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Jill Konkin, MD

Chair,
SRPC Ad-hoc Committee on Regionalization;
Past-President, SRPC

David Howe, MB BS

Member,
SRPC Ad-hoc Committee on Regionalization;
Member, Atlantic Regional Committee, SRPC

Trina Larsen Soles, MD

Member,
SRPC Ad-hoc Committee on Regionalization;
President, SRPC

Prepared for the SRPC by the SRPC Ad-hoc Committee on Regionalization.

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Correspondence to: SRPC, Box 895, Shawville QC J0X 2Y0

All provincial governments in Canada except Ontario have embraced regionalization of health care services. In some provinces this has included a broad range of services, such as acute care, home care, public health, mental health. In other provinces regionalized services have been more limited. Some provinces have made many smaller units, and others have made fewer larger units, but all exercises in regionalization have driven a centralization of services. This has had significant impact in rural communities.

Many communities have lost services, sometimes including their hospitals. Even in provinces that indicated that a goal of regionalization was to increase local input into the health care system, residents and health care professionals of most rural communities now have less input into the health care system than before.

Regionalization has been put forward as the means by which provincial governments will be able to cure many of the problems plaguing the health care system, yet very little research is available to supply evidence that regionalization is the method by which these problems can be fixed. As recently as September 2003 the Canadian Centre for Analysis of Regionalization and Health (CCARH) stated:[1]

"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."

There is a lack of Canadian research into issues of the effects of regionalization, among other things, on access to care, quality of care and recruitment and retention of health care professionals. There is little research on the optimum size and design of health regions. Regions range from those concentrated mainly in a large urban agglomeration, to huge rural regions, to multiple small regions (or districts) with varying abilities to deliver services.

Rural regions may have no common trade patterns, no identifiable regional centres, no other organizational principles that might help them to function as regions other than the dictate of the provincial government that created them. Within the same province, some regions will be able to fully integrate health care services, including home care, public health, primary care, all levels of acute care and tertiary care services. Other regions are so disparate that integration at the primary care level is hard enough, and many secondary services and all tertiary care services are unavailable.

There is also the anomaly that "regional" centres can refuse patients from rural communities without access to the services that these regional centres provide, and it is easy to understand the growing divide between the regions that include large urban centres and regions that are rural in nature.

Given the growing inequities between the residents of rural and remote Canada and their urban counterparts, the Society of Rural Physicians of Canada (SRPC) recommends the following principles regarding the regionalization of health care in Canada.

#1 – Stated, measurable goals

Regionalization experiments have been initiated by governments without clearly outlined goals and the tools of evaluation needed to monitor and measure these goals. Many governments turned to regionalization as a means to contain the increasing costs of health care, yet the massive reorganization of many provinces' health delivery systems has not demonstrated savings. The information about the cost to the system of regionalization is not available, in some cases 10 years after the initial experiments, and this speaks to the need for a rigorous review of the successes and failures of regionalization. A clear definition of the problem(s) to be solved by regionalization and the method in which this will be evaluated is essential.

#2 – Evidence-based decision-making

Changes to existing regionalization schemes or the institution of new structures must be based on the best available evidence.

In many instances regionalization has been accompanied by closure of smaller rural hospitals without recognition of the attending potential risks for rural communities. There is evidence, for example, that women with low-risk pregnancies, and their babies, suffer more morbidity and mortality in the first few weeks after delivery if they have to travel out of their home communities.[2,3] In addition, it has been shown that the longer the interval between myocardial infarction and hospital care, the greater the mortality.[4–6] There are too many instances of obstetrics programs being closed in communities in the name of regionalization when there is evidence to suggest that this will increase, not decrease, the negative outcomes.

#3 – Rigorous cost analysis before changes

Changes to regionalization have been done without rigorous cost–benefit analyses being performed. Analyses must include the hidden costs to patients in the form of missed work to travel to distant services, the cost of travel to and from regionalized services, and the costs for family members who must accompany their loved ones. Citizens of rural and remote Canada often carry a significantly greater financial burden when services are regionalized, compared to their urban counterparts.

#4 – Definition of a viable region

It is hard to believe that there are not standards and definitions for viable, effective regions in this country. There are many examples of rural regions with communities that have no historical ties, no common trade patterns (except with communities outside the region) and no regional centre. Regions must be based on sound operational principles. All aspects of care, from primary through to tertiary care, must be available to all citizens of a region. The inability of the system to integrate vertically calls into question the viability and applicability of regionalization.

When determining regional borders, the realities of geography must be taken into account, from the vagaries of local weather patterns, to impassible mountain passes, and average number of days per year when air evacuation is impossible, to name a few.

All regions within a province must have equitable services, and these services must be available in an equitable fashion to the citizens of each region.

When determining what services will be provided where and by whom, the following elements must be taken into consideration.

- 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. The effect of weather on the ability to travel must be considered.
- Ensuring that services such as home care, ambulance services, telehealth are available in communities from which hospitals and/or services are being removed
- Equity of access

#5 – Equity of access

The Canada Health Act guarantees equal access for all Canadians. Regionalization of health care delivery has exacerbated already existing inequities.

Geography has become a determinant of health in Canada and must be addressed. Regionalization is an urban idea imposed on rural realities and has exacerbated some of the issues that geography places in the way of equity of access to health care services.

#6 – Core services

Governments must define the core services for local, regional and provincial levels of care. Regionalization has continued to whittle away at services in smaller rural communities with no commitment from government that there is a fundamental core of services that must be available as close as possible to all citizens.

The health care needs of the population will be the basis for the delineation of these core services. Determination of the health care needs must be sought through rigorous needs assessments at all levels from individual through community to the regional and provincial levels.

Regional centres are often given more money to fill this role but are then allowed to refuse to take patients from the smaller communities of a region when they are full. The inequities of regional centres continuing to care for the population in the community in which it is situated while turning away citizens from communities without comparable services and for whom the regional centre is to be delivering those services, must not continue. Australia has instituted a law that forbids regional centres from refusing patients from their regions. It is time for Canadian provinces to do the same.

#7 – Meaningful input from local citizens

Communities expect and deserve the ability to influence the decisions made regarding regionalization. Governments have a responsibility to supply relevant information in a non-partisan, neutral fashion.

If provincial governments persist in appointing members of regional health boards, there must be strong, broad-based community councils to advise and question the decisions and assumptions of regional health boards.

#8 – Meaningful input from local health professionals

Health care professionals are in a unique position to provide useful observation and input into the organization of regions and into the policies for service delivery. Modern management theory supports the development of policy and procedures as close to the service provision as possible.

#9 – Education of health professionals and research

Those implementing or changing regional systems must be cognizant of the need for support for continuing education of health professionals and the conducting of health research within the system.

Competing interests: None declared.

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