

## The disconnect between the data and the headlines

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One of the most interesting health policy questions of this decade is “Why is there such a disconnect between what we know from the headlines and what we know from the data?”

In this issue (page 397) Samuel Sheps and colleagues<sup>1</sup> use data to describe the consequences of bed closures and hospital downsizing. British Columbia closed 30% of its acute care beds over the 5-year period 1991–1996. “Doom and gloom” headlines in the Vancouver papers claimed that these cuts caused crises and disasters for British Columbians and their medical care system (“Expect more deaths as hospitals reorganized, nurses’ union says”;<sup>2</sup> “‘Prescription for disaster’ — union and hospital staff decry ministry’s closure of Shaughnessy”;<sup>3</sup> “It’s tougher to get into hospital”). One would expect, however, that if more people had bad experiences after bed closures than before, these results should be showing up in the “data.” If the nurses’ union is right, we should find a higher death rate after bed closures, particularly among vulnerable groups such as elderly people. If indeed it is “tougher to get into hospital,” we should find fewer people getting in. Is this what the data tell us? Sheps and colleagues have, in effect, added up all the anecdotes and all the bad and good experiences before and after bed closures, and what do they find?

Were there more deaths after bed closures? No — the overall death rate was unchanged. Were fewer people getting into hospital? Not really — despite the sizeable bed closures, there were “only minor changes” in the proportion of elderly people who received no facility care or acute care (by my calculations an increase of 2.5%). How could this be? Doctors and nurses served patients well: presumably, they adapted to bed closures by shortening the amount of time patients spent in hospital. Bed closures have not made it tougher for sick elderly patients to get into hospital. Claims to the contrary are false.

But does this mean patients were discharged quicker and sicker, another frequent allegation of those claiming crisis and imminent system collapse? Data from Winnipeg, where 21% of hospital beds were closed between 1992 and 1995, provide more facts about bed closures. The Winnipeg findings about bed closures<sup>3</sup> parallel those of Sheps and colleagues. The closures had little effect on access to hospital care: stays were shortened, and many inpatient procedures moved to the outpatient setting. Death rates were unchanged. There was also no evidence that patients

were discharged quicker and sicker: there was no increase in readmissions, and no increase in emergency department or physician office visits in the 30 days after hospital discharge. Despite bed closures, there were dramatic increases in the numbers of high-profile surgical procedures, such as angioplasty and bypass and cataract surgery.

But was the Winnipeg press any more accurate in its reporting on the effects of downsizing? Not at all. The resulting closures were a constant source of alarmist headlines: “‘We’re at breaking point,’ HSC doctor warns”;<sup>6</sup> and “City braces for ER crisis; patients will likely suffer winter bed shortage, gov’t admits.”<sup>7</sup>

Like Sheps and colleagues’ data, the Winnipeg findings are based “only” on cold, hard facts. What about those treated in the system? What do they have to say? Shapiro and associates<sup>8</sup> interviewed elderly Winnipeg residents before and 1 year after substantial bed closures. The opinions about access to hospital and about the overall quality of care in Manitoba among those who were admitted to hospital during the period when most of the beds were being closed were significantly more favourable than the opinions of those admitted to hospital before the bed closures. The former group were more positive about quality of care and access than those who had never been admitted to hospital — but whose opinion was presumably influenced by what they read in the newspapers.

These findings are consistent with those of other investigators. Although only 20% of Canadians report having confidence in the health care system, more than 50% say that the medical care they and their family personally received in the last year was very good or excellent.<sup>9</sup>

Physicians also point to this gap between headlines and facts. At a rally in Edmonton against Premier Ralph Klein’s privatization Bill 11, on Apr. 16 of this year, Walley Temple, chief of surgical oncology at the Tom Baker Cancer Centre, Calgary, after reviewing available research and his experience working in various systems, stated:

I assure you that our public health care system is a veritable, most equitable, most compassionate, most economic [system] and has health outcomes that are truly awesome.

So does it really matter that there is a wide gap between data describing how the health care system operates and what we read in the papers? Most assuredly it does. The

perpetual “doom and gloom” stories persuade the public that drastic changes are necessary. Temple, speaking at the same rally, noted:

Why would we want to experiment with another model known to be expensive, unreliable...? Why would we want to replicate a problematic system where there will be no turning back and where the results will be measured in people’s lives? Our doctors, our nurses, our health care workers have truly broken their backs to help this province out of debt and keep the system working. And now the government will break our hearts with Bill 11.

Sheps and colleagues have provided us with an important set of facts about the robustness of British Columbia’s health care system after downsizing. We would be well advised to use these to inform our media-fed misconceptions.

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