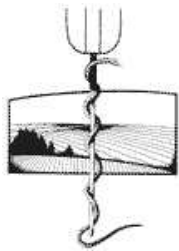
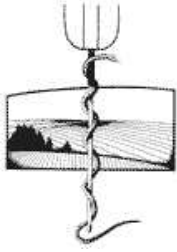


RURAL HOSPITAL SERVICE CLOSURES

April, 2009



***SOCIETY OF RURAL PHYSICIANS OF CANADA
PO Box 893 SHAWVILLE QC, Y0X 2Y0***



Society of Rural Physicians of Canada
Société de la médecine rurale du Canada
www.srpc.ca

***About the
Society of Rural
Physicians of
Canada***

The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. Founded in 1992, the SRPC's mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities.

On behalf of its members and the Canadian public, SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.

The SRPC is a voluntary professional organization representing over 2,700 of Canada's rural physicians and comprising 5 regional divisions spanning the country.

“Nous soignons les régions- We care for the country”

CONTENTS

RURAL HOSPITAL SERVICE CLOSURES

About the Society of Rural Physicians of Canada.....	2
Executive Summary.....	4
Rural is Different.....	5
Rural Health Status.....	6
The Rural Hospital.....	6
The Economic Case for Hospital and Service Closures.....	8
Regionalisation and the Right number of Hospitals and Services.....	9
Conclusions.....	11
APPENDIX.....	12
Acknowledgments.....	12
References.....	12

Executive Summary

.. there is an "inverse care law" in operation. People in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres.
- Roy Romanow, Commission on the Future of Health Care

While Canada's beleaguered health care system still produces outcomes among the best in the world there are growing signs that this is not the reality among Canadians living in smaller or more isolated communities across the country.

When regional management lacks political accountability to the people it serves, it is an easy decision to close, or hobble, a small peripheral hospital and transfer a portion of the funding for those services to the centre of power. However rural health care is usually quite efficient with lower cost per capita in dollars spent, and health care providers engaged, than city care. While the local budget will be reduced, the system itself, will not save money unless access to care elsewhere is prevented, which shouldn't be the point.

Quality arguments for closures occur typically as a veiled slur on the rural institution that fly in the face of the evidence. Canadian research shows that both rural obstetrics and rural appendectomies have outcomes that match or slightly better the city. Rural emergency departments meet triage standards that city hospitals cannot match. There are many more examples, one just has to ask the question before one asserts ones prejudice.

No one can say that there is a need for a hospital in every town. However efficiency and quality measures support keeping average sized rural hospitals. It is only the smallest one to two doctor hospitals where efficiency arguments might dictate closures. Even in those cases, isolation may require keeping the services running to ensure timely patient access.

The rural people of Canada, providers of much of Canada's economy and the food that we put on our tables, should not be deprived of adequate health care for expediency.

All too often closure is done by forces from the center with no buy in at the community or physician level. Closing hospital services has significant adverse effects on the local economy, it often does not realise savings, and may actually increase costs, and will increase difficulties in recruiting new physicians.

Closing rural hospitals risks being a mean spirited substitute for system reform. The work out here is already hard enough. Don't make it any harder than it needs to be.

*“Every citizen in Canada should have equal access to health care regardless of where they live.”
- Mr. Justice Emmet Hall*

There are many health care challenges for Canadians, but none are any greater than the challenge of providing care for those who live in remote and sparsely populated regions of this country. The Society of Rural Physicians of Canada has extensive experience in rural health care analysis.^{1 2 3 4 5} In our presentation to the Standing Senate Committee on Social Affairs Science and Technology we explored rural health trends.⁶ In our invited submissions to The Commission on the Future of Health Care in Canada we discussed how these trends need to be addressed in a fashion to provide a sustainable and affordable health care system for rural Canadians.^{7 8}

Roy Romanow, in the Commission on the Future of Health Care, chronicles how Canadians living in rural and remote communities spoke directly about their serious concerns. They spoke of the need for good health and good access to health care "not only because it is essential to sustain their own quality of life, but also the quality of life in their communities."

He recommended targeting \$1.5 Billion for a Rural and Remote Access Fund to address serious challenges in health care in rural and remote areas of Canada. Not even a penny has been spent leaving these needs unfilled.

Here we will explore rural healthcare needs and hospital resources that help meet those needs, and the ramifications of hospital and service closures.

Rural is Different

*Non-metropolitan areas in Canada are often simply referred to as rural Canada, without enough attention paid to their inner differences. It is clear that non-metropolitan Canada is anything but homogeneous. More research is needed to bring out this diversity so that social policies can be better tailored to the needs of non-metropolitan Canadian populations.
-Howatson-Leo and Earl 1995*

A keen appreciation of how rural health care is unique is important in determining possible models that will work and can be sustained.

Rural Canada has about 20 percent of the employed Canadian workforce, 31.4 percent of the Canadian population and over 99.8 percent of the nation's territory.⁹ It is a highly diverse economy and society, from its coastal regions to its agrarian heartland. Canada's rural natural resources provide employment, forest products, minerals, oil and gas, food, tax revenue and much of our foreign exchange.

While 31 percent of Canadians live in rural areas, only about 17 percent of family physicians and about four percent of specialists practise there.¹⁰

A mean rural population density of one person per square kilometre creates unique and special requirements for the delivery of health care. This density coupled with the need to provide acute time sensitive interventions such as thrombolysis, attendance at birth, treatment of sepsis and trauma, indicate that health facilities need to be located near the people.

In submissions to the Commission on the future of Health Care it was noted that “People's choice of whether or not to live in smaller communities is affected by whether or not they can get reasonable access to health care. That view was echoed by rural physicians who said, ‘geography is a determinant of health’.” This emphasises how important sustaining and improving rural health care is in ensuring that companies can continue to develop industry in rural areas. With increased globalization, rural Canada is going to need better health care if it is to continue being the source of our lumber, metals, oil, minerals, and our food.

Rural Health Status

A basic medical services infrastructure for rural and remote areas [should] be defined, such as hospital beds, paramedical staff, diagnostic equipment, transportation, ready access to secondary and tertiary services, as well as information technology tools and support.

-Recommendation no 27. CMA Rural and Remote Policy 2000

In rural Canada, large numbers of first nations peoples live, our tractors overturn, mineshafts collapse, fishers get swept to sea, smoking rates and obesity rates are higher, poverty is more common and the litany goes on with mortality rates higher for most causes of death.

Health status decreases as one travels to more rural and remote regions. As an example heart disease is common in northern Ontario. Certain types of cancer are found among miners and farmers. There are substantially higher rates of diabetes, respiratory and infectious diseases, as well as violence-related deaths, in some aboriginal communities. Combined, there is an increase in mortality in rural regions as evidenced by life span. In the end our most isolated rural Canadians live three years shorter lives than our urban counterparts.¹¹

The disparity is most striking when one considers where health care dollars are spent. Per capita health expenditures reflect 18.4% underspending for rural patients in one Ontario study. The sicker rural patients get \$490 spent annually in physician services, while urban patients receive \$580.¹²

The Rural Hospital

"Rural doctors identify a series of key attractions of rural practice. First is the greater variety of practice that often includes obstetrics, surgery, anaesthetics and emergency medicine together with hospital access and care of the acutely ill."

-WONCA Policy on Training for Rural Practice 1995

The rural hospital is an unique institution. It is not merely a scaled down version of a city hospital. It is staffed by generalist physicians who provide broad spectrum of care. Many provide obstetrical deliveries, provide anaesthetics, assist in the operating room and staff the emergency room.

Large hospitals offer a remarkable array of technology and consultants, which allows them to be considered centers of excellence in various specialized fields. What they do not do well is provide less specialised care. This is done best with care as close to home as possible, where family and friends can

easily visit, and where familiar health care professionals who know the patients intimately, provide the care. The "will to live" is inspired by these conditions, and is often lost in the larger impersonal hospitals located far away. Similarly, end of life palliative care, close to friends and family is also best provided in the patient's community hospital, especially since many small communities do not have hospice arrangements.

The rural hospital helps support other health services in the community. Home care nurses and ambulance attendants can and do go there to obtain and maintain skills needed in the field and in homes such as starting iv's. Doctors use the skills used in the hospital to maintain and improve the care of their patients. All health care providers find the rural hospital professionally, socially and economically, a reason to come and stay in the rural community.

The rural hospital is not only a centre of excellence for common conditions, and a resource for community health services, it is also a cultural part of the rural community. It's where you go to gather at the death bed. It is also where you may go to celebrate a birth. The people who work there are not strangers but friends and neighbours.

The rural hospital is the economic anchor of the community. The hospital is typically the second or third largest employer. Much of the payroll is spent, and re-spent, locally resulting in spin off service jobs. Often overlooked is the fact that the hospital is capable of attracting industry as mill and factory owners look to it as a resource necessary for their business in turn to attract skilled workers.

The rural hospital is efficient. Despite, or perhaps because of, limited access to specialized testing and referral, per case costs in rural hospitals are usually lower than urban costs. The rural hospital typically needs less total beds for surge capacity (although a larger percentage of total beds) than a larger urban hospital, despite the fact that there isn't another hospital in town that one could divert traffic to if one was full.¹³

The rural hospital provides quality care. Maternity care has been found to be as safe in smaller rural hospitals as in large specialist run centres in Northern Ontario. American studies show that if women have to travel to give birth, costs are higher and results worse. Due to the evidence of safer local access three large medical organizations joined in issuing a statement on the need for rural maternity care in Canada with and without local caesarean capability.¹⁴ Appendectomies done in Western Canada done by GP's in rural communities had slightly less complications than those done in city hospitals.¹⁵ Colonoscopies and other endoscopic procedures done by rural family doctors can be as high quality as those done by specialists.^{16 17} According to the Canadian Institute for Health Information (CIHI) all but three rare and highly specialized procedures studied are done as well in low as in high volume centres in Canada.¹⁸

The Economic Case for Hospital and Service Closures

If Saskatchewan's population was concentrated within a single community, acute care for one million people might be provided by four or five large hospitals.

-Fyke 2001

Conventional wisdom states that fewer hospitals eases administrative complexity and gives a potential for cost savings. Despite many rounds of restructuring, experiential evidence has not supported the assumption that one actually will achieve even the one-dimensional view of efficiency. The cost argument of closing rural hospitals rarely discusses the indirect costs, ambulance, personal, transportation, hotel accommodation, meals away from home, accidents getting to other communities and so on. When increased costs to the patient are assessed, total costs are found to increase.^{19 20}

Even when you ignore such costs its not clear that there will be savings from rural hospital closures. The former Saskatchewan minister of finance, Janice MacKinnon, reflecting back on the 1993 closure of 52, mostly very small rural hospitals, has estimated that only about \$30 million was saved, far less than was planned.²¹

The Manitoba Centre for Health Policy (MCHP) did an analysis of hospital efficiency in Manitoba correcting for varying case mix - different patients with different medical conditions - between hospitals. The most efficient hospitals in Manitoba were found to be the full service medium sized rural hospitals such as the 30 bed Beausejour Hospital.

The report suggested that the most cost savings, 11% of the provincial inpatient budget, could be achieved from improving the efficiency of the largest hospitals to the level of the larger rural hospitals. This was not because the teaching hospitals were the most inefficient, but because they treated 35% of the inpatients and consumed 46% of the provincial inpatient budget. In contrast while the very smallest and isolated rural hospitals were relatively inefficient, they only consumed under 1% of the budget.²²

In an analysis of the Ontario hospital closures of 1996/1997 where Ontario went from 223 to 150 Hospital corporations, short term analysis failed to show gains, although long term projections are hopeful. The authors suggest that this paradox stems from unrealised potential gains, change cost and the finding that large hospitals with high levels of tertiary care are "less efficient in the provision of outpatient and emergency care."²³

This is not to suggest that there are no potential savings from system changes, rather to point out that hospital service closure is a blunt instrument with which it is difficult to obtain significant savings to the system. Any savings risk to be only paper ones where the cost of care is transferred to another balance sheet.

Regionalisation and the Right number of Hospitals and Services

Health care restructuring has centralized, reduced or eliminated hospital-based services without community-based services being enhanced.

-Ministerial Advisory Council on Rural Health 2002

There is no “one right” decision as to what health services will be provided where and by whom. It varies by geography. There are several basic services that for population safety and access need to be as close as possible to where people live and work. By analogy it doesn’t matter that fire halls are inefficient as the vast majority of the time there is no fire to fight. That service is none the less needed in a timely fashion. Similarly basic medical care is needed close to the patient.

Generally emergency care, inpatients and often obstetrics should occur when there is enough served population to sustain a compliment of five or more physicians²⁴ which is a bit over 5,000 population. This both makes the call burden sustainable for most of the professions involved, but also invokes a hospital size that is efficient. These services might need to be supported locally with less population if the next location that can provide this care is over half an hour transport. In Ontario the ministry has used 40 km as the distance between hospitals that have 24 hour emergency room coverage.²⁵

Closure by degree is sometimes contemplated with the argument that much of the ER visits are deferrable and could be seen by a family physician in his office. This is true for all emergency departments, including those attached to large teaching hospitals.

Other arguments flow that night volumes are so small that the department should be closed after midnight. As with firefighting, the purpose of the infrastructure is to be available irregardless of the time of day for the few cases in which timely intervention makes a difference.

When central planning is contemplating closure of services, local consultation with providers and population is essential. Closure of services and hospitals must take the following elements into consideration²⁶:

- Local economic conditions including the role that health care institutions and services play in the local economy
- Geography
- Effect on the retention and recruitment of health care professionals
- Transportation which includes everything from ambulance services to public transport to the state of the roads or air services to the regional centres as well as the effect of weather on the ability to travel
- Ensuring that services like home care, ambulance services, telehealth, etc. are available in communities from which hospitals and/or services are being removed
- Equity of access

The Case Against Closures

A survey of physicians in Bruce and Grey counties in Ontario showed that 80% of the physicians in those 2 counties would leave if their rural hospital closed.

-Rick Mann

Closure of the rural communities hospital has documented repercussions. Studies show a lower quality of care, decreased access to physician services, fewer employment possibilities²⁷ and increased per capita health care expenditure.^{19 20 23} If there is no other hospital in the community per-capita income can drop by 4 percent and unemployment rate increase by 1.6 percentage points²⁸

The largest impact of an imposed hospital closures is the impact on recruitment of new medical and nursing staff.

Fort Macleod is an Alberta town of about 3000 situated 50 kilometres west of Lethbridge. It's at the crossroads of 2 major highways and in between 2 of the largest First Nations reserves in Canada. Prior to 2003 the five doctors who worked there supported a full service hospital, including obstetrics and surgery. In 2003 hospital was converted into Fort Macleod Health Centre with three holding beds and a limited ER. Within a year the two newest doctors, still between them 20 years in town, had left and another doctor semi-retired. Nurses, X-ray and lab technicians began looking for positions elsewhere or retired. Now there is little to attract new physicians to the area and the town is continually trying to fill vacancies and has been consuming 10-15% portion of the provinces locum fund for rural doctors between 2005 and 2007.

In New Brunswick's Upper Saint John River Valley a regional hospital was built in 2007 between Bath and Woodstock to replace three other hospitals, despite massive demonstrations in affected communities. The Woodstock doctors had a vibrant full service hospital that was really a case example of how best to run a rural hospital. Since it has been closed the Woodstock doctors no longer provide inpatient care to the new hospital (except for Obstetrics) as it is perceived as no longer being their hospital, but the regions.

One of the unintended consequences is that the change had undermined the ability for the region to recruit as current New Brunswick legislation would require any new doctor to admit to the hospital - all by themselves. In the mean time the region is subsidizing itinerant physicians to provide this care.

Another case of unintended results is that downsizing can actually decrease efficiency. In Strathroy Ontario closure of the rehabilitation beds has destabilised the hospital. Inpatients that were once rehabilitated to go home or having their condition stabilised while waiting for a nursing home bed, were now decompensating and having to remain at the hospital as long term patients. In the drive to save money efficiency and patient care decreased.

Conclusions

"Many changes in health region boundaries have been implemented without a strong evidence base. Yet the implications for the effectiveness of regionalization policy are great. Not the least of these is the destabilization to health delivery systems that is wrought by the constant changes.

-Newsletter, CCARH, Sept 2003

The issue of service and hospital closures is highly emotionally charged. The local community has much to lose and little or nothing to gain. Closures are the easiest to arrange when there is an alternative institution in the community. Closures of hospitals that would result in populations needing to travel under half an hour for care may be reasonable if so doing, the existing health care providers would agree to join together to form a larger group to share the burden of providing care.

Even if this is the case, it is not at all clear that efficiency would increase. The evidence that exists implies that without meaningful local input it is possible, if not likely, that costs will go up, access will decrease, and there will be negative ramifications to the local economy and for recruitment of physicians.

Hospital service closures are not a substitute for system reform.

APPENDIX***Acknowledgments***

This paper was developed out of a discussion paper of the Ontario Region of the Society of Rural Physicians of Canada. The lead author has been Dr Peter Hutten-Czapski of Haileybury with both provincial and national input.

References

1. Babey K, Barrett S, Bury L, Dawes R, Gains S, Galea S, Hutten-Czapski P, Mann R, Park I, Pong P, Rourke J, Tepper J, Thoburn M, Whiteside C; From education to sustainability - a blueprint for addressing physician recruitment and retention in rural and remote Ontario. SRPC - Ontario and PAIRO December 1998 <http://www.srpc.ca/librarydocs/toc.html>
2. The Society of Rural Physicians of Canada. Comment on "Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited" by Morris L. Barer and Greg L Stoddart The Society 1999 <http://www.srpc.ca/librarydocs/Comonbs.PDF>
3. Hutten-Czapski P, Park I, Arif S, Dawes R, Mann R, Rourke J, Henderson B, Kelly L. A fair share for rural health at the millennium The Society of Rural Physicians 2000 <http://www.srpc.ca/librarydocs/ONprogam.htm>
4. Hutten-Czapski P. Primary health care reform – A rural perspective. The Society of Rural Physicians 2000 <http://www.srpc.ca/librarydocs/hsrcepr.htm>
5. O’Neil D. Response to the Fyke Report. The Society of Rural Physicians 2001 <http://www.srpc.ca/librarydocs/CentralFyke.html>
6. Hutten-Czapski P State of Rural Health Care. The Society of Rural Physicians of Canada 2001 <http://www.srpc.ca/shelf.htm#Romanow>
7. Hutten-Czapski P The Future of Rural Health Care. The Society of Rural Physicians of Canada 2001 <http://www.srpc.ca/shelf.htm#Romanow>
8. Hutten-Czapski P Rural Healthcare- the Chasm Not Crossed. The Society of Rural Physicians of Canada 2002 <http://www.srpc.ca/shelf.html#Kirby>
9. Statistics Canada Population structure and change in predominantly rural regions The Daily Jan 16, 2001 Catalogue 21-006 XIE <http://www.statcan.ca/english/freepub/21-006-XIE/21-006-XIE00002.pdf>
10. The Canadian Medical Association, physician resources data base, the Association 2000
11. Statistics Canada "Life Expectancy" Health Reports, Winter 1999, Vol. 11, No. 3 Statistics Canada, Catalogue 82-003 http://www.statcan.ca/english/indepth/82-003/feature/hr1999_v11n3_win_a01.pdf

- 12 Finkelstein M. Do factors other than need determine utilisation of physicians' services in Ontario. CMAJ 2001; 165(5). 565-570. <http://www.cmaj.ca/cgi/reprint/165/5/565>
- 13 Rohrer JE. Closing rural hospitals: "Reducing institutional bias" or denial of access? J Publ Health Policy 1989;10(3):353-8.
14. SRPC, SOGC, CFPC . Joint Position Paper on Rural Maternity Care. 1997
http://www.cma.ca/index.cfm/ci_id/37319/la_id/1.htm
- 15 Iglesias S, Saunders LD, Tracy S, Thangisalam N, Jones L. Appendectomies in rural hospitals - Safe whether performed by specialist or GP surgeons Can Fam Physician 2003;49:328-333.
<http://www.cfpc.ca/cfp/2003/Mar/vol49-mar-research-3.asp>
- 16 Wilkins T, LeClair B, Smolkin M, Davies K, Thomas A, Taylor ML, Strayer S."Screening colonoscopies by primary care physicians: a meta-analysis" Ann Fam Med 2009; 7: 56-62.
<http://www.annfammed.org/cgi/reprint/7/1/56>
- 17 Kolber M, Szafran O, Suwal J, Diaz M. Outcomes of 1949 endoscopic procedures: Performed by a Canadian rural family physician Can Fam Physician 2009;55 170-175.
<http://cfp.highwire.org/cgi/content/abstract/55/2/170?etoc>
- 18 Canadian Institute for Health Information. Health Care in Canada. The Institute 2005 ISBN 1-55392-617-X 2005 http://secure.cihi.ca/cihiweb/products/hcic2005_e.pdf
- 19 Welch HG, Larson EB, Welch WP. Can distance be a proxy for severity-of-illness? A comparison of hospital costs in distance and local patients. Health Serv Res 1993;28:441-58.
- 20 Merlis M. Rural hospitals. Washington: US Congress Congressional Research Services; 1989. No. 99-296
- 21 Lang M. Health cuts cripple small-town hospitals. Calgary Herald Feb 7, 2009
<http://www.calgaryherald.com/Technology/Health+cuts+cripple+small+town+hospitals/1264795/story.html>
- 22 Shanahan M, Loyd M, Roos NP, Brownell M. Hospital case mix costing project 1991/92. Winnipeg, Man.: Manitoba Centre for Health Policy and Evaluation, University of Manitoba, 1994. <http://mchp-appserv.cpe.umanitoba.ca/reference/htm/casemix>
- 23 Preyra C. Pink G. Scale and scope efficiencies through hospital consolidations. Journal of Health Economics.2006 25(6):1049-68.
- 24 Leduc E. Physician on-call frequency: Society of Rural Physicians of Canada discussion paper CJRM 1998;3(3):139-41 2005
http://epe.lac-bac.gc.ca/100/201/300/cdn_medical_association/cjrm/vol-3/issue-3/0139.htm
- 25 Ministry of Health. The Rural and Northern Health Care Framework. Ontario Ministry of Health June 1997. p7. http://www.cranhr.ca/pdf/RURAL_HEALTH_FRAMEWORK_June_1997.pdf

26 Society of Rural Physicians of Canada Policy Paper on Regionalization: Recommended Strategies. The Society, April 2004 http://srpc.ca/librarydocs/Regionalization_SRPC.PDF

27 Hernandez SR, Kalnzny AD. Hospital closure: a review of the current and proposed research. Health Serv Res 1983;18(3):419-36.

28 Holmes GM, Slifkin RT, Randolph RK, Poley S. The Effect of Rural Hospital Closures on Community Economic Health. Health Services Research 2006 Vol 41(2) pp 467-485
<http://dx.doi.org/10.1111/j.1475-6773.2005.00497.x>