is the home of 15,000 residents.
- It covers 620 square kilometers and 1,100 lane kilometers of roads.
- It has one health clinic with four family doctors in Corunna in the northwest corner of the township.
- They lost x-ray and lab a number of years ago, but the Township partnered with the four family doctors to keep a blood letting facility open.
- Bluewater Health wants to close this facility, forcing residents to drive to Petrolia, Sarnia or Wallaceburg with increased waits for lab services.
- The County of Lambton has invested in 24 hour ambulance care.

- 911 dispatch to hospital delivery is normally in excess of 45 minutes. This is with the emergency departments in Wallaceburg and Petrolia open and in operation.
- The chemical and agricultural industries need the access to local emergency departments.
- Distances from Courtright (centre of the industrial complex): Chatham 71 km, Petrolia 45 km, Sarnia 30 km, Wallaceburg 37 km.
- They have an aging population.

Homecare

Homecare is not accessible and the use of homecare clinics has privatized hospital care and has downloaded an onerous travel burden on patients. Appropriate supplies are not available for patient care.

- In one example, an elderly patient was sent home from hernia surgery. The patient was told to drive to “homecare” clinic 30 km away for dressing change and pick up disinfectant on the way because none is available at the clinic.
- Another elderly patient had a fall and was wounded. A physician cleaned and dressed the wound and arranged homecare. He told patient to refuse to go to the clinic. The CCAC tried to force the patient to go to the clinic to get homecare. The patient refused. Homecare was provided.

Democracy: Governance Structures/Accountability/Consultation

Overall

Witnesses described hospitals run like businesses with disappearing compassion, without concern for clinical needs, with overpaid executives. Many called upon the government to consult properly with communities and evaluate the impacts of health cuts.

Hospital boards and CEOs were criticized as undemocratic and at odds with community values. Hospital CEOs are considered to be overpaid.

Witnesses are angry and alienated from those responsible for hospital oversight at every level and called for the restoration of democratically-elected local boards and local control.

The important contributions of municipal governments is not recognized and respected by the hospitals, LHINs and provincial government. Similarly, small and rural hospital benefit tremendously from local donations of money, equipment, and services. These have been disrespected by all levels of governance.

Provincial government

The provincial government is seen as unresponsive. Their hospital policy does not reflect the values and priorities of communities and discriminates against rural populations.

- Witnesses were opposed to government policy of continually reducing access to local hospital services. Some noted that “change” is not only defined as closing services.
- Community members have never been given an opportunity to provide ideas, input or feedback. Many witnesses called for the government to consult or to talk to local people.
- The government was criticized for conducting its Rural and Northern Panel behind closed doors. Local groups have been denied input and representation.
- Many witnesses are disconcerted that the government had put “a price on people’s lives”, treated people “as a number in someone’s books”, and put “budgets before human life”.
- Many witnesses conveyed the idea that health policy is discriminating against rural populations.

Many witnesses called for oversight by the provincial ombudsman.

- Some noted that the ombudsman should have real independence, or should be appointed in a non-partisan way, and should not be a political appointee.

Witnesses conveyed their dismay at disappearing compassion in the health care system, more bureaucracy, and centralization that treats people as less than human.

- There was total consensus that big is not better.
- Many witnesses noted disappearing compassion, veterans decried human beings treated as a number.
- Centralization was seen as creating more bureaucracy and taking money away from care.

The First Nation community on Walpole Island has made contributions to the hospital, spiritually, mentally, physically and financially. The government has not complied with their duty to consult with the First Nation.

Chatham-Kent Health Alliance

The Chatham-Kent Health Alliance (CKHA) is deeply distrusted and has not answered community questions and concerns. Their actions are seen to be in conflict with the Canada Health Act and community values. Since the Alliance was created, it is believed that the Alliance agreement has been violated and that disproportionate cuts have been suffered by the communities served by Sydenham District Hospital in Wallaceburg. In addition, the Alliance has wasted community fundraising efforts and donations.

- Witnesses held that the actions of the Alliance are not consistent with the Canada Health Act.
- Witnesses believe that there is a growing disconnect between the CKHA and the people of Chatham-Kent and Southern Lambton. They described the CKHA as continually ignoring the people of Wallaceburg, Southern Lambton and Walpole Island.
- Witnesses stated that, with regards to Wallaceburg, the Alliance has:
 - Failed to recruit and retain medical staff

- Reduced services and as a result lowered patient volumes
- Ignored the physical and maintenance needs of the hospital
- Withheld reports citizens should be entitled to review
- Failed to answer community questions
- Conducted sham consultation processes
- Retained consultants to prepare reports that lack credibility
- Ignored requests for real consultation
- Attempted to discredit those who oppose or raise questions
- Witnesses believe that after decades of community work to build it, the hospital has been left unsupported by the CKHA to render it unviable so it can be closed. Many noted that the CKHA has continually removed services and left the building without maintenance. Another noted that when the CKHA was formed, many parts of the Wallaceburg hospital had been rebuilt: the emergency department was four years old, the birthing centre was seven years old and the Centennial wing was thirty-one years old. After the alliance was formed, services were moved out and the hospital was left without significant upgrades and support.
- Despite more than 11,000 signatures on petitions, support of municipal officials and the local physicians, the CKHA has tried to close the emergency department.

It was reported that the true costs of restructuring have not been accounted for by the CKHA. It is unclear whether there would be any savings as a result of the emergency department closure:

- One witness testified that on a per-patient basis, Sydenham District Hospital's emergency department is less expensive than Chatham's. This witness submitted comparative numbers of patients and total staff costs from hospital records.
- It was reported that ambulance costs for the municipality are projected to increase by \$2.7 million if the Sydenham District Hospital emergency department is closed. One mayor testified that the county would require another two ambulances and an ambulance station.
- Costs for renovating both the Chatham site and the Wallaceburg site have not been assessed and considered.

Services and equipment donated from the community have been arbitrarily dismissed by the Chatham Kent Hospital Alliance.

- The CKHA asked the auxiliary to fund and develop a palliative care unit on the 2nd floor located in continuing care. This was opened in 2005. The CKHA cut the unit in 2008 after only three years. A former auxiliary member estimated that \$100,000 in local donations was wasted by this decision.

Strathroy-Middlesex General Hospital

Strathroy Middlesex General Hospital was described as completely undemocratic. The hospital has gone to excessive lengths to force patient user fees for parking.

- Witnesses described the hospital board as appointed by the CEO.
- Board meetings are completely closed to the public and the media.
- So-called public meetings are invitation only and without public notice.

- One witness reported that the hospital paid \$90,000 to buy a piece of land across the street from the hospital. The hospital erected a wall there to stop people from parking for free across the street so they would be forced to use the pay parking at the hospital.

LHINs

A litany of problems with the LHINs were raised by witnesses, including:

- The public cannot see value in the LHINs. They are considered a waste of money.
- LHINs are seen as extra bureaucracy and a political buffer for the government.
- The LHINs misuse expensive consultants. Consultant reports lacked credibility and were described as biased and containing inaccurate data. The use of PR firms was also condemned.
- Care is worsening, not improving.
- The lack of health care qualifications of LHIN CEO and other key personnel were questioned, along with salaries in excess of ten times the local average wage.

If there was a theme in the recommendations, it is overwhelmingly that the LHINs are not respected and are seen as a waste of money. Virtually all submissions state that if money needs to be cut, look at the money the LHINs spend; look at the executive salaries; look at the cost of consultants. There is total consensus that front line health care should be last, not first to be cut.

A serious complaint was raised by witness Adrien McCabe. Her husband Allister was admitted to Petrolia hospital Sept. 23, 2008. The doctors suspected lymphoma. They could not get tests fast enough locally so sent him to London for needle-guided biopsy. On October 8, 2008 a doctor in a London hospital informed them that because Allister wasn't from local LHIN for the London hospital he couldn't go there. They were sent back to their home LHIN and they were back to square one. After the delay in diagnosis, her husband passed away November 9, 2008. One doctor informed family if he had his biopsy earlier he might have already been receiving chemotherapy and may have lived. On April 10 2009, Mrs. McCabe received a letter from London hospital confirming refusal of treatment because they live in a different LHIN and the care they needed could be provided in their LHIN. This issue was never addressed adequately by the LHINs involved. This was one of two examples of London hospitals refusing needed treatment for patients, and attempting to move patients over to the Erie-St.Clair LHIN hospitals without adequate care. These follow newspaper stories in 2009 that raised the same complaint.

Human Resources

Witnesses raised concerns about job losses.

There were many suggestions regarding improving recruitment and retention of physicians and health professionals, including expanding mentoring programs across the region and more support from the hospital alliance in Chatham-Kent.

It is believed that stable, well-equipped and properly managed hospitals can attract physicians, but the instability and constant threats to services hampers efforts by municipalities and physician recruitment committees.

There is broad support for using health professionals, including nurse practitioners, to their full scope and enabling them to practice to help alleviate health system pressures.

There is broad support for enhanced respect for clinical recommendations and staff consultation in planning and evaluation of services.

Economic Development and Community Impacts

In the words of one witness:

“Hospitals play a unique role in the social and economic fabric of small communities. They provide a core of well paid professionals jobs in the community and these jobs in turn support many other jobs in the service industry. They are an attraction to potential investors who are concerned that their work force receives prompt and efficient medical care. They are attractive to retirees...”

The vitality of the local hospitals, and in particular the maintenance of their emergency departments is seen as an integral part of community economic development. In Wallaceburg, many witnesses, including the chair of the economic task force, testified that the presence of the hospital with an emergency department was vital in the recruitment of two recent industries. In that community fifteen factories have closed. Very recently the community attracted two new factories and employment prospects for more than 600 people. Similarly, representatives from municipalities and the agricultural communities testified that the hospitals and emergency departments are required by farmers and the large regional chemical industry in case of accident and injury. It was noted that the livelihoods of farmers depend on continued involvement in farm operations, with many working well past regular retirement age.

Many witnesses noted that retirees from urban centres have moved into the area in part because of the proximity to hospital care.

The local hospital is seen as the priority public service for many residents. There is a pride and commitment to the hospital. Staff are considered like family by many witnesses. The compassion and respect for patients exhibited in smaller local hospitals was noted as important to many witnesses.

Shelburne Hearing including Kitchener and Markdale

Shelburne, March 5, 2010

Access to Care/Quality of Care

Witnesses in the area of northern Dufferin County reported some of the worst access to health care of all the hearings. It is clear from the presentations that expectations are not overly high. No one expects all services to be provided locally. But there is total consensus that basic medical services, staffed by physicians and nurse practitioners are essential and are not in existence in this area. In particular, access to primary care, urgent care, complex continuing care, palliative care and long term care are seriously compromised.

Regarding the larger tertiary care hospitals in Kitchener, witnesses testified to cuts that are damaging access to vital care.

One witness reported to rumours of cuts to or closure of the Markdale hospital.

Shelburne

The area referred to as North Dufferin is located north of #10 side road and includes roughly 26,000 people. There are severe access to care problems in this area. Witnesses described extreme shortages. Shortages include not only Shelburne, but the whole region. Basic medical services are simply not accessible. In recent months, the hospital and LHIN have approved a plan to cut all the hospital beds (26 complex continuing care beds) and the hospital in Shelburne is slated to be closed.

- Many do not have a family doctor. There are no prospects for accessing family doctors in the near future.
- There is a complete absence of public transit.
- Weather and road conditions are extremely poor between the end of October and mid-April.
- Because of lack of access to physicians and the long waits in the emergency department in Orangeville, patients wait until their conditions deteriorate and more aggressive intervention is required.
- The ranking in per capita spending is the worst of the entire province in this LHIN (Central West) for acquired brain injury, community support services, hospitals, mental health and additions. The ranking is second worst for community health centres and long term care homes. The ranking for CCAC funding is 11th of the 14 LHINs in Ontario.
- Rankings for numbers of health professionals are similarly dismal.
 - Family physicians ranked 13th of 14 LHINs.
 - Specialists: 14th of 14.
 - Nurses: 14th of 14.
 - Occupational therapists: 10th of 14.
 - Pharmacists: 9th of 14.
 - Physiotherapists: 8th of 14.

- Dieticians: 8th of 14.
- Midwives: 2nd of 14.
- Services have been cut including outpatient physiotherapy, a heart clinic and a physician clinic.
- There are wait lists for local long term care homes. One witness' mother had to wait two years to get into Dufferin Oaks. (Note: Our research shows 2 ltc homes in Shelburne, 1 in Orangeville and no others in Dufferin County.)
- There were complaints about long waits at the private laboratory. (Access to the lab at the hospital has been closed.)

The Shelburne hospital is seen as more compassionate than larger hospitals and many supported the dedicated site for complex continuing care. Concerns were raised, not only about the loss of the complex continuing care beds, but also the uncertain future diabetes program and the x-ray at that hospital. Witnesses described the loss of the beds as tragic for the families of dying patients. It is felt that the ability for families and friends to visit more frequently is humane and improves patients' health.

The closure of the hospital is seen as "a giant leap backwards". The local communities have seen a continual erosion of services and care. They urgently require support to rebuild access to services and improve their entire local health care system, including hospital care. There was broad support for recruiting and supporting health professionals, including nurse practitioners, to aid in improving access to care.

There are also concerns about where patients will be sent when the beds are closed. There are wait lists at local nursing homes and homecare is inadequate.

- Attempts to move patients out of hospital too quickly were described. In one example, a witness' mother-in-law was transferred to a long term care facility. Between November 30 when she was admitted and December 11 when she died, she spent only 2 or 3 days at the long term care home. The rest of the time she was in the emergency department at Headwaters Health (in Oakville). She was too sick to be in a long term care home. The family believes her condition would have been better if she was care for with stability and closer to home at the Shelburne site.

Orangeville

Headwaters Healthcare Centre in Orangeville was described as understaffed, unorganized, overcrowded and inaccessible.

- Many witnesses described long waits in the emergency department.
- Several complained about unaffordable parking fees. It is recommended that low income patients be given a break on parking costs.
- Witnesses complained of overcrowding and hospital-acquired infection.
 - In one example, a witness' mother-in-law was given an IV in the hallway across from a soiled linen closet. The nurse had to balance IV materials, tubing etc. on her knee as she was trying to run the IV without a table or a tray.
- Orangeville hospital has closed their outpatient physiotherapy.

Kitchener

Witnesses described hospital priorities that do not favour patient care. Hospital cuts and bed shortages are causing problems with access to care.

- In one example, Grand River Hospital has hired 17 new managers but has cut the ability for nurses to give diabetic patients waiting in hospital cookies. 34 nurses have been laid off (termed “displaced”).
- The I.V. team at Grand River has been disbanded. Nurses queried who is going to start IVs on chemo babies or trauma patients?
- Grand River Hospital is closing long term care beds.
- Freeport hospital is closing of psychiatric beds and medical/surgical beds.
- There are emergency department back ups, and in ICU beds are taken by chronic patients and palliative care, while acutely ill patients stay in the emergency department.
- Grand River has the reputation of being the regional hub of cancer care. One week before the hearing, oncology patients could not receive chemo because there were medical patients admitted to the oncology beds. There was no room for cancer patients.

It was recommended that the hospital re-open medical beds so oncology patients can have their treatments.

Markdale

One nurse reported fears that the hospital could be closed.

- There is an unconfirmed rumour that there is a plan to close down all the medical beds and the emergency department. The hospital is planning to move a community health clinic in and close an unclear number of in patient beds. The hospital has conducted a \$3 million study looking at how to renovate the building.
- Markdale had 52 beds in the early 1990s. It now has 14.
- The hospital is operating at over 100% capacity and Owen Sound hospital has an outbreak of VRE (a hospital-acquired infection) and is sending patients to other sites including Markdale.
- The staff have not been consulted nor asked for ideas.

Democracy:

Governance Structures, Accountability, Consultation

Issues of fairness, democracy, accountability, poor communication, secrecy and skewed priorities were raised by many witnesses. It is believed that Headwaters Health has achieved a balanced budget at the expense of the northern part of the county; an area that is already desperately underserved. Access to care is getting worse, not better. The Ministry of Health is portrayed as inaccessible and unsupportive. Many question the priorities of all levels of governance with oversight responsibility for hospitals. The local hospital was reported to be secretive, to have misrepresented the extent of the cuts, to have

extremely poor communication, and to have failed to consult and work with community leaders.

Local Hospital Board

- Northern Dufferin has suffered disproportionate cuts to hospital services. The current proposal to close all beds and the Shelburne hospital site will cut more deeply than required to address the deficit of the hospital.
- It is believed that amalgamation has not served Shelburne well.
- Communications are inconsistent and lack credibility. The initial reason given for closure of Shelburne was to balance the hospital budget. After groundswell of opposition, the hospital said it was patient care.
- The hospital refuses to reveal the costs of operating the beds in Shelburne compared to operating the beds in Orangeville.
- There was no cost estimate for renovation required to the Orangeville site to accommodate the transfer of the complex continuing care beds from Shelburne. Witnesses noted that this information was needed for an informed decision from the hospital board.
- Other questions have not been answered such as why administrative staff continue to be hired when services are being cut and what other budget measures were taken before cutting all the services in Shelburne.
- The hospital board considered three options before deciding to close the Shelburne hospital. The hospital has refused to disclose the other two options that did not involve closure of Shelburne's hospital.
- While the hospital is cutting services, in 2008 the sunshine list revealed \$1 million in executive salaries for those making more than \$100,000 per year.
- The hospital leadership and board are widely described as unaccountable.
- Witnesses did not know how people get on the hospital board. One witness, who is an elected municipal leader, paid \$15 for a membership but has never received any notice of meetings nor other membership correspondence. There is no mechanism to hold the board accountable for anything.
- It was believed that the only public consultation was meaningless and public needs are being ignored. 3,000 people have signed petitions, hundreds flooded a public meeting and there is still no plan to improve care in any way, no improvement in communication, no further consultation. The meeting was described as "an exercise in futility", "window dressing". Nothing has come of all community efforts.
- The chair of the task force on the future of the hospital building in Shelburne reported that they have been waiting of more than six weeks for a call from the chair of the hospital board to have an informal discussion about the future use of the site.

It was the personal experience of one of the panelists that hospital leadership, while recognizing the severe shortage of family medicine in the northern Dufferin region, downplayed and misportrayed the extent of the hospital service cuts.

- This 26-bed complex continuing care ward was continually referred to by hospital leadership as a long term care (which requires a lesser care level).

- The hospital claims there is not a reduction in services, but there is a net reduction in beds from 100 across both sites to 87 to be located in Orangeville, not to mention the total removal of hospital services from Shelburne.
- The hospital projected a number for required cuts at a 0% budget increase for the financial year of 2010/11. However, the provincial budget increased hospital funding by 1.5%, not 0%. The hospital CEO would not disclose what projected budget cuts, if any, were needed if hospital funding was increased by 1% or 2%.
- It appears that the cuts to Shelburne's hospital site exceed the projected deficit for the hospital.

Provincial Government

- The funding formula for the LHINs by the provincial government is not understood by witnesses, though it was known that this area has the lowest funding of any LHIN.
- The mayor of Shelburne was given 1 ½ minutes to ask a question of the Minister of Health, when his community is losing its hospital.
- One mayor reported that the Minister of Health's answer to a question about help for municipalities to attract physicians was that if municipalities have the money they should offer it as an incentive. There was no further support from the province.

Hospital planning and policy at every level are inconsistent with deeply-held public values of equity, fairness, public and non-profit service, and the primacy of patient care and human life.

- Inequity in health planning is a major source of public anger. Referring to the lower funding levels for this LHIN compared to the rest of the province, one witness asked, "Is my health worth 1/5 of someone else's?". Others asked, "Why should my hospital be closed when others are not treated the same way?"
- Several witnesses conveyed their concern that Ontario is moving towards a medicine for profit rather than honouring health care as a basic human right.
- According to one deputy mayor: "Small hospitals should not be discarded without long term planning and consultation with all stakeholders."
- Parking is unaffordable to patients, but is a source of income for the hospital.
- Privatization of labs is seen as both a violation of the public interest ethic of the health system and a reduction in care.
- Bigger is not seen as better. One witness noted: "I am afraid we are refashioning our hospitals after the lucrative sales model of "just in time" delivery and big box stores. The consequence is big box hospitals. Along with the economic advantages, must consider the pathogenic disadvantages."
- A common ethic was described by one witness: "We cannot let money dictate our health policies." It is the recommendation of one mayor to "realize that dollars and bottom lines cannot and should not be the sole factors in removing or providing services to small communities and their surrounding areas." Another witness said, "We used to be treated as respected members of society and not just a number to help balance the budget."

- Many complained about the excessive salaries of senior staff, the protection and even expansion of administrative staff while front-line services are being cut. Examples were given involving both Headwaters Health and Grand River Hospital.

Many complain that they are paying as much in taxes as those in other areas but have unequal access to health care.

- According to one witness, the key issues are fairness and accountability.
- Witnesses complained that they are paying the new health tax to improve health care but access to health care is declining.
- Others noted that the cuts are unfair: “In urban areas there are hospitals within blocks of each other.”

Many believe that hospital boards need improved accountability.

- They should not be different than any Board or Commission or Council and should be subject to oversight.
- They should be subject to the authority of the ombudsman.

The local municipalities have invested in and provide support for improved access to care in their regions:

- The Town of Mono and the County of Dufferin support both the Centre Dufferin and Headwaters doctor search committees.
- Municipalities are involved in a task force to determine usage of the hospital site.
- Many municipal leaders have ideas for and passion to improve access to care. Their input, commitment, ideas and talents are being ignored by the local hospital and the provincial government.

LHINs

Witnesses described the LHIN as unaccountable. Service coordination has not improved. Access to care has not improved. Many question the costs of the LHIN and do not see value in it.

- There was total consensus that the LHINs should be accountable to the people.
- One deputy mayor sent a letter with questions to the LHIN on February 4. By March 5 he still had not received an answer.
- Many municipal leaders cited extremely poor communication and consultation processes.
- One witness reported that the LHIN has not improved coordination of diabetes care. She noted, “there is no coordination.”
- LHIN staff costs were seen as excessive.
- Access to care has worsened, not improved.

Human Resources

Several witnesses focused on nursing cuts in general:

- Nursing cuts lead to poorer health outcomes including increased hospital stays, increased pneumonia, increased urinary track infection, increased death and mortality, increased failure to resuscitate, increased decubitous ulcer, increased work load.
- Ontario has 71.8 nurses per 10,000 while the rest of Canada has 82.9.
- An aging workforce means worsening shortages.

It is recommended that in order to retain RNs, increase full time to 70% (currently it is 65.4%), retain experienced RNs to mentor new graduates, improve work environments and address the shortages.

Many witnesses support recruitment and retention strategies for physicians and health care professionals. The local municipalities are very involved in promoting physician recruitment. There is broad support to increase nurse practitioners.

Given the crisis in access to services in this region requires more support from every level. One witness recommended a strategy involving the province, LHIN, Headwaters Hospital, and the local community to deal with the recruitment and retention of doctors and nurse practitioners. This panel agrees that an emergency task force should be set up to address the critical shortages in northern Dufferin.

Economic Development and Community Impacts

A number of witnesses noted that basic medical services are critical to the economics of business retention and attraction and accommodation of growth. The closure of Setex Plant last year meant 250 highest wage earners out of work. The closure of the Shelburne Hospital means more people unemployed.

Kincardine Hearing

Kincardine, March 6, 2010

Access to Care/Quality of Care

Kincardine

Witnesses are concerned that services are being routinely cut and eroded in Kincardine which is one of the fastest growing areas in Bruce County. Most winters, getting to Kincardine hospital from surrounding areas is very challenging or impossible. Highway 21 closures are frequent and an additional ½ hour drive to Walkerton during stormy weather is not an option.

- In this hearing many witnesses raised the weather conditions that result from living on the coast of Lake Huron. Lots of snow, high winds and drifting are major problems. Roads are inaccessible in the winter. Even getting through to Kincardine from local residences is very difficult.
- Access to the hospital is seen as a matter of survival by witnesses. Many are concerned that more and more services would continue to be lost.

Local residents realize that local hospitals cannot do everything. They rely on London for more specialized care and are concerned to hear of cuts in London.

The proximity to Bruce Nuclear plant was raised repeatedly.

- The containment/casualty unit at the Kincardine hospital is crucial because of the proximity of Bruce Nuclear Power Development, the largest nuclear power station complex in North America. This is a unique facility that is an essential service offered by the Kincardine Hospital.
- This requires a fully functional emergency department at Kincardine.

There is concern about the need to restore capacity. There is no longer anyone in the physician group at Kincardine who can do surgery and no longer a trained anesthesiologist.

There have been cuts to physiotherapy and other services recently. Most recently, health records staff are being laid off and concerns were raised that there are not enough staff left to do the work. At the time of the hearing there was much uncertainty. Staff were told that patient records being moved to Walkerton. There were concerns about declining quality of care. Dietary and housekeeping staff are also facing cuts. Staff have been told to “re-therm” meals then go and finish their shift with housekeeping duties.

- Services lost at the Kincardine site include: obstetrics; supplies and equipment; weekend ultrasound; labs; methacholine challenge testing (now patients have to travel to Durham for this); no director of patient care for one year; increased ER usage with no increase in staffing; loss of physiotherapy.

- In February 2010, additional losses of services were announced by press release: 3 health records FTE positions are being eliminated and the services are being centralized into Walkerton; 14.1 food and dietary FTEs are being cut and “retherm meals” introduced; loss of hospital beds – no numbers provided.

There is poor access to physiotherapy services. Outpatient physiotherapy has been cut and there is no OHIP-funded physiotherapy clinic in the region. Homecare physiotherapy is inadequate.

- Caregivers are expected to do maintenance programs on their own even when more expertise and access to equipment is needed.
- One witness gave an example of her brother, a person with a disability who need maintenance program to keep him mobile while he ages. In the long run, the witness noted, it will cost a lot more for his care if he needs a wheelchair and more staff, not to mention his quality of life and health care needs.

Witnesses oppose the privatization of services.

Bruce Peninsula

The walk-in centre in Tobermory has been closed so residents and cottagers and tourists now have to travel to Lion’s Head for care.

Home Care

One witness noted that home care is touted as alternative to hospitals but one hour a day for needy patients is not enough.

Personal Support Workers are being restricted to 45 minute visits. Giving a patient a bath and attending to other needs plus paperwork is difficult in that time.

Since there is no continuity of staff, the family member has to show staff where things are and explain needs, which takes up time.

Some family caregivers have a huge burden and put their own care at risk while waiting for their elderly family member to get into a nursing home.

Homecare needs more staff and more respite spaces. There is a shortage of community nurses.

There are poor conditions for nurses: they must have their own vehicle; there is no or inadequate pay for driving time; no remuneration for time to do paperwork.

There are waits for months to get into nursing homes.

Witnesses are hearing that clinics, instead of homecare, are going to be introduced in this area for community nursing and patients will have to drive to see a nurse for dressings, IVs,

catheter changes etc. It is difficult for patients to do this. Many are elderly and have difficulty driving long distances. It is not a viable option for some patients.

Sometimes proper equipment is not supplied.

The scheduling for PSWs in Huron Kinloss is out of London. Sometimes only a few minutes are allowed for traveling time when visits are in fact ½ hour to 45 minutes away. This shortchanges patients and caregivers. It seems a city model is being applied in rural areas.

Democracy: Governance Structures, Accountability, Consultation

There is a consensus of opinion that governance, public consultation and accountability are poor. The provincial government is described as unresponsive, technocratic, undemocratic and lacking in knowledge about the needs and workings of smaller communities. The hospital board is considered to be bullying, secretive, administratively-heavy, and unaccountable.

One witness representing her municipality described her frustration trying to be an advocate for rural residents in her township. She said, “It seems like a circle from the LHIN to the hospital board to the province and back to the LHIN. Often each one tells you someone else sets the policy or has the answers to your concerns.”

Provincial Government

There was total consensus that change is needed.

Witnesses testified that the provincial government is not upholding the Canada Health Act. “Technocrats” are running health restructuring. “They have no idea, nor do they care, about the symbiotic relationships these hospitals have with their communities.”

Others noted that provincial government policy is confusing with conflicting priorities.

One witness called for the province to reinstate the Ontario Hospital Services Commission – but separate it from the large teaching hospitals; or to mandate the small and rural hospitals back to the municipalities under municipal management boards.

Many noted that no matter where you live you still have to pay the health care tax. But rural dwellers also have to pay a heavy cost due to the limitations in treatment modalities and non-proximity of expertise.

It is believed that the government fails to recognize that small hospitals are bargains for operating costs.

A letter to the Friends of the Kincardine Hospital from the Ministry of Health was given by a government representative to the mayors and the media before it was given to the FOKH.

Hospital Board

Witnesses described a decline in hospital board accountability and governance practices. It used to be that local boards were well known and respected citizens. A bank manager was usually the treasurer. The Director of Nursing did double-duty as day-to-day administrator. There was no difficulty in general public's access to these individuals to express their views.

Many called for money to go to patient care, not administration. One witness decried the "Large ego-boosting administrative structures so much in vogue. So costly!"

Hospital secrecy was a major issue at this hearing. Many resent the hospital informing the community that they are a "private corporation" and don't have to answer to the public. It is felt that hospitals are sheltered by provisions in the Corporations Act from true and full transparency which is demanded and expected from all organizations funded by tax dollars.

- The local community was told by hospital executives that hospitals are "private corporations" in answer to community questions and demands for accountability. Yet they spend public money and want local people and businesses to fundraise for them. Hospital boards should have more procedures to follow for accountability and transparency just like municipal government do.
- The Friends of the Kincardine Hospital have been trying to get financial information, including a site by site breakdown of operating costs since January 2009. They have been refused. The municipalities of Kincardine and Huron Kinloss have supported these attempts.

Many witnesses described the hospital board as "bullying", "unresponsive", "autocratic", "untouchable" or "a dictatorship". They answer to themselves not the public.

- Some complained of poor decisions of hospital board regarding treatment of workers. Staff were notified of removal of services and job loss through press releases.
- Lack of respect for hospital staff has worsened. Witnesses reported that there has been a directive to staff to not speak up publicly or they will be dismissed. Doctors called the hospital "a dictatorship".

Municipal representation from Kincardine on the hospital board has been refused though other hospitals have municipal representatives. Witnesses reported that hospital leadership stated that this is because of a recommendation from the Ministry of Health and the Ontario Hospital Association.

It is believed that amalgamation has not served Kincardine well. It is the fastest-growing community but continually has service cuts. At the time of amalgamation, the head office of SBGHC was in Kincardine. Now it has been moved to Walkerton. There are few savings

in amalgamations. There are disproportionate increases to upper management. The public is paying new costs through privatized services.

Many witnesses proposed ideas to improve public access to information:

- The public has no way of measuring hospital board performance against other hospitals.
- Amend Freedom of Information legislation to compel hospitals to comply with requests for release of information.
- Amend Public Hospitals Act to include provisions for public consultations whenever a hospital's level of service will be changed.

Huron Perth Hospital Alliance

Community members believe that HPHA (Huron Perth Hospital Alliance) is overstating difficulty getting emergency doctor coverage in a bid to close the emergency department in St. Marys.

The hospital is offloading services to ambulance and long term care but has no control over those budgets.

In St. Marys 900 patients on average per year seen at ER between 11 pm and 8 am.

LHINs

Witnesses describe the LHIN model as flawed and simply hides and deflects accountability.

While the McGuinty government inherited problems, it has made them worse by adopting the LHIN model.

Economic Development and Community Impacts

Local hospitals are seen as a top priority by the municipalities and residents.

Hospitals have symbiotic relationship with their communities. They have stabilized communities and enabled growth.

The local hospital is key to industry, financial and human investment in the community.

The poor in rural areas have less services and a more onerous transportation burden.

Welland – including Niagara Peninsula, Grimsby, Hagersville and Burlington Welland, March 9, 2010

Access to Care/Quality of Care

Niagara

This panel wishes to make a special note that we are deeply saddened by the testimony of the friends and family of Reilly Anzovino who died in December 2009 en route to the emergency department in Welland from Fort Erie (where the emergency department had been closed). We also want to recognize the other witnesses who brought testimony about the deaths of their family members. We thank them all for their testimony and we share the Reilly-Anzovino family's hopes that the coroner's findings will help to prevent any other families from similar suffering.

Witnesses in Niagara described the poorest access to hospital beds and emergency department care of all the regions we visited. Cuts have been and are being implemented without any protections for resident access to care and without funding agreements, functional protocols and enablers in place. This panel observes that hospital care in Niagara is chaotic, perilously short-staffed and under-resourced. The hospital system has lost public confidence.

It is this panel's opinion that the provincial government should send an investigator into the Niagara Health System. There is a very high level of public anger at the hospital board. We heard complaints of disputes with the clinical staff that threaten access to care, including physician resignations in Niagara Falls, no functional protocols established with EMS and no ability to reach a funding agreement for the Urgent Care Centres in Port Colborne and Fort Erie, among other disputes. The hospital has severe financial trouble and there are many serious complaints about access to care and quality of care. Niagara's emergency department wait times exceed provincial average. Surgeries are being delayed and cancelled. In February, local surgeons complained about the postponement of serious cancer surgeries yet more beds are being closed in April. The death rate in Niagara is reported to significantly exceed the provincial average. In the case of emergency, 50,000 people are expected to use the three remaining emergency departments in hospitals that were already experiencing problems and have had serious staff cuts. Several physicians, the Ontario Nurses' Association, municipalities and MPPs have all called for an investigator.

Port Colborne's emergency department closed in July 2009 and Fort Erie's was closed in September 2009. All surgeries and acute care beds have been removed. The Niagara Health System (NHS) – the local amalgamated hospital corporation – intends to close these hospitals (including urgent care centres) by 2013. However, funding systems and functional protocols are not in place, none of the identified "enablers" have been put in place after more than a year, and there is not the capacity at the other regional hospitals, nor in other health care settings, to take all the patients.

- Frequent gridlock, long ambulance offload delays and extremely long emergency department wait times are occurring.
- No funding model Urgent Care Centres in Port Colborne and Fort Erie has been negotiated. As of April 2010, funding for working nights will be reduced by half. Doctors are saying that they cannot work for this level of pay and the UCC will be closed down in Port Colborne at least at night. (This was the NHS plan from the beginning but the LHIN consultant recommended that it be open 24/7 subject to review.)
- Planned renovations for Port Colborne's Urgent Care Centre have yet to move forward, in turn, backlogging improvements to working conditions, appropriate delivery of care and expansion of the family health team.
- Functional protocols have yet to be addressed or solidified between the NHS and the EMS (regional ambulance services).
- One paramedic described the challenges facing EMS. Offload delays have been worsened by the closing of hospitals. Response times are worse. Long delays exist in the remaining emergency departments. There is a severe lack of staff and beds in the hospitals. They are unable to move patients out of emergency. There are not Advance Care Paramedics (ACP) in all ambulances. There is a goal of 68% ACP but that has not been reached. Even with ACP, paramedics cannot do what doctors can do to stabilize a patient.

Many witnesses described long waits in the emergency departments in Welland , Niagara Falls and St. Catharines. To paraphrase one submission, there are clinical consequences of long waits in emergency departments. Patients endure in excess of 24 hours in brightly lit, noisy hallway, without proper bed and care, poor access to toileting facilities, dignity assailed. Care is sub-optimal, pain poorly managed, care plans delayed, health at risk of deterioration and likelihood of complications increased.

- One witness was transferred to the Welland Hospital emergency department because of heart problems. In Welland Hospital, the patient's medication was stopped without his knowledge (despite the patient telling the staff that his family doctor said not to do this). He waited for 22 hours without his meds, without being fed (he is diabetic) for heart specialist. If it wasn't for his wife, he wouldn't have received any food. There was no monitor for his heart. After 18 hours his heart started to race because his medication had been stopped.
- One witness testified that her mother had been taken by ambulance on Friday August 29 to Niagara Falls Hospital from her home in Ridgeway. She thought she had a stroke. The emergency department was full with on doctor on staff for 35 beds and full waiting room, according to the witness. No medication was given. They waited until next day when she was sent for a CT scan and she was found to have had a stroke. She waited in the emergency department for 4 days before she was moved to a hospital bed.
- Another patient waited all night on stretcher in Welland emergency department which was extremely busy. He has type II diabetes and was given nothing to eat.

One nurse described almost impossible working conditions in Welland. There are too few staff. There are too few rooms to examine people. Patients are left in the hallways or even

put in storage rooms. Halls are filled with stretchers contrary to fire code. When the ICU is full, patients who have just had heart attacks are kept in the emergency department, contrary to care standards. In the ICU the staff ratio should be 1:1 or 2:1. Many ICU patients have several IV drips with potent drugs that require constant monitoring and minute-to-minute adjustment according to the patient's condition. In ER each nurse has 5 – 6 additional patients. Staff cuts mean nurses now do EKGs and lab and other procedures normally done by others. Housekeeping cuts leave the place "filthy" at times. People in the waiting room are angry and left waiting for many hours. The emergency departments in the peninsula are gridlocked and paramedics tied up because they can't discharge. There have been extensive lay offs and bed closures.

Bed and staffing shortages are not only contributing to emergency department backlogs, they are also forcing inappropriate discharges from hospital when patients are too sick, long waits for needed hospital care, and poorer health outcomes.

- One witness described an improper discharge without consulting the responsible physician and without a discharge plan that was appropriate. It resulted in her mother's death. The witness' mother was diagnosed with kidney infection and lumbar disc aggravation. She was in hospital from October 7 – October 15th. She was receiving physiotherapy as her legs were unsteady because she had been in bed for so long. She was discharged on October 15. Upon arriving home from the hospital she was unable to walk from the car into the house and her daughter was struggling to help her. She fell on way into house and wounded her leg. She was readmitted to hospital same day with a leg wound from the fall. She got an infection in leg wound led to sepsis. She died of septic shock on November 1, 2009. The witness believes that the premature discharge and fall resulted in her unnecessary death. The sepsis was also not diagnosed until it was too late. The NHS says there is an investigation.
- One witness described her experience. On June 20, 2009 she fell down. She got to Welland Hospital emergency department at 4pm on Saturday. She was informed that her wrist was broken, had pain killers, intravenous, and x-ray. She was told that an ambulance would take her to Niagara Falls because Welland had no orthopedic surgeon on duty. There was no ambulance available so she was sent home with an IV in her vein to wait until 10 am next morning when her brother was to take her to the hospital in Niagara Falls. He took her in at 10 am. She asked for pillow for her arm (she was in pain) and a nurse told her they had no extra pillows. Six hours later, at 2 pm she was moved from waiting area to floor where she was to be operated on. When she was on the operating table the surgeon got a phone call. He told her it was an emergency and he would be right back. She waited for 45 minutes on table alone, cold and shaking. She walked out into hallway. A person in the hallway got her a wheelchair and she called her husband to pick her up. He did and they drove to St. Catharines General Hospital. She waited another 4 hours in the waiting room before orthopedic surgeon could look at her arm. A nurse and cast technician wrapped her arm in soft cast. She sent home and told to call the orthopedic surgeon's office to make an appointment for the surgery. She made the appointment for the following Thursday (6 days after she broke her wrist). The surgery was done to put in three pins to hold shattered bone.

- One witness called for a tool that accurately captures readmissions. He noted that patients are only counted as readmissions if they are readmitted within 24 hours. This does not capture properly the number of readmissions due to discharge too early and/or without adequate care plans.

Several witnesses raised cuts and poor access to mental health services. It was noted that people with mental health problems cannot be expected to navigate a complex health care system. They need support at home and help connecting with the continuum of clinical care and social support.

Services are seen as inadequate or non-existent.

- The NHS is proposing to close down the psychiatry unit at Welland. It serves Welland, Port Colborne, Wainfleet, Pelham and surrounding areas. Transportation is a major problem. They plan to centralize patients to St. Catharines. This is inconsistent with the attempts to move psychiatric services out of large hospitals and into communities. "This is going backwards."
- The mental health services provided by the NHS are reported to be well below the standard required of the Ministry of Health.
 - There is no regional psychiatric team.
 - There has not been a chief of psychiatry for the last 5 years.
 - There are no registered clinical psychologists in the NHS.
- There are only 15 psychiatrists in a region with a population of 450,000. The recommended number, according to provincial benchmarks would be 50 for this region, or 1 per 8,000 people.
- It was reported that the NHS is not making any sincere effort to recruit psychiatrists.
- There are no inpatient beds for mental health for children in the region. Children are either put in pediatrics or in adult psychiatric unit. This is a safety issue and falls far short of the standard of care.
- Niagara Health System cut a psychiatrist from Welland Hospital, affecting all his patients.

Witnesses called for clearer standards and protection of patient access to care, proposing that the provincial government set standards for accessibility to ensure safe and reasonable access to necessary services. Presenters noted that they are not demanding tertiary services, just timely and equitable access to adequate and safe health care services. One mayor called for a template for what's needed for an effective emergency health care system. One witness questioned how a community of 40,000 people is considered to be too small to be worthy of an emergency department.

- A physician noted that the warnings of unnecessary death as a result of emergency department closures have not been acknowledged. Local hospitals have a vital function in stabilizing patients before transfer. Time-critical emergencies that require faster access to ERs include: stroke, heart attack, severe trauma to head, limbs, abdomen or chest, hemorrhaging, shock, patient bluish and gasping for breath, multiparous woman in premature labour, strangulating prolapsed cord. Paramedics not trained or equipped to stabilize time-critical emergencies. He asked, "What good is a Centre of Excellence if a patient is DOA?"

- Simple pediatrics and internal medicine, obstetrics, geriatrics, psychiatry, brief intensive care, minor day surgery etc. should be kept close by a patient's family. It is humane to do so. Family physicians with specialist back up are perfectly capable of doing this core work. It would be more economically viable for them to do so.
- Problems accessing care should be measured and reported on.
- Patients should be able to submit evaluations to the MOH on quality of care.

Witnesses called for the hospitals in Fort Erie and Port Colborne to remain open, with restored services and equipment. Lack of clinical staff and equipment were cited as a problem by several witnesses.

- After a suspected stroke and a heart attack, one witness' mother ultimately requested to go to Fort Erie. The witness described this hospital as the cleanest and most comfortable but seemed to have no monitoring equipment and little physician care. The week she moved in they laid off 10 nurses and the few remaining RNs were asked to work "ridiculous" shifts. The family felt the mother was overfed and complained to the nurses' aides. They had no access to the dietician. She vomited into her lungs, this went undetected and caused her to decline further. She was moved to palliative care. She was not prescribed food or fluids. The witness conveyed her belief that funding cuts shortened her mother's life and decreased her quality of life before she passed away.
- One witness described his experience as follows: his wife had severe osteoporosis and her leg broke. He called 911, five blocks away from Douglas Hospital. The ambulance was sent from Ridgeway. At Niagara Falls they waited for an emergency room bed. His wife's operation successful followed by weeks of recovery. Then she was sent to Douglas Memorial Hospital "to die". She was on IV to keep her electrolytes stable. The IV was removed. On the 2nd floor IVs are not allowed. There are no resuscitating paddles. Nurses are allowed only to apply CPR and call 911. One nurse was on shift for four hours with 22 patients alone.

Community members are concerned that transferring patients all around the Niagara peninsula destroys continuity of care. Family doctors cannot attend to their patients in different hospitals. One witness asked, "Why have a family doctor when they cannot care for you in your greatest time of need?" Because patients are being moved far from their hometown to die, they are denied services and ministrations of their clergy.

Many concerns were raised about traveling distances and accessibility. There is no regional transportation system and there is poor bus service to Niagara Falls and St. Catharines from the southern tier communities and poor bus service across the southern tier to and from Welland. Witnesses called for local driving conditions and distances for the elderly to be factored into accessibility of care. The cost is \$45 for an ambulance to Welland Hospital from Port Colborne. A bus from Port Colborne to Welland takes entire day for round trip, with waits of hours in between buses. Travel costs are experienced as a hardship. The only paid parking in town is by the local hospital. (Fort Erie). The government should consider subsidies for low income families to offset travel costs for care.

Many submissions included concerns about the closure of Alternate Level of Care beds and services for the elderly.

- Witnesses called for Alternate Level of Care (ALC) beds to be maintained to clear the emergency departments.
- Witnesses questioned where patients discharged from ALC beds are going.
- There are more than 1,000 people on wait lists for long term care homes in this area.
- Retirement homes are considered inappropriate.
- Witnesses believed that the Access/Restore program has been set up to get people off the hospital rolls not necessarily to get good care.
- Case managers focus is on getting patients out of hospital not on getting the best or appropriate care.
- The palliative care team is not set up (Fort Erie) There is no dedicated palliative care unit.
- Improve supports for the elderly are needed, including additional supports to age at home.
- Hospitals should implement volunteer “HELP” programs such as that initiated by KGH for frail and elderly.

Many witnesses described poor cleanliness or “filthy” conditions in the hospitals. One witness noted that fewer cleaners means one cleaner travels all through hospital cleaning, without washing hands or changing clothes. Another testified that staff are traveling from site to site without changing their uniforms. These witnesses feared the transmission of infections from one place to another.

Physiotherapy was described as inadequate. Physiotherapy at home is not an alternative to hospital-based services where there is equipment.

Witnesses support the enhanced use of health professionals to allay shortages. Some called for the use of Nurse Practitioners to improve care and reduce emergency department wait times in Welland. Another noted that allied health professionals would enable family health team to be a better model.

Misuse and overuse of drugs was reported as a serious problem and cost. The Ministry of Health should require physicians to do annual review of all medications for patients. Pharmacies should be mandated to do drug interaction studies with each new prescription. Public awareness regarding drug interactions and unnecessary prescriptions should be done through mechanisms such as medication awareness programs; harness seniors organizations and networks to do this.

Others suggested the government do more to promote wellness programs in the workplace and in schools. Encourage healthy lifestyles and roles.

One mayor noted that Urgent Care Centres (UCCs) operate more efficiently in urban centres in tandem with an ER, such as Trillium, Women’s College and Stonechurch. Triage

nurses can decide whether a patient should be seen in the emergency department or UCC. One emergency trained physician can oversee both departments supported by nurse practitioners and physician assistants.

Grimsby

Patients at West Lincoln Memorial Hospital (Grimsby) who need an MRI must be transported to Hamilton. The RPN who travels with the patients is not replaced and therefore patients remaining at the hospital get less care and longer waits. One witness queried the cost of patient transfers.

One patient took six months from the onset of a problem to get an MRI, then another four months to see a specialist. This patient had to go through this three times as the specialist rejected the first two MRIs because of the lengthy delay.

Burlington

More cuts to staff and services were reported at Joseph Brant Hospital (Burlington).

Hagersville

The Board of West Haldimand General Hospital (Hagersville) are proposing to close all complex continuing care (CCC) beds. There is a short fall, according to a local geriatric psychiatrist of 300 long term care beds in the region. The consequences for families include heavy lifting, requirement to provide nursing, physiotherapy, 24 hour care, deal with aggression or other behaviours, provide needles. The current wait time for long term care beds is 1 –3 years. Homecare provides an average of less than 1 hour per day. Cutting CCC beds contributes to ER backlogs as acute beds fill up with CCC patients.

Democracy: Governance Structures, Accountability, Consultation

Provincial Government

The general theme at this hearing was that the Ontario government has secluded itself from the values and input of the people they serve. Government is seen as unresponsive and undemocratic. Many noted that there has been no public consultation. Witnesses believe that the provincial government has no mandate to dismantle the hospitals. They noted that the premier promised to keep the Port Colborne hospital open. There was total consensus that there must be a public consultation process before further restructuring.

- The Town of Port Colborne presented their ideas and model to Health Minister David Caplan more than a year ago. They have yet to hear back with any updates on progress.

- Welland Tribune, Dave Johnston Feb 21, 2002: “McGuinty, who is from Ottawa, said having a 24-hours-a-day, seven-day-a-week emergency room- and hospital – is essential to a city, especially one like Port Colborne which is trying to grow. “It’s not just important, it’s very important for a community to be competitive in attracting families and industry.”... McGuinty made a pledge to the mayor to keep the hospital emergency room open.”
- In the words of one witness, “We need to be treated as adults when it comes to participation in a dialogue concerning our health.”
- Others noted that current practices are not in keeping with the past practice of consultation with community, local government, business, health experts and unions.

Many called for a provincial plan, clearly communicated to the public, and policies to protect access to care.

- Witnesses called for basic standards for emergency care, including times and distances.
- In Port Colborne, the local municipality has done a great deal to create proposals and structures, recruit physicians, enhance primary care etc. “Now time for the province to step up.”
- Witnesses stated: “Information to understand change is lacking,” and “No one has told us the plan.”
- Another witness described the absence of quality of care and minimum care standards by Ministry of Health.

Many called for the restoration of local hospital boards.

- Local boards can integrate care. They were eliminated because they resisted policies that were not in keeping with community values and because they care about lives in their communities.
- “Give back community control and the hospitals would be better.”
- “Publicly provided health care needs to be publicly accountable. The removal of local hospital boards contributes to the disengagement of the community.”

Many decried the lack of accountability for the use of their tax dollars. Government policy is seen as contrary to the values of the community.

- A Burlington resident facing more cuts to staff and services wants to know where their health tax money went. Another witness noted that the government claims it has increased spending in Niagara region by 42%. They wondered “Where did it go? It obviously didn’t improve quality.”
- One witness noted that the cutting of complex continuing care beds is a deep moral and ethical issue. It affects seniors more than any other group. These patients have contributed their entire lives to their hospitals and health coverage. Yet there is enough money for all the administrators’ salaries.
- “As a high school teacher I work hard to prepare my students for adulthood. But what sort of a world am I sending them into when they can’t count on a hospital being there when they really need it the most?”

- “We all pay for the same hospital care through our taxes, do we not all deserve the same care and treatment?”
- “Ontarians deserve to have the same chances to survive.”
- Several witnesses called for the principles of the Canada Health Act to be respected and reenacted. One described the “annihilation of faith in our universal health care system” and called on the Ministry of Health to reaffirm its commitment to Canada’s universal health care plan.

Many are looking for someone with authority to intervene to improve the situation. Witnesses noted that they have appealed everywhere to get someone to listen. The community is waiting for the report from the ombudsman. They are waiting for the report from the coroner. They are waiting for the recommendations of the province’s Rural and Small Health Panel.

- Witnesses called for the Ministry of Health to support citizen advocacy for improvements to care. Advocacy structures should be created with government assistance to help patients navigate the system and to advocate for improved quality of care.
- Several called for the province to allow the ombudsman to oversee hospitals.
- Others called for a way for patients to make complaints and have them matter.

Many witnesses conveyed their opposition to the downloading of ambulance costs onto regional government when the hospitals closed. The region is paying \$3.1 million annually as a result of the closures. Community members believe this should be considered a provincial government responsibility.

Hospital board

The Niagara Health System hospital is deeply distrusted by the community. The hospital is in severe financial trouble and many questioned the priorities of the NHS, citing excessive administrative salaries at the same time as care is being savagely cut. The hospital is seen as undemocratic and autocratic and has had problems developing constructive relationships with municipalities, clinical staff and the public.

The public questioned the priorities of the hospital, with a focus on excessive executive salaries and service cuts.

- One witness said, “If you cut the salary of the NHS CEO, the psychiatry services at Welland would still be open. Whose job is more important?”
- Another sees “a legacy of greed, uncaring and death”.
- Another queried NHS costs for “ridiculous” wages, advertising and per deims.
- Many referred to excessive use of consultants while the staff and the patients are never consulted.
- Many called for a decrease upper management and increase in front-line care: “Put more people on the floor to care for patients”.
- One witness testified that in 2004 34 NHS employees were paid over \$100,000. By 2008 169 NHS employees were paid over \$100,000 totalling over \$21 million. The

CEO had a \$33,000 raise in 2008 for a total income of \$335,000. The Niagara region average income is \$24,000 per year.

- Another witness took issue with the CEO's salary noting that it is \$1,000 per day (including weekends and holidays).

There was consensus that the restructuring is going to cost more, rather than less, and services are getting worse as a result. Financial decisions had no credibility, were seen as erratic and poorly planned.

- Many witnesses noted that the NHS is downloading \$3.1 million costs to supply 2.5 ambulances on the backs of property taxpayers of Regional Niagara.
- The hospital said the closure of the emergency departments would save \$2 million per year. Instead it has cost \$3 million per year in ambulances alone. This does not include renovation costs for the Port Colborne hospital and new costs for the other regional hospitals to take the patient loads. The costing projected a dramatic reduction in emergency department visits, based on no evidence, which has not happened.
- The restructuring is not believed to save any money and there is still no solution for the extremely poor financial position of the hospital. Niagara started amalgamation in the early 2000s with a \$30 million debt. Now their debt stands at \$120 million.
- \$400,000 was approved by the provincial government to renovate Port Colborne's emergency department and expand it. Within months, the NHS had switched its plans and proposed that the emergency department be closed down.

At best, staff described high levels of frustration and demoralization. At worst, they called the hospital environment "poisonous". There are serious disputes between the NHS and staff and many allegations of bullying and intimidation. Certainly there appear to be a high number of alienated and angry staff. According to witnesses:

- The hospital environment is "poisonous".
- "There is poor morale in the medical community."
- The NHS "has a bad reputation for intimidating physicians who speak out for their patients."
- Four years ago, the NHS tried to close the psychiatric unit at the Welland General Hospital. Dr. Abraham was the regional chief of psychiatry and spoke out. The NHS "backed off but fired Dr. Abraham".
- Four physicians resigned from ER at Greater Niagara General Hospital (Niagara Falls) in latter half of 2009 in public disagreement with the leadership style and demands of NHS.
- There is no agreement with the physicians in Port Colborne and Fort Erie to create a funding agreement for the Urgent Care Centres.
- The Ontario Nurses' Association have called for an investigator.
- In Welland, nurses are described as being to frightened to speak out for fear of repercussions; staff are working in "despair and frustration".
- Clinical staff complained they were not consulted when the "Hospital Improvement Plan" (plan to cut the deficit) was being created.
- The three southern communities – Port Colborne, Wainfleet and Fort Erie – passed resolutions calling for an investigator.

- Niagara Falls municipal council passed a motion calling for an investigator.
- Local MPP Kim Craiton has supported call for an investigator.

Many were angry about the lack of democracy in the NHS and the misinformation about the nature of the new St. Catharines hospital.

- Amalgamation was likened to hostile takeover.
- One witness described the hospital as hiding “behind a cloak of secrecy and costly propaganda.”
- Many criticized the eradication of elected hospital boards.
- The communities were told repeatedly that new St. Catharines hospital was a local hospital. Now it is a regional hospital.
- Witnesses were incensed about a “consultation session” held recently at the WMCA in cramped hallway where the public couldn’t fit in, couldn’t hear others’ questions etc.

It is believed that the Port Colborne and Fort Erie areas have been treated unequally and that amalgamation has resulted in the constant withdrawal of services from southern tier:

- Local people have donated in their wills but the services they were donating to are being closed.
- Services and equipment have been moved out step by step from Fort Erie.
- Local advisory committees were seen as unrepresentative and lacked credibility.

Witnesses described their local hospitals in Welland, Port Colborne and Fort Erie as institutions that they had been proud of in the past. These local hospitals were built by local people, locally governed and considered to be efficient. They entered amalgamation in good financial shape. Service clubs and endowments bought necessary equipment and willingly paid for necessary renovations and maintenance. They operated for decades with volunteer boards. The hospitals were trusted and people were proud of their accomplishment. Board meetings were open to the public.

Amalgamation destroyed the democratic governance structure. Successive rounds of reductions in services and removal of equipment have led to deep public anger and mistrust. Residents see access to care worsening, not getting better and are alienated from the hospital system.

LHINs

There was no public confidence in the LHIN. At best, witnesses described it as redundant and could not see a use for it. At worst it was seen as a unprincipled and unaccountable. According to witnesses:

- LHINs are appointed Liberal supporters.
- The LHIN does not have the resources to address the NHS’s financial situation.
- Neither the LHIN nor the government show principles in their decision-making.

- Politicians have avoided responsibility through appointed committees and “pass the buck”.
- There have been no public consultations and no proper debate.
- The health care system is more fragmented, not less. It is difficult to navigate.
- LHINs are a buffer for the provincial government.
- LHINs are another layer of bureaucracy and a monetary drain on the system.
- The hospital plan was described as extremely poorly done. Not only was it poorly costed, but it was developed totally in isolation. There was no community or region input, no consideration of capacities for the CCAC, transport, long term care homes, regional growth plans, town plans, ambulances, community health centre mandate.
- There is now more money spent everywhere except patient care – advertising, holding meetings, paying for studies. None of it has accomplished anything to improve care.
- LHINs are “unaccountable”, “unelected”, “unresponsive”, “undemocratic”.

Witnesses had a variety of recommendations ranging from reducing the pay and status of the LHINs to dismantling them altogether. According to witnesses:

- LHINs should be servants not masters, and their pay should reflect that.
- Dismantle the LHINs and reinstitute District Health Councils.
- Scrap the LHIN or have it directly elected by the people. Its decision making process should also be more public and transparent.
- Eliminate the LHINs. They have become another redundant bureaucracy.

In the words of one witness, “The government claims it has put millions more dollars into health care in the last few years. Where did it all go? The answer appears to be that it stays at the top. LHINs take money. CEOs take a lot of money. Consultants take money. The public relations department takes money to deal with all the negative fall-out from the poor decisions. All the vice-presidents, and directors, and assistant directors etc. How much of the health care budget is spent before even a penny goes to actually looking after patients?”

Economic Development and Community Impacts

Witnesses noted, in particular, that economic growth plans for the region and population demographics are completely contrary to health care planning. Industry does not want to locate where there is not emergency care. Seniors have located in areas where they have access to hospitals and emergency departments.

Hospital cuts have created municipal tax increases for ambulance costs.

Community members are concerned about job losses and impacts on work. Long waits in emergency departments contribute to lost work time. Full time positions are being cut and replaced by part time workers. Families are already hard-hit because of manufacturing and other job losses.

Cobourg and Northumberland Hills

Cobourg, March 10, 2010

Access to Care/Quality of Care

The hospital serves a catchment area of west Northumberland County. It is comprised of a mixed rural and urban population of 60,000 including the Town of Cobourg, the municipality of Port Hope, and townships of Hamilton, Cramaheand Alnwick/Haldimand. Witnesses describe a high proportion of seniors in the area.

Just prior to the hearing, the hospital announced its intention to cut and close a number of services including outpatient rehabilitation, the diabetes education clinic, 11 long term care beds, 8 complex continuing care beds, 16 alternate level of care beds and the urgent care centre attached to the emergency department. The hospital opened in 2003 with 137 beds. As of the hearing, it had 110. After the cuts, it will have 84.

There was widespread opposition to the recently-announced hospital cuts at this hearing. Community members are concerned about the loss of services and worsening access. Many complained that population need and the lack of capacity in community-based services and long term care services were not considered. Many described the cuts as short-sighted and several described them as a violation of the Canada Health Act. There is consensus that the cuts would serve to increase, not decrease, hospital costs over time.

The hospital in Port Hope was closed in the last round of restructuring. Witnesses noted that the community was told that they would be better served with one sustainable hospital in the region and they have already made significant sacrifices; now they are being faced with another round of major cutbacks and poorer access to care.

There were 5,530 visits to outpatient rehabilitation services last year. Most of these were from people without private insurance. Seniors comprised 38% of the physiotherapy visits and 42% of the occupational therapy visits. There is no capacity in the community to provide these services. There is a higher than average senior population and also a higher than average rate of arthritis.

- The Community Care Access Centre (CCAC) recently appeared before the LHIN to make clear that their resources are stretched as a result of hospitals offloading. The CCAC is wait-listing patients indefinitely for physiotherapy and occupational therapy.
- There is no OHIP-funded physiotherapy in the entire County of Northumberland and the nearest public physiotherapy is in Peterborough or Ottawa. There is no occupational therapy offered through private clinics.
- Outpatient rehabilitation services primarily treat acute illness and injury such as acute orthopedic and musculoskeletal problems, joint replacements, fractures, and surgical repairs. Other conditions include stroke, various neurological disorders, amputations, rheumatological and chronic conditions. Loss of service will equate to compromised surgical and non-surgical results, increased complication rates,

delayed recovery times, elevated readmission rates, increased length of stay, increase ER visits and dependence on family physicians, medication dependence, inability to cope with disability, delayed return to work, more disability claims.

- Occupational therapy (OT) services reduce need for hospitalization. The closure of OT will leave no OHIP covered OT in Northumberland County. CCAC cutbacks mean no homecare access also. Private OT services do not have the equipment and resources for assessment and treatment that hospitals do. Most cannot afford private OT.
- It is contrary to best practice for stroke rehabilitation to go without OT after a stroke. Outpatient OT is the only service available to patients who have sustained a stroke and no longer require hospitalization. Outpatient OT is the only service available for custom splinting and hand therapy in Northumberland County. A rise in post-surgical complications and/or compromised surgical results for clients with upper extremity conditions typically seen by OTs in outpatient setting (such as post-fracture, chronic strain disorders, tendonitis, arthritis). The hospital is only outpatient setting that takes WSIB referrals for OT. Outpatient OT is the only service available for comprehensive cognitive and perceptual assessment in Northumberland County. Cutting the service means that assessment for driving cannot be done.
- The outpatient rehabilitation serves patients with neurological and other severe impairments resulting in chronic disability eg. strokes, Parkinson disease, multiple sclerosis, amputees. These patients require the specialized equipment and interdisciplinary care found in hospital, not in private clinics or patient's homes.
- In local private physiotherapy clinics, expertise and care are focused mainly on musculoskeletal problems and sports injury.
- One witness described his experience with knee surgery at St. Michael's Hospital. His new knee was put in crooked. For six months he accessed physiotherapy at the Cobourg hospital 1 – 5 times per week. Private coverage would have run out in less than 2 months. It is very difficult to drive with a "botched" knee even as far as Cobourg.
- Another witness had partial knee replacement in Scarborough. This patient is using physiotherapy twice per week. As a retiree on a fixed income, they do not have the financial resources for months of private physiotherapy.
- Another witness with a broken arm requires physiotherapy to regain arm and hand function. They do not have private coverage from work.
- Another witness had surgery on his knee in 2008. He is self employed on farm without health insurance. His knee replacement was done in November 2009 in Toronto. He is still receiving physiotherapy.
- A witness requiring outpatient physiotherapy for Reflex Sympathetic Dystrophy (RSD) requires intensive physiotherapy to regain use of fingers. This witness works but has no health insurance from work and cannot afford private physiotherapy. This witness described the cuts as devastating.

More than 2,000 people have been seen by the diabetes clinic this year. 1/3 of these are on insulin. 187 of these were inpatients seen for diabetes management. The cuts are seen as

short-sighted and leading to more costs from poor diabetes management. There is no replacement care in the community.

- The diabetes program provides education and support to physicians and hospital staff, reviews diabetes medication orders, consults with physicians and specialists, counsels inpatients and teaches use of glucose meters and insulin administration. It supports inpatient programming and also the dialysis unit and chemotherapy clinic. It also has a compassionate insulin program for those unable to afford this life saving medication.
- The impact of the loss of this service is increased admissions, ER visits, visits to family physicians, readmission, medication errors, hospital admissions. Mismanagement of diabetes poses significant risk to health and quality of life.
- There will be no one to see the inpatients who need diabetes management when the clinic is closed.
- A few patients with diabetes who have an extended stay due to complications would quickly eat up the \$150,000 that the diabetes clinic costs the hospital.
- The diabetes clinic at the new Port Hope Community Health Centre is to counsel of prevention of diabetes, pre-diabetes and non-complicated type 2 patients. It is not mandated to handle complicated type 2 patients on insulin, type 1 patients, insulin pumps, gestational diabetes or pregnant diabetics. It does not have the staff to take the workload from the hospital.
- The diabetes program closure poses significant medical risk to patients.

There are no appropriate community-based alternatives for the patients needing the long term care, complex continuing care and alternate level of care beds.

- Witnesses testified that there is already a \$9 million deficit in homecare. The CCAC appeared before the LHIN in January to report that they are overstretched, have implemented wait lists and are only taking patients in the most severe need.
- The closure of the ALC beds means nowhere to put these patients. They will quickly fill the acute care beds leading to emergency department backlogs and hallway stretchers.
- A number of patients in ALC beds have been turned down for placement in other settings because of behaviour or medical conditions that are beyond level of care in the other institutions.
- Staff have worked in hospital for 20 years. There has always been and continues to be need for ALC beds.
- One witness described the cuts as unfair. Her mother is in long term care unit of Northumberland Hills Hospital. She is 88 and has dementia, congestive heart failure, diabetes and hypothyroidism. Change is disorienting and upsetting to mother. There is no plan from CCAC.

Ongoing access to care issues were also raised by witnesses:

- Rural communities outside of Cobourg already have long distances to travel for care.
- A dialysis patient told the panel that she drives ½ hour each way 3 days per week to get dialysis in Cobourg. She finds it difficult to pay for drugs even though her

- There were complaints of long waits in the emergency departments in Cobourg and Trenton.
- There were complaints about costs for user fees. The poor can't afford to buy own crutches or casts, can't afford ambulance fees, only have municipal transit in 3 towns in Northumberland, no public transit between communities, have to use taxi or community care who charge for it. There were complaints about costs for parking.
- Timely access to care is not equal. Patient may wait days for repair of a fracture or weeks for inpatient mental health consult.
- Foot care has been cut. Patient must pay or go without.
- Every nurse cut means loss of 1,950 hours of patient care. Cuts to the nurses at the hospital means loss of 20,000 hours of patient care annually.

Democracy: Governance Structures, Accountability, Consultation

Witnesses are frustrated at the erratic planning and poor accountability demonstrated at every level of governance. Decision-making conflicts with the values and priorities of the community and the cuts are seen to be a violation of the Canada Health Act.

Many are incensed at wasteful spending on consultants and exorbitant salaries. Every level of governance responsible for hospital oversight - including the provincial government, the LHINs and the hospital boards - were criticized for misuse of public funds.

- They called on the government to "stop wasting our taxes" (giving the example of ehealth) and paying exorbitant management, stating that "cuts always start at the bottom with housekeeping and now we have huge viruses in our hospitals".
- Many recommended streamlining administrative costs and putting more money to care, "cut the management and keep the care", and, "cut the salaries of people making over \$100,000 per year".
- One witness asked: "Why are there new managers being hired when front line services are being cut? Why are there three levels of management in the Stores Department?"
- One witness called for full disclosure of management positions, their job descriptions and their salaries so that the public can make suggestions for cuts.
- One witness described wasteful spending on ehealth and the LHINs, stating, "If these moneys were spent on care we would not have a problem".

Provincial government

The provincial government was described as playing the role of the bully. Witnesses noted that hospital funding is inadequate and cuts are being forced through without regard for the need for those services.

Provincial hospital policy is not in keeping with the public's values and priorities. One witness noted that bailing out the car companies has been seen as more important than bailing out our hospitals. Another stated that life is not about stretching our timeline as humans, it is about quality of a person's life. Another described policy as "underfunding, corporatizing and whittling away what is left".

There is a lack of proper policy and planning. In addition to the inconsistent and wasteful decision-making described here, people noted that there are no standards to suggest what a rural community might expect by way of emergency services and basic hospital care.

Witnesses are frustrated and angry about the erratic nature of hospital policy from the government:

- Part of the rationale for closing Port Hope hospital was that the communities would benefit from one full service hospital. The new Cobourg Hospital recently opened in 2003 with 137 beds. Now it has 110 beds. With cuts that total will drop to 84. The level of beds and services (including those being cut) were approved by the Ministry of Health prior to the construction of the new hospital, based on assessed community needs.
- One witness noted that they just built the beds at the hospital: "Why mothball them 7 years later to build duplicate beds with less services somewhere else? What a waste of taxpayer's money." Another said, "First they closed the Port Hope site, then had to rebuild Cobourg site and now they are trying to close down services in Cobourg."

Hospital

The hospital was described as undemocratic and in conflict with community priorities and values. No staff were consulted or asked for ideas while the cuts were being planned. There is no fiscal advisory committee as per the Public Hospitals Act. One person testified that there was a grant proposal sent in for the Ontario Diabetes Strategy that could fully fund the diabetes clinic, yet it is being closed before they had heard back about the grant. Hospital priorities and values were evidenced in one submission that noted, "the Review Committee wants to increase services based on nuclear medicine "because they are profitable"".

LHINs

Witnesses called for the LHINs to be abolished. They described the LHINs as unaccountable, a political buffer, an unnecessary bureaucracy, and a waste of money. No witnesses had been asked for ideas or input from the LHIN. LHINs are variously seen as dominated by major population centres, ignoring disparities between rural and urban, and favouring centralization and ignorant of the needs of low-income residents and biased towards the middle class. It was felt that smaller communities in big LHINs fare badly. The

LHINs were criticized for poorly defined roles and objectives and heavy use of consultants. The community does not see any value in the LHINs.

Many witnesses described the LHINs as a political buffer. Witnesses described them as existing to “take the heat off the government”. In one submission correspondence was provided showing that a patient sent a letter of concern to LHIN and received a letter back directing them to the local hospital and to the LHIN website.

Economic Development and Community Impacts

The history of the local hospitals and the development of the new Cobourg hospital is very important in this region.

Northumberland Hills Hospital is a priority for the community. Witnesses felt its importance to the local economy cannot be overstated. It is a very important employer and crucial for the economic and social development of the community.

Many are very concerned about the job losses at the hospital. These are compounded by industrial job losses in the area.

Port Perry

Greenbank, March 11, 2010

Access to Care/Quality of Care

Port Perry

The Port Perry hospital is doing relatively well compared to other small hospitals, particularly other hospitals in amalgamated corporations. Local hospital advisory board representatives were very proud and the general feedback here, like in other small communities, is that people are treated as unique human beings in the local hospital, not as "a number". Port Perry has an association with the University of Toronto which has provided the services of numerous interns. There is no shortage of physicians reported for this hospital.

One person with an acquired brain injury told the panel that a program just shut down that provides support for him. There was confusion about whether there are any replacement services available.

Another person with mental health issues called for more respectful and compassionate treatment.

Uxbridge

Uxbridge's hospital has a serious shortage of doctors, RNs and RPNs and service and clerical staff. Funding for a hospitalist and nurse practitioner is recommended. This hospital is needed in the community and there are fears about its future. It is amalgamated to the Markham hospital which is in a different LHIN than Uxbridge and is facing a deficit.

Democracy:

Governance Structures, Accountability, Consultation

Several members of the local hospital advisory committee attended the hearing. They are actively engaged with the hospital and are extremely proud of it.

Unfortunately, it was the observation of this panel that these advisory committee members exhibited intolerance for the opinions and needs of the other presenters. They heckled and made comments when people criticized the hospital. If this is an indication of the attitude of the local committee to the community, this panel could understand why some people might feel disenfranchised.

Policy makers are considered to be unaccountable and unresponsive to community priorities and needs. One person described them as callous. Another stated that government does not care enough or respect those needing care and treatment. Some

submissions hold that that hospital corporations and their boards have lost site of the fact that they exist for those needing care. Others called hospital boards and CEOs “ a law unto themselves: they answer to no one”. Witnesses were proud of their hospital and wanted it – and particularly a new wing that was fundraised for locally – protected. Though the hospital is doing well and there were few complaints about access to care, some decried the lack of local control and described Lakeridge Health (the amalgamated hospital corporation) as dominated by Oshawa.

Participants believed that the ombudsman should have jurisdiction over hospitals and long term care.

LHINs

The LHINs were described as “anything but local”. Their mandate to centralize and rationalize services was seen to negatively impact small rural hospitals the most.

Haliburton/Minden

Minden, March 12, 2010

Access to Care/Quality of Care

Access to care is extremely poor in the Minden area, an area with high levels of poverty. Witnesses described a local hospital that has lost services, an extreme shortage of family doctors, inadequate equipment, indefinite waits for homecare, and a lack of transportation to get to care.

There is only one family doctor in the area. Many people have no family doctor. Many have been waiting for years and have no hope of accessing a family doctor in the near future. Residents that have moved here from other places have retained their family physicians even though they might be an hour or more away because there is no access in this area. These residents must get neighbours to drive them to care, and miss appointments because of bad weather conditions and impassible roads.

In 1992 the community's hospital was cut and the community was left with an emergency department with the ability to hold patients for 24 hours. One witness testified that the community was deceived with false promises. They were told that enhanced services and a trauma unit would be coming. The local emergency department is now under umbrella of Haliburton Highlands Health Services. Haliburton now has 10 doctors, chronic care and inpatient beds. There is a feeling of anger at inequities, not only in comparison with access to care in Haliburton, but also in comparison with urban centres and other communities.

The lack of equipment at the hospital was raised as a problem. One witness testified that both her parents put through needless suffering due to lack of a CT machine in Minden. Her father had a bleeding abdominal aneurysm with a very large abdominal haematoma. It was not visible on repeated x-rays. When he was finally sent for CT scan after a week his health was irreversibly compromised.

One person told the panel that she inquired about getting homecare post-op for a hip surgery. Her husband has been diagnosed with lung cancer and emphysema and cannot care for her. She was told that she would be put on a wait list and homecare may not be available to her because of the long list of applicants.

There is no public transportation. 23% of the population is on social assistance and cannot afford to pay for transportation. One witness provided the cost for transport by Remote Transfer Vehicle. It costs \$815 plus 5% GST to go to Peterborough and return.

Community members asked if it would not be possible to set up a mobile unit that could bring necessary equipment and consultants to rural communities, noting that such a system is already in place for mobile dental clinics.

Democracy: Governance Structures, Accountability, Consultation

The community members that attended this hearing had little faith in any level of governance for hospitals. Continual loss of services has eroded public confidence. One community member told panelists, “every time someone comes in from out of town we lose more services”.

Economic Development and Community Impacts

A viable hospital is seen as a necessity both for access to needed health care, but also for the social development of the community. Local economic development was described as tied to improving access to care. Seniors need improved access to care. The ability to attract younger families is seen as dependent on preserving the local hospital and improving access to care. Many pointed to socio-economic conditions in the area as an important factor in health care planning, noting that high poverty rates increase the need for health care services that are simply unavailable because of the severe shortages here.

Burks Falls

Burk's Falls, March 13, 2010

Access to Care/Quality of Care

Burk's Falls

This community has experienced the closure of its hospital and the total loss of urgent care and hospital beds. The Burk's Falls hospital was closed in December 2009. The Urgent Care Centre was closed in July and seven acute care beds were closed in December.

There is total consensus that the Burk's Falls hospital has borne a disproportionate amount of cutbacks and community needs have been ignored by the Muskoka Algonquin hospital board. The Burk's Falls hospital is located in a different LHIN than the other hospitals in the amalgamated corporation. One witness noted that the hospital board closed Burk's Falls Urgent Care Centre and now it has two emergency rooms close to each other in the south end of the large catchment area and nothing in the north.

Community members are afraid that the loss of local access to urgent care will cause increased risk for patients. Many witnesses expressed concern over long travel distances to the Huntsville hospital, with no transportation system and frequent winter storms making the drive treacherous.

- One senior told the panel he is now facing an 80 km round trip to Huntsville for hospital where he has to pay for parking and waiting times of 3 hours are the norm.
- Others noted that the trip to Huntsville can take more than one hour in winter storms.
- One witness testified that he had a severe allergic reaction and was stabilized at Burk's Falls and transferred to Huntsville. He would not have lived if he had to go all the way to Huntsville.
- Another witness cut his finger and required 5 stitches. They were done in Burk's Falls in ½ hour. If Burk's Falls had been closed, it would have cost \$100 in ambulance fees and at least 3 hour wait once he got to Huntsville.
- Many noted that the cost for an ambulance to Huntsville is \$50 each way.
- One teacher reported that she has a student with a severe allergy to milk. She needs to administer epi-pen and get child to hospital extremely quickly because of the danger of shock. She fears the hospital is now too far for this.
- One person noted that people on blood thinners need prompt access to care if they cut themselves but there is no urgent care left in Burk's Falls.

The cutbacks are divorced from assessment of community need. Presenters noted that both hospitals in Huntsville and North Bay have sent patients to Burk's Falls when there have been shortages in those communities. The area grows by thousands of residents in the summer months but there will be no walk-in urgent care available to them in the region of northern Muskoka. The new family health team will not provide these services.

Several called for standards to clarify and improve access to care in rural areas. Palliative care beds are seen as a necessity in every community. Witnesses called for emergency departments and hospital care to be located within 30 minutes of residents. Acute care beds are needed. Others recommended traveling specialists and mobile care.

In addition to the most recent cuts, witnesses reported ongoing problems in accessing needed hospital care as follows:

- Patients cannot get phlebotomies done anymore in Burk's Falls. This witness has to drive 125 km round trip to Huntsville and pay for parking.
- Travel to Toronto to see specialist is problematic. The Northern Travel Grant does not cover all costs. This witness needs to stay in hotel and pay for meals. It is a 500 km round trip. Train and bus schedules problematic and would require 2 –3 day trip. This person needs someone to go with him to the appointment so he can remember everything the specialist is telling him. Thus, he must pay these costs for two people.
- One person's family member needed physiotherapy. He had to travel to Huntsville for it at a cost of \$50 per treatment and loss of ½ day of work 3 times per week. His doctor is not a member of the family health team. A friend whose doctor is a member of the family health team was able to get physiotherapy in Burk's Falls at no cost.
- Currently the municipal long term care home in East Perry Sound has 128 A-level beds and a wait list of 159 people.
- Homecare is limited in this area.
- Hospital palliative care is now non-existent.

Huntsville

The Muskoka-Algonquin Health Care Corporation is facing a deficit. It has cut a number of services and is planning to cut more. Laboratory processing services in Huntsville were closed in 2008. The board has identified outpatient rehab as a service that would be eliminated as part of the deficit recovery plan. 22 ALC beds are slotted to close and 38.3 FTE positions are to be eliminated.

There were several complaints about lateness and quality of laboratory processing.

- On several occasions blood tests for Coumadin for one witness have gone missing and been as late as ten days. Previously, when lab work was done in Huntsville, his doctor got the results the same day.
- Another witness described his experience with a rare myeloproliferative blood disorder of the bone marrow. If blood tests are delayed, he does not get accurate counts. He is on several medications. To overcome this problem, he would have his blood test taken in Burks Falls lab just prior to pick up time so that it was processed in Huntsville within a couple of hours. Since testing no longer done in Huntsville, his blood is now sent to Brampton and there is a delay of up to 24 hours between time blood is taken and testing is done. His blood tests are now inaccurate and have led to unnecessary changes in medication.

- One staff raised questions about patient safety with nurses doing CBCs (complete blood count) overnight instead of medical lab technologists.

Democracy: Governance Structures, Accountability, Consultation

Community members described governance systems at every level as treating the smaller communities unequally to the urban centres, failing to uphold community values and failing to consult.

Witnesses called for high salaries, excessive bureaucracy and costs for expensive consultants to be contained. One testified that MAHC paid outside consultants to do an audit at a cost of more than \$100,000. This was considered a waste of money since, predictably, the consultants agreed with what was already planned.

There has been no public input into changes and cutbacks. Communities and staff have never been asked for ideas, nor provided with a proper consultation process. Public meetings have been advertised minimally and at the very last minute.

In and around Burk's Falls there is a deep alienation from the hospital board and widespread anger at unequal treatment. Many believe that these northern areas have suffered disproportionate cuts. One witness noted that the MAHC is cutting \$1.8 million by closing Burk's Falls hospital out of their total \$4.1 million deficit. This equals 45% of cuts on backs of 16% of the population. Others pointed to the long list of services that have been withdrawn from their community.

The gulf between the public's values of accessible and equitable care and the hospital board's approach were exemplified in communications from the hospital CEOs. A memo to all the hospital staff from the hospital CEO was provided in one submission. In it, the CEO wrote that the Gravenhurst diagnostic imaging service must become a "profit centre" for MAHC to continue its functioning in the future.⁴ This approach is contrary to spirit and intent of the Canada Health Act. The new interim CEO told the Burk's Falls community at a public meeting after closing their hospital that he was "here for a good time not a long time". Community members were insulted by this cavalier attitude, particularly after they had suffered such a huge loss.

Several concerns were raised about the use of donations and bequests for purposes very different than those that the donors intended. The frequent cuts and changes in hospital policy have made this situation worse. One witness told the panel that a friend had bequeathed a large sum of money to the local hospital because impressed with compassionate care there. The money was intended for use in the Burk's Falls hospital. It was noted that funds raised locally built the palliative care rooms. With the closure of the

⁴ Memo from Barry Lockhard, CEO, June 15, 2009.

hospital, people queried whether their donations had been appropriated by the hospital corporation to use for other purposes.

The funding system for capital development of long term care homes is inadequate to support publicly owned homes. In order to build more long term care beds in the Burk's Falls area, the Ministry would contribute only 40% towards capital costs. The municipalities would shoulder \$21 million to build a 100 bed facility. This is unaffordable.

LHINs

The LHIN has not contributed anything useful to the planning for the hospitals in this area. Witnesses described the LHIN as having "rubber stamped" the MAHC report that led to service cuts in Hunstville without any community consultation. The deputy mayor in Burk's Falls reported that the LHIN still "wasn't aware" of the planned closure of the Burk's Falls site in October 2009 – though the information was printed in the local newspapers and a massive community campaign had been ongoing for months in communities across the area. This was after Burk's Falls' urgent care beds were already closed in July and only 1 ½ months before the total closure.

Economic Development and Community Impacts

The economy of this area is totally dependent upon a robust tourist industry in addition to the influx of thousands of summer residents in this region. Many worry about the impact of the loss of access to urgent and primary health care and the inevitable impact on tourism.

Seniors have also located in this area because of less expensive housing and the proximity to a hospital.

The lack of public transportation compounds the problem of access to health care.

Winchester

Winchester, March 23, 2010

Access to Care/Quality of Care

Winchester's hospital is a stand-alone smaller hospital. It was never amalgamated and is described as doing relatively well compared to other small hospitals. People are proud of the hospital and described the care as personal and humane: "You are treated as a person at Winchester and not just a number". The link with the community is so strong that participants referred to dying at the hospital as dying at home.

It was noted that the hospitals in Ottawa are already overstretched and cannot take regional patients if more services are cut.

Economic Development and Community Impacts

Hospitals are seen as security. It is a community value to keep families close to home when they need hospital care.

Picton including Trenton and Napanee Picton, March 24, 2010

Access to Care/Quality of Care

Picton

This area has good access to primary care with a family health team of 22 doctors, described as “excellent” by local residents. A partnership with Queen’s University department of family practice is credited with aiding in recruitment and coverage. Witnesses see positive changes in implementation of community health centres, family health teams and nurse-led clinics.

Concerns were raised, in particular, about poor access to rehabilitation. One witness noted the inequity between access to physiotherapy in Toronto, Kingston and Belleville compared to Picton. There is only a small amount of homecare physiotherapy available. Patients have to pay for their own and it is unaffordable, so they go for a short time and do not adequately recover. Another presenter had a heart bypass. If he was in Kingston he could get cardiac rehabilitation for free. He is in Picton so he was given the choice to go to a cardiac rehabilitation centre in Kingston 3 – 5 times a week for 3 months (at a cost of \$80 per trip) or go home to Picton with an instruction sheet and take out a membership at a private gym and try to do the exercises on his own.

Many witnesses referred to constant chopping away of services. There were concerns about early discharge of patients without adequate care plans, cuts to nurses, cuts to spiritual care, and more requirements for travel.

Community members described how lack of access to care places an onerous travel burden on patients. One woman was getting injections in Belleville and now has to go to Kingston. It costs \$80 for the transport. Another patient had to drive to Trenton from Picton for an ultrasound. It took him three hours to have a 5min procedure. He asked, “Do you think that’s efficiency?”

There were several additional concerns:

- Paid parking at the various hospital sites was the source of a number of complaints.
- One person with multiple chemical sensitivities has not been accommodated by the hospital. She describes her treatment as unlawful under the Human Rights and Ontarians with Disabilities Act.

Trenton

There are complaints about long emergency department wait times.

Perth-Smith Falls and Napanee

The province has closed the Hospitals in Common labs. These were the public non-profit laboratories created by the community hospitals. They did the work at 75% of the cost of the private labs.

Kingston

Kingston General Hospital set up Clinical Laboratories of Eastern Ontario as a reference lab to all the small area hospitals for quality control and other functions. It was an effective public non-profit program and a good integration of service. The LHIN stopped this and has brought in a consultant for review.

Democracy: Governance Structures, Accountability, Consultation

One of the major themes in this hearing was the eradication of democracy in the hospital and the misuse of the province's powers to appoint a hospital supervisor.

The Quinte hospital board was criticized for its deficit and making public a range of options that would be required to eradicate the deficit. The provincial government sent in a supervisor who eradicated local memberships in the hospital corporation, removed the mayors from the hospital board and set up an appointed board. Witnesses note that the supervisor said that they cannot have a board with geographic representation, but governments and even schools do. This is a normal part of our country's governance and political structures.

The supervisor's pay was exorbitant and was the subject of outrage. According to one participant: "Our tax dollars paid the hospital supervisor as much in one week as the chaplain made in one year". (The chaplain was cut to save money.)

Other than eradicating the municipal representation and democratic hospital board, the supervisor did not do anything different regarding the deficit than the hospital board was already doing. In the end, the provincial government provided the additional funding that was needed before the supervisor was sent in.

Erratic and poor planning was criticized with one presenter noting that the government has just built new hospitals in communities, such as Cobourg and the new wing in Belleville, then cut beds.

Witnesses called for costs to be controlled that are in for-profit control, rather than patient care, suggesting that governments and hospitals look at costs for medical supplies, equipment, drugs and technology.

Several spoke against privatization. For-profit companies tend towards larger centres and privatization does not work to increase choice or access in small communities. The increasing use of business models in hospitals hurts small communities because they always tend towards concentrating the market, therefore going to bigger populations. In terms of privatization of costs and new user fees, one witness said “They are just cutting costs from the system and passing them on to patients”.

LHINs

Several presenters noted the high costs of the LHINs and expressed the belief that they are an unnecessary expenditure. LHINs were criticized for using consultants and consultants were seen as biased and lacking in credibility.

St. Joseph Island and Desbarats

Desbarats, March 26, 2010

Access to Care/Quality of Care

The emergency department in the hospital on St. Joseph Island has been threatened with closure. There was total consensus at this hearing that the closure of rural hospitals would be a fatal mistake. The distances in this area are vast – the island is large and the drive to Sault Ste. Marie for island residents is an hour or more in decent weather. There is no transportation system and neither public transit nor taxis are available.

The preservation of the emergency department is a safety and survival issue. Witnesses fear consequences such as poorer health outcomes, compromise of the “golden hour”, unnecessary death and increased stress for patients. Presenters noted the vital role of small and rural hospitals in stabilizing patients before transfer.

In addition to improving patient safety, this reduces the workload for overstretched emergency departments in larger centres. There are not the resources in Sault Ste. Marie to accommodate the additional patients if the emergency department on St. Joseph Island was to be closed.

Bruce Mines is losing a physician and there are not enough physicians on St. Joseph Island. It is feared that the loss of the emergency department would reduce the communities’ abilities to attract physicians.

As in other communities, witnesses said that they are not asking for highly specialized care. They are asking for basic care in their own home facility. For instance, one resident told the panel that they are able get their blood work done on the island rather than having to drive two hours into Sault Ste. Marie once a week.

Democracy:

Governance Structures, Accountability, Consultation

The local hospital, Matthews Memorial, has developed strong grassroots support through their volunteer base, fundraising and the work they do. However, there was little support for the Sault Area Hospital (the amalgamated hospital corporation that is responsible for Matthews Memorial hospital on the island). Witnesses stated that Sault Area Hospital does nothing to improve services on St. Joseph Island and the community hospital has undergone cuts ever since it amalgamated.

Witnesses decried the lack of democratic processes and consultation:

- “Bring medical staff back into the decision-making circle.”
- “If the health tax is being used to improve health care why are our hospitals deteriorating so much?”

- “The government is not listening.”

Witnesses feel that there is pervasive discrimination against rural residents.

LHINs

It was expressed that the government has not learned lessons from experiments with regionalization across the country. Rural hospitals, mental health and chronic and long term care resources have been overlooked.

Political leaders told the public they were decentralizing health with the establishment of the LHINs, but witnesses think they were trying to insulate themselves from closing hospital beds and cutting care. Patients can't figure out who's in charge. Government and regional health boards blame each other when unpopular decisions are made.

One witness described the LHINs as a squandered opportunity. The government could have created better planning and system design. Instead they created another level of administration.

Witnesses criticized the failure to establish clear lines of accountability, in particular for expenditure on consultants. Others called for a freeze and reduction for all management and administrative wages and an increase in front line medical and support staff.

Inequities were highlighted as a major concern.

- “We pay our taxes like everyone else.”
- Witnesses called on government to address funding inequities for rural areas.

Several called for the LHINs to be phased out.

Human Resources

Economic Development and Community Impacts

Many noted that the hospital is vital to the economic and social development of the island and surrounding communities. People have chosen to retire here because there is a hospital. It is vital also for young families with children with health problems. Tourists that flock to the island in the summer need the access to hospital services.

In general, the hospital is seen as security, critical for health care, and extremely important in the maintenance and improvement of the social and economic development of the island community.

New Liskeard

Access to Care/Quality of Care

Temiskaming Hospital serves a population of approximately 25,000 over 4,200 square miles. It is a 59-bed facility. It has a visiting pathologist and three visiting radiologists. It is affiliated with Northern Ontario School of Medicine (as one of 12 sites). It provides clinics (more than 126 in last year) including nephrology, ENT, orthopedic, psychiatry, ophthalmology, physical medicine and rehab. It hosts more than 1,000 videoconference specialist consultations every year. In March, it was designated a Telestroke Centre. The hospital is trying to recruit a general surgeon and general practitioner anesthesiologist. Since the new provincial definition was set, 30 – 40% of patients in the hospital are considered ALC.

Though a range of hospital services and improvements was reported, there are serious problems accessing primary care and hospital diagnostics and specialist care described by witnesses at this hearing. Witnesses reported that this area is short seven family practice doctors. It is estimated that 5 – 6,000 patients are without a family physician. Not having Family Health Team designation makes recruiting very difficult. There are lengthy waits for appointments. Patients go to the Temiskaming emergency room resulting in longer waits in the emergency department. The MRI wait time was reported to be generally 3 months and wait times are up to 6 months for specialists. There is short-staffing of nurses.

There are many initiatives to improve access to care. Health Force Ontario is working with the hospital to obtain locum coverage for the emergency department and the operating room. However the hospital is incurring the travel and accommodation costs at the expense of other hospital services. New Liskeard doctors have tried to become a family health team twice but have not received approval from the province.

In Hailybury in particular, a serious shortage of physicians was reported. Residents without family doctors cannot access any care at the medical centre. The position for a Nurse Practitioner is vacant. Health care can only be accessed through the emergency department at Temiskaming Hospital. People go just to get prescription refills. In hospital they are exposed to communicable diseases and have to wait for hours.

Additional services are recommended by witnesses to help alleviate problems in accessing care.

- The addition of an MRI at Temiskaming Hospital would improve wait times and reduce pressure on Timmins.
- Walk in clinics would help.
- There is a need for improved access to addictions and detox services. Services and communications need to be improved between care providers.
- There are not enough psychiatrists available to assess patients with mental health needs.

- Access for capacity assessments for dementia patients and others is a problem. There are a limited number of qualified personnel. One witness is waiting for training so assessments can be done in a timely manner.
- There is a need for dedicated palliative care beds.
- There is inadequate cultural sensitivity for First Nations and aboriginal populations.
- The CCAC is cutting back homecare services.
- There is a lack of care space for seniors and persons with disabilities.
- The lack of comprehensive rehabilitation services locally was described as creating further problems for those being discharged.
- There is a need for assisted living and continuum of care for those with long term care and supportive care needs.

There were several additional complaints:

- One witness questioned why patients are required to get repeated tests by different physicians, such as repeat x-rays.
- One witness noted that they cannot sign up to donate organs. The cost of transport while on life support to Ottawa or Toronto rests with the donor. There is no harvesting of organs done in New Liskeard.

Democracy Governance Structures, Accountability, Consultation

There is total consensus that the uniqueness of the North has to be recognized.

Government priorities are not aligned with the expectations and priorities of the community. Community members and physicians have not been consulted on needs and priorities.

- One witness noted that the provincial government is willing to pay extra ambulance services, but not for services at home.
- Others criticized the underfunding of hospitals and continual cuts.
- Others believe that there are funding inequalities that worsen access in communities such as this one.

LHINs

Witnesses believe that LHINs have not helped in service integration and coordination. Health professionals have not been consulted about needs and changes to care, particularly relating to geriatric care. It was noted that the size of the LHIN covering this region is extraordinary and unreasonable. It stretches from the Quebec boarder to White River (west of Sault Ste. Marie), a drive of more than 9 hours from New Liskeard.