In the flurry of activity surrounding health care restructuring—the hospital closures, the laying off of staff, the transfer of patients—rarely are the records given any consideration. Yet it is the records of an institution or activity that tell its history and ensure its memory into the future. This paper will address the challenges that health care restructuring pose in Ontario, though it will also consider the situation in Alberta which underwent similar health care restructuring in the mid-1990s. Although restructuring affects the whole health care system including private and psychiatric hospitals, chronic, and long-term care facilities, public hospitals are the primary focus since these institutions are the most visibly affected, and the ones with which the general public identifies the most.

The emphasis of most Western governments over the last number of years, regardless of political stripe, has been deficit reduction through, to a large extent, cuts to social spending. In Canada, the federal government has reduced provincial transfer payments for programs such as education, social assistance, and health care. Within the provinces, reduced social spending has been a given, but the degree has depended very much upon the ideological bent of the party in power. In terms of health care in Ontario, the current right-wing Conservative government of Mike Harris seized upon a process be-
gun by the left-wing NDP government of Bob Rae, and has run with it faster and cut more drastically than anyone would have believed. One of the first initiatives of the Conservative government when it took power in 1995 was to establish the arm's length Health Services Restructuring Commission to make recommendations on how to restructure the health care system. Much of what the Commission has recommended is the closure of numerous public hospital sites, and the amalgamation of services by transferring governance of one or several hospitals to one or several others. This process is not necessarily a bad thing; however, the rapidity with which it is being conducted leaves little time for careful planning. Governance issues are expected to be completed within months of the issuing of directions, and hospital sites ordered to close are expected to do so no later than the year 2000.²

What are the challenges that such rapid change poses for archivists and health care historians? First, there is a potential loss of records either through neglect or through willful destruction. This problem affects mainly the administrative documentation, not the clinical records. Most hospitals are keenly aware of their responsibilities for patient records, and indeed, the Public Hospitals Act explicitly addresses clinical records, requiring them to be kept a minimum of 10 years. Yet while hospitals have clinical records departments and specially trained staff to deal with patient charts, very few hospitals have a records management program in place to deal with the administrative records documenting the day-to-day activities of the hospital. Some hospitals have their own archives; however, these tend to be repositories for interesting odds and ends: photographs, blueprints, land deeds, and often old medical equipment. These collections are important, but they are rarely tied into the daily administration of the hospital. Often they are the preserve of retired staff, or active staff whose main job revolves around another area of responsibility. Thus, when a hospital closes down, there is no process in place for ensuring that records of the various departments (other than the clinical records) are handled effectively. Generally there is no one designated to make decisions about what records must be kept and what records can be destroyed.

There is also a problem of what to do with the archival collections that some hospitals have built up over the years. For those historically minded hospitals that have set aside old photographs, board minutes, papers of key physicians, nursing alumni papers and artifacts, and so forth, what is to become of those collections? If the hospital is being taken over by another one, will the acquiring hospital be interested in the old, historical documentation of its new partner? Or in the case where a hospital with an archives takes over a hospital without one,
Challenges Posed by Health Care Restructuring in Ontario

will the acquiring hospital make an effort to track down and incorporate records of its new partner into its existing collection?

Another challenge, and the one of which the archival community is most keenly aware, is the lack of organization, preparation and resources to preserve records offered for acquisition. Even a large provincial archives would have difficulty maintaining the voluminous records of large institutions like public hospitals. Furthermore, the speed with which the closures are taking place serves to exacerbate the problem.

Even though health care is a provincial responsibility, that does not mean the provincial archives has any authority to tell public hospitals what to do. Public hospitals in Ontario are funded by the government and subject to the provincial Public Hospitals Act, but they are run by boards of directors and therefore are not government institutions. Unlike some health care facilities, such as psychiatric hospitals which traditionally have been run directly by the government, public hospitals are not subject to government records management authorities which give the Archivist of Ontario the ultimate say over which records are kept and which may be destroyed. Nevertheless, the Archives of Ontario has become involved because its mandate is to collect not just government records, but also private manuscripts that document Ontario society. In dealing with the hospitals, therefore, persuasive arguments must be found to convince administrators that preserving their records is a valuable activity.

First, there is a valid argument to be made about legal and financial liability if records are not handled properly. Some records are governed by provincial and federal legislation and must be retained to meet continuing legal, audit, or other operational and accountability requirements. Second, the value of these records for scientific and academic research should be emphasized. Not only are patient records important for studying the development of diseases and treatments, but scholarly analysis of administrative records will benefit planning and development in the health care system and will advance understanding of health related issues and trends in Ontario. Third, there is an emotional dynamic to hospital closures, particularly within each hospital's local community. It was this latter effect—the emotional response—that convinced people in Calgary of the need to deal with their record-keeping issues.

In the province of Alberta, which began its restructuring process a few years earlier, 6 hospitals closed, 15 were converted to Community Health Centres, and 10 were converted to long-term care facilities. The provincial government established 17 regional health authorities which represented an administrative change from locally appointed hospital boards to provincially appointed regional authority boards. In Calgary,
three major acute-care facilities were ordered to close, including two of the oldest facilities in the province. Historically minded members of the Boards of the Calgary General Hospital and Holy Cross Hospital established "legacy" committees in order to determine how they could preserve a legacy of the hospitals in the city. A local archivist was contracted to work on the legacy project for Calgary General Hospital in order to inventory historical artifacts and determine how the hospital could be commemorated. When she was contacted by Holy Cross Hospital for the same purpose, the Calgary Regional Health Authority (the CRHA) took matters in hand and devised an archives project on a regional basis that would cover eight institutions including both closing hospitals and restructured hospitals remaining open.3

The archivist's tasks involved (a) preparing an inventory of records and artifacts; (b) evaluating records and artifacts and making recommendations on retention and disposal; (c) undertaking preservation measures for materials to be retained permanently; (d) arranging and describing archival records of the three closing sites; and (e) preparing a report identifying options for final disposition of records and artifacts. Her project took 2,500 person-hours over 14 months to deal with 8,000 metres of records. In the end, it was determined that 70% of the administrative records could be disposed of immediately; a further 20% were determined to have short-term value and were put in semi-active storage; and 10% were determined to have long-term evidential or historical value and were retained.

Several disposition options were presented for the archival records including dead storage and deposit in existing archives; however, in the end, the CRHA decided to establish a medical archives program as part of a larger records management program necessitated by the recent introduction of provincial freedom of information and privacy legislation. So far, the archives appears to be successful; staff have arranged and described three quarters of the records, and have fielded several hundred inquiries of which approximately half were internal administrative matters, while the other half were historical, legal, and medical.

Some lessons learned from the Calgary experience are that it often takes the initiative of key people, placed high within the hierarchy, to get such a project off the ground. It also takes the requisite archival expertise and the experts' credibility to work with a volatile staffing situation. Another lesson is that heritage issues, rather than a concern for proper records management, can be a powerful motivator; people have an emotional attachment to their community hospitals, especially to site-specific buildings. In Calgary, several commemorative displays to closing hospitals mounted in continuing hospitals fuelled the interest in an archival program.
In Ontario, the situation is somewhat different. Ontario is Canada’s most populous province, and the scale of the restructuring activities matches accordingly. The Health Services Restructuring Commission (which finished its hands-on restructuring role in April 1999, a year before it was scheduled to cease its work), ordered some three dozen hospitals to close or amalgamate. While the changes have been handled on a regional or municipal basis, there is no structure in place like Alberta’s regional health authorities to co-ordinate activities.

What has Ontario’s archival community done to meet the record-keeping challenges? When the announcement was made about the formation of the Commission, various components of the archival community came together in an attempt to be proactive about dealing with the impending crisis. The Health Archivists’ Interest Group (HAIG) sent out letters to every hospital administrator in the province outlining the concerns and offering advice on how to handle the records issues. Unfortunately, not one response was received. Perhaps these efforts were premature because at the time the letters went out, no hospitals had yet been ordered to close. Then the Archives of Ontario sponsored two consultative meetings with HAIG, the Hannah Institute for the History of Medicine, the Ontario Hospital Association, the Ministry of Health, and various archivists and historians who are knowledgeable about health records. The group devised a strategy to assist in preserving valuable hospital records and also to help closing hospitals deal with their current records problems. The strategy encourages every hospital undergoing closure or amalgamation to prepare an inventory of its information assets—what archivists call a “records inventory.” The inventory should document what series of records exist, where they are located, the physical extent, dates, and so forth. The Ontario Hospital Association’s role has been to revise its voluntary records scheduling guideline, a document originally prepared in 1985 advising hospitals of the legislative framework surrounding certain records and suggesting retention periods. Once completed, this guideline will be invaluable to the hospitals in preparing their records inventories and also in helping continuing hospitals to develop records management programs. The Health Services Restructuring Commission was contacted initially in the hopes that the requirement to prepare records inventories would be made part of its directions issued to hospitals. However, the Commission did not see its role as telling hospitals how to close. Thus, attention was turned to the Ministry of Health which has established a team to deal with implementation strategies. The ministry team was responsive to the archival community’s record-keeping concerns and is working on instructions to encourage hospitals to take proper measures to ensure the proper handling of records.
The strategy does not address the final disposition of records with historical value. Each situation will have to be considered on its own merits in light of local circumstances. Whether local archives, university archives, or the provincial archives can accommodate the archival records of closing hospitals will depend on their resources and the cooperation of the hospitals themselves. However, at least a records inventory provides a good starting point. One idea that has been proposed is to create a centralized hospital archives somewhere in Ontario, or several regionally based hospital archives. For example, a hospital archives might be created in Toronto to handle the records of the 11 hospitals affected in Metro Toronto. Similar centralized archival repositories might be considered for Kingston, Ottawa, London, and Thunder Bay. Unlike Alberta, with its regional health authorities, Ontario has no obvious organizational bodies to take responsibility for such institutions, and thus it is more difficult to imagine how such centralized archives might come into existence.

Another activity in which Ontario’s archival community could engage is to develop an acquisition strategy. Rather than waiting for hospitals to prepare records inventories and approach archivists with donation requests, archivists as a group could decide which hospitals ought to be targeted based on criteria such as age, specialities and unique characteristics, and on the quality of the records themselves. Such a strategy would likely be based on a survey of hospitals in the province and the nature of the records they hold. Here again, Alberta has taken the lead, having completed The Alberta Medical Archives Survey in 1997.6

Despite the successful Calgary model, Ontario faces several roadblocks to ensuring that valuable hospital records are preserved. In Ontario, as opposed to Alberta, there are many more hospitals affected by the restructuring. While Alberta saw only six hospitals close and another 25 converted to other types of health care facilities, in Ontario about 35 hospitals have been ordered closed or had their governance switched to another facility. Another problem faced is that by the time a hospital closes down, or its governance changes, many of the staff have left in pursuit of other jobs. The changes are happening so quickly that there may be no one around long enough to deal with the proper winding up of affairs. Furthermore, records are not a high priority next to patients, equipment, property, and jobs.

The biggest problem the archival community faces is that of coordinating and funding a records acquisition program. How many archival repositories have the resources to take on the records of even one hospital? If a centralized hospital archives is the solution, under whose auspices will it be established? And even if a structure is in place, it re-
quires the confluence of high-level support and professional expertise. The existence of the CRHA's archives owes as much to luck, in the opinion of one of its employees, as to design: the right people in the right place at the right time.

The archival community has taken one approach in responding to the challenges of hospital restructuring, but health care historians also can play an important role. The historical community can encourage the Ontario Hospital Association and the Ministry of Health to ensure that hospital records are dealt with in an appropriate manner. Archivists can speak to the value of hospital records, but historians who have actually used these types of records can do so even better, providing concrete examples of the types of studies which hospital records have supported and could potentially support in the future. On a broader level, health care historians may want to take a national perspective to encourage the long-term preservation of historical health care records in Canada. They could establish a committee (or a series of provincially based committees) to work together with archivists on a public relations strategy targeting hospitals and the general public about the value of these records. Perhaps a joint historian/archivist conference specifically devoted to health care historiography and records could be organized.

While there are many dark clouds overhead, there is a silver lining: if handled correctly, restructuring could be a catalyst for making more hospital records available for research. Most hospitals do not have records management programs that take into consideration their administrative records; a major goal of this process is to encourage not just closing hospitals, but also continuing hospitals to get their documentary houses in order.

The process has also forced the archival community to look outward a little more than it typically does by encouraging the forging of partnerships with other interested groups—the Ministry of Health, the Ontario Hospital Association, individual hospitals—and so far the response has been one of sincere interest. However, the success of the strategy is going to take more than just convincing these partners of the value of hospital records inventories. Space to house records and personnel to arrange and describe them and to provide reference services are required, regardless of who ends up maintaining them. Supportive lobbying from health care historians would also contribute to the success of this initiative. Most importantly, there is a need for vision and leadership. In Ontario, the real challenge posed by health care restructuring is whether archivists and health care historians can take advantage of the changing situation to ensure a lasting legacy for Ontario's public hospitals.
NOTES

1 A slightly different version of this paper was delivered at the annual convention of the American Association for the History of Medicine, Toronto, Ontario, 8 May 1998.
2 The Health Services Restructuring Commission’s website (http://www.hsrc-crss.org) includes its reports, notices and directions.
4 The re-election of the Conservatives in June 1999 means that the course and pace of health care reform are unlikely to swerve.
5 The Health Archivists’ Interest Group is a special interest group of the Archives Association of Ontario (AAO). Its mandate is to promote the development of and co-operation between hospital and medical archives in Ontario.