Office of the Auditor General of Ontario

Value-for-Money Audit:

Hospitals in Northern Ontario: Delivery of Timely and Patient-Centred Care

December 2023

Ministry of Health

Ontario Health

Hospitals in Northern Ontario: Delivery of Timely and Patient-Centred Care

Summary

Northern Ontario encompasses almost 90% of the province's total landmass, but only about 6% of the province's entire population. Thirty-six public hospitals of various sizes serve the approximately 790,000 Ontarians who call Northern Ontario home. Some of these hospitals are located in cities such as Thunder Bay and Sudbury, but the majority of them are smaller hospitals located in more rural and remote areas of the province. According to government and stakeholder documents, compared to the rest of Ontario, residents of Northern Ontario typically have poorer health outcomes, a shorter average life expectancy, and a higher average rate of hospitalization due to injury. Northern Ontario has a higher proportion of residents who are Indigenous and Francophone compared to the rest of the province. In Northern Ontario, there are fewer options for affordable housing and public transportation, and health-care professionals may not have access to the same amenities available in other parts of the province. In addition, a higher proportion of hospital beds in Northern Ontario are occupied by patients who are waiting to receive care elsewhere. All these factors present Northern Ontario hospitals with unique challenges for providing equitable, timely, and quality health care in the communities they serve.

In 2022/23, the Ministry of Health (Ministry) gave hospitals in Northern Ontario almost $1.9 billion to operate. This funding flowed through Ontario Health, an agency created in 2019 that absorbed a number of health agencies and the former Local Health Integration Networks in April 2021 to manage the health system. Both the Ministry and Ontario Health offer various programs to help improve access to hospital services in Northern Ontario, such as incentives to attract physicians and nurses to work and stay in the region. They also offer grants to reimburse travel expenses for Northern Ontario residents who, given the large landmass and limited number of local services available, need to travel long distances to access appropriate health care, so that residents are not disproportionally affected by virtue of living in northern or rural Ontario.

Our audit found that patients in Northern Ontario are more likely to experience longer waits to access the hospital care they need than patients from other parts of Ontario. Between 2018/19 and 2022/23, the percentage of days where patients were admitted in the hospital but were waiting for discharge to other more appropriate settings, such as a long-term care home or home care, was 24%–35% in Northern Ontario hospitals compared to 10%–22% in the rest of the province. This rate is known as the alternate-level-of-care (ALC) rate. Based on cost information provided

by the Ministry and data that was available from 18 of the 36 northern hospitals that reported ALC data to the Wait Time Information System, we estimated that the Province spent $65 million to keep acute-care patients in Northern Ontario hospitals because long-term care spaces and home-care services were not readily available for them. This is especially concerning when a hospital is at or close to capacity because high ALC rates can lead to hospital overcrowding and even longer wait times for patients who require urgent care at hospitals.

We also found that 10 hospitals in Northern Ontario had to close their obstetrics services between July 2022 and September 2023 because of a shortage of physicians and/or nurses; four remained closed as of the end of September 2023, with three of these closed for over a year. As a result, patients who live near these hospitals would need to travel to other locations, often at significant distances, to deliver a baby or obtain other obstetrics care. Ontario Health did not centrally monitor all instances of service closures at hospitals.

In addition, many hospitals in the north had to rely on using nurses supplied by staffing agencies to supplement their permanent nursing staff, more so than hospitals in the rest of Ontario. Between 2018/19 and 2022/23, the use of agency nurses increased 25 times for hospitals in Northern Ontario compared to about two and a half times for hospitals in the rest of the province. At the northern hospitals we visited during this audit, we found that nursing agencies charged them about three times the hourly rate of a full-time hospital nurse, in addition to accommodation and travel costs. For 2022/23, 29 of the 34 hospitals in Northern Ontario that responded to our questionnaire indicated that they paid about $78 million to private agencies for the use of registered nurses and registered practical nurses.

Some of our other significant findings include:

- **The Ministry did not have a dedicated health-care strategy that addresses all the north region's unique challenges; this is critical for improving access to health care for Northern Ontario patients and for supporting hospitals in the delivery of services.** Although the Ministry had started working toward creating a strategy back in 2009 when it established the Rural and Northern Health Care Panel, which recommended a framework for the region, a strategy was never finalized. In addition, Health Quality Ontario, now part of Ontario Health, developed the Northern Ontario Health Equity Strategy in 2018. This strategy recommended that a network be established with representatives from different sectors to help achieve health equity. However, five years later at the time of our audit, this has not been done because, according to Ontario Health, the Ministry did not approve the required funding.
- **Provincial initiatives and tools to manage health-care staffing shortages in Northern Ontario were fragmented.** The Ministry and Ontario Health separately administer health-care staff recruitment and retention initiatives for Northern Ontario. However, they have not regularly evaluated these initiatives to confirm whether they are effective in retaining physicians and nurses. Unlike British Columbia and Saskatchewan, Ontario does not have a provincial health-care staffing strategy that addresses unique challenges of working in health care in Northern Ontario. In addition, hospitals in Northern Ontario report staff vacancy data, but only on a voluntary basis, and neither the Ministry nor Ontario Health take responsibility for the accuracy of the data, limiting its usefulness in providing a true picture of the available supply of staff in the region. Although the Ministry has developed modelling tools to forecast expected demand for physicians, its tools are not all designed to take into account the age, health condition or location of patients, factors that would affect, for example, what specialists would be needed to serve the needs of different local communities.
- **Patients in northern hospitals could not always obtain timely diagnostic imaging services.** Over the last five years, hospitals in Northern Ontario were far from meeting the

target for wait times for MRI scans. There is a limited number of northern hospitals that have MRI and CT machines. Although the Ministry funds the approved operating hours of MRI and CT machines, it does not provide the capital funding for them. Instead, all hospitals in Ontario are expected to purchase these using funds they raise themselves. However, hospitals in Northern Ontario often face difficulties in raising funds compared to their southern counterparts; one hospital we visited estimated that it would take over two decades to raise the funds needed to purchase the hospital's first MRI machine. Patients in the area currently need to travel four hours away to obtain this service.

- **The Ministry's Northern Health Travel Grant Program's mileage rate of 41 cents per kilometre has not been updated since 2007**. The Ministry created this program in 1985 to provide financial assistance to Northern Ontario residents who must travel long distances to access care for a medical specialist or a Ministry-funded health-care facility. This mileage rate is well below the 2023 mileage rate of 68 cents per kilometre that the Canada Revenue Agency set for business travel. Also, the gas price has increased 58% since 2007. The Ministry has not measured the extent to which the program covers the actual mileage and accommodation expenses that patients incurred to access care away from home. Nor has it analyzed how far patients in Northern Ontario must travel to access care. Without this information to inform its funding decisions on what services to add to the hospitals, the Ministry risks perpetuating many of the health inequities that exist in northern communities.
- **Some, but not all, hospitals in Northern Ontario provided an Indigenous healing space for their patients, had traditional practice policies, had dedicated indoor smudging space, or allowed smudging in patient rooms, based on a survey of hospitals done by Ontario Health in early 2023.** About 17% of the population in Northern Ontario identify as Indigenous, compared to less than 5% in other regions of the province. A 2015 report by the Truth and Reconciliation Commission of Canada (Commission) recommended that health service agencies such as hospitals recognize the value of Indigenous healing practices. The report's recommendations also included increasing the number of Indigenous professionals in the health-care field, ensuring the retention of Indigenous health-care providers in Indigenous communities, and providing cultural competency training for all health-care professionals. However, hospitals do not consistently collect data on what proportion of their patients and staff are Indigenous because the *Public Hospitals Act* does not explicitly require it.

This report contains 20 recommendations with 48 action items to address our audit findings.

Overall Conclusion

Our audit concluded that the Ministry of Health and Ontario Health have processes in place to oversee that the delivery of hospital services in Northern Ontario is timely, consistent and meets patient needs, but they can work on improving their effectiveness. In particular, Ontario lacks a dedicated health-care strategy for the north region; a dedicated strategy could go a long way to better meet the unique health-care needs of Northern Ontario residents. As well, patients in Northern Ontario are more likely to experience longer waits to access the hospital care they need than patients from other parts of Ontario.

The Ministry and Ontario Health also did not routinely measure and publicly report the results and effectiveness of their Northern Ontario programs or initiatives to increase health-care staff in the region or to reimburse health-care travel costs for northern residents, and take corrective actions when necessary. In spite of various health-care staff recruitment and retention programs, the region continues to experience physician and nurse shortages, even leading to prolonged hospital service closures in several cases.

In addition, we found that the public hospitals in Northern Ontario did not consistently have effective processes in place to manage their resources with due regard for economy, so that their patients can receive services in a timely and cost-efficient manner. For example, patients in Northern Ontario are more likely to experience longer waits to access much-needed hospital services than patients from other parts of Ontario. This is despite their greater use of agency nurses—which increased 25 times between 2018/19 and 2022/23 compared to about two and a half times for hospitals in the rest of the province—at a significant financial cost. Unlike British Columbia and Saskatchewan, the Ministry does not have a dedicated health-care staffing strategy that would address these critical health-care challenges in Northern Ontario.

OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) thanks the Office of the Auditor General of Ontario for its work, and accepts the overall conclusions of the report and the recommendations that impact the Ministry. The Ministry recognizes the unique challenges of providing equitable access to health care in Northern Ontario, and is committed to working with Ontario Health, northern hospitals and other stakeholder groups on developing and implementing programs and initiatives to address these challenges.

Ontario's health-care plan, Your Health: A Plan for Connected and Convenient Care, is built on three pillars: the right care in the right place, faster access to care, and hiring more health-care workers. Currently under development is an Integrated Capacity and Health Human Resources Plan for Ontario. The goal of this plan is to ensure a greater understanding of the health-care staffing needs in each community, which will inform the development of tailored programs and initiatives. Through innovative programs and initiatives, the Ministry will prioritize areas most in need, such as rural and remote communities, including Northern Ontario, where gaps already exist.

To improve access to health-care services in Northern Ontario hospitals, Ontario has, for example, made investments in the Weeneebayko Area Health Authority to expand the number of patients the hospital can care for, and to build an extended mental health and addictions centre and a long-term care elders lodge, with a goal to reduce wait times and to avoid patients remaining in hallways while they transition to the community.

As part of a long-term sustainability plan, Ontario is analyzing current gaps in the health-care system and anticipating the health-care needs of its population over the next 10 years to determine solutions to address growing health-care demands. With the aim of providing the right care in the right place, faster access to care and hiring more health-care workers in Northern Ontario, the Ministry will continue to work with Ontario Health, hospitals, and other stakeholders to achieve these goals.

OVERALL ONTARIO HEALTH RESPONSE

Ontario Health found the Auditor General's review of Northern Ontario hospitals to be valuable and welcomes the recommendation to collaborate with the Ministry of Health on a dedicated health-care strategy for the north.

Ontario Health North East and North West regions' role is to provide value to the system through health-care planning, funding, delivery, and performance monitoring. We are committed to ensuring that our hospitals, and all health-service providers, have the tools and information they need to deliver quality care in their communities. A dedicated health-care strategy for the North will help inform our Annual Business Plan and our Operational Plans to address some of the complex challenges in the region, such as health human resources training, recruitment, and retention, patient transportation, given its rural/remote locations, and the pressures that hospitals are facing from the COVID-19 pandemic.

It is important to note that the period covered for this audit overlapped with the height of the pandemic from 2020 to 2023, as well as the creation of Ontario Health in 2019, which are contributing factors that directly affect the Auditor General's

findings. The effects of the pandemic are unprecedented, and it needs to be taken into consideration when evaluating hospital performance and their ability to report. Similarly, Ontario Health was newly formed a few months prior to the pandemic, amalgamating 22 organizations, and responding to the crisis by implementing provincial directives such as pausing surgeries and diagnostic testing and by setting aside efficiency and effectiveness performance measures that are understandably an important part of normal operations; however, 2020–2023 was anything but normal. Ontario Health will continue to work with hospitals on pandemic recovery and, at the same time, build its processes to help transform the health-care system. These continuous improvement efforts align with the recommendations in the report.

2.0 Background

2.1 Profile of Northern Ontario

For the purposes of health-care planning and delivery, the Ministry of Health (Ministry) and Ontario Health (a provincial agency established in 2019 to connect, coordinate and modernize the health-care system) define the north region of Ontario as the area from Parry Sound in the south, Kenora in the west, Fort Severn in the north to Mattawa in the east. This area encompasses almost 90% of the province's total landmass, but only about 6% of the province's entire population, or about 790,000 based on 2021 census data. Most communities in the north are rural and remote with small populations—23 of the 36 hospitals in the north region have 60 or fewer beds. Sudbury and Thunder Bay, the two largest urban communities in the north, had populations of 166,000 and about 109,000, respectively, in 2021, and the highest number of beds in the region.

The demographics of Northern Ontario are different from much of the rest of the province. According to Ontario Health, about 17% of the population in Northern Ontario identify as Indigenous (compared to less than 5% in other regions of the province), about 16% identify as Francophone (compared to less than 10% in other regions of the province) and about 3% identify as a racialized population (compared to 13%–47% in other regions of the province).

In 2010, the Ministry published a document titled Ontario Rural and Northern Health Care Framework to guide the unique health-care needs of those Ontarians who live in rural, remote and northern areas of the province. According to that document, Northern Ontario had:

- a lower proportion of residents reporting very good or excellent health status compared to southern rural areas;
- a higher rate of hospitalization due to injury; and
- a higher rate of hospitalization for conditions where outpatient care could prevent or reduce the need for admission to a hospital.

Disparities between the health statuses of residents in Northern Ontario and the rest of Ontario continue to persist. According to more recent publications by Health Quality Ontario (it has since become part of Ontario Health) and the Ontario Medical Association between 2017 and 2021:

- the average life expectancy of those living in the North East and North West regions is lower by two and half years and about three years, respectively, compared to the provincial average;
- the potential years of life lost due to premature death per 100,000 people was 6,255–7,975 years for the North East and North West regions versus 4,198 years for all of Ontario;
- the percentage of inpatient days where hospital beds were occupied by patients who were designated as alternate-level-of-care (that is, they were waiting to receive care elsewhere) was about 23% in the North East and about 30% in the North West, compared to about 15% in all of Ontario; and
- a lack of access to high-speed Internet and unreliable connectivity limits the availability of virtual care for those in remote regions of Ontario.

2.2 Hospital Services in Northern Ontario

The province has a total of 140 public hospitals as of May 2023 spread across Ontario's six health regions: Central, East, Toronto, West, North East and North West; the latter two are sometimes considered one (North) region in certain Ministry and Ontario Health documents. Public hospitals operate on a not-for-profit basis and are funded by the Ministry through Ontario Health. These hospitals provide both inpatient services (requiring overnight stay, such as cardiac surgery and organ transplant) and outpatient services (such as cataract surgery, wound care and diagnostic imaging). Thirty-six or about 26% of the public hospitals in Ontario are located in Northern Ontario, as shown in **Figure 1**. Unlike southern Ontario, Northern Ontario does not have any private hospitals.

Most hospitals in Northern Ontario are located in rural areas and offer limited specialty services and diagnostic imaging services. **Appendix 1** lists the 36 hospitals with their respective number of beds in 2022/23 and acute-care services offered as of September 2023. As well, given their rural locations, some northern hospitals, such as the West Parry Sound Health Centre, are co-located with other health services such as primary care and long-term care. In 2022/23, northern hospitals had about 3,300 beds for various purposes such as acute care, mental health, complex continuing care, and rehabilitation, representing about 10% of all such beds available at Ontario's public hospitals.

2.3 Unique Challenges of Hospital Services in Northern Ontario

2.3.1 Hospital Staffing

Hospitals in Northern Ontario are challenged with health-care staffing issues. According to Ontario Health, northern hospitals have consistently faced difficulties in recruiting and retaining health-care staff, especially in remote locations as the number of health-care professionals who originate from the north and choose to stay and pursue their career in the region may be limited. According to the Ministry and Ontario Health, health-care professionals who relocate to the north from other parts of the province are generally less likely to continue living in the north because of barriers that include fewer options for affordable housing and public transportation, a need for further acquired generalist skills to feel comfortable practising in the north, and reduced or lack of access to the same amenities available in other parts of the province.

The *Protecting a Sustainable Public Sector for Future Generations Act, 2019* (Act), also known as Bill 124, received royal assent in November 2019. This Act limited annual salary increases to 1% over three years for many parts of the public sector in Ontario, including hospitals. In November 2022, the Ontario Superior Court of Justice struck down this Act and declared it unconstitutional. At the time of our audit, the government was appealing the court decision.

The Ministry has several initiatives in place, some of which are administered by Ontario Health, to improve the availability of health-care staff in the north. These initiatives range from increasing the funding for a medical school in the north to providing incentives to bring health-care professionals from other regions of Ontario to work in the north region (see **Appendix 2**).

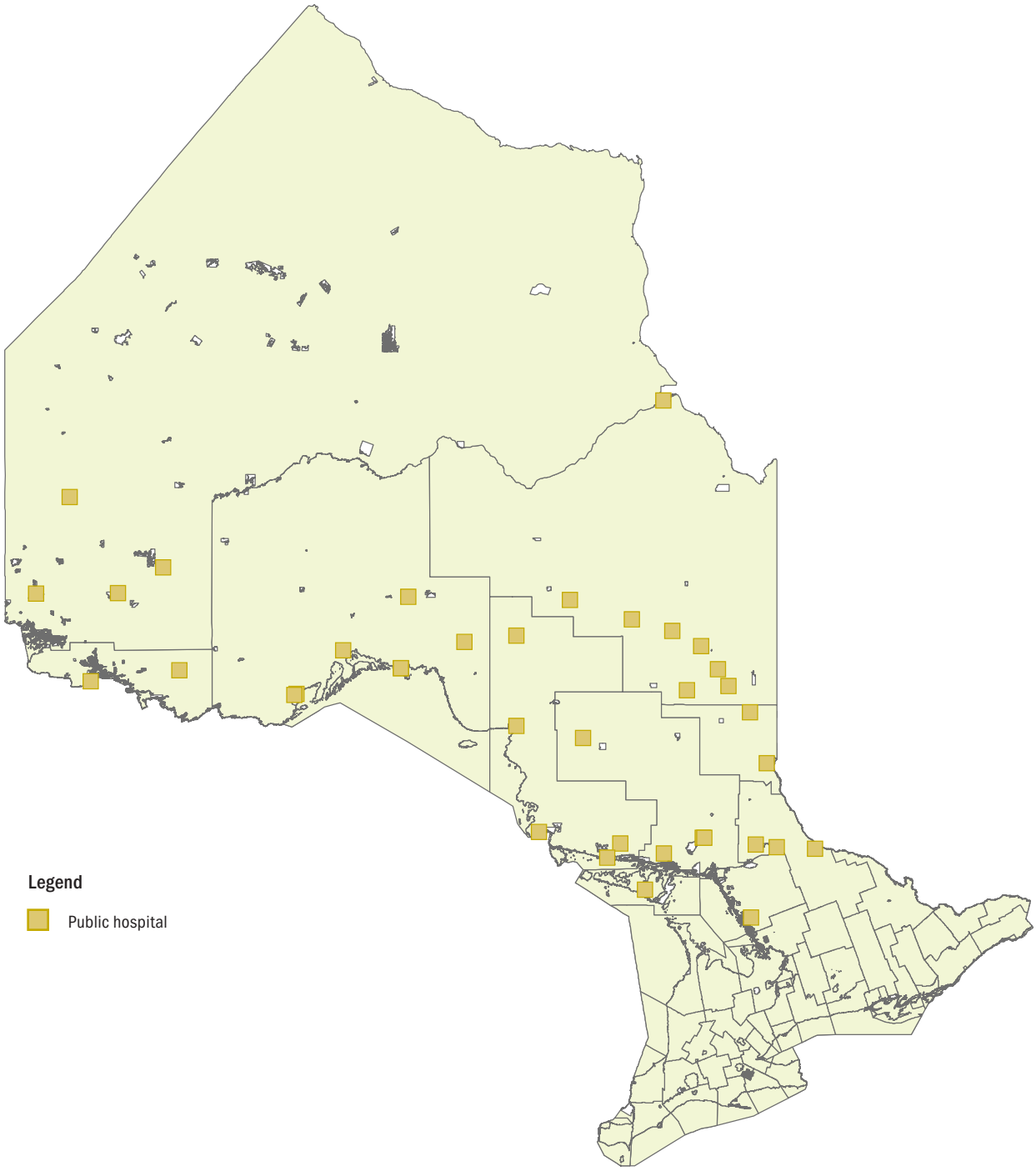
2.3.2 Access to Services

Unlike southern Ontario where hospitals may be less than half an hour away from each other by car, one may have to travel hundreds of kilometres in Northern Ontario to get to the next hospital, to either get to an available bed or access certain specialty services like paediatrics, obstetrics or mental health services.

To help patients in Northern Ontario obtain the care they need, the Ministry administers the Northern Health Travel Grant Program. This program was created in 1985 to provide financial assistance to Northern Ontario residents who travel long distances to access care from medical specialists or Ministry-funded health care facilities. Applicants for the grant have to pay their travel costs upfront and then apply to

Figure 1: Map of Ontario with Locations of the 36 Public Hospitals in Northern Ontario

Prepared by the Office of the Auditor General of Ontario



Note: There are two hospitals located in Sudbury (one acute care and one complex continuing care) and two hospitals located in Thunder Bay (one acute care and one complex continuing care). These locations are layered on one another on this map and therefore the 36 hospitals may appear as 34.

receive the financial assistance after completing their travel. The program provides:

- a grant of $0.41 for every kilometre travelled, based on return road distance travel with a minimum one-way travel of 100 kilometres between the patient's area of residence and the location of the nearest medical specialist or Ministry-funded health-care facility that can provide the required OHIP-insured service; and
- an accommodation allowance of $100–$550, dependent on the number of medically necessary lodging nights, per eligible treatment trip to patients whose one-way road distance to the nearest specialist or Ministry-funded health-care facility is at least 200 kilometres.

In August 2022, a bill was introduced in the Legislature to require the Minister of Health to establish an advisory committee to make recommendations for improving access to health services for people in Northern Ontario by means of reasonable, realistic and efficient reimbursement for travel costs. As of September 2023, this bill was still going through parliamentary discussion and consideration.

Virtual care can help improve patients' access to health services in general, but especially in Northern Ontario given the region's large geographic span. Health services provided to patients virtually can include a patient accessing a physician by phone or video, or a physician at a rural hospital accessing help from a specialist at a larger hospital. The Ministry funds virtual-care services to better connect people with health-care providers across the health-care system.

2.3.3 Meeting the Needs of Indigenous and Francophone Populations

With 17% of Northern Ontario's population being Indigenous and 16% being Francophone, hospitals in the region are expected to have programs that consider the culture, practices and linguistic needs of their local community and have staff who are trained to connect with them.

Indigenous Best Practices

A report published by the Truth and Reconciliation Commission of Canada in 2015 included 94 calls to action—covering areas including child welfare, education, justice and health—to redress the legacy of residential schools and advance the process of Canadian reconciliation. Some of the recommendations are relevant to hospital services in Northern Ontario, including:

- recognize the value of Indigenous healing practices and use them in the treatment of Indigenous patients in collaboration with Indigenous healers and elders where requested by Indigenous patients; and
- increase the number of Indigenous professionals working in the health-care field, ensure the retention of Indigenous health-care providers in Indigenous communities, and provide cultural competency training for all health-care professionals.

Multiple reports have cited best practices in health care for Indigenous peoples in Canada, which involve culturally sensitive approaches that respect Indigenous knowledge, values, and traditions. These practices include:

- cultural competency training for hospital staff to better understand the culture, history, and needs of Indigenous communities;
- involvement of Indigenous peoples in the planning, design, and evaluation of health-care services to ensure these encompass their needs;
- using traditional healing practices, as well as Indigenous patient navigators and interpreters, and incorporating Indigenous artwork and signage; and
- increasing the representation of Indigenous peoples in the health-care system by recruiting and retaining Indigenous health-care workers. These workers can better understand the cultural needs of Indigenous patients and can provide a vital connection between health-care providers and patients.

French Language Services

Under the *French Language Services Act* (Act), a hospital can be designated as French-speaking if it meets certain legislative criteria, including 20 specific requirements. By being designated under the Act, hospitals have to demonstrate that they can provide French language services that are available at all times, offered in an equitable fashion and equivalent to the quality of services offered in English.

Eleven or about one-third of the 36 hospitals in Northern Ontario were either fully or partially designated under the Act as of January 2023. A hospital can be partially designated when it provides only certain programs or services in French. To be fully designated, the hospital must offer all of its services in French actively and on a permanent basis. This means making French-language services available from the first point of contact between the user and the hospital, including all verbal communications and visual communications such as signs, notices and social media.

The 20 specific requirements are grouped in the following major topics: governance, direct services to clients, visual identification and communications, accountability, human resources policy and planning, and community support.

2.4 Key Players in Funding, Oversight and Delivery of Hospital Services in Northern Ontario

2.4.1 Ministry of Health

The Ministry of Health leads the provincial policy work for the health system in Ontario. Several branches within the Ministry work with hospitals in the north region, such as the Hospitals Branch, the Capacity and Health Workforce Planning Branch and the Primary Health Care Branch. While all three branches are responsible for developing policies that affect hospital services, the latter two focus on policies relating to health-care staff and travel grants, respectively.

The Ministry also provides funding to all public hospitals in the province through Ontario Health. The Ministry has the following objectives and priorities for health care in Ontario, as outlined in the Minister's December 2022 mandate letter for Ontario Health for 2023/24: providing the right care in the right place; providing better and faster access to treatments and supports; and hiring more health-care workers.

The Ministry and Ontario Health work together under the terms of a memorandum of understanding (MOU) between the two parties, signed in December 2021 with a requirement to be renewed at least once every five years. The MOU outlines the accountability relationship, roles and responsibilities, ethical framework, reporting requirements, audit and review arrangements, staffing, governance and risk management. In addition, the Ministry and Ontario Health have an accountability agreement between them that outlines Ontario Health's performance goals, reporting requirements and spending plan. This agreement is currently in effect for the period of 2021/22 to 2023/24, and must be renewed upon expiry.

2.4.2 Ontario Health

Ontario had 14 Local Health Integration Networks (LHINs), each a not-for-profit Crown agency covering a distinct region of Ontario. As a result of the Minister of Health's transfer orders under the *Connecting Care Act, 2019*, LHINs' functions related to health system funding, planning and community engagement were transferred to Ontario Health effective April 1, 2021. The north region, which comprises both the North West and North East regions, has a Performance Accountability and Funding Allocation team that is responsible for approving funding and monitoring compliance with the terms and performance targets set out in service accountability agreements with hospitals. Ontario Health also monitors funding to hospitals on an ongoing basis to ensure payments are made according to the hospital's approved spending plans, and are within estimates and program allocations.

2.4.3 Hospitals

Hospitals are independent corporations accountable to their own board of directors. As set out under the *Public Hospitals Act*, hospitals are directly responsible for the

quality of care provided to each of their patients. Hospital administrators are responsible for overseeing the delivery of services and implementation of programs, protocols and procedures adopted by the hospital board, within the parameters of provincial legislation.

The majority of a hospital's funding comes from the Ministry through Ontario Health, but the Ministry may also directly fund hospitals for time-sensitive, specific programs such as expense reimbursements related to the COVID-19 pandemic and capital projects. Hospitals may further raise their own funds through, for example, their foundations, revenues from parking, and allocating space to non-hospital services such as food vendors.

Each hospital signed a Hospital Service Accountability Agreement (HSAA) with Ontario Health. This agreement, standardized for all public hospitals in the entire province, outlines the accountabilities, performance expectations and roles of each party, as well as the requirement to maintain a balanced budget. The agreement also sets out key obligations of the hospital, including meeting all performance standards and reporting requested financial and performance information to Ontario Health.

2.5 Funding and Financial Information

Provincial funding for hospital services is governed under the authority of the *Public Hospitals Act*. It constitutes about 87% of total hospital revenue. The remaining 13% of hospital revenue comes from a variety of sources, such as municipal and federal grants, private insurance, patient self-pay, and fundraising. All revenues are to be used for day-to-day operations—including overhead costs for staffing, supplies and services—and capital initiatives.

In 2022/23, the 36 northern hospitals received total operations funding of about $1.9 billion, equivalent to an 8% share of operations funding for hospitals across the entire province; a similar share was noted in 2020/21 and 2021/22.

Communities play an important role in the success of a hospital in rural areas. Public hospitals often rely on donations, especially from the local community, for capital projects or equipment. Northern hospitals often face difficulties in raising large donations that may be more common for hospitals in the south. According to Ontario Health, the single largest donation to a hospital in Northern Ontario was $10 million in 2022 to Health Sciences North, the largest northern hospital, located in Sudbury. In comparison, a donation of $105 million was made in 2022 to build a new hospital and redevelop an existing one in the Greater Toronto Area.

2.6 Hospital Partnerships with Other Health-Care Providers

In 2019, the Ontario government announced the creation of Ontario Health Teams (OHT). Each OHT is envisioned to include a local hospital, a few long-term care facilities, some home-care agencies and, in some cases, community health clinics or family doctors all linked together in one grouping or team. At maturity, the Ministry expects that OHTs will be responsible for the health outcomes of a population within a geographic area; each will receive its own funding from the government and be subject to a standard set of indicators that will measure their performance in providing integrated care and improving patient outcomes. As of July 2023, the Ministry had approved the operation of 57 OHTs, including 10 in Northern Ontario. As shown in **Appendix 3**, of the 10 Northern Ontario OHTs in place, three were created in 2022 and three were created in 2023 during our audit. These 10 OHTs encompass 32 of the 36 Northern Ontario hospitals.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry) and Ontario Health have effective processes in place to:

- oversee that the delivery of hospital services in Northern Ontario is timely and meets patient needs; and

- measure and publicly report the results and effectiveness of their programs or initiatives, and take corrective actions when necessary.

In addition, our audit assessed whether selected public hospitals in Northern Ontario have effective processes in place to:

- provide hospital services in a timely and cost-efficient manner that meets patient needs and in accordance with applicable legislation and guidelines; and
- use and manage resources with due regard for economy.

In planning for our work, we identified the audit criteria (see **Appendix 4**) we would use to address our audit objectives. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management from the Ministry and Ontario Health reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between January 2023 and September 2023. We obtained written representation from Ministry and Ontario Health management that, effective November 20, 2023, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

Our audit work was conducted at the Ministry, Ontario Health and selected hospitals in Ontario's north region.

At the Ministry, we conducted the majority of our audit work at the following branches: the Hospitals Branch; the Capacity and Health Workforce Planning Branch; the Primary Health Care Branch; the Ontario Health Teams Policy and Operations Branch; the Indigenous, French Language and Priority Populations Branch; and the Health Data Branch. At these branches, we:

- interviewed representatives who are responsible for program areas pertinent to northern hospitals;
- reviewed applicable legislation and regulations as well as documents consisting mainly of briefing notes, information packages for senior management, and information on various programs; and
- obtained relevant data such as those on the Northern Health Travel Grant Program for patients, incentive programs specific to Northern Ontario to recruit and retain physicians and nurses, shortage of health-care professionals, use of agency nurses, and locations of nursing stations.

At Ontario Health, we:

- reviewed documents consisting mainly of financial information, annual business and operational plans, annual reports, agreements, emails and meeting notes;
- interviewed management and staff responsible for program areas including health-care planning, hospital performance monitoring and data collection, health equity and priority populations, the health-care workforce, and use of virtual care;
- obtained and examined data from systems including the Wait Time Information System, the Self Reporting Initiatives, the National Ambulatory Care Reporting System and the Discharge Abstract Database in order to conduct analyses on hospital performance;
- obtained and examined data from the S9 Dashboard for analysis of physician and nurse shortages; and
- obtained and examined data from the Health Force Ontario Unit on locum physicians.

We visited and completed detailed audit work at three hospitals—Health Sciences North in Sudbury, Hornepayne Community Hospital in Hornepayne, and Sioux Lookout Meno Ya Win Health Centre in Sioux Lookout. At these hospitals, we:

- observed hospital operations;
- interviewed hospital administrators and program staff responsible for recruiting and retaining staff, developing hospital strategy, measuring and reporting performance, monitoring patient flow, managing patient and family complaints, integrating hospital services with other service providers, improving

health equity, using virtual care and paying staff compensation;
- interviewed the Board Chair;
- examined documents related to health-care planning, accreditation and quality improvement, patient flow, health equity training, culturally appropriate health services, French language service designation, capital project approval, and Board of Director meetings; and
- obtained and analyzed data related to alternate-level-of-care patients, wait times and patient complaints.

We also visited four other hospitals: Anson General Hospital in Iroquois Falls and Lady Minto Hospital in Cochrane (both part of MICs Group of Health Services); Services de santé de Chapleau Health Services in Chapleau; and West Parry Sound Health Centre in Parry Sound. At these hospitals, we met with hospital administrators and staff and toured the hospitals to understand local best practices and any unique challenges.

Furthermore, we administered a questionnaire to all 36 hospitals in Northern Ontario to obtain data and information on the areas we examined in this audit; 34 or 94% of them responded.

Every few years, hospitals in Ontario participate in a voluntary accreditation process to assess performance against best practices on patient safety and quality of care, infection prevention and control, medication management, organizational culture and effective governance. For the seven hospitals we visited in this audit, the most recent accreditations were completed between 2018 and 2023. We considered the results of these accreditation reports in our audit work, but otherwise did not examine the same areas that were examined by the accreditation body in our audit.

To obtain stakeholder perspectives on hospital operations in Northern Ontario, we met with representatives from Home and Community Care Support Services, the Northern Ontario School of Medicine University, the Ontario Medical Association, Ornge, and the Registered Nurses' Association of Ontario.

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies Canadian Standards on Quality Management and, as a result, maintains a comprehensive system of quality management that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

4.0 Detailed Audit Observations

4.1 Health-Care Strategy for Northern Ontario

4.1.1 No Dedicated Health-Care Strategy for Northern Ontario

The Ministry of Health (Ministry) did not have a dedicated health-care strategy for Northern Ontario that addresses the region's unique health-care needs, including challenges related to geography, the health-care workforce, Indigenous health and other health inequities. In 2009, the Ministry of Health and Long-Term Care had established the Rural and Northern Health Care Panel to define a vision, guiding principles, strategic directions and guidelines to assist the Ministry and the Local Health Integration Networks (since consolidated into Ontario Health) in addressing access to care for rural, remote and northern communities. As a result of this panel's work, in 2010, the Ministry issued an 85-page report titled Rural and Northern Health Care Framework/Plan—Stage 1 Report, which included a reference to two additional stages following

this first stage, to be concluded with the issuance of a final framework for the province.

The report also included the panel's 12 recommendations, as shown in **Appendix 5**, to support the Ministry in developing strategies for rural and northern health care. These recommendations included establishing a process to identify strategies to improve access to health-care services for First Nations communities, continuing to explore innovative ways of attracting health professionals to Northern Ontario, and creating a culture of collaboration and co-ordination among health-care providers in Northern Ontario.

We found that the Ministry never developed a final framework. We noted that Ministry staff last referred to the Stage 1 framework in their work in 2014 and, when we inquired about its status during our audit, they informed us that each government establishes its own strategy. The Ministry told us that, after consulting with the community and making investments to address the panel's recommendations, such as establishing family health teams in rural and northern communities and expanding the Ontario Telemedicine Network, it had determined that a formal framework was not required.

The Ministry told us that it has initiatives and programs specific to the north, some of which are discussed in this report, but it does not have a single document containing a comprehensive health-care strategy for the north region. For example, the Ministry has developed programs to recruit and retain health-care staff in Northern Ontario, such as the Northern and Rural Recruitment and Retention Initiative, the Northern Specialist Locum Programs, the Tuition Support Programs for Nurses and Nursing Community Assessment Visits.

According to the current memorandum of understanding between the Ministry and Ontario Health established in December 2021, the agency's mandate includes "to manage health service needs across Ontario consistent with the Ministry's health system strategies." Having a dedicated health-care strategy for the north is important to guide Ontario Health's focus on the specific areas that would address the unique health-care needs of residents in Northern Ontario.

4.1.2 Province's 2023 Health-Care Strategy Does Not Address All the Unique Challenges of Northern Ontario

The Ministry released Your Health: A Plan for Connected and Convenient Care for the entire province in February 2023. This plan covers three major areas: supporting the right care in the right place, providing faster access to care, and hiring more health-care workers. Apart from enhancing some capacity in northern and rural areas by adding 150 more education seats for nurse practitioners starting in 2023/24, this plan did not provide any specific strategies for addressing the longstanding health inequities identified in Northern Ontario, as mentioned in **Section 2.1.** As well, we confirmed with multiple Ministry branches that they, too, did not have any dedicated strategy targeting the unique challenges facing Northern Ontario hospitals or the north region overall.

The provincial health-care plan was released during our audit and was still being implemented when we completed our work; the Ministry informed us it was developing a mechanism for tracking and monitoring the plan's progress.

This one-size-fits-all approach misses an opportunity to identify all the elements that are needed to provide the best health-care possible in Northern Ontario, and work more effectively to address them. Our discussions with staff from Ontario Health and hospitals identified that non-health-related matters can also influence the quality of hospital services for patients. These include affordable housing, public transportation, child care, Indigenous cultural services and economic development. For example, the scarcity of child care and housing deters many health-care professionals from working in the north region; public transportation and related infrastructure issues can affect physical access to hospitals for both patients and health-care staff; and a lack of culturally safe care contributes to language and communication barriers and mistrust in the health-care system, discouraging some patients from using the health-care services they are entitled to. Also, overall economic development has a broad impact on education, income, employment levels, and access to healthier food options. With a

strategy that also focuses on addressing these unique regional factors, the government could better co-ordinate with other ministries, levels of government and delivery partners to improve the capacity and quality of health care in the region. Multiple stakeholder groups that we engaged with all agreed that there is a need for a dedicated health-care strategy for Northern Ontario. For example:

- Ornge, a Ministry-funded organization that provides air ambulance services across Ontario, indicated that a dedicated strategy for Northern Ontario would help address its specific challenges in the region, including a lack of detailed weather reports and the poor state of runways in some airports with limited de-icing during the winter.
- The Ontario Medical Association reinforced that a dedicated strategy for the north and rural areas is needed, and that a government body needs to be identified to be responsible for monitoring that the strategy is being implemented effectively and that it is leading to improvements in the health outcomes of residents in the north. This is in line with a recommendation in the Ministry's 2010 Rural and Northern Health Care Framework/Plan to create a single point of focus within the Ministry for rural, remote and northern health to increase accountability and make it easier to define and monitor standards for improving access to health care.

Having a dedicated strategy can also help set goals to support timely and accessible health care in Northern Ontario, and allow the government to monitor progress toward these goals. For example, one goal in a dedicated strategy can be to enhance Internet access in rural areas to increase the use of virtual technologies for patient care. Northern Ontario's large landmass limits patient access to services, and virtual care can play a large part to help with this. Providing virtual care is contingent on having reliable, high-speed Internet. A May 2023 report by an organization funded by the Federal Economic Development Agency for Northern Ontario noted that several major areas in Northern Ontario still did not have access to high-speed Internet. In November 2023, the government announced that it will be investing about $11 million to bring improved Internet access to several towns and First Nation communities across Northern Ontario by the end of 2025.

In 2015, the Registered Nurses' Association of Ontario published its Coming Together, Moving Forward: Building the Next Chapter of Ontario's Rural, Remote & Northern Nursing Workforce Report, which proposed 23 recommendations including to:

- "consider the context of rural, remote and northern health-care delivery through meaningful engagement of relevant stakeholders and conducting an impact analysis, when developing new provincial initiatives; and
- invest in ongoing infrastructure renewal and growth in rural and remote communities (i.e., telecommunications, hydro, transportation, housing, etc.)."

Also, before being absorbed into Ontario Health in 2019, Health Quality Ontario (a government agency with a mandate to advise on health-care quality) developed the Northern Ontario Health Equity Strategy in 2018. This strategy included a main recommendation to establish a Northern Network for Health Equity that would support efforts across different sectors to improve health equity for people living in Northern Ontario. According to the World Health Organization, health equity is achieved when everyone, regardless of their social, economic, demographic or geographic differences, can attain their full potential for health and wellbeing. Ontario Health has since implemented some initiatives that align with this strategy's objectives; for example, it has established an internal regional Equity, Inclusion, Diversity and Anti-Racism Committee, and supported hospitals becoming part of Ontario Health Teams to deliver co-ordinated health care that is more connected to patients' local communities. However, five years after it was first developed, the Northern Network for Health Equity had not been established because, according to Ontario Health, the Ministry did not approve its funding request.

We found that jurisdictions in the United States and Australia, and British Columbia in Canada have developed dedicated strategies and initiatives

that address the distinct health determinants in rural regions, much like those in the north, to help improve health-care delivery in these regions. Health determinants are factors such as income, physical environments and social supports that influence population health. We describe these strategies in greater detail in **Appendix 6**.

RECOMMENDATION 1

To better meet the unique health-care needs of Northern Ontario residents, we recommend that the Ministry of Health:

- work with Ontario Health, relevant ministries and stakeholder groups to develop and implement a dedicated health-care strategy for Northern Ontario, considering similar strategies from other jurisdictions as well as factors that may influence the delivery of health care, such as child care and housing;
- review recommendations from the Rural and Northern Health Care Framework/Plan, Northern Ontario Health Equity Strategy, and applicable associations and organizations such as the Registered Nurses' Association of Ontario, Ontario Medical Association and Ornge, and consider them in the dedicated strategy where appropriate;
- develop and monitor performance indicators that measure the goals and outcomes of this dedicated strategy;
- publicly report on the status of implementation of this dedicated strategy annually to show if it is leading to improvements in the health outcomes of residents in the north; and
- establish a schedule to regularly review and update this dedicated strategy.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges this recommendation. The Ministry and Ontario Health will continue to prioritize the health-care needs for residents in Northern Ontario by building on and improving existing programs and initiatives and working toward the goal of providing the right care in the right place, faster access to care and hiring more health-care workers.

The Ministry will review this recommendation and conduct further analysis to determine the feasibility of a dedicated strategy. If this is deemed feasible, the Ministry will determine next steps that may include considering recommendations from other associations and organizations, developing and monitoring performance indicators, reporting on the status of implementation, and establishing a schedule to review and update the dedicated strategy.

4.2 Physician and Nurse Shortages in Northern Ontario

4.2.1 Ministry Did Not Have a Health-Care Staffing Strategy for the North

The Ministry told us that addressing health-care staffing challenges in Northern Ontario is a priority, but it did not have a plan to address these issues for the north region when we completed our audit.

As discussed in **Section 2.3.1**, the Ontario government has multiple programs in place to attract and retain health-care professionals. While there are some programs designed to help the north region, most programs are for the entire province. For example, the Ontario Learn and Stay Grant, offered by the Ministry of Colleges and Universities, reimburses students for tuition, books and compulsory fees for studying nursing, medical laboratory technology and paramedics in priority communities of Ontario. However, this program's list of priority communities includes cities such as Ottawa, Windsor and London, which are larger and typically attract more students than rural towns in the north. The Ministry stated that in 2022, of the 11,452 nurses who initially registered and reported being employed in Ontario, only 6.2% reported at least one nurse employment position in the North East or North West region.

As discussed in **Section 4.1.2**, Ontario has a health-care plan that covers health-care staffing; however,

the initiatives discussed are for the entire province with limited focus on the north region. In comparison, in September 2022, British Columbia and Saskatchewan each published provincial health-care staffing strategies that included specific planned actions for rural and remote areas. We describe these strategies in **Appendix 7**.

Having a health-care staffing strategy that recognizes the unique challenges in Northern Ontario would help address specific situations that effectively discourage recruitment in northern hospitals. For example, in one hospital we visited, management told us that it has a constant fear of losing Indigenous staff to a nearby federally funded health organization that can provide higher wages and tax exemptions to its Indigenous staff. Management told us it has been seeking a tax exemption from the Canada Revenue Agency for its Indigenous employees since 2011, so the hospital can better compete with other employers in the region to attract and retain talent. However, this was still not resolved at the time of our audit.

RECOMMENDATION 2

To better address health-care staffing challenges in Northern Ontario hospitals, we recommend that the Ministry of Health:

- work with Ontario Health to further implement a health-care staffing strategy with specific actions to address the unique characteristics of health care in Northern Ontario; and
- collaborate with the federal government to explore options to better address the particular staffing challenges of Northern Ontario hospitals—for example, by seeking an exemption on income tax applicable to hospitals' Indigenous employees.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges this recommendation. The Ministry is working to improve health-care staffing in Northern Ontario as part of a broader health human resources strategy driven by Your Health: A Plan for Connected and Convenient Care. To date, this has included the deployment of a number of programs to support recruitment and retention in Northern Ontario in 2023/24 and beyond, including the Clinical Scholar Program, the Enhanced Extern Program, the Supervised Practice Experience Partnership, and the Community Commitment Program for Nurses.

The Ministry is working at present to evolve this plan to include the following elements moving forward:

- evaluating and calibrating existing recruitment and retention programs specifically for use in the north; and
- developing enduring solutions to support longer-term recruitment and retention of the health workforce in north.

Further the Ministry recognizes the need to work with sector and intergovernmental partners, including the federal government, to evolve and implement a successful health human resources strategy for Northern Ontario.

4.2.2 Staff Shortages Have Led to Ongoing Closures of Hospital Services in Northern Ontario

As discussed in **Section 2.3.1**, northern hospitals have consistently faced difficulties in recruiting and retaining health-care professionals. This shortage has resulted in hospitals having to either close certain departments or reduce operating hours for some services.

Prior to 2018, of the 36 northern hospitals, 19 had the resources to provide obstetrics services. In the summer of 2022, the Ministry asked Ontario Health to track obstetrics service closures in the province because it was a growing concern at the time. Ontario Health stated during our audit that it stopped reporting this information in March 2023 so that it could first establish a process to track all potential and actual closures, and flag any serious risks and concerns to the Ministry. In August 2023, Ontario Health implemented a process to centrally track closures in northern hospitals'

Figure 2: Closure of Obstetrics Departments at Northern Ontario Hospitals, July 4, 2022, to September 3, 2023

Source of data: Ontario Health

Hospital	Location	Type of Staff Shortage That Led to Closure	# of Times Closed	Total # of Days Closed[1]	Average # of Days[1] of Each Closure
Lady Dunn Health Centre	Wawa	Physician	1	**1,777.0**[2,3]	n/a
Weeneebayko Area Health Authority	Moose Factory	Physician	1	**1,707.0**[2,3]	n/a
Red Lake Margaret Cochenour Memorial Hospital	Red Lake	Physician	1	**427.0**[2]	n/a
West Parry Sound Health Centre	Parry Sound	Nursing and Physician	12	**179.5**[3]	15.0
St. Joseph's General Hospital	Elliot Lake	Nursing and Physician	83	**118.0**	1.5
Notre-Dame Hospital	Hearst	Physician	5	**119.0**[2]	n/a
North of Superior Healthcare Group (Wilson Memorial Hospital)	Terrace Bay	Nursing	1	**96.0**	96.0
Sault Area Hospital	Sault Ste. Marie	Physician	1	**3.0**	3.0
Sensenbrenner Hospital	Kapuskasing	Nursing and Physician	5	**2.0**	0.5
Temiskaming Hospital	New Liskeard	Physician	1	**0.5**	0.5

1. Calculated from hours.
2. Calculated as of September 3, 2023; department remained closed as of the end of September 2023.
3. Includes days closed prior to July 4, 2022, as the data that Ontario Health collected included retroactive information on closures.

obstetrics services. By the end of September 2023, 15 northern hospitals were providing obstetrics services.

Ontario Health also tracks emergency department closures across the province, which are described in our 2023 value-for-money audit of Emergency Departments. Ontario Health does not centrally track other department closures in hospitals in Northern Ontario, indicating this work is mostly done separately by regional teams within the agency.

As shown in **Figure 2**, Ontario Health's information showed that between July 4, 2022, and September 3, 2023, 10 of the 19 northern hospitals had reported closures in their obstetrics services lasting anywhere from half a day to this entire period. The agency told us that these hospitals closed their obstetrics services because of a shortage of nurses or physicians, or both. Patients who live near these hospitals would need to travel to other locations, often at significant distances, to obtain the needed non-emergency services. For example, the obstetrics services at Lady Dunn Health Centre in Wawa, Weeneebayko Area Health Authority in Moose Factory and Red Lake Margaret Cochenour Memorial Hospital in Red Lake remained closed as of the end of September 2023, with the first closed for about five years as of September 2023. Patients in Wawa would need to travel to the nearest hospital with obstetrics services—to Sault Ste. Marie, about two and a half hours by car. Patients in Moose Factory would need to travel to Timmins, a one-hour flight scheduled generally only during weekdays, or to Kapuskasing, which takes several hours of travel by airplane and car. Patients in Red Lake would need to travel to Dryden, which is about two and a half hours away by car. We asked Ontario Health whether there were plans to reopen the services at these hospitals. Ontario Health contacted the hospitals and told us that there was interest in restarting the service at Lady Dunn Health Centre, but there was no expected timeline due to a lack of physicians; Weeneebayko Area Health Authority expressed a desire to restart this service, but had not made any funding requests; and Red Lake Margaret Cochenour Memorial Hospital's Medical Advisory Committee decided that resuming the service would not be considered until at least spring 2024 because of a lack of physicians.

RECOMMENDATION 3

To help hospitals provide more accessible care to patients in Northern Ontario, we recommend that Ontario Health develop a process to centrally compile data on significant hospital service reductions, including reasons for the service reductions; and support hospitals with mitigating any service reductions or their impact on patients.

ONTARIO HEALTH RESPONSE

Ontario Health accepts the recommendation. Ontario Health is committed to connecting, co-ordinating, and modernizing our province's health-care system to ensure all people of Ontario have equitable access to high-quality health care, when and where they need it. Ontario Health supports the ongoing need to ensure service reductions and patient impacts are minimized due to health human resource shortages. Ontario Health will continue to strengthen its internal processes to regularly identify and compile data on all significant hospital service reductions, and work with hospitals to find solutions to mitigate service reductions and the impact to patients.

4.2.3 Lack of Reliable Data on Staffing Supply and Demand

Issues with Ministry's and Ontario Health's Collection of Hospital Staffing Data Limit Its Usefulness, and Information Gaps Persist

Both the Ministry and Ontario Health collect data on health-care staff shortages across Ontario, including Northern Ontario. However, we found that the data collected is incomplete and that neither party centrally oversees or fully reviews the data, therefore missing an opportunity to use the data effectively to assess and respond to staff shortages.

Hospitals report staffing data to the Ministry and Ontario Health mainly via three datasets, but we found some issues with the data collection that limit its usefulness. In **Appendix 8**, we describe these three datasets and the deficiencies we found in each. First, because reporting is not mandatory, not all hospitals report the requested data regularly, so the datasets are incomplete and therefore not fully reliable. Second, having three separate channels to collect similar data, such as the number of physician and nurse vacancies, puts an unnecessary administrative burden on hospitals and can discourage data submission. Having a single, mandatory platform for hospitals to submit their data would make it easier for more complete information to be collected, and help improve the reliability of the data. Third, we found discrepancies in the data reported through the different tools. For example, the Northern Ontario Physician Data Collection Tool reported the number of family physician vacancies in the North West and North East as 71 and 118, respectively, for November 2022; this was significantly different from 4 and 37, respectively, as reported by the S9 Census for the same period.

With incomplete and unreliable data to inform its decisions, the Ministry and Ontario Health cannot effectively respond to changing conditions by making impactful, evidence-based changes to improve the province's recruitment and retention programs for physicians and nurses in Northern Ontario.

Ministry's Tools for Forecasting Staffing Needs Not Useful on a Regional Basis, and Did Not Inform Retention and Recruitment Programs for Northern Ontario

The Ministry uses two modelling tools to forecast supply and demand for physicians in the province and one modelling tool to do the same for nurses. However, we found that it has not used this forecast information to help design and improve its programs aimed at attracting and retaining physicians and nurses in Northern Ontario. Also, the Ministry does not regularly report information generated by these tools.

The Ministry has been using the following modelling tools:

- The Assessing Doctor Inventories and Net-Flows Supply Model can project physician supply for up to a period of 19 years by tracking physicians

from post-graduate training, through their practising years, and to retirement, as well as by age, sex and specialty.

- The Utilization Model estimates the number of physicians required in the province based on a future utilization forecast, which is determined by applying the population's rate of visits by physician specialty, according to Ontario Health Insurance Plan claims, to population projections.
- The Ontario Nursing Simulation Model estimates the supply and demand for registered nurses and registered practical nurses.

We found the following concerns with the Ministry's use of these tools:

- The Ministry uses these tools on an ad hoc basis and has no schedule that defines how often it will generate current information for the nursing model or report this information to internal and any external stakeholders. By regularly using these tools to inform program improvement, the Ministry can keep its programs up to date based on current conditions.
- The Ministry's modelling tools for physicians and nurses do not allow for regional-level analysis or identify the needs of patients in a particular area. Yet, as shown in **Section 2.3.1**, Northern Ontario's health-care challenges are different from other regions. The Ministry informed us that it has historically preferred to rely on provincial-level modelling to identify professions or physician specialties with issues that require a more thorough analysis.
- The Ministry's modelling tools are not designed consistently to consider patients' gender, age and health conditions. We noted that the Ontario Medical Association is currently working on developing a model called the Physician Resources Integrated Model, which would use population health needs and workforce capacity along with artificial intelligence to predict future health-care needs, such as how many family physicians and specialists will be required to meet patient needs in a specific geographic area.
- The two physician modelling tools were last updated in 2021, and the nurse modelling tool was last updated in 2017. These updates included more recent data to improve future projections. The Ministry explained that it has not recently updated these tools because of resources being diverted to respond to the COVID-19 pandemic. It stated that it aims to update these tools every two years.
- As of November 2022, using these tools, the Ministry forecast that the demand for physicians will be 38,295 by 2030, which outpaces the supply of 37,703 by 592 physicians. We found no evidence that either the Ministry or Ontario Health has used this analysis to improve any of the health-care staffing programs for Northern Ontario.

RECOMMENDATION 4

To better plan for health-care staffing, we recommend that the Ministry of Health and Ontario Health:

- identify health-care staff shortage information being collected via different datasets and eliminate duplication, and work toward creating a single mandatory platform accessible to both organizations;
- update all modelling tools every two years, considering input from external stakeholders, such as the Ontario Medical Association, that may have other data elements not included in the Ministry's modelling tools;
- develop and implement a process to forecast health-care staffing needs at a regional level for the six health regions on a regular basis; and
- establish a schedule to periodically forecast the future supply and demand for physicians and nurses, follow the schedule to create forecasts and share them with relevant Ministry and Ontario Health program areas, particularly those that administer health-care staff recruitment and retention initiatives.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges this recommendation.

The Ministry acknowledges the need to avoid the duplication of any data collected from health system employers and staff. The Ministry will work with Ontario Health to identify further opportunities for data integration in support of health workforce planning in the north.

The Ministry continues to work with a number of sector partners to enhance data and evidence in support of health workforce planning for Northern Ontario and the province as a whole. This includes collecting data in relation to physician workforce planning through the Ontario Physician Reporting Centre, a collaborative project of four organizations: the Ministry of Health, the College of Physicians and Surgeons of Ontario, the Council of Ontario Faculties of Medicine and the Ontario Medical Association.

The Ministry will work with system partners including Ontario Health to improve our health workforce modelling tools and examine new methods to incorporate data on a regional level, while avoiding the duplication of any data collected from health system employers and staff.

ONTARIO HEALTH RESPONSE

Ontario Health accepts this recommendation. Ontario Health recognizes the importance of accurate, up-to-date information being available so that hospitals and system partners can make decisions that collectively support the recruitment and retention of health human resources across Ontario. Ontario Health will work with the Ministry of Health to develop a health human resources data plan for the province.

4.2.4 Incentive Program to Attract Nurses to Work in Rural Areas Was Never Evaluated and No Performance Goals Were Established

We found that hospitals in Northern Ontario experienced a higher percentage of vacancies for nurses than hospitals in other parts of the province. As shown in **Figure 3**, in July 2023, 11 northern hospitals reported to Ontario Health that vacancy rates were about 14% for registered nurses and 18.5% for registered practical nurses, while hospitals in other regions had vacancy rates of 13.5% and 12%, respectively. However, not all Northern Ontario hospitals regularly submit vacancy rate information because Ontario Health did not make it mandatory. All 34 Northern Ontario hospitals that responded to our questionnaire stated that they faced a shortage of nurses.

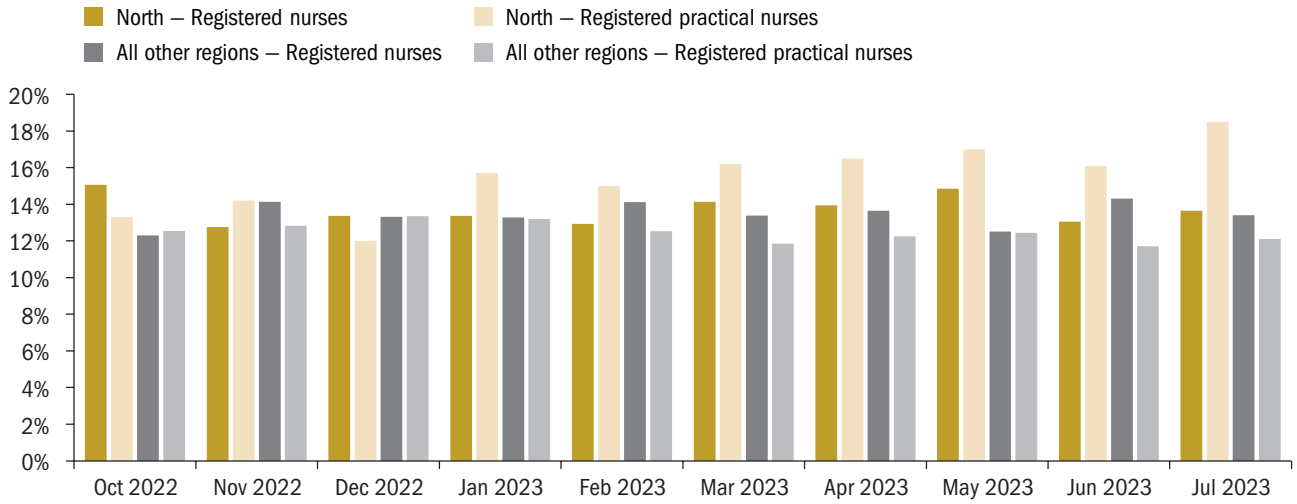
Multiple reports have highlighted a shortage of nurses in Ontario. Management at most Northern Ontario hospitals that we visited told us that they have a dire need for nurses. They also told us that the best way to recruit and retain nurses is to recruit them early in their career. To that end, the Ministry and Ontario Health separately administer nursing incentive programs directed at attracting early-career nurses. However, the only program that focuses on rural areas, which are more common in Northern Ontario, is the Tuition Support Program for Nurses.

The Ministry established this program in 2006/07 to offer tuition reimbursement to recent nursing graduates who choose to work in an eligible underserviced community. Over the last 10 years between 2013/14 and 2022/23, 51% of the program recipients started their nursing careers in a northern community. While more program recipients chose to begin their nursing careers in the north than in the south in five of the last 10 years, the number of program recipients who chose to begin their nursing careers in the north has dropped from 78 in 2020/21 to 35 in 2022/23, as shown in **Figure 4**.

We found that the Ministry has never evaluated the program since its inception about 16 years ago. The Ministry also has not established a target or measured

Figure 3: Vacancy Rates for Nurses at Hospitals in Northern Ontario and Other Regions, October 2022–July 2023

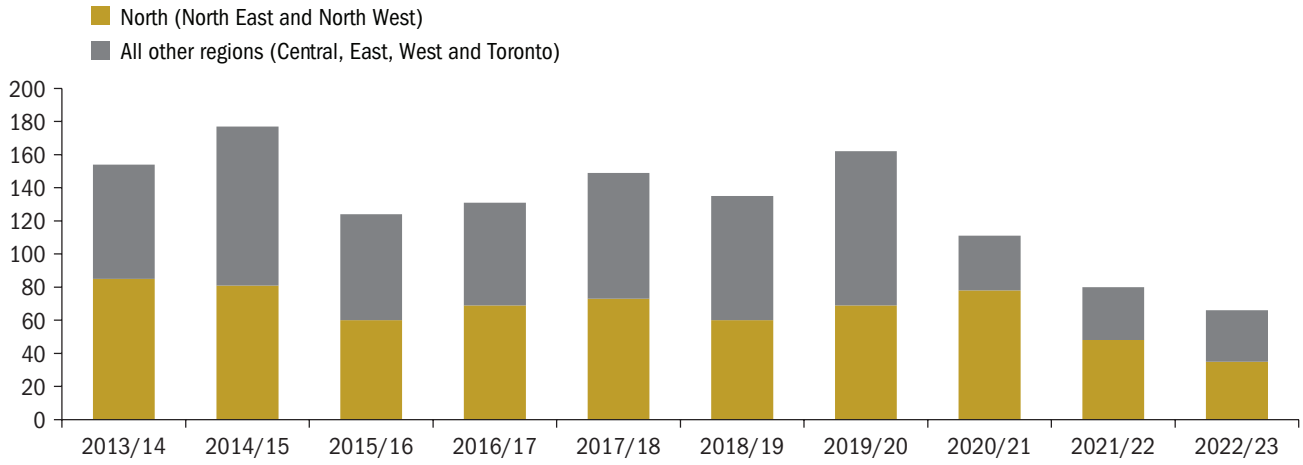
Source of data: Ministry of Health and Ontario Health



Note: October 2022 was the first month that this data was used by Ontario Health. Not all hospitals regularly submit this data.

Figure 4: Number of New Recipients of the Tuition Support Program for Nurses in Northern Ontario and Other Regions, 2013/14–2022/23

Source of data: Ontario Health



how many program recipients remain in Northern Ontario after participating in the program, or tracked whether the nurses originated from Northern or southern Ontario before beginning the program. As such, the Ministry cannot measure whether this program has been successful in building a sustainable workforce of nurses in Northern Ontario.

4.2.5 Northern Hospitals Increased Agency Nurses Hours While Paying Them About Three Times the Amount of Full-Time Staff

Agency nurses are nurses that are contracted through private agencies. The use of nurse agencies is not new in Ontario—agencies have been providing temporary staff to hospitals for many years to cover

vacancies. However, the COVID-19 pandemic has increased the reliance on these agencies, as much of the permanent nursing workforce was reportedly experiencing burnout.

Although the Ministry collects information on hospitals' expenditures on agency staff, the data does not differentiate between expenditures on registered nurses, registered practical nurses and personal support workers, and therefore the Ministry does not know the amount spent just on nursing staff. According to Ontario Health records, which are based on the Ministry's data, northern hospitals spent about $88 million in 2022/23 on health-care staff contracted through nursing agencies.

Of the 34 Northern Ontario hospitals that responded to our questionnaire, 29 of them informed us that they had used agency nurses in 2022/23 and, by their own accounts, spent a total of about $78 million on them.

As shown in **Figure 5**, between 2018/19 and 2022/23, the use of agency nurses in Northern Ontario hospitals increased 25 times, from just over 15,000 hours in 2018/19 to about 391,000 hours in 2022/23, compared to about two and a half times for the rest of the province, from about 540,000 hours to 1.34 million hours for the same period.

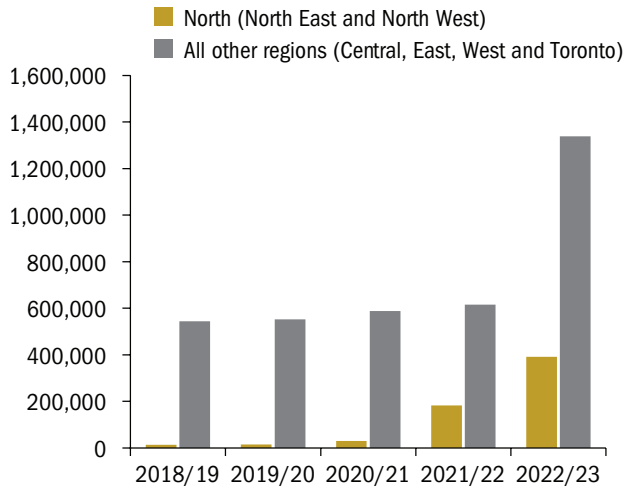
Hospitals in rural areas often have to pay travel and accommodation expenses for some agency nurses compared to hospitals in urban areas, where many agency nurses may already live. We found that, on average, among the northern hospitals we visited during this audit, nurse agencies charged about three times the hourly rate of a full-time nurse employed at a hospital, along with accommodation and travel costs. To illustrate:

- At one hospital we visited, agencies charged the hospital an hourly rate of $83.75–$160 in 2022/23 for a registered nurse, significantly higher than the established wages of $35.50–$42 an hour for that hospital's full-time, unionized registered nurses with up to five years of experience.
- At another hospital we visited, agencies charged the hospital an hourly rate of $120–$155 per hour in 2022/23 as opposed to the unionized wages mentioned above. This hospital also sometimes incurred additional compensation costs because it had to first offer shifts to its fulfill, unionized nurses and pay them overtime wages, but also had to use agency staff to fulfill minimum hours as stipulated in the agency contracts. This arrangement at times can result in more agency nurses than needed working shifts. In addition, this hospital is also responsible for covering the agency nurses' union dues.
- At another hospital we visited, the agency that provides nurses could charge even higher rates for shifts that were booked with less than 12 hours of notice.

At the time of our questionnaire, 30 hospitals had agreements in place with agency nurses; 25 of them had negotiated rates of $101–$150 per hour for a registered nurse, and 27 hospitals had negotiated rates of $76–$125 for a registered practical nurse.

Figure 5: Number of Hours Worked by Agency Nurses in Hospitals in Northern Ontario and Other Regions, 2018/19–2022/23

Source of data: Ministry of Health



In addition, hospitals that hire agency nurses would need to onboard and train them so they can perform the same duties in the same manner as the hospital's own nurses. Our questionnaire results showed that the 30 Northern Ontario hospitals that used agency nurses spent between one shift and four weeks to onboard agency nurses, with many taking about two weeks.

Management at the hospitals in Northern Ontario that we visited informed us that they face unique challenges when using agency nurses. For example:

- Smaller hospitals, which are common in Northern Ontario, typically require nurses to work in multiple departments. In comparison, larger hospitals typically have nurses who only work for a specific department. This workload and other factors have contributed to higher turnover rates among agency nurses.
- Staff from one hospital indicated that they felt they were becoming a travel agent because of the time they spent co-ordinating logistics for agency nurses, including arranging for their housing and transportation, since this is the hospital's responsibility.
- Due to high monthly rents and lack of housing in the community, one hospital we visited purchased its own housing for its agency nurses. However, this also came with additional responsibilities, such as paying for property taxes, Internet, furniture, lawn care and snow blowing, which take away resources from the hospital.

Despite these increased costs, northern hospitals may find it challenging to avoid using agency nurses. Management at one hospital we visited told us the number of agency nurse hours went from 2,000 hours in 2018/19 to over 98,000 in 2022/23 because of a mass exodus of nurses during the COVID-19 pandemic and after the passing of Bill 124, which limited nurses' annual salary increases. Some of these agency nurses had been working at the hospital for over a year. Management at another hospital we visited told us that it had avoided using agency nurses by bringing in more non-nursing support, such as personal support workers, which are staff trained to provide non-medical care such as changing bed linens, and helping patients to the bathroom, brushing their teeth and hair, and helping them be comfortable in bed. However, in October 2023, the hospital started hiring agency nurses to meet its staffing needs.

Of the 30 hospitals that used agency nurses and responded to our questionnaire, 18 stated that they had experienced patient care issues from using agency nurses. In addition, hospitals informed Ontario Health about instances where agency nurses lacked training, resulting in trust issues and extra supervision by physicians. Our 2023 value-for-money audit titled Long-Term Care Homes: Delivery of Resident-Centred Care found concerns regarding continuity of care from agency nurses.

RECOMMENDATION 5

To help increase the availability of nurses in hospitals in Northern Ontario, we recommend that the Ministry of Health:

- establish performance indicators and targets that measure the success of the Tuition Support Program for Nurses, and collect this data at least annually;
- evaluate the Tuition Support Program for Nurses at least once every five years and update the program as needed;
- assess the feasibility of creating a northern-specific program for nurses to help increase the supply of nurses in Northern Ontario; and
- regularly collect hospital spending data on agency health-care staff by type of staff and share it with Ontario Health.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges this recommendation. The Ministry is working to improve health-care staffing in Northern Ontario as part of a broader health human resources strategy driven by Your Health: A Plan for Connected and Convenient Care. To date, this has included the deployment of a number of programs to support recruitment and retention in Northern Ontario in 2023/24 and beyond, including the Enhanced

Extern Program, the Supervised Practice Experience Partnership, and the Community Commitment Program for Nurses.

The Ministry is working at present to evolve this plan to include the following elements moving forward:

- evaluating and calibrating the Tuition Support Program for Nurses and other existing recruitment and retention programs specifically for use in the north; and
- developing enduring solutions to support longer-term recruitment and retention of the health workforce in the north.

Further, the Ministry recognizes the need to work with sector and intergovernmental partners, including the federal government, to evolve and implement a successful health human resources strategy for Northern Ontario.

The Ministry will continue to collect information on compensation expenses for agency staff based on the hours worked by agency staff versus contracted employees who provide direct care/services in the Ontario Healthcare Financial and Statistical System in support of health workforce planning, and will use this information to monitor the utilization of agency staff for particular service departments.

RECOMMENDATION 6

To help increase the availability of nurses in hospitals in Northern Ontario, we recommend that Ontario Health:

- regularly monitor data on the costs incurred by hospitals for the different types of agency health-care staff;
- explore the opportunity to leverage and align procurement of staffing agencies in the region, while ensuring that doing so does not add further risk to hospital service reductions and patient care in rural and remote hospitals; and
- assess the costs of agency nursing versus what may be required to stabilize and retain hospital-hired nursing staff, and share this analysis with the relevant stakeholders and decision-makers.

ONTARIO HEALTH RESPONSE

Ontario Health accepts this recommendation. Ontario Health understands the impacts of nursing agency staff use on Northern Ontario hospitals. Ontario Health will continue to regularly monitor data on the costs incurred by hospitals for the different types of agency health-care staff and develop local solutions with our hospital partners to help stabilize overall health staffing in communities. Ontario Health will explore opportunities to centralize procurement with agency corporations to maximize quality, value, and efficiency, while minimizing risk to hospitals. Ontario Health will analyze the costs of agency nursing to inform opportunities in support of hospital nurse retention.

4.2.6 Physician Vacancies in Northern Hospitals Still High Despite Recruitment and Retention Initiatives

Although the Ministry has introduced multiple programs to address the shortages of physicians in Northern Ontario, vacancies for family physicians and specialist physicians remained higher in that region compared to other regions in the province. The Ministry and Ontario Health began measuring vacancy data in October 2022. As shown in **Figure 6**, in the month of July 2023, 11 Northern Ontario hospitals reported vacancy rates of 11% for family medicine physicians and 11.5% for specialists, compared to vacancy rates of 7.5% and 6.4%, respectively, for the rest of Ontario.

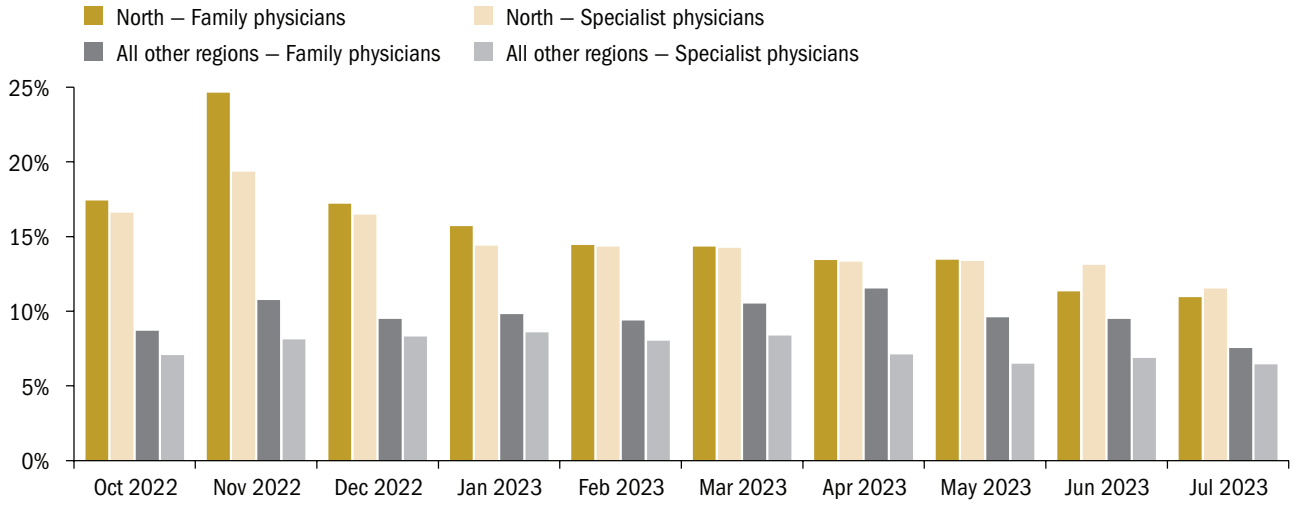
However, the vacancy rates reported by northern hospitals between October 2022 and July 2023 represent 26 of the 36 hospitals in Northern Ontario. Only five of these 26 hospitals reported the vacancy data every month. Ontario Health only encouraged, but did not require, hospitals to submit vacancy information.

Of the 34 hospitals that responded to our questionnaire, 30 stated that they faced a shortage of physicians.

To encourage physicians to work in Northern Ontario, the Ministry manages two initiatives: the Northern and Rural Recruitment and Retention

Figure 6: Vacancy Rates for Physicians at Hospitals in Northern Ontario and Other Regions, October 2022–July 2023

Source of data: Ministry of Health and Ontario Health



Note: October 2022 was the first month that this data was used by Ontario Health. Not all hospitals regularly submit this data.

Initiative (NRRRI) and the Northern Physician Retention Initiative (NPRI).

- The NRRRI, created in 2010, is intended to attract physicians to establish a new full-time practice in eligible northern and rural communities throughout the province. The initiative provides grants ranging from about $85,000 to $125,000 over a four-year period. According to the Ministry, as of March 2023, of the 1,500 physicians who were either actively using or had used the NRRRI, 1,066 or 71% had established new practices in the north region, with 70% of them having settled in the five larger northern cities—North Bay, Sudbury, Sault Ste. Marie, Timmins and Thunder Bay. The Ministry's best estimate of the payments it had made to physicians under this initiative between 2010 when the initiative first began and March 2023 was about $96 million.
- The NPRI, created in 2012, is intended to retain physicians already working in Northern Ontario for at least four years. The initiative pays just over $7,400 a year to each participating physician. The Ministry made $65 million in NPRI payments between 2012 when the program first began and March 2023. Between 2018/19 and 2022/23, about 870 physicians used the initiative annually and there was no notable increase in the number of physicians using the program during this period.

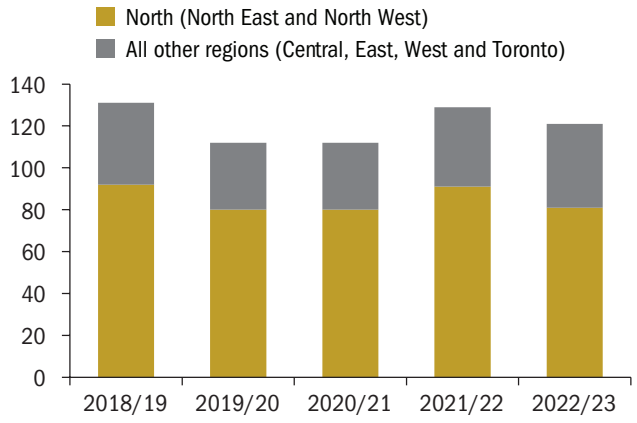
Reliable Data Not Maintained for Physician Incentive Programs

The Ministry admitted that it did not properly track the number of physicians who participated in the NRRRI over the years. The Ministry changed the participation information under the NRRRI multiple times during the course of our audit. As a result, neither we nor the Ministry could rely on this information. The Ministry's best estimate of participation data is shown in **Figure 7;** the number of physicians that received NRRRI funding to establish new practices in the north has fluctuated between 80 and 92 per year between 2018/19 and 2022/23.

Moreover, we found that other than tracking the number of new physicians recruited and retained annually through NRRRI and NPRI, respectively, the Ministry has not established any success measures to assess these two physician incentive programs. For example, the Ministry did not track how many of the

Figure 7: Number of New Physicians Who Received Funding from the Northern and Rural Recruitment and Retention Initiative in Northern Ontario and Other Regions, 2018/19–2022/23

Source of data: Ontario Health



physicians had moved to the north from other regions to show the impact the NRRRI had on bringing more physicians to the north, or how many physicians had completed the NRRRI and subsequently took advantage of the NPRI to show the impact the NPRI had on retaining physicians in Northern Ontario.

Physician Incentive Programs Are Not Regularly Evaluated for Effectiveness

We found that the Ministry has not recently reviewed its incentive program for attracting physicians to Northern Ontario, and it has never reviewed its incentive program for retaining physicians in the region. Regularly evaluating programs, including assessing current market conditions, could help the Ministry make necessary updates to keep the programs effective.

The Ministry conducted an internal review on the NRRRI in 2018, but not since. The internal review had 16 recommendations, which included reducing grant rates to physicians practising in larger northern urban centres to encourage them to move to smaller, rural communities, and introducing needs-based eligibility criteria to ensure program spending is targeted efficiently towards communities with the greatest need. At the time of our audit and five years since the evaluation was completed, the Ministry had implemented less than half of the recommendations and had no plans to implement the remaining recommendations, which include enhancing the advertisement of the initiative and regularly reporting on performance.

The Ministry introduced the NPRI in 2012, but has never reviewed the initiative to measure its effectiveness.

Incentive Amounts Paid to Physicians in Ontario Are Lower Than Other Provinces

Management at the Northern Ontario hospitals we visited expressed concerns that the incentives paid under these two initiatives are not in line with the high costs of living in the north, and therefore do not attract and retain enough physicians in the region. For example, while the Ontario NRRRI pays about $85,000–$125,000 over four years to physicians, Alberta's Rural Education Supplement and Integrated Doctor Experience pays physicians a stipend of $120,000 for a three-year term. As well, Prince Edward Island's Return-in-Service grants pay up to $115,000 for a three-year term in certain rural locations.

Payment Schedule of the Northern and Rural Recruitment and Retention Initiative May Deter Physicians from Staying the Full Work Term

The Ontario NRRRI pays up to $125,000 over four years, 40% of which is within the first year; this elevates the risk that the grant recipient may leave the program after the first year. Paying higher amounts toward the end—rather than the beginning—of a work term would more likely retain physicians for the full five years.

The Ministry did not accurately track program information and was therefore unable to even determine how many physicians have completed the full four years as opposed to leaving early.

In comparison, Saskatchewan recently enhanced its Rural Physician Incentive Program. It created this program in 2013/14 with an incentive of $47,000 over four years, but increased it to $200,000 over five years in April 2023. Qualifying physicians would receive $15,000 at the end of each of the first two years, $20,000 at the end of their third year, and $75,000 at the end of each of their fourth and fifth years.

Incentives Paid to Physicians Based on Outdated Rurality Index Score and No Consideration Placed on Existing Availability of Physicians in the Area

The index score that the Ministry uses to determine incentive amounts under the NRRRI is based on population and other factors from 2006, 17 years ago. This outdated index can mean that current incentive payments to certain communities in Northern Ontario are unjustified.

The Ministry pays different incentive amounts to qualifying physicians in the NRRRI depending on where they will be practising medicine. The Ministry uses the Rurality Index for Ontario (RIO) scores for communities to target funding to highly rural communities, which are prevalent in the north region. The RIO scores are based on three factors: population (count and density), travel time to a health-care referral centre that offers basic physician care, and travel time to a health-care referral centre that offers advanced specialty care. Health-care referral centres in the north are known as Northern Urban Referral Centres. They are located in North Bay, Sault Ste. Marie, Sudbury, Thunder Bay and Timmins. The Ontario Medical Association (OMA), which is responsible for negotiating physician payments with the Ministry, established the RIO scores in 1999/2000, and has not updated the scores since 2008 when they were based on 2006 Census data. If a particular community's population has fallen since then, physicians moving there could be eligible for a higher NRRRI incentive if the rurality score was updated to the current population.

An internal Ministry document from 2009 noted that when the NRRRI program was created, stakeholders were concerned that, among other things, the RIO scores did not take physician supply into account. This means that if a physician wants to practise in a community that has a high RIO score, the program still provides the incentive (and payment) to relocate to that community even if the community already has enough physicians. However, the Ministry still has not addressed this concern, 14 years later. The OMA agreed that RIO scores should likely be updated to account for changes, and told us that it had started the planning work to update them; however, it did not yet have any timelines in place. Any updated scores would then need to be approved by both the Ministry and the OMA.

RECOMMENDATION 7

To increase the availability of physicians in hospitals in Northern Ontario, we recommend that the Ministry of Health:

- establish performance indicators and related targets that measure the success of the Northern and Rural Recruitment and Retention Initiative (NRRRI) and the Northern Physician Retention Initiative (NPRI) and collect this data at least annually;
- re-evaluate the recommendations from its 2018 review of the NRRRI and implement the recommendations if still applicable;
- evaluate the NRRRI and NPRI initiatives at least once every five years;
- identify successful health-care staffing incentive programs from other jurisdictions, including their payment schedules, evaluate their feasibility for Ontario and update the NRRRI and NPRI accordingly; and
- work with the Ontario Medical Association to update the Rurality Index for Ontario scores while considering current market conditions and community demographics.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the recommendation. As part of developing a dedicated northern focus to its health human resources strategy, the Ministry is committed to enhancing the NRRRI and NPRI programs by establishing performance indicator targets and ensuring appropriate evaluation, including examining the experiences of other jurisdictions.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about

significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

The Rurality Index for Ontario is used in several instances by the Ministry; therefore, the Ministry is first considering the impacts of this measure of rurality and remoteness on its business and will engage with the OMA as appropriate following this review.

4.2.7 Ontario Health Did Not Evaluate, or Know the Full Cost of, Its Program to Bring Temporary Specialists to Northern Hospitals

Ontario Health administers the Northern Specialist Locum Programs (program), which aim to bring different specialists to temporarily work in Northern Ontario. A locum physician is one who fills in temporarily in another practice or community. We found that Ontario Health could not determine when it last evaluated this program to formally identify areas requiring improvement. Although Ontario Health tracks data on travel and reimbursable expenses for the program, it does not have access to the Ministry's OHIP billing data, and so it cannot track full information on the fees paid for the hours that locum physicians worked. This information is necessary for understanding the full cost of the program, and to help inform future efforts to improve the availability of specialist physicians in Northern Ontario such that patient access to care can be maintained.

Ontario Health administers two other locum physician programs in Ontario: the Rural Family Medicine Locum Program and the Emergency Department Locum Program. The Rural Family Medicine Locum Program is for temporary physicians for both community clinics and hospitals. We discuss the Emergency Department Locum Program in our 2023 value-for-money audit of Emergency Departments, which noted that four of the top nine hospital users of the Emergency Department Locum Program in 2022/23 were in the north region.

For the purpose of this report, however, we focused on the Northern Specialist Locum Programs. This program was established in 1982.

Across all hospitals in Northern Ontario, for the five-year period from 2018/19 to 2022/23, a total of 38,689 locum days were paid to all specialists participating in the program, averaging about 7,700 locum days per year. The specialties requiring the greatest number of locum days in Northern Ontario were internal psychiatry, general surgery, internal medicine, and anaesthesia. Four large northern cities—Sault Ste. Marie, Sudbury, Thunder Bay and Timmins—received about two-thirds of specialist locum coverage days.

For each specialist physician participating in this program, Ontario Health covered not only the physicians' work fees, but also other expenses including travel and accommodations; an additional premium for any travel days over three hours ranging from $493 to $1,480; daily expenses; and an honorarium of $322 per day. Between 2018/19 and 2022/23, Ontario Health paid about $25 million on travel fees and other expenses alone. The average daily cost of travel plus reimbursement for other expenses for a northern specialist was over $660, but could be as high as $1,802 plus actual travel and accommodation reimbursements.

Specialists who bill the government under the program bill for their work for the higher of either their usual fee-for-service rates through the OHIP billing system or the clinical locum rate (ranging from $595 for three to four hours to $1,786 for nine to 12 hours) through Ontario Health. However, the Ministry and Ontario Health only track the amount of fees specialist locum physicians claim using clinical locum rates, and not fee-for-service rates, and therefore could not determine the full costs of the program.

Ontario Health staff could not confirm when the program was last evaluated to determine whether updates are needed—for example, whether the program's fee structure remains reasonable considering different specialists have different fee-for-service rates.

Ontario Health stated that the program is intended to support patient access and physician recruitment and retention, and that it was never intended to be an alternative for recruitment. It further informed us that it does not have accountability for physician services. The program's eligibility and rates are decided between the Ministry and the Ontario Medical Association. Since Ontario Health administers this program, in our view it is in a unique position to support an evaluation with other stakeholders to determine whether this program still meets its intended purpose.

Patients in Northern Ontario More Likely to Be Transported by Air Ambulance to Receive Care Elsewhere

With much of Northern Ontario sparsely populated, transporting patients by air is a common practice to meet patient needs. For example, Weeneebayko Area Health Authority, located at Moose Factory—an island that is accessible only by water in the spring, summer and fall seasons, and by ice road in the winter months—has to rely on air ambulance services to transport patients to this hospital.

Ornge is funded by the Ministry of Health-and provides air ambulance and critical care transport services to people who are critically ill or injured. Ornge delivers its services through four land bases serving southern Ontario and nine air bases equipped with helicopters and/or airplanes located across Ontario. Six of these air bases are located in Northern Ontario—in Kenora, Moosonee, Sioux Lookout, Sudbury, Thunder Bay and Timmins.

In the five-year period between 2018/19 and 2022/23, Ornge completed on average about 18,000 patient transports per year across the province between health-care facilities, often from one hospital to another. In the month of May 2023 alone, Ornge completed about 2,280 transports into, out of, and within all 14 former Local Health Integration Network regions, with 47% of these activities serving just Northern Ontario alone.

We found that Ministry has not analyzed the cost of transporting patients within Northern Ontario or from the region to other parts of the province against the cost of enhancing local capacity to treat patients closer to home—for example, by bringing visiting specialists to more rural hospitals in Northern Ontario. Ontario Health indicated that it has no access to information from Ornge and it is not responsible for such an analysis. One northern hospital we visited ranked the top five specialists it could benefit from having onsite: vascular surgeon, cardiologist, rheumatologist, respirologist and endocrinologist. Currently, patients have to travel to other hospitals to obtain these specialist services, and use Ornge services if they are in critical conditions. According to Ornge, cardiology patients needed the most transports between Northern Ontario hospitals from 2018 to 2022. In 2022, five of Ornge's 20 longest-distance trips within the north region were for cardiology patients; most of them were transferred from smaller hospitals to Health Sciences North, the largest northern hospital and one of the designated cardiac centres in Northern Ontario.

RECOMMENDATION 8

To better inform decisions on program design for the Northern Specialist Locum Programs (program), we recommend that Ontario Health:

- obtain full billing data on locum physicians using the program from the Ministry of Health (Ministry) to determine whether the program payment structure remains appropriate; and
- work with the Ministry to review the usage of the program to identify systemic issues in an effort to determine sustainable solutions to maintain patient access to specialist physicians in northern hospitals.

ONTARIO HEALTH RESPONSE

Ontario Health accepts this recommendation. Ontario Health will work with the Ministry of Health to support analysis of physician billing data and usage of the Northern Specialist Locum Programs, and discuss opportunities to stabilize and improve equitable access to specialist care in Northern Ontario.

RECOMMENDATION 9

To better serve hospital users in Northern Ontario such that they can obtain more timely care closer to home, we recommend that the Ministry of Health conduct a cost/benefit analysis that considers the cost of transporting patients within Northern Ontario and from the region to other parts of the province and the cost of enhancing the local capacity to treat patients closer to home—for instance, by bringing visiting specialists to more rural hospitals in Northern Ontario.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the recommendation and the importance of providing Ontarians with timely specialist medical services closer to home, particularly in Northern Ontario, which is characterized by low population density and vast landmasses. The Ministry introduced the Visiting Specialist Clinic Program in 1982 to provide visiting specialist clinics on an outreach basis in targeted communities in Northern Ontario where the population base cannot support a full-time physician specialist. The Ministry will consider evaluating the continued effectiveness of this program.

The Ministry will investigate the feasibility of a cost/benefit calculation that considers the cost of transporting patients within Northern Ontario and from the region to other parts of the Province and the cost of enhancing the local capacity to treat patients closer to home. Undertaking this calculation will be determined based on available data and operational feasibility; other methodologies will also be considered if needed. The goal will be to ensure that the needs and preferences of patients in Northern Ontario remain at the forefront of healthcare planning.

4.2.8 Northern Ontario School of Medicine University Offers Opportunity to Help Increase Physician Workforce in Northern Ontario

The Northern Ontario School of Medicine University is funded jointly by the Ministry of Colleges and Universities and the Ministry of Health. It was created in 2002 and was legislated as a university in April 2022. The university is Canada's first stand-alone medical university and one of seven approved medical schools in the province. With campuses in Sudbury (located at Laurentian University) and Thunder Bay (located at Lakehead University), it provides medical education designated with the mandate to be accountable to the cultural diversity of the region it serves, including Indigenous and Francophone peoples, remote and rural communities, and urban centres.

The university offers an undergraduate Medical Doctor program as well as postgraduate residency programs in nine medical specialities including obstetrics and gynaecology, orthopaedic surgery, paediatrics and psychiatry. According to the university, as of November 2022:

- 559 physicians completed the Medical Doctor program since the first graduating class in 2009 and about 51%, or 284, of them practised in Northern Ontario with 63 of them working in rural communities; and
- 689 physicians completed their residency at the university and 57%, or 390, of them practised in Northern Ontario, with 94 practising in rural areas.

With respect to its postgraduate program, the university offers programs in just over 30% of the 28 physician specialties defined by the Royal College of Physicians and Surgeons of Canada. As well, of the total 96 postgraduate education seats available for 2024, only 34 of them are for specialty programs. Having more specialist program offerings can help increase the availability of different specialists in Northern Ontario.

RECOMMENDATION 10

To enhance the availability of the physician workforce in Northern Ontario, we recommend that the Ministry of Health work with relevant partners, including the Ministry of Colleges and Universities and the Northern Ontario School of Medicine University, to assess the feasibility of increasing the number of specialty programs offered at the university.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the recommendation. Ontario has announced an expansion of medical school education with a total of 449 postgraduate positions being added to the system. Of these, the Northern Ontario School of Medicine University is getting a total of 63 positions—38 will be for family medicine and 25 will be for specialty training. Of the 63 positions at the university, 10 have already been added and filled by residents, resulting in an addition of eight more specialty training positions and two more family medicine positions at the university.

The expansion currently under way is dependent on the capacity of the system to expand. Medical schools will be required to support clinical placements for learners and identify preceptors to support their learning. All of this must be factored into any further expansion.

The Ministry continues to work with a number of sector partners, including the Ministry of Colleges and Universities, to enhance data and evidence in support of health workforce planning for Northern Ontario and the province as a whole. The planning of speciality medical education will be informed by this evidence (in addition to the expansion capacity) and will leverage the Northern Ontario School of Medicine University's ability to grow access to speciality services in the north through medical education.

4.3 Barriers to Timely Patient Care in Northern Ontario

4.3.1 Over 330 Patients Waiting for Long-Term Care and Home Care in Northern Hospitals

In the last five years from 2018/19 to 2022/23, patients in Northern Ontario hospitals were more likely to be waiting to be discharged to other more appropriate destinations compared to other regions in the province. This can lead to hospital overcrowding and increased wait times for patients that truly require services at a hospital, especially when the hospital is operating close to or at capacity.

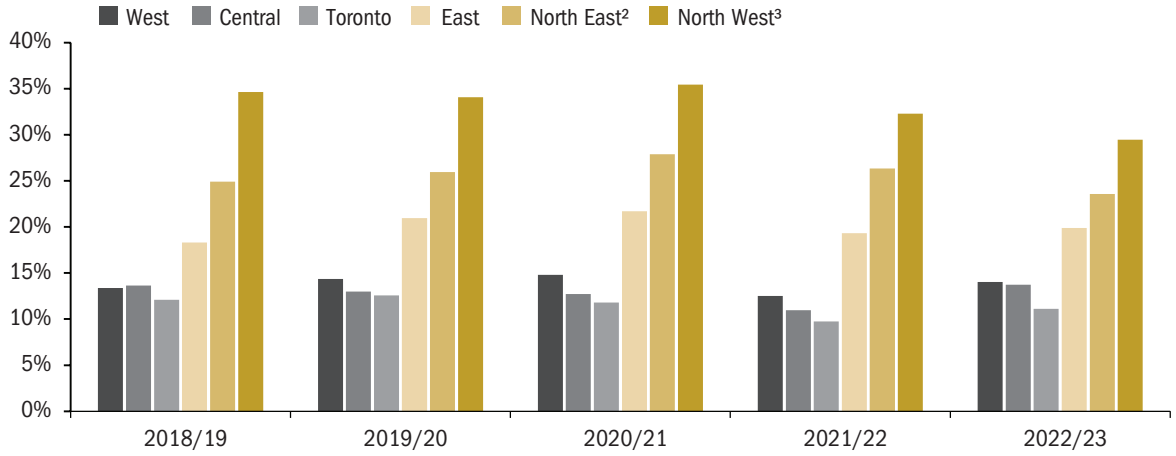
As measured by the percentage of days a hospital bed was occupied by a patient who requires care from another setting such as a long-term care home or home and community care, annual alternate-level-of-care (ALC) rates for Northern Ontario hospitals ranged from about 29%–35% in the North West to about 24%–28% in the North East between 2018/19 and 2022/23. This was higher than rates of about 10%–22% in other regions, as shown in **Figure 8**.

Only half of the 36 hospitals in Northern Ontario report ALC data into the Wait Time Information System. Of the 18 hospitals that reported this data, eight have consistently reported increasing ALC rates over the past five years. As shown in **Figure 9**, Red Lake Margaret Cochenour Memorial Hospital experienced the highest growth in ALC rate from 14% to 45.8% over the five-year period. According to Ontario Health, this represents about five patients; however, this still represents about 30% of the total number of acute-care beds at this hospital, which may affect patient services. As well, 17 hospitals consistently had higher ALC rates than the provincial average throughout 2018/19–2022/23.

As of March 31, 2023, based on Ontario Health's data from 18 hospitals, a total of 549 patients were waiting in northern hospitals to be discharged to other care settings that best meet their needs, with 258 or 47% waiting for long-term care and 79 or 14% of patients

Figure 8: Annual Alternate-Level-of-Care Rates[1] for Hospitals, by Region, 2018/19–2022/23

Source of data: Ontario Health



1. Measured as the number of inpatient days designated as alternate level of care as a percentage of the total number of inpatient days. When a patient is occupying an inpatient bed in a hospital and does not require the intensity of resources/services provided in that care setting (acute, complex continuing care, mental health, or rehabilitation), the patient must be designated as alternate level of care at that time by the physician or delegate.
2. Based on alternate-level-of-care data from six hospitals that reported this information to a central database, out of 24 hospitals in the North East.
3. Based on alternate-level-of-care data from 12 hospitals that reported this information to a central database, out of 12 hospitals in the North West.

Figure 9: Annual Alternate-Level-of-Care Rates for All 18 Northern Hospitals That Report This Data, 2018/19–2022/23 (%)

Source of data: Ontario Health

Hospital	2018/19	2019/20	2020/21	2021/22	2022/23	5-year % Increase/ (Decrease)
Red Lake Margaret Cochenour Memorial Hospital	14.0	20.3	41.6	43.0	45.8	226.8
Santé Manitouwadge Health	19.4	57.0	85.4	84.2	58.0	199.7
Nipigon District Hospital	32.8	35.7	65.4	55.9	45.8	39.7
Atikokan General Hospital	59.6	66.4	63.5	73.3	74.9	25.7
Temiskaming Hospital	41.2	54.2	56.4	56.1	48.9	18.5
Health Sciences North	18.0	21.5	20.5	22.5	20.0	11.2
Sault Area Hospital	20.8	18.0	22.7	20.1	22.1	6.4
Lake of the Woods District Hospital	33.1	36.2	44.1	32.8	34.4	3.9
Sioux Lookout Meno Ya Win Health Centre	36.8	43.8	49.3	44.2	36.2	(1.7)
Thunder Bay Regional Health Sciences Centre	24.7	24.5	26.5	26.6	23.4	(5.2)
West Parry Sound Health Centre	40.8	40.1	44.6	42.1	38.5	(5.7)
North Bay Regional Health Centre	29.7	26.0	29.6	29.7	27.1	(8.7)
North of Superior Healthcare Group	55.9	42.9	31.9	40.2	48.3	(13.6)
Geraldton District Hospital	74.3	68.0	43.4	41.0	58.7	(21.0)
Riverside Health Care Facilities	63.8	58.2	53.8	44.5	48.5	(24.0)
St Joseph's Care Group	38.0	36.2	39.9	28.7	26.5	(30.4)
Dryden Regional Health Centre	35.0	43.9	32.1	44.1	23.4	(33.1)
Timmins and District Hospital	31.3	37.9	38.4	21.8	13.9	(55.6)
North East Average	**24.9**	**26.0**	**27.9**	**26.3**	**23.6**	**(5.5)**
North West Average	**34.6**	**34.1**	**35.4**	**32.3**	**29.4**	**(15.0)**
Provincial Average	**15.3**	**16.2**	**16.4**	**14.2**	**15.3**	**(0.2)**

waiting to be discharged home with home-care services provided by Home and Community Care Support Services. The remaining 39% of patients were waiting for other services, including assisted living, complex continuing care and palliative care. **Figure 10** shows a breakdown of the different destinations active ALC patients were waiting to be discharged to while occupying beds in northern hospitals as of March 2023.

Not being able to discharge patients can contribute to hospitals not having the capacity to care for other patients. In the last three years, the occupancy rates of two hospitals where we conducted detailed audit work were between 94% and 103%; these two hospitals had ALC rates between 20% and 36% in 2022/23, higher than the provincial average of 15% that year. An overcrowded hospital can have a significant impact on patients. For example, at a hospital we visited during our audit, we noted a complaint in March 2023 that an elderly patient who had fallen was confined to a stretcher in the emergency department for about 30 hours. The family was told that the hospital was over capacity and that a bed was not yet available.

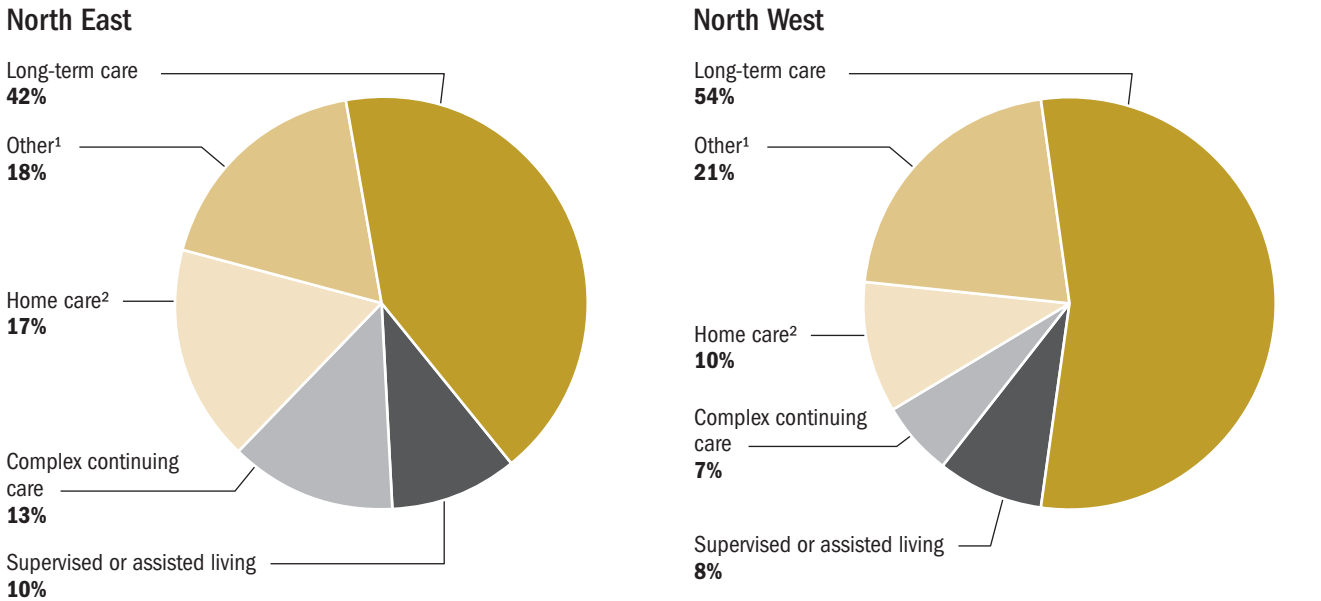
4.3.2 About $65 Million Used in 2022/23 to Support Acute-Care Patients in Northern Hospitals While They Waited for Long-Term Care and Home Care

The associated cost of keeping a patient in a hospital is higher than a long-term care home, which in turn is higher than the cost of home care.

Upon our request, the Ministry calculated that the average daily cost to keep an acute-care ALC patient in a hospital in 2021/22 was $849—this was the most recent data available when we completed our work. In contrast, according to the Ministry, the average daily cost to the province for a long-term care resident was $158 and the average daily cost for home care was $120 in the same period. Based on these daily estimates, in 2022/23, Northern Ontario hospitals used

Figure 10: Destinations for Alternate-Level-of-Care Patients Awaiting Discharge in Northern Hospitals That Report This Data, as of March 31, 2023

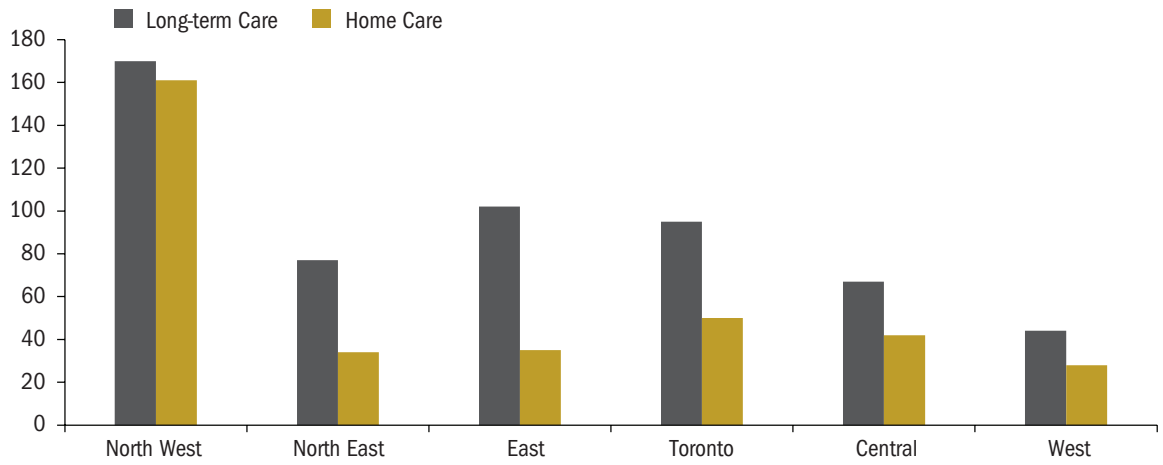
Source of data: Ontario Health



1. Includes rehabilitation facility, home with community services, home without supports, convalescent care, palliative care, mental health beds, and unknown destination.
2. Managed by 14 Home and Community Care Support Services organizations across the province.

Figure 11: Average Wait Time for Long-Term Care and Home Care for Patients Designated as Alternate Level of Care, by Region, as of March 31, 2023 (# of Days)

Source of data: Ontario Health



$79 million of their budgets to keep acute-care ALC patients in these hospitals while they were waiting for long-term care homes or home care. Had the long-term care beds and home-care services been available and the patients been discharged, the provincial cost would have only been about $14 million. This represents $65 million that the province could have saved because long-term care and home care were not readily available for patients ready to be discharged from northern hospitals to these alternate care settings in 2022/23. **Appendix 9** shows the methodology we used to calculate this estimate based on data from 18 hospitals that reported into the Wait Time Information System.

Across Northern Ontario as of March 31, 2023, the wait time for both long-term care and home care for ALC patients ranged from less than 30 days to over five years, with the average wait time being 77 days and 34 days for the North East region and 170 days and 161 days for the North West region, respectively, and as shown in **Figure 11**. The North West region had the longest wait time for both long-term care and home care.

In 2021, Ontario Health prepared a report, titled Informing Care for Seniors, which showed the capacity at the time of the report and anticipated demand for long-term care, assisted living services for high-risk seniors, and community support services at that time, and included recommendations related to the areas in the North West region that faced most significant long-term care pressure. The report determined that additional long-term care beds were required for 13 of the 14 areas in the North West region, with six areas identified as high-priority. Ontario Health told us that the Ministry of Long-Term Care had already approved bed allocations that will partially address these service gaps, if all of these beds are fully approved and constructed. However, none of these beds were actually in service for the people in these areas at the time we completed the audit, since the Ministry of Long-Term Care has a target completion date of 2028. The total number of long-term care beds in Northern Ontario was just below 7,000 from March 2019 to March 2022.

Over the last five years, Ontario Health had not required hospitals to develop improvement plans if they did not meet the performance indicators for ALC. Ontario Health indicated this is to recognize the COVID-19 pandemic's impact on hospitals and ALC being a system-wide issue that requires collaboration among different health-service providers. Instead, to help reduce ALC rates, Ontario Health developed a practice guide that identified leading practices for caring for and proactively managing hospitalized older adults at risk of delayed transition to an appropriate setting. In 2023/24, Ontario Health issued a memorandum to all hospitals in Northern Ontario to

conduct self-assessments on ALC leading practices to help identify required changes and develop action plans. Ontario Health stated that it supported these self-assessments by hosting information webinars and establishing planning committees across the region where representatives from the local health system meet to discuss ALC pressures.

RECOMMENDATION 11

To better care for patients in Northern Ontario in settings that are most suitable to their needs, we recommend that Ontario Health:

- support hospitals across Northern Ontario to adopt leading practices to improve transitions from one care setting to another; and
- work with other health partners including the Ministry of Health, the Ministry of Long-Term Care, and Home and Community Care Support Services to identify and implement solutions to increase the availability of long-term care and home-care services in Northern Ontario.

ONTARIO HEALTH RESPONSE

Ontario Health accepts this recommendation and is committed to continuing its work with northern hospitals on implementing The Alternate Level of Care (ALC) Leading Practices Guide (September 2021). In addition, Ontario Health will continue to work with the Ministry of Long-Term Care on identifying long-term care needs of the region's population and with Home and Community Care Support Services on the need for home care.

4.3.3 Patients in Northern Hospitals Could Not Always Obtain Timely Diagnostic Imaging Services

The timeliness of patient care in Northern Ontario is affected by the availability of services in a hospital. For example, the Ministry funds the approved operating hours of MRI and CT machines but does not provide the capital funding for them. Instead, hospitals in Ontario are expected to purchase these machines by raising their own funds. As discussed in **Section 2.5**, northern hospitals often face difficulties in raising large donations that may be more common for hospitals in other regions.

One hospital we visited estimated that it would take over two decades for it to raise the funds needed to purchase the hospital's first MRI machine; patients in the area currently need to travel four hours away to obtain this diagnostic imaging service.

Similarly, another hospital we visited requires a CT scanner to provide timely support to clinicians so they can diagnose patients more quickly and initiate treatment sooner. Patients at this hospital currently have to travel to another hospital about a 90-minute drive or 110 kilometres away. According to the business case that this hospital developed for the purchase of the CT scanner, it made about 1,900 referrals to another hospital in 2020/21, including for 54 stroke and transient ischemic attack patients, for which a timely CT scan is critical according to stroke diagnosis protocols. Although this hospital has successfully raised the required funds to purchase the required CT scanner through private donations, as of September 2023, Ontario Health had not yet approved the request submitted in November 2022. It informed us that this was due to staff shortages.

RECOMMENDATION 12

To improve access to diagnostic imaging services for patients in Northern Ontario, we recommend that Ontario Health, together with the Ministry of Health:

- assess the need for a dedicated funding model for diagnostic imaging equipment for hospitals in rural areas; and
- review diagnostic imaging equipment proposals submitted by hospitals on a timely basis.

ONTARIO HEALTH RESPONSE

Ontario Health accepts this recommendation and is committed to ensuring equitable and timely access

to health-care services. Ontario Health will work with the Ministry of Health to explore opportunities for funding models for diagnostic imaging equipment. Ontario Health will develop a proposal intake process that ensures all proposals submitted by hospitals are reviewed on a timely basis.

4.3.4 Northern Health Travel Grant Program Outdated and Not Regularly Evaluated

The Ministry provides financial assistance to Northern Ontario residents who may need to travel long distances to access services from a medical specialist or from a Ministry-funded health-care facility, so that residents in Northern Ontario are not disproportionally affected by the travel costs they may have to incur to obtain timely and appropriate health care. In 2022/23, the Ministry, which administers the Northern Health Travel Grant Program as described in **Section 2.3.2**, reported that it approved just over 170,000 applications and paid a total of about $45 million, down from about 205,000 applications and about $56 million in 2018/19.

Northern Health Travel Grant Program Uses Outdated Rate to Reimburse Mileage Expenses and Does Not Cover Meal Expenses

The Ministry has not changed the program's mileage allowance of 41 cents per kilometre since 2007, which is below market rate. This allowance is for either driving a personal vehicle or travelling using commercial means including flights, and is calculated based on the distance travelled after the first 100 kilometres. In comparison, as of June 2023, the Canada Revenue Agency (CRA) allows for Ontario employers to reimburse employees for using their personal vehicle for business purposes for the first 5,000 kilometres at 68 cents per kilometre. Even in 2007, the CRA's rate was 50 cents per kilometre, which was still higher than the program rate set in that year. As well, according to Statistics Canada, the average price of gas in Thunder Bay has increased by 58%, from $1.06 per litre in 2007 to $1.68 per litre in September 2023.

The Ministry last updated the program's accommodation allowance in 2017 from $100 per trip to up to $550 based on the length of the patient's trip, ranging from $100 per night to $550 total for eight or more nights. However, the updated allowance is still not always sufficient to cover the full cost of accommodation; this can cause particular hardship for people living on fixed or low incomes. For example, we found a reported case of two seniors from Northern Ontario living on fixed incomes having to pay out of pocket to obtain the care they needed in Toronto. Although they purchased a hotel room at a discounted hospital rate of $250 per night, the program only covered $100.

We researched similar programs in other jurisdictions. As shown in **Appendix 10**, other jurisdictions pay mileage and accommodation rates closer to market rates. For example, Nunavut's Extended Health Benefits program for residents who have exhausted their third-party insurance, or have no medical travel benefits, pays between $50 and up to the full cost of accommodation depending on the situation and pays for the transportation cost minus a $250 return airfare deductible. Through Newfoundland and Labrador's Medical Transportation Assistance program, patients who travel more than 200 kilometres for medical services can be reimbursed (depending on their locations) for their travel, accommodations and meals at a rate of 100% for the first $1,000, 50% on the next $3,000 and 75% for their remaining expenses per year.

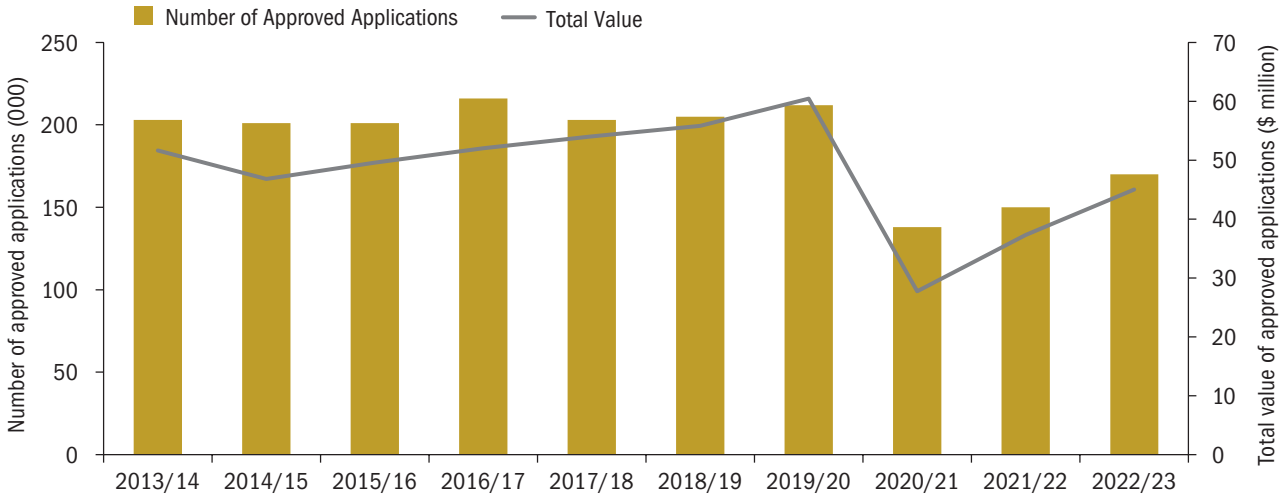
Other jurisdictions, such as New Brunswick and Newfoundland and Labrador, also have meal allowances that include meals in the overall payments. However, the Ontario program does not reimburse meal expenses.

Effectiveness of the Northern Health Travel Grant Program Not Regularly Evaluated

The Ministry monitors monthly data on program spending, number of claims processed, time taken to pay patients once their application is received, and the percentage of applications processed within 30 business days. However, we found that it was missing an opportunity to use the data to identify gaps in the

Figure 12: Number and Total Value of Approved Applications for the Northern Health Travel Grant, 2013/14–2022/23

Source of data: Ministry of Health and Treasury Board Secretariat



health-care services it provides to residents of Northern Ontario. For example, it did not analyze how far patients must travel to access care, and use this to inform its funding decisions on what services to add to the hospitals. Also, it did not measure the extent to which the program covers actual mileage and accommodation expenses that patients incurred to access care away from home. In addition, the Ministry did not properly track the number of approved applications and related amounts, as we found data entry errors. As a result, we could not analyze the data in detail.

We also found that the Ministry has not regularly evaluated the program and has no plans to evaluate it. The Ministry informed us that it considers an increase in approved applications as an indicator of success. **Figure 12** shows that both the yearly number and value of approved applications has been relatively stable from 2013/14 to 2019/20. According to the Ministry, the decrease after 2019/20 was due to reduced medical travel during the COVID-19 pandemic, but applications have since been on the rise.

RECOMMENDATION 13

To improve the effectiveness of the financial assistance for Northern Ontario residents who need to travel long distances to access specialist services or care from Ministry-funded health-care facilities, we recommend that the Ministry of Health:

- re-evaluate the Northern Health Travel Grant Program, considering current market rates for travel and lodging, as well as similar programs in other jurisdictions; and
- establish appropriate performance indicators for the program, collect data to measure program performance and take corrective actions to address any performance deficiencies.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the recommendation and that recent inflationary pressures have introduced additional medical travel costs for Northern Ontarians. The Ministry is committed to continuously improving

the Northern Health Travel Grant Program, and will consider current market rates for travel and lodging as well as similar programs in other jurisdictions. The Ministry will continue to assess opportunities to enhance the program and will consider introducing additional performance indicators to augment the existing service delivery indicators currently monitored.

4.3.5 Nursing Stations Providing Primary Care Not Strategically Located across Northern Ontario

As discussed in **Section 2.3.2**, having timely access to hospital care is a key challenge for patients in Northern Ontario given the large landmass and lack of services at some hospitals. As shown in **Figure 13**, as of August 2023, Ontario's north region has 13 Ministry-funded nursing stations while the federal government funds 26 health facilities that provide primary-care services to Indigenous populations in this area.

Provincial nursing stations serve as primary health-care providers for geographically isolated communities, 80 kilometres or more away from a hospital or other alternative primary-care services where population densities are too small to support a full-time physician. These stations are typically staffed by registered nurses or nurse practitioners, with occasional visits from physicians.

The Ministry established most of the current provincial nursing stations in the 1970s and 1980s. Of the active nursing stations, the most recent one was created in 1993. No new stations have been created since then, though there were seven other nursing stations that had been absorbed into larger health-service providers since 2018 and now operate as secondary clinic locations for these providers. According to the Ministry, as of September 2023, it had no plans to create new nursing stations. As the nursing stations program has been in place since the 1970s, the Ministry could not produce any record to elaborate on the case made to establish each site in their current location.

We found that six of the 13 nursing stations are located less than 80 kilometres away from one or more northern hospitals, as shown in **Figure 14**. Having nursing stations located close to hospitals defeats their purpose of extending access to health services to reach more remote communities. Instead, these resources could be better situated to meet the needs of communities located farther away from hospitals.

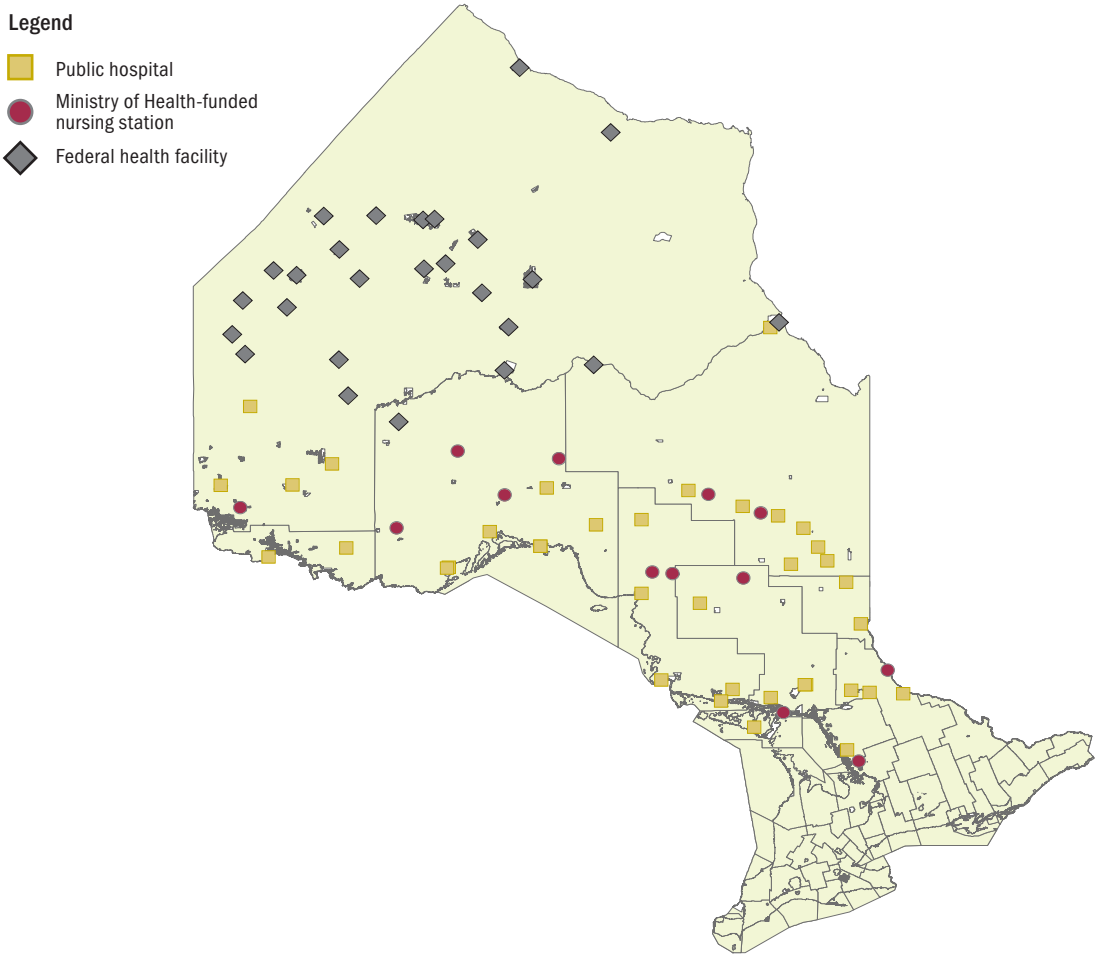
Furthermore, we found that the Ministry does not co-ordinate its nursing stations with the federal government's health facilities—for example, to ensure they are not unnecessarily operating stations near each other or to share common resources. The Ministry stated that it has not co-ordinated with the federal government because the two programs have different mandates and serve different populations.

The Ministry last reviewed the operations of its provincial nursing stations in 2016 to determine if the program was meeting its intended purpose and to make improvements. The review made eight recommendations, including to increase funding to recruit more nursing staff, and to explore collaboration between nursing stations and physicians to avoid duplication of services. At the time of our audit and seven years since the evaluation was completed, the Ministry had implemented less than half of the recommendations and had no plans to implement the remaining recommendations, which included reducing duplication of services between nursing stations and family physician teams, and increasing data-sharing between health-care facilities.

The Ministry also has no plans to conduct another review in the short term, nor has it set any performance indicators or targets for the nursing stations to measure their effectiveness. Ministry staff informed us that the Ministry had not received any complaints about these nursing stations and therefore believed that the model was working well.

Figure 13: Map of Ontario with Locations of Ministry of Health-Funded Nursing Stations, Federal Health Facilities and Public Hospitals in Northern Ontario, as of August 2023

Prepared by the Office of the Auditor General of Ontario



Note: There are two hospitals located in Sudbury and two hospitals located in Thunder Bay. These locations are layered on one another on this map and therefore the 36 hospitals may appear as 34.

Figure 14: Ministry of Health-Funded Nursing Stations Located Less Than 80 km from the Nearest Hospital(s) in Northern Ontario

Prepared by the Office of the Auditor General of Ontario

Nursing Station	Nearest Hospital(s)	Approximate Distance (km)
Fauquier-Strickland Health Centre	Smooth Rock Falls Hospital and Sensenbrenner Hospital	33*
Missinaibi-Mattice Clinic	Notre-Dame Hospital and Sensenbrenner Hospital	33–66
Mactier Health Centre	West Parry Sound Health Centre	37
Nakina Medical Clinic	Geraldton District Hospital	65
Thorne Nursing Station	North Bay Regional Health Centre	68
Dubreuilville Medical Centre	Lady Dunn Health Centre	74

* Distances from the nursing station to the two nearest hospitals are 32.6 km and 33.3 km, respectively.

RECOMMENDATION 14

To enhance access to primary health care for Northern Ontario residents and reduce potential hospital visits, we recommend that the Ministry of Health:

- develop and implement a plan to identify locations in Northern Ontario where nursing stations could alleviate pressure on hospital services; and
- establish new or relocate existing nursing stations to the identified locations.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the recommendation and the importance of having access to primary care to reduce hospital visits.

While nursing stations are staffed exclusively by nurses and administrative personnel, Ontario is moving to expand an interdisciplinary approach to delivering primary care, such as in Nurse Practitioner-Led Clinics. The Ministry's 25 existing Nurse Practitioner-Led Clinics serve approximately 100,000 Ontarians and include interdisciplinary providers like social workers, dietitians, and others. Your Health: A Plan for Connected and Convenient Care includes an investment to create new interprofessional primary care teams in communities with the greatest need. By increasing the number of teams, people in underserviced communities and those without a family doctor will be able to connect to the care they need close to home.

The Ministry will reflect on the role of nursing stations in Northern Ontario in the context of Ontario's nursing and northern health initiatives in workforce planning.

4.4 Cultural and Linguistic Considerations at Northern Hospitals

Ontario Health has participated in multiple initiatives to advance relationships with Indigenous communities to better identify disparities, develop programs and monitor progress. Furthermore, as discussed in **Section 4.5.2**, Ontario Health has added new expectations in its 2023/24 accountability agreements with hospitals to measure and report on health equity. During our audit, we identified several areas that warrant continuous improvement to better meet the needs of Indigenous peoples in Northern Ontario. Below are our observations.

4.4.1 Indigenous Health Services Not Consistently Available at Northern Hospitals

Promoting health equity and anti-racism is a key priority for the Ministry and Ontario Health, as reflected in the Ministry's mandate letter to Ontario Health and also in Ontario Health's annual business plan. As well, the Truth and Reconciliation Commission of Canada (Commission), described in **Section 2.3.3**, called for recognizing the value of Indigenous healing practices and using them in the treatment of Indigenous patients in collaboration with Indigenous healers and elders where requested by Indigenous patients. In February 2023, Ontario Health collected information about hospital services for Indigenous peoples from all hospitals in Northern Ontario; these services include Indigenous healing spaces, traditional practice policies, dedicated indoor smudging spaces and the ability to smudge in a patient's room. Smudging is a traditional spiritual practice that involves burning certain herbs to create a smoke that is used for purification and cleansing.

Appendix 11 shows the results of a survey conducted by Ontario Health. About 33% or 12 of the 36 hospitals in the region did not respond to the survey. Of the 24 hospitals in Northern Ontario that responded, 11 hospitals provided an Indigenous healing space for their patients, 16 hospitals had a traditional practice policy, 13 hospitals had dedicated indoor smudging space, and 11 hospitals allowed

smudging in patient rooms. Two hospitals noted that they did not provide any of these services.

The three hospitals in the northern region where we conducted detailed audit work have each made efforts to offer Indigenous traditional practices. For instance:

- One hospital we visited integrates First Nations principles into many of the services it provides. This hospital has instilled traditional Indigenous values and practices into its governance and leadership structure, patient and client support programs, and healing and medicinal treatments, and offers localized cultural awareness and training, and traditional foods.
- Two of the three hospitals we visited had goals in their strategies to provide culturally safe care to Indigenous patients, and demonstrated a comprehensive range of services for Indigenous patients, including Indigenous patient navigators/interpreters, smudging services, elders in residence, and traditional healing and medicine.
- Two hospitals we visited have instituted advisory or elders councils to offer direction concerning the health of the Indigenous population. One of the hospitals had difficulty filling vacancies on its council, while the other's council also had vacancies but the hospital was undertaking efforts to fill them.

Ontario Health explained that while it requires hospitals to provide culturally appropriate services in a safe environment, it does not specify the type of services a hospital should provide to Indigenous patients because each community would have different needs. Ontario Health expects that hospitals engage with local Indigenous communities to determine the type of services that would be provided to meet their needs, and has a process in place where its staff are available to support hospitals in planning their programs.

Indigenous Culture-Related Training Available at Hospitals, but Uptake Was Limited

The Commission also called for providing cultural competency training for all health-care professionals. Indigenous cultural training can help health-care professionals better understand the unique cultural beliefs, practices, and historical experiences of Indigenous communities. Such training can also contribute to the broader goal of achieving equitable and inclusive health-care experiences for all individuals, regardless of their cultural background.

At the three hospitals where we conducted detailed audit work, we found that staff could access Ontario Health's online Indigenous Relationship and Cultural Awareness Courses, but only one hospital tracked participation, which was low, at 6% as of August 2023. Another hospital we visited introduced a video related to Cultural Safety through an online learning platform and 57% of its staff completed the training. At one of the three hospitals, staff could obtain training from two locally developed courses, though just over half of its staff had completed one or both courses, even though this hospital's internal policy requires that staff complete the required training at least once in their career with the hospital.

We found that Ontario Health does not require hospitals to provide mandatory training for staff to raise their awareness of Indigenous culture, or to track the percentage of staff who completed training. Ontario Health stated that it instead requires hospitals to undergo an accreditation process, which includes an assessment of people-centred care that is culturally safe.

Training staff to raise awareness of Indigenous culture and providing cultural competency and anti-racism training could help reduce negative incidents or complaints about how Indigenous patients are treated in hospitals. For example, at one hospital we visited, there was a complaint about a nurse who interrupted a drumming ceremony in a patient's room and demanded it stop, which the family found to be disrespectful because it did not reflect the wishes of the patient and the family.

4.4.2 Data Collection on Indigenous Staff and Patients Fragmented

As noted in **Section 2.1**, about 17% of the population in Northern Ontario is Indigenous. Collecting relevant data is crucial for identifying disparities, monitoring progress, and developing targeted programs, with

an ultimate aim to reduce health-care inequity for Indigenous peoples. Such data may include Indigenous identity (for example, First Nations, Inuit, Métis), Indigenous population health status, access to culturally appropriate health services, language barriers, and how different services are used. Ontario Health supports an Indigenous-led approach to exploring options of how data can be collected to better identify disparities, develop targeted programs, and monitor progress.

We found that the number and proportion of Indigenous patients at each northern hospital was largely unknown to either Ontario Health or hospitals since not all hospitals have information on the number of patients who self-identify as Indigenous. Some hospital staff informed us that their process to collect data would start through self-identification by including culturally appropriate questions in patient registration forms. Of the 34 Northern Ontario hospitals that responded to our questionnaire, only 13 included specific fields on patient registration forms through which patients can voluntarily self-identify as Indigenous. Of the hospitals where we conducted detailed audit work, one knew that about 90% of its patients are Indigenous; another hospital collected self-identification data in two of its programs and was planning to expand collection to other programs. The third hospital did not collect self-identification data, but serves a small population of just under 1,000 people (as of 2021), of which about 100 identify as Indigenous.

As well, the Commission called for increasing the number of Indigenous professionals working in the health-care field, and ensuring the retention of Indigenous health-care providers in Indigenous communities. Again, we found that neither Ontario Health nor hospitals could provide an accurate count of the number or proportion of Indigenous staff at hospitals. Based on the information reported by 34 Northern Ontario hospitals that responded to our questionnaire, we found that almost 60% of northern hospitals do not collect this data, though 14 hospitals were able to provide an estimated percentage of their staff who self-identify as Indigenous, which ranged from 0% to 10%. Of the hospitals where we conducted detailed audit work, management knew the number of Indigenous professionals on the executive team, but could only roughly estimate the number of Indigenous professionals who provide front-line services. None of the hospitals measured whether these numbers were increasing year over year in line with the Commission's recommendation to increase the number of Indigenous professionals working in the health-care field. Ontario Health indicated that it does not require hospitals to collect self-identification information for patients or staff because the *Public Hospitals Act* does not explicitly require it.

RECOMMENDATION 15

To help reduce health inequities and provide culturally appropriate services to meet the needs of Indigenous peoples in Northern Ontario, while recognizing the spirit of the calls for action from the Truth and Reconciliation Commission of Canada (Commission), we recommend that Ontario Health, in consultation with Indigenous communities, work with hospitals to:

- assess ways in which hospitals can more consistently collect data about the Indigenous patients they serve, as well as their Indigenous staff, in an appropriately sensitive manner;
- collect data from all hospitals on the type of Indigenous services provided on at least an annual basis;
- monitor progress on the Commission's calls to increase the number of Indigenous professionals working in health care and to retain Indigenous health-care providers in Indigenous communities; and
- develop a mechanism to monitor that all hospital staff have access to training to promote health equity and anti-racism, and measure participation rates.

ONTARIO HEALTH RESPONSE

Ontario Health accepts this recommendation. It has built many enduring relationships with Indigenous communities and learned a great deal about working together to remove Indigenous peoples'

barriers to access health care and improve Indigenous health outcomes. Many of our foundational learnings are aligned closely with the Calls to Action from the Truth and Reconciliation Commission of Canada, which is reflected in our Indigenous Health Equity Work Plan.

Ontario Health will explore opportunities with Indigenous Partners (the data agreement holders) and hospitals regarding opportunities to collect data on Indigenous patients and staff to serve Indigenous populations better. Ontario Health will continue to strengthen its annual data collection from hospitals on the type of Indigenous services they provide.

Ontario Health will implement a holistic evaluation plan incorporating Indigenous "Ways of Knowing" and methodologies to support the newly established "local obligations" outlined in the 2023 Hospital Service Accountability Agreements. The obligations include advancing Indigenous health strategies and equitable health outcomes and requiring executives to complete training on the topic. Ontario Health's actions will evolve as Ontario Health's expertise and capacity in this work increases and as its goals are met, and as Indigenous priorities shift.

4.4.3 Hospitals Designated to Provide French Services Not Reviewed in a Timely Manner

As noted in **Section 2.3.3**, about 16% of the residents in Northern Ontario are French-speaking. The Ministry of Francophone Affairs defines a French-designated area as one where Francophones make up at least 10% of the population or a city which has at least 5,000 Francophones. As shown in **Appendix 12**, the North East is a designated area, while the North West is partially designated (that is, it has some "French-designated areas").

According to Ontario Health, as of January 2023, eight northern hospitals were fully designated and three were partially designated. We found that all of the fully or partially designated hospitals under the *French Language Services Act* (Act) are located in the North East.

Hospital representatives told us they have difficulty recruiting health-care professionals in general, let alone those who are bilingual or Francophone. For example, one of the fully designated hospitals we visited did not meet the full designation requirement because, as of April 2023, 26% of its staff who were in French-designated positions did not meet the linguistic requirements for their positions.

Ontario Health has set out further expectations regarding the French language in the Hospital Service Accountability Agreement. The Ministry of Health has also set out requirements for non-designated hospitals that have been "identified" to work towards designation under the Act. We selected a sample of designated, partially designated, and non-designated but identified hospitals in Northern Ontario, and requested the reports that these hospitals are required to submit to Ontario Health, and found mixed results:

- Hospitals that are designated must submit a French language services report annually. In our sample, we found the required reports were submitted.
- Hospitals that are non-designated and non-identified must submit a report annually that outlines how the hospital addresses the needs of its Francophone community. We found that one of the two sampled hospitals did not submit the required report.
- Hospitals that are non-designated and identified must submit a French language services plan and provide services in French according to their existing language capacity. In our sample, we found that none submitted the required services plan. Ontario Health informed us that it asked these hospitals to describe their progress in meeting at least five additional designation requirements each fiscal year. These five requirements are in addition to their previously identified targets, which are individual to each hospital as they are at different levels of maturity. The goal is to reach 20 total requirements to reach designation. However, we found no

Figure 15: Status of Evaluations for Northern Hospitals' Compliance with French Designation Requirements, as of August 31, 2023

Source of data: Ontario Health

Hospital*	Evaluation Due in	Evaluation Completed
Notre-Dame Hospital	2021/22	✓
Smooth Rock Falls Hospital	2021/22	✓
Lady Dunn Health Centre	2022/23	
Chapleau Health Services	2022/23	✓
Timmins and District Hospital	2022/23	✓
Health Sciences North	2022/23	
Sensenbrenner Hospital	2023/24	Evaluation in progress
Lady Minto Hospital	2023/24	
Mattawa General Hospital	2023/24	
West Nipissing General Hospital	2023/24	
North Bay Regional Health Centre	2023/24	

* A total of 11 Northern Ontario hospitals were designated to provide French services under the *French Language Services Act*.

evidence that Ontario Health has been monitoring reported data or the hospitals' progress, for which it cited concerns with a staffing shortage.

Furthermore, the Ministry of Francophone Affairs requires organizations that are fully or partially designated to complete an evaluation every three years to confirm they remain compliant with the designation requirements. In practice, designated hospitals in Northern Ontario provide data to Ontario Health, which assesses the hospitals for compliance with the designation requirements, and shares the results with the hospital. The 11 designated hospitals in Northern Ontario were due for evaluation at different times between 2020/21 and 2023/24, while six of them were due for evaluation between 2020/21 and 2022/23; however, we found that only four of the six were evaluated on time, as shown in **Figure 15**.

Not offering sufficient French language services at hospitals could hinder effective communication and accessibility for Francophone patients in Northern Ontario. For example, at one fully designated hospital we visited that received a total of 39 complaints in the last four years concerning French language services, we found instances where patients complained that they were not "actively offered" French services when they presented themselves to the point of entry screening or while receiving care—a requirement under the Act to be fully designated.

RECOMMENDATION 16

To reduce health inequities in Northern Ontario hospitals and better meet the linguistic needs of Francophone patients, we recommend that Ontario Health:

- monitor that designated hospitals complete their evaluation every three years to confirm they remain compliant with the *French Language Services Act* requirements; and
- monitor that identified hospitals submit services plans to demonstrate their capacities and progress toward meeting designation requirements.

ONTARIO HEALTH RESPONSE

Ontario Health accepts the recommendations outlined in the report to better meet the linguistic needs of Francophone patients. Improving French language services is particularly important to Ontario Health given the large Francophone population it serves in the north regions. Ontario Health will review its French Language Services Operational Plan and identify and implement strategic actions to improve measurement, monitoring,

and evaluation of French language services in the region. Ontario Health will support hospitals, and other health-service providers, on compliance and maturing the process to review their progress to increase the number of designated health-service providers, and support identified health-service providers in improving their capacity toward meeting, or increasing, the number of designation requirements completed.

RECOMMENDATION 17

To reduce health inequities in Northern Ontario hospitals and better meet the linguistic needs of Francophone patients, we recommend that the Ministry of Health collaborate with the Ministry of Francophone Affairs to assess the feasibility of mandating that hospitals in designated areas of Northern Ontario become designated under the *French Language Services Act*.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the recommendation and the importance of accessing acute health care for Northern Ontario residents and the consideration of mandating hospitals in designated areas of Northern Ontario under the *French Language Services Act*.

Further, a hospital that is not designated does not mean that there are no French services offered. Many of these smaller hospitals communicate in both languages because Ontario offers free translation services to all hospitals in designated areas and/or all hospitals that are partially/fully designated. Translation requests are sent to the regional hub (Health Science North in Sudbury) where there is a team of translators and a co-ordinator.

Noting that being designated is volunteer-based, the Ministry respects the decisions of board-governed hospitals on whether to seek formal designation based on community input and an assessment of the costs and benefits. Furthermore, because of access to free translation services, there may not be an additional incentive for smaller hospitals in designated areas in the north to become designated.

The 11 designated or partially designated hospitals represent some of the largest hospitals in the north. These hospitals are situated in more populated regions, making it easier to recruit and retain French health human resources. Consequently, these hospitals can fulfill the requirements needed for designation under the *French Language Services Act*.

The Ministry will consider the potential costs and benefits of mandating hospitals in designated areas to become designated.

4.5 Hospital Performance Measurement and Reporting

To establish and govern the relationship between Ontario Health and public hospitals, as discussed in **Section 2.4.3**, each hospital enters into an accountability agreement known as the Hospital Service Accountability Agreement (HSAA). The HSAA not only outlines the specific responsibilities and obligations of both parties, but also defines the accountability and performance expectations of hospitals, including performance indicators, associated targets, and the frequency of reporting. Ontario Health has regional teams that are responsible for monitoring the performance of hospitals in each region.

4.5.1 Not All Northern Hospitals Submitted a Consistent Set of Performance Information and Ontario Health Had No Defined Timelines to Rectify This

Hospitals submit wait times for surgeries and diagnostic imaging as well as alternate-level-of-care (ALC) information through the Wait Time Information System (WTIS), and Ontario Health is responsible for monitoring this information. The ALC information measures the extent to which patients occupy hospital beds, but in fact no longer require acute-care services; they are ready to be discharged from the hospital, but are waiting for another more appropriate care setting

such as a long-term care home, a rehabilitation facility or home care.

We found that not all 36 Northern Ontario hospitals report wait times, while only half the hospitals reported ALC information through WTIS and the others reported it through a separate system. As such, at the time of our audit, Ontario Health had to rely on multiple sources of information to review the performance of all northern hospitals, or to identify any that may be performing poorly so that issues could be more readily addressed. However, we found that information stored in one source was less complete than the other source, affecting the comparability of the information.

Of the 36 Northern Ontario hospitals:

- six did not report surgical wait times, even though these hospitals provided surgical services to patients;
- seven others did not report wait times for CT scans, a type of diagnostic imaging, even though these hospitals provided diagnostic imaging services to patients;
- 18 did not submit ALC information through the information platform (WTIS) and therefore Ontario Health had to use a different report to obtain the ALC data for these hospitals on a weekly basis. However, this reported data does not substitute the WTIS report because it is only available weekly rather than daily, and only includes acute-care patients instead of all ALC patients, their admission source and barriers to discharge.

During our audit, Ontario Health was collaborating with two of the six northern hospitals that did not report surgical wait times to onboard them to WTIS, but this work was still ongoing when we completed the audit. Ontario Health had no defined timeline to complete the onboarding for these two hospitals. For the remaining hospitals, the agency informed us that it was still in the initial planning stages and timelines had not been established yet. According to a presentation made by Ontario Health to hospitals in 2023 on WTIS onboarding, the process of onboarding required about seven months of effort and resources, including planning, clinical engagement, interface development, testing, mapping, registration, training, data quality and compliance.

4.5.2 Hospitals No Longer Required to Aim for Targets Relating to Diagnostic Imaging and Emergency Department Wait Times

In 2023/24, Ontario Health introduced a new version of the HSAA for all hospitals in Ontario, but some indicators—including wait time for diagnostic imaging and emergency department length of stay—were reclassified from performance indicators to monitoring indicators. In doing so, Ontario Health eliminated the requirement for hospitals in Ontario to achieve specific targets for these indicators. Ontario Health told us this change was necessary because of the current state of the health system, where it may not be reasonable to request an action plan from hospitals when they do not meet targets and it might be more relevant to focus on mitigation discussions. The different types of indicators mentioned in the HSAA are described in **Figure 16**.

Not having a target could deter hospitals from innovating to achieve better results. For instance, **Figure 17** and **Figure 18** show the performance of

Figure 16: Types of Indicators Used in the Hospital Service Accountability Agreement

Source of data: Ontario Health

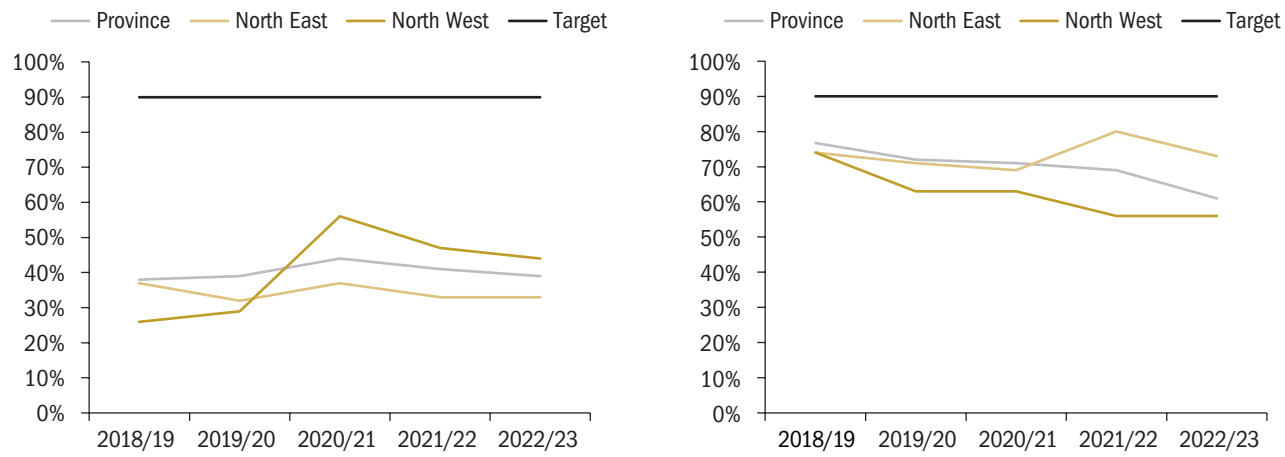
Type of Indicator	Definition
Performance indicator	A measure of hospital performance for which a target is set.
Monitoring indicator	A measure of hospital performance that may be monitored against provincial results or provincial targets, but for which no target is set.
Explanatory indicator	• A measure that is connected to and helps to explain performance in a performance indicator or a monitoring indicator. • May or may not be a measure of hospital performance. • No target is set.
Performance target	The level of hospital performance expected with regard to a performance indicator or a service volume.

the two regions in Northern Ontario compared to the whole province regarding wait times for non-emergency adult MRI and CT scans, and the average wait times in emergency departments, respectively. Over the last five years, North East and North West hospitals were far from meeting the target for wait times for MRI scans, and the average length of stay in emergency departments for admitted patients continued to increase in the regions.

To align with provincial priorities and reflect the current hospital operating environment and focus, Ontario Health introduced two new performance

Figure 17: Percentage of Non-Emergency* Adult MRI and CT Scans Completed within Target Wait Times, 2018/19–2022/23

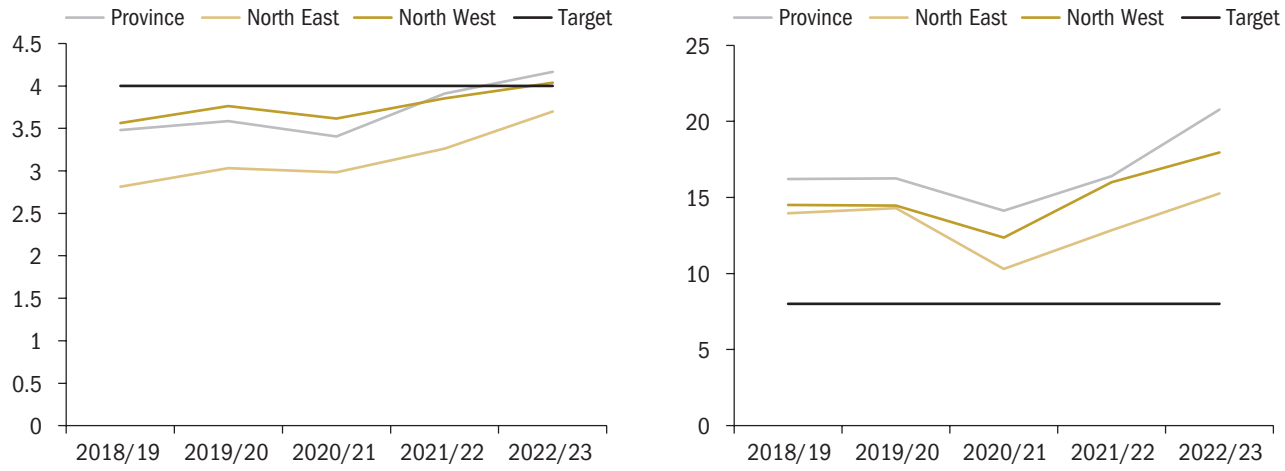
Source of data: Ontario Health



* Non-emergency includes priority 2 to 4 MRI and CT scans (with priority 2 being the most urgent) compared to priority 1 scans, which are emergencies.

Figure 18: Average Number of Hours Spent in Emergency Department for Non-admitted and Admitted Patients, 2019/20–2022/23

Source of data: Ontario Health



indicators in the 2023/24 HSAA, for which hospitals would be required to meet specific targets; these were the percentage of overall long-waiters across all surgical areas (that is, the percentage of patients whose total wait time for a surgical procedure exceeded the target) and ALC throughput ratio (that is, the ratio of discharged ALC patients to newly added ALC patients over a period of time).

In March 2020, shortly after the COVID-19 pandemic was declared a public health emergency, the Ministry had asked all hospitals to cease all non-essential and elective services or reduce them to minimal levels. Ontario Health indicated that this contributed to the increased wait times for diagnostic imaging and surgical services, and setting targets during this time would affect the hospitals' ability to meet targets.

4.5.3 Over 40% of Northern Hospitals Not Contractually Required to Measure and Report on Health Equity

We found that the Hospital Service Accountability Agreement (HSAA) between individual hospitals and Ontario Health does not require hospitals to measure health equity through the use of performance or monitoring indicators. This is despite the fact that both the Ministry and Ontario Health have designated promoting health equity as a strategic priority in 2022/23.

Ontario Health stated that although health equity is not yet measured through the HSAA, it is monitored through expectations outlined under the local obligations of HSAA. In the HSAA for 2023/24, these obligations require hospitals to plan, measure and report on health outcomes, culturally safe access to services, and hospital executive training related to promoting the health of Indigenous peoples. However, Ontario Health staff stated that it will support hospitals to put plans in place by 2024/25 because it needs more time to work on streamlining the planning requirement to ensure consistency across hospitals and to define the metrics that will measure progress.

The 2023/24 HSAA came into effect on April 1, 2023, but as of October 2023, Ontario Health had given extensions to 16 or 44% of the 36 Northern Ontario hospitals to sign this agreement by March 31, 2024. Ontario Health has provided similar extensions to hospitals in other regions given the financial uncertainty faced by hospitals as the Ministry and Ontario Health were still working to fully determine the impact that the overturning of Bill 124 would have on hospital staff's retroactive pay, and as the impact gets realized by the hospitals depending on the arbitration awards, along with inflation and other pressures. Hospitals that had not yet signed the new HSAA would not be bound contractually toward the new indicators and local obligations, though Ontario Health still expects hospitals to report on the new indicators, achieve related targets, and respond to its queries when targets are not being met.

RECOMMENDATION 18

To more effectively monitor the performance of hospitals, we recommend that Ontario Health:

- evaluate the benefits of onboarding all Northern Ontario hospitals that are not currently reporting all information on wait times for surgeries and diagnostic imaging, and alternate-level-of-care rates through the Wait Time Information System, establish an implementation plan with timelines, and collaborate with the Ministry of Health and these hospitals to complete the onboarding;
- reinstate performance targets for wait time indicators for diagnostic imaging and emergency department length of stay in the next iteration of the Hospital Service Accountability Agreement; and
- require hospitals to measure and report indicators related to health equity.

ONTARIO HEALTH RESPONSE

Ontario Health agrees with this recommendation. To ensure effective monitoring, Ontario Health will evaluate the benefits of onboarding remaining hospitals to the Wait Time Information System and develop an implementation plan and timeline in collaboration with the Ministry of Health and

the hospitals. Ontario Health will also review the prior Hospital Service Accountability Agreements' indicators for diagnostic imaging and emergency department length-of-stay for appropriateness in future agreements. Ontario Health will continue to include and expand expectations regarding health equity reporting in the agreements.

4.5.4 Limited Intervention by Ontario Health for Hospitals Not Meeting Performance Targets

Ontario Health collects financial performance indicators from all 36 hospitals in Northern Ontario as part of the HSAA reporting requirements. As shown in **Figure 19**, in 2022/23, 30 of the 36 hospitals showed negative total margins—this is the highest proportion of hospitals in Northern Ontario with expenditures exceeding revenue in the last five years, as illustrated in **Figure 20**. In addition, 14 of the 36 hospitals in 2022/23 experienced liquidity challenges, with their current ratios below one. According to the HSAA, hospitals are required to plan for and maintain an annual balanced operating budget, which means that for each funding year, the total expenses of the hospital must be equal to or less than its total revenue. In 2023/24, the agency put a hold on the need for all hospitals across Ontario to submit hospital improvement plans, to recognize that hospitals face rising agency nurse costs and retroactive pay increases to hospital staff following the strike-down of Bill 124, as explained in **Section 2.3.1**. At the time of our audit, Ontario Health and the

Figure 19: Total Margin and Current Ratio for Hospitals in Northern Ontario, 2022/23

Source of data: Ontario Health

Hospital	Total Margin (%)	Current Ratio
Blind River North Shore Health Network	(11.99)	0.94
Smooth Rock Falls Hospital	(9.46)	0.80
West Nipissing General Hospital	(7.53)	0.97
Temiskaming Hospital	(7.53)	0.82
Geraldton District Hospital	(6.93)	1.69
Nipigon District Memorial Hospital	(6.84)	0.81
Lake of the Woods District Hospital	(6.14)	1.14
Bingham Memorial Hospital	(6.08)	1.09
North of Superior Healthcare Group	(6.02)	0.92
Riverside Health Care Facilities Inc	(5.92)	0.74
Weeneebayko Area Health Authority	(4.16)	1.37
Atikokan Health and Community Services	(4.01)	1.81
Notre-Dame Hospital	(3.86)	1.05
North Bay Regional Health Centre	(3.59)	0.88
St. Joseph's General Hospital	(3.58)	1.59
Dryden Regional Health Centre	(3.32)	1.00
Blanche River Health	(3.20)	1.58
Sioux Lookout Meno Ya Win Health Centre	(2.70)	0.90
Services de santé de Chapleau Health Services	(2.64)	0.97
West Parry Sound Health Centre	(2.49)	1.06
Timmins and District Hospital	(2.16)	0.62
Lady Minto Hospital	(2.08)	1.04
Mattawa General Hospital	(1.88)	2.14
Health Sciences North	(1.85)	0.69
Espanola General Hospital	(1.50)	1.75
Manitoulin Health Centre	(1.29)	0.90
Lady Dunn Health Centre	(1.26)	1.87
Red Lake Margaret Cochenour Memorial Hospital	(0.79)	1.57
Anson General Hospital	(0.65)	1.03
Thunder Bay Regional Health Sciences Centre	(0.20)	0.88
Sault Area Hospital	0.18	1.03
Sensenbrenner Hospital	1.13	1.22
St. Joseph's Continuing Care Centre of Sudbury	2.11	1.98
Santé Manitouwadge Health	2.37	1.27
St. Joseph's Care Group	2.50	1.01
Hornepayne Community Hospital	2.66	2.28

Figure 20: Hospitals in Northern Ontario with a Negative Total Margin,[1] 2018/19–2022/23

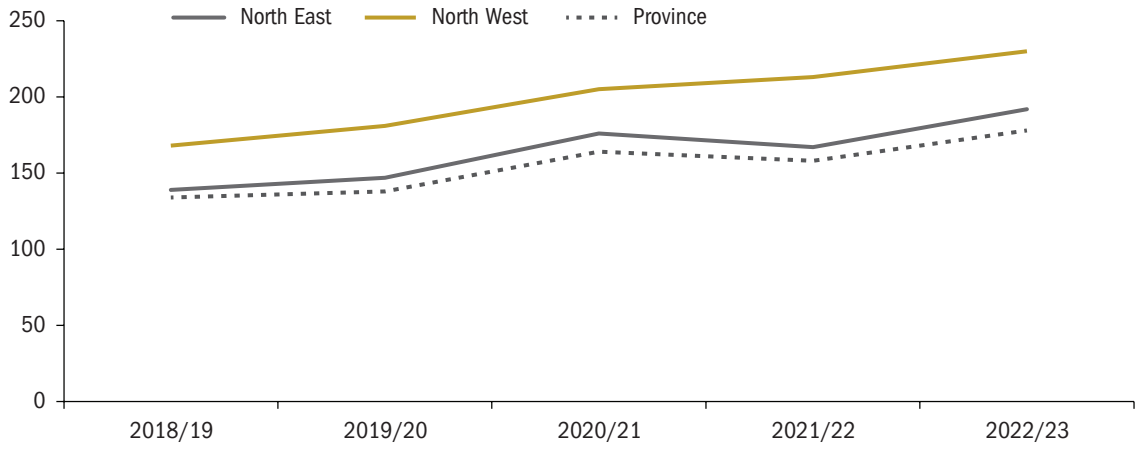
Source of data: Ontario Health

	2018/19	2019/20	2020/21	2021/22	2022/23
# of all hospitals[2]	37	37	37	36	36
# of hospitals with a negative total margin	11	9	1	3	30
% of all hospitals that had a negative total margin	30	24	3	8	83

1. Negative total margin means total hospital expenses exceeded total revenue.
2. In 2020/21, Englehart & District Hospital Inc. and Kirkland and District Hospital merged to become Blanche River Health, reducing the total number of hospitals from 37 to 36 in following years.

Figure 21: Average Wait Times for All Adult Surgeries, by Region, 2018/19–2022/23 (# of Days)

Source of data: Ontario Health



Note: Wait times include time waited from referral to first clinician appointment, and time waited from decision to surgery.

Ministry had not finalized their plans to help hospitals manage these financial deficits.

We also found that Ontario Health did not consistently require underperforming hospitals to submit hospital improvement plans, even before it put a hold on the need to submit these plans. For instance, 11 hospitals had deficits for one or multiple fiscal years between 2018/19 and 2021/22, but were not required to have operational reviews or submit hospital improvement plans. Ontario Health did not have documented justification for why all hospitals with poor financial performance did not develop and submit hospital improvement plans. Ontario Health stated that it considered multiple factors—including the magnitude of the deficit, forecast future revenue, and the reasons for the deficits and whether they were within the hospital's control—when determining whether to request hospital improvement plans from hospitals that underperformed.

We also noted that over the last five years, the North East and North West regions' surgical wait times for adults rose consistently year over year and consistently exceeded the average wait times for the entire province, as shown in **Figure 21**. In response to this, Ontario Health worked with hospitals to establish recovery plans aimed at improving surgical wait times and reducing the percentage of long-waiters (that is, patients who have waited longer than target wait times) to 30%, which is higher than the HSAA target of 20% but was within the agency's established acceptable range of results. During our audit, Ontario Health started working with northern hospitals that missed the provincial target for diagnostic imaging wait times, which we described in **Section 4.5.2**, to help them establish recovery plans to address their underperformance.

RECOMMENDATION 19

To recognize that hospital performance could be affected by outside factors beyond their control, but still drive improvements in other ways within a hospital's control, we recommend that Ontario Health identify and monitor alternative performance indicators if it concludes that a hospital is not meeting targets because of factors beyond their control.

ONTARIO HEALTH RESPONSE

Ontario Health agrees with this recommendation. Ontario Health will continue to monitor relevant indicators for hospitals in support of driving improvements in areas within a hospital's control, and will explore opportunities to identify and develop other indicators to drive improvements in areas beyond a hospital's control.

RECOMMENDATION 20

To hold hospitals more accountable for delivering expected performance levels, we recommend that Ontario Health work with underperforming hospitals to develop and implement a mutually agreed upon action plan to rectify performance issues, and monitor their progress.

ONTARIO HEALTH RESPONSE

Ontario Health agrees with this recommendation. Ontario Health supports holding hospitals accountable for delivering expected performance and will continue to work with underperforming hospitals to ensure performance improvement plans are in place and progress and effectiveness is appropriately monitored.

Appendix 1: Number of Total Beds and Type of Acute-Care Services Offered in All 36 Public Hospitals in Northern Ontario

Source of data: Ministry of Health and individual hospitals in Northern Ontario

			Acute-Care Services Offered[2]					
Hospital	City	# of Beds[1]	Emergency Care	Obstetrics and/or Gynaecology	Paediatrics	Surgical Care	MRI	CT
Health Sciences North	Sudbury[3]	561	✓	✓	✓	✓	✓	✓
Thunder Bay Regional Health Sciences Centre	Thunder Bay	442	✓	✓	✓	✓	✓	✓
North Bay Regional Health Centre	North Bay[3]	431	✓	✓	✓	✓	✓	✓
Sault Area Hospital	Sault Ste. Marie	288	✓	✓	✓	✓	✓	✓
St. Joseph's Care Group[4]	Thunder Bay	263						
Timmins and District Hospital	Timmins	192	✓	✓	✓	✓	✓	✓
St. Joseph's General Hospital[5]	Elliot Lake	75	✓	✓		✓		✓
Lake of the Woods District Hospital	Kenora	70	✓	✓		✓	✓	✓
Temiskaming Hospital	New Liskeard	69	✓	✓		✓		✓
Weeneebayko Area Health Authority[5]	Moose Factory[3]	68	✓	✓[6]	✓[6]	✓		✓
Sensenbrenner Hospital	Kapuskasing	67	✓	✓		✓		✓
St. Joseph's Continuing Care Centre of Sudbury[4]	Sudbury	63						
West Parry Sound Health Centre	Parry Sound	63	✓	✓		✓		✓
Meno Ya Win Health Centre	Sioux Lookout	60	✓	✓	✓	✓		✓
Blanche River Health	Kirkland Lake[3]	58	✓		✓	✓		✓
West Nipissing General Hospital	Sturgeon Falls	49	✓					✓
North of Superior Healthcare Group	Terrace Bay[3]	45	✓	✓		✓		
Riverside Health Care Facilities	Fort Frances[3]	44	✓	✓	✓	✓		✓
Notre-Dame Hospital	Hearst	42	✓			✓	✓	✓
Dryden Regional Health Centre	Dryden	42	✓	✓		✓		✓
Anson General Hospital	Iroquois Falls	34	✓					
Lady Minto Hospital	Cochrane	33	✓			✓		
Manitoulin Health Centre	Little Current[3]	32	✓	✓				
North Shore Health Network	Blind River[3]	27	✓					

Hospital	City	# of Beds[1]	Acute-Care Services Offered[2]					
			Emergency Care	Obstetrics and/or Gynaecology	Paediatrics	Surgical Care	MRI	CT
Geraldton District Hospital	Geraldton	23	✓					
Services de santé de Chapleau Health Services	Chapleau	20	✓		✓			
Mattawa General Hospital	Mattawa	19	✓					
Red Lake Margaret Cochenour Memorial Hospital	Red Lake	18	✓			✓		
Bingham Memorial Hospital	Matheson	17	✓					
Espanola General Hospital	Espanola	17	✓					
Smooth Rock Falls Hospital	Smooth Rock Falls	17	✓					
Atikokan General Hospital	Atikokan	15	✓					
Nipigon District Memorial Hospital	Nipigon	15	✓					
Lady Dunn Health Centre	Wawa	12	✓					
Santé Manitouwadge Health	Manitouwadge	9	✓					
Hornepayne Community Hospital	Hornepayne	3	✓					
Total		**3,303**						

1. Based on number of "Total Beds (daily average)" as reported by hospitals to the Ministry of Health via the 2022/23 Bed Census Summary.
2. Based on data reported by individual hospitals that responded to our questionnaire in September 2023.
3. City of main site—hospital has multiple sites.
4. This hospital provides non-acute care services such as mental health, rehabilitation, or complex continuing care.
5. Offering of acute-care services based on information provided by Ontario Health.
6. Services provided by visiting specialist(s).

Appendix 2: Provincial Programs to Recruit and Retain Physicians and Nurses in Ontario Hospitals

Source of data: Ministry of Health and Ontario Health

Program	Description	Operated by	Designed for Northern Ontario
Northern and Rural Recruitment and Retention Initiative	Helps attract physicians to establish a new full-time practice in eligible communities throughout the province, including the north, by providing payments between about $85,000 and $125,000 paid over a four-year period.	Ministry of Health	✓
Northern Physician Retention Initiative	Helps retain full-time physicians in the north who have already completed at least four years of continuous full-time practice by paying a retention incentive equivalent to just over $7,400 for each year they continue to practise in the region.	Ministry of Health	✓
Tuition Support Program for Nurses	Helps attract nurses from rural and remote communities to return to practise in eligible communities across the province within their first year of graduation by offering tuition reimbursement. The length of return of service required is based on the number of year's tuition that is reimbursed.	Ministry of Health	
Physician Return of Service Programs	Includes multiple programs that help physicians commit to practise in an eligible Ontario community for up to five years in exchange for training or interest relief support.	Ministry of Health	
International Medical Graduates Return of Service	A type of return-of-service program that provides an opportunity for physicians educated outside of Canada to apply for residency positions through the Canadian Resident Matching Services. This return of service is five years, and can be completed anywhere other than the Greater Toronto Area and Ottawa.	Ministry of Health	
Repatriation Program Return of Service	A type of return-of-service program that offers participants an opportunity to complete a residency training position in order to meet Canadian certification. In return, participants commit to practise medicine in an eligible Ontario community for up to five years. This can be completed anywhere other than the Greater Toronto Area and Ottawa.	Ministry of Health	
Northern Specialist Locum Programs	Provides relief and vacancy locum coverage to help support the recruitment and retention of specialists in Northern Ontario communities.	Ontario Health	✓
Emergency Department Locum Program	Helps hospitals avert closure of an emergency department because of physician unavailability; provides urgent locum coverage as an interim measure of last resort to designated hospitals facing significant challenges covering emergency department shifts.	Ontario Health	

Program	Description	Operated by	Designed for Northern Ontario
Rural Family Medicine Locum Program	Supports the viability of rural practice and helps to maintain ongoing primary medical care in eligible communities in Ontario by providing short-term locum coverage for practising rural family physicians.	Ontario Health	
Community Commitment Program for Nurses	Helps attract registered nurses, registered practical nurses and nurse practitioners who have not worked as a nurse in the prior six months to work in hospitals and other health-care facilities by providing $25,000 for a two-year commitment. Program started in May 2022.	Ontario Health	
Distributed Medical Education programs	Provide rural and regional clinical education opportunities outside of Academic Health Sciences Centres (Health Sciences North and Thunder Bay Regional Health Centre in the north) to undergraduate and postgraduate medical trainees at all medical schools. One of the goals is to promote physician practice in rural and northern communities.	Medical Schools	
Hospital Special Premium Payment	Physicians with a practice location with a Rurality Index for Ontario score >=40 receive a hospital special premium payment of a) $7,500 if they have provided $2,000 in eligible hospital services, and b) an additional $5,000 if they have provided an additional $6,000 or more in eligible hospital services, for a maximum of $12,500.	Ministry of Health	

Appendix 3: List of Ontario Health Teams in Northern Ontario and Date Created

Source of data: Ontario Health

Ontario Health Team	Region	Hospital	Date Created
Nipissing Wellness	North East	North Bay Regional Health Centre	Dec 7, 2019
		West Nipissing General Hospital	
All Nations Health Partners	North West	Lake of the Woods District Hospital	Dec 9, 2019
Algoma	North East	Sault Area Hospital	Jul 23, 2020
		North Shore Health Network	
Rainy River District	North West	Atikokan General Hospital	Nov 18, 2020
		Riverside Health Care Facilities (sites: La Verendrye Hospital, Rainy River Health Centre, Emo Health Centre)	
Maamwesying	North East	St. Joseph's General Hospital*	Oct 14, 2022
		Espanola General Hospital*	
Noojmawing Sookatagaing (previously City and District of Thunder Bay)	North West	Thunder Bay Regional Health Sciences Centre	Oct 14, 2022
		St. Joseph's Care Group	
		Nipigon District Memorial Hospital	
		Santé Manitouwadge Health	
		Geraldton District Hospital	
		North of Superior Healthcare Group (sites: McCausland Hospital and Wilson Memorial General Hospital)	
Kiiwetinoong Health Waters	North West	Red Lake Margaret Cochenour Memorial Hospital	Oct 14, 2022
		Dryden Regional Health Centre	
		Sioux Lookout Meno Ya Win Health Centre	
Timiskaming Area	North East	Blanche River Health (sites: Kirkland & District Hospital; Englehart & District Hospital)	Jul 13, 2023
		Temiskaming Hospital	
Cochrane District	North East	Smooth Rock Falls Hospital	Jul 13, 2023
		Timmins and District Hospital	
		Sensenbrenner Hospital	
		Notre-Dame Hospital	
		Anson General Hospital	
		Bingham Memorial Hospital	
		Lady Minto Hospital	
		Services de santé de Chapleau Health Services	
		Hornepayne Community Hospital	
Sudbury Espanola Manitoulin Elliot Lake	North East	Manitoulin Health Centre (sites: Little Current, Mindemoya)	Jul 13, 2023
		St. Joseph's Continuing Care Centre of Sudbury (sites: Greater Sudbury, South Bay Rd, Clarion Hotel)	
		St. Joseph's General Hospital*	
		Espanola General Hospital*	
		Health Sciences North	

* This hospital participated in two Ontario Health Teams at the time of our audit.

Appendix 4: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

Ministry of Health and Ontario Health
1. Provincial strategies are in place and being achieved to support the delivery of timely and patient-centred services in hospitals in Northern Ontario.
2. Performance indicators and targets are established and continuously monitored against actual results to ensure that intended outcomes are achieved and corrective actions are taken on a timely basis when issues are identified.
3. Provincial programs to recruit and retain qualified health-care professionals in Northern Ontario hospitals are regularly monitored and assessed to ensure cost-effectiveness.
4. Initiatives to increase accessibility to hospital services are regularly monitored and assessed to ensure they are meeting their intended purposes.
Selected Hospitals
1. Hospitals co-ordinate with other health service providers to ensure that patients have timely and equitable access to care and health services.
2. Hospitals provide culturally and linguistically appropriate services to patients.
3. Hospitals use available financial and health human resources with due regard for economy and efficiency.
4. Sufficient, appropriate and timely information is available to allow effective oversight of hospital operations.

Appendix 5: Recommendations from the Rural and Northern Health Care Framework/Plan—Stage 1 Report, 2010

Source of data: Rural and Northern Health Care Panel

1.	Create a single point of focus within the Ministry of Health and Long-Term Care (now the Ministry of Health) for rural, remote and northern health. Identifying one person, group or section responsible for rural and northern health will increase accountability in this critical area, and make it easier to define and monitor standards for increasing access to health care.
2.	Establish a process to identify strategies and guidelines to improve access to health-care services for First Nations communities. First Nations communities have unique and complex health-care needs. Any plan to improve access to health care in rural and northern communities must consider these, while also considering the needs of remote, isolated and distant non-Indigenous communities.
3.	Continue to explore innovative ways of attracting health professionals to rural, remote and northern communities in Ontario. There is a constant need for doctors and nurses, as well as nurse practitioners, pharmacists, dieticians and other health-care professionals. Any plan to attract these professionals to rural and northern communities must also be integrated into the broader strategy to attract health-care professionals to Ontario.
4.	Explore ways of better integrating Emergency Medical Services (land and air) with the planning and delivery of local health services in rural and northern communities in Ontario. Currently, Emergency Medical Services are organized at a municipal level and funding and delivery models vary across different regions. This can create barriers to access, particularly in a region as vast as Northern Ontario. Better integration with Local Health Integration Networks (LHINs)* will lead to increased collaboration and co-ordination, resulting in better patient care.
5.	Explore ways of better integrating Public Health services in rural and remote Ontario. As is the case with Emergency Medical Services, public health services and delivery models vary from region to region. This can create imbalances and fragmented services. Better integration with LHINs can help to correct those imbalances.
6.	Support a "local hub" model of health planning, funding and delivery in rural, remote and northern communities. By integrating services across different health sectors and across different communities in rural and Northern Ontario, all parts of the health-care system can work together to deliver the best possible care to patients.
7.	Create a culture of collaboration and co-ordination amongst health-care providers in rural and Northern Ontario. Clearly identify roles and responsibilities and put in place the necessary infrastructure to support a better system of referrals, more efficient patient transfers and better overall access to care.
8.	Improve and strengthen relationships between academic health sciences centres (teaching and research hospitals) and local providers in rural, remote and northern communities. Bigger hospitals have much to offer in the way of support to local providers, and formal networks should be established to enable and encourage that support. This includes telemedicine, patient transfers, remote consultations and the sharing of best practices.
9.	Engage local communities to actively participate in the decision-making process for health-care planning, funding and delivery. The very best way to identify and meet local health-care needs is to consult with local communities. Improved collaboration and dialogue between the public, health-care providers and LHINs is a critical component of any plan to increase access to health-care services.
10.	Conduct a review of how best to improve planning, co-ordination and funding of inter-facility transfers. Moving patients from one facility to another can be difficult, particularly in rural and remote areas. Improving access to care means improving the ways in which we move people between the facilities where they receive that care.

11. Conduct a review of how best to enhance community-based non-urgent transportation solutions. The availability of non-urgent (i.e., not Emergency Medical Services or ambulance) transportation services is very limited in many rural, remote and northern areas of the province. This results in residents either not being able to travel to access care, or incurring high out-of-pocket costs while doing so. The new rural and northern health-care framework must contain measures to enhance non-urgent transportation in areas of the province where it is lacking.

12. Increase the availability of clinical and education technology. Electronic information management holds great potential to improve health care, and that is particularly true in rural and remote areas where travel can be difficult and there may be relatively fewer health-care providers. Any plan to improve access must take advantage of services such as eHealth, telemedicine, and simulation learning, and should include incentives to encourage their use by health professionals.

* On April 1, 2021, the Local Health Integration Networks (LHINs) continued to operate under a new business name, Home and Community Care Support Services, with a narrowed mandate to deliver and arrange patient services. Non-patient functions, such as funding, planning and community engagement, were transferred to Ontario Health.

Appendix 6: Examples of Other Jurisdictions' Health-Care Strategies Targeting Rural Areas

Prepared by the Office of the Auditor General of Ontario

British Columbia

Northern Health released its 2020–2023 Strategic Plan and 2020/21–2022/23 Service Plan, which included initiatives that focused on:

- partnerships to develop and support accessible affordable housing;
- innovative practices in transportation, accommodation, and technology to balance the fact that services are not available in every community;
- increasing the participation of Indigenous workers in health care and health sciences; and
- partnerships to support the employment of locally representative workforces.

Virginia, USA

The Virginia Rural Health Plan 2022–2026 focuses on seven priority areas to monitor the overall health and well-being of the state's rural communities. These areas include education, nutrition and food security, healthy moms and babies, access to health-care services, behavioural health, substance use disorder and recovery, and workforce development.

Queensland, Australia

The Rural and Remote Health and Wellbeing Strategy 2022–27 outlines what the state calls a "whole-of-system approach" to achieving health equity for its rural and remote populations. The strategy recognizes the importance of building stronger partnerships with health, non-health, public, not-for-profit and private system partners to align activities, share resources and share accountabilities.

Australia

The Department of Health and Aged Care's Stronger Rural Health Strategy aims to build a sustainable, high-quality health workforce by 2028 that is distributed across the country based on community need. With a focus on rural and remote communities that have difficulty attracting health-care professionals, the strategy includes many initiatives related to teaching, training, recruitment and retention to improve the health of people in rural areas.

Appendix 7: Examples of Other Jurisdictions' Health-Care Staffing Strategies with Actions Targeting Rural Areas

Prepared by the Office of the Auditor General of Ontario

British Columbia
The Health Human Resource Strategy—Putting People First includes immediate new actions as well as initiatives under way for health professions including paramedics, pharmacists, nurses and physicians. The strategy includes 70 actions that will span five years, focusing on four areas—retain, redesign, recruit and train—to achieve a healthy and productive workforce. Certain actions help direct health-care professionals to rural communities. For example, one action is to develop a new provincial travel resource pool to help deploy nurses to communities of need for short-term support. Another action is to collaborate with other ministries to develop a provincial health sector housing strategy to address barriers to recruitment in communities where market housing is not readily available. In addition, the strategy introduces specific approaches to support and protect Indigenous patients and providers.
Saskatchewan
The Health Human Resources Action Plan includes investing more than $60 million into four areas to address the challenges in health-care staffing and build a more sustainable health-care workforce. The four areas are recruitment, training, incentives and retention, and each area includes action items. For example, one action item aims to add 100 new full-time positions in rural and remote areas for professions such as registered nurses and licensed practical nurses, among others. The plan also mentions converting 150 part-time positions to full-time permanent positions in rural and remote areas for some health-care professions. The Saskatchewan government also intends to provide up to $50,000 in incentive funding over three years for a return-of-service agreement for hard-to-recruit positions, mainly in rural and remote areas. The plan also calls for developing a First Nations and Métis recruitment and retention strategy.

Appendix 8: Tools Used to Track Staffing Data in Northern Hospitals and Deficiencies of Each Tool

Prepared by the Office of the Auditor General of Ontario

Tool	Inception Date	Frequency of Reporting	Description	Deficiencies
Ontario Health North Workforce Profile Tool	Late 2022	Ongoing	• Enables hospitals in Northern Ontario to create and maintain profiles for their current workforce, including nurses. • Ontario Health would use this information to understand the vacancy and agency staffing rates across multiple sectors, as well as to forecast future needs and staffing pressures by geography and type of pressure (such as physician vs. nurses).	• Not yet fully implemented; Ontario Health plans to fully implement this information tool by March 2024. • Participation rate was just over 50% of all northern hospitals as of May 2023, according to Ontario Health.
HealthForceOntario—Northern Ontario Physician Data Collection	2018	Twice yearly	• HealthForceOntario (now part of Ontario Health) began collecting this data in 2018, in partnership with the Northern Ontario School of Medicine (NOSM). • Ontario Health collects data on the number of physicians working and the number of physicians that hospitals were recruiting for at the time.	• Ontario Health must conduct a significant amount of follow-up to obtain complete data, which is then passed to NOSM and discussed with stakeholders.
S9 Census	Apr 2020	Monthly*	• Hospitals report data including physician and nurse shortages, vacancies and absenteeism rates. • Ontario Health began measuring this data from October 2022. Ontario Health uses the data from this census for its monthly internal reporting.	• Reporting is voluntary; as such, some hospitals may submit the data late or not at all. The Ministry of Health sends hospitals email reminders to submit data, but does not mandate reporting. • 10 of the 36 hospitals did not submit data on vacancies between October 2022 and July 2023 (based on information from Ontario Health). • Four of the seven hospitals we visited submitted the data between October 2022 and July 2023. • We found data anomalies, and were told by Ontario Health that reporting of physician information may not be fully accurate because physicians are not hospital employees and may work in multiple locations.

* At Ontario Health's request, the Ministry of Health asked all hospitals to report data weekly starting April 2020, then changed it to monthly starting May 2023.

Appendix 9: Methodology Used to Estimate Additional Costs to Provide Hospital Acute Care to Patients Designated as Alternate-Level-of-Care (ALC) and Waiting for Long-Term Care and Home Care, 2022/23

Prepared by the Office of the Auditor General of Ontario

Data Used	Most Recent Data From	Source of Data
Step 1: **Calculate the total estimated cost to keep all acute-care patients designated as ALC in northern hospitals.**		
Average daily cost for an acute-care[1] patient to stay in a hospital	2021/22	Ministry of Health
Number of days patients were designated as ALC (ALC days) at northern hospitals that submitted this information through the Wait Time Information System	2022/23	Wait Time Information System
Step 2: **Subtract the estimated cost the province would have incurred if the proportion of ALC patients waiting for long-term care had received beds in long-term care homes instead.**		
Average daily cost for a resident to stay in a long-term care home (net of resident's basic bed co-payment adjusted to the estimated collection rate)	2021/22[2]	Ministry of Health
Proportion of hospital ALC days belonging to acute-care patients who were waiting for long-term care homes	2022/23	Wait Time Information System
Step 3: **Subtract the estimated cost the province would have incurred if the proportion of ALC patients waiting for home care had received home care instead.**		
Average daily cost for a home-care client to receive care at home	2021/22[2]	Ministry of Health
Proportion of hospital ALC days belonging to acute-care patients who were waiting for home care	2022/23	Wait Time Information System
Result: $65 million		

This estimate excludes:

- ALC patients in 18 of 36 Northern Ontario hospitals that do not report this information into the Wait Time Information System.
- The number of days acute-care patients designated as ALC waited in hospitals for a long-term care home or home-care application to be processed. This could vary from one case to another, but Home and Community Care Support Services could not provide a standard timeline.
- Data on whether a hospital is at capacity or not.
- Capital costs related to long-term care beds and any additional start-up costs to operate long-term care beds and home care services.

1. Cost data provided by the Ministry is for acute-care patient only and excludes non-acute or post-acute care patients such as those in mental health and rehabilitation beds. Does not consider co-payments by patients waiting for long-term care who need to contribute a co-payment toward their stay at the hospital.
2. Though 2022/23 information was available for long-term care and home care, to keep cost information across all three sectors consistent, we opted to use 2021/22 for this analysis.

Appendix 10: Comparison of Ontario's Northern Health Travel Grant Program with Similar Programs Offered in Other Provinces

Prepared by the Office of the Auditor General of Ontario

Province/ Territory	Program	Covered Expenses			
		Meals	Accommodations	Mileage	Companion[1]
Ontario	Northern Health Travel Grant	$0	$100 per night, up to $550 for ≥8 nights; trips must be over 200 km one way	For trips over 100 km—$0.41 per km for transport by land and air	Yes, but if travel by personal vehicle, the reimbursement is split
Nunavut	Extended Health Benefits[2]	≤$50 per day depending on the situation	$50 to full cost per day, depending on the situation	Full cost with $250 return airfare deductible on approved medical travel	Yes, but not for accommodations
Newfoundland and Labrador	Medical Transportation Assistance[3]	Trips must be over 200 km one way. Depending on the patient's location, either: 1) 100% for the first $1,000; 50% for the next $3,000; and 75% for the remaining expenses per year; or 2) $400 deductible on the first claim. The first $100 of eligible expenses in excess of $400 is reimbursed at 100%; the next $3,000 is reimbursed at 50%; and any remaining eligible expenses in excess of $3,500 during the 12-month period are reimbursed at 75%.			Yes, but not for accommodations
Manitoba	Northern Patient Transportation Program[4]	$0	$0	Full cost	Yes, plus ≤$24.65 per day for meals; ≤$65 per night for accommodations (or $30 if staying in private home); ≤$35 in miscellaneous transportation for up to two days and, if driving, reimbursed at the cost of bus fare
New Brunswick	Out of Province Hostel Facilities & Meal Allowance[5]	≤$110 per day for meals and accommodations; if required to stay more than 30 days, ≤$2,500 for accommodations, but not meals		$0	Meals at ≤$66.74 per day

1. A companion is someone—usually a family member or a caregiver—who escorts the patient to obtain care elsewhere. Most programs reimburse expenses for companions only when prior approvals are given, such as when it is medically necessary to have an escort accompany a patient.
2. Eligibility: All residents who have exhausted their third-party insurance or have no medical travel benefits.
3. Eligibility: Residents who incur substantial out-of-pocket travel costs to access specialized insured medical services that are not available in their immediate area of residence and/or within the province.
4. Eligibility: Residents living north of the 53rd parallel from the Manitoba-Saskatchewan border to Lake Winnipeg, with a Manitoba health card or treaty status.
5. Eligibility: Patients who are required by their physician to travel outside the province but still within Canada and remain at least three consecutive nights at a hostel.

Appendix 11: Indigenous Healing Spaces and Cultural Practice Policies in Northern Hospitals, February 2023

Source of data: Ontario Health

Hospital	Location	Indigenous Healing Space	Traditional Practice Policy	Dedicated Indoor Smudging Space	Smudging Allowed in Patient Room
Manitoulin Health Centre	Little Current	✓	✓	✓	✓
St. Joseph's Care Group	Thunder Bay	✓	✓	✓	✓
Health Sciences North	Sudbury	✓	✓	✓	
Lady Minto Hospital	Cochrane	✓	✓	✓	In some cases[1]
Lake of the Woods District Hospital	Kenora	✓	✓	✓	
Sioux Lookout Meno Ya Win Health Centre	Sioux Lookout	✓	✓	✓	
Red Lake Margaret Cochenour Memorial Hospital	Red Lake		✓	✓	✓
Sault Area Hospital	Sault Ste. Marie	✓	✓	✓	
Thunder Bay Regional Health Sciences Centre	Thunder Bay	✓	✓	✓	
Anson General Hospital	Iroquois Falls		✓		✓
Blanche River Health	Kirkland Lake	✓		✓	
Espanola General Hospital	Espanola		✓		✓
Geraldton District Hospital	Geraldton	✓		✓	
Mattawa General Hospital	Mattawa	✓		✓	
Nipigon District Memorial Hospital	Nipigon		✓		✓
North of Superior Healthcare Group	Terrace Bay		✓		✓
North Shore Health Network	Blind River		✓		✓
Bingham Memorial Hospital	Matheson				✓
Dryden Regional Health Centre	Dryden			✓	
Santé Manitouwadge Health	Manitouwadge		✓		
Notre-Dame Hospital	Hearst				✓
Riverside Healthcare Facilities[2]	Fort Frances		✓		
Atikokan General Hospital	Atikokan				
Lady Dunn Health Centre	Wawa				
Hornepayne Community Hospital	Hornepayne	n/a			
North Bay Regional Health Centre	North Bay	n/a			
Sensenbrenner Hospital	Kapuskasing	n/a			

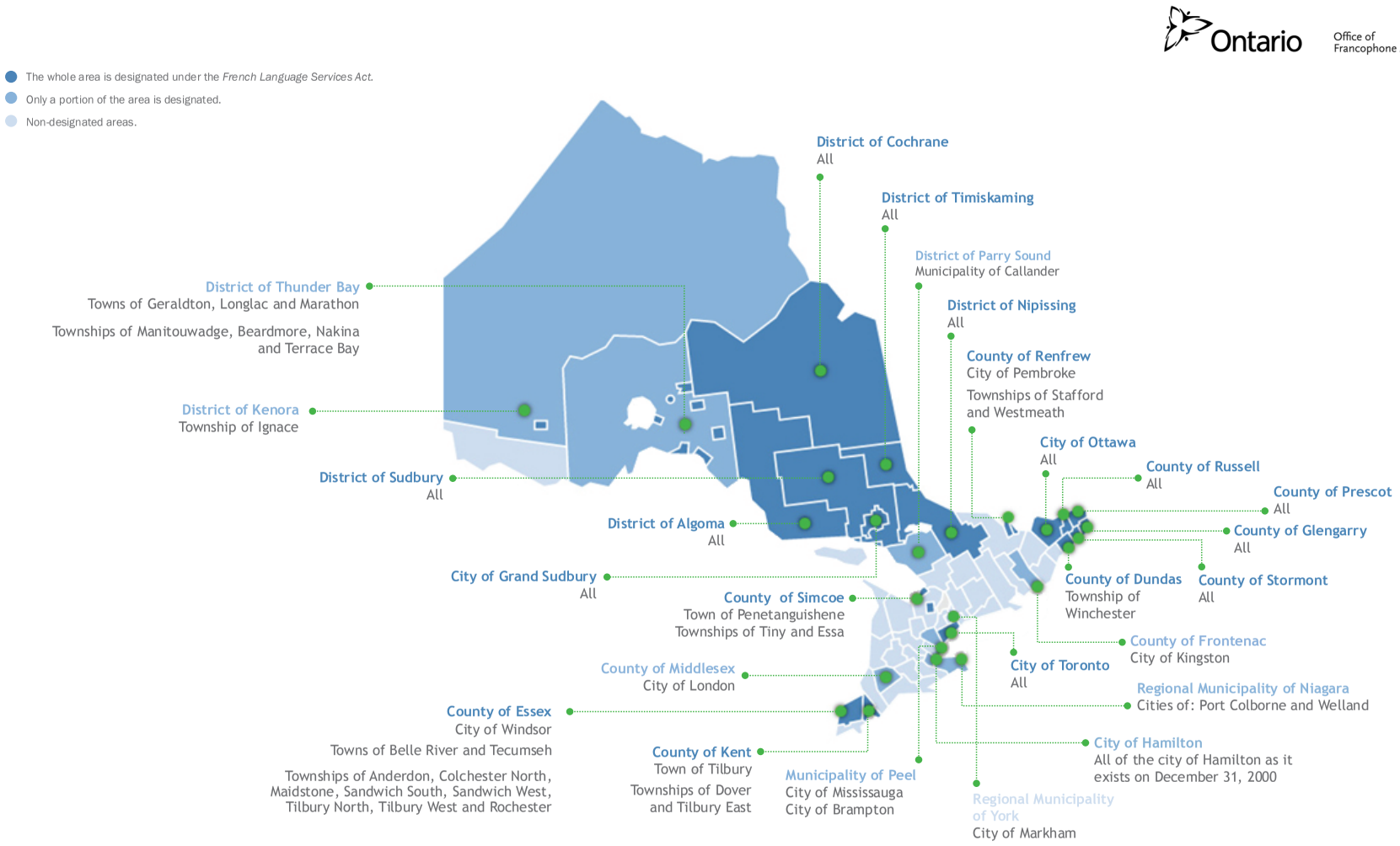
Hospital	Location	Indigenous Healing Space	Traditional Practice Policy	Dedicated Indoor Smudging Space	Smudging Allowed in Patient Room
Services de santé de Chapleau Health Services	Chapleau		n/a		
Smooth Rock Falls Hospital	Smooth Rock Falls		n/a		
St. Joseph's Continuing Care Centre of Sudbury	Sudbury		n/a		
St. Joseph's General Hospital	Elliot Lake		n/a		
Temiskaming Hospital	New Liskeard		n/a		
Timmins and District Hospital	Timmins		n/a		
Weeneebayko Area Health Authority	Moose Factory		n/a		
West Nipissing General Hospital	Sturgeon Falls		n/a		
West Parry Sound Health Centre	Parry Sound		n/a		

n/a: Hospital did not provide information to Ontario Health.

1. According to Ontario Health data, permission to smudge in a patient's room at Lady Minto Hospital depends on the case, and it may be allowed with a portable venting system.
2. Data covers three hospital sites including Emo Health Centre, La Verendrye General Hospital and Rainy River Health Centre.

Appendix 12: Map of French-Designated Areas in Ontario, as of January 2022

Source: Ministry of Francophone Affairs



Note: Last updated on January 14, 2022, through the Ministry of Francophone Affairs website, https://files.ontario.ca/ofa_designated_areas_map_en.pdf

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