



PODIUM: DOCTORS SPEAK OUT LA PAROLE AUX MÉDECINS

A strategic plan for eliminating rural hospital services through the process of regionalization

Trina M. Larsen Soles,
MD

Golden, BC

Correspondence to:
Dr. Trina Larsen Soles;
PO Box 1170, Golden BC
VOA 1H0

We're now into our 3rd year of regionalization in BC. As those of us in rural communities deal with the restructuring, it often seems as if our communities have been specifically targeted for change. This essay grew out of the suspicion that perhaps these changes have a more sinister goal than just "saving money and streamlining a more effective health care delivery system." Maybe they want to shut us down. And maybe if they succeed in BC, the methods could become a blueprint for getting rid of the pesky challenge of delivering effective rural health care in the rest of the country. . . . So here is some advice for governments interested in getting rid of the problem of rural health care once and for all!

RATIONALE FOR THE "PLAN"

1. Seventy percent of Canadians live in urban areas. Therefore it makes sense to locate all hospitals in the area of maximum use and benefit.

2. There has been significant rural-urban migration during the past century, an international trend. This indicates ample opportunity for rural citizens to relocate to urban areas should they wish to. Those remaining in rural areas do so either through lack of initiative and/or motivation to move to the cities, or through deliberate choice to live in a rural area. Those making such a decision must assume the responsibility for the risks associated with a rural location and must no longer expect the calibre of services available in urban areas.

3. It doesn't make economic sense to maintain significantly costly medical services for the relatively small proportion of the population so affected.

THE "PLAN"

1. Divide the province into mega-regions. The first step in regionalization must be to organize the infrastructure in such a way as to eliminate local access. To accomplish this goal, regions must be as large as possible. The management must be located in the largest city in the region. The management team and controlling board should be as urban as possible, both in location and philosophy. You may include a rural representative to minimize local political fallout, but ensure that objections can be easily outvoted. This ensures representation and rural input but eliminates the need to take such concerns seriously.

2. Eliminate local hospital boards and health councils. When rural communities must access a board representative in another city it reduces any possibility of a sympathetic hearing due to previous relationships with representatives. You also must eliminate local administration. It's much easier to justify closing services at 1 small facility when the administrator is responsible for 2 or 3 small hospitals. Services can be eliminated either because a similar service is located at some other small facility somewhere in the region (ignoring practical barriers to access) or because a service is not provided in other small facilities in the region.

3. Close hospitals. When possible, close the local hospital outright if another facility is close enough to justify such a move (whether or not the other facility has the capacity to handle any more volume). If this isn't possible, downgrade the hospital to a "primary care centre." This has the advantage of claiming to provide better services under the umbrella of preventive and population health indices, while eliminating costly emergency services. It's more politically correct in the current federal health climate and potentially can cost much less.

4. Destabilize hospitals. Where it's impossible to close or downgrade a hospital due to distance factors, it's possible to destabilize it to the point where the nursing and medical staff will become so frustrated that enough will quit and render the facility non-functional. Then the closure becomes easy to justify. Practical methods to achieve this include:

A. Refer all on-site problems to off-site administration. When nursing and medical staff must deal with out-of-town administration, problems are likely to become much more significant before being dealt with — if they are dealt with at all. It is also helpful to schedule as many meetings out of town as possible, at times most likely to interfere with the actual provision of medical care. Give as little advance notice as possible. Make sure the majority of meetings are last-minute emergencies.

B. Centralize scheduling and downsize beds and nursing staff at the same time. Make it very difficult to understand the new schedule, and delay filling vacant shifts until the last possible moment to keep the nursing staff unsettled. Do not make any special effort to staff rural OR days. These are difficult at the best of times, so benign neglect will be enough to eliminate many OR days. This, combined with bed cuts, will decrease the number further. When numbers are small enough the service can be closed due to arguments about numbers needed to maintain competence. Remember rural ORs are very expensive and benefit relatively few patients.

C. Obstetrical care presents a special challenge. Promote literature assuring it is safe to give birth in communities without C/S back-up, in case any locals are aware of the data that shows that closing rural obstetrical services leads to poorer outcomes. Having no local access to C/S will increase the numbers of women who leave the community to give birth. Eventually, delivering elsewhere among

strangers will become the norm and the rural service will close due to stress among providers caused by inadequate local resources. Alternatively, if we could promote home births extensively we might be able to entirely eliminate the need for hospital maternity services in rural areas.

D. Centralize all supplies and drugs. Do not make it clear whose responsibility it is to keep the hospital stocked. (This can be accomplished by careful elimination of clerical staff.) This will ensure that needed supplies and drugs for emergency care are often missing at a critical moment. This will, in turn, generate more stress for nurses and doctors, promote staff conflict and ultimately result in loss of nurses and physicians from the community.

POLITICAL CONSIDERATIONS

1. A relatively small number of voters live in rural areas and, should this plan achieve success, the numbers will be significantly diminished over the next decade.

2. There is a small chance that rural citizens could be seen as victims in this plan, therefore all actual closure mechanisms must be marketed to demonstrate the benefit for rural communities in centralizing services. Likewise, whenever possible the movement to closure of rural facilities must appear to be rural led (e.g., the community is unable to cope with the challenges so they choose to defer services to larger centres).

3. Reports from independent consultants are extremely useful in minimizing political fallout from closures. A properly crafted study can easily find statistical evidence supporting the desired outcome.

CONCLUSION

This paper demonstrates a plan to eliminate the costly problem of providing acute care medical services in rural communities over the next decade. Implemented correctly, there should be minimal political fallout. Eventually the new standard of care will be seen as the only reasonable choice. Lack of access and delayed access in rural communities will further reduce costs to the system because morbidity and mortality will decrease the number of rural citizens accessing the system.