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Alberta Consumers' Association

Consumers' Association of Canada (Alberta)

Response to the "Blue Ribbon Panel" on Bill 37

"Purpose of a universal public health insurance program"

There is no single expense that can devastate a family more than the cost of ill health or injury. The cost, quality, safety and availability of healthcare goods and services have a powerful influence on the financial security of individuals, families and the society in which they live. The high costs of care, and loss of income which often accompanies illness and injury, can lead to financial hardship or ruin. The inability to obtain care can lead to unnecessary suffering, disability or death. These high stakes are one of the reasons that prices for medical services and products are so difficult to control. Faced with pain, anxiety, the inability to work and enjoy life - or the loss of life, patients and families are in no position to negotiate price and quality of healthcare services at time of need. Nor do they usually have the required skills, knowledge or past experience. Few people buy bypass surgery as often as they buy tomatoes.

The product that citizens buy with Canada's public health insurance system is security and good value for money. The purpose of Canada's public health system should not be confused with the role of government as a whole (federal, provincial, municipal) whose purpose is to protect and promote the health, safety, security and economic well being of citizens or the "health of the population".

In order to assure the sustainability of our healthcare system, policy makers need to be aware of the growing body of evidence that demonstrates increased reliance on private payment and private business is a major *cause*, not the solution, of higher costs and less than ideal patient care. Growing public awareness of this evidence has been the driving force behind the opposition to the introduction of Bill 37 and the appointment of the Blue Ribbon Panel. In light of this evidence, CACA believes the question is not whether we can afford our public health system - but whether we can afford *not* to have it and *not* to manage it well.

Tel: (780) 426-3270 or E-mail *contact@albertaconsumers.org*

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Attachments to submission

The Alberta Consumers' Association understanding of Bill 37

There appear to be three major thrusts:

1. Requiring the Minister's approval for any privately owned "treatment" facility to perform (non-insured and insured) medical services on a yet to be identified restricted list developed by the College of Physicians and Surgeons and described in regulations under section 67.9. As a regulation, this list would be subject to change without any prior public notification. The legislation as written appears to indicate that any private medical facility (i.e. other than an "approved" hospital) providing diagnostic or treatment options would be restricted from providing on the listed medical procedures. However, we were advised by Alberta Health that this section did *not* apply to diagnostic facilities or sub-acute facilities or dialysis units or any type of facility other than a specified non-hospital surgical facility (NHSF) - as defined by the College of Physicians and Surgeons of Alberta. Yes, we're confused.

2. Requiring that the Minister approve all contracts for insured services between Regional Health Authorities and privately owned surgical facilities - an authority which we believe the Minister already has. While the *Government Reorganization Act* and the *Regional Health Authorities Act* allow a Minister to delegate his authority to RHAs, these Acts did not require it and Minister still remains ultimately responsible. Furthermore, in a letter obtained through FOI (Freedom of Information) dated August 21,1997, the Minister stated that he had written to all the Chairs of the RHAs and indicated that any contractual arrangements with private providers of inpatient health services would require his approval. He also noted that *"it is my responsibility to ensure that any new initiatives in the delivery of health care services do not negatively impact health care in Alberta."*

3. It removes an existing prohibition on private insurance for auxiliary hospitals.

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CACA Recommendations to Protect the Public Health System

Enhance the visibility of public system changes and accountability

CACA recommends that Bill 37 be rewritten using "plain language" criteria for drafting legislation. References for expertise can be provided upon request.

CACA recommends that the Health Law Institute, the Health Economics Department and the Public Health Sciences Faculty at the U of A and CACA participate in the development of guidelines to define the public interest as identified in Bill 37.

CACA recommends that a process of prior notice and opportunity for input by affected parties be established related to the approval of NHSF & treatment facility contracts.

CACA recommends that current legislative (AHCIP) and contractual restrictions (AMA/AH Confidentiality Agreement & RHA/ facility contracts) on access to information on quality outcomes and fees paid to all private facilities/agencies be removed into order to make this information accessible to the public and researchers.

CACA recommends that private facilities be required to report any additional services or products purchased by the individual related to the provision of the insured services as a condition of public payment. Such charges in both private and public facilities need to be reported regularly in a manner digestible and relevant to the public.

CACA recommends that Alberta Health identify in its Annual Statistical Supplement a listing of all private facilities/programs offering more than "primary care" services by type of service provided. (e.g. rehab clinics, pain clinics, dialysis clinics, sports clinics, etc) as well as number and type of private facilities accredited by CPSA.

Limit present and future markets for private for-profit facilities & private insurance for medically necessary services.

CACA recommends that government policies and legislation should be directed to limiting present and future markets for private for-profit facilities that are fostering their growth.

CACA recommends that the provincial government rescind the "Twelve Principles" document at the opening of the upcoming Legislative Assembly.

CACA recommends that the removal of the prohibition on private insurance for auxiliary hospitals be deleted from Bill 37.

CACA recommends that the provincial government clarify and enforce rules prohibiting private insurance payment for medically necessary physician and hospital services.

CACA recommends that the "Enhanced Goods and Services Policy" of Alberta Health be changed or at least regularly audited in a manner compatible with the public interest. At a minimum, all facilities (public and private) should be required to post currently undisclosed standards for publicly insured products and services developed by "relevant professional bodies", as well as the developers of the policy and the rationale.

CACA recommends that opted in physicians be specifically prohibited from charging more for the same services than they receive from the public plan or be required to opt out .

CACA recommends that the Alberta Cabinet direct through regulations the WCB to pay private facilities and physicians with public billing numbers the same amount they pay to public facilities and physicians based on the Federal/Provincial Coordinating Committee's Guidelines for Reciprocity in order to protect the "single payer" or "single price" concept and cost controls.

CACA recommends that physicians who have opted out of the public plan in order to charge higher fees should not have access to public hospitals to service their patients. Patient care should be turned over to an opted-in physician if hospital services are required.

CACA recommends that all physicians be prohibited from billing a professional fee for any insured surgery (e.g. cataract surgery) provided in a private facility unless they have a contract with the local RHA for a facility fee for that service (when they are over quota)

CACA recommends that the provincial government establish a method of monitoring and reporting "misleading" representation of either insured or non-insured services by private

facilities providing services on contract. Rules restricting such activities should be in contracts.

CACA recommends that Alberta Health cease paying the costs of physician malpractice insurance.

CACA recommends that all patients be provided with a statement identifying the date, the amount being billed on their behalf to AHCIP and the findings of the physician and follow-up advice (at point of service) as a requirement of physician payment.

CACA recommends that the Bill 37 be expanded to include contracts with all private facilities and agencies providing direct care and/or include authorization to do so at the discretion of the Minister through regulations.

Get a new team together.

This will take a phenomenal amount of will and effort by the policy makers and leadership from members of the medical community who have not yet abandoned the public system either physically or philosophically. It will need public interest minded health economists, health policy analysts, epidemiologists, health law experts and consumer groups who understand some of the industry /professional pressures behind the current situation. In order to retain some of the benefits and recover from the many unintended negative consequences of recent reforms Albertans need leadership from individuals who understand that reducing the range of services paid for by the public plan and/or the quality or timeliness of these services does not save the plan.

The current Summit planned for Calgary lacks the involvement of these knowledgeable parties. While many ideas sound great in theory, the test is in the evidence and there is ample evidence both locally and from around the globe that indicates Alberta desperately needs to adjust course in the area of health care. Policy makers and the public need these resources to properly evaluate the outcomes of initiatives in health care reform. While most health care professionals are dedicated individuals, there are few suppliers of any good or service who do not believe passionately in the value of their product, seek regulations that will benefit their economic interests in the absence of a challenge, and grossly overestimate the ability of a consumer (end user) to understand the risks and benefits and protect his/her interests at point

of sale/use. This is doubly so in the area of health care, where the knowledge imbalance is so profound and the stakes are so incredibly high. Therefore:

CACA recommends that the Department utilize some of the available expertise listed above in a new Utilization Monitoring Committee and include at least three public/consumer reps with some background experience in evaluating these issues from a public interest perspective.

CACA recommends that the provincial government fund a U of C Communications Faculty hosted "Lay Consensus Panel Conference" on the issue of Public vs. Private Health Care and the risks and benefits to consumers to enable public exposure of the complexity of the issues.

CACA recommends that the Department of Health deliberately *move away* from contracting-out core services and functions of the Department in order to restore some corporate memory, expertise and leadership. Reliance on too many transient and external single task consultations has resulted in great inefficiencies and an inability to provide quality information and direction to policy makers or continuity with community groups.

Response to Question #1 - Does Bill 37 meet the government's stated objective of safeguarding the public health system?

CACA believes Bill 37 is inadequate to safeguard the public health system. The provisions dealing with "treatment facilities" and NHSF appear to provide some potential and limited safeguards. These provisions would enable the Minister to prevent a total exodus of certain skilled specialists from the public system and retain the marginal cost and safety benefits associated with centralization for a limited number of surgeries on a list. However, Bill 37 falls short of addressing the majority of concerns that led to its introduction. Furthermore, by removing the prohibition on private insurance for auxiliary hospitals - facilities which are used increasingly for the delivery of medically necessary services formerly provided in acute care hospitals (e.g. care of the terminally ill and sub-acute care), this provision could substantially erode the public system.

CACA has serious reservations regarding the ability of the Minister to fulfill his/her obligations as identified this Bill. In our view, Alberta Health currently lacks both the human resources and access to information required to evaluate the impact of proposed contracts for either NHSFs or treatment facilities on the cost, quality and accessibility of medically necessary services for Albertans - an end point we anticipate would be part of any "public interest test. [1] Therefore, if the provisions regarding facilities are going to be implemented, other regulatory or policy changes will need to be made in order to ensure the collection of such information.[2] Given the latitude provided to the Minister, CACA also believes that such

[1] In 1985 the State of Arizona decided to no longer regulate the number of hospitals providing open heart surgery. Within a year the number of hospitals providing this service in Phoenix rose from 4 to 11. A year later a study was done in order to determine the impact of this deregulation: the mortality rate for this procedure had gone up 35% and the cost of the procedure had increased 50%. (Consumer Reports, J 1992)

[2] Information required would include: current patient access to specialists and related services in various regions; extent and amount of charges to patients for marketed add-ons to publicly insured services in comparable facilities and proposed facility; potential rate of complications from both insured and non-insured services provided in the facility; level of conflict-of-interest and economic incentives for physicians which could affect patient access to medical procedures and additional administrative, legal and regulatory costs. The experiences of many U.S. States (particularly Florida) and Australia in moving the delivery of publicly funded care from non-profit to for-profit

a process needs to be transparent and subject to input by potentially affected and interested parties, yet this is not specifically addressed.[3]

Finally, given the failure of the provincial government and physician self-regulatory bodies to utilize existing regulatory mechanisms and/or management tools, CACA is hard pressed to understand how one more unknown, unmonitored, unenforced and highly subjective regulation will help resolve the problems and concerns which led to Bill 37. Despite rules to the contrary, a recent survey by CACA found many unauthorized activities and questionable charges at private surgery clinics. We have filed complaints but are skeptical action will be taken.

facilities should be carefully reviewed for other points. Health economics and health policy literature as well as local newspapers and Consumer groups in Australia and the United States have documented a number of unanticipated negative outcomes which would need to be considered in the review process.

[3] Serious consideration could be given to various models used by State Attorney General Departments in the U.S. for public review and assessment of "conversions" of public and non-profit hospitals to for-profit status in order to protect the public interest. (Health Affairs Journal, March/April, 1996)

Response to Question #2: Does the Bill meet the requirements of the Principles of the CHA?

IMPORTANT BACKGROUND:

The Principles of the *Canada Health Act (CHA)* are sound economically as well as socially. They were designed to control inflation and overall costs to individuals and the community by creating a *single payer* or single major buyer of highly valued health care services at a *single price*. Under the *CHA*, the only exceptions to required coverage of all provincial residents are those circumstances where the provision of medical care falls under another Act of Parliament (i.e. Armed Forces) or provincially *legislated* Workers Compensation Plans. This ensured that the provision of services in such circumstances would be conducted in a manner *compatible with the public interest* through accountability to Parliament or Provincial Legislatures. [4]

By covering all residents of every province (**universality**) the plan does away with the need for high cost and unreliable private health insurance policies and money being directed towards administration and profits instead of actual care. Suppliers of covered medical services (doctors and hospitals) lose access to multiple large pools of buyers and payment mechanisms which would allow discretionary increases in prices. This motivates them to sign up with the public plan and provide their services to plan members for capped prices negotiated with the province. Elected representatives are accountable) for the quality, cost and availability of resources required (**public administration** to provide the majority of services which are effective in relieving or avoiding suffering, dysfunction or death (**comprehensiveness**) - without any financial barriers or denial of treatment options based on

[4] For example, under the *Alberta WCB Act*, private employers pay for injured workers in return for freedom from liability - seen as a social good. In order to protect the public interest (both WCB plans and Medicare), the *Act* gives the Cabinet the power to make rules guiding the activities of the WCB including whether or not it can build its own hospitals and how much it pays individual providers.

ability to pay at time of need (**accessibility**) or where a family lives or travels (**portability**). This theoretically leaves few uncapped services for which an individual could be held hostage by arbitrarily high prices in order to obtain needed care. It also provides a mechanism to encourage individuals to avoid future medical costs by removing financial disincentives to access services which have a demonstrated impact on future health and social costs (e.g. timely assessment of debilitating chest pain or other symptoms, etc)

> By avoiding the rapid inflation, high costs and unreliability of private health insurance and private markets for medical care, Canadian families are left with more *disposable income* to spend on the larger determinants of health such as food, housing, education, recreation, self-esteem and a sense of purpose and value in life.

Under the *CHA*, all "medically necessary" physician and hospital services are covered. Hospital services were actually listed. These include such things as **nursing care, drugs, lab and x-ray services, operating rooms, case rooms, supplies, physiotherapy, and services of all staff in hospitals.** At the time the CHA was written, most activities related to the assessment, diagnosis, treatment, recovery and rehabilitation of individuals occurred in provincially "approved" public hospitals which provided 24 hour one-stop access. Public hospitals also provided support for physicians in the public plan to carry out their work.

The advantage of a single payer **(single price)** system can be demonstrated in the following comparison of physicians' fees. In Alberta there is one major payer, the Alberta Health Care Insurance Plan which pays a negotiated and capped fee. Physician fees for "non-entitled persons" covered under the exemptions to the *CHA* have historically been paid at the same general rate as that paid by the provincial plan. In comparison, there are multiple public and private payers in California. Twenty-five percent of American physicians refuse to treat public patients because of the low fees and 2/3 of those who do, limit the numbers they treat because of the low fees. This puts constant pressure on the public plan to increase payments to physicians in order to maintain accessibility for publicly insured individuals. For example, the following information was obtained by CACA from Alberta Health and by calling a number of physician offices/clinics listed in the phone book in California. The private insurance price quoted is an average of 5 different price quotes.

Comparison of Physician Fees Only

Alberta vs. California (June 1996)

Physician fees	Alberta	California public plan Medicare	California individual pts./ private insurers
EKG (heart tracing)	**$ 23.75**	**$ 57.75**	**$ 71.25**
Colonoscopy	**$ 99.87**	**$ 315.00**	**$ 590.00**
Cataract surgery	**$505.13**	**$ 1086.00***	**$ 2600**

* This includes a patient co-pay of $256 dollars

A similar pattern can be found in Australia which has both universal Medicare and a private insurance option for the same services. (The Consumers' Association of Australia)

There are many other economic advantages to the Principles of the Canada Health Act

Universality: Just like private insurance plans, maximum benefits are obtained by spreading the risks and costs across a large group. It also enables bulk buying power. While casual observers often assume the "universality" provision adds to the cost of health care services in Canada, it actually decreases the amount Canadians are forced spend on both health insurance and actual services and increases the number of people with access.

Comprehensiveness: Enables maximum flexibility and maximum options to match individual and community needs and maximum value for money through marginal cost and safety benefits associated with vertical integration and one-stop shopping.

Accessibility: Inflation is controlled by prevented suppliers from arbitrarily adding on charges or upping fees without good reason and approval. Assessment or treatment is not delayed resulting in higher costs or more serious conditions. Individuals are not forced to sell assets or go into significant debt in relation to accessing appropriate and effective healthcare benefits.

Public Administration: Public (not-for-profit) administration of this plan in the public interest requires accountability for good value for plan members and enables

more money to be diverted to the needs of plan members from complex administration procedures for sales, administration and collection – as well as returns to investors. By doing away with multiple private insurance and individual payers for the most substantial portion of medical costs, administrative and legal costs for insurers, providers and claimants are dramatically reduced. One of the greatest benefits for patients is lack of the crippling paperwork encountered in multiple payer systems with private insurance models of co-payments, etc. [5]

Portability: Removes disincentives to the free flow of goods, services and people across provincial boundaries due to differential access to health care, thus encouraging economic efficiency and growth as well as maximum "choice" for citizens on where they want to live and work. There are fewer disincentives for small business due to need for health benefits.

It is through the inter linking of these five Principles that value for money, quality and equal access based on need is added to the public health system. The *CHA* also specifically stipulates that all "medical necessary" and insured services should be provided to plan members under the same terms and conditions – unlike discriminatory private insurance.

Based on this background and understanding and the experiences of Alberta consumers today, the Alberta Consumers' Association does not believe that Bill 37 meets the requirements for the Principles of the CHA – due to errors of both commission and omission.

For example, auxiliary hospitals are increasingly being used to provide medically necessary services previously provided almost exclusively in acute care hospitals and fully funded by the public health system. Examples include care for the terminally ill (palliative care) and for patients recovering from episodes of illness (infection, accidents) or surgery (e.g. hip surgery). The buzz-word of the day is "sub-acute" care. Removing the prohibition for private insurance on auxiliary hospitals introduces a second large potential payer and will lead to an increased need for Alberta families to have more comprehensive private insurance to cover them in time of need. This provision erodes the universality, comprehensiveness and accessibility of historical medically necessary services and will add to the overall cost of health care for Alberta families. It introduces additional barriers through private insurance co-payments,

[5] At one time, the health and life insurance industry in Canada made twice as much on their investments as they paid in claims - *before* they collected premium payments. Private health insurance in Canada suffers from a serious lack of consumer protection legislation.

deductibles and limitations and removes the incentive for suppliers and public system to ensure good value and consistent quality.

> Increasingly, end-of-life cancer patients with high emotional and physical comfort needs are placed in auxiliary hospitals or other long-term care facilities. Despite the fact that most of these individuals still retain a primary residence, many are being charged user fees in the form of "residency" fees of $25 dollars per day plus other charges on a short term basis - often a significant burden for them and their families in their final days.

2. This Bill does not address the continual erosion of comprehensiveness and accessibility related to the growth of privately owned diagnostic and treatment facilities and accompanying shifting of costs from the public plan to multiple individuals and employer benefit plans.

> Albertans are encouraged to check their pay stubs and call their benefit plan to find out what changes in premiums and coverage have occurred over the past 5 years. They may be surprised to find their shrinking paycheck may not be due to taxes, but due to increased premiums for their private employer-sponsored supplemental benefit plans.

For example, increasingly, Alberta patients are finding themselves directed to these private facilities and private sources of payment for needed care: private surgery clinics, private MRI clinics, private sports clinics, private pain clinics, private rehab centers, private prostate treatment clinics, private home care agencies, private dialysis clinics, private neurophysiology labs, private in vitro fertilization clinics, etc. Most provide both insured and non-insured services. There are seven categories of private diagnostic and treatment facilities currently accredited by the College of Physicians and Surgeons of Alberta. Many others are not accredited or even listed anywhere. It is up to the College to determine if there is sufficient risk at these facilities to require registration and accreditation. This requires that certain protocols and management techniques be in place but appears to be a bit of a "paper tiger". The College's ability to monitor and enforce standards in these facilities rests almost solely on individual complaints by patients against individual physicians for violations of these standards - which most of the public aren't even aware exist.

Paying at Private MRI clinics to get to the front of the line for treatment. . . .

Calls to Consumers' Association and Letters to the Editor pages in Alberta dailies suggest it has become relatively commonplace for patients in severe pain, difficult to

diagnosis conditions and/or problems with mobility to be told there is nothing the doctor or health system can do to help them *until* they get a new diagnostic test called a MRI. They are then advised that the public waiting list is 9 -18 months long. However, if they *choose* to pay $750 - $1500 dollars at a private MRI clinic, doors suddenly open up to surgery, radiation, physiotherapy, pain control and disability payments. Given this new barrier to treatment, a number of patients have contacted us wondering if their treating physician or clinic has a pecuniary interest in these new private pay facilities and what doctors did before MRIs? [6]

Paying extra for alleged "safety and quality" at private eye surgery clinics. . .

Patients going for cataract surgery in private clinics (and increasingly in public hospitals) are routinely advised that while the public system pays for one *quality* of service, if the patients wishes to avoid unnecessary discomfort and complications such as infection (patient hears "possible blindness") they can *choose* to pay an extra $250 - $750 dollars. This is for a special intraocular lens implant *recommended* by his/her surgeon to provide the best results from surgery. This lens is provided at no cost for patients having cataract surgery in Lethbridge and Lamont at the discretion of the surgeon. Surgeons appear divided on the relative value of the lens implant. The most common price in Calgary is $400 dollars where 100% of surgery is done in private clinics and $250 dollars in Edmonton where only 20% is done privately. The most common brands of these newer implants wholesale for between $100-$200 dollars with lower costs for bulk purchases. CACA has received three reports of surgery being canceled or postponed when patients did not *choose* this "upgraded" option. In Calgary, patients *no longer have a choice* to

[6] The first MRI used in a clinical or non-research setting occurred in Ontario in 1985. By 1993, Alberta had 4 public and 2 private MRIs while BC (with 1/3 more population) had 5 public, and Saskatchewan and Manitoba had 1 each. Today in Alberta, there are 5 public MRIs and 3 private MRIs used for general clinical diagnosis. There are also 3 additional public MRIs in Calgary which are used for specific research or programs. The actual value of these tests in diagnosis, however, is the subject of significant controversy.

have any type of eye surgery from corneal transplants to cataract surgery done in a public facility. All eye surgery is contracted out to private facilities run by business interests.[7] [8]

Paying for the economic sustainability of family units to private care agencies. . .

Elective surgeries are canceled daily at the Royal Alex hospital and patients sent home quickly. Since the level of assistance provided in the home by the public system (usually by private home care agencies on contract) is often inadequate to provide a level of security and comfort, families are forced to spend $15.00 dollars per hour for workers from these same agencies to care for family members who they feel cannot be safely left alone - or quit their jobs.[9][1] These minimally trained agency workers are usually paid $8 dollars per hour for split shifts with no benefits, resulting in rapid staff turnover and stress on patients and families due to lack of continuity of care.[2] In Calgary, a number of physicians have reportedly invested in a facility where patients recovering from childbirth or surgery can pay $250 dollars per day for assistance with hygiene, nutrition and comfort including wound care, pain relief and supervision by a Registered Nurse - rare commodities in the public system these days. Health Resources Group (HRG) located in the old Grace Hospital in Calgary also offers a "hotel" option following surgery. There are no licensing requirements or mandatory standards for home care or nursing agencies or facilities and no means to identify increased volumes of personal and professional nursing care bought privately since health reform began because this is carefully guarded competitive information.[10]

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[7] There are currently 51 private surgical clinics or *non hospital surgical facilities* accredited by the College. The first one opened in 1972, by 1986 there were 12, and by 1991 there were 36. The first cataract surgery done outside a hospital occurred in 1980 and by 1990 there were 8 private NHSF providing eye surgeries. These 51 private surgery clinics provide anesthesia services and surgical settings for the entire range of eye surgery from tumor removal to corneal transplants. They also do arthroscopies of joints, dental surgery, hernia repairs, fistula repairs, facial and sinus surgery, ear and throat surgery, foot and hand surgery, plastic surgery and much more. At least three (Health Resources Centre, Holy Cross, and Surgi-Centers Inc) have significant capacity and are looking at expansion into other areas such as sub-acute care, major surgery, diabetic counseling or rehabilitation.

[8] Reliable sources indicate that per case payment for cataract surgery in private facilities is $550-$600 (on top of $432 dollar surgeon fee, $87 anesthetist fee and optional patient charges of $250-$750 dollars) whereas public per case costs obtained by CACA range from $235 to $500 dollars. NOTE: These patient charges may account for Albertans decreasing enthusiasm for user fees. An Angus Reid Survey (Feb/98) found that Albertans' support for user fees in health care had dropped from an all time high in 1993 in contrast to incremental increases in other provinces.

[9] Transportation has also become another major cost and drain on family resources (daily physio or intravenous treatments on an outpatient basis for 5-14 days). These are usually sick people unable to safely drive

[10] See Manitoba Study comparing public and private delivery of home care. (e.g. Shapiro, Evelyn, The Cost of Privatization, Canadian Centre for Policy Alternatives) and research done by Neena Chapell @ the Department of Gerontology, University of Victoria. It is interesting to note that a WCB contact indicated that they too (just like individual families calling CACA) have a difficult time evaluating and obtaining consistent quality from private agencies. The major players appear to be Olsten, Paramed, Comcare and We Care.

Analysis: incompatibility with principles and spirit/intent of the CHA

Barriers to Reasonable Access for Medically Necessary/Required Care:
In reality, the evidence indicates that some of these marketed private-pay tests, treatments, and services are valuable and appropriate for individual patients while others are not. However, there is no way for a patient or family to know the difference- no reason for him/her to trust the decisions of a public health plan whose sole purpose appears to be cutting costs - and no real choice if they want to retain the goodwill and/or cooperation of the doctor upon whom they must rely for access to further treatment. This makes these tests, treatments and services **very** medically necessary from the perspective of any patient.

Physicians and hospitals or others providing medicare services do not stop mid-sentence and say "What I'm telling you now is no longer my professional advice, it's just what I am trying to sell you to make a few extra bucks." Nor would it make any difference. If a senior doesn't like the price an eye surgeon is charging for a lens implant, is he/she seriously going to change the surgeon who has been recommended to them and delay their surgery? The Principles of the Canada Health Act were designed to prevent patients from being put in situations where pressure and power differentials would force them to pay unnecessary or inflated amounts to access needed care.

It is also important to note that since payment most privately paid medical procedures such as MRIs and lens implants are claimed as personal income tax deductions, this activity reduces the tax revenues available to both federal and provincial governments to put into the public health system. Employer-sponsored benefit plan contributions are also tax-deductible – a de facto subsidy of these products by all contributing taxpayers.

Loss of price and cost controls provided by the Principles of the Canada Health Act
In the absence of any evidence to the contrary either locally or internationally and based on information obtained by CACA on comparative costs in public facilities, these private suppliers appear to be much more expensive to both individuals and public payers. Use of these private suppliers has also decreased the transparency and accountability of the public system. Information on the amounts paid to these facilities and physicians by both the provincial government and Regional Health Authorities cannot be disclosed due to restrictions in the Alberta Health Care Insurance Act, a Confidentiality Agreement between the AMA and AH and *contract confidentiality*. In fact, the Capital Health Authority wrote a clause in all

their contracts with private facilities limiting disclosure of which facilities have contracts with the Region. These practices are a recipe for compromised safety and fraud.

There seems little recognition by policy makers that the increased reliance on individual patients and private insurers to sustain these facilities has *driven up* the cost of medically necessary care to Alberta families. Individual Canadians ultimately pay the entire cost of health care (or lack of health care) one way or another - through taxes, premiums, cash, savings, VISA and in the cost of goods and services produced by business.

Paying for High Cost Private Providers

The public appears to be getting very poor value for money with the provision of cataract surgery in non-hospital surgical facilities. While surgeons in all settings receive $432 dollars in professional fees for performing the surgery from the province, RHAs also facility fees of $550-$600 dollars to private clinics. Patients may also pay $250-$750 per eye for access to alleged "better" foldable implants. This compares to <$500 dollars facility costs at the Royal Alex and Wetaskiwin Hospital (1996) and is substantially more $235 dollars for direct and indirect costs at Stony Plain (1998) or the $170 (direct costs) at Lamont Hospital, which does include a "foldable" lens implant.

Benefits of Bulk Purchasing

Some chronically ill patients have been reluctant or unable to leave the hospital environment because they are totally dependent on "tube" feedings which cost about $400-$450 per month when purchased individually at a retail drug store. If such individual purchases are reimbursed by employer benefit plans, the entire $450 dollars is passed on to the plan and eventually to premium payers. When this same product is bought in bulk by a public institution the price drops to about $100 dollars per month. A new provincial program run by the Calgary and Edmonton RHAs to enable these savings to occur almost did not proceed because of concern by retail pharmacies over lost profits.

BOTTOM LINE:

The current practices and policies in Alberta related to the use private facilities for the delivery of both private and publicly paid medically necessary health care are incompatible with the Principles of the Canada Health Act – or the economic and social benefits these Principles were designed to support. Bill 37 does not address any of these issues. It seems clear that while provincial government representatives and even HRG claim to support the Principles of the Canada Health Act, they simply do not understand them.

Response to Question #3: Determine if, in the absence of such a bill, a legislative gap exists which inhibits government's ability to prohibit or control private health facilities.

In our view, a small amount of private medicine may be therapeutic, but too much is toxic. Small private sector initiatives have often been an important source of innovation for specialized services to marginal or poorly serviced groups such as the chronically or the terminally ill, certain "orphan" diseases, womens health services and even under serviced geographic areas. But these types of facilities and agencies have usually been more *service* than *profit* oriented and committed to the needs of the specific group of patients rather than third party investors or created solely for additional income for health professionals. They have also usually kept their prices low and/or not aggressively marketed unnecessary services. The problem is how to ensure that any such ventures are driven and operated based on real

community or group need and not investor or provider greed and opportunism. The beauty of the *CHA* is that it theoretically solved this problem by reducing market opportunities and generous sources of 'uncapped" payments. The challenge faced by regulators is that while a small amount of private sector activity in health care can be an important safety valve and source of innovation, too much can be both dangerous and expensive. Therefore, we would suggest that it is prudent to create *disincentives* to the growth of commercially oriented agencies without actually banning them altogether.

Coming from behind is never easy. The dilemma the Minister faces today is that the need for legislation to control the growth and activities of independent health facilities and agencies run by private business interests and the physicians who own and work in them has arisen as a direct result of specific Alberta Health policies. Other than an initial bid to reduce laboratory and physiotherapy costs – an initiative which has *never* been evaluated or at least publicly disclosed)[11], many other policies and directives have driven a growth in both the numbers and scope of activities provided by private facilities and increased payments by individuals and private insurers.[2] In fact, there appears to have been a deliberate attempt to ignore existing legislative and management techniques which had proven somewhat effective in the past.

Instead, the province appears to have bought into the argument used by many clinic owners. This argument is that allowing and encouraging captive patients to pay higher prices for additional and/or "higher quality" or speedier access to medical care, combined with the cross-subsidization of these private agencies through public contracts, would work to everyone's benefit - without ever asking the people who would be paying these extra costs.

This strategy was codified in a policy document (not legislation) called the **"Twelve Principles to Guide Alberta Approach to Private Clinics"** developed during the private clinic dispute with Ottawa. It still guides and directs Alberta policies.[12] These Principles and policies have continually increased the opportunities for public subsidies of private facilities by creating new products at uncapped prices and providing increased access to public and private money and patients. *They also reflect a view that patients', employers' and workers' money is "free" new money - to be had simply for the taking.*

[11] Attempts by CACA to determine the extent and impact of the cost shifts to private insurance and accessibility failed when an FOI request revealed many discussions and decisions being made in consultation with the Health and Life Insurance Council of Canada (a trade association for private insurers) but only whited-out pages.
[12] "Public/Private Health Services, The Alberta Approach", May 17th, 1996, obtained through FOI

Here again, the strategy appears to be to simply quit paying for some services (or services for certain populations) while these same services continue to be recommended by many physicians. An example is the payment for the controversial Prostate Specific Antigen (PSA) testing in some populations. An unpublished CACA 1996 survey of the price of these tests to individual consumers outside medicare ranged from $25-$100 dollars.

Almost every service decanted from public hospitals over the past decade (diagnostic, treatment, recovery and rehabilitation) has gone to facilities and/or agencies run by private business interests. Many of the costs for these medically necessary services have been shifted either completely or partially into individual pocketbooks or private insurance policies. In some programs, Alberta Health will not even consider paying for the service if the individual has a private insurance policy capable of picking up the costs. Even universal publicly funded programs in the community are increasingly based on a private insurance model with co-payments and deductibles. For example, the New 1992/1993 Home Intravenous Program in Alberta (which replaces intravenous therapy once provided exclusively in hospitals) has a $5000 deductible for drugs/solutions which only kicks in with the absence of a private insurance plan and 25% co-pay for supplies and equipment.

The strategy appears to be one of providing a minimal and often inadequate level of service by contracted private providers and then letting desperate families "top up" with these same providers. These co-payments, deductibles and top-ups create significant disincentives for patients and families to recover from an episode of illness or cope with chronic illness in the community. It is difficult to reconcile the incongruency of provincial policies that on one hand support increased care in the community and yet create financial disincentives for choosing to receive treatment at home - although increasingly there is no *choice.*

It is difficult to say if legislated gaps exist. Policies which appear to have the most impact have not been legislated. Other legislated policies have been totally ignored. For example, private insurance payment for medically necessary services and required hospital and physician services is technically banned in the province's own legislation. (While the option of private insurance payment was *implicitly* removed by the Principles of the Canada Health Act, the Alberta government *explicitly* banned private health insurance in its legislation.) This was reportedly done out of widespread public concern that patient access and a physicians medical judgment can be clouded by financial incentives.

Yet this has not stopped individual physicians or the AMA in collusion with Alberta Health and the College of Physicians and Surgeons from simply redefining the nature of the insured service. Previously insured components have been shifted to private insurers by

- changing the circumstances in which a procedure is insured based on a physician's assessment of the need (dental anesthesia, removal of moles, facial surgery, etc.)
- changing the comfort and safety of an insured service through the sale of "enhanced" products such as soft splints or fibreglass casts to stabilize a limb and lens implants in cataract surgery over and above the basic product, and
- changing the comprehensiveness of care by unbundling charges for telephone calls, notes for daycare and telephone prescription renewals from the historical 40% allocation for running an office and a medical practice built into fee-for-service physician payments.[1]

The Health Resources Centre (HRC) has also specifically targeted employer and disability plans as a major market in their Business Plan with nary a word from the province.

Increased opportunities for private insurance billing by physicians and private facilities are also behind the thrust for a definition of *core* services and *guaranteed time lines* for access to publicly insured medical procedures.[13] Principle #11 of the "12 Principles" will enable physicians to use a definition of core services (developed by physicians) and guaranteed time lines (developed by physicians) to determine public coverage for a specific procedure based on a "wallet biopsy" or the availability of a private insurance plan. This temptation would seem more than any mortal - even a physician - could resist. Given the high level of physician investment in private facilities and so little leadership from the organized medical community or control by regulators, any moves in this direction would seem folly.

Missing pieces. . . Bill 37 does not address the significant volumes of publicly funded surgeries already decanted and duplicated in multiple private surgical facilities. Perhaps up to 80% of the various types of surgeries previously provided exclusively in public hospitals could now be done on a day surgery basis in private clinics - from hernia repairs to arthroscopies of joints. Some NHSFs do a greater variety and higher number of surgeries than many rural hospitals. There isn't a lot left to "save" for public facilities - only the high cost cases and complications. Nor does it address the reinvention of hospitals through the addition of other services such as sub-acute care and overnight "hotel" services to the same location as a private day surgery clinic. It is ironic that "hospitals" (the consolidation of services) are being

[13] "Enhanced goods and Services Policy" (AHCIP Bulletin #35), AMA Suggested Fee Guide and CPSA minutes

reinvented by the private sector in order to save money and make more profits for their owners. Bill 37 also does not address the many other types of private facilities and agencies outside of NHSFs. Yet the rationale for controlling these facilities is just as valid as the rationale for controlling NHSFs. This includes controlling the unnecessary duplication of expensive equipment and facilities and the reduction of marginal cost and safety benefits. [14]

Finally, Bill 37 does not deal with the fact that, regardless of the existence of a contract for the facility portion of care in private clinics, surgeons can continue to bill the *AHCIP* for a unlimited number of professional fees for surgical procedures performed after their contract and quota for facility fees is expired. While not as lucrative as when the Region also pays the clinic a contracted facility fee for use of the premises, this mechanism enables facilities to keep their volumes up. At one private NHSF in Calgary which performs cataract procedures, a combination of the surgeon's fee and the "optional" patient charge for access to a "higher quality" lens brings in *more* dollars ($ 432+ $750) than when the surgery is fully through a RHA contract without a patient charge ($432+ $600).

The referee has left the ice . . .

While the opportunity for physicians to increase their income and public spending through additional fee-for-service billings to the provincial health plan has always been somewhat problematic, there has been the opportunity for some controls. These controls have included moral suasion and peer scrutiny in group settings, limitations on facility capacity to perform procedures, and management techniques such as utilization review and the creation and enforcement of rules of conduct. However, since 1992/1993, the provincial government appears to have given up on its responsibilities for managing the plan responsibly.

Instead of encouraging the good players to work hard for the team through calling penalties on those who do not follow the rules, provincial government policies appear to have given bonuses to those who have stepped out of line. Every effort seems to have been made to support increased private business and income opportunities for public billing physicians who invest in private facilities to the detriment of the cost-efficiencies in public hospitals and

[14] For example, the accuracy of prenatal ultrasounds can vary up to 40% depending on a number of variables with the highest level of accuracy being found in facilities which perform higher volumes. When it comes to dealing with complex human skills and technology, the evidence suggests there is a curve where quality drops off at both ends – i.e. too low or too high volumes. For example, unrealistic volumes for technologists evaluated pathology slides have led to a number of serious concerns regarding false readings in the United States. When dealing with technologies requiring a high level of skill and concentration in order to assure safety and accuracy, it's a good idea to rely on reasonably consistent and well paid staff who are motivated to do a good job.

public system costs and professional resources. In the business world, this would be akin to Telus giving bonuses to their top executives for selling Sprint after hours or setting them up with their own telephone business.

Disregarding the "health of the population" . . .

Support for the growth of private medicine is primarily based on a false belief that all medical procedures are intrinsically safe and have a value to everyone: "It's just too bad we can't afford it all." This is simply not true. [15]While the idea of providing increased opportunities for private business and physicians to aggressively market new tests, treatments and products may have seemed to the government like a good way to avoid having them bill the public health plan, it demonstrates both a poor understanding of the risks and benefits of medical products/services - and the hidden costs to both the public and the public purse. This is particularly true in Canada where the complications from such procedures are treated in the public system. Even physicians' malpractice insurance premiums in Canada are heavily subsidized by taxpayers. It is difficult for CACA to understand how a policy of encouraging Alberta families to spend more money on unnecessary, expensive or potentially harmful tests and treatments can possibly be good for "the health of the population" - another frequently identified mandate of Alberta Health. It has been therefore of great concern to CACA that the growth of these hybrid facilities has resulted in a much more highly commercialized health care environment which downplays the risks involved from use of such tests or treatments.[1, 2]

Furthermore, a unique feature of Health Canada's regulatory system for pre-market clearance of medical devices (e.g. lasers, implants, etc) allows many products and procedures to be used in commercial settings *before* they have been fully evaluated and often years before they are cleared for such settings in the U.S. The safety of any product or treatment restricted to *medical use* is highly dependent on a number of variables and is not well suited to commercial environments where there are increased risks that the margins of the safety envelope will be pushed for economic gain. The more powerful the technology or medical therapy; the greater the need for care. Many of new technologies and services offered or marketed by private facilities are poorly evaluated (from a long term perspective or on certain types of candidates) and/or are higher risk, particularly when used on the wrong person for the wrong reason in the wrong setting or by the wrong person. [16]The skills and care applied to evaluating the value of a particular test or treatment for an individual are as important as the actual physical skills

[15] The Consumers' Association has an over 40 year history of looking at the evaluation, approval and marketing of medical devices and drugs. It is instructive to consider that whenever a new drug or medical device comes out it is deemed to be so much safer than the previous one. Yet just the week previously, you will often find reports of the former drug or device being touted as "completely safe".

involved. There are also no warrantees and medical procedures are not covered under traditional consumer protection legislation. Neither is the content of advertising. There are no readily available sources of information for consumers to make a truly informed choice. Alberta and Canadian law, the courts, regulators and social structures are currently ill prepared to deal with such a high degree of commercialism in healthcare.

> While some physicians today see no difference between their sales activities in private facilities and those of other businessmen, there *are* major differences. Physicians who are opted in to the public health plan services are paid by the public system for their *advice* and have *guaranteed access* to patients who are forced to rely on them *for access* to insured services. When these physicians and private facilities provide insured services (on contract or individually), consumers tend to make assumptions about the value and safety of marketed products and are less cautious than they would be in other circumstances.

Physicians have historically been granted the privilege of some leeway on this issue of private sales of non-insured services and technologies in Canada. It has been done with the expectation that professional ethics and fiduciary obligations would guide their behavior, and the knowledge that they would be minimally tempted to market unnecessary services to meet the expenses required by large capital investments because of the availability of public facilities. This has changed substantially over the past decade.

Another major problem faced by a public health system with a less monitored and less managed co-existing private system is that the aggressive promotion of non-insured or insured health products creates expectations and demands for the public system - often inappropriately. This increases the use of tests, treatments and products of extremely limited value and the use of these tests in ways which do not necessarily benefit patients.

This is why using a blunt instrument such as drastic cuts to the public system without addressing the issue of value and appropriateness puts both individuals and the public at such great risk. The evidence clearly indicates there is usually *more (not less)* inappropriate and inadequate care in private health systems than in public systems. Increasing or decreasing the

[16] Given international evidence, CACA urges Albertans to use caution in evaluating their need and/or desire for many of the new aggressively marketed vision correction surgeries and their choice of practitioner. Some of have a checkered history, unknown long term results and a number of variables can affect outcomes.

amount spent on health is no guarantee that only appropriate treatments will be funded or provided. In fact, this is why patient user fees do not accomplish their frequently identified purpose of stopping "abuse" – as well as the fact that most medical care is physician directed. User fees impede both necessary and unnecessary care.

Response to Question 4: Determine if the bill preserves the public health system, by clearly defining the limitations on the role of non-public health providers?

The answer to this question may already be self-evident from previous comments. CACA does not believe Bill 37 adequately defines the role of non public health providers or the preservation of the public health system. Many of the claims made by private business interests regarding the use of privately owned facilities and increased reliance on private payment have not proven to be true in other countries and should be carefully evaluated. The following are two of the unsubstantiated claims regularly made by such business interests:

Claims

> "*We will relieve the burden on the public system and increase access to patients waiting in line for public health services"*
>
> *"Private business can do it cheaper and better"*

Reality Check:

According to Dr. John Yates of the Health Services Management Centre in Birmingham, England and a researcher and author of a book on waiting lists :

> *"I see no evidence that it (the British private system option) is relieving the burden on the NHS system and it is certainly not making quality care accessible to all. Waiting lists and waiting times are much larger and longer in Britain than they are in Canada and that the differential access between the private sector and the NHS is quite staggering. In 1994, (waiting time) was an average of two weeks in the private sector and 25 weeks in the NHS to see an orthopedic surgeon. An analysis of median waiting times between 1989/90 and 1994/95 showed that in that period NHS waiting times for any surgical operation increased from 41 to 46 days, whilst for private patients in the NHS it went down from 12 to 10 days. For excision of breast in 1994/95 median waiting time in the NHS was 15 days but for private patients seven days, and for prosthesis of lens operations 175 days in the NHS and 17 days for private patients. A dual system almost certainly guarantees inequity. We in Britain look with envy and some disbelief at the Canadian system which seems to be more equitable than our own and also has shorter waiting times (based on Fraser Institute data). "* (personal e-mail to CACA representative)

Closer to home and in the face of media reports of an average two year wait for cataract surgery creating political and public support for the expansion of private clinics, CACA conducted a sample survey of cataract surgeons in the province in April of 1994.

INITIAL KEY FINDINGS 1994 ACCESS TO CATARACT SURGERY SURVEY

- The average wait for cataract surgery ranged from 2 to 6 weeks for surgeons who only worked in public hospitals. Longer waits for hospital surgery, up to 18 months, were only experienced by patients *whose surgeons also had a more lucrative private pay option*.

- Charges ranged from $700 to $1275 dollars per eye for surgery in private clinics compared to per case costs of less than $500 dollars documented by 3 public hospitals.

Subsequent interviews revealed that patients were not advised of much shorter waiting lists with other equally competent surgeons and/or that in most cases surgeons have some flexibility to adjust their surgical schedules to in patients in need of "urgent" surgery to maintain independence - as the following case history demonstrates.

> *Early in the summer of 1995 Mrs. Irma S. made an urgent appointment to see her local optometrist in a rural area about an hour and half out of Edmonton. Over the period of about a week, she had completely lost her vision in one eye. Her optometrist referred her to a cataract surgeon in Edmonton who advised her that she had a very dense cataract in the eye and would need surgery to restore her vision. He advised her that there would be a nine month wait for surgery in the hospital but he could do the operation immediately in a private surgery clinic for $1000 dollar fee. Although this was a lot of money for Irma, her fear of going blind was greater. "I was so worried that I would lose my vision in the other eye during the nine month wait and the doctor said he couldn't say whether or not this would happen with the other eye" so she decided on the spot.*

In June of 1998, following a ruling in 1995/96 by the federal government that no patient fees would be allowed at private surgery clinics for services that were fully insured when provided in hospitals as well as private clinics, CACA conducted a second survey.

1998 ACCESS TO CATARACT SURGERY SURVEY

Consumers' Association of Canada (Alberta) surveyed the offices of 48 ophthalmologists identified previously as offering cataract surgery. Our callers represented themselves as an individual with a family member who had been diagnosed with a cataract by another health provider and who was now seeking information on waiting times and any associated costs. The 3 sites in Alberta that performed the highest volumes of cataract surgeries (on Albertans) in 1997 were Calgary, Edmonton and Lethbridge. Less substantial numbers were also performed in Medicine Hat, Red Deer, Stony Plain, Wetaskiwin, Grande Prairie, Westlock and Lloydminister. In Calgary, 100% of publicly paid cataract surgery is contracted out to private clinics. In

Edmonton, 80% of surgeries are performed in public hospitals and 20% is contracted out to private clinics. In Lethbridge, 100% of cataract surgeries are performed in public hospitals.

KEY FINDINGS:

Based on information provided to our callers, the following "choices" are available to Albertans:

• Albertans have a choice of 23 surgeons in Calgary, 15 in Edmonton and 3 in Lethbridge.

• Following an assessment and a decision to proceed with cataract surgery:

- In Calgary, Albertans could find waits which varied from 1 to 40 weeks
- In Edmonton, Albertans could find waits which varied from 2 to 8 weeks
- In Lethbridge, Albertans could find waits which varied from 1 to 8 weeks

- In Calgary, Albertans could expect an "average" wait of 16 to 24 weeks
- In Edmonton, Albertans could expect an "average wait" of 5 to 7 weeks
- In Lethbridge, Albertans could expect an "average" wait of 4 to 7 weeks

- Albertans had a 56% chance of having surgery in < 12 weeks in Calgary*[17]
- Albertans had an 87% chance of having surgery in < 12 weeks in Edmonton
- Albertans had a 100% chance of having surgery in <12 weeks in Lethbridge

In order to follow his/her surgeon's advice for the best outcomes which include that the patient purchase of a newer "foldable" lens promoted as providing various combinations of less infection and/or complications, better vision, less trauma, faster healing and less discomfort); patients advised to have cataract surgery by a cataract surgeon in Alberta had:

- In Calgary, about an 80% chance of a surgeon offering an upgraded implant for prices ranging from $250-$750/ eye in Calgary with the most common charge $400 per eye.

- In Edmonton, about a 40% chance of a surgeon offering an upgraded implant for prices ranging from $250-$425 per eye with the most common charge $250 per eye.

- In Lethbridge, a 0 % chance of paying additional fees for cataract surgery in Lethbridge, as the same type of implant is provided at no cost.

The majority of written information provided by surgeons' office regarding these implants was promotional material from lens manufacturers.

[17] That is to say that 56% of cataract surgeons surveyed were booking surgery for 12 weeks or less.

Depending on which surgeon an Albertan was referred to by his or her optometrist or family physician, he/she could also expect:

- Being offered shorter wait with multiple surgeons at one clinic if they choose to pay extra
- Being refused by at least one surgeon unless they choose to pay extra

CAC Alberta has also received 3 reports from individuals who were advised that their surgery was going to be postponed to make way for paying customer, unless they chose to pay extra, however, none of these individuals are willing to come forward publicly.

There are also varying opinions on the value of these newer "foldable" lenses and many variations of implants - all of which claim to be better than the others. Most wholesale individually to physicians for $100 - $200 dollars per implant and bulk purchases can reduce this cost. The "Conflict of Interest Guidelines" of the College of Physicians and Surgeons theoretically limit physicians earning more than a 15% administrative fee above the wholesale cost of products which they recommend to patients according to a representative of the College. On November 16th, 1998, the CACA filed a complaint under the Medical Professions Act against 16 surgeons for violation of these Guidelines. No decision has been reached.

Therefore, while the private sector *may* be able to do it cheaper, there is little evidence that they *do* except at the expense of quality and access. After all, their cost of borrowing capital is higher and investors require returns. International health economics and health policy research indicates there are a number of external and internal factors which can affect the potential value of contracting to private facilities for publicly paid services. Here in Alberta, private cataract clinics cannot seem to provide the same service without add-on charges. The Alberta Workers' Compensation Board needed to increase their facility fees (up to 500%) and include a specified 20% profit margin in order to get timely care at the private Health Resources Group Surgery Centre. The experience in other jurisdictions is that private suppliers will often come in with a low bid to wipe out public competitors and establish themselves in the market. Once that occurs, prices rise and quality of service often drops.

Reports from Australia and the US indicate that drastic cost over-runs and even outright fraud are not uncommon - adding to legal, administrative and regulatory costs for the public purse.

[18]While historically both these countries have had co-existent public and private payment and delivery systems, much of their recent grief has been as a direct consequence of public purchasers being enticed by offers from private companies to build and/or run hospitals and service plans paid by the public purse. In one particularly example in Australia, a decision to save 15 million dollars by having a private company build a local hospital turned into a lifetime loss - with costs running over double the original cost estimate (143.6 million instead of 50 million) and the permanent loss of this asset at the end of twenty years. Contracting out to private business has also been demonstrated to often increase fragmentation of the delivery of care, making coordination of services an elusive ideal. This is exacerbated by heavy reliance on poorly paid and/or part time and casual staff - from cleaners to physicians, leading to a lack of continuity of care and poor or inconsistent quality.

Ironically, both the introduction of Bill 37 and the work of the Blue Ribbon Panel demonstrate one of the frequently hidden costs of the "privatization" of healthcare – the added legal, administrative and regulatory costs to the public. The creation of the legislation and the work of the Panel are not cost-neutral. Economists often refer to these costs as "transaction costs"

Final Words

In the words of Sally Nathan of the Australian Consumers' Association, a country where they have had much more experience with private hospitals.

"In theory it shouldn't matter who owns a hospital; in practice, it can matter a lot."

[18] "Consumer Reality Check on Private Health Care", CACA, 1997, "Who wants Medicare Dead", Choice Magazine, Australian Consumers' Association, November, 1997, Ashton, Toni, "The Health Reforms: to Market and Back?", Contracting for Health Services in New Zealand: A transaction cost analysis", 1996, "Contracting Out" Conference Papers, Centre for Health Economics and Policy Analysis, McMaster University,1996, Parker et al, "Comparison of Community-Owned Not-for-Profit Hospitals and Columbia/HCA For Profit Facilities in Six Florida Markets", 1997

If the private business sector can provide a better quality product for a lower price without sacrificing accessibility and quality, then the Alberta Consumers' Association heartily supports the use of this sector. However, the issue must be evaluated at both the macro system level and a micro level in order to make such an evaluation. Appropriate policies also put in place to protect the public interest. The evidence to date suggests that too much reliance on the uncontrolled and often uncontrollable private sector in healthcare does not often work to the benefit of citizens. Certain aspects of Bill 37 provide some opportunities for such control, but we do not believe that Bill 37 can accomplish the originally stated goals without changes to both the Bill itself and other policies.

Thank you for this opportunity for input to your deliberations.

Tel: (780) 426-3270 or E-mail *contact@albertaconsumers.org*