**IN THE MATTER OF THE HEALTH QUALITY COUNCIL OF ALBERTA ACT,**
**S.A. 2011C H-7.2 (THE ACT);**
**AND IN THE MATTER OF A PUBLIC INQUIRY CONCERNING THE POSSIBILITY OF IMPROPER PREFERENTIAL ACCESS BEING GIVEN TO PUBLICALY FUNDED HEALTH SERVICES IN ACCORDANCE WITH S. 17 OF THE ACT**

# Written Submissions of the Consumers' Association of Alberta (the Association) to the Alberta Health Services Preferential Access Inquiry

March 28, 2013

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**INTRODUCTION**

These are the Closing Submissions of the Consumers' Association of Alberta (the Association) to the Health Services Preferential Access Inquiry (the Inquiry) constituted by Order in Council 80, 2012 dated February 28, 2012. The terms of reference of this Inquiry are twofold:

1. To answer whether improper preferential access to publicly funded health services in Alberta is occurring, and

2. If there is evidence of improper preferential access to publicly funded health services occurring, to then make recommendations to prevent such improper access in the future.

Although this Inquiry was intended to examine allegations of improper preferential access, there was evidence heard that there are concerns about barriers to access to publicly funded health services that are equal to if not more deserving of examination and recommendations. Some examples of groups who may experience barriers include:

- Rural populations (Rimbey Renal Dialysis submission),
- Individuals without family doctors, particularly those with complex medical issues,
- citizens with addictions and/or mental health issues,
- the elderly,
- the individual whose first language is not English,
- those with hearing or vision loss and those with mobility issues.

The issue of preferential access to publicly funded health services is but one issue plaguing health care in Alberta and in Canada today. With the reduction in hospital capacity, patients and their families increasingly have to arrange and pay for services that were once provided in a hospital setting. The delisting of services or the scope of services such as recuperation and rehabilitation has further added to the challenge of access to what were formerly publicly covered services. Patients or their families now face considerable barriers because of the difficulties of finding and having to pay out of pocket if they don't have a private or employer insurance plan. There are concerns about resource and workforce allocation, quality and safety, and what services are covered under the public system.

The evidence presented at the Inquiry was about decision making, relationships and use of discretion. It was imagined at the outset that we might hear about situations of patients being moved up in the queues that exist for some diagnostics or treatment as a result of threats or intimidation by politicians or leaders in health care organizations. The Inquiry was dubbed the 'queue jumping inquiry.' Many health care services, however, don't have access through organized queues. Thousands of decisions about resource

allocations are made every day that directly or indirectly impact a person's heath, financial situation, and quality of life. The majority of these decisions, including those related to who should get a service and what kind, are made without transparency, accountability or known recourse or appeal. This Inquiry has made the invisible visible in a number of areas of the health care system. It is hoped that what is learned from this Inquiry about decision making and discretion in relation to preferential access will be considered and applied more broadly to ensure access to health care is fair, ethical and appropriate throughout the health care system.

## THE CONSUMERS ASSOCIATION OF ALBERTA

Founded in 1947 and incorporated as a non-profit society in Alberta in 1978, the mandate of the Consumers' Association of Canada (Alberta) is to improve the quality of life and standard of living for Albertans by protecting and promoting consumer rights and vital interests in relation to health and safety, access to information and justice, and fair dealing. Our focus in health care matters is from both an individual patient and broad public interest or a societal perspective. This sets us apart from many other interests such health professionals, business and research interests, public and private insurers, regulators and disease specific lobby groups.

There is no single expense that can devastate a family more than the cost of medical care and the loss of family income that often accompanies illness. The availability, cost, and quality of care have a powerful influence on the safety and financial security of individuals and the society in which they live. The inability to obtain necessary care can lead to suffering, disability or death.

Changes in the landscape of health care in Alberta and across Canada, and how these changes affect fair and appropriate access to essential health care services, has been a priority for our organization for decades.

Much of our work in health care has focused on collecting and presenting evidence of otherwise unseen effects on patients, families and society at large. We have undertaken investigative reports on health care cost and access issues in Alberta including; Taking Stock (1995), The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mineshaft (2000) and Eldercare on the Auction Block (2002).[1] We have also done work on the safety and benefits and harms of pharmaceuticals and procedures involving medical devices, and private health insurance options.

Our experience has clearly demonstrated that the perspectives of patients and families who use, rely on and pay for health care services often differs from those working in the

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1 Available at

health care realm. The voices of patients and their families are far too frequently overlooked or dismissed.

## PUBLIC VOICE IN THE INQUIRY

In October 2012, we learned that the only organizations applying for Intervener Status in the Inquiry were the Alberta Government, the Alberta Medical Association and Alberta Health Services. We felt it was essential that an organization with a patient and public interest voice be "at the table" to fully participate in the Inquiry process.

We applied for standing and funding to support our participation and were granted both by the Commissioner, Judge J. Vertes. We'd like to express our deep appreciation to the Commissioner, the Government of Alberta (for providing the option of intervener funding in its Order in Council) and the people of Alberta who have ultimately funded our participation.

Over the course of the Inquiry, we have worked with our legal counsel to research, identify and draw out the evidence and implications for Albertans from the testimony of witnesses and documentary evidence. We have encouraged the public to tell or send their stories to the Inquiry, suggested witnesses, and provided the Inquiry counsel with leads and suggested lines of questioning. We have also attended and participated in cross examination of witnesses at all the scheduled hearing sessions.

One of the challenges of the Inquiry was to attract individual patients who have experience or knowledge of preferential access, and organizations advocating for special populations, with the exception of the Rimbey Dialysis Group who was provided funding to assist in preparation of a submission. There were many reasons for this, including the reluctance of individuals to put themselves at risk of public exposure, alienating a provider or jeopardizing access to future care. It is also difficult for individuals or advocacy groups and organizations to obtain the necessary level of evidence despite anecdotal information that would support or prove their experiences. The Association's experience is that information has been difficult to obtain on what decisions are being made, where they are being made, who is making them, and why they are being made.

## THE LEGAL FRAMEWORK OF HEALTH CARE

The Association would like to provide some additional insights and comments in relation to the legal framework provided by the Inquiry Counsel.

*"Health care insurance plans are only an important part of the healthcare system, but they are not the health care system."*[2]

2 p. 25 (lines 7-10) Lahey

- Dr. Lahey pointed out that his presentation only focused on the *Canada Health Act* (CHA) and Alberta legislation relevant to "insured services" under the *Act*.

- Many publicly funded health services such as vaccine campaigns and provincial mental hospitals or long term care are not "insured services" under the *Canada Health Act*.[3] The Canadian (and Alberta) health care system is actually a mixture of public and privately funded components. Canadians rely more on out-of-pocket expenditures and private insurance to pay for health care than do citizens in many comparable OECD countries.[4]

- There are other legislative frameworks governing the delivery (rather than the financing) of health care services. These other frameworks can and do influence the accessibility of publicly insured services, such as frameworks relating to the safety of health care products, services and settings.

*Canada Health Act Objectives*

Under the universality criterion, 100% of the residents of a province must be covered under uniform terms and conditions. The intent of the phrase "uniform terms and conditions", unlike private health insurance, is that provincial health insurance plans for CHA defined hospital and medical services cannot take into account things like age, sex, health status, occupation, or whether or not someone is employed.[5] It would seem that provincial health insurance plans cannot discriminate based on personal habits or lifestyle as do private insurance plans.

The uniform terms and conditions phrase in the Act puts into question current examples and hypothetical situations raised by two physicians on the Inquiry's expert panels that it may be reasonable to refuse services or access based on factors such as being overweight or smoking.[6]

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3 As Ms. Whitnack, Mr. Saunders, Mr. Mason, Dr. Sherman, Prof. Lahey and others have pointed out, most of the health care services (medications, long term care, home care, etc) that have become increasingly important are either not publicly funded or funded under very different terms and conditions than CHA services.

4 See Organization for Economic Co-operation and Development, Metadata on Health Systems,

5 p. 34, Lahey

6 p.3398, Heisler, p.3403-3404 Alter

*Insured Services*

The comprehensiveness criterion in the CHA requires that provinces cover "all insured services" rendered by hospitals and medical practitioners and describes hospital services in some detail. [7] For fullness of understanding the list of defined hospital services are inserted below.

Insured hospital services are "any of the following services provided to inpatients or outpatients at a hospital if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an illness, injury or disability, namely:

a) accommodation and meals at the standard or public ward level & preferred accommodation if medically required,
b) nursing services,
c) laboratory, radiological and other diagnostic procedures, together with necessary interpretation,
d) drugs, biologicals and related preparations when administered in the hospital,
e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
f) medical and surgical equipment and supplies,
g) use of radiotherapy facilities,
h) use of physiotherapy facilities, and
i) services provided by persons who receive remuneration therefore from the hospital,

but does not include services that are excluded by the regulations."

As some of these services have been moved out of purview of full public funding, private businesses have developed to offer these services. While some public funding may still be available, many of these programs/services are income or means tested, have deductibles and co-pays or are purchased out of pocket. There has also been a growth in the types of employer based programs that purchase these services in order to reduce their rising benefit costs.

*The Alberta Health Care Protection Act*

The *Alberta Health Care Protection Act* includes a prohibition on queue jumping in relation to publically insured surgical procedures. The Inquiry has shown that this section is not widely known despite it being created in 2000 in response to some eye surgery clinics and surgeons offering expedited cataract surgery based on the purchase of enhanced medical services.[8]

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7 p. 37, Lahey

8 Reference to the *AHCP* and this clause as a means of addressing preferential access was notably absent from the evidence of providers, politicians, and government representatives.

## ANALYSIS OF THE EVIDENCE

For the most part the Association accepts the extensive review of the evidence provided by the Inquiry Counsel between pages 19 and 70 in their submission; however, we would like to provide some additional commentary to expand or clarify. Although it is ultimately the role of the Commissioner to determine definitions of proper and improper preferential access, the Association would like to suggest some criteria that came out of the evidence and submit it might be applied to assist him in his work.

These criteria include such things as the purpose and intended outcomes of the decisions and an assessment of harm, the latter being a particular feature of improper preferential access. As discussed by the experts, harm is not a defined term but should be broadly defined so as to reflect the impact on the multiple stakeholders who may be affected. It would be our submission that the following aspects arising directly or indirectly from the evidence should be considered in assessment of harm:

- possible violations of provincial obligations in relation to the *Canada Health Act*
- increased financial burdens for the sick and ill and their families;
- evidence of unfairness in access to scarce resources or services;
- loss of confidence in the public health care system;
- psychological, physical, economic, legal, social impact on patients;[9]
- damage to the integrity of the public health care system;
- inappropriate demand based on marketing of unneeded or potentially harmful tests and treatments increasing demands on publicly funded services;
- moral distress of staff as a result of pressure to deviate from normal operating procedures[10]
- inflationary pressure on the price of essential health care services;
- increased and unmanaged conflicts of interests;
- decreased trust in providers, funders and each other.

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9 Written submission of CPSA, dated March 28, 2013.

10 Counsel Inquiry submission, Execs on call, p.31-35

Dr. Alter stated that there is little evidence of actual harm to an individual in terms of negative health outcomes arising from preferential access. The Association submits that there is evidence of harm to health and related determinants of health available, however it is more readily found in the social sciences literature.[11] It is also found in Dr. Mohtadi's recent health policy research on wide ranging effects of unreasonable delays in diagnosis of those with acute knee injuries and the work of many others. It is important not to discount what is not seen. If you don't "hear the splash," it's hard to know someone has fallen overboard.

In applying the above criteria to the examples which came before the Inquiry we found it helpful to conceptualize not two separate and distinct categories of proper and improper preferential access. Instead we found that the assessment of situations we heard about were very contextual in nature and the simplest of changes in the facts changed how we viewed the situation. Therefore, we adopted the use of a continuum of preferential access ranging from proper to improper. We found there were some situations that were on the border between proper and improper because of being so fact dependent that we included a zone with shades of grey.

The proper end of the continuum is characterized as being related to prioritization based on the concept of medical need. At the extreme end of proper preferential access, these are thoughtful and deliberate attempts to ensure fairness in the use of scarce resources. Examples of this kind of prioritization would be the triage processes in the CACS screening, emergency departments, and certain surgeries that we heard about through a variety of witnesses.

As we move along the continuum, we also felt that some decisions are made by individuals in their everyday roles about how resources are used and are pragmatic decisions based on the information at hand at the moment. They may be applications of common sense, a sense of necessity out of expediency or to use an advantage or an opportunity. Generally these decisions are made with good intentions and any harmful impacts are minimal.

Further along the continuum is a category tolerated preferential access. There are some programs in existence that were mentioned but not explored in the course of this Inquiry. Whether these are proper or improper preferential access, it could only be determined through a full examination of their operations which was not the subject of the Inquiry.[12]

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11 Such as the loss of income or job related to illness/injury, informal caregiving demands and/or social exclusion related to health condition affecting the ability to maintain health and manage health conditions, recognized in Dr. Heisler's description of the Western Canada Waiting List recommendations for prioritization of cataract surgery.

12 Over the past two decades there has been a surge of disability and absentee management companies (unrelated to injuries on the job), disability insurers and provincial motor vehicle insurance schemes that operate on the same model as the WCB in relation to arranging expedited care under the radar of the public and authorities. Even less is known about these companies/insurers and their interaction with publicly-funded services.

In this category, we would include CHA exempted programs such as Workers' Compensation Boards (WCBs), along with First Nations care, Armed Forces, Veterans Affairs and RCMP.[13]

This category may also include some research projects that single out certain populations for expedited or preferential access to treatment, of the kind we heard about in Dr. Mohtadi's evidence – i.e. that the availability of a particular surgical procedure in any given year can be influenced by his participation in a particular clinical trial,[14] and it was also a driver in the establishment of the Colon Cancer Surveillance Centre (the CCSC).[15] These situations would claim that they advance the care of certain groups of people ahead of others for purposes of learning to support the greater public good, and demonstrate the tension between the allocation of finite resources for medical research interests and improved access to clinical care.

We would place a grey zone between the proper and improper which includes issues that are controversial and context dependent. These issues need further consideration and on examination could tip either into proper or improper. Examples include:

- Private patient paths in Emergency Departments;
- Practice focus on a narrow population (e.g. sports injuries) to the exclusion of others who may need similar services reflecting an unexamined bias that could be harmful

The Association would like to apply some of these considerations to the evidence following the structure as set out in the Inquiry Counsel's submission.

1. **VIP's and Their Treatment**

Although the evidence with respect to these occurrences heard in the Inquiry are somewhat dated the Association would submit that where is evidence of interference in care amongst patients directed by someone of authority such as in bed assignment, particularly where there is a negative impact on the staff, would in the Association's view be in the range of improper.[16] The evidence of the expectations created by the calls resulted in confusion and stress for the health care providers.[17] Furthermore, it had the

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13 It should be noted that WCB health expenditures are classed as public expenditures by CIHI.

14 p. 1333, Mohtadi

15 p. 2051 Rostom, 2796, Bridges

16 p.1005 – 1011, Juric

17 p.105-111, Juric, p.875-876 , Sherman, p.900-901 + Exhibit 25, Holyrod & Park, p.1256, Janice Stewart

potential of setting a tone and standard of exception to the general rules in the culture. Covenant expended significant energy and time into creating extensive policies to ward off the impact of the practice of Capital Health on the Covenant culture.[18]

We agree with Inquiry Counsel regarding the potential breach of patient privacy of health care as another factor to be considered in these situations.

It is the Association's submission that MLAs play an important and legitimate role in advocacy for patients, families and groups particularly with respect to navigating the health care system, and identifying needed changes. Based on the evidence heard, the Association would submit this would be considered appropriate advocacy.

2. **Professional Courtesy**

It is important to separate out the concept of physician advocacy from professional courtesy. There was significant evidence of the need to 'make the case' for patients to get them access or to get them proper access based on their medical need. The proviso is that advocacy should not be influenced by personal or business interests. For the most part physician advocacy is a welcomed and necessary activity and would fall in the proper end of the continuum.

However, there was evidence, albeit somewhat dated, of where caution needs to be taken related to where physician advocacy/professional courtesy (influence of connection) can go further than what may be accepted or tolerated e.g. the Findlay case. This case was where the standardized referral form indicated 'right hip pain' but as a result of a telephone call between her father and a radiologist, the patient was moved up in priority as her father, in adding to the information on the form, "made the case" for her being handled as an urgent referral that was then slotted in for an MRI within mere hours of the referral by her father.[19]

Clearly public perception as evidenced by letters to MLA's and the Minister and media coverage disclose that this was considered a situation of improper preferential access and therefore may impact the confidence the public has in the health care system and providers. It is interesting to note that preferential access on these facts was not perceived, characterized or addressed in the subsequent investigations by both the College[20] and Alberta Health Services. Dr. Findlay justified this situation on the basis of it being a pragmatic decision given there was time in the radiology department not being used and she was available. It is the Association's submission that she was available

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18 p.683-738 & Exhibits 41 – 51, Self and Covenant, p.22459-2460 (Boswell, Beninger)

19 p.1532-1540, Findlay

20 P. 2322-2326, Theman

however on the basis of the relationship her father had with Dr. Naik through a combination of professional advocacy and professional courtesy.

An additional aspect of this situation is that Dr. Anderson, who investigated on behalf of Alberta Health Services, rationalized the priority put on Ms. Findlay's need, but on factors related to her professional career i.e. professional or 'elite' athlete.[21] Bias by providers on the basis of unsupportable or erroneous assumptions - such as the notion that only athletes will push through the pain of an injury resulting in additional harm - is an issue for many Albertans who struggle to get access and appropriate and timely care.[22] The bias in favour of athletes and weekend warriors[23] must be weighed against the discrimination by factors such as age where both Drs. Anderson and Mohtadi[24] were clear about who they would treat first. Nonetheless, given evidence of the importance of identifying the potential risk of harm for each different individual's circumstances (based on fact rather than assumption)[25], we put this in the grey zone.

3. **Vaccinations**

The critical context of the examples related to vaccinations pertains to the circumstances that this was a national pandemic of a far more serious flu virus than normal with an unexpected interruption in supply. An analysis of the evidence in relation to vaccinations of ordinary flu strains might draw different conclusions.

The Association submits that the situations of nurses using the vaccine H1N1 leftover from the mass inoculation clinics in ways of preventing or minimizing wastage in light of public health principles, the limited shelf life and shortage of supplies of the vaccine which were alluded to but not well outlined in the evidence may fall within the parameters of proper or pragmatic decisions. A similar argument of acceptability of these actions could be made with respect to nursing staff being vaccinated as front line workers in a pandemic.

It is a more difficult determination when individual nurses are attending the mass outlets along with family members through back doors to get past the long line ups. This again needs a balancing of the principles of public health and those of fairness to the public.

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21 p.1402-1437, Anderson

22 p.1425, Anderson

23 p.1423-1429, Anderson

24 p.1361, Mohtadi

25 P. 1439, Anderson, p. 3478-3479, Heisler

Interestingly, the Flames vaccinations during this pandemic were immediately perceived by the public as an example of improper preferential access when the College again did not characterize it as such at all.[26] The analysis of this particular situation should include the context of the pandemic, the number and relationship of the people vaccinated, and the impact on public confidence and trust.

4. **Expedited Treatment of Health Care Professionals**

Expedited access may relate to occupational health and safety requirements (e.g. needle pricks) and may be acceptable as being proper and pragmatic. The evidence is that there has been some attempt to bring the practice of treating health care professionals suffering illness or injury on the job into some protocol. It is hard, however, to imagine justification for off-hours, non-work and non-emergency related situations getting priority.[27]

5. **Expedited Treatment of other Emergency Responders**

While there may be some arguable social utility in getting police and fire fighters back on the job as soon as possible after an injury, any determination made about priority based solely on the type of work would be inappropriate, particularly since they are most often covered by Workers' Compensation Board which provides expedited health care based on their employment. Giving off duty fire fighters preferential treatment would seem to push the limit of appropriateness and in the Association's view would be improper.

The Inquiry heard from a number of witnesses that front line staff would welcome protocols or policy about this kind of professional courtesy to set out the limits of when it becomes improper.[28]

6. **Colonoscopies**

The Association submits that the evidence heard with respect to Helios Health and Wellness (Helios), a public-private executive clinic founded by Dr. Fong, and the Colonoscopy Cancer Screening Centre founded by Dr. Bridges, fall within the "is occurring" criteria of the Inquiry's Terms of Reference. This evidence disclosed many interesting facets, including the complex relationship among the University of Calgary's Faculty of Medicine, the Health Trust, Alberta Health Services (and the former Calgary Health Region) and Helios.

There are many aspects of this evidence that warrant consideration in assessing whether there was preferential access. Some of these aspects include that both Dr. Fong and Dr.

26 P.2331, Theman

27 p.2, Church written submission (expert)

28 ER staff

Bridges have a very strong and long standing relationship and both of their initiatives originated in their work together in research and voluntary sector. It appeared from their evidence that they both operate with some distaste or lack of appreciation of the rules, legislated rules, organizational standards and policies that govern their medical practice.[29] They both explained their good intentions, Dr. Fong for financial support for the University of Calgary Medical School and Dr. Bridges who stated his intention was to help people access the system.[30] Dr. Bridges' positions and stature in the medical community made him beyond approach even when there were concerns identified.

The Association submits that the evidence supports a finding that the decisions to give the Helios's patients and Dr. Bridges personal patients priority over the thousands of people on the waiting list for colonoscopy screening came about because of the relationship between the founding physicians. While for a short period after opening in 2008 there may have been some pragmatic justification, as suggested by Ms. Pontifex, that these referrals were used to fill some openings in the schedule. However, it is the Association's submission this justification cannot possibly be extended to defend this practice continuing over the next four years. At the time that the CCSC was transitioned into Alberta Health Services the policy developed by Dr. Megran of May 10, 2009 was in existence and the practices with respect to Helios and Dr. Bridges's private path patients (the evidence of which is set out well in the Inquiry Counsel's submissions) appear to be breaches of this policy. It is the submission of the Association that there are numerous aspects that make this situation fall squarely in the area of improper preferential access.

## RELATED ISSUES ARISING FROM THE EVIDENCE

The evidence raises a number of issues which may not be within the jurisdiction of this Inquiry but are worthy of mentioning because they have become features of our health care system as it exists today and have for the most part not had much robust discussion.

### 7. Membership-based Concierge Practices and Dual Providers

Although it was unexpected at the outset of the Inquiry there has been considerable evidence related to what are called executive, concierge, or, boutique clinics and prevention or health and wellness centers. These centers offer enhanced access to publicly funded physician services bundled together with a variety of non-insured services such as massage, physiotherapy, dietary consultation, psychological counseling, genetic testing and fitness programs. There is an enrollment fee or yearly membership fee. In his evidence Dr. Fong identified a number of other executive health and wellness centres with medical practices similar to the Helios model.[31]

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29 p.2683-85, Fong

30 p.3023, Bridges

31 p. 2701-2702, Fong

Some of the issues arising from these arrangements include:

- physicians are attracted to practice in these clinics for a variety of reasons. They can spend more time with patients and get compensation beyond what they would get in public practice clinics;

- there is an unmeasured impact in the migration to dual practice as evidenced in the cross examination of Dr. Caine and the letters to the Minister expressing concern with the loss of their family physician;

- there is a concern that these creates a financial barrier for some patients to publicly insured physician services who can't afford to join these centers;

- the promotion and provision of unnecessary screening tests (either public or privately paid) that may result in physical, emotional or financial harm to clients and also create unnecessary demands on publicly financed services;

- the question of double payment for the same services. [32]

8. **Privately Paid MRIs**

We heard in the evidence that patients who privately purchase an MRI may receive expedited or preferential access to publicly paid services or treatments if it identifies a need for follow-up investigations verify the results of the MRI or treat if specific condition is identified.[33] At the same time, Dr. Mohtadi suggested that many MRIs are unnecessary in his line of expertise (knee injuries) and delaying surgery or other treatment alternatives due to lack of timely assessment by other means often creates even greater problems down the line as well as additional costs to patients and the public plan. [34] It also raises questions about:

- Private MRI marketing driving demand on the public system
- Conflict of interest arising in relation to personal financial interests

9. **The impact of competing obligations and multiple streams of income**

One of the most striking features of the testimony before the Inquiry was evidence of a remarkable number of roles and responsibilities that many physicians fulfilled in relation

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32 p.2548- 2559, Caine

33 Heisler and others

34 p. 1304-1305 and 1318, Mohtadi This was reinforced by a recent *Edmonton Journal* article by Elise Stolte: "Researchers find most lower back MRI scans unnecessary", March 25, 2013.

to administration, teaching, research, clinical services, fund-raising, professional commitments and private business interests. [35] This raises a concern about how to assess how many physicians are in full-time equivalencies providing clinical services in the public system.[36], [37]

## CONCLUSIONS

The Health Services Preferential Access Inquiry has managed to accomplish what seemed impossible at its beginning. It has made the invisible visible. The evidence of witnesses has surprised even those organizations that are part of the health care system as well as the public. The Inquiry has uncovered troubling practices, trends and issues in relation to access to health care in some of the least expected places and raises numerous issues to be further explored. It has also uncovered some reassuring practices and dedicated and courageous front line clerks, health professionals and administrators, the public's front line of defense. Without the important information it has uncovered, there would be no opportunity for adjustments.

## RECOMMENDATIONS

The Association submits that just as the situations that came before the Inquiry spanned a range from proper to improper preferential access with many shades of grey depending on context; evidence from the experts, the policy literature and the extensive experience of our association suggests that recommendations need to be responsive to these variations. Some practices are easier to regulate or influence while others more difficult. There are also trade-offs that must be carefully considered.[38]

We respectfully submit that if the Commissioner makes a finding that preferential access to publicly funded services is occurring that he consider the following in crafting his recommendations to prevent improper preferential access in the future.

The Association has assembled these considerations under four themes: education, resources, protocols and transparency.

### Education

1. There needs to be opportunity for

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35 Identified in both the CVs and testimony of numerous physicians before the Inquiry

36 p.932-2937, p.2989, p.3087, Swain

37 There are also many different and often complex compensation arrangements with various parties (AHS, Faculties of Medicine, Research Grants, Alberta Health Care Insurance P

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- investigation to increase awareness and understanding of the interactions between the publicly and privately financed components of the overall health system to better inform development; understanding the effects of dual providers (both organizations and individuals) and multiple streams of income;

- encourage the development of an initiative that will allow an open online forum for policy makers, politicians and the public;

- education related to the multitude of issues related to access and particularly concerns about bias and other barriers to access;

- education about the ethical issues related to preferential access and related applicable policies, professional standards and legislation;

- making all parties aware of the provisions of the HCPA and reporting required under the Act, and making this information more accessible to the public.

- Raising the profile of all of the paths available for citizens to take to make complaints.

2. Ensure the testimonies, documents and ultimate findings of the Commission find a readily accessible and permanent archival home to capture the valuable information and discussion for ongoing public and academic use and enlightenment.

3. Education on appropriate and inappropriate advocacy for patients and their families and friends, health professionals, MLA offices and formal advocacy organizations, including the need to be made more aware of the benefits and criteria for "making the case" in relation to medical need as discussed by the Experts appearing before the Inquiry.

**Resources**

4. Investigate innovative approaches to reduce the queues such as has been done in the Acute Care Knee Injury Clinic, Calgary.

5. Recommend that funding be made available to facilitate education of the public and providers about why certain standards and legislation exist.

6. Recommend the resourcing of a Health Advocate, whose role relates to patients and family advocacy based on knowledge of law, policy and practice in relation to both public and privately financed services. [39]

**Protocols**

7. Recommend reviewing processes for investigation and amend bylaws or other barriers preventing full inquiry into allegations.

8. Whistle blowing protection should be extended to include individuals working in the private sector, including physicians.

9. Where mutual self-interests are likely to be advanced, such as policies around the boundaries of professional courtesy, it is important that there be broad consultation and validation from bioethicists and other significant groups and experts.

10. Policy makers and organizations should identify processes vulnerable to preferential access and to take steps to address the same to prevent future preferential access. The Inquiry heard from a number of witnesses that front line staff would welcome protocols or policy about professional courtesy to set out the limits of when it becomes improper.

11. Promote ethical decision-making, defined as the rigorous systemic process of considering options and providing justification for behaviour of profound human importance, and promoting ethical decision-making as a standard of best practice throughout the health care system.

12. Add allegations of preferential access as a viable category of complaint by Colleges and other bodies with complaint processes.

**Transparency**

13. Take steps to identify situations where conflicts of interest that create divided loyalties may result in deliberately expedited and inappropriate access and have appropriate disclosure of these situations.

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14. Publicly release breakdowns of the nature of complaints from all Patient Complaint offices.

15. Register healthcare and disability companies under the Ministry of Health for purpose of tracking numbers.

16. Take steps to resurrect the previous manpower planning committee and related collection of information by relevant parties. It is critical that policy makers know, for example whether or not 23 FTE gastroenterologists in Calgary are available to provide services to medicare patients or if, due to other obligations, the number is really 7.5 FTE before adding on new specialist intensive programs such as a province wide colon cancer screening program.

Respectfully submitted,

Deborah Prowse, QC
On behalf of the Consumers Association of Alberta
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**Selected Bibliography**

Adams, P., and Bridges, R.,), *Building your Babylon*, Can J Gastroenterol. 2008 March; 22(3): 233–235, (interview with Dr. Bridges re: Forzani CCSC) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2662196/

Alberta Committee of Citizens with Disabilities (2011) *Barrier-Free Health and Medical Services in Alberta,* http://justice.alberta.ca/programs_services/humanrights/bibliography/Documents/Barrier-Free-Health-Final.pdf

Alberta Mental Health Patient Advocate
https://www.mhpa.ab.ca/Contact/Pages/default.aspx

Alberta Ombudsman http://www.ombudsman.ab.ca/

Allison, J. and Meijer, G. (2012) *Colonic Polyps: The Harm of Overdiagnosis*, Practical Gastroenterology, November 2012, http://www.practicalgastro.com/pdf/November12/Allison.pdf

Armstrong, W. (2000), *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in a Mine Shaft*, Consumers' Association of Canada (Alberta), available at www.albertaconsumers.org

Batt, Sharon (2005) *Marching to Different Drummers: Health Advocacy Groups in Canada and Funding from the Pharmaceutical Industry*, Women and Health Protection, January, 2005 http://www.whp-apsf.ca/en/index.html

**Benefits Canada Magazine** http://www.benefitscanada.com/

Boychuk, G. W. (2012), *Grey Zones: Emerging Issues at the Boundaries of the Canada Health Act,* Commentary #348, C. D. Howe Institute**,** http://cdhowe.org/pdf/Comm_348.pdf

Boychuk, G.W. (2008), *The Regulation of Private Health Funding and Insurance in Alberta Under the Canada Health Act: A Comparative Cross-Provincial Perspective*, The School of Policy Studies, U of C, http://policyschool.ucalgary.ca/sites/default/files/research/boychuk-final-web-dec-2008.pdf

Born, J.D. (2003), *The Emperor's Clothes: Description of a new epidemic related to diagnostic imaging***,** Acta Neurol Belg. 2003 Sep; 103(3):140-3.

Breslin et al, (2005) *Top 10 Ethical Challenges Faced by the Canadian Public and health-care professionals,* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1180442/

Browne, A. and Browne, K., *Morality, Prudential Rationality, and Cheating***,** Cambridge Quarterly of Health Ethics (2007), 16, 53-62

Cassels, A., van Witenburg J, Armstrong, W., (2009) *What's in a Scan? How well are consumers informed about the benefits and harms related to screening technology (CT and PET scans) in Canada?,* CCPA. April 2, 2009**,** http://www.policyalternatives.ca/publications/reports/whats-scan

CHEPA, Hurley et al (2009**)** *Parallel Payers and Preferred Access: How Canada's Workers' Compensation Boards Expedite Care for Injured and Ill Workers***,**

http://www.chepa.org/docs/working-papers/chepa-wp-07-090129EA94F35A.pdf?sfvrsn=2

CHEPA, Hurley, J. , Guindon, G. E, (2004) *Private Health Insurance in Canada*, CHEPA working paper series 08-04, http://www.chepa.org/docs/working-papers/chepa-wp-08-04-.pdf?sfvrsn=2

Choudhry, S, Choudhry, N., Brown, A. (2004), *Unregulated private markets for health care in Canada: Rules of professional misconduct, physician kickbacks and physician self-referral, CMAJ March 30, 2004,* http://www.cmaj.ca/content/170/7/1115.full

Church, J. , Smith, N., *Health Reform and Privatization in Alberta (2006),* Canadian Public Administration 49, NO. 4 (Winter 2006), PP.486-505, http://ipac.ca/documents/churchSmith.pdf

Deber, R., *Getting what we pay for: myths and realities about financing Canada's health care system*, 2000, http://www.teamgrant.ca/MTHAC%20Greatest%20Hits/Bonus%20Tracks/Getting%20What%20We%20Pay%20For.pdf

Deber, R., *Delivering health care services: Public, not-for-profit or private? Commission on the Future of Health Care in Canada (Romanow*), Discussion paper 17, August 2002 http://teamgrant.ca/MTHAC%20Greatest%20Hits/Bonus%20Tracks/Delivering%20Health%20Care%20Services.pdf

Donaldson, C. and Currie, G., *The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity*, Working Paper 00-9, http://www.ihe.ca/documents/2000-09paper.pdf

Fuller, Colleen (2009) *Caring for Profit: How Corporations Are Taking Over Canada's Health Care System*, CCPA, 2009

Fuller, C., (2012) *Follow the money: The growth of private health care in Canada,* Rabble.ca, September 19, 2012, http://rabble.ca/news/2012/09/follow-money-understanding-growth-private-health-care-canada

Gildiner, Alina (2006) *Measuring Shrinkage in the Welfare State: Forms of Privatization in a Canadian Health-Care Sector,* Canadian Journal of Political Science 39:1, March 2006

García-Prado, A. and González P. (2011) *Whom Do Physicians Work For? An Analysis of Dual Practice in the Health Sector,* Journal of Health Politics, Policy and Law, Jan 1, 2011 36: 265-294**,** http://jhppl.dukejournals.org/content/36/2/265.abstract

Giacomini, M.; DeJean, D.; Hurley, J. 2012. Fair reckoning: *A qualitative investigation of responses to an economic health resource allocation survey,* Health *Expectations*. 15(1)

Health Canada (2004) *Strategic Overview Book 1*, "Options for Private Delivery", Page 40, obtained through FOIP, and acknowledges CHA implications of current activities.

Health Canada (2010), Canada Health Act Report, Compliance Issues, http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2011-cha-lcs-ar-ra/index-eng.php#intro and **2011/2012**, http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2012-cha-lcs-ar-ra/index-eng.php

Insurance Bureau of Canada - the trade association for property and casualty insurers- (2001), *Restoring Confidence: Insurance Bureau of Canada Submission to the Commission on the Future of Health Care in Canada and the Standing Committee on Social Affairs, Science and Technology***,** 2001, http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/Bonus%20Tracks/CP32-80-3-2001E.pdf

Mohtadi, N., Chan D., Lau, B. , Lafave, M., (2012) *An Innovative Canadian Solution for Improved Access to Care for Knee Injuries using "Non-Physician Experts": the Calgary Acute Knee Injury Clinic***,** Rheumatology, 2012.

OECD, *Metadata on Health Systems,* http://www.oecd.org/els/health-systems/TableofContentMetadataOECDHealthData2012.pdf

Points West Consulting (2000) *Confronting Medcan: Disability mana ernent vs corporate profit,* A report to the B.C. Teachers' Federation and the Canadian Union of Public Employees

Premont, *Marie-Claude* (2011) *Payments by patients for health care paid out of public funds,* English translation published here, http://cupe.ca/updir/PremontPayments2011_EN.pdf

Reid, L., *Diminishing Returns? Risk and the Duty to Care in the SARS Epidemic*, Bioethics, volume 19, Number 4, 2005, 1467-8519

Silversides, A. , (2009), *Outcome of health-related legal challenges is sometimes surprising CMAJ* November 24, 2009 181:E247-E248; published ahead of print October 13, 2009, doi:10.1503/cmaj.109-3075 , http://www.cmaj.ca/content/181/11/E247.full

Silversides, A., (2008) *Merchant Scientists: How commercialization is changing research in Canada*, The Walrus Magazine, May 2008 magazine, http://walrusmagazine.com/article.php?ref=2008.05-science-and-commercialization-ann-silversides&page=

The Tyee.ca (2009) *Supreme Court Showdown for Private Clinics How two BC lawsuits could change health care in Canada,* Tom Sandborn, *http://thetyee.ca/News/2009/09/07/PrivateClinicShowdown/*

Tuohy, C, Flood, C. , Stabile, M. (2004), *How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations*, Journal of Health Politics, Policy and Law June 1, 2004, http://jhppl.dukejournals.org/content/29/3/359.abstract

Vancouver Sun**,** *A new Day for health care (2002),* Doug Ward (re: opening of Specialist Referral Clinic in BC by Dr. Brian Day, April 08, 2002

White Coat; Black Art (CBC) (2012, Nov. 3 podcast), *Unnecessary Surgery Show,* http://www.cbc.ca/whitecoat/episode/2012/11/03/unnecessary-surgery-out-from-under-the-knife/

*Western Canada Waiting List Project (2001)* http://www.wcwl.ca/library/final_reports/ *www.wcwl.ca/media/pdf/library/final_reports.16.pdf*