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Regionalization and the Closure of 52 Hospitals in Rural Saskatchewan

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Abstract

In the early 1990s Canada was in a recession and the government of Saskatchewan felt the pressure of a growing deficit. In 1992, the provincial government decided to reduce the health care budget by 3.3%. The following year, the government undertook regionalization of health care services through the *Health Districts Act*, with a focus on promoting preventative health care rather than solely treatment-based care. The budget cuts resulted in the closure of 52 rural hospitals, leading to a public outcry. Evaluations of the reform were not able to show a definite detrimental effect on health outcomes in the corresponding communities. Community members expressed increased caregiver burden, travel costs and travel time to the next nearest hospital, and potential inequalities in access to care. When undertaking reform, it is important that government consider the voices of local communities in the decision-making process.

Au début des années 90, le Canada était en récession et, en Saskatchewan, le déficit budgétaire posait un problème pressant au gouvernement provincial. Celui-ci décida de réduire le budget de la santé de 3,3% en 1992. L'année suivante, le gouvernement mit en place une régionalisation des services de santé fondée sur la Loi sur les Districts de Santé*, avec comme objectif de favoriser la prévention par rapport aux soins purement curatifs. 52 hôpitaux ruraux durent fermer à cause des coupes budgétaires, entraînant une réaction de rejet de la part du public. Les évaluations de la réforme n'ont pas pu établir avec certitude une détérioration de la santé dans les communautés concernées. Les habitants des communautés concernées ont exprimé une charge accrue pour les aidants, des coûts et temps de transports plus élevés pour se rendre à l'hôpital le plus proche, et d'éventuelles inégalités d'accès aux soins. Les voix des populations concernées devraient être écoutées lors de la prise de décision sur de telles réformes.*

Key Messages

- Evaluations of the closure of 52 rural hospitals resulting from the *Health Districts Act* were not able to show a definite detrimental effect on health outcomes of communities served.
- Strengths of the reform included a decrease in Saskatchewan government health spending, a number of staffed beds per 1000 population closer to the national average, a focus on wellness, and the creation of autonomous district boards that better understood population needs.
- Weaknesses of the reform included not considering transportation costs and costs of potentially negative health effects, how the public consultation process was conducted, higher caregiver burden, and potential inequalities in access to care.

Messages-clés

- *Les évaluations menées à la suite de la fermeture de 52 hôpitaux ruraux résultant de la* Loi sur les Districts de Santé *n'ont pu établir d'effet négatif certain sur la santé des communautés concernées.*
- *Parmi les points forts de la réforme, on peut citer une baisse des coûts de santé pour le gouvernement, un nombre de lits par habitant plus proche de la moyenne nationale, une orientation sur le bien-être, et la création de conseils autonomes de districts pouvant mieux comprendre les besoins locaux.*
- *Parmi les faiblesses de la réforme, sont mentionnées l'absence de considération des coûts de transports et des coûts des effets potentiels négatifs sur la santé, la manière dont la consultation du public a été menée, une charge accrue sur les aidants, et d'éventuelles inégalités d'accès aux soins.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

In 1990, Canada fell into a recession that lasted approximately three years (Thorlby 2011). The New Democratic Party (NDP) won a majority government in the 1991 Saskatchewan General Election, and subsequently undertook reform in order to eliminate a portion of the provincial debt and reduce soaring health care costs. The new premier, Roy Romanow, led a health reform, beginning in 1992, that shifted away from a clinical care approach towards a wellness model, which was focused on community care and health prevention (Liu et al. 2001). Through the *Health Districts Act*, passed in 1993 (Government of Saskatchewan 1993), health services were regionalized into 30 health care districts; reduced from 400 boards representing hospitals, ambulances, home-based care, and long-term care services (James 1999). Budget cuts and regionalization led to the closure of 52 hospitals for acute care services in 1993 in rural areas which created a backlash from affected community members (Liu *et al.* 2001). An impact evaluation of this reform demonstrated that mortality in the affected rural communities did not increase (Liu *et al.* 2001), but this study has limitations. Other evaluations reveal that the reform may have resulted in an increased burden on rural women, decreased availability of health services, and higher travel costs (James 1999; Petrucka and Smith 2005) which temper the success of the reform.

2 HISTORY AND CONTEXT

Saskatchewan is known for the creation of Medicare, implemented by an NDP government in 1962 (Lepnurm and Lepnurm 2001). In the period leading up to World War II, the population of Saskatchewan lived mostly in isolated rural areas, with hospitals dispersed throughout the many communities (James 1999). Following the war, the government funded the construction of 166 hospitals; more than 50% had fewer than 25 beds. At this time, due to the small, dispersed populations, community hospitals were able to meet the needs of these populations (James 1999). However, between 1950 and 1980, several factors led to a change in the way that hospitals were serving the population. The construction of larger road networks allowed people to travel farther for care and rural to urban migration of young individuals changed the utilization patterns of hospitals. More elderly individuals remained in rural communities therefore there was a shift away from acute care towards longer-term care (James 1999).

By 1991, Canada experienced a 3.3% decline in real GDP and a recession ensued (Wilson, Dungan, Murphy 1994). In Saskatchewan, two terms of a Progressive Conservative (PC) government brought about a deficit of approximately $9 billion (Liu *et al.* 2001). Health care accounted for one-third of total provincial government program spending at this time, and was increasing faster than other government costs (Marchildon 2007).

3 GOALS OF THE REFORM

The government of Saskatchewan conducted health care reform in order to achieve the primary goal of reducing health care expenditures. This occurred by reducing the health budget, regionalizing the health care system and moving the health care system towards health prevention and overall wellness rather than only treatment of illness (Marchildon 2007).

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government's agenda

In the 1980s, the Saskatchewan Health-Care Association (SHCA), an umbrella organization that represented providers delivering community or institutional health care services, encouraged the government to decentralize the co-ordination of health services to the regional level. Their reasoning was that regional authorities would better understand the needs of patients and match them more appropriately to health services (Boychuk 2009). During this time, there was also a rise in Saskatchewan government budget deficits (Marchildon 2007). In response to this rising debt and encouragement of decentralization, the PC government established the Murray Commission on Health Care in 1988 in order to provide recommendations for health care reform in the province (Boychuk 2009). These recommendations included replacing over 400 health care facilities and their corresponding boards with 15 regional health authorities in order to decrease government spending on health care (Marchildon 2007). The PC government did not begin implementation of the Murray Commission recommendations because the NDP was elected in 1991. This change in government, along with the pressure of a recession and high health care spending, opened a window for health care reform to occur.

4.2 The final decision was made

The 3I framework (Interests, Ideas and Institutions) is utilized to assess how the final decision was made (Gauvin 2014).

4.2.1 Ideas

The NDP health care reform aimed to move the health system towards a wellness paradigm with a focus on preventative medicine, health promotion, social medicine and public education (Boychuk 2009). Government interest in "wellness" was common following the release of the Lalonde report in 1974, which was a Canadian federal policy document that emphasized the importance of social determinants of health in addition to biomedical definitions of health (James 1999). The reform also aimed to rationalize health services in the province, hoping this would contain health care costs. In 1991, Saskatchewan had an average of 2.5

more hospital beds per 1000 people than the Canadian average, and most rural hospitals in the province were being used for long-term care of the elderly (James 1999). While cutting spending on health care did not reflect the typical ideology of the NDP, the financial crises, a high number of potentially under-used hospital beds, and the ideology of wellness led the government to move ahead with the reform.

4.2.2 Interests

Key players in the health field at the time, such as the Saskatchewan Union of Nurses (SUN) and the Saskatchewan Medical Association (SMA), supported the initial plan for reform. The SMA feared that if they retaliated against government plans, the public would no longer trust the health system (McIntosh and Marchildon 2008). Prior to the reform, there was no backlash from the public towards the proposed plans for reform. However, the public had witnessed the creation of Medicare in the 1960s and supported accessible, publicly funded care (McIntosh and Marchildon 2008). As the reform progressed, public support waned.

4.2.3 Institutions

The newly elected NDP government was a majority government, with the PCs winning 10 of the 66 provincial seats and the Liberals winning only one. This allowed the government to move ahead with changes with little opposition from the other parties (McIntosh and Marchildon 2008).

5 HOW THE REFORM WAS ACHIEVED

5.1 Policy instruments

In order to reduce health care spending and increase efficiency of the health care system, the government used two different methods, employing both economic and policy instruments. First, the health care budget was reduced by 3.3%, leading to the closure of 52 rural hospitals in 1993 (Thorlby 2011). Second, health care was regionalized through the 1993 *Health Districts Act*. This act described the consolidation of 400 hospital, ambulance, home care and long-term care boards into 30 health care districts (Government of Saskatchewan 1993). These district boards were responsible for looking after health services in their own district areas and now had the authority to allocate budget (Marchildon 2007). Instead of being funded based on past patterns of service utilization, district boards were funded based on prospective estimates of population needs for health services (Boychuk 2009).

5.2 Implementation plan

To decrease health care spending, the government decided to close 52 rural hospitals by October 1993 (Thorlby 2011). Twenty-three of these hospitals were converted to long-term care facilities, while the other 29 hospitals were converted to wellness centers and were given one-time funding to do so (Liu *et al.* 2001). All hospitals that were closed had a patient occupancy of less than eight patients per day (Thorlby 2011). Additional criteria considered for closure was the distance to the nearest neighbouring hospital (Lepnurm and Lepnurm 2001).

5.3 Communication plan

When the government was elected in 1991, they were clear about their intentions for health care reform and conducted community consultations throughout 1992, under the direction of the Saskatchewan Minister of Health, Louise Simard (Marchildon 2007). The goal was to gain feedback from the community and other stakeholders on the wellness approach, to educate them about the reform and to determine the boundaries of the health districts (Marchildon 2007). However, in a 1997 survey, community members indicated that the community consultations did not consider community opinions; rather, the ministry had already decided that they would close these hospitals. They also stated that they were not made aware of the planned changes to the health system, in particular those that would directly affect their access to services (Liu *et al.* 2001).

6 EVALUATION

The Saskatchewan Health Planning and Policy Development Branch had set a target of achieving 2.5 to 3.0 beds per 1000 population by 1995 (Petrucka and Smith 2005). Between 1991 and 1994/1995 (the period of the NDP reform) the number of staffed beds per 1000 population in Saskatchewan decreased from 7.2 to 4.6, a move towards this target (James 1999; Tully and Saint-Pierre 1997). National averages were 4.7 in 1991 and 4.1 in 1994/1995 (James 1999; Tully and Saint-Pierre 1997). From 2006 to 2015 the indicator in Saskatchewan never rose above 4.0 beds per 1000 population and in 2015 was 2.8 (Canadian Institute for Health Information 2006-2015; Statistics Canada 2017).

Several studies have attempted to measure the impact of the 1992/1993 health reforms. A study by Liu et al. observed that communities that were affected by hospital closures had a larger decline in mortality rates from time-sensitive conditions (such as myocardial infarction, stroke, and injuries from motor vehicles) between 1991 and 1996, compared to communities that still had a hospital or that never had a hospital (Liu *et al.* 2001). However, the authors state that they were unable to prove a causal relationship between hospital closures and lower mortality and acknowledged that other factors may have influenced this health outcome (Liu *et al.* 2001). The study also excluded First Nations communities,

which could have resulted in an underestimation of mortality rates and hospitalization rates. Finally, study data revealed that community members facing hospital closures had to drive an average of 50 km to the next closest hospital, whereas communities that never had a hospital traveled only 40 km, on average (Liu *et al.* 2001).

James (1999) highlighted potential effects of the reform that were not considered by government. These included increased burden on informal caregivers, out-of-pocket transportation costs and the potential for decreased quality of life for community members. She argued that the closures in Saskatchewan were made before additional services were given to the communities, leaving a gap in care (James 1999). Another study by Petrucka and Smith (2005) found that rural women affected by the closure were not listened to during the consultation process and emphasized the importance of rural women being involved in decisions that directly affect their communities.

While the overall government spending on health care was reduced by 3.3%, there is a lack of analysis on the effect of the hospital closures on costs. For example, costs for possible delayed treatment for time-sensitive emergencies, and ambulance costs for longer transfers have not been explored. It is possible that these unstudied costs could have resulted in higher government spending in the long run.

After the hospital closures in 1992, the public as well as rural providers lobbied against the Saskatchewan Ministry of Health (Lepnurm and Lepnurm 2001; Liu *et al.* 2001). Public opposition to the health care budget cuts and hospital closures continued into the late 1990s (McIntosh and Marchildon 2008) and in 1996 the government increased the health care budget by $50 million to prevent any more hospital closures (McIntosh and Marchildon 2008).

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

The strengths, weaknesses, opportunities and threats of health care reform of the early 1990s in Saskatchewan are presented in Table 1. Stakeholder perspectives are indicated in parentheses.

Table 1: SWOT Analysis of the Saskatchewan Health Reform from 1991-1995

Strengths	Weaknesses
• Decrease in government health spending (*government*) • Decrease in # beds/1000 population, closer to the national average (*government*) • District Health Boards can better represent community needs (*government*) • Wellness approach focuses on social determinants of health, prevention and population health (*government*)	• Cost for home care and transportation costs not considered (*public*) • Increased burden on caregivers (*public*) • Criticisms of the public consultation process: consultations did not consider community opinions (*public*). • Communities not given enough advanced warning of health reform (*public*)
Opportunities	**Threats**
• Decrease in government health spending (*government*) • Move to prevention based health care rather than solely curative (*government*)	• Potential threat to equality because access to hospitals limited for some communities (*James 1999*) • Continued criticism of hospital closures throughout the decade that followed (*public*) • Insufficient evidence to conclude that hospital closures had no impact on patient health outcomes • Lack of cost analyses (e.g., transportation costs, cost of potential negative health outcomes)

8 CONCLUSION

The government of Saskatchewan was facing a recession in the early 1990s and due to high health care costs at that time, undertook a reform of the health care system. They achieved reform through regionalization, cuts to the health care budget and the closure of 52 rural hospitals. There is insufficient evidence to conclude that the hospital closures had no impact on patient health outcomes. Strengths of the reform included a decrease in the number of staffed beds per 1000 population during the time of the reform, a number

which was closer to the government target of 2.5 to 3 staffed beds per 1000 population and closer to the national average, a new focus on health promotion and prevention, and the creation of district boards that better understood population needs. Weaknesses included the lack of cost analyses examining transportation costs and costs of potentially negative health effects, criticisms of the public consultation process, higher burden on caregivers, and potential inequalities in access to care. Public backlash was so great that this ended up influencing government spending, causing an increase to the health care budget in 1997. Future reforms should ensure that local voices are involved in the decision-making process.

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