



The Senate

Standing Senate Committee on Social Affairs,  
Science and Technology

# The Health of Canadians - The Federal Role

Final Report on the state of the health care  
system in Canada

*Chair:*

The Honourable Michael J. L. Kirby

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**Volume Six:  
Recommendations  
for Reform**

## 2.4 Academic Health Sciences Centres and the Complexity of Teaching Hospitals

Teaching hospitals in Canada form part of what is known as Academic Health Sciences Centres (AHSCs). AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes (see Appendix 2.1 for a list of the 16 AHSCs in Canada and their affiliated hospitals). Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals. They also offer the newest and most highly sophisticated services and treat the most difficult, complex cases.

**AHSCs consist of a teaching hospital, a university faculty of medicine, and other health-related research and health care institutes. Because these centres are responsible for not only patient care but also teaching and research, they are much more complex than community hospitals.**

Hospitals with teaching/research activity have higher costs per weighted case than community hospitals. This is due to the required teaching infrastructure, specialized programs, higher utilization of diagnostic testing, and the use of resources needed for more innovative and aggressive treatment procedures:

*Studies have shown that procedure costs at academic health science centres are higher than in community hospitals. This is not only due to the costs of the complexity of care provided or the introduction and evaluation of leading-edge practice. To fulfill its teaching and research mandate, some clinical procedures cost more than average and result in lengths of stay that may be longer than average. Additionally, a major research and education centre incurs facility and operating costs as a result of providing space and supporting the medical staff in these endeavours.<sup>67</sup>*

Because of the educational and research aspects of AHSCs, funding comes traditionally from at least two separate provincial government departments and, within those departments, from a variety of sources. While it is almost impossible to distinguish precisely the academic mission from the health care delivery mission, government funding can be placed into three broad categories.<sup>68</sup>

First, the department of education provides operating grants to universities that in turn provide budgets for health faculties, including salaries for their academic staff. Second, the department of health provides hospitals with budgets for clinical education to pay the salaries of post-graduate trainees and partial support of the incomes of clinical faculty. Third, hospitals receive operating grants from provincial health ministries to help pay for the added cost of research and training activity.

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<sup>67</sup> S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 12.

<sup>68</sup> Lozon and Fox (2002), *op. cit.*, p. 16.

As a result of this complexity, service-based funding poses a number of problems particular to AHSCs. Patients of AHSC often require very sophisticated treatment, the cost of which may not be accurately captured in case-mix measurement systems. For instance, Kevin Empey, Chief Financial Officer, University Health Network (Toronto), stated:

*(...) both pacemaker and defibrillator implants are included in the same [case-mix group] and thus would be assigned the same case weights and funded identically. This weighting, and any rate-based funding would not reflect the dramatic differences in the costs of the devices implanted. The cost of a typical defibrillator implant procedure is approximately 2.5 times that of a pacemaker implant.*<sup>69</sup>

Similarly, it is estimated that the cost of one multi-organ transplant costs \$213,000 per patient. However, due to the complexity and the uniqueness of the treatment, rates have not been determined in Canada for the transplants. As a result, teaching hospitals in Toronto receive funding at the same rate as for single-organ transplants, which is a fraction of the true cost of the multi-organ treatment.<sup>70</sup> For these reasons, Dr. Hugh Scott of the McGill University Health Centre stated:

*if you want to put it in a formula, there has to be multiples. Any time we try to put cardiac surgery and psychotherapy in a magic formula, there will be problems. When you then add in a teaching environment and so on, you will have even more problems. I look forward to simplicity and elegance, I think sometimes multiple factors have to be taken into account.*<sup>71</sup>

Dr. Jeffrey Lozon from St. Michael's Hospital (Toronto) discussed the complexity of financing teaching hospitals given the variety of activities they perform:

*The most appropriate funding vehicle is the one that most closely aligns the accountability of the academic health sciences centre and its outputs in a fair funding system. Our centres are accountable for their outputs. However, it must be understood that our outputs are going to be different than what they would be in a community hospital or in a rural environment. They will be more complex. We have different levels of output: we have output around the knowledge that we create; and we have output around the numbers of students that were educated.*

*We would probably be uncomfortable with a one-size-fits-all funding formula that might suggest my hospital be as low cost as a hospital in Yorkton, Saskatchewan. The hospitals do different things and so the cost varies. We need to measure the things we do*

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<sup>69</sup> S. Kevin Empey, Brief to the Committee, 22 May 2002, p. 6.

<sup>70</sup> S. Kevin Empey, *op. cit.*, p.10.

<sup>71</sup> Dr. Hugh Scott (63:17).

*and we need to be held as accountable as the hospital in Yorkton. However, it is a more complicated endeavour than strictly counting up the dollars.*<sup>72</sup>

The AHSC experts who appeared before the Committee supported the service-based funding methodology as long as case-mix groups and weights are established for AHSCs, distinct from those developed for community hospitals. Such a funding methodology for AHSCs should take into account a variety of factors, including the complexity of procedures and treatments, the introduction of new technologies and the use of costly drugs. Experts also stressed that consideration should be given to funding the cost of teaching and research infrastructure out of a different envelope with its own set of incentives for efficient delivery.

In their recent paper “Academic Health Sciences Centres Laid Bare”, Jeffrey Lozon and Robert Fox stated that AHSCs should be considered a national resource in the health care system and that the federal government should enhance its role in the funding of AHSCs. The authors argued that “no longer can the AHSC struggle to arrange funding from a variety of providers and without the support of the federal government.”<sup>73</sup>

The Committee agrees with the witnesses that Academic Health Sciences Centres are distinct from community hospitals in that they perform a wide range of complex activities ranging from delivery, to teaching and research. Accordingly, the Committee recommends that:

**Service-based funding should be augmented by an additional funding method that would take into account the unique services provided by Academic Health Sciences Centres, including teaching and research.**

Moreover, the Committee strongly believes that, since they play an essential role in teaching, performing research and delivering sophisticated care, AHSCs constitute a national resource in the Canadian health care system. They are a crucial part of the health care infrastructure in Canada. Thus, the federal government is particularly well positioned to sustain AHSCs across the country, through its well-recognized roles in financing post-secondary education, funding health research, supporting health care delivery, financing health care technology and planning human resources in health care. These issues are discussed in subsequent chapters in this report.

***The Committee believes that AHSCs constitute a national resource in the Canadian health care system. The federal government is particularly well positioned to sustain AHSCs across the country.***

## **2.5 Small and Rural Community Hospitals**

Because larger and medium-sized community hospitals do not face the same set of challenges as small or rural community hospitals, problems might arise if the same funding

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<sup>72</sup> Dr. Jeffrey Lozon (63:16-17).

<sup>73</sup> Lozon, Jeffrey and Robert Fox (2002), “Academic Health Sciences Centres Laid Bare”, lead paper in *Healthcare Papers*, Vol. 2 No. 3, p. 30.

formula were to be applied to both types of hospitals. For example, Raisa Deber, Professor at the University of Toronto, stated that:

*(...) on issues related to service-based funding, particularly for hospitals in smaller provinces or smaller communities, (...) such funding will not be enough to cover the infrastructure costs of running the organization.*<sup>74</sup>

In addition, the Canadian Healthcare Association indicated in its brief that:

*Service-based funding would be difficult to implement in rural and remote areas, particularly if there is only one provider and/or organization available to provide services.*<sup>75</sup>

The review of the testimony provided to the Committee suggests that, for the most part, small and rural community hospitals are faced with problems of:

1. Limited economies of scale – Small rural hospitals are often faced with fixed overhead costs and low or unpredictable patient volumes. This leads to higher costs per patient.
2. Isolation – A hospital in rural Canada is considered to be isolated if the next closest hospital is more than 150 km away. That hospital then becomes the primary provider of health care for an entire geographic area. A hospital that is responsible for a large region must be able to provide a greater range of services despite low and sporadic patient volumes.
3. Remoteness – Remoteness refers to the distance between a hospital and the closest tertiary hospital care centre. Hospitals can be remote but not isolated (a number of hospitals may serve a particular region but be at a considerable distance from a tertiary hospital care centre). However, much like isolated hospitals, remote hospitals often have higher fixed overhead costs and must provide a wider range of health care services compared to community hospitals located near tertiary centres. All these factors result in higher costs per patient.
4. Special needs population – Many remote hospitals must care for special needs populations such as residents of First Nations reserves. The health status of these residents is often below the provincial average, which leads to higher admission rates.<sup>76</sup>

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<sup>74</sup> Raisa Deber (59:12).

<sup>75</sup> Canadian Healthcare Association, Brief to the Committee, p. 7.

<sup>76</sup> Ladak (1998), *op. cit.*, p. 31.

Therefore, the funding formula used for larger community hospitals is often not suitable for small and rural hospitals. As a result, the funding formula must take into consideration the particular challenges faced by smaller, rural and remote hospitals.

A number of the witnesses were concerned about the effect of a service-based funding method on the mix of services offered by rural and smaller community hospitals. For example, Mark Rochon of the Ontario Hospital Association stated:

*We also need to consider that service-based funding should not create incentives for providers to stop offering necessary services in communities. The needs of specific communities must be considered as well as the adequacy of service provided in those communities.*<sup>77</sup>

Kevin Empey, of University Health Network, added that:

*Some providers, when it becomes a full rate based or service based system, will choose to specialize a little more or get out of something. Certainly in small communities you cannot afford the major providers, that is, the hospitals, to get out of something just because of the rates.*<sup>78</sup>

The Committee agrees with the witnesses that, in order to preserve access to commonly required services, service-based funding should be adjusted to reflect the particular circumstances of small and rural community hospitals. Therefore, the Committee recommends that:

**In developing a service-based remuneration scheme for financing of community hospitals, consideration be given to the following factors:**

- **Isolation: hospitals located in rural and remote areas are expected to incur higher costs than those in large urban centres. An adjustment should reflect this fact.**
- **Size: small hospitals are expected to incur higher costs per weighted case than larger hospitals. An adjustment should recognize this fact.**

## **2.6 Financing the Capital Needs of Canadian Hospitals**

As indicated in Section 2.1.7, provinces and territories use a method for funding hospital capital expenditures that is different from the method used in relation to funding

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<sup>77</sup> Mark Rochon (56:43).

<sup>78</sup> S. Kevin Empey (56:45).

operating costs. All provinces and territories use a project based method as their capital funding approach. The project based method is well suited to large-scale, one-time projects.

The Committee was told that the capital needs of Canadian hospitals are significant. We heard that the current level of capital investment by provincial and territorial governments, along with hospitals' well established fundraising infrastructure and charitable giving, is not sufficient to ensure the sustainability of the hospital sector in Canada. Information provided to the Committee revealed that:

- Between 1982 and 1998, real public per capita spending on new hospital construction decreased from \$50 to \$2, or a reduction of 5.3% annually.<sup>79</sup>
- Since 1998, real public per capita expenditures on new hospital machinery and equipment has fallen by 1.8% annually.<sup>80</sup>

As a result, there is a substantial gap between the need for new and renovated physical plant and equipment and a hospital's ability to finance capital investment. For this reason, several witnesses proposed that the federal government provide some funding. The Association of Canadian Academic Healthcare Organizations told the Committee that there is precedent in this regard:

*It should also be noted that there is a precedent when it comes to the role of the federal government in this area. In 1948, the federal government introduced the Hospital Construction Grants Program – which was funded on a cost-sharing basis with the provinces.<sup>81</sup>*

The Canadian Medical Association stated that, in addition to government investment in hospital capital, it may be necessary for hospitals to develop innovative approaches to financing capital infrastructure. According to the Association, there is a need to explore the concept of public-private partnerships to address capital infrastructure needs as an alternative to relying solely on government funding.<sup>82</sup>

While the Committee has supported the consolidation of the hospital sector that has taken place in recent years in all provinces, we are very concerned that the number of beds in some hospitals may not be sufficient to respond to the significant increase in demand for hospital services that exists in a few areas in Canada where there is high and fast population growth. Indeed, we learned that there are a few regions of the country in which population growth has been so great that more hospital beds are needed now and many more will be needed in the coming years. This is particularly true of some metropolitan areas of Alberta (Calgary), British Columbia (Abbotsford, Vancouver), Nova Scotia (Halifax), Ontario (Oshawa, Toronto), Quebec (Montreal), and Saskatchewan (Saskatoon).<sup>83</sup>

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<sup>79</sup> Association of Canadian Academic Healthcare Organizations, Brief to the Committee, 13 June 2002, p. 17.

<sup>80</sup> *Ibid.*

<sup>81</sup> *Ibid.*

<sup>82</sup> Canadian Medical Association, *For Commissioner Romanow: A Prescription for Sustainability*, 6 June 2002, p. 26.

<sup>83</sup> Based on the 2001 Census data of Statistics Canada (<http://geodepot2.statcan.ca/Diss/Highlights/>).

Accordingly, the Committee believes that the federal government should get involved once again, as it did in 1948, in financially supporting hospitals with the greatest capital needs. Such federal participation would not involve ongoing financing but should rather be considered a “catch-up” measure. Even though it would be a one time measure, federal funding for any given project could be spread over a period of several years.

Specifically, the decision to provide federal support for hospital capital should be made on the basis of a formula that would indicate that, when population growth in a particular region exceeds the provincial average by 50%, the federal government would make one-time only funding available on a cost-shared basis with the province for capital investment in hospital expansion. Such federal investment could work as follows: the hospital should be able to take the federal commitment to pay a fixed amount per year over a 10-year period to a financial institution and borrow against that commitment so that construction could begin right away.

The Committee also believes that provincial/territorial governments should give consideration to public-private partnerships as a means to obtain additional investment in hospital capital. Therefore, the Committee recommends that:

**The federal government provide capital financial support for the expansion of hospitals located in areas of exceptionally high population growth; that is, areas in which the population growth exceeds the average rate of growth in the province by 50% or more. Such federal financial support should account for 50% of the total capital investment needed. In total, the federal government should devote \$1.5 billion to this initiative over a 10-year period, or \$150 million annually.**

**The federal government should encourage the provinces and territories to explore public-private partnerships as a means of obtaining additional investment in hospital capacity.**

Capital investment is also of concern for AHSCs. The Association of Canadian Academic Healthcare Organizations informed the Committee that building replacement is underfunded and depreciation is not fully recognized by the federal and provincial governments for funding purposes. Furthermore, most capital investment decisions appear to be based on short-term responses to needs rather than a long-term planning horizon. In some cases, additions or renovations are made to poor structures, when full reconstruction might have been a better policy decision.

While there are variations in the capital requirements of teaching hospitals, it is clear that significant investment is needed. For example:

- The Montreal University Health Centre has undertaken an evaluation of existing facilities (in which some buildings are 40 to 100 years old) and determined that it will cost \$475 million to upgrade its facilities.
- The University Health Network of Toronto estimates that its capital requirements for the next 10 years will be over \$500 million (i.e., in excess of \$50 million per year).
- The St. John's Healthcare Corporation (Newfoundland) recently completed the development of a Children's and Rehabilitation Centre at a cost of \$70 million.

Based on the information made available to the Committee, the Committee concluded that the federal government should contribute some \$4 billion for the infrastructure renewal of the 16 AHSC sites. We believe that such federal funding should be provided in response to requests initiated by AHCSs themselves, subject to review by a group of independent experts. This, in our view, would ensure transparency.

More precisely, AHSCs should be required to accompany a request with a sound rationale for additional resources. Each application should be evaluated on its own merits by an independent expert group that would report to the Minister of Health. Moreover, in order to ensure accountability, successful applicants should report on their disposition of the funds received.

Therefore the Committee recommends that:

**The federal government contribute \$4 billion over the next 10 years (or \$400 million annually) to Academic Health Sciences Centres for the purpose of capital investment.**

**Academic Health Sciences Centres be required to report on their use of this federal funding.**

## **2.7 Public Versus Private Health Care Institutions**

In Section 2.3 above, the Committee underlined many advantages to service-based funding for hospitals, one of which relates to the ownership structure of health care institutions. We indicated that service-based funding means that the insurer (the government) would be *neutral* with respect to the ownership of a hospital. The funder/insurer would purchase the service from an institution, provided that it met the necessary quality standards. Since comparable institutions would be paid the same amount of money for a given procedure, and since all institutions would be subject to the same independent and rigorous quality control and evaluation system, the

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ownership structure would not be a matter of public policy concern. For this reason, the Committee is neutral to the ownership question.

As indicated in Volume Five, the Committee believes that the patient and the funder/insurer will be served equally no matter what the corporate ownership of a health care institution may be, as long as the two conditions enumerated above with respect to pricing and quality control are met. The Committee wants to emphasize that it is not pushing for the creation of private, for-profit, facilities. But we do not believe that they should

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be prohibited, just as they are not now prohibited under the *Canada Health Act*. Indeed, we fully expect that the overwhelming majority of institutional providers would continue to be, as they are now, either public or private not-for-profit institutions.

Furthermore, the Committee recognizes that there is no reason why the private for-profit provision of publicly funded health services would result in a so-called “two-tier” health care structure, as long as the *funding* of services remains *publicly* based and referrals to institutions continue to be determined by clinical need. This situation with respect to hospitals is no different from the provision of primary health care, most diagnostic services, and some day surgeries – services that are currently delivered in Canada by private for-profit entrepreneurs and facilities.

Currently, within Canada’s health care system, only 5% of hospital care is delivered by the private for-profit sector. For example, the Shouldice hospital in Ontario is a private for-profit facility; its status was grandfathered when Medicare was enacted in that province. Facilities like this one are regulated on a rate of return basis, to reduce the risk of overcharging patients. In Alberta, private for-profit facilities are allowed, under provincial legislation (Bill 11), to compete with public and private not-for-profit hospitals for the provision of a set of publicly insured surgical services. Canada also has a number of private for-profit health care facilities (“private clinics”) that treat only patients who pay privately for the services they receive.

***The Committee recognizes that there is no reason why the private for – profit provision of publicly funded health services would result in a so-called “two-tier” health care structure, as long as the funding of services remains publicly based and referrals to institutions continue to be determined by clinical need.***

Despite the presence of these private for-profit health care institutions and facilities in Canada, which appear to provide the same quality of care as not-for-profit and public institutions, an intense debate continues about the potential role and impact of for-profit hospitals and clinics in the health care system. This debate culminated in May 2002 with the publication of a meta-analysis study by P. J. Devereaux *et al.* in the *Canadian Medical Association Journal*. This study found, based on a review of 15 different observational studies, “that private

for-profit ownership of hospitals in comparison with private not-for-profit ownership in the United States results in a higher risk of death for patients.<sup>84</sup> The authors concluded that the profit motive of private for-profit hospitals may result in limitation of care that adversely affect patient outcomes:

*Why is there an increase in mortality in for-profit institutions? Typically, investors expect a 10%–15% return on their investment. Administrative officers of private for-profit institutions receive rewards for achieving or exceeding the anticipated profit margin. In addition to generating profits, private for-profit institutions must pay taxes and may contend with cost pressures associated with large reimbursement packages for senior administrators that private not-for-profit institutions do not face. As a result, when dealing with populations in which reimbursement is similar (such as Medicare patients), private for-profit institutions face a daunting task. They must achieve the same outcomes as private not-for-profit institutions while devoting fewer resources to patient care.<sup>85</sup>*

When he appeared before the Committee, Dr. Arnold Relman, Former Editor-in-Chief of *The New England Journal of Medicine*, expressed similar views:

*(...) most, not all of the current problems of the U.S. health care system, and they are numerous, result from the growing encroachment of private for-profit ownership and competitive markets on a sector of our national life that properly belongs in the public domain. It is no coincidence that no health care system in the industrialized world is as heavily commercialized as ours, and none is as expensive, inefficient, inequitable, or as unpopular. Indeed, just about the only people happy with our current market-driven health care system in the U.S. are the owners and investors in the for-profit industries now living off the system.<sup>86</sup>*

On the basis of this evidence, many observers have noted that it is plausible, if not likely, that the results of the American experience can be generalized to the Canadian context should Canada decide to “open the door” to private for-profit hospitals.

The Committee learned, however, that the Devereaux *et al.* study has a number of caveats. First, Brian J. Ferguson, Professor at the Department of Economics at the University of Guelph (Ontario), informed the Committee in a recent paper that the authors of the meta-analysis specifically excluded public hospitals from their study, on the basis that Canadian hospitals are technically private not-for-profit institutions behaving more or less like American private not-for-profit hospitals.<sup>87</sup> Professor Ferguson argued, however, that private

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<sup>84</sup> P.J. Devereaux *et al.*, “A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals”, in *Canadian Medical Association Journal*, Vol. 166, No. 11, 28 May 2002, pp. 1399-1406.

<sup>85</sup> *Ibid.*, pp. 1404-1405.

<sup>86</sup> Dr. Arnold Relman (48:8-9).

<sup>87</sup> For more information, please consult the recent paper by Brian S. Ferguson, *A Comment on the Devereaux et al. Meta-Analysis of Mortality in Private American Hospitals*, Draft, Department of Economics, University of Guelph, Ontario, June 2002.

not-for-profit hospitals in the United States do not operate at all in the same environment as Canadian private not-for-profit hospitals: American private not-for-profit hospitals work in a very competitive context and have considerably more freedom in terms of decision-making than their Canadian counterparts.

In this regard, Professor Ferguson contended that Canadian private not-for-profit hospitals are much more like American public hospitals than they are like American private not-for-profit hospitals. In his view, including public hospitals in the Devereaux *et al.* meta-analysis could have led to very different results.<sup>88</sup> In fact, a number of studies have shown that public hospitals in the United States have higher risk-adjusted 30-day mortality than for-profit hospitals, which in turn have higher mortality than not-for-profit hospitals.<sup>89</sup>

Second, Professor Ferguson also criticized the methodology used by Devereaux *et al.* on several grounds: criteria for the inclusion of pertinent literature; selection of particular results for inclusion in the analysis; choice of the dependent variable; omission of some variables; etc.<sup>90</sup> Finally, in a different paper, Professor Ferguson indicated that it is almost impossible to derive proper conclusions on the potential role of private for-profit hospitals in Canada from the American literature.<sup>91</sup> The health care system in the United States is made up of several public and private insurers, involves a multiplicity of public and private (not-for-profit and for-profit) providers, and operates under intense competitive pressures – a situation that is unlikely to happen in Canada with our single insurer system.

Moreover, the regulatory framework for the provision of hospital care in the United States is different from that in Canada. This explains why we cannot simply transpose what is happening in the United States to Canada. For example, Dr. Arnold Relman told the Committee:

*Throughout the American health care system there is inadequate regulation of private, for-profit health care, as well as private not-for-profit health care. In the for-profit system, there is so much money in for-profit nursing, hospital care, ambulatory services, and pharmaceutical services that the regulatory agencies have been co-opted, at times you might say intimidated, by the political and financial influence of the owners.*

*(...) In the United States, there is a huge amount of money involved in providing for-profit health care. That money in part is used to ensure that regulation is weak. It applies to the Food and Drug Administration. It applies to all sorts of regulatory agencies. I served for six years on a state agency studying the quality of care in Massachusetts hospitals. It is very clear to me that financial concerns play a major role.*

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<sup>88</sup> *Ibid.*

<sup>89</sup> These studies are summarized in a paper by Stephen Duckett, “Does it Matter Who Own Health Facilities”, in *Journal of Health Services Research Policy*, Vol. 6, No. 1, January 2001, pp. 59-62.

<sup>90</sup> Brian J. Ferguson, *op. cit.*, June 2002.

<sup>91</sup> Brian S. Ferguson, *Profits and the Hospital Sector: What Does the Literature Really Say?*, Health policy working paper prepared for the Atlantic Institute for Market Studies, February 2002.

*(...) If we did have good, aggressive, unbiased regulation, many of the problems I have talked about in terms of quality would be solved. However, we do not.*<sup>92</sup>

The findings of the Devereaux *et al.* analysis also contrast with those a Canadian study published in 1999 in the *Canadian Medical Association Journal* which compared the quality of care in licensed and unlicensed homes for the aged in the Eastern Townships of Quebec.<sup>93</sup> For example, this study found the quality of care provided to elderly residents by large unlicensed (private for-profit) long-term care facilities to be comparable to that of large licensed (private not for profit) facilities.<sup>94</sup> In addition, the study found that the majority of both licensed and unlicensed long-term care facilities (no matter what their size) were delivering care of relatively good quality.

Overall, the Committee acknowledges that the literature on the comparative costs, quality, effectiveness and general behaviour of private for-profit and private not-for-profit facilities is quite extensive. We also recognize that these studies reach mixed conclusions. Some of them suggest that for-profit facilities perform better, while others conclude that not-for-profit facilities or public hospitals do so. Still, other studies have found no difference in the performance of the two.

Given the evidence in the literature, the Committee believes that leaving the *Canada Health Act* as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will *not*, as some critics maintain, weaken or destroy the health care system as we know it now.

***The Committee believes that leaving the Canada Health Act as it currently is – which means permitting private for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) – will not, as some critics maintain, weaken or destroy the health care system as we know it now.***

Other advanced countries, with perfectly well functioning universal, publicly funded and organized health care systems (such as Australia, Denmark, Germany, the Netherlands, Sweden and the United Kingdom), already permit private for-profit hospitals to exist; their presence has not caused any insurmountable problems or difficulties.

The debate surrounding public versus private not-for-profit versus private for-profit health care institutions does not seem to arouse the same kind of passion elsewhere. As a matter of fact, the Committee reviewed the operation of the health care system of seven different countries (see Volume Three) and visited three countries (Denmark, Sweden, United Kingdom), and found that there are no articles or studies in European countries and Australia comparing the quality or outcomes of for-profit and not-for-profit or public hospitals. In this sense, this debate is uniquely North American.

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<sup>92</sup> Dr. Arnold Relman (48:23).

<sup>93</sup> Gina Bravo *et al.*, «Quality of Care in Unlicensed Homes for the Aged in the Eastern Townships of Quebec, *Canadian Medical Association Journal*, Vol. 160, No. 10, 18 May 1999, pp. 1441-1445.

<sup>94</sup> The interpretation of the study findings in terms of ownership status (for profit versus not for profit) were facilitated by information provided by the statistician who participated in the realization of this study, Marie-France Dubois.

The Committee believes that it is unlikely that, as a result of the introduction of service-based funding, Canada would see the emergence of full-scale private for-profit hospitals, such as those that operate in Australia or the United Kingdom: in both countries, private health care insurance runs parallel to the public system, and physicians are permitted to have large-scale private practices, a system that seems unlikely to develop in Canada. It is more likely that private clinics would remain small and specialized. Such clinics would emerge in niches where their founders expect to be able to make a profit by operating at lower cost than the public system does, either by taking advantage of economies of scale or, as seems more likely, by taking advantage of economics of specialization. These clinics would bring additional capital into the health care system, since they would be funded privately. This is another reason it is unlikely that they would develop into full-scale general hospitals: private funding for so ambitious, and also risky, an enterprise would be much harder to come by than would funding for specialized clinics.

The Committee strongly believes that there is a need to improve hospital performance and to develop hospital report cards in Canada, regardless of ownership. This can be appropriately done through the independent evaluation process recommended in Chapters One and Ten of this report. Requiring that a single regulatory process apply to *all* health care institutions would contribute much to ensuring high quality of care no matter where it is provided.

## **Appendix 2.1**

### **Academic Health Sciences Centres in Canada and their Affiliated Hospitals and Regional Health Authorities**

#### **1. Memorial University of Newfoundland and Labrador**

Healthcare Corporation of St. John's  
The General Hospital  
St. Clare's Mercy Hospital  
Janeway Children's Health and Rehabilitation Centre  
Waterford Hospital  
Dr. L.A. Miller Centre  
Dr. Walter Templeman Health Centre

#### **2. Dalhousie University**

Capital Health  
IWK Health Centre  
Queen Elizabeth Health Sciences Centre II  
Dartmouth General Hospital  
East Coast Forensic Hospital  
Eastern Shore Memorial Hospital  
Hants Community Hospital  
The Nova Scotia Hospital  
Twin Oaks Memorial Hospital  
Musquodoboit Valley Memorial Hospital  
Atlantic Health Sciences Corporation\*  
Saint John Regional Hospital  
St. Joseph's Hospital  
Sussex Health Centre  
Charlotte County Hospital  
Grand Manan Facility

#### **3. Université Laval**

Centre Hospitalier Universitaire de Québec  
Hôpital Laval, Institut Universitaire de Cardiologie et de Pneumologie

#### **4. Université de Sherbrooke**

Centre Universitaire de santé de L'Estrie  
Sherbrooke Geriatric University Institute

#### **5. Université de Montréal**

Centre Hospitalier de l'Université de Montréal  
Hôpital Sainte-Justine  
Institut Cardiologie de Montréal  
Hôpital Maisonneuve-Rosemont  
Hôpital du Sacré-Coeur de Montréal

Institut Universitaire de Gériatrie de Montréal

**6. McGill University**

Montreal University Health Centre  
Jewish General Hospital  
St. Mary's Hospital  
Douglas Hospital

**7. University of Ottawa**

Sisters of Charity of Ottawa (SCO) Health Services  
Ottawa Hospital  
Children's Hospital of Eastern Ontario

**8. Queen's University**

Kingston General Hospital  
Hotel Dieu Hospital  
Providence Continuing Care Centre

**9. University of Toronto**

University Health Network  
St. Michael's Hospital  
The Hospital for Sick Children  
Sunnybrook Health Sciences Corporation  
Mount Sinai Hospital  
Toronto Rehabilitation Institute  
Baycrest Centre for Geriatric Care  
Centre for Addiction and Mental Health

**10. McMaster University**

Hamilton Health Sciences Centre  
St. Joseph's Hospital

**11. University of Western Ontario**

London Health Sciences Centre  
St. Joseph's Health Centre

**12. University of Manitoba**

Winnipeg Regional Health Authority  
St. Boniface General Hospital  
Health Sciences Centre

**13. University of Saskatchewan**

Saskatoon District Health Board  
Royal University Hospital  
Saskatoon City Hospital  
St. Paul's Hospital  
Regina Health District  
Regina General Hospital  
Pasqua Hospital

**14. University of Calgary**

Calgary Health Authority  
Rockyview Hospital  
Foothills Hospital  
Alberta Children's Hospital  
Peter Lougheed Hospital

**15. University of Alberta**

Capital Health Authority  
Royal Alexandra Hospital  
University of Alberta Hospital  
Grey Nuns and Misericordia Hospital

**16. University of British Columbia**

Provincial Health Services Authority  
Children's and Women's Health Centre  
BC Cancer Agency  
Vancouver Coastal Health Authority  
Vancouver Hospital and Health Science Centre  
Providence Health Care/St. Paul's Hospital

Source: Based on information provided by Glenn Brimacombe, Chief Executive Officer, Association of Canadian Academic Healthcare Organizations.

\*AHSC functions as main New Brunswick campus for Dalhousie University and Memorial University of Newfoundland and Labrador.

