

Canada's experience with deficit reduction, told through
case studies of two provinces

Managing health reform through an economic downturn

Research summary

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Managing a tight budget at the same time as reforming health services is a substantial challenge, but it is not without precedent. In the 1990s, following an economic recession, many provincial governments in Canada cut their health budgets while also implementing structural reform. To learn from Canada's experience of managing changes to health systems through an economic downturn, the Canadian Health Services Research Foundation (CHSRF) and the Nuffield Trust jointly organised a seminar in May 2011, which heard first-hand accounts from senior figures in two provinces, Ontario and Saskatchewan. This summary paper gives an account of the presentations and discussion at the seminar, with some additional context. We are most grateful to Jennifer Verma and Stephen Petersen of CHSRF and the three main speakers – Mark Rochon, Louise Simard and Terrence Sullivan – for their assistance in preparing this summary.

Key Points

- In the 1990s, many provincial governments in Canada were forced to cut their health budgets for successive years, while also implementing structural reform.
- Two provinces, Ontario and Saskatchewan, succeeded in closing, converting and reconfiguring a substantial number of hospitals. In Ontario the task was delegated by government to an independent commission, while in Saskatchewan the Government led an intensive, province-wide consultation.
- Central drive, strong leadership and a coherent narrative were common features in managing the restructure programmes. This was underpinned by an awareness that local organisations were unlikely to undertake such fundamental reform on their own.
- An important first step was the communication by government that budget cuts were unavoidable – something that is largely absent from the current health debate in England.
- The hospital reconfigurations and closures led to increased waiting times in some specialties, but no adverse impact on mortality. Public satisfaction with health services declined during the period.
- The financial crisis created pressure for new and innovative approaches to delivering efficient health care that subsided when spending began to rise again. Financial pressure can be an opportunity for positive change.

Introduction

In an effort to reduce the UK's public sector deficit, in October 2010 the British Government announced substantial cuts to public spending for the subsequent four years (HM Treasury, 2010). Although health spending was spared from these cuts, the real-terms increase for the National Health Service (NHS) budget was very small, amounting to just 1.3 per cent cumulative real-terms growth from 2010 to 2014. This modest increase may have left the NHS better off than most other government programmes; however, as demand continues to rise in line with an ageing population, higher than expected inflation means that most health care providers will see no growth in the resources available to deliver more services (Smith and Charlesworth, 2011).

Faced with this constrained budget, the English NHS must generate efficiency savings of £20 billion by 2015 in order to meet the needs of an older population with increasing rates of chronic illnesses. Some efficiencies are likely to come from reducing staff numbers and pay, but others will need to be achieved by restructuring services, in particular reducing the use of expensive hospital facilities. During this four-year period, the Government also intends to restructure the organisations which purchase or 'commission' NHS services in England, alongside other reforms to providers and regulatory bodies, with the aim of improving the responsiveness and effectiveness of health services (Department of Health, 2010).

 Cutting spending at the same time as reforming services is a substantial challenge.

Cutting spending at the same time as reforming services is a substantial challenge, but it is not without precedent. In the 1990s, many provincial governments in Canada cut their health budgets following an economic recession, while also implementing structural reform. At a joint CHSRF and Nuffield Trust seminar in May 2011, participants heard about the scale of the deficit facing Canada in the 1990s, and listened to first-hand accounts from two provinces, Ontario and Saskatchewan, both of which implemented substantial cuts to hospital services.



Background: the story of Canada's reform in the 1990s

Health care in Canada

Health care in Canada is broadly similar to the UK's. It is funded primarily through taxation, with universal coverage for inpatient and physician services, which are free at the point of use. Patients must pay for the cost of drugs outside hospital, and for ancillary services such as dentistry and optometry. The majority of Canadians have supplementary employer-provided insurance to cover these services. About 70 per cent of health care spending in Canada is publicly financed, compared with 83 per cent in the UK. Canada spends a slightly higher proportion of its national wealth on health care compared to the UK: 10.4 per cent of gross domestic product (GDP) in

2008, compared with 8.7 per cent for the UK (OECD, 2010). Effectively, UK residents pay less for a broader base of coverage than Canadians, who share a border with the world's most expensive health system, the United States (US) (OECD, 2010).

70%

of health care spending in Canada is publicly financed

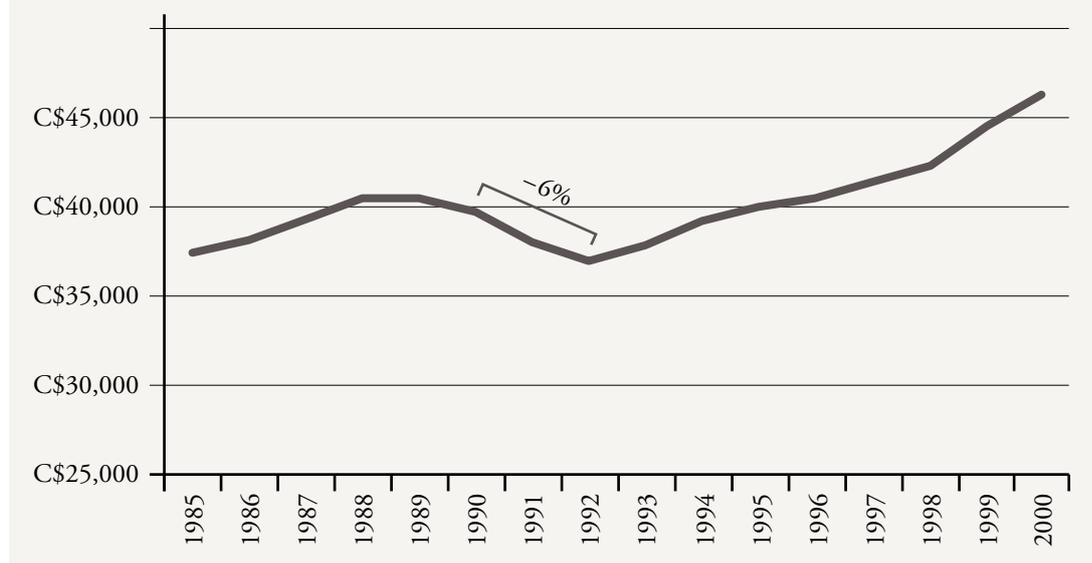
Canadian provinces are responsible for administering health services, which are paid for by local taxation and transfers from the federal government. Most physicians are paid by the province on a fee-for-service basis and hospitals are, with few exceptions, run as independent, arm's-length, not-for-profit entities, largely paid for through accountability agreements and contracts. Almost all

provinces in Canada also enjoy some form of regional authority that plays a role in coordinating and integrating services within a specified population and geography.

Canada's recession in the 1990s

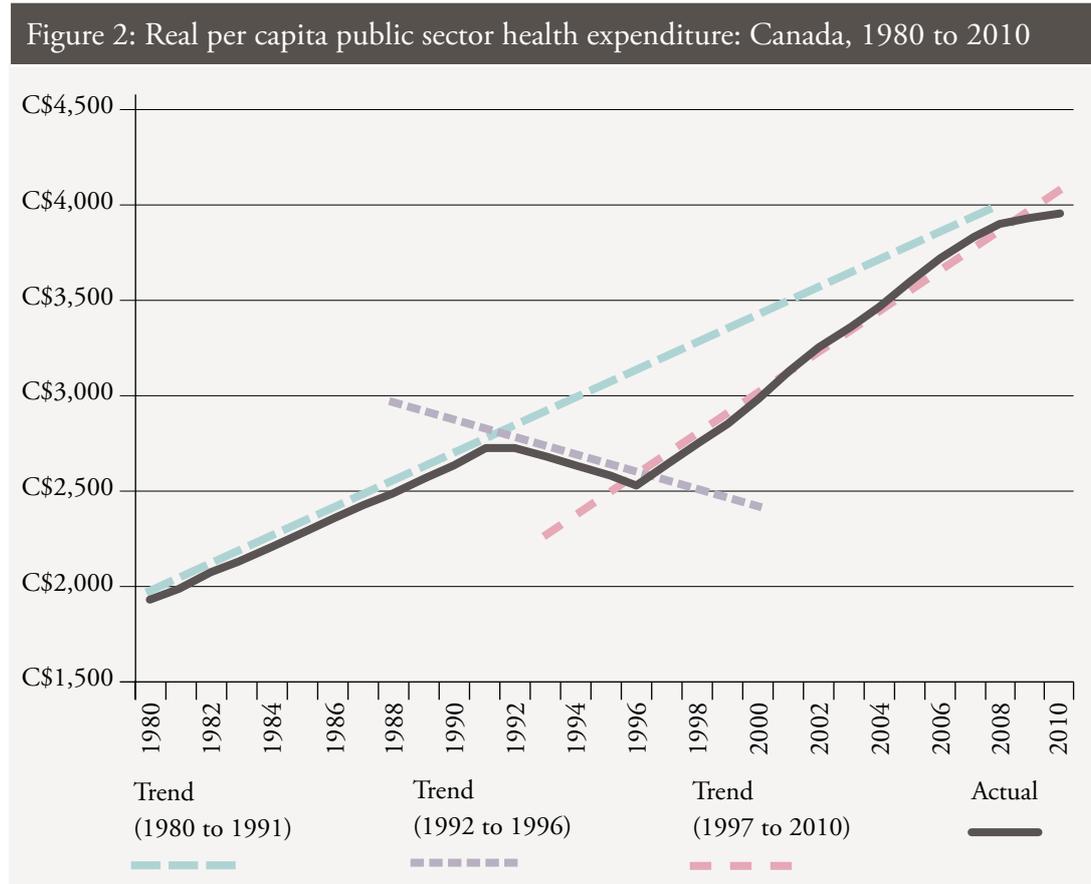
Canada's economy was pushed into a recession in the first few months of 1990, which was provoked by an economic downturn in the US. The recession lasted approximately three years, and saw a 6 per cent reduction in real per capita GDP from 1990 to 1992 (see Figure 1).

Figure 1: Real per capita GDP, Canada: before, during and after the recession (1985 to 2000)



Source: CHSRF analysis of Canadian Institute for Health Information (2000) data

As GDP fell, concern grew about the scale of Canada's public debt, forcing both federal and provincial governments to make deep cuts in public spending and incur deficits for several consecutive years from 1992 to 1996. Federal transfers to provinces were cut, pushing provinces further into debt themselves. As a result, provincial governments cut health spending, which accounted for the largest portion of government programme spending. Growth in per capita public sector health spending for Canada as a whole was reversed during this period, following a long period of continuous growth (see Figure 2).



Source: Canadian Institute for Health Information 2010

Impact of budget cuts on health services

For Canada as a whole, the impact of cuts to hospital and other health service budgets can be seen in some of the trends in the provision and utilisation of services (see Figures 3 to 5), with obvious decreases in the number of doctor consultations per capita and physician density. Hospital beds saw an accelerated fall, against a background of a long-term decline in bed numbers and in common with many other health systems.

Figures 3 to 5: Changes in doctor consultations, and hospital and physician density: Canada, 1980 to 2007

Figure 3: Number of doctor consultations per capita

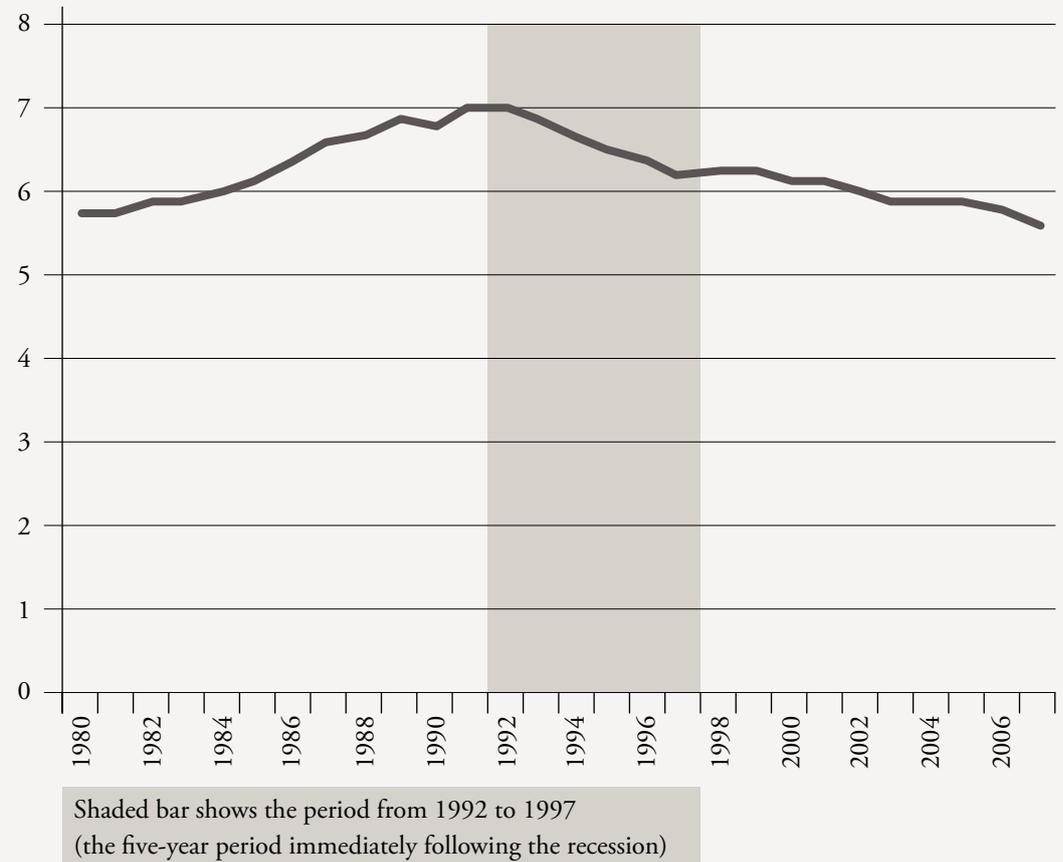
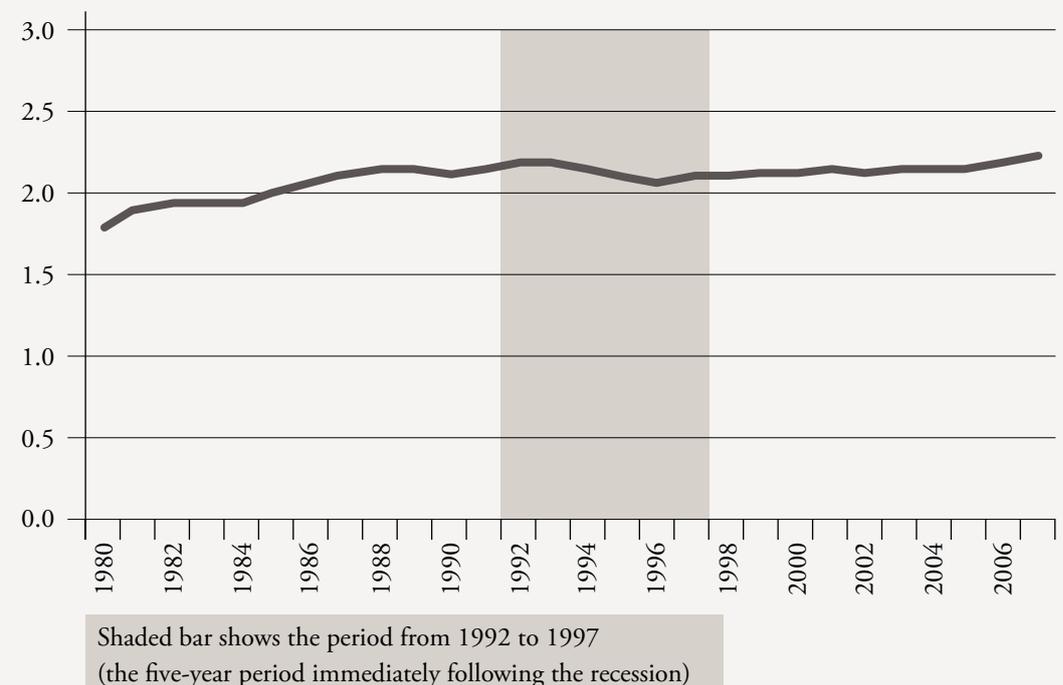
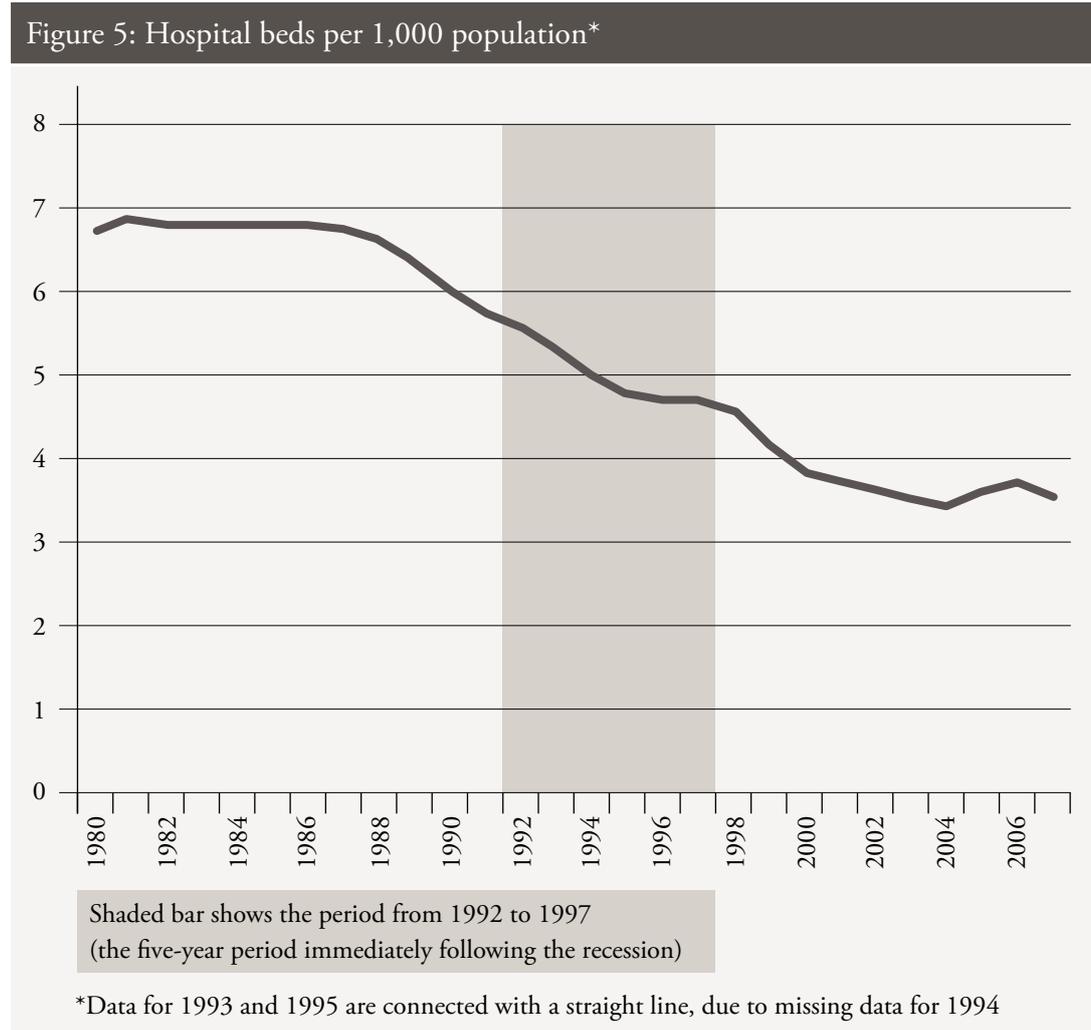


Figure 4: Physicians per 1,000 population





Source: CHSRF analysis of OECD (2010) data

During this period, concern grew among the public and some professionals that waiting times were increasing (Shortt and others, 2004) and although there was an absence of routine measurement of waiting times, studies have found that waiting times did increase in the 1990s in some surgical specialties (Simunovic and others, 2005). Another casualty has been public perceptions of health care in Canada. According to the Commonwealth Fund's International Health Policy Survey of 2001, the proportion of Canadians saying that their health services needed to be 'rebuilt' completely rose from 5 per cent of respondents in 1988 to 23 per cent in 2001, while the proportion of those believing that problems were only 'minor' fell from 56 per cent to 20 per cent over the same period (Commonwealth Fund, 2001).

Case studies: two approaches to health reform

In the 1990s, the provinces of Ontario and Saskatchewan implemented substantial budget cuts to their health services, which involved restructuring and merging hospitals, as well as other cost-saving actions. Both provinces took very different approaches to achieve these changes. In Saskatchewan, politicians embarked on a centrally directed process of hospital reform with extensive engagement of stakeholders across the province. In Ontario, politicians delegated the task to an independent commission, which undertook the planning, consultation and implementation of hospital restructuring.

Health care reform in Saskatchewan in the 1990s: lessons from Louise Simard, Minister of Health, Saskatchewan (1991–1995)

Saskatchewan is home to about 3 per cent of Canada's population (1 million people), spread over an area larger than France. About 40 per cent of the population lives in or near the two largest cities, Saskatoon and Regina, but a substantial minority (35 per cent) lives in rural areas.

The early 1990s brought together two forces for change. The first was an acknowledgement among a range of stakeholders that health care reform was needed: Saskatchewan's health system had an excess of hospitals compared to other provinces, and as a result, higher utilisation rates without commensurate health outcomes. The second was the scale of the deficit. The previous decade had seen a gradual build-up of public debt as government spending exceeded revenues. This meant that Saskatchewan was particularly vulnerable to reductions in federal transfers in the early 1990s, which brought the province to the verge of bankruptcy.

The new provincial Government, elected in 1991, first took action to initiate health care reform by calling stakeholders together to articulate a reform programme. Known as the 'Wellness Strategy', it aimed to reorganise the governance and organisation of health in the province by reducing 400 health boards to 30 and reorienting health services away from hospitals toward primary care. At this point, most stakeholders supported the goals of reform.

In early 1992, the newly-elected Government passed a health budget that planned to reduce spending by 3.3 per cent, ushering in a four-year period when health spending growth consistently declined (after a period of close to 4 per cent growth over the preceding five-year period, compounded annually). Hospital budgets were hit particularly badly: real per capita growth was minus 5 per cent in 1993, minus 9 per cent in 1994, and minus 6 per cent in 1995 (CHSRF calculations using Canadian Institute for Health Information (2010) data).

As the implications of the budget constraints sank in, the Government realised that the reform programme needed to be stepped up. The Government announced that 52 small rural hospitals would need to close or be converted to ambulatory care centres. These hospitals all had an average daily occupancy of fewer than eight patients. Most changes involved removing acute services and downgrading the provision to ambulatory care, rather than closing the facilities completely. Nevertheless, the rural nature of the province meant that hospitals were symbolically important as well as a source of employment for local people.

The hospital closures were closely managed by the Government. Local district health boards had to complete their plans by August 1993 and implement the hospital conversions/closures by October 1993. There was considerable opposition to the closures not only from the public, but also from health professionals, many of whom had been initially supportive of the reforms.

Opposition to hospital closures was addressed at face-to-face town hall meetings, where cabinet ministers attempted to explain the rationale for the reform and respond to the concerns of local people. Over 600 meetings were held across the province over a one- to two-year period, with most meetings occurring in 1992. The Government gave local health boards guidelines on how to develop plans for core services and on implementation, and also piloted conversions in two areas to ensure that alternative emergency and acute facilities would function adequately. A utilisation commission provided data analyses on patterns of hospital use for boards.

Evaluation of the closures seven years later found that standardised mortality rates were lower in the areas where hospitals had been converted, compared to areas where hospitals remained open (Liu and others, 2001). Despite the opposition to the hospital conversions, the incumbent party was re-elected to power in 1995, though with a reduced majority. Public spending on health increased from 1996 onwards.

Observations on the ingredients of success in implementing budget cuts and health reform

- Reform needs a champion: the minister responsible needs to be interested and motivated.
- The stage needs to be set so that there is a readiness among the general public and stakeholders to accept change.
- Reform needs to be launched early in a government's mandate.
- There needs to be a body of research that supports the change.
- A vision and the goals must be compelling and clearly defined.
- The vision needs to offer hope in order to make the tough measures that will be required more palatable.
- Stakeholders (including unions) should be involved in the development of the vision and goals, and in the development of the strategic plan for implementation.
- Once defined, the vision needs to be communicated to a larger audience – the public. Public opinion leaders need to be part of the process – they should be encouraged to hop on the bus.
- Steps for implementation need to be set out with clear deadlines for accomplishing the various steps. It is also helpful to have materials advising and guiding the implementers through the various steps of implementation.
- The plan needs to be flexible. If change is required, it is a two-way process.
- The consistency of the message needs to be maintained.

Restructuring health and hospitals: the Ontario experience: lessons from Mark Rochon, CEO, Health Services Restructuring Commission (1995–1998)

Ontario is the most populous Canadian province. Over 13 million Ontario residents account for nearly 40 per cent of Canada's population. In common with other provinces, Ontario's public spending was badly affected by reductions in federal transfers and reduced revenues from its own recession-hit economy. By 1994/95, the accumulated debt stood at C\$90.4 billion, or 32 per cent of provincial GDP. Growth in health spending, which had been over 3 per cent in real terms between 1986 and 1991, fell sharply to minus 1.3 per cent between 1992 and 1997.

As in Saskatchewan, it became apparent that containing spending without restructuring hospitals was impossible and there was a shared awareness within the province that hospital reform was needed. Throughout the 1980s, there had been a gradual decline in inpatient beds and a shift to day cases, but there had been neither a reduction in excess capacity within hospitals nor any effective planning of health services.

In 1995, the newly elected Conservative Government, elected on a mandate for radical change (including public deficit reduction), set up an arm's-length commission to design and implement reform in the hospital sector. The Health Services Restructuring Commission (HSRC) was created through legislation that allowed the Government to delegate its legal authority to close hospitals to the HSRC. The Commission was given a mandate to provide advice to government on the restructuring of other health services and make binding decisions about the restructuring of hospitals.



Growth in health spending, which had been over 3% between 1986 and 1991, fell sharply to –1.3% between 1992 and 1997.

The Government's objective was a financially sustainable health system. Although there would be no overall reduction in funding for health, the Government committed to cutting hospital budgets by 18 per cent in three years. The HSRC quickly recognised that if 220 hospitals acted individually to achieve the cuts, there would be serious service disruption and challenges to coordinating care (HSRC, 2000). The Commission was therefore needed to counterbalance the 'individualistic cultures' of hospitals, whose leaders were often able to see the need to change but were unable to deliver it.

The Commission's first task was to tackle restructuring within eight major municipalities, which accounted for 65 per cent of hospital spending. It developed an assessment framework that considered the performance of acute care, projections for population change and determined the capacity requirements for each community. Restructuring decisions were made on the basis of quality, accessibility and affordability. The Commission visited every community, met with local stakeholders and the media, used evidence based on data analyses as a foundation for its plans and

presented the plan to the hospital, media and community with a 30-day window for negotiation and revision, after which the plan would be concrete and binding. In the case of non-compliance, Ministers had the power to remove chief executive officers and appoint a supervisor, but this power was rarely used.

At the end of the process amalgamations, takeovers and closures reduced the number of hospitals from 225 (in 1989/90) to 150 in 1999. Twenty-seven public hospitals were closed. All 'savings' from the closures were reinvested in other areas of the health sector, particularly long-term care, although this process often lagged behind the hospital restructuring. The Commission was wound up in 2000.

Reflections on the work of the Health Services Restructuring Commission

- The Commission acted as an effective catalyst for change, a way of making urgent decisions where previously there had been stalemate.
- Delegation does not need to undermine accountability. Although the elected politicians had delegated power to the Commission, they were seen as publicly accepting responsibility for the closures.
- The Commission generated a clear narrative for the need for change and communicated it effectively. It was important that hospital closures were located within a wider narrative of health service improvement rather than being seen as a means to save money.
- Each decision was driven by local considerations, underpinned by data analysis and consultation rather than a one-size-fits-all approach.
- The Commission was able to persuade the Government to invest in long-term care and non-hospital alternatives (although there was a time lag).
- Intensive, repeated, face-to-face engagement by the Commission with stakeholders and the media was very important.
- There were a number of areas where the Commission and the Government could have done things better. These include faster investment in alternatives to hospitals, having a presence on the ground in local areas to assist with communication, and better involvement of primary care representatives, who were largely absent from the group of stakeholders involved with restructuring.



What can the UK learn from Canada's experience?

Although both provinces took a number of different measures to contain costs, including restraining wages and reducing the number of nursing staff, it was the approaches taken to restructuring hospitals that attracted the most comment and questions at the seminar from the NHS/UK audience. Closing hospitals in the NHS on efficiency grounds has proved highly controversial and in some cases negotiations are unresolved after several years, as local communities have steadfastly opposed reforms. Several themes emerged from the discussion of how Saskatchewan and Ontario handled their hospital reconfiguration.

The process of closing or changing hospitals has been centrally managed: local players are unlikely to do this by themselves

Although each province adopted very different approaches, central drive and strong leadership were key features in both cases. This was underpinned by an awareness that local organisations, left to themselves, were unlikely to reform services, however strong the plans or the financial imperative. In Saskatchewan, 30 newly formed health boards undertook the reform process, but their timetable was driven by the provincial Government, which also took a very active role in communicating with stakeholders at a local level. In Ontario an executive body with a clear, time-limited mandate was able to execute hospital closures and mergers. Overcoming institutional and local loyalties was key to implementing change.

A narrative and vision are needed, with clear political support

A coherent narrative is essential to sell the reforms to the public and key stakeholders. A vital first step is the communication by government that drastic budget cuts are necessary to all services including health. It is then crucial to develop a narrative for change that goes beyond budget cuts and articulates some positive vision for the future. In the case of Ontario, the Commission took the lead in developing this narrative.

The process of communication has to be extensive and continuous. Both Saskatchewan and Ontario benefited from a prior acceptance within the health community that structural change was needed, and both administrations were elected with a clear deficit-reduction mandate. Despite this, once the scale of change was understood, opposition was vociferous, even among those who had initially supported reform. In both cases, sustained engagement with stakeholders was undertaken.



Both Saskatchewan and Ontario benefited from a prior acceptance within the health community that structural change was needed.

In the case of the NHS in England, the Coalition Government has only recently departed from its narrative of having protected the NHS from the cuts that are being implemented in other public services, and begun to talk about the reality of the efficiency savings that will be needed on the very small rates of growth for the NHS. On the subject of hospital reconfigurations, Government ministers have been largely silent, in contrast to an anti-reconfiguration stance taken while in opposition. Stakeholders and the public in England are some distance from being engaged in the kind of dialogue needed to undertake reconfigurations on the scale of either Saskatchewan or Ontario.

Thought needs to be given to sustaining reform beyond a financial crisis

One of the striking features of Canada's experience is the speed with which health spending growth resumed at a faster rate once the worst of the recession was over (see Figure 1). By 2008, per capita expenditure was the same as it would have been had growth continued at pre-recession pace. Reflecting on the experience of Saskatchewan and Ontario, there was a sense that the pressure to implement wider-reaching reforms – for example, to primary care, long-term care and community alternatives to hospital care – had lessened as pressure from the financial crisis subsided.

In this sense, a financial crisis might be seen as an opportunity for innovation and for taking new approaches to efficient health care that might not otherwise exist. In the case of the NHS, it is far from clear when public finances will, if ever, recover to the levels seen prior to 2009. Nevertheless, in the short run, the financial pressure could drive potentially beneficial change, provided some of the lessons from Canada's experience are heeded.

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