



Parkland Institute, University of Alberta.

Public Bodies, Private Parts

Surgical contracts and
conflicts of interest at
the Calgary Regional
Health Authority



A study for The Parkland Institute,
University of Alberta by
Gillian Steward

About the Author



Gillian Steward

Gillian Steward is a Calgary-based writer and journalist who has been examining Alberta politics for over 25 years. In 2000 she co-authored with Kevin Taft Clear Answers: The Economics and Politics of For-Profit Medicine. In the 1990s she wrote a syndicated column for Southam News and was Managing Editor of the Calgary Herald from 1987 to 1990. Her work has also appeared in Canadian Business Magazine, The Globe and Mail and The Financial Post.

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Parkland Institute is an Alberta research network that examines public policy issues. We are based in the Faculty of Arts at the University of Alberta and our research network includes members from most of Alberta's Academic institutions as well as other organizations involved in public policy research. Parkland Institute was founded in 1996 and its mandate is to:

- conduct research on economic, social, cultural and political issues facing Albertans and Canadians.
- publish research and provide informed comment on current policy issues to the media and the public.
- sponsor conferences and public forums on issues facing Albertans.
- bring together academic and non-academic communities.

Executive Summary

In September 2000 The Health Care Protection Act (formerly Bill 11) was proclaimed and established as law in Alberta. Since the Act permits private, for-profit surgical facilities to keep patients for more than a 12-hour stay, it is only a matter of time before for-profit hospitals are approved and operating in Alberta. The first ones are likely to appear in Calgary.

If current practices at the Calgary Regional Health Authority (CRHA) are any indication, these private hospitals will become part of a confusing web of partly public, mostly private, for-profit health care services that will further erode Medicare as most Canadians know it. Doctors will be allowed to work in both the public hospitals and the for-profit hospitals thereby draining the public hospitals of staff and resources. In addition, senior medical officers of the CRHA will be allowed to hold financial interests in these private hospitals just as they now do in private surgical clinics that contract with the CRHA.

The CRHA currently contracts out more surgical services to private, for-profit clinics than any other regional health authority in Alberta. But these contractual arrangements raise many serious questions about conflicts of interest and appear to favour private interests rather than the public interest.

Major Findings regarding the CRHA and Conflict of Interest

- Three of the private, for-profit surgical facilities that have current contracts with the CRHA are owned or partly-owned by senior medical officers of the CRHA.
- The largest contract for the provision of surgical services was awarded to a private, for-profit clinic owned by a CRHA medical officer and his business partners.
- Two of the five private, for-profit surgical clinics that provide virtually all the eye surgery in Calgary are owned or partly owned by CRHA medical officers.
- The private, for-profit eye surgery clinics in Calgary appear to cooperate with one another in regards to the facility fees they charge to the CRHA rather than compete with one another.

- Two of the private, for-profit surgical facilities that have contracts with the CRHA are located in former public hospitals once owned or operated by the CRHA.
- An internal CRHA review regarding conflicts of interest and the purchaser of the former Holy Cross Hospital raises serious questions about the sale of the hospital that could only be resolved by an independent inquiry.
- The new owners of the Grace Hospital site are planning a development that would include “all levels of medical services.” A CRHA medical officer stands to benefit financially from the proposed complex.

Conclusion

Given that it is only a matter of time before the first private, for-profit hospitals are approved and operating in Alberta it is not unreasonable to suggest that the contractual model established by the CRHA, and condoned by the Alberta government, will continue, but on a wider scale. Since both the Alberta government and the CRHA have chosen to overlook serious conflicts of interest arising from the contractual arrangements some medical officers of the CRHA and their business partners stand to be among the first, and few, to benefit.

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1. The Business of Government in Alberta

Private vs. Public Interest

It is generally accepted in modern democratic societies that people elected or appointed to serve the public in government or government agencies must put their duty to the public above their private interests. They cannot use the knowledge, experience and contacts gained while working in the public sector to financially benefit themselves, or close family and associates in a way that would not be available to ordinary citizens.

We expect public officials - whether they are permanent or contracted public servants, elected representatives or senators - to serve the public interest. Where there is a conflict between the public interest and the private, family, or party interests, the public interest should always prevail. (Honest Politics, Greene and Shugarman, 1997, p. 46)

During the last 25 years in Canada, various levels of government have adopted Conflict of Interest legislation which spells out the standards elected representatives and high level bureaucrats must obey or face penalty. Some governments have also created the position of Ethics Commissioner. Usually a judge, the ethics commissioner is responsible for advising public officials on how to effectively separate their public and private interests. Sometimes, for example, an MP may have to divest himself/herself of certain assets or place them in a blind trust. The rules are even stricter, and more complicated for cabinet ministers because they wield so much influence. Should a minister of tourism be allowed to own a hotel? Should a minister of energy be allowed to hold shares in an oil company? Should a government minister be allowed to have a financial stake in a company that has a contract with the government or a government agency? Conflict of Interest legislation spells out the rules regarding such questions. Ethics Commissioners advise individual elected officials on these matters and also have the authority to conduct a quasi-judicial inquiry should a breach of the rules be brought to their attention.

The adoption of legislation and the appointment of ethics commissioners has followed on the heels of a greater public awareness of the importance of ethical behaviour in public life.

Canadians may be willing to offer their politicians an unexpected amount of slack in matters confined to their private lives, but they will pull the leash taut as soon as any issue spills over into the public realm or involves the public purse. (A Question of Ethics: Canadians Speak Out, Mancuso, Atkinson, 1998, p. 191)

Ethics and Government in Alberta

In Canada it is generally understood that there are three levels of conflict of interest:

- An *apparent* conflict of interest arises when, even if all, the rules are followed, there remains a “reasonable apprehension which reasonably well-informed persons could properly have, that a conflict of interest exists.”
- A *potential* conflict of interest occurs when a public official “finds him or herself in a situation in which the existence of some private economic interest could influence the exercise of his or her public duties or responsibilities...provided that he or she has not yet exercised such duty or responsibility.”
- A *real* conflict of interest occurs when a public official “has knowledge of a private economic interest that is sufficient to influence the exercise of his or her public duties and responsibilities.” (Shugarman and Greene, pgs. 47-48;85;Chapters 3,4)

Although various jurisdictions in Canada have adopted conflict of interest legislation and codes of ethics and conduct, they are not all the same and tend to reflect the ideology and priorities of the government that introduced them. The Alberta government didn’t appoint an ethics commissioner until 1992 and didn’t have fully functioning conflict of interest legislation until 1993. Until then the rules were pretty loose and often it was the Premier who decided how MLAs should behave when it came to conflict of interest.

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Recommendations

- The Alberta government prohibit physicians and surgeons from working in the public health system and with private health care providers simultaneously.
- The Alberta government adopt strict conflict of interest guidelines that apply equally to all regional health authorities.
- Conflict of interest guidelines for RHAs that prohibit RHA senior officers from having financial interests in private clinics/hospitals that contract with RHAs.
- Conflict of interest guidelines for RHAs that prohibit rather than manage apparent, potential and real conflicts of interest.
- A Code of Conduct and Ethics for RHAs that clearly delineates their responsibilities to the public.
- A public inquiry into the circumstances surrounding the sale of the Holy Cross Hospital by the CRHA to Enterprise Universal Inc.
- An independent public investigation of the circumstances surrounding the sale of the Cross Hospital by the CRHA to Enterprise Universal Inc.
- Election of RHA Board members so the RHAs are more accountable to the public.

In the 1970s and 1980s, for example, MLAs and cabinet ministers held shares outside blind trusts in Alberta Energy Company (AEC) even though the government owned half the company and could implement policy and regulations that favoured AEC. In 1979 it was revealed that Premier Peter Lougheed and his wife Jeannie had accepted airline tickets from CP and Air Canada for personal vacations. Mr. Lougheed eventually covered the cost of the tickets but not before vehemently defending his actions as acceptable behaviour for someone in his position. (Corruption, Character and Conduct, Langford and Tupper, 1993, p. 154). During his tenure as Premier, Don Getty was part-owner of several producing oil wells (Langford and Tupper, p.161)

Why were such conflicts of interest viewed as normal and acceptable by Alberta's political elite when they would have raised alarm bells, or at the very least eyebrows, in other provinces? The answer may lie in the fact that Alberta has long had a political culture that tends to favour private interests over public interests. Public life is seen as a way of furthering business interests and thereby making the province more prosperous.

Under Peter Lougheed's dominant leadership between 1971 and 1985, the Conservatives, backed by allies in Alberta's legal, commercial and corporate elites, saw themselves as talented governors who were performing a public service by running the province instead of pursuing business careers, and for whom public office became a possession not a trust. Ethical debate bored them and both Lougheed and his successor, Don Getty, refused to acknowledge errors of judgement or to engage their critics in serious argument about standard of conduct. Under this rather regal view of governance a minimalist view of ethics emerged. (Langford and Tupper, p.152).

Following several public controversies involving conflict of interest and patronage, the Getty government introduced conflict of interest legislation in 1991 and named Robert Clark, a former politician, as ethics commissioner in 1992. But the legislation and the ethics commissioner cover only elected officials of the provincial government. The Public Service Act deals with conflicts of interest through a "Code of Conduct and Ethics for the Public Service of Alberta and applies to persons appointed to the public service, senior officials; wage staff; and persons engaged on a contractual basis".

But even after the Conflicts of Interest Act was put in place it was deemed weak by some critics. In 1995 it was revealed that Premier Klein’s wife, Colleen, had accepted a gift of 10,000 shares in Multi-Corp., a software company that translated texts from certain Asian languages into English. Less than a month before Mrs. Klein was given the shares at below market value by Multi-Corp’s president, the Premier had attended a ribbon cutting ceremony at the company’s Hong Kong office. Afterwards, he attended a private meeting with company officials and investors. Liberal MLA Frank Bruseker requested that the Ethics Commissioner investigate the situation and report back to the legislature. Mr. Clark’s report cleared the Kleins of real conflict of interest charges. And since the Alberta legislation doesn’t include apparent conflict of interest, even though it was obvious there was one, the Premier and his wife were not found to be in contravention of the law.

The public controversy over the Multi-Corp. affair prompted Premier Klein to ask the Ethics Commissioner to appoint a panel to review the Conflicts of Interest Act and recommend changes. Mr. Clark named Allan Tupper, a political scientist at the University of Alberta, Patricia Newman, Mayor of Innisfail, and Francis Saville, a Calgary lawyer to the panel. Their report was released in January 1996 and recommended the following major changes to the Alberta’s ethics legislation.

- The Act should cover *apparent* conflicts of interest, as in British Columbia
- Senior public servants with influence over policy decisions should be covered by the Act.
- Those covered by the Act should be required not only to avoid financial conflicts of interest but to “act impartially in the performance of their duties.”
- The Chairs of standing committees in the legislature and the leader of the opposition should be subjected to the same restrictions that apply to cabinet ministers, such as a “cooling-off” period after leaving public office and before working for related private companies (which period the panel recommended extending from six months to a year).
- Members should be obliged to research relevant information about their spouses, minor children and associates in order to discuss how to avoid conflicts of interest with the commissioner.
- The Act should be expanded to cover the registration of lobbyists.

ronto. The subsequent acquisition of Gimbel Vision International makes Aris one of the largest companies of its kind in the world. Dr. Gimbel’s private, for-profit clinic has the second largest CRHA eye surgery contract.

The takeover by Aris of Gimbel Vision International also raises the spectre of other multi-nationals entering the health care market place in Calgary. That might end the closed shop but it could also introduce other disadvantages. Large multi-nationals could undercut local bidders because they deal with such a high volume of business. That would certainly place the CRHA in a difficult position. It would have to decide if lower prices, and possibly a monopoly supplier are better than a cooperative, but more expensive, group of local providers. But who would help the CRHA decide? All the ophthalmologists in Calgary own or work in private clinics. They would all be in a conflict of interest.

The Centre for Health Sciences and Policy Research at UBC suggests that it is possible to devise a regulatory framework that could overcome many of the problems cited.

One might require providers to work within the public hospital system, or in the private contracting system, but not both. One might forbid contractors from selecting patients individually and require them to accept a package of cases, both simple and complex. One might forbid private contractors from accepting any separate payment from insured cases, or from caring for non-insured patients. One might require private firms to open their books to public scrutiny, regardless of proprietary concerns, so that actual cost structures could be ascertained. But the chances of achieving such transparency and foreclosing opportunistic profit seeking are vanishingly small... They vanish altogether in a political environment where the government has made it clear that it wishes to encourage the growth and prosperity of private delivery, organizations and is relatively unconcerned about side-effects. (Private Highway, One Way Street, March 2000, p. 30)

Paving the Way for the Multi-Nationals

It would be easy to assume that the cozy arrangement that the CRHA promotes regarding surgical contracts is simply another way of promoting Alberta entrepreneurs. But it appears the private, for-profit clinics/hospitals and their publicly funded contracts will not necessarily remain in local hands. Once medical services are commercialized there is nothing to stop US or Mexican health care from bidding on the contracts.

In fact, one multi-national health care provider already has a contract with the CRHA. In December 2000, Dr. Howard Gimbel announced that he and his wife Judy had signed a letter of intent to transfer their shares in Gimbel Vision International (approximately 64 per cent of common voting shares) to Aris Vision Inc. In return Aris Vision Inc., a publicly traded company, would give the Gimbels common voting shares and name Dr. Gimbel medical director of its international operations. Two months earlier Los Angeles-based Aris had merged with ICON Laser Eye Centres Inc. of To-

- In recognition of these changes the Act should be renamed the “Integrity in Government and Politics Act.” (Integrity in Government in Alberta: Towards the 21st Century. Tupper, Newman, Saville, January 1996)

The Alberta government eventually amended the Act to include some of the Tupper Report recommendations:

- The Opposition leader be subject to the same rules as cabinet ministers.
- A separate code of ethics for staff of cabinet ministers and the Opposition.
- A new code of conduct and ethics for senior public servants.
- Greater onus on politicians to report the financial status of their spouses and children.

It decided not to include apparent conflict of interest in the Act as well as several other changes recommended in the Tupper Report.

Premier Klein’s exoneration in the Multi-Corp. affair sent a clear signal: in Alberta it’s completely acceptable for the Premier and/or the Premier’s wife to receive a gift that would not be available to the general public. An even clearer signal was sounded when the government decided to ignore the recommendations of the Tupper Report and continue to allow elected officials to engage in apparent conflicts of interest. While it is generally accepted that “justice” must be “seen” to be done as well as simply done in public institutions in order to create public trust, the Alberta government has no such misgivings about the importance of appearances, or the importance of setting an example by committing to the highest ethical standards. Instead it chose to continue condoning apparent conflicts of interest, which arise when, even if all, the rules are followed, there remains a “reasonable apprehension which reasonably well-informed persons could properly have, that a conflict of interest exists?” If the Premier’s wife can accept a gift not available to the general public, an apparent conflict of interest, and get away with it why would anyone in a lesser position worry about it? (Especially when the laws, rules and regulations regarding conflict of interest for elected officials, their staff, and provincial government bureaucrats, don’t cover government delegated authorities, boards and institutions.)

2. Lax Conflict of Interest Legislation: The Trickle Down Effect

As the Alberta government devolved authority to appointed local boards, or privatized government agencies in the mid-1990s most of the quasi-government bodies were left to draw up and implement their own conflict of interest guidelines. The result was a patch-work of guidelines and practices that vary according to the priorities of the different organizations. In 1994, for example, it created 17 regional health authorities and gave them the power to create their own by-laws, including conflict of interest guidelines, subject to the approval of the Minister of Health. As we shall see this has led to a situation at the Calgary Regional Health Authority (CRHA) where apparent conflict of interest on the part of senior medical officers is openly tolerated. And while steps have been taken to contain potential and real conflicts of interest they have not always been successful. It is also clear that the private interests of these medical officers hamper the execution of their responsibilities as stewards of the public health care system. But despite these blatant conflicts of interest both the Alberta government and its appointees who control the CRHA have done precious little to protect the public interest. Instead, they have not only allowed, but encouraged, high-ranking medical officers of the CRHA to have financial interests in private, for-profit clinics that contract with the CRHA.

Reading Between the Guidelines

Like the Legislature and the Public Service, the CRHA has conflict of interest guidelines. The guidelines for medical officers apply to “all Division Chiefs, Department Heads, Site Co-ordinators, Senior and Chief Medical Officers and other physicians in similar positions of authority (CRHA, Regional Policy, Personal Conflict of Interest, Jan. 2000 p. 2). The guidelines also refer to the “fiduciary duty” of senior officers - their responsibility to act in the best interests of the public: “...It is a breach of this duty to concurrently gain from the fiduciary relationship even if no direct harm accrues to the trustor (the public).” But when it comes to conflicts of interest, rather than prohibit certain conflicts of interest the CRHA guidelines spell out how they will be managed:

To achieve this the CRHA has condoned serious conflicts of interest on the part of CRHA medical officers who have financial interests in private clinics contracting with the CRHA. The Health Care Protection Act now prescribes closer scrutiny of the process for tendering and awarding contracts. But slipshod processes in the past have allowed certain private clinics owned by CRHA medical officers to gain and maintain a foothold in the multi-million dollar business of surgical contracts.

There are countless questions and issues surrounding the CRHA’s surgical contracts. And while the public funds diverted towards the private, for profit clinics are a small amount of the total CRHA budget, it is not unreasonable to suggest that the CRHA model now in place will be used with private hospitals as well. It’s no secret that Health Resources Group (HRG), a for-profit health care company, has been lobbying the CRHA and the Alberta government to provide hip replacement surgery at its facility in the former Grace Hospital. The former 180-bed Holy Cross Hospital, now owned by private investors, is also likely to become a for-profit hospital. Given the CRHA’s past performance it is likely the knowledge, experience and reputation of medical officers of the CRHA will be used to overwhelming advantage in these for-profit hospitals.

The CRHA Competes with Itself

Supporters of for-profit health care often cite the competition factor as one of the most important benefits. They argue that competition among private providers of health care and competition between the private providers and the public providers will result in more efficiencies and lower costs (Zelder, 2000). But how can that be when the for-profit providers are all paid the same facility fees as is the case at the CRHA? Doesn’t that encourage collusion? And when the providers are in short supply, as is the case with physicians and surgeons in most areas of Canada, doesn’t that give the providers the upper hand when it comes to setting the price? And should a public health care system such as the CRHA be facilitating competition with itself? Should it be encouraging physicians and surgeons to establish private, for-profit clinics that will drain off doctors thereby lengthening waiting lists in the public system? The individual conflicts of interest that the CRHA, and the Alberta government, condone produce a much larger conflict of interest that endangers the entire public health care system.

7. Conclusion

In November 1999 when Premier Ralph Klein announced that the Alberta government was going to expand the use of private, for-profit surgical clinics, he cited hip, knee and hernia surgery as specialized procedures that could be undertaken on a contractual basis by private clinics. The announcement signaled a major change in health care policy. Until that time only minor surgery, or day surgery, had been permitted in private clinics. With the subsequent passage of the Health Care Protection Act (HCPA) and its provision for overnight stays in private clinics, it's only a matter of time before the first private, for-profit hospital makes its appearance in Alberta.

But the groundwork for the introduction of private hospitals in Alberta had been laid long before the HCPA was passed. Successive governments in Alberta have long promoted private interests, and the private sector, over the public interest. In addition, lax conflict of interest legislation has enabled elected officials, public servants and those delegated by government to put their private interests ahead of their public responsibilities. In the case of the CRHA, as outlined in this report, it is important to note that the existence of conflict of interest does not necessarily mean that the official involved has acted improperly or profited from his public position. However, it is clear that the nature of the public positions and the private interests are problematic for a public institution such as the CRHA.

In 1996 the Alberta government intentionally blurred the lines between public and private health care when it drew up an agreement, later signed by the federal government, in which it agreed to pay private surgical clinics for services previously provided by public hospitals. It also agreed to allow physicians and surgeons to work in the public and private sector simultaneously, even though that would create conflicts of interest.

The Calgary Regional Health Authority (CRHA) also helped lay the groundwork for private hospitals. It began contracting out surgical services to private, for-profit clinics in 1995. Now virtually all eye surgery in Calgary is performed in private clinics as well as anesthetic oral surgery, pregnancy terminations, podiatry services and dermatology.

Potential conflict of interest will be managed through mechanisms established to avoid any actual (real) conflict of interest...

Perceived (apparent) conflict of interest will be minimized through the use of unambiguous communications and clear decision making process...

Actual (real) conflict of interest will be avoided by the affected CRHA officer by removing him/herself from discussions, decisions and recommendations that would otherwise breach the fiduciary relationship (CRHA Regional Policy, p 2).

Other CRHA officers, staff and board members are expected to conduct themselves in similar fashion. Essentially, they must disclose their conflict and remove themselves from decisions involving their private interest. But is this enough, particularly when CRHA medical officers have pervasive influence and access to information denied most employees? Or is it simply complying with the letter of the law while flouting the spirit of the law?

Other Codes of Conduct and Conflict of Interest Guidelines adopted by publicly funded institutions are much more specific about what is acceptable.

The Alberta Conflicts of Interest Act states that Members of the Legislature (MLAs and Cabinet Ministers) generally cannot be involved in "contracts with and payments from the Crown." (Conflicts of Interest Policy, Office of the Ethics Commissioner, Alberta, 2000)

The Code of Conduct and Ethics for the Public Service of Alberta states:
Employees are in conflict of interest and violation of this Code if they:

- a) take part in a decision in the course of carrying out their duties, knowing that the decision might further a private interest of the employee, their spouse, or minor child.

- b) use their public role to influence or seek to influence a Government decision which could further a private interest of the employee, their spouse or minor child
- c) use or communicate information not available to the general public that was gained by the employee in the course of carrying out their duties, to further or seek to further a private interest of the employee, their spouse or minor child.

The conflict of interest guidelines for the City of Calgary, which has an annual budget and workforce comparable to the CRHA's are also much more straightforward.

The City of Calgary (also) requires that employees govern their outside interests to ensure that they are capable of providing full commitment to The Corporation, without providing an opportunity for a conflict of interest. For the purpose of this Code, outside interests shall include, but not be limited to, such activities as secondary employment, business undertakings and involvement with charitable, political, community service and professional organizations (City of Calgary Administration Manual 1995)

The Manual also states:

...a conflict may exist when:

1. the employee's ability and/or judgement is influenced by their own interests or those of a third party against the best interests of The City of Calgary.
2. the outside interest involves the performance of work which must be inspected or approved by another civic employee where a conflict of interest or preferential treatment may exist.

As we shall see both of these stipulations are applicable at the CRHA but are not part of its conflict of interest guidelines.

The Calgary Board of Education's employee code of conduct states that "employees shall be deemed to be in conflict of interest if they...have a shareholding interest in

a general question from Calgary eye surgeon John Huang. It passed without a ripple. No one asked how the premier could casually drop a drastic policy decision the convention had not addressed. (Lisac, November 2, 1999)

In response to a question from the opposition in the Alberta Legislature in April 1996, Premier Klein cited the Huangs as a good example for other would-be medical entrepreneurs:

If the hon. member wants to see something that is working and has taken pressure off the system in the hospitals, one only needs to go to the city of Calgary and the clinic that is operated by the Huangs, Drs. Peter, Ian, and John Huang, whereby they contract to the hospital and are doing an outstanding job and have taken pressure off the hospitals and are performing a phenomenal number of cataract operations (Alberta Hansard, April 15, 1996)

The Huang's company, Enterprise Universal Inc., owner of the former Holy Cross Hospital, recently formed a partnership with Extendicare, one of North America's largest for-profit providers of long-term care to operate 42 long term care beds for the CRHA. Extendicare, which has three other contracts with the CRHA, contributed a total of \$17,000 to the PC Fund from 1995 and 1999.

Between 1994 and 1999 individuals and corporations affiliated with HRG donated at least \$42,617.00 to the PC Fund or individual PC candidates. Crown Life/Crownx, an insurance company that invested in HRG donated \$15,000.00; MDS Inc., another investor in HRG, donated \$11,700.00; HRG director Peter Burgener donated \$9,117.00; Gerald Chipeur, HRG legal counsel donated \$2,650.00; HRG donated \$2,150.00; Health Design Group, the architectural firm that managed the renovations at the HRG site, donated \$1,500.00.

Dr. Kabir Jivraj is on record as having donated \$500.00 to the 1997 election campaign of Lyle Oberg the MLA for Strathmore/Brooks. Dr. Oberg is currently the Minister of Learning and was chair of the Standing Policy Committee on Health Restructuring from 1995 to 1997.

6. Party Politics and For-Profit Health Care

In its zeal to privatize health care, both the Alberta government and its appointed delegates (the Board of the CRHA) appear to be willing to overlook situations that compromise the interest of taxpayers, citizens at large and patients. Instead the owner/operators of the private, for-profit clinics are given a lot of leeway. Presumably the government sees them as shining examples of its preferred ideological and policy options. In turn, the Chief Electoral Officer's records of political party donations show some of the owners of these private clinics have been generous to the Alberta Progressive Conservatives.

Between 1993 and 1999, members of the Gimbel family and Gimbel-related corporations contributed \$19,275.000 to the PC Fund. In addition, the Howard Gimbel Professional Corp. contributed \$1,000 to Premier Klein's 1997 election campaign in Calgary Elbow. Dr. Gimbel's wife and business partner, Judy Gimbel, also served as a director of Premier Klein's constituency association.

Dr. Peter Huang, his brothers Dr. John Huang (an ophthalmologist) and Dr. Ian Huang (an ENT specialist), and Enterprise Universal Inc. which owns the former Holy Cross Hospital, contributed a total of \$19,350.34 to the PC fund between 1994 and 1999. Dr. Peter Huang alone contributed \$8,766.67 of that amount in 1995. Dr. John Huang is a director of the Calgary Varsity PC Association. That constituency is currently held by Murray Smith, Minister of Gaming, formerly Minister of Labour and Minister of Economic Development.

According to Edmonton Journal columnist Mark Lisac, it was a soft ball question lobbed by Dr. John Huang during an early morning session of the 1999 PC policy convention that gave Premier Klein the opportunity to announce the government's new policy regarding expanded surgical clinics or private hospitals. It was early Saturday morning and only 20 delegates were in the meeting room.

The (original) decision came out of cabinet and caucus discussions and back-door lobbying. Klein offhandedly announced it Saturday in response to

private corporation which has a subsisting contract with the Board under which money of the Board is payable or may become payable...use information gained through their positions as employees of the Board to gain pecuniary benefit either directly or indirectly." (Calgary Board of Education, Chief Superintendent's Operating Policy, 1994)

The CBE code goes on to state that employees can seek approval from the Chief Superintendent or a delegate before entering such contracts. But it is clear that such arrangements are to be discouraged.

The Calgary Catholic Board of Education "directs that its employees will not engage in any activity that conflicts or raises a reasonable question of conflict with their responsibilities in the school system." (Policy and Regulation Handbook, Calgary Catholic Board of Education, June 1995.)

In comparison the CRHA's guidelines appear to accommodate conflict of interest as nothing more than an operating hazard that officers and employees need to be aware of but not unduly concerned about.

Apparently, Anything Goes as Long as it Furthers the Political Agenda

In recent years the Alberta government has made several policy and legislative changes in order to allow for privatization of publicly funded health care. In 1996 it convinced the federal government to sign an agreement that "ensures a strong role for the private sector in health care" in Alberta. Principles outlined in the agreement include allowing doctors to work in both the public and private sector at the same time, and allowing patients to purchase goods and services over and above what is medically necessary. In May 2000 the Alberta government passed Bill 11 now known as the Health Care Protection Act which allows for surgical clinics outside public hospitals to keep patients overnight thereby opening the door to private hospitals. The CRHA publicly supported Bill 11 even before it became law and appears eager to privatize and/or contract out medical and other services to private, for-profit operators (Clear Answers, Taft and Steward, 2000). In this sort of political environment the toleration of conflicts of interest will have ramifications

for the entire public health care system. It not only allows for situations where senior CRHA medical officers and their private interests could benefit at public expense but it further erodes the public health care system. In effect, officers entrusted to manage a publicly funded institution can by their example encourage other would-be entrepreneurs eager to establish parallel, privately-owned, publicly subsidized health care services.

The CRHA Board is appointed by the provincial government and is now chaired by Jim Dinning, a former Alberta Treasurer, so it should come as no surprise that the Alberta government and the CRHA share similar attitudes towards health care privatization, and ethical issues. And given the long standing support of private interests over the public interest on the part of successive Alberta governments, it is not surprising that those who have sought to rectify the situation at the CRHA have come up against a brick wall. During the Bill 11 debate the Opposition repeatedly asked the Premier and Health Minister Halvar Johnson about the conflicts of interest only to be told the Alberta government didn't have jurisdiction over conflict of interests and that each RHA has its set own guidelines. In May 2000 the United Nurses of Alberta (UNA) and the Health Sciences Association of Alberta (HSAA) compiled a report on the apparent conflicts of interest at the CRHA and asked the Auditor General to conduct a special investigation. The AG turned down the request but said he would look into the matter for his next annual audit. During the summer of 2000 the Calgary Chapter of Friends of Medicare asked Ethics Commissioner Robert Clark to recommend extending the Conflicts of Interest Act to include RHAs. He declined saying it was not within his jurisdiction. Gary Mar, the current health minister has even gone so far as to state "...I am satisfied no conflict of interest exists" in the latest round of surgical contracts awarded by the CRHA even though he knows that senior medical officers of the CRHA have a financial interest in three of the private, for-profit clinics in question. (Minister's Rationale for Approval of Contracts under the Health Care Protection Act, Sept. 29, 2000). Mr. Mar obviously has a different definition of conflict of interest than the one commonly accepted by most experts.

As soon as the CPSA made its announcement regarding new standards Dr. Miller began publicly promoting HRG/Networc. "HRG adds additional resources to the region, so that if lack of facilities is a problem then we could help them," he told the Calgary Herald (Walker, January 26). In addition, Lorraine Lynch-Geisler, a spokeswoman for the Workers' Compensation Board, said the WCB would "certainly consider" having major procedures done at HRG/Networc (Walker, January 26). This raises all sorts of questions. Will Dr. Miller continue as Chief of Orthopedics at Foothills? Will he be able to decide how many hip replacements or other orthopedic procedures are done at Foothills and how many will have to be shuffled off to HRG/Networc, his private, for-profit clinic? Will he be recruiting orthopedic surgeons away from Foothills and over to HRG/Networc? Should the CRHA award a contract to HRG/Networc when it already has a contract with WCB? After all, the WCB sends clients to HRG/Networc because it can provide surgery faster than public hospitals. But let's not forget that CRHA medical staff perform that surgery for HRG/Networc. Should the public system be expected to subsidize a facility that competes with it for doctors? Doesn't that lengthen waiting lists in the public system? And isn't that likely to be used as a rationale for sending more patients to private, for-profit clinics?

Whatever the nature of the relationship between Healthchoice Corp. and HRG/Networc they both stand to benefit if the site of the former Grace Hospital is developed into a complex catering to seniors and their medical needs as proposed. Healthchoice could provide housing, daily assisted living, and long-term care. HRG/Networc could provide surgery as well as sub-acute care. If past performance is any indication, Dr. Miller will continue as Chief of Orthopedics at Foothills and the CRHA will contract for major surgery with HRG/Networc despite all the conflicts and complications.

units, long-term care, sub-acute clinical care and primary medical care. He said the current development plans do not include major surgery performed at HRG. Construction is expected to get underway in the fall of 2001.

Tom Neufeld, Director of Marketing and Communications for HRG said during an interview (January 8, 2001) that the only relationship between Healthchoice and HRG is that of landlord and tenant. But these declarations seem to fly in the face of a document issued by Healthchoice Corp. in October 2000 which profiles the key players involved in the redevelopment proposal. It includes profiles of two HRG executives Rowena Rizzotti, Director of Marketing for HRG's surgical suites, and Lisa Blaskovits, Director of Operations.

Mr. Neufeld also said that HRG and Network Health Care Inc. amalgamated in November 2000 and "there is no more HRG." Network Health Care Inc. was originally owned by Frank King, Dr. Stephen Miller and Tom Saunders, former president and CEO of HRG (See Magazine, March 2, 2000). They are still listed as directors of Network along with two other former HRG directors, Robert Allan (MDS Inc.) and Iain Harrison. Company documents also name Network as the operator of the third floor surgical facility at the old Grace hospital. Clearly, Network is HRG by another name. In November of 2000 HRG/Network secured its first surgical contract with the CRHA. It will receive \$126,500 a year for two years to provide podiatry (foot) services - everything from bone grafts to toenail repair. HRG/Network continues to provide day surgery and other rehabilitation services for the WCB (John Cowell, HRG/Network's Chief Operating Officer, was CEO of the WCB until 1997). According to company documents 83 specialists have applied for operating privileges at HRG's surgical suites (MDS Capital/Health Care and Biotechnology Venture Fund Annual Report 1999).

In January 2001, the College of Physicians and Surgeons of Alberta (CPSA) announced that in accordance with the Health Care Protection Act (formerly Bill 11) it had approved standards regulating major surgery at private clinics. This means HRG/Network is a big step closer to becoming a private hospital that specializes in hip or knee surgery. It will have to put its plans before the CPSA for a decision, but if the CPSA decides the procedures can be done safely at HRG facilities, HRG/Network will become the first private, for-profit hospital in Alberta.

3. Contracts and Conflicts of Interest at the CRHA

The Main Players

The Calgary Regional Health Authority has contracted out surgical services to private for-profit clinics since 1995. It began by contracting out eye/ophthalmology surgery and later moved to contract services for other sorts of day surgery, such as abortions, ear, nose and throat surgery, podiatry, dermatology, oral surgery and publicly insured dentistry procedures. The latest round of contracts were announced in September 2000, the day after the Health Care Protection Act (formerly known as Bill 11) was proclaimed into law.

Regional Health Authorities such as the Capital Health Authority (Edmonton) and Headwaters Regional Health Authority (Banff) also contract surgical services but to a much lesser extent than the CRHA. Contracting out surgical services is so well-established and profitable in Calgary that two Calgary-based private, for-profit clinics have expanded into Edmonton and secured contracts with the CHA.

Examination of the current round of contracts reveals several glaring conflicts of interest:

- If the contract for pregnancy terminations is excluded, companies owned by CRHA medical officers account for the largest and second largest total contract awards (ophthalmology and anaesthetic oral surgery).
- The largest contract (for eye surgery) was awarded to a private clinic partly-owned by the Division Chief for Ophthalmology.
- Two of the five private, for-profit clinics contracted to provide virtually all the eye surgery in Calgary are partly-owned by CRHA officers.
- A contract for podiatry surgical services was awarded to a private, for-profit clinic partly-owned by the Chief of Orthopedics at Foothills Medical Centre, Calgary's largest hospital.

The CRHA medical officers with financial interests in clinics contracting with the CRHA are:

- The CRHA’s Chief Medical Officer and senior vice-president, Dr.Kabir Jivraj, and his wife Munira are part-owners of Surgical Centres Inc. which was awarded eye surgery contracts worth \$1.4 million over two years in September 2000. Surgical Centers Inc. was also awarded a \$396,000.00 contract (over two years) to provide anesthetic oral surgery to the CRHA. Surgical Centres also has a contract with the CHA (Edmonton) for \$50,110 per year. As Chief Medical Officer, Dr. Jivraj earns \$242,000 a year (CRHA Annual Report, 1999-2000) and is responsible for virtually all aspects of medical services provided by the CRHA. Dr. Jivraj was a part-owner of Surgical Centres Inc. when he was appointed Chief Medical Officer in October 1999. But even though Surgical Centres Inc. had contracts with the CRHA, at the time he was not required to divest himself of his financial interest. CRHA documents describe Dr. Jivraj and his wife as “indirect” owners and point out that Dr. Jivraj has no links to the operation and management of the clinics.
- The CRHA Division Chief for Ophthalmology, Dr. Peter Huang, is part-owner of Holy Cross Surgical Services which has the largest CHRA contract (\$5 million over two years) to provide eye surgery. As Division Chief for Ophthalmology, Dr. Huang has a range of roles and responsibilities including day to day management of the department, scheduling times for operating rooms and diagnostic facilities, matching the supply of services to demand, clinical standards, equipment, recruiting and complaints against medical staff in his department. Dr. Huang’s private eye surgery clinic was the first to contract with the CRHA (1995) and had contracts with the CRHA when he was named Division Chief in 1997. But he was not required to divest himself of his financial interest. Two months after he was appointed Division Chief Dr. Huang and his business partners purchased the 280-bed Holy Cross Hospital from the CRHA. Holy Cross Surgical Services was also awarded a \$396,000.00 contract (over two years) to provide anesthetic oral surgery to the CRHA in the fall of 2000.
- Dr. Stephen Miller, Chief of Orthopedics at Foothills Medical Centre, Calgary’s largest hospital, is also chief medical officer and a major shareholder of Health

Premier Klein’s plans fit perfectly with those of HRG which had been lobbying to provide just those kinds of surgical services to the CRHA (Clear Answers p. 73). With the passage of Bill 11 in May of 2000 and its provision for overnight stays in private surgical clinics, HRG received the green light it had been waiting for.

There’s no question that Dr. Miller’s position as Chief of Orthopedics at the nearby Foothills Medical Centre benefited HRG. He would have insider knowledge of demands for specific types of orthopedic surgery, waiting lists, operating room capacity, budgets and available surgeons. He had influence with both CRHA executives and medical staff. Without him would HRG have been able to arrange a meeting with 25 CRHA orthopedic surgeons as it did in April of 1999 to discuss a CRHA “pilot project” at HRG (Clear Answers, p. 73)?

But it’s not so clear why the CRHA would allow Dr. Miller to continue as Chief of Orthopedics at Foothills when he was at the same time promoting a for-profit hospital in which he had a large financial stake.

The Doors to Private Health Care Swing Open

Even as Bill 11 entered the last stages of debate in the Legislature before being passed into law, HRG was maneuvering to take advantage. According to an email sent by Healthchoice director Jim Malcolm, it appeared that a friendly takeover of Healthchoice Corp. by HRG was in the works. This would give HRG control of the whole building as well as the 5.4 acres surrounding the site. Subsequent emails sent by Mr. Malcolm outline plans for redevelopment of the entire site that feature HRG as a major partner. In a telephone interview (January 8, 2001), Mark Himmelspace, a director of Healthchoice Corp. confirmed that Healthchoice is planning to re-develop the existing hospital building and the 5.4 acres of land around it into an “aging in place facility” that provides “multiple levels” of medical services to meet the varying needs of seniors. He also said nothing had come of the plans to merge HRG and Healthchoice. “HRG is simply a tenant,” he said. In a subsequent interview (February 27, 2001), Healthchoice CEO Paul Rushforth, said the complex will include condos for seniors, assisted living

representative for MDS Health Ventures, a venture capital fund owned by MDS Inc. In 1997, HRG convinced Jim Saunders, Chief Operating Officer for the CRHA, to become HRG's executive director. ([Clear Answers](#), Taft and Steward, 2000)

After it received full accreditation from the College of Physicians and Surgeons (CPSA) HRG began pushing hard to become Alberta's first for-profit acute care hospital. It planned to start with third party contracts with organizations such as the Workers' Compensation Board and the Department of Defense and then acquire contracts with regional health authorities for publicly insured surgical procedures. But it needed permission from the CPSA to keep patients overnight (more than 12 hours) a change in policy that would have turned the day surgery clinic into a hospital. The CPSA refused to give permission because it believed such a decision would have far reaching implications on future health care policy.

By that point HRG already had Health Minister Halvar Johnson on side. In a letter dated August 27, 1997 Mr. Johnson told Peter Burgener, HRG Chairman:

I am writing to confirm discussions that have been on going between my department and your CEO. These discussions have lead me to the conclusion that HRG is fully aware of the principles of the Canada Health Act and that your business plan ensures that HRG operations will not in any way contravene any of the principles of the Canada Health Act.

The letter then goes on to describe a meeting to take place between HRG, Alberta Health and Health Canada "to clarify and confirm the above understanding." The letter is copied to Premier Klein, the Cabinet and the chairs of the regional health authorities.

In the spring of 1998 Health Minister Halvar Johnson introduced Bill 37 which would have given him the power to approve private hospitals. But there was so much public opposition to the bill the government eventually withdrew it. In November of 1999 Premier Klein went on television to announce that his government was going to introduce legislation that would allow regional health authorities to contract with private providers of hip and knee surgery. This would reduce long waiting lists, he said, and save the RHAs money because they wouldn't have to invest in "bricks and mortar."

Resources Group (HRG) which was awarded a contract worth \$253,000.00 over two years for the provision of podiatry services. As Chief of Orthopedics at Foothills Medical Centre, Dr. Miller's responsibilities include scheduling operating theatre time for orthopedic surgeons, managing waiting lists, clinical standards and staff recruitment. Dr. Miller signed the CRHA contract on behalf of HRG. This is HRG's first contract with the CRHA although it has been lobbying government for several years for permission for overnight stays in its surgical suites.

The Privatization of Public Hospitals by Insiders

Besides creating conflicts of interest, the CRHA's contracting out process has also encouraged the privatization of public hospitals. Holy Cross Surgical Services, for example, is located in the former Holy Cross Hospital which was sold to Enterprise Universal Inc. for \$4.5 million in 1997 shortly after a \$35 million extension/renovation. The shareholders of Enterprise Universal Inc. are Dr. Peter T. Huang (CRHA Division Chief for Ophthalmology), Dr. Ian T. Huang (Ear, Nose and Throat Specialist), Dr. John T. Huang (Ophthalmologist), Henry Huang and Mi-Yu Huang. Peter Huang and Ian Huang are also listed as directors of Enterprise Universal Inc.

According to CRHA documents, Holy Cross Surgical Services includes a 25,000 square foot surgical facility, four operating rooms and five additional operating rooms "that can be activated", and a five-bed recovery room. Holy Cross Surgical Services provided 3501 ophthalmic procedures in 1999/2000 (CRHA Rationale, Vendor Profile). Enterprise Universal Inc. also announced recently that it has formed a partnership with Extencicare, one of North America's largest providers of long-term care for the purpose of contracting with the CRHA to provide 42 long-term care beds in the former Holy Cross Hospital (Koziey, December 2000)

The former 100-bed Grace Hospital which was owned by the Salvation Army and operated as a public, not-for-profit hospital until the CRHA closed it in 1996 is now the site of a private, for-profit surgical clinic. Health Resources Group (HRG) also known as Networc Health Inc., leases the third floor from the building's new owners, Healthchoice

Corp. Dr. Stephen Miller, Chief of Orthopedics at Foothills Medical Centre, is also chief medical officer and a major shareholder of HRG/Network. Healthchoice Corp., HRG's landlord, also has a contract with the CRHA - to provide daily assisted living services from the second floor facilities. Phyllis Kane, a former CRHA board member, was a consultant to Healthchoice when the contract was acquired.

The CRHA closed three public hospitals in 1996. The 450-bed Bow Valley Centre was demolished, the other two were sold to the private sector investors. The CRHA now leases beds and surgical facilities from the new owners.

The Closed Shop

All three CRHA medical officers are engaged in apparent conflicts of interest because even if they follow all the rules designed to limit their influence when it comes to awarding contracts, to the ordinary onlooker they still appear to be taking advantage of their public positions to further their private financial interests. They are also engaged in potential conflicts of interest since they are all in a position to benefit financially from decisions they might make concerning the CRHA and contracted surgical facilities. Given their influence and responsibilities, the opportunities for real conflicts of interest, situations in which they could in fact exercise influence to further their private interests, are numerous. For example, Dr. Huang and Dr. Miller have enough influence in their respective departments to create the need for outside providers of surgical services. By either acting directly to bring about an unworkable situation in the hospitals or by simply omitting to speak out for budget and space allocations, they could push CRHA patients into private, for-profit facilities. As Chief Medical Officer, Dr. Jivraj has even greater influence when it comes to establishing and condoning conditions that would further the use of private, for-profit clinics by the CRHA.

With such obvious conflicts of interest involved it would have been prudent of the CRHA to establish a completely transparent process for tendering and awarding contracts for surgical services. Instead it created a closed shop in which the bidders/contractors were not required to publicly reveal anything about their proposals or contracts.

5. Public Trust? What Public Trust? Profiting from The Grace

In 1996, the CRHA closed 'The Grace', Calgary's favourite maternity hospital, and turned it back to the Salvation Army. Five years later it is poised to become Calgary's first full-scale private, for-profit hospital. The machinations designed to achieve this have been advanced by a web of connections between the CRHA and Health Resource Group (HRG), a consortium of investors that wants to use the former public hospital as a base for a national network of private hospitals (HRG 1997). Dr. Stephen Miller, head of orthopedics at the Foothills Medical Centre, Calgary's largest public hospital, is a shareholder in HRG and medical director for the HRG facility housed on the third floor of the former Grace. Dr. Miller is also a part-owner of Columbia Health Care, a network of private physiotherapy and rehabilitation clinics. He often speaks about the need for "re-privatization" of health care (American Back Society Symposium, 1995). HRG's landlord is Healthchoice Corp. a consortium of venture capitalists who took control of the former public hospital in the spring of 2000 and appear eager to take advantage of what they call the "deregulation of medical/healthcare services" (Northridge Canada, 2001). Paul Rushforth, CEO of the CRHA between 1995 and 1999 was recently named CEO of Healthchoice.

When HRG first leased the space in the former Grace from the Salvation Army it immediately began to lobby the CRHA for contracts. In a letter dated September 27, 1996 and addressed to Jeanette Pick, CRHA Chief Operating Officer, Acute Care, Dr. Miller made it clear HRG was going to create "a true hospital environment." Within a few months the third floor of the former Grace had been converted into a plush hospital/hotel which included 37 residential rehabilitation program beds, 8 day surgery beds, 6 post-anesthetic recovery beds, 3 full service operating theatres and assessment and rehabilitation services

HRG was a mix of local and larger corporate interests led by Frank King, the former president of the 1988 Calgary Winter Olympics. Also among the directors were Calgary architect Peter Burgener, who was married to Tory MLA Jocelyn Burgener, and William Cochrane, former President of the University of Calgary and the western Canada

What if this incident had occurred at Dr. Huang's private clinic, or at the clinic in which Dr. Jivraj has a financial interest? Could the public expect an unbiased investigation?

Even the contentious facility fees which covered the costs associated with providing the surgical service such as mortgage and lease of the building, nursing staff and medical supplies, were kept secret. By creating this kind of cartel in which only members knew the facility fees paid by the CRHA and the number of surgical procedures allocated to each clinic, the CRHA gave its insiders even more advantage.

Excerpts from a memo dated February 8, 2000 and sent to Charlotte Richels (Executive Director to CRHA President and CEO, Jack Davis) by Barbara Boyer (CRHA Project Leader for the Surgical Advisory Committee -SAC) reveal just how important it was for the owners of the private clinics to keep this information close to their chests.

As per your request I have attached the facility fee payment for your information...As I have mentioned to you, I am very concerned about any release of this information. We have had numerous requests from a variety of sources over the past year (MLAs etc.) We have asked the providers for their permission to release this data in the past, and they are adamant that it not be released.

Further in the memo Ms. Boyer states:

The Ophthalmology fees are known to all five Ophthalmology providers, as they are all paid the same, but they are not known to non-facility owner ophthalmologists, or to the public. The Oral Surgery fees are the same for all five oral surgeon facility owners, but is not known by other oral surgeons, and it is based on the 1996/1997 ADA fee schedule. For ENT and Podiatry, these are not known to anyone except the sole provider with whom we have a contract... If you would like the actual lists that include every procedure, I can forward those, but they are medical descriptions of medical procedures, and therefore may not be all that clear to Mr. Dinning (Jim Dinning, Chairman of the CRHA Board).

In addition, the private,for-profit clinics were not required to publicly reveal their contract proposals (tenders), owners and/or shareholders, the number of procedures they had been contracted to provide, a cost-benefit analysis of the facility fees charged, or the cost of each contract to the CRHA.

The Health Care Protection Act has forced the CRHA to be more transparent about its contracting process. Contracts are now posted on the CRHA's web site (www.crha-health.ab.ca/contracts) as are the rationales for contracts in ophthalmology, pregnancy terminations and oral surgery. The terms, total amount of each contract and the facility fees paid for each procedure are now a matter of public record. Some details regarding ownership, shareholders and directors are also now public. The CRHA has also provided a financial analysis that shows the average unit cost of performing a surgical ophthalmology procedure (incorporating all categories of procedures) is \$100 less than the cost of the CRHA providing the service at either a hospital location or a free-standing off-site location. According to the CRHA, the summary provided (in the Rationale) employed full costing and incorporated all operating, overhead and capital costs related to operating and setting up a hospital or CRHA freestanding facility (CRHA Rationale regarding Ophthalmology Agreements, p.4)

The CRHA also states that it completed detailed costing of ophthalmology procedures within the hospital setting and has obtained external pricing benchmarks for both Edmonton and Calgary

The analysis demonstrates that the ophthalmology pricing obtained through this commercial process represents good value when compared to both in-hospital and external financial benchmarks. The new pricing for 2000 - 2002 is 4.6 % lower than the previous contracts. This corresponds to a \$184,000 per annum savings to the region when compared with the previous contract (Rationale for Ophthalmology Agreements, p. 4)

However, the CRHA and the contractors will still not reveal some of the most important details of the business arrangement: proposals (tenders), the number of surgical procedures allocated to each clinic, an analysis of the facility fees charged for each procedure, built-in profit margins, evaluation criteria or the cost of previous contracts. Since

with some of his complaints about the cataract surgery allocation system? An email memo dated April 8, 1999 and sent to CRHA executive officer Hume Martin (by Barbara Boyer of the Surgical Advisory Committee) indicates that this is entirely possible. It reads in part:

...I also have a letter from Gimbel today, asking for detailed info on how his allocation from last year was determined and why he did not receive his full (the number is deleted) cases. I will refer him back to the committee, but I feel that trouble may be brewing on that front.

What if there was a critical incident or death at one of the private eye surgery clinics? Could the public be sure that the Chief Medical Officer and the Division Chief for Ophthalmology would put their public responsibilities first and their private interests second? An email memo entitled Ophthalmology Incident Follow-Up, dated August 3, 2000 and sent by Pat Sayer (Patient Care Manager) to Barbara Boyer (Surgical Advisory Committee) indicates this is not out of the realm of possibility either.

- Hi Barb - As requested here are the issues that you may wish to pursue via surgical meetings.*
- a) Who is responsible for arranging transport for patients being transferred from a private clinic to the hospital? (clinic expected nursing unit to arrange transport with CRHA transport team-who pays???)*
 - b) Surgeon claims there is no OR (operating room) time available to him - OR cites time is available - what is the obligation of surgeon to wherever possible do the surgery in-house versus privately if admission is evident??? Are costs associated with patient transfer an issue??*
 - c) Physician orders must accompany patient with transfer to hospital-unit. Should not have to "track" physician down for orders after arrival.*

I hope this covers the issues we talked about - I have not included patient name nor physician name as I believe this applies to all ophthalmologists in the region. Let me know if more info is needed.

Pat

underway shortly after the sale was finalized it is not unreasonable to ask whether the purchasers had been assured prior to the sale that the CRHA would move certain CHRA operations to that site. It also appears that right from the start moving the ophthalmology clinic to the former Holy Cross Hospital was the CRHA's "preferred solution" to a shortage of facilities. Consequently, it is not unreasonable to ask whether the CRHA gave Enterprise Universal Inc. "preferred" status over other bidders for the hospital property. Did the CRHA prefer to sell it to Enterprise Universal Inc. because it knew it could lease back the facility? Did the CRHA actively encourage Enterprise Universal Inc. to buy the hospital? Did Enterprise Universal Inc. have the inside track because one of its owners was also a CRHA medical officer? Since details of the transfer of The Holy Cross Hospital, an important public asset, to the private sector have not been made public it is impossible to answer these questions.

The Web of Conflicts and its Far Reaching Effects

Both the CRHA's Chief Medical Officer and its Division Chief for Ophthalmology have financial interests in private, for profit clinics that compete with one another for contracts. So apart from being on the inside track when it comes to securing surgical contracts, they could easily spy on each other's facilities. As CMO, Dr. Jivraj could find out a lot about Holy Cross Surgical Services. As Division Chief for Ophthalmology, Dr. Huang can't help but know a lot about his rivals at Surgical Centres Inc. If the for-profit clinics of two senior CRHA medical officers are competing with one another for business this seems to encourage a competitive, rather than a collaborative relationship, between those two medical officers. Is that in the best interests of the public?

If public controversy arises from the eye surgery allocation process or any aspect of the private surgical clinics, how can the Chief Medical Officer be expected to render impartial observations or decisions when he himself has a financial interest in a private clinic providing eye surgery to the CRHA?

For example, because Dr. Howard Gimbel is often featured in the Calgary news media, he is likely the best known eye surgeon in Calgary. What if he were to go public

most of the recent awards have gone to private, for-profit surgical clinics that have been contracting with the CRHA for several years and the cost of previous contracts is used as a rationale for present contracts, public information on previous contracts is more than pertinent.

Managing the Conflicts of Interest

Everything but emergency eye surgery in Calgary is now contracted to five clinics: Gimbel Eye Centre, Holy Cross Surgical Services, Mitchell Eye Centre, Rocky Mountain Surgical Services and Surgical Centres Inc.

"The approved contracts are specific to the provision of medically required and insured ophthalmic procedures under the Alberta Health Care Insurance Plan. The scope of work covers cataract procedures and approximately 50 different types of general ophthalmic procedures. The cataract procedures are primarily elective; the general ophthalmic procedures involve primarily elective procedures and in some cases, urgent procedures. Emergency cases are primarily done in the hospitals. Presently, approximately 6,000 cataracts and 2,000 other non-cataract ophthalmic procedures are contracted by the CRHA with five accredited facilities. The total value of the contracts is currently \$4.1 million per annum and these contracts represent the vast majority of the Region's surgical ophthalmic procedures." (CRHA Rationale for Entering into Agreements for Ophthalmology Surgery Facilities, p 2)

The situation in Edmonton is markedly different. Only 24 per cent of cataract surgery is contracted to private clinics and only 6.7 percent of other ophthalmic surgery.

To date the CRHA has undertaken a series of changes in order to manage conflicts of interest. According to Mark Scharf, CRHA's director of Corporate Business Development, the process by which proposals are requested, reviewed and awarded is closed to all but a few CRHA staff appointed to deal with it and a steering committee named to oversee the process. Membership on the steering committee varies depending on the contract in

question. For example, if it is a pregnancy termination contract a hospital-based physician with experience in that field will be asked to sit on the committee. Committee and staff members are expected to complete the process with complete confidentiality. “Any person who communicates beyond me on these matters is immediately disqualified,” Mr. Scharf said during an interview. Decisions regarding the awarding of contracts are then forwarded to CRHA executives and the Board.

But the micro-managing of conflict of interest may actually be hindering the efficacy of the process by which private clinics are awarded contracts. For example, since there are no hospital-based ophthalmologists in Calgary, the medical committee which oversees the awarding of contracts does not include an eye surgeon lest there be a conflict of interest (Mark Scharf). Since Dr. Peter Huang, the CRHA’s Division Chief for Ophthalmology is also an owner of a private, for-profit clinic, he too has been excluded from any direct involvement in the process used to parcel out virtually all the publicly insured eye surgery done in Calgary. As well, Dr. Huang no longer sits on the committee that allocates cataract procedures to eye surgeons although he has a hand in the appointment of committee members.

However, as Division Chief of Ophthalmology Dr. Huang is clearly accountable for administering everything from clinical standards to waiting lists. How can he properly execute his responsibilities when he has to be excluded from important decisions because of his conflict of interest? And given his wide range of responsibilities, how can he possibly remain at arm’s length from decisions that would benefit his business at all times? The CRHA’s answer to this dilemma appears to be one of accommodation to circumstances. Rather than insist on a hospital-based, independent ophthalmologist for Division Chief, it has tailored the position to suit the fact that the current Division Chief is a director and part owner of a private for-profit clinic that has the largest contract (\$5 million over two years) for ophthalmic surgical services. This situation raises another important question. What is more important to the CRHA’s Chief of Ophthalmology, the administration of eye surgery and other ophthalmologic procedures within the public health care system or the administration of a growing private, for-profit sector subsidized by the public purse?

- The record does not show staff were aware of the interim conflict of interest policy published in the Acute Care Division’s recently published Administrative Policy Manual.(CRHA Administrative Review, p. 14)

Mr. Flynn also noted that “there was no documentation of most of the meetings held to discuss the transfer...no documentation of the process for consultation with other ophthalmologists and the reasons for excluding some.” Mr. Flynn also found that there was an appearance of bias toward the “preferred solution” and a lack of formal process for engaging the marketplace on the basis of a level playing field including measures to guard against the risk of creating an unfair advantage.

In a letter dated March 23rd 1999, Dr. Jarrell (CRHA/Chief Medical Officer) wrote: “the considered opinion was that the Division Chief who is currently an owner/operator could continue to be an owner/operator and a Division Chief if indeed the perceived conflict of interest was managed.” Dr. Jarrell went on to say that the reviews had instructed the Division Chief on “how to act with respect to conflict of interest.” He also suggested that the choice of the new ophthalmology centre should be made in the ophthalmology division in a “fair and democratic manner.”

Once again, the Division Chief for Ophthalmology had been in a position where he could have easily influenced decisions that would benefit his private interests. But once again the CRHA stopped short of removing him from his position, asking him to divest himself of his financial interest or recommending that someone without a conflict of interest be appointed to the position.

The former Holy Cross Hospital did not become the site of the CRHA’s ophthalmology clinic, the surgery was parceled out to several clinics. But Holy Cross Surgical Services’ eye surgery contract for 2000 accounts for almost half of all eye surgery provided to the CRHA. The HCSS contract is three times the amount of the second largest contract, awarded to Gimbel Eye Centre.

The CRHA’s internal review regarding the site selection for the ophthalmology clinic also raises questions regarding the sale of the Holy Cross Hospital by the CRHA to Enterprise Universal Inc. Since plans to move the CRHA’s ophthalmology clinic got

a time of enormous change at the CRHA. Three hospitals had been closed and many medical services were being consolidated and/or relocated. As Chief Ophthalmologist for the CRHA and part-owner of the new site, Dr. Huang would be involved in the decision making from both ends of the arrangement. By June negotiations with Dr. Ian Huang, Peter Huang's brother, had been completed and a lease agreement signed by Enterprise Universal Inc. In October, the CRHA Board's Quality Care Services Committee expressed concern.

The committee was concerned that notwithstanding the merits of the proposal, a conflict of interest may have occurred or could be perceived due to the fact that the CRHA's Regional Division Chief of Ophthalmology, Dr. Peter Huang, is also a principal shareholder in Enterprise Universal Inc. and may stand to gain materially as a result of the contemplated lease agreement.
(Administrative Review of CRHA Process for Selecting A New Site for the CRHA Ophthalmology Clinic, November 19, 1998, p. 3)

On October 26 1998 the Quality Care Services Committee recommended to the CRHA Board that the proposal to move the Ophthalmology Clinic from the Rockyview Hospital be "frozen." CRHA management was also directed to review the process in relation to conflict of interest guidelines and consult with ophthalmologists who not previously consulted. The review was undertaken by George Flynn, CRHA's Health Policy Leader (Review, p. 3) He looked at all aspects of the issue including the purchase of the Holy Cross Hospital by Enterprise Universal Inc., the decision to close the site at the Rockyview and the decision to re-locate it at the Holy Cross Site. Mr. Flynn found that CRHA's focus on fast action to solve the problem had indeed created a situation for conflict of interest. At the top of his list of preliminary findings he noted "A lack of Documented Process to Avoid Conflict of Interest",

- The record does not describe any process for acknowledging conflict of interest and the steps taken to avoid it.
- The decision making process and the role of key decision-makers was not mapped out beforehand.

Since all the ophthalmologists in Calgary now own/operate or work in private, for-profit clinics, how does the CRHA ensure that the process for awarding contracts, for determining facility fees, clinical standards and cataract allocations are overseen by ophthalmologists with knowledge of the field but no vested interest in promoting private, for-profit clinics?

The Chief of Ophthalmology is not the only CRHA medical officer who has a financial interest in CRHA contracts to provide ophthalmic procedures. Dr. Jivraj, CRHA's Chief Medical Officer and senior vice-president, is part owner of Surgical Centres Inc. which has a contract to provide ophthalmic services worth \$1.4 million over two years. Would Dr. Jivraj be inclined to call for an investigation into the operations of the eye surgery clinics if patients or staff complained? Would CRHA staff want to bring concerns about the operations of private, for-profit clinics to the attention of the Chief Medical Officer when they know he has a vested interest in one of the clinics? And if the Chief Medical Officer were to recommend that the CRHA use more private facilities, as he did in 2000 when MRI waiting lists got out of hand, could he expect to be seen as unbiased? (Vernon, Medical Post, January 2000)

More to be Gained than Publicly Insured Patients

CRHA eye surgeons are allocated a specific number of surgical procedures by the CRHA each year. The surgeon then chooses the private clinic he/she wants to operate in and bills the Alberta Health Care Insurance Plan (AHCIP) for each procedure he/she performs. The CRHA contracts with each clinic to cover the facility fees associated with each surgical procedure. The more surgeons with allocations a clinic can attract, the more money it receives in facility fees.

From the patients' point of view this arrangement appears to be the same as the usual process of visiting a doctor and having the cost covered by the Alberta Health care Insurance Plan (AHCIP). But there are significant differences. The not-for-profit clinics that most physicians work in operate on a fee for service basis. The money received from the AHCIP has to cover overhead (office expenses) as well as the doctor's time. Since the

doctors are not shareholders or employees of for-profit companies it is easier for them to put the welfare of their patients, rather than their business interests, first. In addition, most not-for-profit medical clinics offer only publicly insured procedures.

In the case of the private, for-profit ophthalmology clinics, doctors offer an array of uninsured procedures and services, such as laser vision correction, that patients must pay for out of their own pockets. Because the private, for-profit clinics by definition need to drum up as much business as possible in order to make a profit, the person who attends a private, for-profit ophthalmology clinic is likely to be treated more like a consumer than a patient and consequently may have to adopt a “buyer beware” attitude.

This shift from patient to consumer can easily be read between the lines of the Health Care Protection Act. It allows doctors treating insured patients to offer enhanced goods and services such as additional lab tests, explanatory videos or uninsured surgical procedures, as long as they specify in writing the costs to the patient and the reasons for recommending them. The patient must then sign an agreement giving consent. The HCP Act doesn’t explain how the RHAs could possibly monitor each transaction to ensure that doctors don’t take advantage of their patients. But this section of the act certainly makes it clear that publicly insured patients directed to private, for-profit clinics can be enticed with all sorts of other goods and services that they will have to pay for out of their own pockets. In other words, contracting out ensures that a certain number of patients will be delivered to facilities where they can be sold all sorts of other things that they may, or may not, need.

The Deliberate Blurring of Public and Private

While the Health Care Protection Act prescribes measures to be taken regarding public scrutiny of contracts, there are no provisions regarding conflict of interest. Doctors are not prohibited from working for the regional health authority, as officers, employees or contractors while owning or working in private, for-profit clinics. In the past, this kind of cross over was frowned upon because doctors working in public hospitals would be in a position to refer patients waiting for treatment to their private clinics. But in 1996, after

As for the concern that eye surgeons could be unduly influenced by a CRHA officer to choose a particular clinic, Dr. Arnold concluded:

Each cataract surgeon within the Division of Ophthalmology can choose to perform surgery at the facility of his/her choice, within logistical limits. Four of the five facility operators are cataract surgeons as well. When surgery is performed at a facility, regardless of the surgeon performing the operation, the facility ownership is paid the facility fee. Although there is a degree of lobbying by certain facility owners encouraging surgeons to move their site of operations, no member interviewed had felt coerced or threatened by this, although some found it offensive. (CRHA Review Page 5)

The review cleared Dr. Huang but it didn’t completely clear up the confusion surrounding the Division Chief for Ophthalmology and his conflicts of interest. And it stopped short of recommending that someone without a financial interest in a private, for-profit clinic that contracts with the CRHA be appointed Division Head.

Conflict of Interest and Site Selection for the CRHA Ophthalmology Clinic.

As early as 1995, Dr. Huang expressed interest in taking over one of the three hospitals that the CRHA had announced it was going to close in order to provide surgical and medical services for Americans and Albertans (Walker, April 7, 1995). In 1997, Dr. Huang and his business partners (Enterprise Universal Inc.) tendered the successful bid for the purchase of the Holy Cross Hospital from the CRHA. The shareholders of Enterprise Universal Inc. are Dr. Peter T. Huang, his brothers Dr. Ian T. Huang, and Dr. John T. Huang, Henry Huang and Mi-Yu Huang. The directors are Dr. Peter Huang and Dr. Ian Huang. At the time of the purchase Dr. Peter Huang was CRHA Division Chief for Ophthalmology.

Shortly after the purchase of the 180-bed hospital and surrounding buildings was finalized in early 1998, CRHA staff proposed that the region’s centralized ophthalmology clinic at the Rockyview General Hospital be relocated to the Holy Cross site. It was

allocations to work at his facility. As well, he could influence allocations to other clinics and would have knowledge of operations at all the private clinics even though they were supposedly competing with his clinic for business. In addition, as Division Chief for Ophthalmology Dr. Huang was ultimately responsible for establishing clinical standards for the all private clinics so as to ensure quality medical care for patients.

Problems arose when Dr. Huang decided to change the formula used to determine how many operations were allocated to each surgeon. In the past the formula had been based on a surgeon's waiting list and his/her service to the ophthalmology department in the areas of research, teaching and administration. Dr. Huang's new formula would have given more weight to the credits gained from service to the department.

Dr. Arnold's review, which included discussion with 14 ophthalmologists and CRHA staff, found that there was a "potential conflict of interest" when Dr. Huang was appointed Division Chief. Dr. Arnold also concluded there was an "apparent" conflict of interest and that the process of cataract surgery allocation suffered from a "lack of complete transparency."

However, Dr. Arnold didn't find "an actual conflict of interest." In the previous months the process of allocation had been changed so the Division Chief was no longer directly involved in the allocation of cases to either himself as a surgeon or to his facility via other surgeons.

The fiduciary duty of the CRHA to the public in the allocation of cataract cases is now managed through committees and with processes which do not permit the autonomous actions of the Division Head to determine the results.

Dr. Arnold also remarked that "the ongoing authority of the Division Head to appoint allocation committee members and to approve the recommendations for that committee limit the necessary distance of the arm's length relationship between the Division Head and the allocation process, regardless of the personal integrity of committee members." His report also made several suggestions as to how the ophthalmology department could be democratized so power wouldn't reside in only a few hands.

the Alberta government agreed to cover facility fees in private eye clinics, past protocols were thrown out the window. The "working understanding" with the federal government ensured that the province would not be penalized under the Canada Health Act if it paid the facility fees or if its physicians worked and billed simultaneously in the public and private sectors. The government's move in effect paved the way for and endorsed conflict of interest in the health care sector as normal practice.

Dr. Kabir Jivraj was president-elect of the Alberta Medical Association (AMA) when the Alberta government opened the door to private clinics in 1996. In early 1997 when he was AMA President he and several other doctors established Surgical Centres Inc. which eventually secured surgical contracts with the CRHA. Obviously, Dr. Jivraj was a supporter of privatized, for-profit health care long before he was appointed a steward of Calgary's public health care system.

4. CRHA Investigations Prompt Insight but no Oversight

During 1998 the CRHA conducted two investigations into conflicts of interest arising from the activities of its recently appointed Chief of Ophthalmology, Dr. Huang. The first focused on the allocation of eye surgeries to surgeons. The second focused on the selection of the former Holy Cross Hospital, recently purchased by Dr. Huang and his business partners, as the new site for the CRHA ophthalmology clinic. The reviews were conducted by separate investigators and involved consultation with numerous CRHA medical and administrative staff.

The review regarding allocation of eye surgery uncovered evidence of apparent and potential conflicts of interest. But it concluded that while there had been a real conflict of interest when the investigation began, the situation had been rectified. The review regarding site selection for the new ophthalmology centre concluded that documentation of the process was so slipshod it was impossible to know exactly what had transpired - leaving open the possibility for real conflict of interest.

A close reading of the two reviews provides clear insight into the ramifications of conflict of interest on the daily decisions and operations of the CRHA with respect to its ophthalmology division.

Conflict of Interest and the Allocation of Eye Surgery

The first facility contract for eye surgery was awarded in 1995 when the CRHA decided to contract all eye operations (about 1600 a year) done at The Foothills Hospital to a private clinic. Dr. Peter Huang's clinic outbid other private clinics and was awarded the facility contract. In 1996, the CRHA decided to contract out all cataract surgery performed in the region's hospitals and Dr. Huang's clinic was apportioned another share. In September 1997, Dr. Huang was appointed CRHA Division Chief for Ophthalmology. Until that time there been no regional Chief of Ophthalmology, instead each hospital had its own chief ophthalmologist.

In April 1998, Dr. John Jarrell, the CRHA's Chief Medical Officer requested a review of the process of allocating cataract surgery to see if there was any perceived or real conflict of interest. The review was undertaken by Dr. David Arnold, Medical Officer, Clinical Affairs for the CRHA. ("A Review of Issues Regarding Conflict of Interest in the Allocation of Cataract Surgery within CRHA", Oct. 22, 1998.) At the time all cataract surgery was performed in private clinics which were paid facility fees by the CRHA. There was a finite pool of money for facility fees and a capped number of surgical procedures allocated to surgeons each year. The question of conflict of interest arose because the procedures were allocated by a committee led by the Chief Ophthalmologist, Dr. Peter Huang.

This capped pool of cataract surgeries with attending facility fee payments is largely managed within the Division of Ophthalmology. Concerns have been voiced over management of this finite pool of cataract surgeries, in part because the Division Head of Ophthalmology is concurrently both an eye surgeon and an owner of a private surgical facility contracted by the CRHA. (CRHA Review, p. 3)

Dr. Arnold's review outlined three main issues:

1. Does the Division Head, Ophthalmology, or any other CRHA officer stand to benefit personally from decisions he makes regarding cataract allocation?
2. Have the processes used to allocate cataract surgeries been specifically biased to benefit a CRHA officer?
3. Is the choice of site for cataract surgeons free of undue influence from a CRHA officer (i.e can a surgeon choose which facility to operate in, with subsequent payment of a facility fee to the owner/operator)?

The allocation committee of the Division of Ophthalmology had six members: two co-chairs and four additional members. All were appointed by the Division Head, Dr. Huang, from a roster of ophthalmologists who volunteered to sit on the committee. Dr. Huang's position allowed him influence in allocating eye operations to surgeons who worked at his clinic. He was also in a good position to lobby eye surgeons with cataract