Will hospital closures mean physician unemployment in Ontario?

Charlotte Gray

In brief

Dr. Duncan Sinclair, the former dean of medicine who heads the commission charged with restructuring Ontario’s health care system, said something dramatic was needed to revamp the system. He wasn’t kidding. His commission recently called for the closure of 3 hospitals in Ottawa and 10 more in Toronto. In a wide-ranging interview with Charlotte Gray he talks about the commission's goals and their potential impact on physicians.

En bref

Le Dr Duncan Sinclair, ancien doyen de la médecine qui dirige la commission chargée de restructurer le système de soins de santé de l’Ontario, a déclaré qu’il fallait prendre des mesures spectaculaires pour moderniser le système. Il ne blaguait pas. Sa commission a préconisé récemment la fermeture de trois hôpitaux à Ottawa et de dix autres à Toronto. Dans le contexte d’une entrevue générale avec Charlotte Gray, il parle des buts de la commission et de leurs répercussions possibles sur les médecins.

By nature, Dr. Duncan Sinclair is one of the most straightforward men you could hope to meet. Since he was appointed head of Ontario’s Hospital Restructuring Commission, he has been blunt about what the commission is trying to accomplish. When he appeared on CBC’s National news show in March, he announced: “We’ve got to do something dramatic; the government is out of money.”

When questioned about why the government must go after hospitals rather than other parts of the health care system, he chuckles: “Why do bank robbers rob banks? Because that’s where the money is.”

And Sinclair, the veterinarian who was one of Queen’s University’s most successful deans of medicine, has lived up to his promise to do something dramatic: his commission has already announced that 24 Ontario hospitals must close. But when I asked him recently what impact this will have on physician employment, he was uncharacteristically equivocal.

“You’re asking me to look into a crystal ball for that,” he explained. “We don’t know. A large number of other questions must be answered first. What is the appropriate range of care for a given community? What is the optimum ‘doc-pop’ ratio? What should be the relationship between primary care physicians and specialists, or between specialists and subspecialists? We know that many services currently provided by doctors can be provided by other health professionals, so what is the appropriate relationship between physicians and other health professionals?”

Since medicare was introduced more than 30 years ago, there have been several unsuccessful attempts to answer these questions. One of the most woeful problems facing Sinclair’s restructuring commission is the lack of data. “It is incredible,” he told a Canadian Club audience recently, “that in the year 1997, in the technologically and educationally advanced province of Ontario, we do not have a comprehensive, up-to-date information system firmly in place to support the effective operation of our most highly treasured and single most expensive so-
cial program,” Ontario Health Insurance Plan billing records are the only province-wide database, and they were never designed to yield information on practice patterns or patient profiles.

But Duncan Sinclair knows that CMAJ readers have a very particular interest in the questions he raises. It does not require a degree in veterinary science, statistics or medicine to know that closing and merging hospitals will inevitably reduce the number of jobs available for hospital-based physicians. Reducing the number of operating rooms will mean a drop in demand for surgeons and anesthesiologists. Closing emergency departments will reduce the need for emergency physicians. Increasing the use of nurse practitioners will shrink the need for primary care physicians. One way or another, a large number of Ontario’s doctors will likely be directly affected by fallout from the hospital closures.

Creation of Sinclair’s restructuring commission did make sense. Even though health care, at $17.7 billion a year, consumes one-third of the provincial budget, Ontario is the last province to come to grips with its health care bills. Until the commission was appointed, Ontarians had suffered the worst kind of slash-and-burn approach to spiralling health care costs. The 2 previous provincial governments had closed 10000 hospital beds without closing any of the province’s 220 hospitals. They talked about shifting to preventive and community care, but without any strategic redirection of resources. When Mike Harris became premier, his government immediately imposed a $1.3 billion cut on hospitals, spread over 3 years. It also gave Sinclair’s commission a 4-year mandate to rationalize the hospital sector and leave Ontario with a reoriented health care system that serves the needs of citizens, not institutions.

In Ottawa, 3 of the restructuring commission’s 8 commissioners came to town last fall to listen to local hospitals plead their case for survival. As a vice-chair of the board of the Children’s Hospital of Eastern Ontario, I was part of the CHEO team that filed into a windowless board room to face the commissioners and their staff. We had been warned by those who had already appeared that the commissioners wanted steak, not sizzle. “Don’t sing the praises of your services and medical staff,” we were told. “Commissioners’ eyes glaze over if all they hear is bragging.”

So far every commissioner had attended every meeting required and read every piece of paper put in front of them. What they wanted were strong arguments and solid information — and a sense that the hospital in question was oriented toward the future.

When one of my colleagues began to extol an established program, Sinclair interrupted: “The status quo is not an option. Nothing is untouchable.”

When another member of the CHEO team produced some comparative information from another province, Marc Rochon, the commission’s executive director, leaned forward eagerly: “I don’t know this. Can you send me a copy of these findings?”

We had less than an hour to make our case, as did each of the other institutions invited to appear. Four months later, the commission released its recommendations: 3 of the city’s 8 hospitals should be shut down. It also recommended that the Brockville Psychiatric Hospital, which had not realized that its fate hung in the balance, should go too.

The death list did not name CHEO but it did include the Montfort, the province’s only French-language hospital. The implications of that decision are still reverberating across central Canada — both Prime Minister Jean Chrétien and Quebec Premier Lucien Bouchard protested. However, the decision to close the Montfort was taken on both financial and health grounds, and was typical of Sinclair’s single-minded attention to his goal. He does not see himself as being in the national-unity business: he wants to create a real health services system from what currently exists — a collection of very good institutions and organizations that operate almost independently of one another and eat up a disproportionate amount of health care dollars. If considerations of language policy prompt politicians to invest money in French-language health care services, reasons Sinclair, they can do so out of the language-policy budget.

His no-nonsense approach has won him the media label “Darth Vader” and earned his commission the title “travelling executioners.” Sinclair simply smiles, and protests that he is a white knight. “Our whole purpose is to protect Ontario’s biggest and most cherished social program by giving the health services ‘system’ the ‘tough love’ necessary to make it affordable and to preserve its accessibility and its quality.”

A week after the commission released its 119-page report on Ottawa, it unveiled its proposals for Toronto. Out
of 38 hospitals in Canada’s largest city, 10 were handed death sentences; the list included Women’s College Hospital, a centre well known for its expertise in women’s health. Just as Ottawa’s francophones kicked up a fuss about the Montfort, supporters of Women’s College organized a save-our-hospital campaign.

Sinclair’s commission still has to issue its reports on Hamilton and Windsor, but with conclusions already issued on Thunder Bay, Sault Ste. Marie, Sarnia, Petrolia, Pembroke and London it has covered facilities that consume 65% of the province’s total hospital budget. Sinclair intends to have looked at every hospital by the end of 1997. The commission will then move on to phase 2: “creation of a genuine, integrated, coordinated health service system for Ontario.”

So where does this leave physicians? Once again, the crystal ball is too cloudy for Duncan Sinclair to make any easy predictions. He says he intends to appoint a fact-finding team to look into questions such as optimum physician–patient ratios, or different working environments for physicians. “Do specialists have to be hospital-based?” he muses. He also acknowledges that the human-resources policy the commission is developing for hospitals will not be appropriate for physicians, who are rarely employees. They will need custom-designed adjustment policies.

So will some doctors be out of work? “Who likes the prospect of anybody being out of work?” counters Sinclair. “We know that unemployment is bad for anybody’s health. But you know, sheer budgetary pressures have thrown a lot of people out of work. Why should physicians, who are very privileged, enjoy any special protections?”

Those most at risk are not highly specialized physicians but family doctors, pediatricians and specialists who cluster around teaching hospitals in large cities, and who may find they no longer have admitting privileges at any institution.

In Sinclair’s view, however, doctors who are squeezed out of practice in large cities could be the answer to chronic physician maldistribution in the province. “If they are prepared to move, to fill unmet demand, they could solve the problem of lack of access to health care services” in Northern Ontario, for example. He points out that a dictatorial approach to maldistribution won’t work, but market forces might. “There may well be unemployed physicians at the end of this process if they are not prepared to relocate.”

In the commission’s recently issued vision statement and several speeches, Sinclair has called upon doctors, along with nurses and other health professionals, to exercise leadership. I asked what opportunity physicians might have to show leadership in coming months, and he suggested that the fragmented nature of the current system is partly responsible for the dearth of leadership from all the players, from doctors and hospitals to politicians and governments. “Everyone put their own interest ahead of the public interest. Everyone, including doctors, knew what the problems were, [but] only a few physicians were prepared to take leadership on reforming the system.”

He argued that medical associations have always focused too narrowly on physicians’ interests. “But professional associations represent the interests of those members that attend their meetings. It is a pity more members, with wider interests, didn’t always care to get involved.”

By the year 2000 the restructuring commission hopes to have put in place the foundations of a publicly funded system that revolves around the population it serves. The Ministry of Health will be accountable for this system, but most operational decisions will be handed off to various integrated health care systems. These will include services that currently function with little coordination, from hospitals and long-term care to home care. A key characteristic of these integrated systems is capitation funding, which involves enrolling, registering or rostering defined populations with health service organizations charged with meeting their needs.

As yet, the commission has made no pronouncements on how doctors will be remunerated in this new system. However, it is clear that fee-for-service payments would be an anomaly in a system in which costs were controlled far more carefully.

Many physicians in Ontario, and in Canada, for that matter, would be justified in feeling nervous about their futures. Given this uncertainty, I asked Sinclair whether he would advise young Canadians to pursue careers in medicine? “Absolutely!” he replied without hesitation. “It is a wonderfully rewarding life. And it is a more challenging profession than it has been for many years, for those individuals who want to be, as they once were, genuine community leaders as well as practitioners.”

It was only after we had finished our telephone interview that I remembered that Sinclair’s son is bassist in the Tragically Hip, perhaps Canada’s best-known rock band. Compared with the vagaries of the music world, membership in the medical profession must seem like a lifetime guarantee of employability.