Are children's hospitals an idea whose time has come and gone?

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The freestanding children's hospital, that icon of caring medical care, seems to be an idea whose time has passed by. Today, health care managers who make the expensive decisions squint hard at cost effectiveness and health outcomes — standards that things such as children's hospitals cannot even be measured against. They quash plans for new buildings, and some think that Canada's 10 existing children's hospitals should be amalgamated with other facilities.

Alberta's recent decision to overturn plans to build a Northern Alberta Children's Hospital (NACH) probably marks the end of the construction of children's hospitals in Canada. In 1991, the Alberta government reversed an election promise made in the mid-1980s, shrugged off Edmonton's craving to keep up with Calgary, which already had a children's hospital, and abandoned its plan to build the NACH despite considerable pressure from pediatricians and the public.

Don Phillipon, Alberta's associate deputy minister of health, explains the turn of events. "Edmonton hospitals were providing good — not great — pediatric services. Some people felt that to attract pediatric specialists in some highly specialized areas, there had to be more of a focus, more of a centre."

But a slowdown in capital construction for all hospitals put the health ministry on the side of nay-sayers who argued that the proposed hospital was an unnecessary expense. A revised plan called for a principal site surrounded by satellite units at other hospitals, each with no more than 10 beds for minor pediatric conditions. Work on this plan is now under way.

Although it is not in a separate building, the pediatric centre at the University of Alberta, called the Children's Health Centre, has its own board and a mandate to ensure that children's services get top priority.

Phillipon feels strongly that the right decision was made, and that no children will suffer as a result. In the sparse northern Alberta catchment area, an overspecialized hospital would pull patients away from other tertiary care centres, leaving expensive diagnostic and treatment services underused. "It was going to cost $100 million just to start up the new hospital," he says.

Canada is apparently running out of catchment areas large enough to justify free-standing children's hospitals. Former public health nurse, Ottawa mayor and member of Parliament Marion Dewar recalls that when the Children's Hospital of Eastern Ontario (CHEO) was built 18 years ago, there were doubts that the catchment population (about 1 million people, including those living in western Quebec) was large enough to justify the building because seriously ill children could be evacuated to Montreal by air in 20 minutes, and to Toronto in less than an hour. In fact, a determined cadre of opponents tried to dissuade decision makers from building CHEO by arguing that its construction was unjustifiable.

Manon Caris, a CHEO spokesperson, explained that in

Résumé : Puisque les Canadiens s'inquiètent en général du rapport coût-efficacité des soins de santé, il semble improbable que d'autres hôpitaux pour enfants soient construits au Canada. Même si les hôpitaux pour enfants attirent les dons d'un public qui témoigne d'empathie, de nombreuses personnes estiment que leur autonomie est un luxe inutile et que leur principe a peut-être fait son temps.

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1979 the hospital raised the upper age limit for its patients from 14 years to 18 years to maintain its patient flow. "The catchment area is small and more children were needed," she said, adding that the higher age limit ensured continuity of care for children with pediatric disorders.

Ultimately, however, CHEO's success in filling beds depended on closing all other pediatric beds in the community. "This means, for many parents, that they have to drive past the Queensway-Carleton Hospital, the Ottawa Civic Hospital and the Riverside Hospital on their way to CHEO," notes Dewar. "It can be really inconvenient."

Today, CHEO is both a specialized and general children's hospital. Ruth Derek, the director of public relations, says it has seen a steady increase in the "intensity of care" it provides. Up to 45% of its patients, many with multiple trauma, now arrive from outside the Ottawa area. There has been a corresponding growth in community clinics to handle less severe problems. The average length of stay is 5 to 6 days, despite day-care programs for minor surgery.

Promoters of children's hospitals still love them. They argue that dedicated hospitals for children provide better specialized care, create enough critical mass to attract pediatric specialists, and draw public support in the form of volunteers and donations.

Dr. Agnes Bishop, a professor and head of the Department of Pediatrics at the University of Manitoba, and physician-in-chief at the Children's Hospital of Winnipeg, does not advocate children's hospitals for every small town, but feels specialized pediatric care is not easily obtainable when adults and children are mixed together.

"Why should children not have their own institution when they require a very specialized type of care, including investigative procedures and personnel trained in pediatrics?" she asks. "All subspecialties require a pediatric component. Pediatric subspecialists are now being recognized and require specific training."

Bishop reinforces the CHEO idea that the upper age limit for children's hospitals is arbitrary; to some extent, it may be influenced by the need to follow adolescents with "pediatric" diseases such as cystic fibrosis or leukemia.

Diane C. Barei, executive director of the Canadian Association of Paediatric Hospitals, emphasizes the special types of care and technologies children need, ranging from nurses who use hand puppets to allay children's fears of surgery, to technicians trained to take x-rays of children. In a general hospital in which only 1 in 10 patients is a child, she claims, the technicians will have less experience dealing with children and will take longer to position them.

"The idea of a stand-alone children's hospital is a bit of poetic licence because it is likely to make large demands on other services outside that building."
— Stephen Birch, CHEPA

Dr. Lionel McLeod, president and chief executive officer at University Hospital in Vancouver, "grudgingly" admitted that ill children get better support in a children's hospital. [Dr. McLeod died Apr. 10, a few months after this interview was conducted. — Ed.] However, he said "the need evolved from our own mismanagement in not being able to establish priorities within a major institution. The rationale behind building children's hospitals was for community focus and to attract subspecialists into pediatrics. Pediatric subspecialty development was all related to the establishment of hospitals for kids."

Even so, specialists who usually deal with adults also provide care at many children's hospitals. At the Izaak Walton Killam Hospital for Children (IWK) in Halifax, public relations officer Heather Spidell says these consultants are used in almost every specialty but pediatrics, and specifically in ophthalmology, orthopedics, neurosurgery and dermatology.

The most compelling reason for building and maintaining children's hospitals is their ability to attract donations. Robert Evans, professor of economics at the University of British Columbia and director of the Population Health Program for the Canadian Institute for Advanced Research, puts it plainly: "By hiving off the children's hospitals, you create a much more powerful voice for drawing in donations. It's obviously a lot easier to get people to donate to kids' hospitals than to long-term care facilities or to facilities for drying out alcoholics."

Even the name "children's hospital" is magic. The most extreme example of harnessing this power can be found in Hamilton. Chedoke Hospital and the McMaster University Medical Centre amalgamated in 1979. Both were general hospitals when they amalgamated, but in 1988 the children's facility was designated a children's hospital — a hospital within a hospital. Shared services include pharmacy, laboratory and magnetic resonance

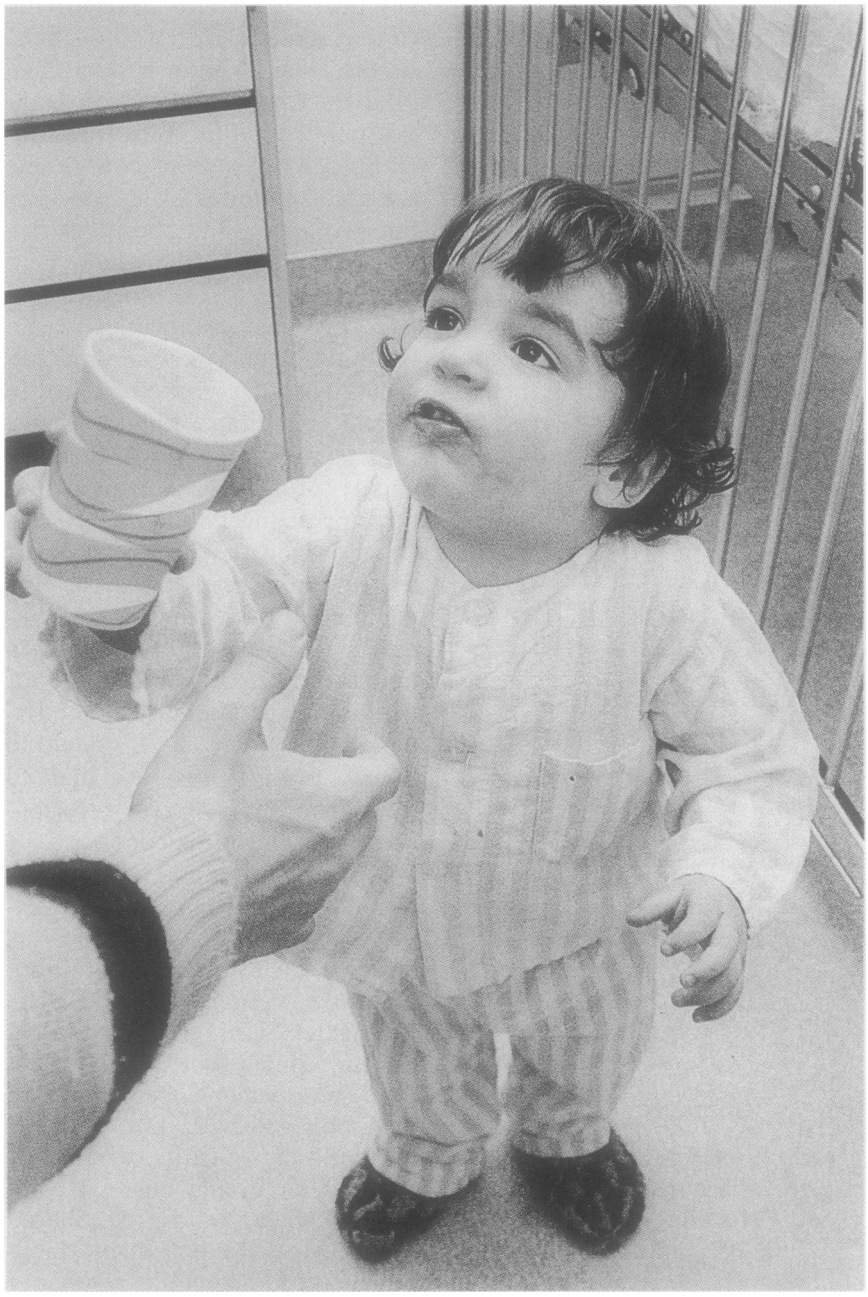
imaging (MRI). According to spokesperson Josey Panetta, the "new" facility was created "to recognize the level of pediatric expertise at our hospital."

Julia Abelson, research coordinator for the health policy section of McMaster University's Centre for Health Economics and Policy Analysis (CHEPA), offers another explanation. "It was funny. All of sudden you would drive by and see this sign 'Children's Hospital' at the old hospital. I can't figure out why they would decide to use that title, unless they are calling it that to raise money."

Other cities are using the "in-name-only" technique to good advantage. The Children's Hospital of Winnipeg is one of five hospitals that make up the Health Sciences Centre (HSC), which spokesperson Shirlee Ojah says is the largest hospital amalgamation in Canada.

Chris Anderson, director of operations for the hospital, says "there was opposition to the amalgamation. From the beginning the idea of losing a children's hospital [was upsetting.] It is 82 years old, one of the oldest in Canada. We've still kept the name 'Children's Hospital'. Being a children's hospital helps us attract funds. In the last year, when donated dollars were going down all over, people were still donating to children's hospitals. We've ended up with potentially the best of both worlds; we're amalgamated with the HSC, but we also have this independent hospital with our own pediatric nurses."

CMAJ *file photo*



Stephen Birch, a CHEPA member and associate professor in McMaster's Department of Clinical Epidemiology and Biostatistics, is looking at a bigger picture. It is wrong to build children's hospitals simply "because children are special," he says, and also because designated donations can undermine planning within the entire health care system. He wonders if consigning children to a children's hospital for specialized treatment is different from placing the aged into geriatric hospitals, whose worth has yet to be proven. "I think the idea of a stand-alone children's hospital is a bit of poetic licence because it is likely to make large demands on other services outside that building."

As Birch sees it, the solution is an effective planning system that can make the difficult decisions easier. "What is happening in Quebec, where the government controls charitable-donation spending, required a very strong political decision. The way it is everywhere else at the moment, the resources sort of go where the providers are. We want to get to a system where the resources go to where the health care needs are." He says that building a hospital just to attract specialists is an expensive and simplistic solution.

Phillipon also feels that Canada has wasted money over the years building independent, free-standing hospitals. "The bigger

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lesson, something that goes beyond pediatrics, is the notion that hospitals can no longer have everything under their own roof. There has to be a coordinated approach" to hospital services.

In Vancouver, McLeod described a common purchase/service arrangement linking the British Columbia's Children's Hospital, the Salvation Army Grace Hospital and University Hospital. "One of us provides food for the others, the other provides pharmacy for the rest. We also share biomedical services, MRI, even janitorial services."

Halifax's IWK shares 14 services with the Grace Maternity Hospital, but there is no talk of amalgamating boards of the two hospitals. The Hospital for Sick Children in Toronto also shares services with nearby hospitals. Chris Anderson says the Winnipeg amalgamation has brought not only economies of scale but also smaller boards and reduced administrative requirements.

CHEO shares a few services with three nearby Ottawa hospitals. Elma Heidemann, chairperson of the Ottawa-Carleton Regional District Health Council, says a strategic plan involving the four main teaching hospitals is currently being developed. "But at the moment, no one knows what to centralize. We don't know if it's just as easy to do it with four separate administrations or if it would be easier to do it with a combined administration." Amalgamating the boards, she feels, would encourage global health planning and would not eliminate jobs.

McLeod said there are three barriers to amalgamation: professionals' fear of losing some of their autonomy, the potential merging of unions that were independent bargaining units, and the threat of lost jobs among middle managers. A clear mission objective will improve the chances of successful amalgamation, he added.

Dewar, who is mildly appeased by the talk of amalgamation, questions the psychology behind the creation of children's hospitals. "Why is it that hospitals have to be specific to children's orientation? Children feel comfortable at home and homes aren't built just for children, so why should hospitals be? What we are really saying is that we have a society that is unfriendly to children so we have to build a special hospital for them."

Why not simply incorporate the user-friendly features of a children's hospital into the children's wing or ward at a general hospital? "We should be catering to families in all hospitals, allowing openness so that the children — or the elderly — feel comfortable," argues Dewar. "You don't have to have a special hospital for children to allow families to stay overnight. You should be doing that with any family member anyway. It would improve the accessibility of health care for anyone."

Unless future studies show that children get better care in a separate facility than in a children's ward or wing of a general hospital, it is unlikely that another children's hospital will ever be built in Canada. Smaller general hospitals will have to learn to harness some of the appeal that comes naturally to children's hospitals, and do the good work that children's hospitals now claim.■

Concours de dissertation en éthique médicale Logie
Date limite : le 1er juin 1993

Le *JAMC* parraine de nouveau le Concours de dissertation en éthique médicale Logie ouvert aux étudiants en médecine des universités canadiennes. Cette année, les prix sont de 1 000 $ pour le lauréat, de 750 $ pour la deuxième place et de 500 $ pour la troisième, mais le *JAMC* se réserve le droit de suspendre certains prix ou la totalité de ceux-ci si la qualité des textes est jugée insuffisante. Le jury est formé d'un groupe de rédacteurs de l'équipe scientifique et celle des informations générales du *JAMC* qui choisiront les lauréats en fonction du contenu, du style de rédaction et de la présentation des manuscrits. Les dissertations ne doivent pas dépasser 3 500 mots, y compris les références, et être dactylographiées à double interligne. Les auteurs choisis devront remettre leur dissertation sur une disquette. Les citations et les références doivent être conformes aux Exigences uniformes pour les manuscrits présentés aux revues biomédicales (voir *J Assoc Méd Can* 1992; 146 : 871-878). Les dissertations choisies seront remaniées quant à la longueur, la clarté et l'uniformité avec le style de la revue. Les auteurs recevront une copie remaniée avant la publication. Veuillez faire parvenir vos textes à l'attention du Rédacteur aux informations générales, *JAMC*, CP 8650, Ottawa (Ont.) K1G 0G8.

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