

THE NEW ALBERTA HEALTH ACT: RISKS AND OPPORTUNITIES

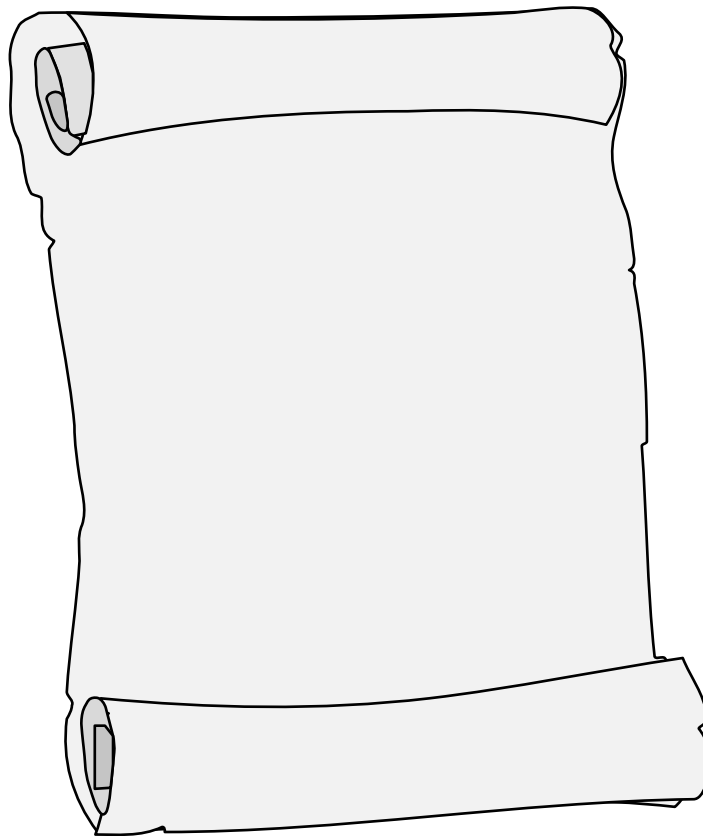
Report I

Risks of the Alberta Health Act

A Discussion Paper

By Diana Gibson and
Colleen Fuller

May 2010



PARKLAND INSTITUTE

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A Discussion Paper

by Diana Gibson and Colleen Fuller
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ABOUT THE AUTHORS

Diana Gibson and Colleen Fuller are co-authors of the Canadian best-selling book, *The Bottom Line: the truth behind private health insurance in Canada*. Diana Gibson is the Research Director of the Parkland Institute and author of numerous reports, book chapters and articles on social policy issues. Colleen Fuller is a Vancouver based health policy researcher, and author of *Caring for Profit*, and a contributing author to *The Push to Prescribe: Women in Canadian Drug Policy* amongst other books, reports and articles.

ABOUT THE SERIES

Parkland Institute will be releasing two reports in the series - *New Alberta Health Act: Risks and Opportunities*. The first will address the risks associated with the legislative reforms as proposed. It will be based on analysis by a broad cross-section of researchers, lawyers, health activists and practitioners. The second will be a discussion document for use in public consultations on the proposed legislation. It will examine the opportunities presented by the *Alberta Health Act* conversation, and the question: How can an *Alberta Health Act* be used to strengthen public health care and make it more sustainable?

ABOUT THE PARKLAND INSTITUTE

Parkland Institute is an Alberta research network that examines public policy issues. It is based in the Faculty of Arts at the University of Alberta and its research network includes members of 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; and
- bring together academic and non-academic communities.

All Parkland Institute reports are academically peer reviewed to ensure the integrity and accuracy of the research. For more information visit <http://parklandinstitute.ca>.

Executive Summary

Alberta's government has undertaken to reform the existing health legislation and create a new *Alberta Health Act*. The initiative is summarized in "A Foundation for Alberta's Health System" (subsequently referred to as the Foundation).

The rhetoric in the Foundation document heavily emphasizes individual responsibility and flexibility of delivery systems. It replicates rhetoric seen in Ralph Klein's Third Way and the 2002 Mazankowski report.

In this report we identify the potential risks associated with such an act. The report is based on reviews of materials available on the new health act initiative with input from a national working group and a research symposium. Three main areas of concern with the initiative emerged:

1. The risk of expanded profit delivery.
2. Risks arising from merging various existing health care acts and standardizing definitions.
3. The risks associated with the patient charter.

1. RISK OF EXPANDED FOR-PROFIT DELIVERY

The government's main focus with this initiative is to "reorganize and revamp the delivery system." The Alberta Health Services states it as, "Recognize role of private and non-governmental organizations in service delivery within the Canada Health framework." The submission by the Calgary Chamber of Commerce takes it one step further, stating that "Surgical facility operators have commented that the system would function at much higher level of efficiency if AHS were stripped of its regulatory function." It also states that the Chamber has long advocated the repeal of the *Health Care Protection Act*.

FOR-PROFIT DELIVERY DOES NOT DELIVER

The research on for-profit hospitals reveals three main areas where they fall short:

- i. Quality and safety of health services.

ii. Costs of health services.

iii. Quality of jobs.

Findings include higher death rates in private hospitals and dialysis clinics, more quality deficiencies and less nursing care in nursing homes and less care to the dying in hospices. Investor-owned hospitals spend much less on nursing care than not-for-profit hospitals, and their administrative costs are 6% higher. Privatization takes money from the pockets of underpaid, mostly female health workers and gives it to investors and highly paid managers.

2. RISKS OF MERGING THE ACTS

One of the key priorities identified for the new *Alberta Health Act* is to make definitions standard across health care legislation in Alberta by merging a number of the acts and standardizing definitions. This includes the *Nursing Homes Act* and the *Hospitals Act*. Protections in the *Nursing Home Act* include ratios for nursing staff, as well as a variety of other regulations protecting quality or care. The *Hospitals Act* is the main act that applies the *Canada Health Act* provisions within the province.

Standardization may lead to the lowest common denominator. It also may be used to get rid of wording that limits for-profit involvement, protects the public sector, or dictates higher quality standards such as nursing ratios.

The repeated commitments that the new *Alberta Health Care Act* will comply with the *Canada Health Act* are hardly reassuring. Alberta's legislation already exceeds the *CHA* in important areas. These include limits on the evolution of a parallel private system through bans on doctors working in both systems. There is no indication that these protections will not be lost.

3. RISKS WITH A PATIENT CHARTER

A number of other jurisdictions have experimented with the patient bill of rights. These are very controversial. The online survey being conducted by the Advisory Committee contains a number of elements in the patient charter that raise concerns.

i. RIGHTS TO TIMELINESS AND ACCESS

There is debate as to whether or not time guarantees should be included in a patient's charter. Some legal and policy experts argue it could be used to improve accountability and outcomes on wait times. Others suggest that it could be used as a vehicle for opening the door to more privatization in a Chaoulli-style lawsuit. The risk of this would depend very much on how those rights were articulated. For example, Quebec's charter includes timeliness and access provisions, but those are limited specifically to the public system and by caveats related to the limits imposed on the public system.

ii. RESPONSIBILITIES

The act as proposed places strong emphasis on personal responsibility. The online survey includes a section on patient responsibilities such as: learn how to better access health services; use services appropriately and wisely; and make healthy choices. This shifts responsibility from health care providers and the government to individuals, and is a significant move away from universality.

Emphasizing patient responsibility for health can lead to system biases against people with unhealthy habits such as smoking, poor diet or lack of exercise. Personal responsibility is important, but these issues should be dealt with through public education and intervention programs and policy initiatives.

4. CONCLUSIONS AND RECOMMENDATIONS:

Considerable resources are required to create a new *Alberta Health Act* and important risks are associated with that scale of legislative change. This report finds that there is nothing to be gained with the new legislation as proposed to date that could not be done under the current legislation and much that could be lost. The initiative should not proceed as proposed.

The legislation should only be changed if the real objective is to strengthen the public health system and better integrate the community sector within it, and to put a limit on any further for-profit delivery. This is the topic of the forthcoming second report in this series.

I. Introduction and Background

Alberta's provincial government has embarked on an initiative to reform the existing health legislation and create a new *Alberta Health Act*. The initiative was recommended by the Minister's Advisory Committee on Health and is outlined in the January 2010 report: "A Foundation for Alberta's Health System." This report will subsequently be referred to as the Foundation report.

That report recommended that a new law, the *Alberta Health Act*, be built around core principles. The committee also recommended a patient charter, the affirmation of *Canada Health Act* principles, a consolidation of core legislation, stronger support for evidence-based decision making and ongoing citizen engagement. The minister accepted all four recommendations on behalf of the government in January 2010. On April 29, 2010, the minister announced that MLA Fred Horne would be leading consultations and will be presenting a report to the minister on September 30, 2010 with a detailed plan on how to move forward.

As part of those consultations, the Minister's Advisory Committee has created an online survey. This form of survey is extremely limited as a tool for public consultation. It is limited by the questions asked, the

space allowed and by offering only a narrow number of specified options for consideration. It does not replace the need for public town halls or open discussions. The survey itself is also problematic in its content, which is discussed in the attached survey discussion guide.

The rhetoric in the act heavily emphasizes individual responsibility, flexibility of delivery systems, and the marketization and corporatization of health care delivery. It replicates rhetoric seen in Ralph Klein's Third Way and the Mazankowski report.

This project undertakes to produce a series of discussion papers, one on the problems with that *Health Act* as proposed in the Foundation document and survey. The second paper will be released subsequently, and will propose ways that the *Alberta Health Act* could strengthen public health care and take real steps toward improving affordability, quality and accessibility of health care in Alberta. These papers are meant to stimulate public debate about the *Alberta Health Act*.

NOTHING TO GAIN, MUCH TO LOSE

The Foundation report is very vague and drowning in rhetoric. Much of the rhetoric is in direct contradiction to policies and budget decisions of the current government. It is clear from the rhetoric and previous government policies as well as the submission by Alberta Health Services (AHS) that this is an initiative aimed at expanding privatization and further weakening the public system, including weakening the protections enshrined in the various existing acts.

The health system is almost continually undergoing reform while key problems fail to be addressed. It is very hard to find any real benefit in the initiative being proposed. At best the initiative feels much like a shuffling of the deck. It may look different but will still be the same deck. At worst, as the analysis in this report will show, it will likely weaken provisions that protected public health care in Alberta and further expand for-profit health care.

There are certainly problems within the current system that need fixing, but the barriers to reform are political, not legislative. Without the political will to account for the health impacts of social policies, without the political will to fund adequate public health services, and without the political will to limit the profits of pharmaceutical companies, pharmacies, and private insurers, legislative changes are not likely improve health care outcomes or sustainability in Alberta.

The conversation about an *Alberta Health Act* does offer an important opportunity to talk openly about how medicare can be strengthened and health sustainability and affordability improved. That is the topic of the second report in this series.

TOMMY DOUGLAS PHASE II

The Foundation report begins with the following quote from Tommy Douglas:

When we began to plan medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the delivery system – and of course that 's the big item. It's the big thing we haven't done yet.

This quote clearly embodies the opportunities posed by the conversation about the *Alberta Health Act* (AHA). However, there is nothing in the Foundation document or current government policy that reflects this quote, nor any indication of a commitment to Tommy Douglas Phase II. This report will explore how the Foundation and AHS submission indicate a misuse of this quote with an emphasis on revamping the delivery system and the intention to privatize it further.

First, it is important to note that many compromises have been made, meaning that Tommy Douglas's Phase I itself is incomplete. For Tommy Douglas, Phase I was the removal of financial barriers between those giving the service and those receiving it. That vision included universal, public long-term care and dental coverage as well as pharmaceuticals. For many types of health services and such as long-term care, continuing care and home care, the financial barriers are still enormous. As Albertans pay the highest out-of-pocket costs for health care in the nation, costs still create significant barriers to access.

With regards to Phase II, Tommy Douglas envisioned the extension of medicare to home care, long-term care, community care, pharmacare and a much greater focus on illness prevention, health promotion, and the policies required to address the social determinants of health, particularly poverty and inequality. The Alberta government is going in the absolute opposite direction on long-term care, home care and community care, integrating more for-profit providers and reduc-

ing the public role. The same applies to the social determinants of health. With 80% of wealth concentrated in the top half of households and high levels of poverty, Alberta has clearly been going the opposite direction. The 2009/2010 budget reveals clear commitment to staying on that path, with \$1.7 billion in cuts to affordable housing initiatives, children in care, people with disabilities, and other programs that directly impact on social determinants of health.

This paper will start with an overview of the Foundation document and the AHA initiative. It will then address the three main areas of concern with the initiative:

1. The risk of expanded for profit delivery.
2. Risks arising from merging the acts and standardizing definitions.
3. The risks associated with the patient charter.

SUMMARY OF THE ALBERTA GOVERNMENT'S NEW DIRECTIONS

Evidence from previous policy initiatives combined with the language in the Foundation document gives a clear indication of the direction the AHA reforms are likely to go. Also, the AHS submission to the Minister's Advisory Committee, as well as the submission by the Calgary Chamber of Commerce, also gives a good indication. These are briefly summarized below.

The mandate given to the **Advisory Committee** was as follows:

In September 2009, Alberta's Minister of Health and Wellness established the Minister's Advisory Committee on Health to make recommendations on updating Alberta's health legislation. The Committee was

asked to establish a new framework for legislation that would:

- Remove barriers to accessing health care.
- Promote wellness.
- Promote ambulatory and community-based care.
- Enable the public health system to respond to emerging issues on a timely basis.
- Encourage evidence-informed innovation.
- Establish clear lines of accountability.

The minister and committee state clearly that the reforms will be premised on compliance with the *Canada Health Act*.

CORE COMMITTEE RECOMMENDATIONS:

1. Articulate a set of principles to be used throughout the health system

Principles:

- Put people and their families at the centre of their health care.
- Be committed to quality and safety.
- Ensure equitable access to timely and appropriate care.
- Enable decision-making using the best available evidence.
- Be focused on wellness and public health.
- Foster a culture of trust and respect.

2. Legislate an *Alberta Health Act*

The *Alberta Health Act* should have the following key components:

- The principles for health care and services in Alberta.
- Identification of roles, responsibilities and

accountabilities for key players in the health system.

- Clear and consistent definitions that apply across all health legislation.
- Provision for an arm's-length entity to ensure use of best available evidence in decision-making.
- Provision for an Alberta patient charter to be developed in consultation with Albertans.
- Consolidation of core health acts that deal with publicly funded services.

3. Ensure ongoing Citizen Engagement in Development of Legislation, regulation and policy

Public involvement in setting priorities for health services and developing the Alberta patient charter.

- Developing a transparent process to ensure the alignment of existing and new legislation,
- regulation and policy with the principles and intent of the *Alberta Health Act*.
- Public representation in the ongoing process of ensuring evidence-based decision-making.
- Validating the proposed framework to guide future directions for the health system.

4. Develop directions to guide the legislative, regulatory, policy and program delivery changes

The **Alberta Health Services** submission to the Minister's Advisory Committee included the following key priorities:

- Patient/client focus
- Emphasis on wellness
- Shifting care to community
- Right care, right place, right provider
- Primary care emphasis
- Enabling people to take responsibility for their own health
- Ensuring seniors and people with disabilities are provided with services, opportunities which maximize independence

- Using all resources in most effective manner
- Using skills of all health care providers to the full scope of practice
- Enabling innovation to be quickly adopted and spread
- Giving providers information necessary to improve quality.

The submission by the **Calgary Chamber of Commerce** to the Minister's Advisory Committee provides insight into the pressures behind the AHA initiative, and an indication of probable directions the government will choose to take.¹

The submission stated that:

The Calgary Chamber of Commerce has long advocated for legislative change with regards to the Health Care Protection Act (HCPA). The repeal of the HCPA will result in at least two clear benefits that align with the suggested recommendations for legislative reform in the terms of reference:

[1] establishing clear and efficient lines of accountability between public, private, and both profit and non-profit health care providers and their contracting agents, and

[2] removing barriers to accessing health care.

Private providers currently are overseen by the AHS, Alberta Health and Wellness and the College of Physicians and Surgeons (CPS). The submission goes on to state that "Surgical facility operators have commented that the system would function at much higher level of efficiency if AHW were stripped of its regulatory function." This would make providers accountable to the AHS and CPS, eliminating direct oversight by the government of Alberta.

The Chamber strongly advocates a larger role for

¹ Calgary Chamber of Commerce, Submission to the Minister's Advisory Committee on Health, October 15, 2009.

private providers and increased competition with the public sector, saying, *“The current legislative framework inhibits competition by functioning as a barrier for entry into the facilities market. Other systems that are not covered by the HCPA, like diagnostic services and long term care facilities, have experienced success at attracting private capital and encouraging competition. Thus, as part of any legislative reform, the Chamber recommends that the Government of Alberta adjust the current legislative framework to encourage competition among public and private providers, both for-profit and non-profit.”*

The Chamber submission also advocates that the playing field be levelled between private and public facilities, saying, *“Ensure, where possible, that any legislative change helps create a level playing field for all health care providers by cooperating in the distribution of resources.”* For instance, this would mean that private providers should be able to benefit from economies of scale attained through the public system such as bulk purchasing of pharmaceuticals.

The Foundation document and submissions by the AHA and Chamber give a good indication of the direction health legislation reform in Alberta will take. A thorough review of those documents in the context of the government’s track record on this issue make it clear that there are significant risks associated with this initiative for the public health system and for health care policy across the country.

II. Expansion of For-profit Delivery

It is clear from the opening quote by Tommy Douglas that the government's main focus with this initiative is to "reorganize and revamp the delivery system." Much of the rhetoric in this area centres on more flexible delivery, and a moving away from a system based on institutions. The April 29 press release specifically stated, "new legislation that will move the system from an overemphasis on the needs of institutions and providers to one that better recognizes and responds to people and families needing health services." The quote from the Alberta Health Services submission best articulates that the initiative is clearly aimed at enabling private for-profit delivery to expand. It states the goal of the legislative reform as: "*Recognize role of private and non-governmental organizations in service delivery within the Canada Health framework.*"

Alberta already has private surgeries and other clinics as well as labs, pharmacies and diagnostic imaging and that sector has been growing.

According to Cambridge Hospital/Harvard Medical School authors, Woodlander and Himmelstein:

For ordinary citizens, the drive to privatize is most evident in health care. In the United States, investor-owned firms have come to dominate renal dialysis, nursing home care, inpatient psychiatric and reha-

ilitation facilities and health maintenance organizations (HMOs). They have made significant inroads among acute care hospitals (now owning about 13% of such facilities), as well as outpatient surgical centres, home care agencies and even hospices. Canada has lagged behind the United States, but by increments the private delivery of publically funded services increases. The for-profit barbarians are at the gates.²

Alberta is certainly at the forefront of this. Efforts by government to get private hospitals accredited to deliver publicly funded long-stay surgeries has been to the legislature twice in Bill 37. Private cataract surgeries were already being contracted out from the public system. That was expanded to include new orthopaedic day surgeries when the Health Resources Group was accredited by the Alberta College of Physicians and Surgeons in 1997 to conduct day surgeries.

One of the prodigal clinics, the Health Resources Centre in Calgary, declared bankruptcy in late April 2010. It operates in a decommissioned hospital, origi-

² Belsen K. Executive pay: a special report: learning how to talk about salary in Japan. *New York Times* 2002 Apr 7;12. as quoted in Woodlander, Steffie, and David U. Himmelstein, 2004, The high cost of for-profit care, *Canadian Medical Association Journal* , 170(12):1503.

nally the Salvation Army Grace Hospital, one of three Calgary hospitals closed by the provincial government in the mid-'90s. The Alberta government intervened in the bankruptcy and has had to commit significant funds to protect patients and prepared contingency plans. As the public debate unfolds, there is significant pressure on the government to take over the facility and once again run it as a public hospital.³

The Grace Hospital is a clear example of the direction the Alberta government has chosen to take in health care. The government refused to pay for not-for-profit surgeries at the Grace and shut it down but willingly supported paying for for-profit operations at the same facility.

The same drive to support for-profit expansion has been seen in long-term care, assisted living and continuing care.

FOR PROFIT DELIVERY DOES NOT DELIVER

Numerous academic studies have found that quality of health services and cost are different in for-profit versus not-for-profit settings. The findings include:

- i. lower quality and worse outcomes,
- ii. higher costs, and
- iii. worse working conditions for staff.

i. LOWER QUALITY AND WORSE OUTCOMES

A number of academic studies have shown that care in for-profit institutions is often lower in quality than in

³ See for example, Bill Graveland, Alberta Health seeking bankruptcy protection for private hospital, Canadian Press May 1, 2010.

not-for-profit institutions, and that the health outcomes of patients treated in market-oriented enterprises are inferior. Findings include higher death rates in private hospitals and dialysis clinics, more quality deficiencies and less nursing care in nursing homes, and less care to the dying in hospices.⁴

P.J. Devereaux's meta-analysis of studies comparing for-profit and not-for-profit mortality rates in US hospitals found that investor-owned hospitals were associated with ~5% more deaths and ~20% higher costs. The investigators concluded that "Evidence strongly supports a policy of not-for-profit health care delivery at the hospital level."⁵ The same study reported that meta-analysis evaluating for-profit and non-profit haemodialysis clinics in the US found that for-profit clinics were associated with 1200 to 1400 "excess deaths" per year.

ii. FOR-PROFIT COSTS MORE

A meta-analysis of 38 studies concluded that the weight of evidence shows that Canada's single-payer system, which has much less for-profit-involvement than the US, achieves health outcomes that are at least equal to, and in many cases better than those in the United States at two-thirds the cost.⁶ Another study finds that investor-owned hospitals spend much less on nursing care than not-for-profit hospitals, and their

⁴ Devereaux, P.J. et al, 2004. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta analysis, *Canadian Medical Association Journal* 170(11):1503. Also see Vikram R Comondore et al, 2009, Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis, *British Medical Journal*, 339:b2732. See also research by Neil R. Powe et al, 20009, summarized in For-profit dialysis facilities have higher mortality rates and lower transplant referral rates than not-for-profit facilities, *New England Journal of Medicine and John Hopkins*, 11:59. Also see Woodlander and Himmelstein op cit.

⁵ Devereaux, 2004.

⁶ Guyatt, G. Devereaux, PJ, Lexchin, et.al. 2007, A systematic review of studies comparing health outcomes in Canada and the United States, *Open Medicine*, Vol 1, No 1.

administrative costs are six percentage points higher.⁷ The same study finds that they also have higher CEO salaries.

iii. INFERIOR PAY AND WORKING CONDITIONS

People employed in for-profit health companies have inferior working conditions and usually lower wages, and their employers often do not invest in further education of the workforce. In not-for-profit facilities, particularly those with elected community boards, employees often have a voice in governance matters, a feature that is not characteristic of the for-profit sector. But the community also has less of a voice in for-profit companies than in publicly-funded facilities and there is less transparency and accountability in for-profit entities. Pay scales are relatively flat in government and not-for-profit health institutions; pay differences between the CEO and a housekeeper are perhaps 20:1. In US corporations, a ratio of 180:1 is average.⁸ In effect, privatization takes money from the pockets of low-wage, mostly female health workers and gives it to investors and highly paid managers.

The *Alberta Health Act* aims to entrench and expand the role of private and for-profit providers in Canada's health care system. Given that this results in higher costs and worse health outcomes, it is a serious concern and the Act as currently envisioned and framed should not proceed.

DEREGULATION OF FOR-PROFIT DELIVERY IS DANGEROUS

Stripping the government of its role as direct regulator

of private surgeries is extremely risky. The AHS has yet to prove its worth even as a contractor and administrator of health care service, and has been mired in controversy since its inception. The board is made up of business representatives, not health care professionals, and is not directly accountable to the public.

SUMMARY

The initiative is clearly aimed at expanding and entrenching the role of for-profit delivery in the health system. It aims to reduce regulation and oversight of that sector and open the public sector to increased direct competition, in effect stripping the government of its role as regulator. For-profit involvement in health care has been associated in academic studies with lower quality, poorer outcomes, higher costs and worse wages and working conditions. There are significant problems with the current delivery system and the structure of the CHA, but the initiative as proposed does not address those concerns and threatens to make the situation worse. These concerns and possible solutions will be discussed in the second report in this series.

RECOMMENDATION:

The Alberta Health Act as proposed should not proceed as it does not solve problems related to the delivery of health care and will likely exacerbate them by significantly expanding the role of for-profit providers. The Alberta Health Services Board should be collapsed into Alberta Health and Wellness and all health care directly overseen directly by the ministry with full accountability and transparency. Regulation of for-profit providers should not be reduced but increased with full accountability and transparency for outcomes and costs.

⁷ Woolhandler S, Himmelstein DU. 1997, Costs of care and administration at for-profit and other hospitals in the United States. *N Engl J Med*; 336:769-74.

⁸ Woodlander and Himmelstein, 2004.

III. Risks Associated with the Merging of the Acts

One of the key priorities identified for the new *Alberta Health Act* is to make definitions standard across health care legislation in Alberta by merging a number of the acts and standardizing definitions. This includes the *Nursing Homes Act* and the *Hospitals Act*. Protections in the *Nursing Home Act* include ratios for nursing staff, as well as a variety of other regulations protecting quality or care. The *Hospitals Act* is the main act that applies the *Canada Health Act* provisions within the province.

The proposed legislative reform raises concerns for a number of reasons. There are huge differences across the acts and the standardization may lead to the lowest common denominator. It also may be used to get rid of wording that limits for-profit involvement, protects the public sector, or dictates higher quality standards such as nursing ratios.

SOME ACTS ARE IN THE PUBLIC HEALTH SYSTEM, OTHERS ARE NOT

The desire by government to merge those acts and standardize definitions is risky in that definitions such as insured services may be narrower for those acts outside the system. Also different acts evolved because of the unique nature of different aspects of the health system. It may not be efficient to simply merge them.

The report starts off with very negative assumptions regarding the current legislative framework including the following statement:

Alberta needs clarity of purpose and direction for the health system. We currently have 30 separate pieces of legislation and 100 regulations to guide the health system. This complex and cumbersome framework does little to support efforts to find the most effective solutions to issues around health service delivery and improving health outcomes. It

encourages inefficiencies. It hinders ready access to care from the most appropriate provider as close to home as possible. It leads to confusion around roles and accountabilities across the system, thereby undermining transparency and trust. Its complexity can get in the way of ensuring skills are used appropriately and that Alberta derives the maximum value from its health expenditures in terms of both time and money.

What hinders ready access to care close to home is not the legislation, but the lack of funding to public services in communities and the lack of adequate long-term care infrastructure in the province. The acts and regulations have evolved to protect patients and the public health system. There is no indication that the merging would maintain the highest standards and in fact every indication to the contrary.

WHAT WILL NOT BE IN THE HEALTH CARE ACT

The repeated commitments by the AHS and Advisory Committee that the new *Health Care Act* will comply with the *Canada Health Act* is hardly reassuring. The CHA is a bare minimum and is weak in many areas (see section II). Also, Alberta's legislation already exceeds that CHA in important areas. These include limits on the evolution of a parallel private system through bans on doctors working in both systems, usually termed "double-dipping," and preventing private insurance plans from covering items covered by the public plan. There are no commitments anywhere in the Foundation document or AHS submission that these additional protections for universal public health care would not vanish.

IV. Patient Charter: Charter of Rights vs. Bill of Rights

The most well-known Canadian charter is the *Canadian Charter of Rights and Freedoms*. The basic concept of a charter is that it trumps laws and is enforced by the courts. Any law that a government passes that is contrary to the *Charter* is null and void. The history of charters goes back to the Magna Carta, which limited the power of the king in favour of the aristocracy.

Charters are about limiting the power of the government to legislate. The Alberta government is not about to do that. Precedents show that it will not allow that form of charter. What the government is talking about is not a charter but a bill of rights.

Prior to the *Canadian Charter of Rights*, we had a bill of rights. The bill was found to be limited in scope, was easily amendable by Parliament, and it had no application to provincial laws.

Many other jurisdictions have experimented with patient bills of rights, while many private facilities use them to articulate standards of care and living conditions. A number of other provinces have some form of patient bill of rights. Ontario has a bill of rights for patients as does Quebec. In Nova Scotia, the provincial government originally tasked the Provincial Health Council with developing a patient's bill of rights, how-

ever, the council produced a set of "Expectations for Health and Health Care in Nova Scotia" after concluding that a legislated patients' rights document "would pose innumerable legal problems that might take decades to resolve through the courts."⁹

The risks associated with the patient charter/bill of rights will depend very much on the final document. Most likely, the charter will be broadly worded and not will mostly restate rights that are not already protected under common law, such as those to respect, dignity and privacy. As it is written in the survey, the patient charter includes nothing related to how those rights would be exercised other than the right to receive a timely response. It does not include designation of a specific ombudsperson or expanding the role of the Alberta ombudsperson to address those rights. Without that, the patient bill of rights will most likely be a series of aspirational statements that is basically paper on the wall.

⁹ Nova Scotia, Provincial Health Council, "Expectations for Health and Health Care in Nova Scotia," 18 May 2000.

RISKS ASSOCIATED WITH THE HEALTH CARE PATIENT BILL OF RIGHTS

There are three key areas where risks arise with the patient bill of rights: the inclusion of rights to timely access to care; the inclusion of responsibilities, and the lack of an enforcement mechanism.

There are some general concerns with patient charters/bills of rights. First, it can set a collision course between patients exercising individual rights and the broader system. Where the broader system prioritises priority based on need, the patient rights may conflict. Also, they may come into conflict with the necessary allocation of limited resources. There is a risk that it might increase the adversarial climate within health care and increase conflict for health care staff and professionals. In the UK, Health Secretary Frank Dobson publicly stated that the patient charter increased violent attacks on front line staff and front line health workers found it increased conflict and made it more difficult to make decisions. That bill of rights was later revoked.¹⁰

i. RIGHTS TO TIMELINESS AND ACCESS

It is possible that new rights may be created related to timeliness of care, or the right to certain type of treatment within a certain time. The use of the term in the patient charter survey for both timeliness and access is disconcerting, as it is not clear how that would be defined or by whom that would be determined.

Opinions on patient rights with relation to wait times is mixed. University of Toronto health lawyer and

10 Health patient's charter blamed for attacks on NHS staff, BBC News, Wednesday, October 28, 1998. <http://news.bbc.co.uk/2/hi/health/202942.stm>.

author Colleen Flood advocates inclusion of wait time guarantees in a patient bill of rights as a mechanism for improving accountability and outcomes on wait times.¹¹

However, the inclusion of timeliness and access guarantees may increase risks of the charter being used as a vehicle for opening the door to more privatization. The Chaoulli case in Quebec reveals that wait time guarantees can be used to expand the role of for-profit providers in Canada.¹² This would depend very much on how those rights were articulated in the patient bill of rights. Likely the charter would not be determinative, but could be brought in as evidence in a Chaoulli style case.

Quebec's charter includes timeliness and access provisions, but those are limited specifically to within the public system and by caveats related to the limits of the public system. Quebec's charter ties health and social services entitlements directly to structural and economic constraints. Accordingly, the entitlement to health services and to choose one's health care professional and institution must be exercised within the framework of the legislative and regulatory provisions relating to the organizational and operational structure of the institution and within the human, material and financial resources available to the institution.¹³

This may make it less risky to include such rights in the charter, though it begs the question of its usefulness.

ii. RESPONSIBILITIES

The patient charter portion of the province's survey includes a section on patient responsibilities. It is clear

11 Colleen Flood and Tracey Epps, 2004, *Waiting for health care: What role for a patient bill of rights*, *McGill Law Journal*, 49: 3, p515-555.

12 Flood et al, 2005, *Access To Care Access to Justice*, University of Toronto Press, Toronto.

13 Margaret Smith, 2002, *Patient bill of rights - a comparative overview*, Government of Canada, PRB 01-31E.

that the intention of the charter is to include both rights and responsibilities, including:

- Learn how to better access health services
- Use services appropriately and wisely
- Make healthy choices, where I can
- Ask questions, follow instructions and understand my care plan
- Treat other patients and health providers with respect

The Foundation document and AHS submission also place strong emphasis on personal responsibility. The Foundation document states, *“Albertans must embrace their roles and responsibility.”* While the AHS goal is stated as, *“People have access to personal information that enables them to take more responsibility for their own care”¹⁴* and *“enabling people to take responsibility for their own health.”*

Emphasizing patient responsibility for health can lead to system biases against people with unhealthy habits such as smoking, poor diet or lack of exercise. This emphasis on individual responsibility shifts responsibility from doctors and the government to individuals. It is a downloading of responsibility to individuals, and a significant move away from universality.

The healthy choices obligation opens up the possibility of priority and access being impacted by choices made by individuals such as smoking or obesity. For example, it had been proposed previously in a bill that AHS could recover health care costs from criminals who were committing crimes at the time of their injury. This indicates that the door is open too allocating health care resources based on lifestyle decisions made by the patient. That is a slippery slope.

14 Duckett, Dr. Stephen, *AHS Recommendations for Legislative reform*, Presentation to the Minister’s Advisory Committee on Health, October 2009, p.17.

Healthy choices and problems such as obesity, smoking or lack of exercise are social problems, not individual problems. They are problems of poor public policy and lack of government commitment to health promotion. These are public policy issues that should be dealt with through public programs and policy initiatives such as smoking and fast food bans and public health programs rather than penalizing individuals.

iii. WHISTLEBLOWER PROTECTIONS

In other jurisdictions, discussions of patient charters have included whistleblower protection for health care providers. This would be a great addition to the protections under the act, but is not at all being considered in the current proposal. Gag orders on nurses and other health professionals are, in fact, counter to the government’s professed goals and rhetoric on creativity and innovation as well as accountability and transparency.

iv. ENFORCEMENT MECHANISM

It is unclear what the mechanism will be, if any, for exercising patient rights. Most likely there will not be rights that can be exercised, which are also called substantive rights, but simply rhetorical devices which will serve to increase adversarial temperature in the system. For the most part there would be other grounds of recourse, as currently exist. For example, the courts can offer recourse for cases of inequitable treatment and the Supreme Court has made decisions on rights to confidentiality, or access based on language.

In the UK the charter did not impact on litigation, but did increase the number of complaints. Though it did not increase the actual rights, by codifying those rights more people asserted them more often.

Canadian examples include mechanisms for exercising patient rights. The Quebec act includes a

two-tier regime. At the first tier, local service quality commissioners and regional service quality commissioners examine complaints in relation to services and activities coming under their respective authorities. At the second tier, the Health Services Ombudsman hears appeals from complainants who are dissatisfied with decisions at the quality commissioner level. The act also gives the Health Services Ombudsman the power to intervene in circumstances where there are reasonable grounds to believe that a person or group of persons has been or may likely be adversely affected by an act or omission of an institution or a regional board.¹⁵

ALBERTA'S OMBUDSMAN

Alberta has an ombudsman responsible for complaints regarding their treatment by government authorities, including health authorities. The mandate of the ombudsman's office is very limited as it deals only with administrative fairness, not the merits of individual complaints. The ombudsman can only make a determination of the administrative fairness of the complaints process and recommend a case be re-examined and processes be changed.

SUMMARY

At best the patient charter is a public relations exercise for the AHS, which is currently plagued by mistrust, and at worst it is a mechanism for increasing the strength of private for-profit deliverers. As proposed, it transfers responsibility away from public policy and doctors onto patients. It opens the door for differential treatment of patients based on health such as smoking and obesity. The inclusion of timeliness guarantees is risky and may open the door to a Chaoulli-style lawsuit. For the most part, it would repackage rights that a patient already has, but it will likely not include meaningful enforcement, making it meaningless.

Alberta does not need a charter, it needs to raise awareness for patients of their rights which already exist, and expand the role of the ombudsperson and Health Quality Council to ensure access and quality.

RECOMMENDATION:

The patient charter should not proceed as proposed in the survey. Alberta should not proceed with a patient bill of rights. If that bill proceeds, the responsibilities section should be removed in its entirety, timeliness guarantees should be limited strictly to the public system and include caveats relating to the limits of that system, and an effective stand alone enforcement mechanism for resolving complaints should be created. The bill should include effective and substantive protection of whistleblowers in the health system.

¹⁵ Government of Canada op cit.

V. Good Ideas in the Foundation Document

Mandating a body of experts to review and decide on services and technologies to include within the public system on the basis of the best evidence is positive. However, it is not clear that there is a need for a new body to do this. Questions include: is there an existing agency that could take on this role? How would the body be constituted? How would it be accountable? What would its mandate be? The second phase of this project will explore those alternatives in more detail.

INCREASE ACCOUNTABILITY FOR QUALITY

Certainly a positive goal. However, this could easily be done through increasing the transmission of information of the Quality Council and expanding and strengthening the existing complaints and patient-driven processes, including the ombudsperson.

PATIENT-CENTRED

Involving patients more in their health care decisions and ensuring they are better informed about their options is positive. Numerous reports and studies exist outlining the different ways this can be done,

including providing increased information and decision support to patients.¹⁶ However, this cannot be done without increasing costs and time allowances for health care staff. Otherwise it can lead to patients just being handed copies of complex tests result reports they cannot read and which are a waste of paper.

Making the system patient- and family-centred means more than that, however. It also means implementing policies that put patients at the centre. Making health care in Alberta truly patient-centered means asking, “Is this good for patients?” in relation to any health reform. Making the system patient-centred also means using the best evidence available. The government has failed to do this. For example, best evidence shows that private for-profit clinics take doctors and other health professionals out of the public system and increase wait times in the public system. Thus, patients are best served by eliminating the for-profit clinics altogether. Patient-centred means policies preferring patients to owners/investors.

¹⁶ Saskatchewan Health Quality Council, Shared decision making: Helping the system and patients make quality health care decisions. <http://www.hqc.sk.ca/download.jsp?u0stky0toeVpTSydwUWU7jBlzBf0QLkUwK4QBZaJu3JVVaQmdGhw==>

EMPHASIS ON WELLNESS AND SOCIAL DETERMINANTS OF HEALTH

The rhetoric in the Foundation document on the social determinants of health is strong, However, it is hard not to be cynical when government policy is moving the absolute opposite direction. The biggest barrier to progress on wellness and social determinants of health is the disconnect between different ministries. A stand-alone, independent body that reports across ministries on the health impacts of social policy decisions would be a great mechanism for breaking down silos and improving articulation of policies around health and wellness. Such a mechanism is not being considered in the current AHA initiative.

VI. Conclusions and Recommendations

This report identifies risks associated with the new *Alberta Health Act* initiative in a number of key areas:

- **Privatization of delivery:** It is clear that expanding for-profit involvement in Alberta's health care system is a driving force behind the initiative. It is also clear that there is significant risk that the initiative will be used to strip AHW of its regulatory functions and increase competition with the public sector.
- **Merging the acts:** Standardization to the lowest common denominator and loss of protections that prevent doctors from working on both sides.
- **Patient charter:** Shifting responsibility onto individuals and opening the door to a Chaoulli style lawsuit.

This report has shown that academic studies clearly find that for-profit health care delivers inferior health care services at higher costs. These are significant areas of concern and make it advisable to oppose this act in its entirety unless it is significantly rewritten to limit for-profit involvement and strengthen the public health system.

Considerable resources are required to create a new *Alberta Health Act* and important risks are associated with that act. Given that there is no clear benefit, it really begs the question, "Why change the legislative framework?" Everything the government claims to

want to achieve can be done under the current legislation. The legislation should only be changed if it is a real initiative to strengthen the public health system and better integrate the community sector within it, and to put a limit on any further for-profit delivery.

The second report in this series by the Parkland Institute outlines how the *Alberta Health Act* could be used as a vehicle for real change towards improving quality, access and affordability through strengthening the public system. It addresses mechanisms for placing limits on any further involvement by for-profit providers, it explores options for better incorporating community health delivery within the public system, mechanisms for improving the determinations of what is to be included and what is not under the public system, and models for controlling the cost of pharmaceuticals.

