Case Study

Hospital closure in Ontario, Canada

Health Services Restructuring Commission, Ontario, Canada

Background

The Canadian healthcare system is broadly similar to the NHS: it is taxpayer funded, free at the point of use, and delivers universal coverage for primary and secondary care. Provinces are responsible for providing healthcare, and are funded by regional taxation and central Government funding. In the 1990s, economic recession and rising deficits in public finances forced the Canadian government to undertake dramatic cost containment strategies in healthcare. In 1994-95 Ontario, Canada's most populated province, the provincial government had a deficit of C$10.2 billion or 22 per cent and debt had reached 32 per cent of provincial GDP. Serving debt exceeded payments to hospitals, and like many other provinces, Ontario was forced to make significant cuts in public spending.

Method

In 1995 a new government, elected on a mandate for radical change to cut the deficit in the public finances, set out plans to achieve greater value for money in healthcare. While the total health spending was to be maintained at the 1995-96 level of C$17.4 billion, hospital budgets were to be cut by 18 per cent over three years, cutting C$1.3 billion out of the C$7.3 billion budget, to force providers to rationalise and deliver efficiency savings. In addition, the Government recognised that Ontario's hospitals needed to be reformed, as spending cuts within the current framework would lead to decreased quality of care and wide-scale service disruption. Due to the need to rapidly restructure the hospital landscape and depoliticise the process, The Health Services Restructuring Committee (HSRC) was set up as an arms-length body for a four year term. This panel of healthcare experts was to make binding decisions on the restructuring of hospitals, advise the government on restructuring other elements of the health system and create an integrated system that delivers high quality services, access to care and is affordable.

The case for change had been long established, with District Health Councils frequently demonstrating the overprovision of acute services. Changes in technology and medicine had decreased the need for acute services and create the opportunity for care to be provided in alternative settings. Fewer patients required hospitalisation and length of stay had been reduced, with day-surgery and home care becoming more common. The HSRC calculated that 10 per cent of acute care hospital bed days in 1996-97 were used by patients that could have been cared for in more cost effective and appropriate settings.

In the years before the HSRC the number of hospital beds in Ontario had been in decline. Between 1989 and 1995 the number of hospital beds had fallen by 11,000 or 20 per cent. While this was equivalent of closing 30 medium-sized hospitals, there had been no closures among Ontario's 250 hospitals.

The HSRC initially focused on restructuring hospital services in the major urban areas. This represented 65 per cent of total health spending, where hospital care was most concentrated with the greater potential to achieve savings through reconfiguration. Building on past assessments and restructuring plans, as well as drawing on input from the local community, the HSRC set out specific proposals for local areas. Individual assessments were made of bed requirements based on local demands and expected growth. The HSRC’s recommendations

1 OECD (2010), OECD Economic Surveys: Canada.
5 Ibid.
were based on three primary criteria: quality, accessibility and affordability. Local plans sought to ensure services reached critical mass, were clinically coherent, were accessible and appropriate for local populations, and delivered efficient services, economies of scale and direct savings from restructuring. Stakeholders were invited to respond to the proposals, and these representations were considered, along with additional analysis, before final restructuring plans and a set of recommendations were issued to the Minister of Health.

Alongside recommendations of appropriate hospital configurations, the HSRC proposed changes to the governance of hospitals. While previous reports, particularly by the District Health Councils, had demonstrated the need to reconfigure hospitals, local communities had failed to address duplication of services and make difficult choices to maintain or cut existing providers. To ensure that hospitals could be merged or closed the HSRC mandated new governance structures for hospitals, such as amalgamating hospitals into a single corporation, forming alliances between different hospitals, and developing Joint Executive Committees. The new governance structures were directed to implement the HSRC’s proposals of restructuring.

Public engagement
Although “health insiders” were aware of the need to reconfigure Ontario’s hospital infrastructure, there was anxiety among the wider public. In particular, members of the public were not aware of the “big picture” of the challenge facing Ontario’s health system, with debate becoming focused on “cuts” and not reinvestment and concerns over job losses. The HSRC sought to set out a clear message that the status quo could not be preserved, and justified their recommendations as locally led and independently reached. In addition, the Commission continued to explain its mission as reforming delivery to maintain and improve an integrated healthcare system that delivers quality, accessible and affordable healthcare. To further aid this communication strategy the HSRC released a “vision of the future health system” in 1997 and invited responses as part of a consultation on the development of the system throughout the HSRC’s term.

Reinvestment
Reinvesting resources in new health services was key to the mission of the HSRC. In 1998 the Commission released guidelines for reinvestment to develop a restructured health system. One of the guiding objectives of the HSRC was that no hospital should be closed until community and relocated hospital services were set up, and the Commission put pressure on the Government to expedite investment decisions. The HSRC recommended C$2.2 billion of reinvestment across 92 sites in what would be the largest single investment in new facilities in Ontario’s history. In 1998 the Government announced C$2 billion of reinvestments into community and long term care. As a result of reinvestment, by early 2000, the Government of Ontario had approved 58 projects at 40 sites valued at C$1.6 billion. In subsequent years a total of 96 sites were able to benefit from hospital development projects worth C$2.1 billion.

Reconfiguration in Toronto
In the Toronto Metropolitan Area, the Commission’s findings recommended the closure of 11
hospital sites, bringing the number of hospital organisations down from 39 to 24.17 This would reduce the number of inpatient beds from 10,351 and 7,579, but reinvestment would increase the number of long term care beds from 11,674 to 16,881.18 Through restructuring, the HSRC identified C$469 million of savings, or 17.5 per cent of the area’s C$2.7 billion spend on healthcare.19

The first hospital to close was the Doctors’ Hospital, at the time Toronto’s smallest with a total of 319 beds. Doctors’ Hospital services were fully integrated into the Western Division of the Toronto Hospital, with the two hospital boards merging and a new governance structure developed that was representative of the two communities. A new hospital corporation was created by amalgamating the Orthopaedic and Arthritic Hospital, Sunnybrook Health Science Centre and Women’s College Hospital in order to govern all services provided by the three hospitals. The Women’s College and Orthopaedic and Arthritic sites were closed. Another new hospital corporation was created by amalgamating The Mississauga Hospital and Queensway Hospital, retaining the Queensway site as an ambulatory care centre. A new corporate structure to govern the provision of inpatient and outpatient services in the community was located on the Mississauga Hospital site. Ownership, operation, management and control of most of the inpatient programs, services, buildings and assets of the Wellesley Central Hospital were transferred to St. Michael’s Hospital. The Wellesley site was closed and the Central site established as an ambulatory care centre, governed by a separate board representative of the community, with 40 per cent of members selected from the board of St. Michael’s Hospital.20

Overcoming opposition
The public was initially skeptical of the administration’s strategy, with previous attempts to contain costs in healthcare leading to “slash and burn” tactics. Resistance was faced from certain segments of the medical profession; particularly family doctors, paediatricians and specialists clustering around teaching hospitals in large cities, who faced the prospect of losing admitting privileges and significant changes to their employment contracts. Although the HSRC was intended to depoliticise the process, there was still political resistance, with politicians resisting local changes, while the political calendar did influence the timetable and decision making. Planned hospital closures resulted in numerous legal challenges being brought against the HSRC; all of which were unsuccessful.21

Despite these reservations, the implementation of the reforms benefitted from a widespread acceptance both from the public and the health community that structural change was needed to ensure the future sustainability of Ontario’s health system. In the context of the mid-1990s recession and consecutive federal and provincial deficits from 1992 to 1996, the Commission undertook a public relations campaign to clarify the need for change to preserve the province’s universal health system and improve the quality of care.22

Problems
A number of problems with the HSRC process have been highlighted.23 The inadequacy of data and information on hospital performance made decision making and monitoring very problematic.24 The HSRC believed that rather than focusing on disinvesting in hospital services, it should have started with proposals to reform primary and community care; while others argued that the Commission should have included primary care representatives in their deliberations. Similarly, the development of strategy for an integrated system as part of Phase II of its mandate should have taken place alongside the proposed recommendations to

18 Ibid.
19 Ibid.
20 Ibid.
22 Ibid.
the hospital infrastructure. Although the Commission worked hard to convey a positive message of reform and improvement through the media, the absence of a coordinated communication strategy across the different institutions of government led to public confusion and uncertainty. Reforms to governance structures were not always sufficient to allow changes to services, and some hospital boards should have been replaced, not simply merged. According to the Ontario Hospital Association: “The lack of that essential, coordinated strategy to achieve spending cuts, the insufficient time allowed for capturing proposed savings and the desire to avoid sweeping service reductions meant that budget targets were not achieved.”

The restructuring of Canada’s healthcare services in the 1990s did see public satisfaction decline. In 1991, 61 per cent of respondents rated the system as either “excellent” or “very good”, yet by 1999 this figure had fallen to 24 per cent. There was a public perception that waiting times for procedures and tests, and access to specialists, had deteriorated. However national performance on waiting times was maintained.

**Outcomes**

Despite the problems that the HSRC encountered, the Commission did oversee a significant transformation of Ontario’s health landscape and acted as a catalyst for change. In total, 22 communities were affected by the restructuring plans. 51 public hospitals, six private hospitals and six provincial psychiatric hospitals were closed. 44 hospitals were amalgamated into 14 new organisations, 18 rural hospital networks were created, and joint committees were established to share the governance of multiple organisations within a geographical locality. The HSRC identified C$1.1 billion of annual savings, with C$800 million in acute care.

This process resulted in the reduction in the number of hospitals in the province from 225 in 1990 to 150 in 1999 through closures or amalgamations. Between 1995 and 1998, the number of hospital beds in Ontario had fallen by 18.5 per cent from 39,746 to 32,375. The report set out an 18 per cent cut in the hospital budget, including savings of C$1 billion from long term and acute care in urban hospitals. Since the changes of the 1990s there has been a growing take up of non-acute services. The number of hospitalisations for “ambulatory care sensitive conditions” (long term health problems that can be treated in community settings) declined from 456 per 100,000 population in 1995–96 to 304 per 100,000 in 2001–02. Expenditure on hospitals as a proportion of the provincial health budget fell from 52 per cent in 1981 to 37 per cent in 2008. The latest OECD economic survey noted that bed numbers and number of hospital discharges are among the lowest in the OECD.

---

25 Ontario Hospital Association (2011), OHA Position Statement on Funding and Capacity Planning for Ontario’s Health System and Hospitals. Also see Office of the Auditor General of Ontario (1999), Institutional Health Programme – Transfer Payments to Public Hospitals, which highlights concerns that Ministry approval disinvestment and reinvestment programmes were often delayed.


28 Ibid.

29 Ministry of Health and Long-Term Care (2004), Ontario’s Health System Performance Report.
