

**The Consumer Experience
with Cataract Surgery
and Private Clinics in Alberta**

Canada's Canary in the Mine Shaft



**Consumers' Association of Canada (Alberta)
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By Wendy Armstrong

NOTE: This electronic copy has been reformatted for a PDF version resulting in changes to the numbering of headings and pages. A limited number of minor revisions have also been made to the text and Illustration headings to improve clarity without affecting content. Additional footnotes have been added and labeled 2003. The Report opens with a one-page Author's Update.

The Alberta Chapter of Consumers' Association of Canada is an independent non-partisan, not-for-profit, provincially incorporated consumer rights organization. (1968). The purpose of the organization is to protect consumers' rights to health and safety, access to reliable information, and fair and honest dealing in the marketplace. Funding for activities comes from donations, memberships and ad hoc non-restrictive grants and fees. It is affiliated with the national Consumers' Association of Canada (founded in 1947). The author of this report, Wendy Armstrong, is a public interest researcher and advocate who has been affiliated with the Association for over 10 years.

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Author's Update February 2003

Following release of this report, the provincial government commissioned an external review of the literature relating to the merits of contracting out publicly insured surgical services. The paper, “Summary of the Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity”(Donaldson and Currie) can be found at <http://www.ihe.ab.ca/>.

Public pressure over the additional out-of-pocket charges and excessive retail mark-ups for cataract lens implants in Regional Health Authorities contracting out to private surgery clinics identified in the report led to full Medicare coverage of these implants for all patients. Payment was limited to suppliers' wholesale price plus a regulated mark-up.

Bill 11 (the successor to Bill 37 described in this report) was passed in the Alberta Legislature a few months later. It allows, but limits the mark-up on sales of certain types of goods and services sold in relation to publicly paid *surgeries* in public and private facilities – but does not apply to facilities providing diagnostic, medical treatments or convalescent care. Bill 11 also expanded opportunities for contracting out inpatient hospital-type care to commercial interests. The College of Physicians and Surgeons has now developed accreditation standards for inpatient care in “long stay non-hospital surgical facilities” (private hospital type facility). The province has approved a number of contracts.

The strategy of “unbundling” the components of an insured service (e.g. health workers, facility settings and products) in order to shift payment responsibilities for previously insured care to patients is now being copied in new substitute settings for long and short term convalescent care. Patients are left to purchase associated non-insured components of care at higher and unregulated retail prices. Families and/or employers are expected to cover the shortfalls either directly or through the purchase additional private insurance policies. (See 2002 Consumers' Association report entitled “Eldercare – On the Auction Block” accessible in PDF format on the Association's web-site.)

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

Sally Nathan, Australian Consumers' Association

Table of Contents

Table of Contents

List of source documents in separate Appendix

Acknowledgments

Executive Summary

1. Introduction: Testing a New Environment	1-5
2. Cataract Surgery: A Valued Medical Procedure	6
3. In the Beginning: Public Hospitals and Public Payment	7-11
4. Crossing the Divide: From Public Hospitals to Private Clinics	7-11
5. A Snapshot on the Impact of Extra Billing on Alberta Families	12-16
6. Letting the Genie(s) Out of the Bottle	17-20
7. The Transformation of Extra Billing into Facility Fees	21-23
8. The Growth of Private Surgery Clinics in Alberta	24-26
9. Alarm Bells Start to Ring in the Provincial Government	27-29
10. The Focus Shifts Back from Controlling Costs to Shifting Costs	30-33
11. The Klein Revolution and its Impact on Cataract Patients	34-35
12. Expanding the Potential Market for Private Eye Clinics	36-39
13. Fitting a Square Peg into a Round Hole - U.S. Style Managed Care	40-43
14. Market Positioning and the Gimbel Foundation Act	44-46
15. Consumer Reality Check 1994	47-52
16. A Swing and a Miss - the Federal Government Goes to Bat	53-61
17. A Tale of Two Cities	62-63
18. The Evolution of Facility Fees into “Enhanced” Lens Fees	64-69
19. Waiting Patients become Unwilling Pawns in a Quota War	70-72
20. The Reinvention of Hospitals by the Private Sector	73-84
21. Consumer Reality Check 1998	85-91
22. A Snapshot of Accountability for Commercial Medicine in Alberta	92-98
23. Evaluating the Canary in the Mine Shaft: a Postmortem	99-103
24. Conclusion & Recommendations	103-106
Quote of Sally Nathan, Australian Consumers’ Association	107
Selected Bibliography	108-119

Listing of original source documents in separate Appendix

1. Chart of Gimbel Vision International (Excerpt from Alberta Securities Commission Filings, 1998)
2. Conflict of Interest & Principle of Ownership Policies (College of Physicians and Surgeons of Alberta)
3. Excerpts from Alberta Securities Commission Filings by Surgical Centres Inc. (1998)
4. Excerpts from Alberta Health 1991 Paper on *Ambulatory Care*
5. Series of Alberta Health Directives on *Enhanced Goods and Services* (1992 to 1996)
6. Excerpts from FOI (Freedom of Information) Request to Alberta Health on shifting costs to private insurers related to physiotherapy payments.
7. Alberta's 12 Principles on Private Clinics
8. Response from CHA to Request for List of Contracted Private Surgery Clinics
9. Letter from Lamont Health Centre re: per case costs of cataract surgery and upgraded lens implant.
10. Excerpts from Business Plan of Health Resources Group
11. Correspondence re: complaints to Alberta Health and CPSA
12. List of contracted private surgery clinics providing cataract surgery in Alberta

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Most of all, I want to thank the individual Albertans who took the time and chose to share their stories and experiences with CAC Alberta so that all Canadians will have an opportunity to give some sober second thought to the path we appear to be heading down.

Wendy Armstrong

EXECUTIVE SUMMARY

Since the early 1990s, Canadian governments have been preoccupied with elimination of public deficit and debt. A major strategy for achieving this goal has been to reduce expenditures on public services, especially in health care, social services and education. The Province of Alberta was the first to eliminate its deficit, after affecting major expenditure reductions. Over a three-year period, expenditures in health care were dramatically cut by approximately 19 per cent, although due to an increase in population, these cuts were even greater on a per capita basis.

A key aspect of the expenditure reduction strategy adopted by Alberta has been outsourcing and privatizing the delivery of health care services. However, this phenomenon is not new. In fact, Alberta has been shifting the provision of services from public hospitals to the community for the last two decades. In the process, the provision of these services has become increasingly reliant on (and driven by) private business interests. Since the early 1990s, the tendency to “farm out” the provision of health services to private providers in community setting has been facilitated and encouraged by government policy. By significantly reducing the capacity of the public health care system, the government has created an environment in which frustrated regional health authorities, health care providers and patients alike have been looking for alternative means to deliver necessary health care services. This environment has been reinforced by the Regional Health Authorities Act, which specifically allows regions to contract with private providers for the provision of services.

For example, the Calgary Regional Health Authority currently contracts out *all* eye surgery and many various types of day surgery to private providers. Private corporations, which are often owned in whole or in part by senior managers of the regional health authority, are major beneficiaries of this process. Yet no conflict of interest is perceived by the government. Ironically, many of these services are being provided in facilities that were originally built with public money, but were sold to the private sector at fire sale prices as a result of downsizing. In addition, both Calgary and Edmonton have contracted with large regional monopolies in the private sector for the provision of regional laboratory services.

The commitment of the Alberta government to increased privatization of health care stems from the common assumption that private sector provision of health services results in cost savings, decreased waiting lists and improved quality. Yet, none of these often stated benefits are apparent from the privatization of cataract surgery provision in Alberta. In fact the opposite appears to be true. The best available information indicates that private contractors are more expensive to the plan. In addition, surgeons who also operate in private facilities appear to have longer waiting lists for public facilities than those surgeons who operate only out of public facilities. This suggests that surgeons operating in both the public and the private sector may be artificially inflating their public waiting lists as a means of enticing their patients to receive care in private facilities. Private surgical facilities also offer opportunities for physicians enrolled in the provincial health plan to spend more of their time providing higher paying non-insured services which have uncapped fees. In terms of quality of care, there appears to be no perceived difference in the quality of care received in either public or private facilities based on patient satisfaction.

Another troubling side effect of the current environment is the increased commercialization of the behavior of health service providers. Private sector health providers, contracted by the CRHA to

perform necessary eye surgery, have attempted to reap significant profits by selling enhanced service packages to prospective patients. The choice of the enhanced service package is said to involve a less painful and more successful procedure, and most tellingly, will sometimes ensure quicker access to surgery. Patients are left to make these decisions without good information and often under significant duress.

The net result is that some surgeons are billing the government the set rate for the procedure and at the same time charging patients directly for enhanced service packages. The cost of the surgery can be lower than the cost of the enhanced service package. In some areas of Alberta which only provide cataract surgery in public facilities, the cost of providing the same enhanced product is substantially lower than when provided in the private sector. This creates differences in the level of coverage of the same insured service around the province. Neither the government, nor the Provincial College of Physicians and Surgeons has taken serious action to prevent this creeping commercialization of professional practice, despite the clear evidence that it is more costly to the public and marketing practices are often questionable.

The current government initiative to introduce legislation to “regulate” the activities of the private sector could remove current restrictions on the scope of activities of private providers. If this occurs, regional health authorities would be able to contract out the provision of almost all surgical services (not just day surgeries) to private providers. The Calgary Regional Health Authority appears to be amenable to this approach to service delivery.

The experience by Alberta consumers, with moving the provision of cataract surgery from public hospitals to private clinics, demonstrates how a significant shift from community controlled institutions and agencies to private, investor-controlled suppliers, results in the loss of price and cost controls possible when health services are publicly financed and delivered through public facilities. The shift of cataract surgery from public delivery to private delivery has resulted in increased prices for consumers and increased administrative overhead and transaction costs for the health care system. The benefit for government has been the ability to shift costs from the provincial health plan to out-of-pocket expenses and private insurance premiums. The provision of cataract surgery provides a telling example of what the current move to privatize significant portions of health service delivery will hold for Albertans and may serve as a bellwether for the rest of Canada.

In summary, the evidence in this report found that increased reliance on private surgical facilities in Alberta to deliver publicly insured cataract surgery has:

- increased public waiting lists
- increased the cost of the services to the plan
- increased the price of the service to patients
- decreased patient choice of surgeon and site of care within the plan
- created unequal levels of coverage (and quality) for insured service across the province
- provided poor value for money
- led to a number of conflicts-of-interest which jeopardize taxpayers and patients
- decreased public plan accountability, public scrutiny and public control, and
- created increased risks with little protection for either patients or taxpayers

A New Direction

Recommendations to Control the Cost of Health Care to the Community and Increase the Safety, Quality, Timeliness and Accessibility of Medical Care

1. Identify a credible public body to determine the dollar value of health expenses shifted from the provincial plan to private payers (including lost or replaced income waiting for treatment) since 1980 or 1985. (e.g. employer sponsored health plan, out-of-pocket, workers compensation programs and health, life, home and auto insurance premiums).
2. Determine how to best shift this money back into the public health system in a fair and equitable manner in order to maximize price controls, timely access and value for money. This shift is how Canadian Medicare was originally created. It is a success story that can be built upon.
3. Begin a deliberate effort to shift the ownership and control of facilities and agencies providing public insured services in the community (outside hospitals) from private investor-driven agencies to a controlled number of government approved and community driven not-for-profit agencies which are globally funded and publicly accountable. Limit and regulate existing private facilities.
4. Limit opportunities for physicians opted into provincial plans to provide privately paid services including prohibiting private direct sales of products or services related to an insured service. Restrict other publicly legislated programs (such as Workers' Compensation Plans) from paying higher fees to practitioners and facilities. Maintain restrictions on private insurance coverage.
5. Restrict the scope, size and circumstances of physicians' investment in private health ventures in order to avoid conflicts which may adversely affect patient care. Patients should not have to be on guard for a sales pitch when seeking vital medical advice.
6. End the use of strategies that have fueled the growth of commercial activities in the health services sector and driven up costs to the community. Such strategies have included: a) delisting services, quality or timeliness from the provincial plan b) providing commercial interests with generous access to public money and captive public patients, and c) creating new direct purchasers of health care services. Instead, provide appropriate coverage of old and new services and technologies.
7. Apply the Principles of the *Canadian Health Act* (as identified by Federal Minister, Diane Marleau on January 6, 1995) to the full range of diagnostic, treatment, recovery and rehabilitation services moved outside hospital settings. Being a "payer of *first resort*" for a comprehensive range of services required to recover from an episode of illness or manage a chronic condition, is the best way to maximize flexibility, choice and value for money.
8. Ensure quality and compassion within the public plan and equal public plan coverage of an insured procedure regardless of the location of delivery.

9. Increase public access to information on decisions and supporting rationale regarding plan coverage and issues relating to the development, cost, evaluation, regulation and marketing of medical services and products. Ensure adequate appeal processes and representation on decision-making committees for plan members.
10. Legislate that any significant changes to the terms and conditions of the provincial health plan required prior written notice to plan members, public hearings, and intervention opportunities for academics, workers, employers and citizen groups and that evaluations of the impact of changes are based on the overall cost, quality and accessibility of health care services to the community at large - not just the impact on the budget of one government department or health plan.
11. Reduce the unnecessary additional costs of administering multiple assessment, treatment and payment streams (e.g. workers' compensation). Bring direct payment of medical care under one roof. It makes little economic sense for force Canadians to rely on separate systems and insurers depending on where, when or how an injury or illness occurs.
12. If changes are not made to the current model of increased reliance on commercial interests and outsourcing, significant taxpayer dollars will need raised or shifted to invest in consumer and taxpayer protections related to the documented problems associated with increased commercial activities by investor-driven suppliers and private insurance companies.

1. Introduction: Testing a New Environment for the Delivery and Payment of Medical Care

Years ago, British coal miners developed a system for testing for the presence of lethal gases in a newly dug shaft prior to entering the shaft themselves. They would put a canary in a cage and lower it into the new environment. Some time later they would pull up the cage. If the bird was ailing or overcome the shaft was considered unsafe for miners until corrective action was taken or a new shaft dug.

No single expense can devastate an individual or family more than the cost of ill health. This is related to both the high prices of medical care and the inability to maintain income or other responsibilities in the face of illness, injury or a chronic health condition. The cost, quality and accessibility of medical care have a powerful influence on the safety and financial security of families and the communities in which they live. High costs can lead to financial hardship or ruin. The inability to obtain care can lead to unnecessary suffering, disability and/or death. These high stakes are one reason that prices for medical services and products are so difficult to control. High prices in turn impede access to health services.

The product that citizens in most developed countries “purchase” either individually or collectively is not solely a specific medical procedure or product. It is a method of payment as well as a system of delivery of medical care which will protect them from the high prices and unpredictability of illness or injury, and provide a measure of security and freedom from fear of being unable to obtain or afford care when they need it. Citizens also purchase through their governments the type and amount of regulation necessary to control prices, ensure adequate distribution and provide an acceptable level of safety in medical services and health plans.

The Introduction of Public Health Insurance in Canada

In order to achieve this highly valued “freedom from fear” and improve the community’s value for dollars spent on medical care, Canadians in the 1950s and 1960s supported the gradual introduction of universal publicly funded health plan coverage. This replaced an administratively expensive patchwork system of private health insurance coverage and charity that had left many Canadians at various times in their lives compromised or disabled by lack of access to medical care or deeply in debt from paying for medical care.

The Canadian public health plan (known as “Medicare”) is actually a loose collection of provincially run health payment plans jointly financed by the Federal and Provincial governments. In return for financial support from the Federal government, provincial governments agreed to take responsibility for providing first dollar coverage and payment for all medically necessary and medically required hospital and physician services to meet the needs of the population.

In order to achieve this objective, health care facilities providing valued medical care and trained staff (hospitals) and independent skilled professionals (physicians) the opportunity to sign up to provide services for the provincial plan in their home province. By doing so, they agreed to provide services to any resident of the province or visitors from other provinces for a specified amount of money negotiated regularly with the provincial plan administrators. In return, these hospitals (historically built and run by religious charities or governments on a non-profit basis) and private physician practices (historically run as small private businesses governed by professional codes of conduct) benefit from guaranteed payments, reduced administration costs and the opportunity to service a larger pool of patients.

Medicare was designed to slow inflation in the prices of highly valued medical services and make more medical care available to more Canadians - to the benefit of families, employers and communities - through the cost savings achieved by the design of the Plan. This design included five Guiding Principles (universality, public administration, comprehensiveness, accessibility and portability) which were reaffirmed in the *Canadian Health Act (1984)* to maximize price and cost controls, safety, choice and the availability of hospital and medical care.

The Five Required Criteria for Public Health Plan Coverage

By covering all residents of every province (**universality**), the Plan did away with the need for high cost and unreliable private health insurance products and ensured that no one was denied access to medical coverage due to pre-existing conditions. It also spread the risks and costs of health care coverage among a large group of people similar to large group insurance plans, and maximized the ability of provincial plan administrators to control distribution and prices through central planning and bulk purchasing. Elected representatives were made responsible for running provincial health plans on a non-profit basis in order to minimize costs to the community and enable citizens to scrutinize and influence decisions about the quality, cost and accessibility of services covered by provincial plans (**public administration**). Plan administrators were also given an obligation to ensure the availability of adequate resources to service the population without any financial barriers which would impede timely access to medically necessary care (**accessibility**), regardless of where individual Canadians lived or worked (**portability**). By providing access for all members of the community to the full range of hospital and medical practitioner services required to relieve or avoid unnecessary suffering, disability or death (**comprehensiveness**), plan members would have a wide

choice of physicians, locations, and treatment options. This left a limited number of services with uncapped prices for which an individual could be held hostage by arbitrarily set high prices at time of need. It also provided a mechanism to encourage individuals to use services which have a demonstrated impact on limiting future social and health costs by eliminating financial disincentives to seek timely assessment and treatment before a crisis occurred.

There is ample evidence in international health economics and health policy literature of the success of Medicare in accomplishing these goals - along with the highest level of citizen satisfaction in all OECD countries surveyed, including the U.S. (Blendon et al, 1990). In marked contrast to the period prior to the introduction of Medicare, the cost of providing this care (to far more families) as a percentage of the GNP or GDP remained relatively flat compared to the U.S.

Pressure for a Changing Environment

None-the-less, in the late 1980s and early 1990s, many politicians, business leaders and members of the public began to be concerned over rising expenditures by provincial health ministries in difficult economic times. With concern about debts and deficits growing, provincial health budgets that consumed 30% of provincial expenditures were an obvious target. There was also growing unrest among the public (echoed in other countries) with the increasing fragmentation and depersonalization of modern institutional care and modern medicine. Many patients and families were frustrated with the lack of responsiveness by many physicians, institutions and provincial plans to pleas for more user friendly options. Some began marching with their private dollars to alternative therapists who appeared to be far more responsive and willing to provide more user friendly alternatives and a personal relationship.

To many Canadians, it seemed as though they were paying a lot of money both publicly *and* privately (drugs, ambulance services and home care) without receiving the level of service or benefits they wanted and expected. These concerns over both expenditures and a lack of responsiveness led to many different strategies being proposed and pursued by various parties to improve the quality, cost and accessibility of healthcare for Canadian families.

One of the most visible and seemingly effective lobbies today which claims to have the solution to rising costs and less than ideal patient care has been one which makes assertions that increased reliance on investor driven private business interests to provide publicly insured health care services along with new opportunities for private sales and private insurance coverage, will offer greater convenience, greater choice, greater flexibility and better access to new valuable technologies. This model is also promoted as a way of bringing new funds into local economies by marketing services to foreign visitors. Most importantly, claims are made that increased reliance on private delivery and private payment will “relieve the burden” on the public system, resulting in shorter line-ups and improved access. In fact, supporters often claim this model is the only way to ensure the sustainability of public health care in Canada. The key message appears to be that the

delivery of publicly insured services by private business interests will automatically reduce the price of services to provincial plans, and the infusion of new private money will make urgently required medical care more readily available outside the plan. This would be accomplished without any loss of access for those who cannot pay more - or any additional costs to taxpayers.

Citizens in every province are increasingly pressured to support this new hybrid public/private environment for the delivery and payment of medical care. The alleged benefits of this model hold an obvious appeal for families and employers frustrated by delays in assessments, lengthening of waiting lists for some tests and treatments, a shrinking basket of services covered by provincial plans, and an increased reliance on out-of-pocket expenses or private supplemental benefit plans. The problem is that this model represents a radical departure from the primarily single government payer, globally funded, non-profit delivery model put in place by Medicare

Individual Canadians want to know if, and how, changing the traditional type of supplier of health services and the method of payment will affect the cost, quality and accessibility of health care services for their families. Will increased reliance on private business and the introduction of new private payment alternatives for patients really be more effective in controlling prices, ensuring adequate distribution and providing a greater level of safety and choice? Will such changes shorten waiting lists and increase access to physician recommended care? Will it provide good value for money? What will it mean to families – now, and in the future? Canadians are looking for real information and clear and honest answers about the wisdom of heading into this new environment.

Testing a New Environment for Health Care

A look at the health system in the province of Alberta may provide some insights. These strategies of increased reliance on private business interests to provide publicly insured services and the creation of alternative sources of private payment for physician recommended care are really not all that new in Alberta. Over the last two decades, many components of traditional hospital care have been increasingly pushed and pulled outside public hospital settings to the community. In the transition, the provision of these services has become increasingly reliant (and driven) by private business interests.

Since universal coverage and full payment for services provided outside hospitals is allowed - but *not required* by the Canada Health Act, this change in venue has shifted much of the financial burden for health costs to patients, employer sponsored benefit plans, individually purchased private insurance plans and health care charities. It has also created new sources of private revenue for health providers.

The character of suppliers providing publicly paid health has also changed from small individual professional corporations or service oriented non-profit organizations such as the Victorian Order of Nurses, religious denominations and local governments to large publicly traded and privately owned for-profit companies with obligations to third party investors and shareholders.

Examples include MDS Laboratories, DC DiagnostiCare, Olsten, and Gimbel Vision International. Many physicians opted into the provincial health plan seem to be spending increasing amounts of their time and energy dealing with business investments and marketing higher paying non-insured services to individuals outside the public health plan.

Nowhere are these changes more evident than in the specialty of ophthalmology and the delivery of one highly valued medical procedure - cataract surgery. Up until 1980, 100% of cataract surgeries performed in Alberta were performed in public hospitals. By 1998, almost 100% of cataract surgeries performed in Calgary, Alberta's largest urban centre, were performed in private surgical facilities owned and operated by private business interests on contract to a newly created local public funding authority.

Just as the British miners' canary was used to test the health and safety of a new mine shaft, a careful look at the history of the experiences of Albertans over the past 20 years in an increasingly privatized environment for both the delivery and payment of cataract surgery can provide insights into how these proposed changes will ultimately affect the cost, quality and accessibility of both medical care and health plan coverage for Canadian families.

This report documents the experiences of Albertans from the perspective of a consumer of both a specific medical procedure and health plan coverage.

2. Cataract Surgery: A Valued Medical Procedure Covered by the Public Health Care Plan

Sight is universally cherished and valued. Good eyesight helps us carry out tasks and activities necessary for both survival and pleasure. As we age and experience other limitations on our ability to maintain independence, reliance on eyesight and the value we place on it increases. Any eye condition which severely limits our ability to perform daily tasks can have a profound impact on our own quality of life and that of friends and family who may depend on us - particularly if the condition is uncorrectable with glasses.

Cataracts & Cataract Surgery

A cataract is the clouding of all or part of the natural, and normally clear, lens of the eye. This clouding, depending on its size and location, can interfere with the ability of the lens to focus incoming light on the retina at the back of the eye and causes hazy or blurred vision. If a cataract is located on the outer edge of a lens where it does not interfere with vision, an individual may not even be aware it exists unless it is identified during an eye examination.

This clouding can develop on only one eye or both eyes at the same time. It can progress slowly to the point of being static or develop quickly over a period of months - although this is rare. Cataracts usually develop gradually over a period of years. If only a small part of the lens becomes cloudy or the opacity progresses slowly, eyesight may only be slightly hampered and a new prescription for glasses will restore normal vision. If a large area is affected, sight in the affected eye may be partially or completely limited until the cataract is surgically removed. Cataract development is a major source of self-reported visual impairment after the age of 65. Less frequently, cataract development is congenital or associated with the use of certain medications, systemic diseases, trauma to the eye or exposure to ultraviolet light.

If there is no other eye disease affecting vision and a cataract is present, the most widely accepted guide for determining the appropriateness of cataract surgery is a vision test (eye chart) of less than 20/40. This is the acuity required to maintain a driver's license in Alberta. However, subjective symptoms such as foggy vision, ghosting or the effects of glare from headlights also need to be considered. Rarely, other disease conditions of the eye dictate an urgent need for cataract extraction.

Cataract surgery today consists of removing the cloudy natural lens and replacing it with a synthetic man-made lens implant. With the surgical techniques most commonly used today, patients no longer have to wait until the cataract reaches a certain degree of density called "ripened" (which severely compromises vision) before the natural lens can be successfully removed. Although cataract surgery is not risk free, the success rate is 95% in patients with an otherwise healthy eye. It is usually performed on a day surgery basis with either local freezing or topical anesthetic drops that may also require sedation.

3. In the Beginning: Public Hospitals and Public Payment

Twenty years ago, all cataract surgeries in Alberta were performed in public hospitals - primarily in Edmonton and Calgary, the two cities where the majority of specialists who perform cataract surgery have historically settled. These “approved general hospitals” had been built and funded with public money from both donors and taxpayers.¹ They were run by largely independent but publicly accountable boards under the authority of municipal and provincial governments or voluntary agencies (usually religious charities) on a non-profit basis. Some hospital facilities built by the federal government to provide services to special groups covered by federal programs also provided cataract surgery.

In 1958 when Alberta opted into the federal cost-shared program (created by the *Hospitals and Diagnostic Act* of 1957) to provide public hospital insurance for residents of the province, the provincial government voluntarily took over financial responsibility for building and equipping all hospitals, but left the day-to-day control of these hospitals to individual boards.² At the same time, the province restricted future hospital construction to prior approval by the Minister of Hospitals and Medical Care in order to maintain control over liability for operating expenses. Later, when Alberta opted into the expanded federal cost-shared program created by the *Medical Care Act* of 1966, it also committed to providing compensation for all required physician services as well as hospital care.

This agreement included a provision that all insured services were to be provided to all residents of Alberta and visitors from other provinces “under uniform terms and conditions” regardless of their age, state of health or financial status. The *Act* also included an obligation for participating provincial governments to ensure appropriate standards, an adequate supply of services, and reasonable compensation to hospitals and physicians funded by their plans. The federal government retained responsibility for payment of hospital and medical care for individuals already covered by other Acts of Parliament. (e.g. RCMP, Armed Forces, Treaty Indians, Federal Prisoners, etc). Provincial governments were also exempted from paying for medical and hospital services rendered “under any law of the province relating to workers’ compensation”, although they retained ultimate control through legislation.³

¹ Under the provincial *Hospitals Act*, a hospital cannot be called a hospital unless it is an “approved hospital” designated as such by the Minister and this designation is tied to public funding. A “hospital” is defined as an “institution operated for the care of diseased, injured, sick or mentally disordered people”: a “general hospital” as “a hospital providing diagnostic services and facilities for medical or surgical treatment in the acute phase for adults and children and obstetrical care or any of them.”

² In 1969, the Province negotiated an agreement to compensate voluntary hospital boards for the ongoing erosion of the charities’ equity in the facilities which they had originally built and equipped prior to 1959. The terms of this agreement remain in dispute to this day. (Catholic Health Association of Alberta and Affiliates)

³ A more detailed history of the evolution of Medicare in Canada can be found a recently published book by Colleen Fuller entitled “Caring for Profit” published by New Star Books & the Canadian Centre for Policy Alternatives. <http://www.policyalternatives.ca/bc/index.html>

During this era, hospitals were viewed by governments, health professionals and communities as a cost-effective means of centralizing medical expertise and expensive equipment and providing “one-stop” twenty-four hour access to both outpatient and inpatient care for the diagnosis and treatment of illnesses and injuries. Acute care or general hospitals were seen as a safe place where compromised individuals could expect assessment and monitoring by skilled personnel, relief of symptoms, and medical treatments such as wound care, drug and fluid therapies or surgery. Trained nurses also helped patients deal with the side-effects of therapies and surgery, and assisted them with hygiene, getting mobile and learning how to manage their condition. Diagnosis, treatment, recovery and rehabilitation from an episode of illness or injury usually occurred entirely within hospital walls.¹

In order to maintain flexibility to adapt to local needs and reduce administrative expenses, operating costs were provided through a yearly grant (global funding) based on prospective budgets and actual expenses. Services provided by these hospitals to Albertans covered by federal government programs or the Workers Compensation Plan were reimbursed or paid by the party responsible. These well-equipped hospitals also provided important supports for physicians. They ensured the availability of equipment and supplies required for medical and surgical procedures, on-site testing, ready access to peers and other health professionals for consultation and 24 hour monitoring and care of patients. Hospitals also provided a physical location to support clinical research and the education of health professionals - and an environment that enabled a level of peer and administrative scrutiny to help maintain professional standards.

Hospital and Physician Payment for Cataract Surgery

In the 1970s, public hospitals provided all the tests, equipment, supplies, drugs, special facilities and nursing care for someone undergoing cataract surgery. Individuals were admitted as inpatients in order to be prepared for the surgery, have it performed in a safe environment, and recover from the effects of anesthesia and surgery under the watchful eye of nurses trained to identify and respond to any complications. Cataract patients remained in the hospital until they were adequately recovered to a state of self care. There were no charges unless the patient chose a semi-private or private room.

¹ “Hospital services” in the subsequent *Canada Health Act (1984)* were defined as “any of the following services 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 and injury, illness 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 anesthetic 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.

The individual's surgeon and the doctor who provided the anesthesia were paid a predetermined fee for their services from a separate pool of money provided by the province which was unrelated to the funds provided hospitals. The amount of money in the pool of money, and the fee for each service was, and still is, negotiated on behalf of physicians opted in to the provincial Medicare Plan by the Alberta Medical Association (AMA)¹ A list of services and amounts authorized to be billed for each is listed in a *Schedule of Medical Benefits*. The items on the *Schedule* and the fees are determined by the AMA during negotiations with the province, based on the advice of the different medical specialty groups within the AMA.

For services routinely performed in hospitals such as cataract surgery or inpatient hospital visits, this fee is considered payment purely for the actual professional service rendered. In contrast, the designated fee for services routinely provided in physicians' private offices (e.g. an assessment of the need for surgery or a post surgery check-up) also factored in an additional amount to cover the overhead of running the physician's private office and maintaining a medical practice. An assumption of 40% was the average used by the AMA and Alberta Health in their fee calculations, although overhead costs for practitioners obviously varied by location and type of specialty.² A number of private free standing laboratories and radiology facilities owned by pathologists and radiologists (more common in Alberta than in many other provinces) were also paid on fee-for-service billing.

Physicians who enrolled or chose to sign up to provide services for the Alberta Health Care Insurance Plan (AHCIP) retained the technical right to extra bill patients an additional fee over and above the amount paid by the AHCIP although most physicians usually billed provincial plan rates. They could also charge a discretionary and independently set fee for services rendered to patients from other countries. Physician services provided to individuals covered by existing Federal Government Plans or provincially legislated Workers Compensation programs (identified in the *Canada Health Act* as pre-existing publicly controlled payers of first resort) were also usually compensated at about the same rates as those paid by the provincial plan. However, some federal programs had in-house salaried physicians. Practitioners opted in to the provincial Plan also retained the right to charge patients covered by the Plan for procedures *not* included in the Schedule of Medical Benefits - such as certain cosmetic surgeries, which were not considered "medically necessary".

In practice, there was a great deal of latitude within the Plan, and if a medical practitioner who had signed up with AHCIP considered a procedure necessary or beneficial to the health of a patient covered by the Plan, it was usually paid. Furthermore, if *any* surgical procedure required the use of a general anesthetic, a safe operating environment and equipment or emergency back-up, the use of hospital facilities was considered "medically necessary" and the cost of equipment, supplies and staffing were absorbed by the hospital at no charge to patients or physicians.

¹ The AMA is a voluntary trade organization for physicians which actively pursues both the monetary and professional interests of its members. The College of Physicians and Surgeons of Alberta is the regulatory body which licenses and disciplines physicians and is mandated to protect the public interest.

² Northcott, H. "Extra-Billing and Physician Remuneration", Canadian Public Policy, Spring 1982.

Medicare turned out to be a boon for most practicing physicians and hospitals - especially for those who had continued to treat sick or injured individuals despite a family's inability to pay. More families could now access their services and physicians were assured of getting paid regardless of a family's finances or insurance limitations. Office expenses dropped dramatically when medical practices no longer had to bear the expense of billing and collecting from multiple private insurance plans and families or absorbing bad debts. These could be substantial, particularly when patients died. The fees paid by the province and duplicated by in-house federal government plans and Workers Compensation programs were generally accepted by physicians as adequate and complete compensation.

The Emergence of Extra Billing

Under the terms of the federal/provincial *Medical Care Act*), provinces had an obligation to ensure that the manner of payment for medical services did not “impede or preclude either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons.” This appears to have been interpreted to mean that physicians opted into provincial plans were not explicitly banned from billing patients an additional fee over and above the fee set by the provincial plan unless the practice became so widespread that it began to affect overall access. Given the increase in income experienced by physicians following the introduction of Medicare, extra billing did not become an issue until the late 1970s. Then, in the midst of a booming Alberta economy, many physicians began to feel their fees were lagging behind and began to bill patients an extra fee for everything from routine office visits to surgery in hospitals. Some cataract patients soon found themselves facing stiff out-of-pocket charges. (Illustration 1)

Illustration 1

EXTRA-BILLING THROUGH THE EYES OF A STUDENT NURSE (1979)

“During my time on duty I watched one particular surgeon repeatedly come in the night before surgery or early in the morning to collect cheques for \$800 dollars from every patient scheduled for cataract surgery. One day I confronted him at the desk about this practice. I told him that I found it terribly offensive given that there were other eye surgeons equally as good not charging patients a penny. His response was ‘How much are your eyes worth to you. . .’ ” (K. Corey R.N., interview, May, 1998)

The only restriction on extra billing at this time was a directive put out by the College of Physicians and Surgeons of Alberta (CPSA) that there be a prior agreement between the patient and the doctor on payment of additional fees in advance of the service being provided. By 1980, extra billing was becoming a major political issue both in Alberta and some other provinces such as Ontario and Quebec. The federal government was starting to take notice.

They appointed Justice Emmett Hall to investigate. Alberta responded by passing Bill 94. This Bill enabled patients to have a physician's extra billing charge reviewed by a Committee of the CPSA, regardless of the existence of a prior agreement. ¹ The provincial government also took a very

important step and began to monitor the amount of extra billing in order to determine the magnitude of the problem.

However, even with Bill 94, the fear persisted that disclosure of an inability to pay extra might affect a doctor's availability or influence treatment decisions. In addition, most Albertans wanted to avoid the discomfort and humiliation of being means tested by the doctor's office staff. The net result was that many patients were less than forthright about their ability to pay at the time of their appointment.² In the early 1980s, the economic boom in Alberta was also starting to collapse. Many families were seeing their income drop dramatically but were reluctant and embarrassed to identify difficult financial circumstances. Many physicians also did not ask.

According to Dr. Alex McPherson, a stated long time supporter of salaried physicians, many specialists at that time tended to charge extra *only* for those services for which patients were perceived to be "willing to pay."³ These tended to be one time services with a high degree of success and patient satisfaction such as the delivery of a healthy newborn or cataract surgery which dramatically restored vision. After all, he noted "It's much more difficult to charge patients for medical care which involves ongoing treatment such as cancer". Dr. McPherson also points out that the ability to leverage additional fees was often factored into decisions made by AMA specialty groups on the allocation of money for certain fee codes. For example, when funding for physician fees dramatically increased in 1981, the obstetricians/gynecologists group made a decision to increase other fee-for-service payments but maintain low fees for normal deliveries because of the perceived willingness of expectant parents to pay for specialty care.

The point to note is that the existence of this extra billing option for medical services turned out to be pivotal in the early development of private surgery clinics in Alberta.

¹ "Russell gets tough on extra billing: MDs face Medicare ban", Calgary Herald, 11/11/79, "Emmett Hall appointed to review Medicare system", Globe and Mail, 18/09/79

² Avoidance of such situations had been a powerful motivation behind public support for the introduction of Medicare a decade previously. (Fuller, Colleen, "Caring For Profit", New Star Books, 1998)

³ Taped interview with Dr. Alex McPherson, Spring 1998. Dr. McPherson was President of the AMA in 1981/82 and subsequent provincial Deputy Minister of Hospitals and Medical Care

4. Crossing the Divide: From Public Hospitals to Private Clinics

About the same time that extra billing for surgery in public hospitals began to flourish, advances in both anesthesiology and surgical techniques were decreasing the risks of cataract surgery and improving the results. These advances were also reducing both the time required to perform the surgery and the length of hospitalization.^{1,2} This created the possibility of providing cataract surgery on a day surgery basis. The removal of previous severe restrictions on activity following cataract surgery (limited head movement and bed rest) also increased the number of potential and willing candidates.

The concept of outpatient day surgery was gaining cautious support with the provincial government at that time as a means of reducing hospital costs. It was also attractive to a number of patients eager to avoid the anxiety often associated with seemingly inflexible hospital routines for inpatient care. In 1969, the Foothills Hospital in Calgary opened Alberta's first outpatient surgery unit with 10 beds. By 1971, there were 38 beds and a recovery room and in 1972 a special operating room in the day care area was opened to reduce delays created by moving patients back and forth from the main operating room. It could not be determined if cataract surgery was performed in this day surgery unit.

The Development of Private Surgi-Centres in the United States

Outpatient surgery had advanced earlier in the United States than in Canada and was originally hospital-based. By the early 1970s, a number of free-standing private surgical facilities called "Surgi-Centres" had also opened in many states.³ Although use of these facilities was originally enticing to insurers, private Blue Cross Plans in the U.S. quickly found themselves in financial difficulty after expanding their funding of day surgery procedures at these centres because of the lack of a corresponding decrease in the use of inpatient services and no overall savings.¹ Many plans also found that *per case costs* for hospitalized patients increased when the lighter cases were moved to private surgery centres and hospitals were left with a higher cost case mix.

¹ Advances included new types of anesthetic drugs which reduced the degree of sedation required and the revival and refinement of a surgical technique using an intraocular implant made of a high tech plastic material (PMMA) pioneered by Dr. H. Ridley in England shortly after WW II. Although Ridley's surgery was quite common in the 1950s, when complications did occur they were serious. This procedure fell into disfavor until the 1970s when it was revived with new equipment (e.g. phacoemulsifier), microsurgery (visual enlargement of the operative area), and new designs in lens implants. These changes resulted in smaller incisions and fewer complications. In the intervening period, the cloudy natural lens was simply removed to let in light through a technique called intracapsular extraction and post surgical vision was augmented with contact lenses or thick coke-bottle glasses. (Dr. G. Gillan, retired cataract surgeon, 1995)

² These new techniques were relatively well established in public hospitals in Calgary by the late 1970s according to Karen Gimbel, contact for the Gimbel Eye Centre in Calgary. They were not widely adopted in Edmonton until the mid 1980s according to Dr. H. Climenhaga, an Edmonton area cataract surgeon.

³ Lacny, Lech K., "Ambulatory Care", Graduate Paper, 1975, Alberta Health Library.

Alberta's First Private Surgery Clinic

Moving the provision of anesthesia and surgery outside a hospital environment was not eagerly embraced by many physicians at the time. Such activities were perceived to carry a number of risks. In the early 1970s, a few Alberta dentists began providing anesthesia options in their offices to deal with overwhelming demands for dental services, but it wasn't until 1972 that the first privately owned clinic specifically designed for anesthesia and surgical procedures, the East Palliser Surgical Centre in Calgary, was established.² According to a former staff member, it opened its doors "to provide low stress [outpatient] anesthesia for children's dental surgery and to meet the demand for increasingly popular breast implants and other cosmetic procedures."³

The physician owners of the Centre anticipated that people would be willing to pay extra to have surgery done privately in order to avoid waits for hospital surgery where the cost of the facility was fully covered for these procedures and often most of the physician fees as well. However, they found that most patients would rather wait than bear the burden for paying for the entire cost of the operation. This led to an application for provincial government funding which was ultimately refused by the Minister of Hospitals and Medical Care, Neil Crawford.

Two funding options appear to have been available to the Minister at that time. One would have been to provide a yearly grant covering the operating expenses of the facility (similar to hospital grants) by designating it an "approved" hospital. The second would have been to incorporate the facility costs into a physician fee-for-service payment similar to the model already in existence for the payment of lab and radiology procedures in smaller community facilities owned by licensed pathologists and radiologists. The Minister's decision not to proceed with either option may have been influenced by increasing demands on the physician fee-for-service budget and the failure of an

¹This phenomenon, unique to the healthcare industry is called "**Roemer's Law**", named after the American economist who first identified it in 1959. It describes a dysfunctional market dynamic in which the availability of supply or capacity dictates demand, and where perverse clinical behavior results in hospital beds filling up to the extent that they are available. The same phenomenon has been documented in relation to some other medical services.

²The population had not yet benefited from fluoridation of water and many patients, including children, required extensive and complex dental work in order to relieve pain. In fact, dentists at that time could barely cope with the workload. Dental work also required specialized drills and positioning which hospitals could not provide. Most patients did not have dental benefit plans until the late 1970s and paid out of pocket. (Dr. K. Powell, dentist, personal interview, 1998)

³ Former staff member from the East Palliser Clinic and "The cosmetic surgery boom: the search for a reputable doctor", (F), MS, April 5'78, "Nosejobs Clog Alberta hospitals", G&M,D4. skimmed the easier cases from hospitals.¹

attempt to conduct a detailed study of comparison costing between the day surgery operations at the Foothills Hospital and the East Palliser Centre. This study was unable to proceed because of such significant differences in the intensity of surgical cases performed at the hospital and the clinic. The differences reflected the same concerns that had already been expressed in the U.S. that private surgery centres simply skimmed the easier cases from hospitals.¹

Still, the East Palliser Surgery Centre managed to survive and thrive until it closed in 1986. By 1980, three more private surgery clinics had opened in Edmonton (1973) and Calgary (1973 and 1977) to provide anesthesia for dental and plastic surgery.

The Regulation of Private Surgery Clinics

While some regulations may have been in place for private medical clinics before this time, a new *Medical Professions Act (1975)* formally gave the College of Physicians and Surgeons of Alberta both the authority and responsibility to determine and monitor standards for all diagnostic and treatment facilities where medical and surgical procedures performed were of a sufficient risk to require compliance with explicit standards of practice- *except those facilities that are operated by the federal, provincial or municipal governments and those facilities approved under the Hospitals Act.*

Responsibilities of the College of Physicians and Surgeons

In order to protect the public interest, the College was given great latitude under the new *Act* to investigate both medical and financial arrangements and the ability to make by-laws relating to all matters pertaining to the establishment and operation of such facilities. However, the exact nature and outcomes of activities undertaken by the College as a result of this authority has been difficult to determine due to limited public access to College records and an organizational culture which is not generally conducive to public disclosure.

The primary mechanism used to fulfill the College's mandate is an accreditation process. Designated types of facilities are required to register with the College and have their practices reviewed in order to ensure that certain explicit physical and management standards and procedures are in place. Determining the types of medical facilities requiring accreditation is left to the discretion of the College. More have been added though the years.² The only method of enforcement available to the College under the *Medical Professions Act* for the business practices of such facilities is its authority to investigate and discipline individual practitioners in response to a patient complaint regarding the "practice of medicine" of a licensed physician at such a facility.

¹ Lacny, Lech K, "Ambulatory Care", Graduate Paper, 1975, Alberta Health Library

² For example, sports clinics, pain clinics, breast clinics, prostate clinics, dialysis clinics, etc. do *not* require explicit registration and accreditation. Only recently has there been a decision to require explicit registration and accreditation of laser eye surgery clinics. Since 1975, the list of designated facilities identified as requiring registration and explicit standards includes: 1) medical laboratories 2) diagnostic imaging facilities 3) pulmonary function laboratories 4) non hospital surgical facilities 5) neurophysiology facilities for EEG, EMG, EVR 6) sleep medicine 7) vestibular testing.

In order to be able to regulate the activities of privately owned diagnostic and treatment facilities through regulation of the medical practice of individual physicians, physician ownership and/or control was originally considered essential. Practitioners in such settings were considered bound by professional codes of conduct in any circumstance where professional responsibilities and personal economic interests would conflict.

Through the years a number of codes and policies were also developed by the College to identify the responsibilities of physicians in such circumstances. For example, a *Principles of Ownership* policy directs that only a doctor can *own* a practice of medicine. This includes such things as the diagnosis and treatment of patients, access and confidentiality of records, the quality of staff and equipment, the ethics of the advertising, and the propriety of the billing practices. A *Conflict of Interest* policy was also developed to protect patients from being taken advantage of by a physician's abuse of his/her professional power. This policy "directs that a doctor cannot make money from his/her power and authority to refer a patient to a facility or profit from the sale of products which he/she recommends to a patient. A physician can only make money for the professional service he/she provides to a patient or on behalf of a patient."¹

However, the College's interpretation of these policies adds a number of nuances and compliance relies heavily on the ethics of each practitioner and the courage of his/her peers or an individual patient to file a complaint. Few complaints against individual practitioners regarding money are received. The College also does not have legislative or regulatory power beyond that granted by the *Medical Professions Act*, nor jurisdiction over commercial interests.

The First Cataract Surgery Outside a Public Hospital

In 1980, the existence of four already established privately owned surgery clinics enabled a very popular and highly skilled cataract surgeon, Dr. Howard Gimbel, to expand his volume of surgery outside a hospital setting.² He initially began performing additional cataract procedures at one of the three private surgery clinics in Calgary which had opened up to provide dental and plastic surgery. Since cataract surgery was an insured procedure listed in the *Schedule of Medical Benefits*,

¹ Dr. Bryan Ward, Assistant Registrar, College of Physicians and Surgeons of Alberta (taped interview, 07/98). See separate Appendix for copies of CPSA documents.

² Other medical practitioners were also expanding their opportunities for income. In 1979 the concept of extended hours, no appointment "walk-in clinics" to obtain the services of a general practitioner was introduced to Alberta by Dr. S.B. Cassin. The growth of these Medi-Centres radically changed the nature of the public's contact and care by general practitioners. It also significantly increased the volume of billings for minor medical visits to Alberta Health. While a welcome relief for busy families, the introduction of this option also led to a greater tendency for individuals to seek medical care for minor self limiting illnesses and led to more frequent duplicate assessment and testing. Lack of continuity of care can also make accurate diagnosis difficult and increase risks from multiple conflicting treatments.

In 1982, 23 new private radiology clinics also opened. The addition of all these new sites and billings created significant pressure for additional money in the physicians' fee-for- service budget.

Dr. Gimbel and the anesthetist could continue to bill the province for their professional fees, but because no consideration was included in this fee for the cost of equipment, supplies and staff normally provided by public hospitals, patients faced a personal charge to cover these expenses. According to Karen Gimbel, these charges were simply considered an extension of the existing practice of extra billing for hospital based surgery: “After all, someone had to pay for the facility and supplies. Since patients were already accustomed to extra billing, this was not an issue.”¹ A few years later in 1984, Dr. Gimbel and his wife Judy who had joined the organization as chief administrator in 1982, went on to open their own private clinic in the same mall. Part of the motivation may also have been the opportunities expanded capacity in a new private facility presented to begin offering a new uninsured surgery to correct nearsightedness called Radial Keratotomy.²

In retrospect, there were a number of factors that facilitated the transition of cataract surgery from public hospitals to private clinics. These included the evolving changes in medical technology, the lack of restrictions on physician ownership of private surgical facilities, and a legislated mechanism through the new *Medical Professions Act* to determine minimal standards for privately owned surgical facilities. Patient discomfort with often rigid inpatient hospital protocols may also have played a role. However, the public subsidy to these clinics through the continued payment of professional fees for insured services outside a public hospital setting, and the ability to extra bill patients an unregulated amount to cover facility costs and higher professional fees, were probably the most crucial determinants.

¹ Karen Gimbel (structured telephone interviews with private clinic managers conducted by author)

² Judy Gimbel’s marketing and business skills are credited by many observers as a major factor in the success of the Gimbel Eye Centres. According to the organization’s Internet site, Judy Gimbel is currently the owner and CEO of I Care Services Ltd., the management company operating the Gimbel Eye Centre. She founded the Gimbel Eye Foundation, and still serves as its President and CEO. (<http://www.Gimbel.com>) The Gimbel Foundation funds research, and along with Gimbel Educational Services, publishes newsletters, videos and information for patients, staff and physicians which also help increase the visibility of the Centres.

Mail-outs to prospective cataract patients (upon request) are informative and professionally packaged. The package obtained by the author also included information on the Gimbel Centre’s current battle with the Regional Health Authority to increased its quota of publicly funded cataract surgeries. A unique feature of Gimbel Eye Centres which is both lauded and condemned by various parties is the opportunity provided to have one’s surgeon pray for positive outcomes by filling in a Prayer Card. There are a number of corporate entities within the constantly evolving Gimbel family of companies. (e.g. Gimbel Vision International, I Care Services, Shooting Star Technologies, IC Medical.) identified in reports filed with the Alberta Securities Commission. In 1996, Shooting Star announced plans to establish Gimbel Eye Centres in Vancouver, Toronto, Las Vegas and Beijing. By 1997, joint venture agreements were also in place in Thailand, Australia and Brazil. Copy of chart of Gimbel Vision International from Alberta Securities filing in separate Appendix.

³ This procedure involved sculpting the cornea of the eye with a scalpel to correct refractive errors. It was popular in the U.S. at the time despite concerns about the unpredictability of results and possible long term negative outcomes due to scarring of the cornea. (FDA & Consumers Union, United States)

5. A Snapshot of the Impact of Extra Billing on Alberta Families

“Aged plead for help as AB MDs bill extra” read a headline in the Toronto Star on January 6th, 1982. Extra billing for cataract surgery and many other physician services may not have been perceived as a problem when captured from a health professional perspective; however, the picture was often quite different when seen through the eyes of patients and families who had to come up with the money. (Illustration 2)

Illustration 2

1982 CONSUMER GROUP SURVEY ON THE IMPACT OF EXTRA BILLING

In order to determine the impact of extra billing on Alberta families, a provincial consumer advocacy group conducted a telephone survey of 420 households in January of 1982. They found that extra-billing was a problem for many. Some individuals who experienced above-normal illnesses were billed up to 25 times in the previous year. In Edmonton, 16.92% of the households and in Calgary 19.5% of households indicated existing levels of extra billing were creating financial problems.

More than one quarter of the households that had been extra billed said they were reluctant to visit physicians because of this practice. Three quarters of the households disagreed with a physician or a physician’s employee assessing their financial status in order to determine whether or not they should be extra-billed.

70% of the households surveyed were not aware of the existence of the Assessment Committee of the College of Physicians and Surgeons which was responsible for handling extra-billing complaints and 30% were not willing to run the risk of complaining if their doctor would find out. **Press Release, Consumers’ Association of Canada (Alberta), 1982**

ANALYSIS OF GOVERNMENT DATA ON EXTRA BILLING (1982)

Claims that these additional charges had been necessary to augment flagging physician incomes and that low income patients were exempted were also challenged. A study of data collected by the Minister of Hospitals and Medical Care on the extent of extra billing found that 58% of the physicians in Calgary, 42% of the physicians in Edmonton and 31% in other regions still continued to extra bill despite a recently negotiated 21% increase in physician payments in 1981. Even though the College of Physicians and Surgeons had issued a directive requesting physicians to refrain from extra billing low income patients, all low-income groups were found to have experienced extra billing, including patients on welfare. While the percentage of those on subsidies who were extra-billed declined slightly between 1979 and 1981, the total dollar amount extra-billed grew. **(Plain, Dr. Richard, Health Economist, University of Alberta, “Evidence of the Social Injustice created by Extra Billing”, 31/03/82)**

Soon patients referred to other cataract surgeons in Alberta faced the same option as Dr. Gimbel's patients - wait a very long time, or come up with around \$1000 dollars. Just a few months after the Gimbel Eye Centre opened in Calgary in 1984, an Edmonton area ophthalmologist opened a private eye surgery clinic. The next year six eye surgeons in the Edmonton area got together to open another. Waiting times for hospital based cataract surgery with these surgeons at that time ranged from 12 to 18 months.¹

The motivation for opening these clinics appeared subject to three major influences: patients' frustration with long waits for a particular surgeon to whom they had been sent by a optometrist or family physician; growing public awareness of the advancements which made this surgery much more attractive; and the attraction to surgeons of more control and additional income with increased surgical time in their own facility.

New techniques had reduced the actual surgical time from an average of 90 minutes to less than 30 minutes and hospitalization from an inpatient stay of a week or more to an inpatient stay of 1-2 days or outpatient surgery. This theoretically should have increased the number of patients accommodated in public hospitals, however, there are many factors which can affect an individual surgeon's access to operating room time. Hospitals also had little incentive to expand day surgery because of a provincial compensation formula providing greater financial rewards for inpatient care. Furthermore, with no limit on the number of procedures billed to Alberta Health by surgeons or the amounts charged to patients, investing in private clinics and expanding the volume of surgeries performed represented potentially lucrative opportunities. This potential was demonstrated in a *Calgary Herald* story on May 11th, 1985 which read "Eye surgeon's 83 billing topped 1 million".

While the die may already have been cast with the opening of the East Palliser Surgery Centre in 1972, when the provincial government allowed Dr. Gimbel to set the precedent of moving a highly valued and fully insured procedure into his own private facility, it opened the door for many more surgeons to follow this route. In the absence of any controls on the ability of cataract surgeons to expand the volumes of surgery performed in a proliferating number of private clinics, both the price charged to patients and the number of surgeries performed became increasingly subject to a surgeon's need to recoup his investment and his/her desire for additional income.

Within five years, the rate of cataract surgery in Alberta almost doubled, from 7.18 surgeries per 1000 males and females 45 years and older in 1982/83 to 13.90 in 1987/88 - the highest rate in Canada.² (Refer to Table #1 next page)

¹ Structured telephone interviews with private clinic managers, summer 1998

² Chart from Utilization Monitoring Committee Report, Alberta Health. 1993.

Unable to transfer graph to electronic document. The graph is dated October 25th, 1993 and was produced by the Professional Services of Alberta Health.

The final year for which data was collected (1991) is reproduced below.

**Number of cataract surgeries provided by all specialties
per 1,000 covered population for the year ended
March 31, 1991**

NFLD.	9.87
PEI	N/A
N.S.	12.89
N.B.	11.60
QUE.	10.55
ONT.	13.18
MAN.	11.34
SASK.	15.84
ALTA	21.00
B.C.	16.34

As the number of private clinics grew, many seniors were faced with difficult decisions. In 1986, in response to press reports of record earnings for cataract surgeons, a Letter to the Editor from a St. Albert woman was published in the *Edmonton Journal*. In this letter, the woman, while decrying the high billings to Alberta Health by some cataract surgeons, pointed out that these high public billings in fact did not reflect the surgeons' total income, which also can include significant charges to patients. She went on to describe the experience of her neighbor whom she had accompanied to a recent eye appointment. (Illustration 3)

Illustration 3

A NEIGHBOUR'S VIEW OF HER FRIEND'S "CHOICES"

"The small bleak waiting room was packed. We were told the professional corporation (as doctors like to call themselves) had run out of chairs hours ago. After 45 minutes of listening to the clerk demand 'That's \$10 dollars for the appointment', I suggested perhaps the doctor might use the day's take to buy some chairs. Finally, my neighbor was called in. When she emerged some 30 minutes later, I was summoned to a small private room where the office nurse confirmed that, yes, my neighbor did indeed need cataract surgery. 'Problem is', she said, 'we are only assigned a few hospital beds at this time and I'm afraid the waiting list for hospitalization is about one and a half years.' However, we were told, if the patient got the OK from her family physician, she could come into the hospital as an out-patient, have the surgery and go home the same day. 'You'll only have to wait eight to 10 months', the nurse said. I guess when you're 82 and going blind, eight to 10 months is a long time and a year and a half is forever. Understandably, my neighbor became quite upset.

But wait. There's a third alternative. 'We have a first-class surgical suite here in our office', the nurse told us. 'We have the latest equipment and our own fully qualified staff.' And guess what: Surgery could be scheduled as soon as two weeks from tomorrow. There is a catch however. Alberta Health Care does not cover private surgical suite procedures and the patient therefore must pay the bill out of his own pocket. How much, you ask? Why, just \$1200! Suddenly, *The Journal's* \$1.1 million figure (*of one ophthalmologist's billings to Alberta Health*) pales in comparison of what a doctor's total income is likely to be."

(Excerpt, Stibbie, Letters to the Editor, Edmonton Journal, June 25th, '86)

7. The Transformation of Extra Billing into Facility Fees

To the relief of many Albertans such as Mrs. Stibbie's neighbour, the threat of federal fines eventually led to an agreement between the Province and the Alberta Medical Association (AMA) on October 1, 1986 to bring an end to extra billing. Despite strong opposition from the Alberta government and physicians, the federal government imposed a ban on extra billing in the *Canada Health Act* (1984) with a deadline for compliance.¹ Once the agreement between the province and the AMA took effect, specialists such as surgeons and anesthesiologists lost the ability to increase their income through patient charges for hospital based procedures - including cataract surgery. This was seen as a major blow to some medical practitioners.²

Owners of private surgery clinics had also been worried about how such an agreement would affect them. The ability to extra bill an unrestricted amount on top of publicly paid professional fees for some surgical procedures had been instrumental in the emergence of these clinics and crucial to their continued survival. A lot was at stake for some physicians who had invested heavily in these facilities. They did not relish seeing both their investment and ability to generate future income jeopardized. Nor were they eager to opt out of Medicare and lose their cushion of unlimited access to publicly insured patients and public billing opportunities.

Luckily they found a strong ally in the Alberta government who had negotiated a way to get around the ban on extra billing. The province envisioned these private clinics playing an important role in reducing the strain on the Health Budget by shifting more responsibility for payment of medical services to individual patients willing to pay extra dollars for timely access. The Minister responsible also had plans for arbitrarily delisting a number of previously insured services outright (e.g. routine eye exams, surgical sterilization procedures) and limiting circumstances in which other services would be paid by the public plan (e.g. facial reconstruction). Patients would need somewhere to go to obtain these procedures which were often still valued by patients and recommended by their doctors. The problem created by the ban was expeditiously resolved through the miracle of repackaging.

Overnight, patient charges at private surgery clinics, previously labeled "extra billing" were repackaged as "facility fees" - with the agreement of a new federal government.

¹ In a presentation before the Parliamentary Standing Committee on Health, Welfare and Social Affairs on Feb 20th, 1984, Alberta's Minister of Health argued that allowing skilled physicians to price themselves out of reach of many Albertans was an important means to reward and keep these skilled physicians in Medicare. This rationale behind this position, also championed by many provincial medical associations, particularly those in Alberta and Ontario, was challenged by Dr. Gordon Guyatt in a *Globe and Mail* article at the time. (Extra-Billing: MDs claims won't wash", Jan 27/86). Regardless, the growth of "extra billing" was seen by Federal Health Minister Monique Begin to be creating unacceptable barriers to access and system efficiency. ("Preserving Universal Medicare" Position Paper, 1983). Most of the earlier smaller pre-paid health plans run by physicians prior to introduction of Medicare also prohibited patient charges above the negotiated fee. (Fuller, C., "Caring For Profit", New Star Books, 1998)

² "Specialists to hurt most over extra billing ban", *Calgary Herald*, 02/08/86, "Extra billing ban slashes MDs income", *CH*, 08/11/87

The only change in the payment for cataract surgery with the end of extra billing and the creation of facility fees in 1986 was one which was invisible to patients but very important to private clinic owners. The province had initially decided to pay for the intraocular lens implant used in the cataract surgery at these clinics. Paying for the implants was viewed as an absolute necessity according to Marvin Moore, the Minister of Hospitals and Medical Care at that time, “because it was paid for when patients had this surgery in a hospital.” The lens implant was seen as an essential component of the actual surgery - not of the cost of providing a facility.¹ This decision created a major dilemma because of the lack of any legislated mechanism to deal with such funding. Eventually arrangements were made to allow two clinics to bill the Foothills Hospital in Calgary and the Misericordia Hospital in Edmonton up to \$225 dollars for the cost of each lens implant.² For undisclosed reasons, these arrangements were *not* extended to other private clinics open at the time or those which opened later. Despite years of protest by these clinic owners over the lack of a level playing field and the additional costs they had to pass on to their patients, only the original two clinics appear to have received this special consideration until it was discontinued in 1994.³

In reality, there was really no perceptible change for patients going for cataract surgery despite the re-labeling exercise. They still had to pay when they went to a private clinic. Most patients having surgery at these clinics were not aware their surgeon and anesthetist were double-dipping by billing the provincial health plan as well as charging patients. According to Christine Lawrence, former Executive Director of the Alberta Council of Aging, “Seniors believed they were paying for the entire cost of the surgery right up until the intense media coverage in 1994/1995. They were quite shocked when they found out differently.”

A combination of the loss of extra billing for hospital-based surgery, increased demands for hospital operating room time to perform both new surgical procedures and higher volumes, and the ability of private clinic owners to include an extra billing component in uncapped facility fees, created even more incentives for surgeons to expand the use of private surgery clinics. The next year, 1987, a fourth private eye surgery clinic opened in Stony Plain, a small town on the outskirts of Edmonton.

The burden of these facility fees for a growing number of seniors may have been one of the reasons behind an attempt in 1987 by then Minister, Marvin Moore, to bring in a Bill which would have eliminated a section of the *Alberta Health Care Insurance Act* specifically prohibiting

¹ Telephone interview, Hon. Marvin Moore, former Minister of Health, July 1998.

² Letter from Don Philippon, Deputy Minister of Health, August 19th, 1993, CACA files. It is not known if these clinics continued to invoice this full amount despite the fact that the price of the most commonly used lens implants dropped significantly over the next decade to an average of less than \$50.00 per implant.

³ Ironically, one cataract surgeon reported that although he felt keeping patient charges as low as possible was important, he not only experienced peer pressure to keep his prices but some patients were suspicious that lower prices meant lower quality. (personal interview in 1995)

private insurance coverage for medical services covered under the provincial plan.¹ After political pressure from the opposition New Democrats in the Legislature and a public outcry, the government let the Bill die on the order paper.

Private insurance for publicly insured services had been explicitly banned in Alberta by the Manning government when Alberta opted into the national Medicare program in order to discourage physicians from treating only patients whose generous private insurance coverage would allow them to collect higher fees than those set by the public plan. According to Dr. Roy leRiche, former Registrar of the College of Physicians and Surgeons and a key player in the evolution of public health insurance in Alberta: “the thinking at the time was that there needed to be deliberate effort made to remove any financial barrier to a physician’s medical assessment or professional treatment decisions”.

Regardless, Moore’s proposal to open the doors for optional private insurance coverage for publicly insured services would not have resolved the plight of most seniors who increasingly felt they really had no choice but to pay for timely cataract surgery at private clinics if they wished to follow their physician’s advice and/or restore failing vision. Efforts in the late 1980s by the Alberta Council on Aging to find a private commercial supplier for a supplemental group insurance plan for their members proved futile because no insurer wanted to take on a high user group like seniors - at any price.

The transformation of extra billing into facility fees also ended any formal tracking of the extent and amount of patient charges related to publicly insured services. Formal tracking was an important initiative taken in the early 1980s by David Russell, Alberta’s Minister of Hospitals and Medical Care, in order to monitor barriers to accessibility. Public disclosure of the information collected had been a powerful force behind public pressure to ban extra billing. This decision to end any tracking of private charges related to insured services would have a profound effect on the future direction of healthcare in Alberta. Both policy makers and the public lost access to key financial information required to evaluate the impact of private facilities on the *real* cost of medical services to the public.

¹ The *Canada Health Act (1984)* does not appear to explicitly ban private commercial insurance coverage for services covered by provincial health plans, although such a ban has been explicit in policy interpretations through the years and implicit in the Principles which guide the provision of insured services. According to a series of overheads that formed part of a presentation by a Health Canada representative in 1996, the Principle of “public administration” means “private insurance may cover all but medically necessary hospital and physician services”. (personal files). The *CHA* also eliminated any significant potential market for private insurance policies by requiring coverage and reasonable access for all medically necessary hospital and physician services. Services excluded from *required* coverage by the *CHA*, but *not excluded* from optional coverage by the provinces were ambulance services, drugs outside hospital, optometrists, chiropractic services, most dental care and homecare. (NOTE: Without sufficient actuarial data based on the claims histories of a large numbers of enrollees in various circumstances and geographic areas, it is also difficult for private insurers to determine premiums and offer policies.)

8. The Growth of Private Surgery Clinics in Alberta

Continued public subsidies of privately owned surgery clinics through the payment of professional fees by Alberta Health along with officially sanctioned patient charges called facility fees maintained the viability of existing clinics and encouraged their growth. Despite the development of 74 new and replacement public health facilities in Alberta between 1975 and 1989, more surgical procedures were pulled and pushed out of hospitals and into private clinics. In 1975, there were only 2 privately owned surgery clinics in Alberta and by 1986 there were 12. This number almost doubled to 22 in 1989 and jumped to 36 by 1991. These clinics were almost exclusively located in the large urban centers of Edmonton and Calgary where there were large potential markets and a concentration of specialists. While the Province had been rapidly adding both hospital and operating room capacity in rural Alberta based on the “if you build it , they will come” philosophy, communities outside of Edmonton and Calgary continued to have difficulties attracting surgeons to less populated areas.¹

These private surgery clinics provided anesthesia (by medical practitioners licensed with the College of Physicians and Surgeons of Alberta) and additional capacity for many procedures which could be safely performed in an outpatient setting *on otherwise healthy patients* - for an additional fee. More complex cases or patients with greater anesthetic or surgical risks were left to the public hospitals. About half of these clinics provided medical anesthesia for a limited number of dental surgeries covered by the provincial plan as well as other procedures which were paid by individual patients and employer or government sponsored private dental plans.²

In 1988, a group of anesthetists “frustrated with the lack of access to operating room time for non-insured services and the continual decanting of hospital services”, opened the first of three all purpose private surgical facilities in Calgary to provide anesthesia service for a wide

¹ “Tories building hospitals to buy votes critics say”, CH, Ja 17 ‘88, pB6, “Rural hospitals face critical shortage of surgeons, CH, Jl 9’88, pA1

² Examples of publicly insured dental surgery include procedures such as removal of tumors from jaws, biopsies of soft tissue or bone lesions, operations to remove foreign bodies from sinuses, etc. Oral-maxillo surgeons are licensed dental surgeons and all dentists are licensed as dental surgeons trained to provide surgery on the oral cavity, jaw and associated structures of the maxillo-facial complex. Non-publicly insured surgery would include removal of wisdom teeth. It is interesting to note that rising dental claims (both volumes and the fee charged for each service) on employer benefit plans have become a major issue for employers in recent years. Increased claims on private plans are eventually passed onto employers and employees through higher premiums, larger co-payments, decreased limits and less full time jobs to reduce the high costs of benefit packages. Some Plans run by Alberta Blue Cross now limit the amount reimbursed to dentists. This has resulted in the emergence of extra billing by some dentists over and above the fee set by the carrier and direct billing of patients by dentists which forces individuals to pay up front and then seek reimbursement. The ability of dentists to set their own prices and simply pass them on to insurers led to a 54% increase in fees between 1987 -1997.

variety of surgical specialists - eventually including cataract surgeons.¹ This was the first multi-use private surgery clinic in Alberta. As well as non-insured procedures, any insured procedure listed in the *Medical Benefits Schedule* which could be safely provided on a day surgery basis (on low risk candidates) could also be offered and paid for with a combination of professional fees billed to Alberta Health and facility fees billed to patients.

According to a Prospectus filed in January 1998 with the Alberta Securities Commission, Surgical Centres Inc., has seen its volume of surgeries increase from 700 per year to 1400 per year between 1990 and 1997. Procedures span ophthalmology, plastics, urology, oral and dental surgery, orthopedics, podiatry, dermatology, gynecology and general surgery. This company went public in 1998 in order to raise capital to expand its base and establish another two private surgery centres in other Alberta cities. It also hopes to expand into three complementary lines of business including; the distribution of drugs and supplies, the provision of equipment and facility leasing services and the provision of “sub acute” care.²

This corporation, which has a major contract with the Calgary Health Authority, is owned by a group of investors which includes many anesthetists working in public facilities. Some are in positions to obtain privileged information and influence key decision makers on issues which could significantly affect their investments.³

The Growth of Private Eye Surgery Clinics

In 1990 five more private surgery clinics dedicated exclusively to eye surgery opened. There were now at least eight clinics providing cataract surgery: four in Edmonton and four in Calgary. Between April 1, 1990 and March 31, 1991, almost one third (31.97%) of the 11, 657 cataract surgeries in Alberta were performed in private clinics.⁴ (Refer to Table 3). Patient fees averaged about \$1000 dollars per eye, and Alberta Health was invoiced for around \$730 dollars in professional fees - although this was probably closer to \$900 dollars with the inclusion of pre and post surgery evaluations and additional minor procedures. The province also paid \$225 dollars for each lens at two private clinics.

¹ Dr. Nanji, President of Surgical Centres Inc., structured telephone interview by author (June/July 1998).

² “Sub-acute” care refers to the provision of short term medical therapies or convalescence following surgery or acute illness (previously provided in acute hospital settings) in long-term or continuing care facilities. First dollar coverage or full payment by Medicare Plans in these settings is not required by the *CHA* due to traditional use as a substitute for a primary residence, and standards (e.g. staffing) are not as onerous as “approved” acute care hospitals.

³ One of the directors of Surgical Centres Inc. is Dr. Kabir Jivraj. Dr. Jivraj was a member of the AMA executive from 1994 - 1998. During his tenure as President he sat on the Alberta Standing Policy Committee on Health Restructuring. In 1999, Dr. Jivraj was appointed to a senior administrative position in the Calgary Regional Health Authority. Excerpts from Securities Commission filings available in separate Appendix.

While some surgeons appeared to open these clinics eagerly with large investments and plans for expansion, others felt pushed and opened them reluctantly. In one clinic manager's words: "We really had no choice. With waits of six months for hospital-based surgery and the proliferation of other private surgical suites, our waiting cataract patients were metastasizing (traveling) down the street to heavily advertised surgeons who could do them sooner. We were losing both our patients and our business." Another identified frustration with hospital procedures such as the inability of surgeons to slot in another patient if one canceled because the hospital "required two weeks prior notice to manage the paperwork."¹

This identified shortage of operating time may also have been affected by an emerging trend to automatically book surgery on both eyes a few weeks apart and the number of eye surgeons jockeying for access.^{2,3} While not all ophthalmologists perform cataract surgery, the total number of practicing ophthalmologists rose significantly between 1981 and 1991 as identified in Table 2.

Table 2

Number of ophthalmologists in Alberta per covered population			
as per information in Alberta Health Statistical Supplements 1980, 1990, 1997			
Year population	Ophthalmologists	Population	Number/per
1980	59	2, 186, 456	37,100
1990	75	2, 612, 691	34, 800
1997	87	2, 786, 408	32,000

¹ Structured telephone interviews with managers/owners of private clinics conducted by author in June/July 1998.

² Opinion on the advisability of this practice, particularly when there are significant differences in the degree of impairment between eyes, varies among cataract surgeons. The *Alberta Clinical Practice Guidelines for Cataract Surgery* 1996, published by the Alberta Medical Association avoids the issue entirely. The Canadian Ophthalmology Society also cannot provide any information on current or recommended practices. The Alberta Health supplemental plan coverage for Seniors limits the frequency of lens replacement in eyeglasses regardless of whether one lens or two need replacing, thus creating a strong incentive to have both eyes done close together.

³ The "1996 Preferred Practice Pattern: Cataract Surgery in the Adult Eye", published by the *American Academy of Ophthalmology*, "cataract surgery in both eyes is an appropriate treatments for patients with bilateral cataract-induced visual impairment in order to restore binocular vision. Patients (with reduced vision in both eyes) receiving second-eye surgery experience significant improvement in visual function. The indication for the second-eye surgery is the same as for the first eye. Prior to performing surgery on the second eye, the patient's first eye should have a stable postoperative refraction and the patient should perceive improved function, and sufficient time should have elapsed to evaluate and treat early postoperative complications, such as endophthalmitis. The patient needs sufficient time to assess of the results of his or her first eye surgery to determine the need and appropriate timing for surgery in the second eye. *Surgery should not be performed in both eyes at the same time* because of the potential for bilateral visual loss. However, there may be rare circumstances under which bilateral surgery may be performed, but these should be critically considered."

9. Alarm Bells Start to Ring in the Provincial Government

By 1991 alarm bells were starting to ring in the provincial Ministry of Health over both charges to patients and the rapidly rising number of physician billings to the provincial plan which appeared related to the growth of private surgical and diagnostic facilities. These facilities did not require the same type of approval as hospitals.^{1,2} At the same time, officials recognized potential economic advantages in moving to less reliance on inpatient hospital care.

A report in 1989 had already recommended that all private facilities, including physician offices, be registered with Alberta Health and that certain types of facilities require prior government approval in order to ensure some control over their development and use.³ Key areas the report looked at included diagnostic imaging, pathology laboratory services, minor surgeries and physician minor office visits which appeared to have soared with the advent of walk-in clinics. It left the government with 132 recommendations including the need for increased monitoring of physician billings, continued utilization review and more regulation of medical services. The Report also suggested that Alberta Health take a look at alternative models of outpatient or ambulatory care in order to maximize potential cost savings from advances in technology without creating uncontrollable demands on the health budget.

A Serious Look At Available Options

Based on the Committee's recommendations, Alberta Health developed an internal discussion paper entitled *Ambulatory Care Services in Alberta*.⁴ This paper noted the many opportunities that new technology presented to provide day surgery and medical treatments safely and cost-effectively on an ambulatory care basis and described some of the benefits. These benefits included the reduction of cross-infection between inpatients and greater convenience for patients who preferred to convalesce at home.

¹ According to CPSA data provided to Alberta Health in 1991, as of August 31, 1990 the number of accredited private diagnostic facilities in Alberta included:

- 423 base laboratories & 316 satellite and collecting labs
- 148 diagnostic radiology facilities
- 13 neurophysiology facilities.

² A public outcry in 1987 over the delisting of a number of procedures such as sterilization procedures and routine eye exams and an illegal nurses strike early in 1988 which was seen to be driven by concerns over decreased staffing following earlier hospital budget cuts were putting pressure on the government to look at other options for reducing healthcare costs.

³ "An Agenda for Action", Medical Services Utilization Review Committee, 1989

⁴ Ambulatory care was defined as "the mode of service provision that requires the patient to ambulate to the location of the provider and leave on the same day after receiving care. It *excludes* inpatient care and home care." (Discussion Paper: *Ambulatory Care Services in Alberta*", Alberta Health, February 14th, 1991)

It also identified potential problems maintaining quality standards in decentralized settings and continuing reliance on the existing model of for-profit private surgery clinics and charges to patients: “Fears exist about the possibility that facility fees might impair access to some services should they move entirely from the hospital setting. Concerns exist about the possible contravention of the Canada Health Act and two-tier medicine.” The document noted the need for adequate home and community support programs if such a shift were to occur and the potential of continuing increases in the volumes of surgical procedures billed to Alberta Health and patients if no limits were placed on the growth of these privately owned facilities. It then briefly described five existing models of ambulatory care or day treatment and created a chart summarizing the potential risks and benefits of each.

- hospital-based outpatient clinics
- hospital-affiliated free standing clinics,
- independent for-profit free-standing facilities
- independent non-profit free standing clinics and/or
- government owned and operated clinics

Finally, this paper noted the lack of research and evidence necessary to guide decision making on the most appropriate model. In the end, three legislative options were identified aimed at increasing the use of ambulatory care while attempting to maintain control over development and doing away with patient charges. One of the options was modeled after the original Ontario *Independent Health Facilities Act (1990)* which gave priority of licensure to either publicly owned or non-profit agencies and local suppliers of services. This had been done in an attempt to ensure that real community needs, not investor or supplier driven profit motives, would influence the expansion of community-based facilities. However, these criteria were recently removed from the Ontario Act through amendments brought forward by the Harris government due to political pressure by U.S. commercial interests in medical care citing free-trade agreements such as NAFTA.¹

Following completion, this discussion paper was sent to the Alberta Medical Association (AMA) for comment. There were constant references by media and government officials to a forthcoming joint AMA/Alberta Health report on private clinics, but no report was ever made public. A 1993 written response from Don Philippon, Deputy Minister of Health, to a request by the Consumers’ Association of Canada (Alberta) referred to two discussion papers; *Ambulatory Care Services in Alberta* and *Ambulatory Care* developed by Alberta Health and the Alberta Medical Association. He noted that the intent was to develop a policy on freestanding clinics but that both reports were currently under review by the various

¹ Ontario Ministry of Health contact, Independent Health Facilities Branch, June 1, 1998.

stakeholders and were not available for public circulation.¹ Despite the potential impact on the cost, quality and availability of medical care and provincial health plan coverage, the paying public was not considered a stakeholder.

Whatever enthusiasm there may have been in 1991 to deal with the patient charges and the perceived negative influences of the uncontrolled proliferation of private surgical clinics disappeared into a great void with the resignation of Premier Getty and the subsequent political upheavals within the reigning Conservative government during 1992.

Behind the scenes, many of the activities in Alberta Health had been put on hold in order to rush implementation of drastically revamped patient registration and medical practitioner billing system to replace one which had proven woefully inadequate. Patients, medical practitioners and facilities were assigned unique lifetime identifier numbers to track their activities in the system - although there was little public visibility of these activities.

In retrospect, the rush to bring in this new system appears to have left a number of gaps which subsequently limited the ability of the government to monitor or manage many of the rapid changes which were soon to come. Other major problems were also created with the abandonment of previous activities and Committees. These had provided important oversight and accountability - including monitoring individual physician billings and billing patterns. Historical comparative statistics from institutions and programs on manpower and costs were also ended.

¹ A copy of the paper discussed here was provided by CAC Alberta (CAC). When Freedom of Information legislation was passed in Alberta in 1996 which allowed greater access to government documents, the CAC made a request under the *Act* for any reports or discussion papers on ambulatory care and/or private clinics. The organization specifically named this document in their request having received it “unofficially” in 1994. According to Alberta Health, there were no such documents or reports on file and the request came up empty handed. However, by this time, the staffing at Alberta Health had also been significantly reduced and many roles and positions restructured - although it was verified by telephone that at least one senior official contacted was aware of the document. Excerpts from the paper are available in separate Appendix. Full text available from author.

10. The Focus Shifts Back from Controlling Costs to Shifting Costs

In that tumultuous period 1992-1993, fundamental policy decisions were made which ultimately dramatically altered the terms and conditions of public health coverage in Alberta. These policies were directed at reducing the comprehensiveness and volume of services provided by the public system. They also shifted payment for these services directly on to patients and/or private insurance policies and employer benefit plans.¹ While hospital “user fees” had been technically ruled out, the Province simply changed the circumstances in which hospital or physician services were insured.² Other Alberta Health Policies encouraged the “unbundling” or separating out of the cost of products or supplies related to the provision of a medical procedure or service, removing the visible and historic accountability of hospitals and physicians for the quality and safety of the products and supplies used to provide care.

A Directive from Alberta Health dated April 6, 1992 informed administrators of acute care hospitals that the *Alberta Hospitalization Benefits Regulation* had been amended to address non-insured patient services in Alberta hospitals. Hospitals were now *required* to charge all inpatients and outpatients for the use of public hospital facilities *if* the actual procedure or professional service provided was *not* specifically insured by the provincial plan, such as in the case of cosmetic surgery. Some professional fees had previously been removed from the Schedule of Medical Benefits as a cost-cutting measure. This Directive meant that the provision of hospital and surgical facilities were no longer considered medically necessary and publicly insurable if the professional fee for the procedure was excluded from the public plan. Prior to this time, patients often had the option of avoiding private facility fees by waiting to have the non-insured procedures done in a hospital setting, although they still had to pay the practitioner’s fee. This Directive advised that patients were now to be charged for use of public facilities at rates already established by the Minister for “non-entitled” persons.³

This same Directive also appears to be the origin of Alberta Health’s policy on *Enhanced Goods and Services*. Hospitals were directed to charge patients for any good or service not considered “medically necessary” or medically beneficial by the “attending physician”.

¹ “Patients face US restrictions: out of country treatments now cost thousands” Calgary Herald (CH) F’92, “ Foreigners facing hike: hospitals up surcharge”, CH May ’92, “ Province to wield knife on hospitals, CH Je 25’92. It also became the responsibility of the attending physician to determine when a service listed in the Schedule of Medical Benefits (e.g. nose restructuring) was done for medical purposes (to relieve pain, discomfort or suffering) and fully insured, and when it was done for cosmetic purposes and not insured.

² “User fees ruled out: but Betkowski gives nod to increased hospital funding”, CH Nov. 26’91

³ Non-entitled persons are residents of Alberta whose healthcare expenses are covered all the time (or under specific circumstances) by other federal or provincial legislation (e.g. RCMP, First Nations, WCB, etc) as well as out-of-province and out-of-country patients. Rates, which may vary according to the category of non-entitled persons, are established by the Health Minister through a Ministerial Order based on the base rates established by the Federal/Provincial Coordinating Committee for Reciprocity. These rates vary according to the category of a non-entitled person and appear to be regularly updated. (M.O. #23, Alberta Health, 1996 & 1998)

The example used was a circumstance where a patient “requests” services and supplies such as a higher cost prosthesis strictly for convenience. In order to create an incentive to charge patients, hospitals were allowed to keep this money as additional income. “Convenience” was not defined. Over the next few years, patients would increasingly face a wide array of new charges in both private physician offices and public hospitals. These included charges for assessments and required medical authorizations for third parties as well as dressing supplies used for biopsies of suspicious moles at doctors’ offices - items which had previously been considered part of a medical practice and included in the fees set by the provincial plan or visits paid by the plan. Some hospitals began charging for a special dye used for certain types of X-rays as well as supplies and splints applied following inpatient surgery or treatment in Emergency departments.

These Directives, which may have been originally developed to deal with the integration of unusually expensive and relatively *unproven* new technologies, rapidly evolved into an excuse to charge for commonly used products with a *demonstrated value* which are now considered medically beneficial and standard practice.¹ An example is current patient charges for fiberglass casts and soft splints. Today, patients are frequently *advised* by physicians and hospital staff that these products will provide less irritation and discomfort, increased mobility and independence, enhanced hygiene and better protection to avoid further injury or complications - all important objectives of medical treatment.

There were no immediate changes as a consequence of these policies for patients in need of cataract surgery. Those would come later in 1996. It was business as usual for Alberta’s private surgery clinics, except that there were now a lot more of them, and they all had to generate sufficient volumes of business in order to pay off their investments and maintain viability. Marketing picked up significantly and advertisements began appearing in newspapers along with a proliferation of information seminars which included “free” eye exams, although free to whom is an important question since these exams could be billed to Alberta Health. Name recognition and product differentiation among seniors and referring optometrists was seen as crucial to success of a clinic.

Nor were these eye surgery clinics restricted to cataract surgery. There were many surgeries which could now be billed to both the patient and the public plan by virtue of being able to be done on an outpatient basis, including glaucoma surgery, tumor removal and corneal transplants. Cataract surgery was one of the biggest attractions because of the elective nature of the procedure (i.e. no severe worsening of the actual outcome of the surgery if delayed although lifestyle and independence could be severely compromised), and the “willingness to pay” of patients because of fears of a further anticipated loss of vision.

The following *Fee Guide* for cataract surgery (Illustration 4) was distributed by one clinic to potential referring optometrists and physicians along with 10 pages of prices for specified procedures. These included: YAG capsulotomies - a procedure which uses a laser beam to remove visual clouding which sometimes occurs some months following cataract surgery corneal transplants, corneal wound repairs, scleral wound repairs, iredelectomy, enucleation, enucleation with silicone implant and magnetic intraocular foreign body removal.

¹ Copies of series of *Enhanced Goods and Services* Directives in separate Appendix (provided in response to request to Deputy Minister of Health of Alberta for origin and authority for these charges.)

Illustration 4

SAMPLE CATARACT FEE GUIDE OF ONE PRIVATE EYE SURGERY CLINIC PROVIDED TO OPTOMETRISTS FOR REFERRAL PURPOSES (CIRCA 1992)

Cataract Surgery Fees (per eye)

Pre-Surgical Testing:	\$ 94
Anesthesia	\$ 178
Surgical Procedure	\$ 553
Lens Implant	\$ 225
Facility fee	<u>\$1050</u>
Total	\$2100

Alberta patients pay	\$1050 (Alberta Health covers other fees)
Saskatchewan patients pay	\$1275 (Sask Health pays all except facility fee and

lens fee. If patients have MSI coverage they may submit the \$225 intraocular lens bill to MSI for reimbursement.)

Quebec patients pay	\$2100
Patients from all other provinces:	\$1275

Physicians and Optometrists pay a reduced facility fee of \$500

“Payment is requested in advance of surgery. Cash, personal cheques, money orders, VISA and Mastercard are accepted.”

Authors note

- This fee charged for the lens & facility is over 2X the per case cost documented at 3 public facilities (1995)
- Facility fees charged varied substantially by clinic/surgeon.
- Most provinces do not routinely cover facility fees at private clinics in other provinces
- Some clinics also offer to arrange pre-authorized debits based on monthly pension or old age security

While media reports of excessively long waiting lists for hospital based cataract surgery added to the attractiveness of private cataract clinics, no-charge surgery in public settings (with successful outcomes) appears to have been an readily available option for some patients. This was highly dependent on where and to whom a patient was referred. The following case histories reflect a number of complex factors which could influence an individual’s access to timely cataract surgery (Illustration 5 and 6). These histories were obtained through a request sent out through seniors’ organizations by the Alberta Chapter of Consumers’ Association of Canada (CAC) in the

Spring of 1998 seeking individuals who had undergone cataract surgery within the past five years. Individuals were requested to contact the author for a confidential telephone interview or to receive a questionnaire to fill in. Names and place of residence have been changed to protect the identity of respondents - but not the site of surgery.

Illustration 5

CASE HISTORY Mrs. Tillie P. from Buck Lake (1992)

Mrs. Tillie P. from Buck Lake, blind in one eye for twenty years, was having problems with her vision. While her optometrist diagnosed a cataract as the cause of her difficulties, she had to visit him monthly, and then weekly for six months, because he told her there was no point in seeing a specialist because the cataract had to “ripen” before they could do surgery. (*Author’s note: The need for “ripening” of cataracts relates to an outdated surgical technique used by only 2% of Canadian surgeons according to a 1992 survey by the Manitoba Health Sciences Research Centre*) “Finally I insisted on seeing an ophthalmologist in Edmonton and had surgery four weeks later.” Mrs. P. was given her choice of two rural hospitals for outpatient surgery and she chose the one most convenient for her family. She had a local anesthetic and “although I am afraid of needles, I didn’t find it at all painful or a problem”. Her eyesight was better than expected following surgery and she was very satisfied with the care.

(Structured interview, 06/98)

Illustration 6

CASE HISTORY Mrs. Ellen R. from Coalman (1993)

Mrs. Ellen R. from Coalman was referred by her family doctor to a local surgeon in Lethbridge at her request because of problems with blurring of her vision. “I do a lot of crafts so good vision is important to me”. She knew who she wanted to go to because friends had gone to this doctor and had been pleased with both him and the care provided at the Lethbridge hospital. Although she’d heard a lot about the private clinics in Calgary, “I didn’t want to go to a different doctor and I just felt more comfortable being closer to my family”. Once Mrs. R. decided to have the surgery there was a 6 week wait for the first eye and an 8 week wait for the second, neither of which created a problem for her. She had both surgeries with a local anesthetic. The improvement in her eyesight met her expectations and she was very satisfied with the quality of care at the hospital. (Structured interview, 06/98)

11. The Klein Revolution and Its Impact on Cataract Patients

When Ralph Klein won the leadership race in December of 1992 and the provincial election in June 1993, significant reforms aimed at reducing public health expenditures had already been implemented or were in the process. The 1992 Conservative leadership campaign and subsequent provincial election was fought on the issue of deficit and debt reduction. Klein, with his campaign slogan of “he cares, he listens”, was seen by many Albertans as a kinder and gentler alternative to the only contenders seen to have the potential to take over the reins of government; former Health Minister Nancy Betkowski in the leadership campaign or Liberal Leader Lawrence Decore. Rural Albertans were very concerned over Betkowski’s plans to close a number of smaller underutilized hospitals which Klein said he’d protect. They also feared electing Liberal leader Lawrence Decore who had campaigned with a ticking calculator identifying the rate at which Alberta’s debt was growing and the need for even more drastic budget (and hospital) cuts.

In the Fall of 1993, the newly elected Klein government began health care reform with renewed zeal. The health budget was cut from 4.3 billion in 1993 to 3.7 billion in 1995.¹ Even more cuts were anticipated. This was part of a stated agenda for smaller government with a balanced budget and a reduction in the provincial debt. It was also part of major ideological shift to an entrepreneurial model for the delivery of government services which included increased contracting out to the private sector, the development of a number of public/private partnerships and less reliance on government services in general. The Premier declared that Alberta was “Open for business!”

Whereas the previous Minister of Health appeared poised to end facility fees at private surgery clinics and limit their expansion, user fees and private facilities were now given a green light, at least philosophically.² In response, the Gimbel Eye Centre from Calgary spent over 1.3 million on equipment for an expanded private facility in Edmonton.

The Klein revolution brought other changes as well which affected access to cataract surgery. Seniors on fixed incomes already confronted with finding extra money for cataract surgery at private clinics soon faced dwindling financial resources as well. Every program that had supported seniors prior to 1993 suffered some loss either through cancellation of the program, reduction of the benefit, or the introduction of new charges. *Waiting for cataract surgery now began to include the wait to save up enough money.* (Refer to Illustration 7)

¹ A new type of private clinic had also emerged just before the election, providing individuals who were “willing to pay” out of pocket speedy access to a relatively new diagnostic test called Magnetic Resonance Imaging (MRI). Newspaper ads extolled the value of this technology for diagnosing major life-threatening conditions which could be masquerading as minor medical problems. Unlike existing physician owned labs and X-ray facilities (where the cost of the facility was included in the negotiated fee-for-service) or private surgery clinics (where Alberta Health paid the professional fee and patients paid a facility fee), both unregulated professional and facility fees were billed to patients. Most of these clinics’ investors were radiologists working in the public system. It should be noted that the first MRI, a machine that employs a powerful magnetic field over 10,000 times the pull of earth’s gravity to create images of vessels, joints and soft tissues, was used in a clinical setting in Canada in 1985. By 1993, 28 were in operation and 6 were to be installed in the near future - including 3 public MRIs (plus 2 private) in Alberta, 5 in BC, 1 in Saskatchewan, 1 in Manitoba and 12 in Ontario. (Technology Brief, March 1993, Canadian Coordinating Office for Health Technology Assessment).

Illustration 7

CASE HISTORY of Mr. Jim R. from Airdrie (1993/94)

Late in 1993, Jim R., an active senior, went for a routine check-up with his regular eye doctor, an ophthalmologist in Calgary, because he thought he needed new eye glasses. Both driving and reading were getting to be a real strain. His doctor said he had cataracts and would need surgery on both eyes. Mr. R. decided to pay the \$900 dollars per eye to have it done at his doctor's private surgery clinic and didn't investigate other options. " He told me I'd have to wait a long time for public surgery and I didn't want to go to a different surgeon. I wanted to continue with Dr. X as my regular eye doctor. I liked and trusted him, so I saved up my \$900 dollars. It meant a lot to me to have someone I know and trust to do the surgery. It took a few months before I could save up the money but it wasn't a particular hardship. I didn't do without food or anything." The surgery on one eye was done two weeks after Jim was able to pay the full amount and he was very satisfied. You can't argue with success". He had a local anesthetic and a rigid lens implant and was very pleased with the quality of care but still has not got around to having his second eye done."

(Structured telephone interview, June 1998)

Public pressure began to grow. Letters and calls began coming in to the Alberta Council on Aging. The Consumers' Association wrote a letter and called on Prime Minister Kim Campbell to investigate the facility fees which the Association believed to be a violation of the Canada Health Act.¹ The Friends of Medicare, a coalition formed to fight extra billing a decade previously began to reemerge.

¹ "Consumers' group urges Ottawa to ban private medical clinics", Edmonton Journal, S30'93,A1

12. Expanding the Potential Market for Private Eye Clinics

Cataract patients found themselves with even less access to hospital-based surgery when the new provincial Health Minister, Shirley McClellan, announced sweeping hospital closures in Edmonton and Calgary in 1994, the two cities where most cataract surgeons work. This included closing two hospitals in Calgary and one in Edmonton plus the significant altering of five others in these cities. Soon after, another major Calgary hospital was declared surplus and destroyed. Confusion ensued as doctors, nurses and patients were shifted from historic locations and patterns of care, and scarce financial resources were directed to restructuring organizations in lieu of front-line staff. These closures also led to a protest rally by 15,000 citizens in Edmonton, but the Premier refused to blink.

There was also a deliberate effort by the government to restructure the provision of healthcare services by clearly separating the functions of purchaser and provider of healthcare services in the pattern of 1993 health reforms in New Zealand. New Zealand had created four regional purchasing agents and mandated competitive bidding and the use of explicit legal contracts between the purchasing agents and private suppliers for the delivery of services in an attempt to reduce costs.

The new *Alberta Regional Health Authorities Act (1994)* contained a number of provisions creating new opportunities for contracting out both the management and delivery of public healthcare services to private business in lieu of public or non-profit agencies. Modeled after the *Alberta Government Reorganization Act (1994)* which allowed a Minister to delegate any power, duty or function conferred or imposed by an *Act* or regulation, this *Act* gave newly created legal entities called Regional Health Authorities the power to create subsidiary corporations and delegate responsibilities, powers and duties to either public, private or hybrid agencies.¹

The mantra was that the provincial government was now going “to steer, not row”.

With the stated objectives of obtaining efficiencies of scale through the centralization of administration, establishing a seamless continuum of care and bringing decision-making closer to the community, Alberta Health was dramatically downsized.

Responsibility for the allocation of provincial funding and the coordination and delivery of publicly insured services was given to the seventeen newly created geographic Regional Health Authorities which replaced over two hundred collapsed public hospital boards. Thirty-five voluntary hospitals run by charities were allowed to keep their boards and autonomy and guaranteed the opportunity to negotiate contracts with the new Regional Health Authorities. The Cancer Board, an administrative entity in Alberta responsible for all inpatient and outpatient hospital services for cancer stayed intact with an equivalent status to an RHA. The Mental Health Board was also given status equivalent to a Regional Health Authority.

¹A companion piece of legislation to the *Government Reorganization Act* called the *Delegated Administration Act* which would have allowed for the outright transfer or sale of government services to the private sector died on the table after repeated and effective criticism from Bettie Hewes, acting leader of the Liberal Opposition. Although the first *Act* enabled delegation to the private sector, there was still a requirement for some level of control by the government.

Payment for physician services remained with Alberta Health with the notable exception of private laboratories. The government moved quickly to remove these services from the physician fee schedule. It decreased the available funding and delegated the responsibility for laboratory services to the RHAs with a directive to contract to the private sector.¹

Physiotherapy services were also removed from the fee-for-service plan and put under the authority of the RHAs. According to a briefing memo dated April 5, 1995 to Health Minister, Shirley McClellan, this would enable private insurers, who had been previously been restricted from providing coverage for fee-for-service physiotherapy services covered by the Alberta Health Care Insurance Plan, to develop policies to cover such these services.²

The closure of public hospitals and the creation of these new governance structures for contracting purposes represented many new opportunities for private eye clinics. Their cataract business had been dropping as 6 new clinics opened in Alberta between 1990 and 1993 and they all competed for a limited pool of seniors willing and able to find the extra dollars.

According to Alberta Health Statistics provided to CAC Alberta, the total number of cataract procedures performed in Alberta on Alberta residents climbed from 9,931 in 1990 to 12,543 in the year ending March 31, 1994. The numbers performed in private clinics climbed from 2, 849 in 1990 to 3, 727 in 1992 (31.97% of total volume) and then dropped to 2,588 (20.80% of total volume) in 1994. (Refer to Table 3 on next page)

The Growth of Refractive Surgeries in Canada

Clinic owners and cataract surgeons had already been looking for new products to sell in light of threats of future limits on publicly paid fees and/or volumes of procedures and the proliferation of private competitors. Some had already made major investments in very expensive photorefractive lasers and related promotional activities to market a new method of corneal sculpting

¹ This was seen as an opportunity to bring in competitive contracting for public services. However, the major lab companies quickly merged into two large corporate entities or virtual private monopolies for contracting purposes - one in northern Alberta (Dynacare/Kasper Medical Laboratories) and one in southern Alberta (MDS/Kasper), leaving smaller companies out in the cold. One small independent lab remains in Calgary. Many hospital labs were closed in order to accommodate the Minister's direction. The Calgary Regional Health Authority created a numbered company and formed a partnership with MDS/Kasper called Calgary Laboratory Services (CLS) with an agreement to share in any profits. The Edmonton RHA closed 94 public and individual private laboratory sites within 3 months. The chief of lab medicine at one Edmonton hospital quit his job to protest the shut-down of a brand new \$12 million dollar public lab facility at his hospital, saying that the government was very determined to privatize and his view that their decision did not have much to do with either economics or patient care.

According to College of Physicians and Surgeons' data (05/98), the number of accredited private labs in Alberta has dropped to 93. This number includes 4 major labs, 60 basic labs, 8 extended labs, 4 special labs, and 17 physician office labs. This compares to 423 base labs and 316 satellite and collecting labs in 1991. No information is publicly available on the impact of these change on availability, timeliness, quality and cost of lab services to the public system or the community.

² Memorandum to Hon. Shirley McClellan re: Private Insurers as first payer for physiotherapy obtained through FOI request by CAC Alberta. Excerpts from FOI request in separate Appendix.

**NUMBER OF SERVICES PAID BY THE ALBERTA HEALTH CARE INSURANCE PLAN
TO ALBERTA PHYSICIANS FOR CATARACT SURGERY SERVICES BY LOCATION OF SERVICES FOR YEARS
ENDING MARCH 31, 1990 TO MARCH 31, 1995**

LOCATION	NUMBER OF SERVICES	1990		1991		1992		1993		1994		1995	
		%	DIST.	%	DIST.								
PRIVATE	2,849	28.69	3,066	28.28	3,727	31.97	3,186	26.65	2,588	20.85	2,596	17.43	
CLINIC (NHSE)													
ALL OTHER	7,082	71.31	7,775	71.72	7,930	68.03	8,767	73.35	9,825	79.15	12,302	82.57	
TOTAL	9,931		10,841		11,657		11,953		12,413		14,898		

This data consists of fee-for-service items which the AHCP paid to Alberta physicians during the years ending March 31 for services provided to Alberta residents and compiled on a DATE-OF-PAYMENT basis. It includes services provided in the payment year as well as services provided in the previous year due to delays in the submission and processing of claims. Excluded from the data are any claims paid for services which were provided to: a) Alberta residents by non-Alberta physicians and b) non-Alberta residents by Alberta physicians.

This information was provided to CAC Alberta by the Professional Services Branch of Alberta Health in response to requests to the Minister's office over a three year period.

to correct nearsightedness.

These machines had been aggressively marketed by U.S. manufacturers to eye surgeons in Canada because of a unique feature in Health Canada's Health Protection Branch (HPB) approval system for medical devices. This feature enabled the Eximar Laser (and other technologies) to be used in private "commercial" settings in Canada on an *investigational* status at least five years before restrictions on its use outside academic settings were lifted in the U.S.¹

Under this pre-market mechanism, potential patients were to be advised of the investigational nature of the procedure. Radio or television advertising (not print) was to identify this status as well. However, most advertising did not reflect this information. Anecdotal reports suggest many of the individuals who paid over \$2,000 per eye for this procedure were unaware that they were essentially part of one large clinical trial, the results of which were required to be reported to Health Canada, but not required to be publicly disclosed.

More cautious eye surgeons in Alberta held off investing in this technology until there was better information and studies on long term effects of this procedure (particularly on patients with significant refractive errors or systemic conditions). But the impending approval of the U.S. Food and Drug Agency in 1995 for minor refractive errors and the increasing uncertainty of public healthcare dollars led more surgeons to make the investment in order to obtain some of the lucrative rewards to be had from private sales of this surgery. Medical practitioners and members of the public also tend to be attracted to any new technology. This fact can work both for and against patients given the challenges of effectively evaluating the safety and value of procedures, drugs, and medical devices in short term clinical trials and the delays in disseminating reports of unanticipated complications once in widespread use.

The key to developing a market of paying customers for non-insured vision correction surgery was a steady source of guaranteed income from publicly insured services to cushion the high start-up costs and spread the cost of equipment, physical plant and staff. Public patients also increased name recognition and opportunities for the promotion of these new procedures as well as enhancing public confidence in the quality of privately paid services provided in the same location.

The possibility of securing either more publicly subsidized cataract patients willing to pay extra dollars for timely service and/or contracts with Regional Health Authorities to pay the facility fees of these patients represented an important opportunity for many clinic owners. In fact, some had already been lobbying the provincial government for increased access to public money through a U.S. model of "managed care" contracting. There seems little doubt this lobby was a powerful force driving the provincial government's new direction for health reform.

¹ Dr. Freeland, Health Protection Branch, Health Canada, 1995, "The Eximar Laser", Technology Brief, CCOHTA, April 1992. In 1995, laser manufacturers conducting clinical trials through private clinics in Canada were not required to report the number of patients who did not return for follow-up to their original surgeon, possibly missing dissatisfied customers. In the United States, these lasers had been restricted to controlled university settings up until 1995 and then only approved for use on limited candidates because of concerns about the intensity and pattern of energy from various lasers and problems with a previous version of this surgery done with scalpels. (personal communication, Dr. Beers, Ophthalmology Division, Food and Drug Agency, U.S.)

13. Fitting a Square Peg into a Round Hole - U.S. Managed Care

Managed care contracts are legal agreements between a funder, usually an employer or a state, and a corporate entity called a managed care organization. Such organizations take responsibility for purchasing and “managing” the cost, availability and delivery of some or all health services for individuals covered by a specific public or private plan. Specialists, such as cataract surgeons, often form Preferred Provider Organizations (PPOs) and bid on short term contracts to provide specified services at reduced prices to a specific group or managed care company in return for guaranteed higher volumes and exclusivity. Many different models exist but all involve shifting the risk and the control of input costs to suppliers.

One proponent of such contracting, a Calgary lawyer, Gerry Chipeur, confidently declared that “Alberta could save millions by turning over 99% of all eye surgery to the private clinics”.¹ He did not provide a lot of details of exactly where these cost savings would come from, nor did he mention that patients and referring optometrists in U.S. health plans were often very restricted in their choice of surgeon and site of care because of these contracts.² Instead, increased consumer “choice” was frequently identified as a benefit.

The History of U.S. Managed Care

The concept of managed care had actually arisen a decade earlier in California as a relatively consumer friendly alternative. It was originally developed by concerned health professionals, innovative employers and community non-profit organizations in response to rapidly rising physician and hospital fees which were pricing many members of the public out of the market for medical care. These higher fees were primarily due to the ability of U.S. physicians and hospitals to set their own fees and pass them on to private insurers without any challenge. Unlike Canada, where provincial governments negotiate fees on behalf of health plan members (residents of the province), arbitrary increases by suppliers south of the border were simply passed on to private insurance companies. Insurers in turn passed these higher fees to employers, workers and individuals in the form of higher premiums. In order to avoid losses, insurance companies penalized those with significant

¹ “Private clinics save the system millions - and cost less” Edmonton Journal, Nov. 1, 1994. These types of legal contracts (and increased reliance on private insurance products) present many new opportunities for the legal profession. In a letter (January 5th, 1995) sent to prospective clients, Chipeur identified the many steps his law firm, Milner Fenerty, had taken since 1993 to develop expertise in U.S. managed care law. It noted “the significant role” they had played in the reform of the Alberta health system, including acting as general counsel for RHAs, preparing managed care contracts on behalf of both payers and providers and litigating payment contracts on behalf of hospitals and other providers.” He was also one of two principals named in a newly formed insurance company structure (The Canadian Health Assurance Corporation Act, Nov. 15, 1993)

² “Managed Care Update”, American Academy of Ophthalmology, Volume 1, Number 2, Winter, 1993

or repeat claims (e.g. diabetics, heart disease, multiple sclerosis, congenital defects) by raising premiums. This had a major impact on both the disposable income of families and the profit margins of employers who play a major role in funding health plans in the U.S. Insurers used other strategies as well. These included: claims refusal after the fact; non-renewal of policies, higher co-payments, and excluding anyone with a chronic illness or high risk occupation from coverage.¹ Employers, particularly small employers were beginning to think twice about hiring anyone who had a child or spouse with a chronic health condition.

While the U.S. has publicly funded health plans for the very poor (i.e. those earning less than minimum wage) and one for the elderly (i.e. those who are too high a risk for private insurers), enrollment is limited. Many families cannot access either public or private health plans or needed medical care. Because compensation by U.S. public plans to suppliers often lags behind the amounts reimbursed by private insurers, public patients are frequently refused care, particularly by skilled specialists.² This puts constant pressure on the public plans to increase fees in order to maintain access to these practitioners. Table 4 demonstrates how this inflationary pressure has affected physician fees in the U.S. Similar pressures are seen in Australia where physicians often provide both public and privately insured services for different fees.³

Table 4

Comparison of Physician Fees 1995			
Single Payer (Price)	Canadian System	\$ Multiple Payer (Prices)	U.S. System
Physician fee (private)	AHCIP	U.S. sample (public)	U.S. sample
EKG (heart tracing)	\$ 23.75	\$ 57.75	\$ 71.25
Colonoscopy	\$ 99.87	\$ 315.00	\$ 590.00
Cataract surgery	\$505.13	\$ 1086.00*	\$ 2600.00

* This includes patient co-pay of \$256 dollars (Medicare for Seniors in U.S.)

These figures were obtained in 1995 during research for an article in the CAC Alberta newsletter. Alberta Health supplied the information on AHCIP fees. U.S. information was obtained by direct calls to the billing staff of a sample list of physician offices and contacts provided U.S. Consumer Group contacts in Oregon and California. (Kaiser Family Foundation and Families USA.) These reflect only the professional fees paid to physicians and do not include hospital or clinic fees for these procedures that would also be paid.

¹ “Skyrocketing Premiums: From \$1,272 to \$14,670 (per year)”, Washington Post, 05/05/92, “In Sickness and in Debt”, Families USA, 1994, “Health insurer profits by being very choosy in selling its policies”, Wall Street Journal, 20/0920/94, “The Crisis in Health Insurance, Consumer Reports, 09/90.

² One study found that twenty-five percent of U.S. doctors refused to treat Medicaid patients because of the low fees and 2/3 of those who did, limited the numbers they did treat because of the lower fees. (Watson, Sidney F., “Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest”, American Journal of Law and Medicine, Volume XXI, Numbers 2 & 3, 1995)

The original concept behind managed care was that physicians and facilities would agree to reduce their prices and try to improve the coordination and appropriateness of care in return for a guaranteed volume of patients. Most of the early plans were guided by dedicated professionals and community groups committed to improving access to medical care - particularly for the growing ranks of part-time, casual and contract workers who could not access affordable group insurance through an employer. Despite the seeming success and consumer satisfaction with these earlier versions of *non-profit* managed care plans, by 1993 these plans were turning into a nightmare for the American public as more *for-profit* suppliers got into the business. Under pressure from employers who could no longer absorb the rapidly rising costs of health benefits, traditional commercial insurers who were beginning to lose their market share to these upstart non-profit plans quickly formed their own managed care companies in order to maintain traditional high returns for their investors. They began to aggressively slash costs.

One of the first actions taken by this strategic industry was a deliberate effort by these private insurers to go out and acquire their own facilities to deliver services in order to reduce reliance on external facilities whose costs and activities they could not control. They bought up or leased a number of existing cash strapped public and voluntary hospitals at fire sale prices.¹ This strategy of using in-house facilities to provide services was in direct contrast to the strategy being pursued in Alberta at the same time. In Alberta, new public funding bodies were being pressured to divest themselves of in-house capacity and increasingly rely on external facilities owned by private business interests.

These investor-driven plans became even more aggressive in their cost control efforts as they ran out of new acquisition opportunities and the genuine fat was cut from the system. Access to medical care for plan members was restricted to a shrinking number of constantly changing physicians on contract - creating major problems with continuity of care. Prior management approval was often required for patients to obtain tests, access to specialists, hospitals and even emergency room visits. Consumer groups in the U.S. were reporting long and dangerous delays waiting for approval and arduous appeal processes. Almost overnight, Americans found themselves going from being cautious and fearful of undergoing unnecessary tests or treatments recommended by physicians to being fearful about receiving inadequate care due to the severe restrictions by managed care companies.

¹ In the U.S., designated public hospitals are required to provide *emergency* care to the uninsured who may arrive at their door, and try and collect later. Carrying bad debts for these patients and the cost of public interest activities such as teaching and research had historically increased the per-case costs of these hospitals to private insurers. In the U.S., the sale or lease of a public or non-profit hospital to a for-profit company is called a "conversion". Many states now have a formal process to protect the public interest. According to the Deputy Attorney General of California, failure to review these hospital conversions in an open and transparent manner usually reflects one of three things: the legislators don't know what they are doing and are afraid someone will find out, they failure to grasp that donor money is public money, or there really is something untoward going on. ("Hospital and Health Plan Conversion", Health Affairs Journal, 03/97)

Canada's Regulatory Void for Managing Commercial Health Interests

During the debate in Alberta, promoters of increased reliance on investor owned facilities and U.S. style managed care contracting, did not identify the complete void of expensive legislative and regulatory mechanisms required to protect the interests of taxpayers, patients, employers and consumers of health plans in such a commercially oriented environment.¹ The lack of need for these regulatory mechanisms (frequently included and/or referred to as “transaction” costs by economists) has been a source of major cost-savings with Canadian Medicare.

Studies in the U.S. and in other countries have repeatedly demonstrated that physician investment in private medical facilities can lead to inappropriate self-referral and increased testing and treatment. For example, one study found that physicians with investments in diagnostic facilities ordered tests 2 - 3 times more often than physicians without such investments. By 1993, the U.S. was spending millions on complex regulations and enforcement to limit the degree of physician ownership in medical facilities and inappropriate self-referral (e.g. *Safe Harbor* Legislation, *Anti-kickback Statutes*). By 1994, even more disturbing practices were emerging as ownership and control of private facilities and agencies shifted from practicing physicians to third party investors and shareholders looking for maximum returns on their equity.²

Both the medical and legal journals and the media in the U.S. reported these issues at great length, but such information never appeared in the mainstream media in Alberta. Instead, the press here dutifully reported the claimed benefits of reliance on an expanding private sector and the benefits of managed care contracting championed by private health interests.

The provincial government dismissed calls for caution as irrational fear-mongering, despite the fact that importing American-style managed care and new private payment options into Canada's health care system without legislative and regulatory checks and balances could create even greater problems than those experienced in the United States.³

Ironically, Canada's health system *is* already a method of “managing” health care which has kept prices of medical goods and services and administration substantially lower than the U.S. while maintaining universal coverage and wide patient choice of physician and site of care.

¹Neither the federal *Competition Act* nor most provincial consumer protection laws have historically applied to health services and products. Canada does not have the equivalent of State Attorney General Offices mandated to protect the public interest. Health Canada rules regarding misleading advertising are primarily enforced by voluntary industry organizations. Self-regulatory bodies for medical practitioners are responsible for monitoring business practices in private facilities. Regulation of health insurance in Canada is minimal.

² Anders, George, “Health Against Wealth”, Houghton Mifflin, 1996, “Consumerism & Competition, Striking a Balance”, Institute for Health Law and Consumers Antitrust Studies, Chicago School of Law, '95)

³“ Universal medicare in peril - lobbyist (private MRI clinics criticized)”, Edmonton Journal, 12/04/93, “Doctors prescribe strong medicine; more private clinics, physicians on contract among the alternatives being examined”, “Private clinic offers high-tech tests for a fee; Albertans who can afford to pay \$1,000 can bypass the lineup”, Edmonton Journal, S 25'93.

14. Market Positioning and the Gimbel Foundation Act

In light of the lack of regulation to protect the interests of Alberta consumers and the provincial government's aversion to restricting business activities, many private healthcare investors were looking to get their feet firmly planted in Alberta soil. In the spring of 1994, the Premier was quoted in the *Edmonton Journal* saying "private hospitals and clinics should be allowed to expand in Alberta."

A few months later, the Alberta Report magazine identified that Lifeshare Healthcare Systems West had already been lobbying to buy the Holy Cross Hospital in Calgary to establish a private hospital. Plans were to specialize in cardiac surgery and transplants, employ over 100 physicians and take advantage of the low Canadian dollar to charge patients from the U.S. "Services at the hospital would be reserved entirely for individuals from other countries *at first*" said Lifeshare's President. It was difficult for some members of the public to reconcile this plan to hire 100 physicians with the identified shortage of specialists in Alberta they kept hearing about in the media. Some critics also questioned what would happen if the Canadian dollar went up and this private hospital suddenly lost its U.S. market. Would it demand access to an Alberta market?

However, these plans were consistent with a world wide phenomenon. The big money makers for private health ventures around the world have been heart surgeries, hip replacements and cataract surgery - not always to the benefit of patients. In 1985, the State of Arizona decided to no longer control the number of hospitals performing open-heart surgery and let market forces determine the need. The number of hospitals in Phoenix providing this service rose from four to eleven within one year. A retrospective study to determine the impact of this deregulation found that the death rate from this surgery had increased by 35% and the average cost of the procedure went up 50%.¹ A 1994 retrospective study in England found that increased private sales of heart, hip and eye surgeries over time decreased private waiting lists and increased public waiting lists.²

Fueled by visible support from the Premier, those individuals who stood to gain the most spoke out publicly. Not unexpectedly, these were primarily a number of specialists who stood to benefit financially by gaining access to new markets where professional fees would not be limited by the negotiated contract with Alberta Health, where volumes of procedures could be increased without scrutiny, and where additional income and control could be realized by contracting the use of their own facilities to public funders or newly created private payers.

¹ "Wasted Healthcare Dollars", Consumer Report, July 1992. Studies found hospitals performing fewer than 150 open heart procedures a year have higher death rates. Eagerness to increase volumes may have led to this surgery being performed on patients with minor conditions where the risk outweighs the benefits.

² Personal correspondence with Dr. J. Yates, author of 1994 study of waiting lists in England

“Both (Chipeur) and Gimbel do not believe that governments in Canada should be solely responsible for the provision of health care and that there is a place for private health care” (**Healthcare Advocate, 06/94**)

“Dr. Dennis Modry, a leading heart surgeon in Edmonton and a well-known fund-raiser for the Conservative party advocated his perspective. ‘Government should sell all hospitals to the private sector, introduce (private) medical insurance and restrict Medicare to the poor’, but he said he wouldn’t purchase a hospital himself unless ‘it was offered as a fire sale.’ ” (**Doctors Digest, July 1994**)

“What we are talking about is taking over running of certain programs, take them out of the heavy duty hospitals and deliver them better in a light duty institution’ says Huang who along with his brothers has proposed to take over either Calgary’s doomed Salvation Army Hospital or part of the Holy Cross Hospital or Bow Valley Centre to provide a wide range of services under Medicare, including outpatient ear, nose, throat and eye surgery, diabetic and hypertension counseling and outpatient mental and community health services. Besides Huang says, ‘Albertans who don’t believe we already have a two-tier system are kidding themselves.’ ” (**Calgary Herald, June 1995**)

Contracting out the provision of services paid by the provincial health plan was clearly in the cards for Alberta. Those who had been lobbying for such an environment now had to move quickly to position themselves in order to secure potentially lucrative public contracts. In order to beat out competitors and become an exclusive supplier to a large purchaser such as an RHA it was important to reduce some of the historical higher input costs faced by the private health sector such as taxes on purchase of capital, equipment and supplies. This would maximize opportunities for securing a contract with a low bid and ensure an adequate profit margin once a contract was secured. Once a contract was secured, there would be major financial and administrative disincentives for an RHA to change suppliers because of the significant disruptions it would cause for administrators, professionals and patients - and the difficulty of finding new viable competitors with adequate resources in place.

The Gimbel Foundation Act (1994)

One such effort at market positioning was a privately sponsored Bill, the Gimbel Foundation Act (Pr6), introduced in the Spring of 1994.¹ This Bill would have permitted one eye surgeon /clinic owner to create a privately controlled foundation capable of providing a range of private health services including medical, surgical, and nursing services. It quickly became a lightning rod for public and professional concerns.

¹ This Foundation would be in addition to the existing Gimbel Eye Foundation. An earlier version of this Bill brought forward the year before appears to have been postponed because it included “hospitals” as well as other types of facilities. As noted previously in this report, the word “hospital” is a protected title in Alberta and is synonymous with “approved hospital” which confers an obligation for public funding.

In the media, supporters of this Bill and private clinics in general cited existing two year waits for cataract surgery in public hospitals as rationale for enhancing the opportunities for expansion of private clinics. More private clinics were claimed to be both necessary and effective in relieving the demand on a stressed public system. Despite strong support by the Premier, presentations by a number of groups to the Private Bills Committee and a leaked letter from the Alberta Health bureaucracy to the Committee expressing serious reservations about potential negative implications of passing this Bill led to its eventual demise. It also resulted in the eventual departure from Alberta Health of the individual who had signed the letter.¹

In presentations before the Private Bills Committee, Dr. Ruth Collins-Nakai of the University of Alberta's Faculty of Medicine called for public discussion. Dr. Harold Climenhaga, a cataract surgeon himself, pointed out the substantial financial power and economic edge such a corporate structure would have to the detriment of other providers and the public system.² Hazel Wilson of the Alberta Council on Aging spoke about life before Medicare and the disparities that existed, noting that the Bill would support more private medicine and a return to those disparities. The Alberta Association of Registered Nurses noted the incongruity of the Bill with the government's intention to maintain a publicly funded system with accessibility based on need rather than income.

The Consumers' Association of Canada (Alberta) questioned the wisdom of providing tax relief to a corporate entity committed to advancing higher priced private health care at the very time the public system needed all the tax dollars it could get to maintain services. It also pointed to the precedent this Bill would set for other practitioners and corporate interests. Dr. Donna Wilson, a nursing professor, described how such a Foundation would erode the public system by drawing away important medical resources. Dr. John Dosseter, a noted and respected pioneer in kidney transplants and medical bioethicist, questioned how a physician could balance a patient's best interests with his own business interests. Finally, the Association of Health Care Philanthropy noted that passage of the Bill would be unfair to other charitable organizations and would discourage accountability.

In the end, even Dr. Gimbel had to concede there were a variety of motives for bringing the Bill forward. According to an *Edmonton Journal* editorial, "While Dr. Gimbel declared that the purpose of the Act was to ensure his work continued after he retired, he also admitted that with Medicare's future up in air, it was prudent to create a framework as broad as possible in order to be able to take advantage of whatever situation arises."²

¹ "The quiet path to private health care; provincial Tories support bill to reassure private medical facility investors", WR, My 2'94 "Private clinics filling gaps in Medicare; but profit motive is shutting some Albertans out, local clinic official says" EJ, Mr 23'94, "Doctor fears private clinic (plan) signals start of privatization", EJ, A12'94 "Gimbel tax plan suspect", CH Ap 27'94

² "Gimbel clinic bill should be delayed", Editorial, *Edmonton Journal*, May, 1994.

15. Consumer Reality Check 1994

By the time the Gimbel Foundation Bill came before the Private Bills Committee, disturbing calls had been coming in to the Alberta Chapter of the Consumers' Association of Canada (CAC) for over a year.¹ Some callers complained about the long waiting lists for cataract surgery which they felt forced them into paying at private clinics. When their doctor said they "needed" surgery, they felt they had no choice but to get the surgery as soon as possible in order to avoid blindness. While some of these callers had poor vision and faced losing their driver's license or some other limitation, others said they had no significant visual impairment - just that the doctor had said they needed surgery. Some had discovered they needed this surgery through eye exams offered by private clinics at information sessions.

Other individuals called seeking information on which clinic had the shortest waiting list or the best quality. Some had heard from a friend or been advised by a private clinic that hospital surgery required long inpatient stays and the doctors weren't as good. They wanted to know if this was true. A few callers reported that either they or a friend and/or family member had gone for a routine eye exam at a private clinic and been told they needed cataract surgery. Due to a lack of money, they'd made the difficult decision that they simply could not afford the private clinic and gone to see another surgeon fully expecting to be put on a long waiting list for the public hospital. Instead they were amazed to find that not only was hospital surgery readily available at no cost through the second surgeon but it did not involve an overnight stay unless there were mitigating medical circumstances. Some had gone on to have the surgery. They had found the hospital surgery very convenient and were delighted with the results. They wanted the consumer group to let other people know that there really was a choice. There were also some reports by patients who had been assessed at a private surgery clinic and been told they needed cataract surgery, but were then advised by a second ophthalmologist that surgery was not urgent and/or even of value to them because the cataract was not interfering with their vision - or that cataract surgery wouldn't help because their deterioration in vision was due to other eye conditions.¹

Callers seemed equally pleased with the results of their surgery, regardless of where it was performed. Most liked the lower stress day surgery option in both public hospitals and private clinic settings as long as they had help at home, knowledge of what problems might occur, someone to call if problems did occur, and no difficulties getting to their appointment the next day. Some preferred an overnight stay if they did not have family available to assist them. There were a

¹ Many of these calls and inquiries were responded to by the author.

² It should be noted that variations on the advisability of surgery can also differ among physicians within the public sector. These differences are related to a variety of factors including: the patient's description of the problem; the physician's experience, evaluation and communication skills; the availability of viable options; other relevant conditions or risk factors of the patient, and the particular pattern of medical practice in a geographic locale. Patients and physicians also attach different values to the inconveniences, risks, direct and indirect costs and possible benefits of any specific medical treatment depending on their own unique history, circumstances, medical condition and values. This makes good information and good patient/physician communication essential. (Research findings from joint CAC Alberta/AMA Partners in Care Project 1997)

few complaints about complications and quality of care in *either setting*. The quality of a patient's experience appeared to be highly dependent on the individual competencies and the personalities of staff, surgeons and anesthetists as well as time spent in waiting rooms and convenient parking - all of which varied in both public and private settings. The most frequently identified and valued feature of the private clinics was "not having to strip down to one's panties and shiver in a backless gown", a definite comfort and avoidance of stress issue to which public hospitals have not been sympathetic in the past.

Waiting Lists Check

Meanwhile, media reports of routine two year waits in public hospitals and continued reports of health budget cuts appeared to be driving more and more prospective patients to private clinics. In response to inquiries by the CAC, Alberta Health said their best information was that waiting lists for cataract surgery were about three months, although they stated the Ministry did not do any formal tracking and could not identify any individual surgeon with a long or short waiting list. Nor could they identify the amount charged by various clinics. In their view, private payments by patients at private clinics had nothing to do with them. The College of Physicians and Surgeons and the Alberta Medical Association said it was not their mandate to track either waiting lists or charges. What choices did Albertans really have?

In April 1994 the consumer group conducted a sample survey of cataract surgeons' offices in five major Alberta cities to try and find some answers. Two questions were asked by an individual posing as a prospective cataract patient: "How long will it take to get an appointment with the ophthalmologist?" and "If the doctor recommends cataract surgery, how soon after the initial appointment could the surgery be performed?" When a private option was offered, the cost of the surgery was also queried. The results of this survey were startling to the Association at that time. (Refer to Illustration 8)

Illustration 8

KEY FINDINGS CONSUMER ACCESS TO CATARACT SURGERY SURVEY: 1994

Albertans requiring cataract surgery who seek the services of a surgeon who performs the procedure as a regular component of his/her practice and offers the procedure *exclusively* in public hospitals can expect an initial appointment within 3 to 4 weeks and have the surgery performed within 2-6 weeks. Longer waiting periods for fully paid surgery in hospital are encountered *only* by patients whose surgeon offers both a public hospital option and an expedited private surgery clinic option with patient fees ranging from \$700 to \$1275 per eye. In both hospitals and private clinics, the surgeon and anesthesiologist bill the provincial health plan for their professional fees.

(Access to Cataract Surgery Survey, CAC Alberta, 04/94)

These results raised some disturbing questions for the consumer group. Patients whose cataract surgeon only provided this surgery in a public hospital setting where it was fully paid by the public health plan had reasonably timely access to this surgery. Only patients whose ophthalmologist also offered a choice of paying extra for more timely surgery in a private clinic setting faced reportedly long waits for fully insured hospital based surgery. Furthermore, cataract surgeons at one private clinic contacted *only* offered a private facility service. Although lack of access to surgical time in public hospitals for some eye surgeons may have been the original motivation for the opening of private clinics, could the rapid growth of these clinics now be creating disincentives for surgeons to send patients to public hospitals in order to maintain volumes and the viability of their private facility?

In searching for answers, the CAC found that this phenomenon had been noted in other countries where physicians were allowed to provide the same services privately for a higher price than they were paid for providing the service under a public plan.¹ Physicians in such settings often appeared to employ a strategy of either discouraging more public access and/or reporting long waits in the public system in order to induce patients who were willing (and able) to pay more privately to choose the private option.

Further credence was lent to this possibility when subsequent investigation by the CAC challenged claims that private facilities provided a lower cost option. (Refer to Figure 1) Facility fees charged to patients at the private clinics surveyed ranged from \$700 to \$1275 dollars. The actual costs of providing this service incurred by these clinics could not be obtained. Estimates of the average cost incurred carrying out cataract surgery in two public hospitals in Alberta were \$488.09 and \$369.90 dollars respectively.² The higher fees at private clinics seemed even more

¹ Barrer, Morris, "Accommodating Rapid Growth in Physician Supply: Lessons from Israel, Warnings for Canada", *International Journal of Health Services* (1989), 19(1):95-115. Originally released in Feb/88. **The phenomenon of longer waits for publicly insured cataract surgeries with surgeons who also offer a private pay alternative has also been documented in a Study completed by the Manitoba Centre for Health Policy and Evaluation.** The study, completed from billing data, found that patients waited up to 13 weeks longer for cataract surgery if his/her surgeon also operated in a private clinic. **"Moonlighting surgeons keep Medicare patients waiting longer, researchers say"**, G&M, 11/08/98)

² "Taking Stock", CAC Alberta, 1996. The hospitals from which the information was obtained were 2 small to medium size non-teaching hospitals with relatively low volumes. Health economists point out that higher volumes usually reduce per case costs because of economies of scale. (i.e. the greater the volume, the more the fixed costs can be spread over a number of cases) One hospital, the Wetaskiwin Hospital was part of a national tracking study on hospital costs and the per case costs included both direct and indirect costs. The other in Stony Plain included all direct and most indirect costs. (NOTE: As of July 1998, the Operating Room Manager at the Stony Plain Hospital reported that the hospital's per case cost for cataract surgery has since gone down from \$389.90 in 1994 to \$235 dollars. This is primarily because the special equipment required to do the surgery, a phacoemulsifier, is now paid off. Medical supply distributors often allow both public and private buyers to pay for their more expensive surgical equipment by adding an extra amount on to the price of each lens implant invoiced.) Another smaller hospital providing cataract surgery in Alberta, the **Lamont Health Centre**, identifies their current per case *direct* costs only (including a foldable lens and payment for new phacoemulsifier) at \$170.07. (letter, Harold James, E.D., Lamont Health Care Centre, Dec/98. See separate Appendix). No information is available on the cost of capital for public or private facilities.

remarkable when it was identified that most of these clinics did not bear the expense of providing twenty-four hour on-call coverage and relied on local emergency departments to manage off-hours complications.

Furthermore, despite these higher charges to patients, the surgeons and anesthetists at these clinics continued to bill Alberta Health a combined professional fee of about \$705 dollars for the surgery alone, a fee which had not changed substantially over twenty five years. As with many other procedures, this fee had been set years before when cataract surgery was riskier, more time-consuming and less common. While the procedure had now become a relatively common procedure now averaging less than 15 minutes for an uncomplicated case done by a skilled surgeon doing sufficient volumes, no significant changes had been made in the fee.¹ The demands on anesthetists had also been reduced as the most common type of anesthesia used changed from a general anesthetic which rendered a patient unconscious (and higher risk) to local freezing or topical drops.

Most surprisingly, the consumer group noted during their investigation that many surgeons routinely performed cataract surgery in *both* public hospitals and private surgery clinics. This made it difficult to imagine how the “good” doctors in private clinics could suddenly become less competent when they worked in a public hospital. (Illustration 9)

Illustration 9

CASE HISTORY Mr. Neil A. from Edmonton (1995)

In 1995, Mr. A. was referred by his “regular eye doctor” to an eye surgeon after he found he was having to change his glasses prescription frequently due to poor vision related to the advancement of cataracts in both eyes. He waited six to eight weeks for cataract surgery for each eye at the public hospital where his ophthalmologist (eye surgeon) worked and was very pleased with the quality of care and outcome of surgery. Between surgeries, Mr. A., who worked with a seniors group in Edmonton took a call from someone who claimed to have a connection with one of the private clinics in town. The caller was very upset with the organization’s lack of support of private clinics as reported in the press. When Mr. A. said that he’d personally already had one cataract surgery done at the hospital with great results, the caller told him he’d made a terrible decision because the “majority of people who have cataract surgery at hospitals have complications and infections. You’ll be sorry. The doctors who work at the hospital just don't have the same skills as the ones in the private clinics.” (Structured interview, 06/98)

¹ There had been incremental adjustments. On May 12th, 1995, Alberta Health Communications identified the combined fee as \$705.54 (\$526.18 for the surgeon and \$179.36 for the anesthetist). In a 1993 letter Alberta Health identified the combined fee as \$ 728.50. The 1992 fee guide from a private clinic identified \$731 (\$553 for the surgeon and \$178 for anesthetist) as the combined fee. This does not include pre or post operative care or a number of modifiers which may affect the fee paid to medical practitioners.

Another nagging concern for the consumer group was the recent exposure of problems in the United States with private surgery centres. Two separate television investigation shows had identified that some cataract surgeons with large private surgery centres were recommending and doing unnecessary surgery in the absence of a clinically significant cataract. Could the same thing be happening in Alberta?

According to one investigative television report by ABC Network, aggressive marketing and free cataract screening attracted many patients to one large volume surgery clinic in the U.S. where 5 out of 7 undercover test patients with no complaints of visual changes were advised to have cataract surgery. Two other highly credentialed cataract surgeons who had tested these patients previously had determined the surgery was either unnecessary due to lack of visual impairment or that it would not be beneficial due to other eye disease present. Individual surgeons associated with the private clinic investigated were expected to perform up to 40 surgeries per day and the surgeon who did the surgery was not the same one who assessed the need for surgery.¹

Was the high rate of cataract surgery in Alberta simply the result of improved surgical outcomes making it more attractive to a larger portion of the population, the aging of the population, a higher prevalence of cataracts in Alberta or some surgeons pushing the margins of the envelope through opportunistic case finding and recommendations for unnecessary surgery - or a combination of all of these?

Informing Prospective Patients and the Public

The Consumers' Association had for a number of years championed the development of decision-making guides called Clinical Practice Guidelines to assist physicians and patients in determining the appropriateness and value of a specific medical intervention for an individual at a given time. In 1994, no such officially sanctioned guides existed in Alberta. Nor was there any reliable user-friendly and widely accessible patient information. CAC Alberta wrote a letter to Alberta's Minister of Health calling for development of such Guidelines and better patient information to aid in making a decision when to proceed with surgery.

Meanwhile, Dr. Graham Gillan, a retired ophthalmologist from Calgary who had worked in a variety of settings both in Canada and Britain during his career, pointed out to the CAC that it is difficult to determine the existence of a clinically significant cataract *after* it has been removed. "Unlike other surgeries where tissue can be examined afterward to determine the existence of pathology, lens removal during cataract surgery destroys the tissue. Therefore society must rely on the ethics of individual physicians and a certain level of scrutiny by payers." He noted that these ethical dilemmas were as old a medicine itself, but felt the public could still have confidence in the majority of cataract surgeons. Based on his own experience as both a fee-for-service and salaried physician, Dr. Gillan felt very strongly that having physicians work in a public system provides a measure of protection for patients in that physicians did not have to concern themselves with worrying about profits on business investments related to their professional practice.

¹ "20/20 Vision", Prime Time/Live, ABC, 1994, "Cataract Cowboys", NBC, 1994.

As a senior himself who was active in the community, Dr. Gillan was deeply disturbed with the activities of some of the private clinics which he felt were taking advantage of compromised seniors and lowering professional standards by using fear of going blind and advertising in Senior's papers to stampede individuals into paying for immediate surgery at these clinics.¹ He was equally concerned with the growing discouragement of local surgeons who were suffering financially and professionally if they chose not to follow such a route. Dr. Gillan voiced his concerns and his advocacy for both Medicare and strong professional standards in letters to the College of Physicians and Surgeons, the *Medical Post* and the mainstream media right up until his untimely passing in the spring of 1998.

While the Consumers' Association survey results were frequently provided to the reporters (both regionally and nationally) by a number of well known commentators and researchers on health care issues, it was over a year before there were any sightings in mainstream media. The evidence just didn't seem to fit with reporters or editorial board assumptions. It may also be that the possibility of some physicians being influenced by financial incentives creates too much stress on the psyche of both the public and other physicians given the profound knowledge and power imbalance in a physician/patient relationship. Mistrust can be exhausting.

The American media and public have developed a body of wry humor around this issue. Public bodies, consumer groups and professional leaders in the U.S. also continually monitor, expose and try and limit the conflict-of-interests arising in commercialized medical markets. In contrast, the Canadian media, public bodies and professional leaders appear to have chosen to not even acknowledge such problems could exist (despite the incentives introduced through new private market initiatives) and have largely abrogated their responsibilities to provide the level of scrutiny and intervention necessary to protect citizens.

¹ "Private clinics in Alberta blow stats out of proportion to serve own goals", Letter to the Editor, *The Medical Post*, Spring, 1995.

16. A Swing and a Miss - the Federal Government Goes to Bat

By June of 1994, the federal government and provincial Ministers of Health were beginning to feel the heat with respect to fees being charged at a growing number of private clinics across the country. A conference of Federal and Provincial Ministers had directed the collection of information in each province and based on that information and their discussions, all provinces, with the *exception* of Alberta, supported managing the development of the private sector to prevent a second tier of medical and hospital services. They agreed to continue to work on a regulatory strategy for private facilities. Alberta reserved its decision pending its own review of private clinics in collaboration with the Alberta Medical Association. The war of words continued.¹ On January 6th, 1995, the Federal Health Minister, Dianne Marleau acted. She wrote to each provincial Minister of Health announcing a new *Canada Health Act* legal interpretation concerning facility fees and gave the provinces until October 15th to have a framework in place for ending patient charges in such settings. (Illustration 10)

Illustration 10

MARLEAU INTERPRETATION OF THE CANADA HEALTH ACT (JANUARY 6, 1995)

“The accessibility criterion in the *Act*, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents received all medically necessary care without financial or other barriers and regardless of venue. Secondly, as a matter of legal interpretation, the definition of “hospital” set out in the Act includes any facility which provides acute, rehabilitative or chronic care. As a matter of both policy and legal interpretation, therefore, **where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.** (Excerpts from a letter to Provincial Ministers of Health from Federal Minister, Hon. D. Marleau, Jan 6, 1995)

¹ “Put up or shut up on private clinics, Dinning tells Marleau”, EJ, N 24’94, “ Morgantaler clinics are a Canada-wide complication”, EJ, D10’94. NOTE: Many individuals who did not support other types of private surgery clinics did often reluctantly support private abortion clinics. This was often based on a perceived difference in the motivation for their emergence (i.e. lack of a hospital alternative and refusal of many physicians to do abortions) and their track record of relatively low fees charged to patients. Wendy Sutton, a law student at Osgoode Hall has documented the legal/social history of Independent Health Facilities in Ontario based on her personal 15 year experience trying to start a free standing birthing centre in Toronto. She provides convincing arguments that both the motivation for community based facilities (i.e. community defined need versus business opportunity) and control (community group versus self-interested investors) need to be carefully considered when weighing the benefits and risks of such facilities and type of regulation and funding mechanisms required. (Sutton, W., “The Independent Health Facilities Act: Its relationship with community based birth centre project” & “Submission to Standing Committee on Bill 26: Toronto Birthing Centre”, 1996)

Despite the letter, there were few indications that anything would change for the many cataract patients paying hefty fees at private clinics in Alberta. With the deadline for compliance with Federal policy six months away, Premier Klein indicated his intention to push for changes in the *Canada Health Act* so people could pay to receive faster hospital treatments, a view which he acknowledged “could be construed as two-tiered medicine”. The next day, Dr. Fred Moriarty, president of the Alberta Medical Association backed Klein’s position. He was quoted saying that Albertans could and should have the option of waiting for publicly insured procedures such as cataract surgery or pay the entire cost privately if they wanted it sooner, noting that private insurance options “would soon” be available to protect patients from these extra costs.^{1,2}

These comments suggest discussions between the AMA and Alberta Health regarding possible amendments to the *Alberta Health Care Insurance Act* in order to remove the existing prohibition on private insurance for publicly insured services may already have occurred. Regardless, the definite implication was that physicians would continue to retain their public billing number in order to be able to maintain their volumes, while also being able to take advantage of any opportunity to charge higher fees privately.

Later in the week, Premier Klein suggested that what he *really meant* was that there needed to be a better definition of essential and non-essential services under the *Canada Health Act*.³ Dr. Lyle Oberg, MLA for Bow Valley, pointed to routine ultrasounds for pregnant women and excessive cholesterol testing as two of “the many non-essential services that taxpayers shouldn’t have to shoulder”. However, neither he nor the Premier clarified whether the same physicians on whom individual Albertans are forced to rely for advice and publicly insured services would continue to *recommend* such “non-essential” tests and treatments. While Dr. Oberg’s statements regarding the frequent inappropriate use of these tests *are* backed by the medical literature, such strategies provide little comfort to individuals who feel they have little choice but to place more credence on the advice of their physician than a government (or a private employer benefit plan) clearly committed to deficit reduction at any cost. Nor do most patients have the information necessary to determine the circumstances in which such tests would be valuable for their particular circumstances.

Furthermore, since these tests or treatments would no longer be publicly insured in a number of circumstances, the price of these tests or treatments would not be subject to the set fee, negotiated by the provincial plan. Suppliers would be free to charge any amount they wished

¹ Edmonton Journal, 05/04/95

² “AMA head likes two-tier plan”, Edmonton Journal, 06/04/95

³ “Klein, McClellan urge PM to spell out basic services”, Edmonton Journal, 06/04/95. This concept of describing “core”, “basic” or “essential” services is initially attractive until one realizes that a test or treatment which may provide dramatic medical benefits and be essential for one person at a certain point in time may be unnecessary, useless or even harmful to someone else at another point in time.

to patients. In fact, this was already occurring.¹

Still later in the week, the Premier noted that central to any reform would be a role for entrepreneurs in providing health services and a realization that some procedures may need to be deinsured and provided on user pay basis.²

In reality, provincial policies had already quietly gone this direction.

Behind the Scenes (Circa 1995)

In the public's eye, the provincial government appeared to simply deinsure a limited number of services such as the removal of non-cancerous warts and moles and routine adult eye exams - decisions which may have had some unintended consequences.³

The Province also deinsured general anesthesia provided as part of an uninsured dental procedure, consistent with their policy on uninsured medical procedures such as cosmetic surgery. Beyond the public eye, the government initiated a rapid shift in *where* medical care was provided, *who* provided the care and *who paid*. Diagnostic tests, medical therapies, nursing services and rehabilitation rapidly moved from public hospitals to patients' homes, extended care facilities and private homecare agencies and from physicians (whose services were covered under the *Canada Health Act*) to other professionals. Workers providing services changed from professional staff in hospital settings to minimally trained workers and families in community settings. Many services were contracted out to both large and small private businesses under the banner of increasing efficiency and reducing costs.

This strategy provided Alberta Health with the opportunity to shift at least part of the cost of services to other government programs, individual patients, workers and employers through the introduction of user charges, co-payments, deductibles and income testing for previously fully insured services. Alberta Health also attempted to limit its responsibilities for payment of some needed services to only those circumstances where a patient had no other resources. Many more costs were shifted by conscripting family members and friends, both willing and unwilling, to take on the management of wounds, drainage tubes, respiratory therapies including oxygen therapy, tube feedings, dialysis, intravenous

¹ The Consumers' Association was alerted to this variation in pricing for uninsured PSA (prostate specific antigen) tests in the Fall of 1995 during the course of research for "Taking Stock", a report on the outcome of health reform in Alberta. A survey in January 1996 of public and private laboratories revealed charges ranging from \$0 - \$100 dollars for privately paid PSA tests. (unpublished data, CAC Alberta files)

² Globe and Mail, 14/04/95.

³ The deinsurance of non-cancerous skin lesions reportedly created a financial disincentive for patients to have suspicious growths removed and/or biopsied. There are also reports that the deinsurance of routine eye exams may have sent more patients to ophthalmologists for higher cost "medical" exams in lieu of lower cost (but uninsured) optometric exams or resulted in delays of treatment and damage from contact lens use.

therapies, pain control, lifting and transfers, equipment and supply purchases, and monitoring for complications of individuals recovering in community settings.¹ Because only services provided in hospitals or by doctors in the community were technically required to be covered by provincial plans under the *Canada Health Act*, changing the location where services were delivered and who provided the service provided the opportunity to shift many costs to patients, families, employer benefit plans and other government programs.²

This policy direction was reinforced in a July 19th, 1995 letter to the Capital Regional Health Authority from Alberta Health (AH) on a new program to enable patients dependent on tube or intravenous feedings for nutrition to move out of institutions and live at home. The letter recommended that all participants be required to share in the cost of equipment and supplies as well as the cost of nutrition products “based on ability to pay”. It noted that “currently cost-sharing is a well established process for Albertans needing medical equipment and supplies to enhance independence in the community.”³ It appears as though Alberta Health had already decided that medical care moved from hospital to community settings was “non-essential”. Meanwhile, politicians continued to insist publicly that full funding would follow the patient as the site of care was moved, implying universal first dollar coverage similar to that in public hospital settings. It’s little wonder the public was confused!

¹ This has created a boom in the private commercial homecare industry with families purchasing nursing and support services because of the perceived inadequacy of homecare nursing services paid by the public plan. Since the non-professional nursing care paid by the public plan is provided by these agencies, they are readily available to families to “top up” hours of service for a price. The market is dominated by large investor driven companies (Comcare, Olsten, Para-Med, We Care) which usually provide poor wages (\$6-\$8), split shifts, poor hours, and no benefits. This leads to high staff turnover and a lack of continuity of care. A WCB contact reports that the number of agencies has increased substantially over the past decade and the quality of services is often inconsistent and difficult to assess. Families report that while they are pleased to have privately paid care available so a family member is not faced with taking time off work, the costs can be a tremendous burden at a price of around \$15/hour for non-professional care. Families also increasingly pay private agencies to take care of loved ones in hospitals to make up public staffing deficits.

² Such a precedent had already been established with a trial home intravenous therapy program in 1992/93 which included a 25% co-payment for equipment and supplies and coverage for the expensive intravenous therapy drugs *only* if the patient did not have a private drug plan and *only* after the patient had paid the first \$5000 dollars. For details on current state of intravenous therapy see “Publicly Funded Drugs in Community Settings”, C.A. MacDonald & Associates, February 6, 1998, Alberta Health, obtained through FOIP request by the Consumers’ Association.

³ In a demonstration of the savings that can be achieved by public system bulk purchasing, a “Draft Guidelines for Supporting Home Enteral/Parenteral Nutritional Therapy” developed by Alberta Health, reveals that the CHA could bulk purchase special liquids to provide nutritional needs for individuals unable to eat or tolerate solid foods for \$140 dollars/month per patient compared to \$ 458 dollars per month at local retail pharmacies. According to a Regional Program contact (later confirmed to the author by Don Ford, Deputy Minister of Health in 1998) this Program almost did not proceed due to opposition from private pharmacies concerned over reduced profits due to the loss of higher priced individual purchases. Currently, the public portion of this cost-share Program (equipment, supplies, nutritionists, pharmacist, nursing and administration costs) is paid by Alberta Health through Provincial Program Funding.

In the midst of all these changes even more physician and investor groups were coming up with new schemes. These were designed to take advantage of public infrastructure and access to a captive clientele in order to cross- subsidize and enhance private income opportunities, similar to the model employed by the private eye clinics in Alberta. One such consortium with the unlikely name of “Hotel de Health”, headed by an Edmonton emergency room doctor, came very close to leasing space in some recently downsized rural hospitals close to Edmonton. This was stopped largely through the efforts of the lobby group called the Friends of Medicare, and an articulate family physician, Dr. Hubert Kammerer, who was their spokesperson at the time. This group played a key role in informing the public and

Dr. Kammerer did much to restore Albertans’ flagging faith in the medical profession.

Another reason this type of venture was enticing to physicians was the precedent already established by some private surgery clinics of aggressively marketing their services in neighboring provinces and states in order to attract patients whose professional fees would be reimbursed by other provincial health plans or private health plans outside the country.¹ This practice was aided by gaps in policy created by the historic evolution of Medicare through the inter linking of separate provincial plans. In fact, this strategy by some clinics proved so successful that previously established automatic reciprocity agreements between Alberta and Saskatchewan to cover physician fees for services provided outside a resident’s home province were restricted in 1996 to prior approval for cataract surgery by Saskatchewan Health.² Another gap enabled physicians opted into their home province’s health plan (and restricted from directly charging residents for procedures covered by the plan) to bill residents from another province whatever fee they wished as long as it was paid privately.

While growing public concern was being expressed over many of these new proposals for increased reliance on private funding and facilities controlled by private business interests, the Alberta Government appeared to be working quietly with the Alberta Medical Association, the College of Physicians and Surgeons and private clinic owners to enhance opportunities for future development of the private sector.³ As Marleau’s deadline for penalizing the provinces approached, Alberta and Ottawa remained deadlocked.

¹ One Spring 1996 advertisement in the Saskatoon Star Phoenix from the Gimbel Centre read **“If you can’t afford to spend months on a waiting list to have your cataract eye surgery done here, now you can afford to have it done immediately in Calgary.”** It went on to say **“ Like too many other Saskatchewan seniors, you may be on a waiting list for cataract surgery, a waiting list you may be on months, even years from now. Your eyesight may even deteriorate dramatically while waiting your turn for surgery. That’s time “wasted” and pleasures lost because of impaired vision.”** It also promoted a “ Special Limited Time Offer” of \$1500 dollars per eye (both eyes could be done at the same time) and a price for bus transportation and hotel for \$300 dollars. (CAC files)

² Because of variation in provincial plan benefits across the country, automatic reciprocity and the latitude provided for portability of coverage is largely a matter of voluntary cooperation among the provinces.

³ “ Private clinic called threat to Medicare; but MDs group sees no conflict.” EJ, JE 15’95

The Premier insisted that the clinics took the pressure off the public system and threatened legal action against the federal government. However, polls showed Albertans firmly in support of Ottawa's position and the federal government began deducting \$420,000 dollars per month from transfer payments.¹ By now many Albertans had friends or family members who had confronted the realities of a well established two-tier healthcare system in the provision of cataract surgery and the lack of *real* choice facing individuals such as Irma S. (Illustration 11)

Illustration 11

CASE HISTORY of Mrs. Irma S. from Smoky Lake (1995)

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 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 9 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. She decided on the spot. "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." Mrs. S. had surgery with a local anesthetic the following week and was very satisfied. (Structured telephone interview, 06/98)

It never occurred to Mrs. S. to ask if she could be referred to another equally competent surgeon who would be able to perform the surgery sooner. (Recall the CAC Alberta survey of cataract waiting times) Or, if given the urgency of her need, there was a process to get her in for surgery sooner, which there is, according to a number of ophthalmologists and public administrators contacted. Mrs. S. simply relied on the information and advice provided by her own optometrist and the surgeon to whom she had been referred.

Alberta's Twelve Principles (to support the growth of private clinics)

Meanwhile, the provincial government was busy drafting a set of 12 Principles to protect the interests of investors in private facilities, expand the opportunities for a rapidly growing commercial healthcare industry and still satisfy Ottawa.²

The Alberta Health document detailing these Principles is entitled *Public/Private Health Services: The Alberta Approach*. It contains a number of quite remarkable statements coming

¹ "Showdown over private clinics backfiring for Alberta's Klein", TS, O 15'95

² "Private billing for MDs advocated: sole obstacle to federal acceptance of Alberta 12-point plan", Edmonton Journal, N8'95

from a provincial government whose mandate is to ensure the accessibility of safe, effective, and publicly funded health services for Albertans.¹ One Principle is “ensuring a strong role for the private sector in health care both within and outside the publicly funded system”. A second states that “consumers have the right to voluntarily purchase health services outside assessed need”.

While Albertans always have had the right to privately purchase health services *not covered* by the Provincial Plan or purchase care from physicians not enrolled in a Provincial Plan, these two principles opened the door for physicians to determine public coverage based on a patient’s desire and ability to pay privately for expedited care. The mechanics of this policy were detailed in Principle #11. While Health Canada officials were initially opposed out of concern over this Policy would be applied, Alberta finally won over federal politicians (and a new federal Minister of Health) who were far more preoccupied with the upcoming Quebec referendum and needed Alberta’s support for the battle ahead. The two parties eventually signed a “Working Agreement” on Principle #11. (Refer Illustration 12)³

Illustration 12

FEDERAL/PROVINCIAL WORKING AGREEMENT ON PRINCIPLE #11

“The same physician can practice in both the public and private system if he/she is offering insured services which are fully paid for by the public system and non-insured services which are paid for privately. All medically necessary services are insured services. A service is non-insured when deemed to be not medically necessary in that it does not meet a Clinical Practice Guideline (CPG)² which would include criteria of medical condition, *appropriate timeframe*, etc., *or is otherwise determined not medically necessary through a medical decision*. In addition, services can be deemed non-insured by regulation for the purpose of determining coverage under the health insurance plan (e.g. third party examinations, telephone advice, services provided by practitioners to their own family members are not insured services). In the CPG situation, the patient pays the full cost of the procedure provided the patient is informed why the particular service does not meet the CPG and that the service would be covered if it met the CPG. At all times reasonable access to insured services must be maintained.” (Working Agreement on Principle #11, dated May 17th, 1996)

¹ A detailed history and analysis of these Principles can be found in a paper entitled “The Economic and Social Impact on Medicare of Privatizing and Commercializing Hospital and Medical Services Within Alberta: The Public Interest Perspective “. (Dr. Richard H. M. Plain, Department of Economics, University of Alberta, Jan, 2000).

² See footnote # 2 next page for more information on Clinical Practice Guidelines concepts.

³ **2003 update. In a media interview some years later with Mark Kennedy of the Ottawa Citizen, Dianne Marleau stated she had refused to sign the document presented by her bureaucrats, as did a later Minister of Health, Allan Rock. None-the-less, since this time, increasing opportunities for physicians opted into Medicare to be paid directly by patients or other third party insurers) in a number of provinces has been key to the growth of private facilities and new third party payers such as employer disability plans.**

By the time this agreement was officially signed off, Jane Fulton, Alberta's outspoken Deputy Minister of Health had already directed the Clinical Practice Guidelines Program administered by the Alberta Medical Association to make the development of a Guideline for cataract surgery an urgent priority. In a CBC radio interview at the time, Fulton explained how this new system would work. For example, if a surgeon *using such a Guideline* determined that a patient had a particular eye condition which required cataract surgery, then the surgery would be provided at no cost to the patient within a period of time stipulated by the Province.¹ Medicare would pay all the costs of the surgeon, the anesthetist and the facility. However, if the patient did not yet meet the Guideline criteria, but chose to have the surgery anyway, he/she could have the same surgery done privately by the same surgeon and pay all costs him or herself. Alberta Health would no longer pay the doctor's fee. (Surgeons would also be free to charge the patient whatever fee they wished for both the use of the facility and professional fees.)

Under such a model, medical practitioners could earn more money for performing a procedure if he/she decided the patient's need for the procedure didn't fit with a physician developed Guideline or an individual physician's own evaluation of medical necessity. Technically, patients could also now pay the complete costs of a procedure, including unregulated professional fees to a physician (also opted into the provincial public health plan), if the specified waiting time identified by Alberta Health, also based on the advice of physicians, created too much duress or inconvenience.

Changes in the provincial public plan over the previous decade had already led to Alberta Health increasingly leaving it up to individual physicians to determine when minor surgical procedures or treatments were "medically necessary" and publicly paid or when a patient should pay privately. For example, reconstructive surgery done by plastic surgeons following a car accident or to relieve a medical problem is considered an insured service, but if done simply to enhance personal appearances without any underlying medical reason, it is considered "cosmetic" and not covered. In hospitals, fiberglass casts are theoretically covered if the attending physician considers it medically beneficial, otherwise, a patient must pay.

The introduction of a means of legitimizing higher charges to patients based on ability and willingness to pay through often arbitrary decisions regarding the circumstances of public coverage created enticing opportunities for physicians, private clinics, and even public hospitals - which few mortals could be expected to resist. It created a potential minefield for patients because of the new incentive for Alberta Health and physicians to limit or reduce the number of *core* publicly

¹ Radio transcript, Consumers' Association of Canada (Alberta) files

² A Clinical Practice Guideline (CPG) is a decision making tool to assist physicians and patients sort through the maze of often conflicting information in order to decide the most appropriate course of action to take in a given set of circumstances. CPGs usually describe, based on a review of international research, what factors need to be considered and what course of action is recommended to ensure the best outcomes in a particular set of clinical circumstances. e.g. what tests to do if a patient appears to have a thyroid problem or when cataract surgery may provide a definite benefit and the least risk of unnecessary harm. CPGs are usually based on outcomes such as changes in objective testing, functional improvement, cost-benefits, least risk of harm, etc. They are not legally binding or a substitute for standards of care. (CPG Program run by the Alberta Medical Association & the College of Physicians and Surgeons). However, in the U.S. Guidelines are now increasingly used as mandated funding criteria and care instructions by Managed Care Companies.

insured services with set fees, and increase the number of *complementary* services or procedures for which physicians and facilities could charge uncapped fees directly to patients or employer benefit plans and private commercial insurers. Alberta Health could reduce public spending on healthcare by decreasing the basket of services covered by the plan, while maintaining or increasing physicians' income and ensuring the viability and financial success of investor owned private facilities.¹

A New Era Begins for Private Clinics in Alberta

In a News Release on May 30th, 1996, it was announced that the Federal government and Alberta had come to an agreement to end patient charges for facility fees at private clinics in Alberta as of July 1, 1996. Patients on waiting lists for cataract surgery at private clinics were delighted. Albertans had lost \$3.585 million in transfer payments from the federal government. Private clinics could still provide non-insured services on a privately paid basis, but all publicly insured surgeries performed in private clinics would require full payment by the Province to cover “facility fees” previously charged to patients.

Patients could not be charged for receiving a service insured by Alberta Health - but they could still be charged for non-insured products or services related or associated with an insured service. The Provincial Minister of Health at the time indicated she had consulted the Alberta Medical Association (AMA) and they foresaw no problems with possible undue physician influence over patient decisions to purchase additional services or products. Yet in a recent interview, Dr. Bryan Ward, Assistant Registrar of the College, said that the College is well aware of the “enormous problems” with both physician and private investor ownership of medical facilities in other countries, noting that currently the College relies very heavily on trust. Furthermore, given the experiences of regulators in other countries, he does not believe that the College has the ability, resources or mandate under the *Medical Professions Act* to regulate all the necessary elements of the rapidly growing commercial health care industry in Alberta.²

In another remarkable slight-of-hand, community based private MRI diagnostic clinics (which directly charge patients both facility and professional fees for expedited access to this diagnostic test recommended by a physician and provided at no cost in hospitals) were not included in this Agreement. According to the AMA this is because Alberta Health never agreed to a fee-for-service payment code for MRI tests done outside of a public hospital. According to a senior bureaucrat in Ottawa, the federal government allowed this approach for MRI clinics in order to give the province some leeway and because the test itself is physically performed by a technician, not a physician - although it requires a physician's order and interpretation.

¹“Defining Basic Services Overdue”, Alberta Doctors' Digest, May/June 1994

²Taped personal interview by author, June, 1998

17. A Tale of Two Cities

While cataract patients had been watching these protracted negotiations over facility fees between Alberta and Ottawa going on during the Winter of 1995/96, major changes were already afoot in the two major cities of Edmonton and Calgary where most Albertans went to have cataract surgery performed.

As detailed earlier, some private clinic owners in Calgary had already initiated an intensive lobby to move all eye surgery out of public facilities and into privately owned surgery centers. Driven by the loss of public hospital capacity, an ideological bent heavily influenced by the high concentration of physician owned private surgery facilities, and the fact the most eye surgery was moving to a day-surgery status, the Calgary Regional Health Authority (CRHA) had already taken steps to move towards increased contracting-out to the private sector.¹

When the Foothills Hospital was undergoing renovations in early 1995, the CRHA put out a Request for Proposals (RFP) to existing private clinics looking for blocks of operating room time on an 18 to 24 month contract, and for options for shared use of resources such as staff and supplies. The successful clinic was to be used by all eye surgeons who normally operated at the Foothills Hospital. The CRHA saw this as a pilot project anticipating that more procedures would be relocated if the pilot were successful. It also clearly identified that any contractual relationship would be conducted under the principles of the *Canada Health Act* which prohibits user fees for insured hospital services. In fact, patients were to be considered patients of the Foothills Hospital under this arrangement. The successful bid came from Dr. Peter Huang and the Bow River Surgery Centre. The per-case facility fee was reportedly significantly lower than that charged privately to patients by private clinics.

In contrast, a number of cataract surgeons in Edmonton under the leadership of Dr. Ian MacDonald, head of Ophthalmology and Dr. Tom Noseworthy, CEO of the Royal Alexander Hospital, had spent the previous year developing a plan to bring more cataract surgery back into public facilities through the creation of an expanded day surgery setting (and new eye clinic) at one central hospital location.² This group included a number of surgeons who had invested in private clinics a number of years previously. Some of these physician clinic owners identified their increasing discomfort charging patients as motivation for this effort along with a fear that patients would eventually lose access to all hospital based surgery and centralized ophthalmology expertise if any more eye surgery moved to private clinics.

¹ The Holy Cross and Grace Hospital were shut down in 1994 and the General Hospital demolished in 1997. The high number of well paid and well insured American executives in Calgary may have also been influential in encouraging the growth of private clinics due to the attraction as a potential market for services.

² “Eye doctors offer new vision of care; changes at Royal Alex may end need for private cataracts surgery clinics”, Edmonton Journal, October 27’95

One Edmonton surgeon had already discontinued using his private surgical suite the year before as access in the public system had improved. He and a few other local surgeons had also taken up offers by neighboring regions with hospitals within reasonable driving distance of Edmonton to provide cataract surgery at those sites for local residents. This provided extra operating room time without the investment, hassle or expense of maintaining a private clinic and rural patients were often delighted not having to deal with Edmonton traffic.

Finally, the University of Alberta Medical Faculty and local ophthalmologists were extremely concerned that the loss of public capacity for eye surgery would have a negative impact on the viability and quality of the Ophthalmology Residency Program and the future of ophthalmology research in the province. This Residency Program is the only one in Alberta.

A notable exception to the support for pulling eye surgery back into public facilities was the Gimbel Eye Centre that had recently opened a new larger private facility in Edmonton. Instead, this organization promptly moved to reduce potential future competitors by buying controlling shares in another private clinic in the same area which had been used for years by a number of local cataract surgeons and discontinued all cataract surgery at that site.

Those involved in designing the plan for bringing the majority of eye surgery back into public facilities were confident that their efforts would increase patient access through reduced costs and higher volumes. One of the surgeons bought out by the Gimbel Centre said that he sold his ten year investment because he believed that private clinics could no longer compete with the public system with the new Regional Program. His waiting list at the hospital was 6 to 8 weeks and the per case cost was \$500 dollars compared to the \$1000 charged at his private facility.¹

As a consequence of the radically different directions taken by these two cities in 1995/96, by 1998, patients in Calgary had no choice but to have their surgery at one of a number of private for-profit surgery clinics. These business interests provided 100% of cataract surgeries on contract to the local Calgary Regional Health Authority. In contrast, by 1998, 80% of patients in Edmonton were most likely to have cataract surgery performed in a public hospital while another 20% were operated on in private clinics under contract to the Capital (Edmonton area) Regional Health Authority.

¹“ Eyebrows raised as Gimbel buys into clinic”, EJ, O 8’95) .

18. The Evolution of Facility Fees into “Enhanced” Lens Fees

As of July 1, 1996, delighted patients were no longer faced with finding up to \$2550 dollars (for both eyes) over and above the amount paid in professional fees by Alberta Health for reportedly more timely cataract surgery at private clinics.

The Regions were directed by the Minister to contract with existing private clinics and pay the facility fee component. While paying these facility fees at private clinics would create new demands on the provincial health budget, amendments to the *Hospital Act* coming into effect August 1st, 1996 would bring in new money to offset this expense.¹ Contracts still had to be negotiated and extra money transferred to the RHAs to cover the additional costs. The Regions and clinics anticipated that contracting would result in successful clinics receiving less money for each procedure in return for higher volumes - based on the earlier trial run of such a model in Calgary. During an interim three month period over the summer, all clinics were allowed to invoice Alberta Health the full amount of the fee formerly charged to patients. While these contracts were being negotiated, there were reports of some clinics working well into the night in order to take advantage of these generous reimbursement rates.²

On October 1st, 1996, contracts were finally in place. Reliable sources suggest the compensation to clinics dropped from an average of \$1000 dollars/eye paid by patients to around \$600 dollars.³ Although the theory behind the benefits of contracting included a competitive bidding process, the CRHA stated publicly it hoped that all the clinics would get together and submit *one* bid. It never materialized, but all clinics submitting a bid reportedly received contracts.

¹ “Amendments to Third Party Liability Program to Come Into Effect August 1, 1996” (Press Release, Alberta Health, June 21, 1996) These amendments greatly expanded the circumstances in which the cost of an individual’s use of public health services such as hospital, physician, physical therapy, dental surgery and home care would be recovered from individuals or their home or business and auto insurance policies. As a consequence of these amendments, Alberta auto insurers paid Alberta Health 32.1 million in 1997 and were due to pay another 47.5 million in 1998. This would be considered payment for the healthcare costs of individuals who required public healthcare services due to an accident where another party was at fault - or partially at fault. These additional costs are simply incorporated into the premium paid by drivers. Other changes also gave Alberta Health the authority to recover costs where an act of omission or commission results in an injury to someone in situations other than auto accidents even if the injured party does not sue. (e.g. a neighbor or friend trips down your stairs).

² Statistics obtained from Alberta Health billing data verify these increases in the monthly volumes of cataract surgeries compared to previous monthly volumes. (Dr. Richard Plain, Health Economist, U of A)

³**Information on the amount paid per procedure, the number of procedures performed, etc. is considered commercially confidential and cannot be obtained by the public.** In the Capital Health Authority (CHA), contract confidentiality even restricts disclosure of the *names* of clinics with contracts without prior authorization. A request for disclosure of the names of contracted private surgery providers as background for this report was sent by the CHA to all suppliers and 4 providers of ENT and General Surgery Services refused to have their names disclosed. See separate Appendix for copy of letter from CHA.

In light of the unprecedented jump in the number of surgeries performed during the summer, the Calgary Region also officially put a quota on the number of cataract procedures in order to limit their financial exposure. Edmonton may have done the same. There are no quotas on any other types of eye surgery.

It is impossible to access relevant information on these public contracts. As well as confidentiality clauses in the actual contracts, access to individual physician and facility billings in Alberta is restricted. This is due to historical interpretations of the *Alberta Health Care Insurance Act*, the exemption of this *Act* from the *Freedom of Information and Privacy Act* and a *Confidentiality Agreement* between Alberta Health and the Alberta Medical Association. Regional Health Authorities contacted said they cannot share comparison information on details of these contracts among themselves or divulge the administrative and legal costs of negotiating, monitoring and enforcing them. In contrast, the facility fees paid by Ontario Health to Independent Health Facilities are a matter of public record. In British Columbia, individual physician and facilities' public billings are published and listed yearly by name

In the end, cataract patients' relief at no longer facing charges for timely surgery was short-lived. Almost as soon as the contracts had been signed, reports began to surface that many individuals going to private clinics were *still* paying. Investigation revealed that although both the surgeon's fee and the facility fee were now paid with public dollars, patients were now being asked to pay for a special "upgraded" intraocular lens implant and related supplies in order to improve the quality, safety, comfort and outcomes of surgery. (This was in lieu of the standard products covered by the provincial plan). Some were offered a shorter wait in return for purchasing this option. Patient charges in private clinics had once again been repackaged - this time as an "enhancement" or "lens fee". In some cases, this appears to have been a method of recovering per case income lost through contracting. One clinic that had previously charged patients \$1275 for a facility fee now charged \$675 for an enhanced package including an upgraded lens implant. The difference coincided with the reported RHA contract price of around \$600 dollars.¹

Following complaints from the public and possibly the Federal Minister's office, Alberta's Minister of Health issued a Press Release reaffirming and clarifying the government's policy on "*Enhanced Goods and Services*" (1992) which had also been identified at the time of the agreement to end facility fees. This time, references to the policy included government acceptance of patient payment for a "sophisticated intraocular lens" used in cataract surgery, but the Minister issued a stern warning stating that all such fees must be *optional*. (Refer to Illustration 13) It was left to individual patients to be aware of the detailed rules in this two page Bulletin and to challenge their surgeon or complain to Alberta Health or the College of Physicians and Surgeons if they felt they were unfairly charged.

¹ "Eye patients paying extra \$675 at local clinic: Surcharge at center of dispute.", EJ N2'96.

**HIGHLIGHTS OF UPDATED ALBERTA HEALTH POLICY
ENHANCED GOODS AND SERVICES (1996)**

“Patients can be charged for a higher standards of appliance (e.g. sophisticated intraocular lens, fibreglass cast), but only if there is no medical indication for the use of such an appliance” and the medical indications for specific appliances are to be identified by “the relevant professional organizations”. (Press Release, Alberta Health, 11/96)

“Patients who purchase enhanced services must not be allowed faster access to medically required services than those patients who choose not to purchase the enhancements: nor must the promotion of enhanced services imply that patients will get faster access.” (Alberta Health Care Insurance Plan Bulletin #35, Nov. 6, 1996)

Consumer Choice: Fact or Fantasy

While the government appeared to take great comfort in this policy, it was of little comfort to patients or their families. Claims of the benefits of these “sophisticated intraocular lens implants” and related supplies often implied safer and more comfortable surgery with better results. Other frequent claims included “less infection, fewer complications, clearer vision, faster healing, no stitches”, and/or “no need for glasses” and/or “no needle”.¹ The implication for most patients was that *not* choosing this lens implant would lead to a greater chance of reduced vision or possible blindness, more pain or discomfort and a longer recovery time leading to less independence and quality of life.

Fear of blindness is universal. Reducing the risk of complications, avoidance of unnecessary pain and discomfort, and opportunities to improve eyesight are highly attractive to individuals with reduced vision facing impending surgery. Furthermore, this advice was usually provided by the same surgeon on whose good will, skill and possible future care the individual requiring surgery or a family member would depend for good outcomes. Requests by the Consumers’ Association to clinics offering this option for medical studies to support their claims went unanswered.² There were sometimes other enticements for patients as well. (Refer to Illustration 14)

¹ “No needle” refers to the use of eye drops to numb the eye before surgery as opposed to local freezing administered through a small needle into tissue beside the eye. However, not all surgeons who use foldable implants use or recommend topical anesthetic and/or recommend it for all patients. It requires the patient to be able to limit their eye movements while the surgeon works on the eye. It may also require some use of sedation. There are actually many different types of “foldable” lens implants. Variations include the type of material, the number of components, and of the shape of stabilizing arms that hold the implant in place. In Canada, foldable silicone lens implants have been available for 10 years. Foldable hydrogel implants received pre-market approval in Canada on an investigational status two years ago.

³ This lack of response led CAC Alberta to request a formal evaluation from the Technology Assessment Unit of the Alberta Heritage Foundation for Medical Research (AHFMR) in January of 1998.

One patient's view of lens fees & enhancements (1997)

“I went to this particular clinic for cataract surgery mostly because of the extensive advertising and name recognition. As soon as they tell you there is less chance of infection, you want to take the package right away - no questions. Besides, if you didn't take the package, you'd have to wait for months. This was because they only had one day (per week or per month, I can't remember) that they did the operation for people who didn't buy the package. I'd already been putting surgery off for many years and now I really needed it. I'd quit driving because I didn't feel safe.

They do a fantastic job of marketing and provide excellent service. They were all so 'clucky' and presentable and really suck you in with the fantastic equipment, want a little prayer . . . subtle coercion. They also keep sending you letters asking for donations to set up clinics in other countries, supposedly because you are so lucky that you got an improvement in your own eyesight. The atmosphere is quite different when they ask for your cheque or VISA. Then they are very hard nosed and businesslike. I paid \$425 dollars for each eye on my VISA, but I know some people who have paid \$1500 for both eyes.

I'm calling you because I think these kind of charges are wrong. Years ago in Quebec when I was first married we were very poor and when I became pregnant, the family doctor said “I can't look after you” and sent me to Montreal where all the charity cases went. It was so demeaning. There were 20 women in labor in one room. Years later here in Alberta my husband needed medical care and it was all paid for. It made such a difference. I never want anyone to have to go through what I did years ago with one type of care for people with money and another for those who don't. Yet that seems to be happening more and more here in Alberta. Many people don't have a lot a money at some point in their life - particularly if they are sick and can't work.”

(documented call to CAC Alberta, 18/11/98)

Given the claimed benefits, these “foldable” implants soon became a drawing card and an important source of additional income for private clinics. In order to attract and keep potential patients, surgeons who primarily operated in public hospitals began to make these newer implants available to patients having surgery in public hospitals by selling them through their offices. The patient paid the surgeon for the implant at least two weeks prior to surgery and the surgeon ordered it and took it to the hospital on the day of surgery or ordered it through the hospital. Hospitals weren't adverse to this practice because it saved them the cost of the standard PMMA (polymethyl methacryalte) lens implant (usually less than \$50 dollars) and often some related surgical supplies. It also enabled more money to be left in hospital budgets to increase the amount of operating time available to surgeons. As more surgeons began recommending these implants, patients perceived this to be a clear admission and an indirect message from their surgeon that the quality of supplies used for surgery in public hospitals was substandard.

According to Alberta Health's Policy on *Enhanced Goods and Services*, medical indications for use of products and services were to be identified by the "relevant professional organizations". Yet repeated requests to Alberta Health and professional organizations have failed to reveal any involved in an assessment of lens implants for cataract surgery. The College of Physicians and Surgeons, the Alberta Medical Association, the Ophthalmology Department at the University of Alberta and the Ophthalmology Society all deny having been requested to provide such information.

In reality, most decisions about which supplies will be bought and used in surgical procedure, from scalpels to pacemakers and cataract lens implants, are made by purchasing agents or surgeons at an institutional level. Decisions reflect a number of considerations relating to the complex task of assessing the risks, benefits and cost-benefit of supplies that are often bundled together from different distributors. According to Calgary and Edmonton Health Authorities, the consensus among their own surgeons has been that there is inadequate evidence to suggest the more expensive lens implants provide substantial benefits, except in a limited number of cases related to the presence of other eye or systemic diseases, in which case the Region pays. Yet many of these same surgeons continued to recommend these newer implants routinely to patients - and some patients were glad to have the chance to pay. (Refer to Illustration 15)

Illustration 15

Another patient's view of lens fees and enhancements (1998)

Early in 1998, Mrs. Joyce R. went for a routine check-up with her eye doctor and he diagnosed cataracts in both eyes. This made sense because she'd noticed that she was having problems seeing her TV clearly. He referred her to one specific surgeon he liked and she had her first surgery done in 8 weeks and waited 9 weeks for her second. The wait didn't create any problems for her. Her surgeon told her she had a choice of which kind of lens would go in her eye after the cataract was removed, but there was a charge of \$250 dollars for the "soft" lens. The soft lens meant that she would have "no stitches". Using the soft lens would mean "less chance of infection and other complications", particularly because her use of prednisone could adversely affect her rate of healing. It would also give her "better vision" and "last longer".

Although the \$500 for both eyes was a financial hardship, Mrs. R. felt it was worth it. She was given written information on the lens and had to pay three weeks in advance to have them ordered from the States. Her vision after surgery was much better than she expected and she had "no complaints" about the comfort and quality of care at the hospital. Although she had the same anesthetist for both eyes, the first local anesthetic was much better than the second, "more comfortable, less painful". Since her surgery, she has talked to many people who weren't offered the new lens and they just couldn't believe that it was possible to have the surgery with "no stitches". According to Mrs. R., this lens should be offered to everyone because of the "no stitches", even if Alberta Health will not pay.

(Structured interview, June/98)

Shifting Costs to Patients and Private Insurance Policies

As charges for the cataract lens implants became more the norm than the exception, a number of patients automatically expected their employer benefit plans or the Alberta's Seniors' Benefit Plan would pick up these extra costs. Although there is some evidence that a few plans reimbursed these charges, some cataract surgeons' offices and the Alberta CAC report a number of patients have been upset to find out the lens implants were not covered by their supplemental health plan. In some cases, patients had agreed to purchase the lens based on an assumption their private plan *would* pick up the costs.

According to Susan Bramm of Alberta Blue Cross (a private not-for-profit carrier for the Alberta government's supplemental health plans and privately purchased employer benefit plans) most of their plans will not normally cover these charges. Irene Klatt of the Health and Life Insurance Council of Canada, a trade association and lobby group for commercial for-profit health insurance carriers, states that their members are not supposed to reimburse these implants "because they are considered part of a publicly insured procedure", although she believes some slip through. Both the Alberta and BC offices of Consumers' Association of Canada report receiving calls from a consulting firm in 1997 seeking information on lens implant charges to patients because they had noted that claims for the same brand of implant paid out by private insurers varied dramatically. This would seem to indicate that some such private insurance claims are being reimbursed. Other patients requiring surgery managed to avoid such decisions altogether. (Illustration 16)

Illustration 16

CASE HISTORY of Mrs. Hazel R. (1996)

Mrs. Hazel R. lives on a farm 60 kilometers south of Edmonton. In early 1996, she noticed that she was having some double vision, particularly with oncoming car lights. It wasn't handicapping her a great deal but she was concerned. She made an appointment with Dr. X, an eye doctor in the city her daughter had seen and whose name she knew. He diagnosed her as having cataracts on both eye which would need surgery. Once she decided to have the surgery, the wait was 2 to 3 weeks for the first eye and another 2 to 3 weeks for the second. Hazel had no costs other than travel and eye drops. She had a local anesthetic but doesn't know what kind of lens was used as she wasn't advised there were different types. The improvement in her vision after each surgery was much better than she expected and she couldn't believe how much more vibrant colours seemed. As a painter, she was attuned to colours. She was "very satisfied" with the comfort and quality of care she received at the University hospital and felt there was nothing that could have improved the quality or comfort of her care. (Structured telephone interview, June 1998)

19. Waiting Patients Become Unwilling Pawns in a Quota War

An even bigger surprise was in store for many cataract patients one year later in the Fall of 1997. A number who had already undergone preliminary examinations and purchased prescribed eye drops at the Gimbel Eye Centre were sent a letter. This letter informed them that their surgery had been canceled because the clinic's annual quota of 1,147 contracted cataract surgeries with the Calgary Regional Health Authority (CRHA) had been reached and the CRHA refused to pay for any more procedures.

This letter offered patients two options - waiting 10 to 18 months for publicly funded surgery or paying the full cost of the surgery identified at \$1,995 per eye.¹ If the individual chose to wait for publicly paid surgery when quotas would be redistributed in the spring, he or she could also choose to purchase an additional enhanced service package for the sum of \$750 dollars. This included an intraocular lens implant with enhanced features as well as "unlimited and convenient access to a not-for-profit private eye testing laboratory".

The new Minister of Health, Halvar Jonson, reacted swiftly. Charging patients for medically necessary services was only acceptable if the physician was opted out of Alberta

Health Care Insurance Plan according to the Minister. According to media reports, Dr. Mitchell, another Calgary cataract surgeon who had reached his quota the previous week had also started charging patients, although the amount was not specified. In a news story he went on to say "those who can't afford surgery or in his view can't wait, are operated on free of charge".² However, this statement may actually have misled the public.

Although private clinics could not receive any more facility fee payments from the CRHA for cataract surgeries until the next year, surgeons who had run out of their quota *could still bill the Alberta Health Care Insurance Plan* a surgeon's fee of \$505.13 for each cataract surgery performed and anesthetists could still bill Alberta Health for their services at these clinics. *Patients could also still be charged for "enhanced" options that included an "upgraded" lens implant and surgical supplies.* Depending on the amount charged to patients for such enhancements, some clinics could bring in more per case by billing the physicians' fees to Alberta Health and charging patients for enhanced services than other clinics could earn by providing the surgery entirely within the public funding envelope. For example, the CRHA was reportedly paying \$600 dollars per case for publicly insured surgeries while the enhancement fee at one cataract clinic in Calgary was \$750 dollars.

While the affected clinics reluctantly complied and agreed to meet with Alberta Health officials to work out a solution, the Gimbel Centre took out a large ad in newspapers in an attempt to get the policy changed.

¹ The AMA Clinical Practice Guidelines Program published Guidelines for Cataract Surgery in August 1996, but the CPG Advisory Committee balked at developing Guidelines with purely objective criteria as a funding cut-off tool. This would have been counter to the objectives of the Program.

² "No fees Jonson tells eye surgeon", Calgary Herald, Nov. 8'97

The CRHA responded.¹ In a letter to the Alberta Council on Aging (ACA) it noted that:

- Calgary's rate of cataract surgery was 20% higher than the provincial average after excluding non-residents and adjusting for population, age and sex.²
- The large increase in the number of surgeries performed during the summer when the province was paying the full invoiced price could not be sustained with available funding.
- All surgeons were aware of a process in place to allow them to request approval of surgery for those patients they felt could not safely wait.

The Region also provided supporting statistics and a list of surgeons who still had quotas.

While the option of charging patients privately for the full price of cataract surgery was essentially stopped in its tracks, the patient dilemma of paying extra for “foldable” lens implants remained unresolved. In fact, it probably intensified. Patients going to surgeons who had used up their quota may have been put under more pressure to choose an enhanced package in order to help cover a clinic's costs and maintain volumes. Many patients may have been advised they had no choice except to endure a long wait for the surgeon who had assessed them or to whom they had been referred. Most assumed that all surgeons' waiting lists were equally as long. Once having been assessed, the time and effort required to book with another surgeon and trepidation about one's comfort level with a new doctor and new location also may have created disincentives for individuals to change surgeons.

The method for determining surgeons' quotas in Calgary was, and still is, a major issue among cataract surgeons and patients. According to the CRHA, once assigned a publicly undisclosed quota of cataract surgeries, surgeons who do not own a private clinic are required to identify in advance the clinic they wish to use. Questions have been raised about the fairness of the process used to allocate quotas and surgical time. The Chief of Ophthalmology for the Region who makes the final decision on quotas has financial interests in a private clinic which recently dramatically expanded its potential capacity.³

¹ “ War of words heats up over cataract surgery; Gimbel clinic says 18 month waits, RHA says 8 weeks”, EJ N14'97, “ Gimbel clinics still charging out-of-province patients; one third of 3,000-4,000 patients from outside Alberta”, EJ, N16'97.

² Statistical breakdown by Region provided to Alberta Council on Aging by the CRHA

³ “Eye surgery reduction comes under fire: conflict denied”, Calgary Herald, April 2, 1998

Contracting Out

Internationally, contracting out the provision of publicly paid health care services, particularly to private business, was not turning out to be the panacea it had been claimed for “managing” care and costs back in 1994. In fact, this model was turning out to have a whole new set of unanticipated problems.

This reality had become obvious in New Zealand, a country that had initiated many similar reforms to Alberta a number of years earlier. Speaking at an International conference on “Contracting Out” sponsored by the Centre for Health Economics and Policy Analysis (CHEPA) at McMaster University in 1997, Toni Ashton, a senior health economist in New Zealand, noted: “The jury is still out as far as the overall success or failure of reforms, but policy makers acknowledge that the contracting process has been more difficult and costly than originally envisaged and efficiency gains to date have been less than expected.”¹ New Zealand had already retreated from their original model of regional purchasing authorities and short-term contracts and collapsed their regions into one entity.

Another speaker from the United States, Dr. Jeffrey Harris, pointed out the disruptions in care and additional costs incurred due to constantly changing contracts with suppliers - was well as the stress and barriers to coordinated care that this environment created for professionals and patients. Australian and U.S. government run public plans were also running into unexpected problems and costs by contracting to private business, including major cost over-runs, inconsistent quality, fraud and the need for ever increasing scrutiny and regulation - paid by the public purse.²

A decision by an Australian state to save 15 million dollars by having a private company build and manage a new hospital turned into a disaster with costs running over double the original estimate and the permanent loss of this asset at the end of twenty years.

Hidden benefits of the traditional role of local governments and charities in the delivery of health care services were also becoming more visible to the U.S. public in the wake of the many takeovers of public and non-profit hospitals by private business.

A 1997 survey in 100 cities by the Voluntary Hospitals Association of America found that Americans preferred to be treated (4 to 1) in community owned hospitals rather than investor owned or for-profit hospitals. Respondents also identified community owned hospitals as most likely to:

- **treat anyone regardless of ability to pay (83% to 5%)**
- **improve community health (72% to 11%)**
- **provide personalized service (62% to 18%)**
- **contain costs better (60% to 22%)**

¹ Ashton, Toni, “The Health Reforms: to Market and Back?”, Contracting for Health Services in New Zealand: A transaction cost analysis”, 1997.

² “Who wants Medicare Dead?”, Choice Magazine, Australian Consumers’ Association, Nov/ 1997, “Comparison of Community-Owned Not-for-Profit Hospitals and Columbia/HCA For Profit Facilities in Six Florida Markets”, Parker et al, 1997. Excerpts from Choice Magazine in separate Appendix.

20. The Reinvention of Hospitals by the Private Sector

By 1997, lens implant fees for cataract surgery were not the only new expense Albertans faced for recommended care by medical practitioners with one foot in the public system and the other firmly in the commercial realm.¹ There were now a multitude of private facilities, many owned by new corporate entities financed by third party investors, aggressively advertising their products, both insured and non-insured. Flashing signs at Eskimo Football games identified the value of a local private MRI clinic for diagnosing injuries. Billboards for private surgery clinics dominated the Calgary skyline. Newspaper advertisements encouraged the public to consider a wide variety of new refractive surgeries. Radio announcers encouraged women to protect themselves by going for publicly paid bone density screening at a private diagnostic centre (located in a non-profit facility) which could also conveniently arrange for a physician's visit if the patient's own physician wasn't available or cooperative.²

Paying privately for an MRI examination to avoid long waits in the public plan was quickly becoming the key to obtaining access to publicly insured treatment for cancer, sports injuries, multiple sclerosis complications in order to recover mobility and obtain pain relief. It was also increasingly a requirement to be able to access disability insurance payments.

This highly commercialized environment and growing reliance on private payment was a natural evolution of the direction set for health system reform in 1993/1994. It also seemed unstoppable despite the fact that a 1997 survey by Angus Reid found support for user fees in health care had continued to climb incrementally in every province of Canada - *except* Alberta, where support had actually dropped from an all time reported high in 1993.

¹ "Deathbed bill is truly shocking", EJ, Ja 23'97, "Klein defends lifting cap on doctors' fees, EJ, Mr 9'97, " "Longer MRI backlog predicted: private clinic expects business to pick up", EJ, 25/04/97,"48 docs earn extra under WCB plan" EJ, 12/04/97, "Health spending plummets: level lowest in Canada", EJ, Ag 22 "Medicare is back in the design shop: Report (core services) suggests moving towards partial Medicare", EJ, O 9'97.

² In 1997, Alberta Health spent over 7 million dollars on physician fees for this test which is done primarily in private diagnostic facilities. Procedure billed climbed from 2, 518 in 1994 to 39,563 in 1997. While this test does appear to have some value for monitoring a limited number of disease conditions, according to many well respected sources, there is no international agreement on a "normal" value (average readings even vary by geographical areas) and little inter-reliability between machines. There is also no significant evidence that it accomplishes its identified purpose as a screening tool for potential risk of future fractures. In fact, a series of 8 questions has been demonstrated to be more accurate, and reliance on this test can cause harm through incorrect diagnosis and expensive treatments or inappropriate lifestyle changes such as decreased activities to avoid risk. (Hailey et al, "Statement of Findings: Summary, International Network of Agencies for Health Technology Assessment Project on Bone Density Measurement and treatments for osteoporosis", AHFMR, 1996; Mintzes, B, "Blurring the Boundaries, Health Action International, 1998; Dewar, Elaine, "Breaking News: Blowing the Whistle on Osteoporosis, Homemakers Magazine, October, 1998; "Bone Mineral Density Testing: Does the evidence support its selective use in well women?", B.C. Office of Health Technology, No. 11, Spring 1998)

This test *has* proven to be an effective marketing tool for drug companies manufacturing products for the treatment of "low readings" who have funded much of the development and dissemination of this technology. It is also a great source of revenue for radiologists and privately owned diagnostic facilities.

Private surgical facilities had clearly established themselves as major players in Alberta's healthcare system, particularly in Calgary where the CRHA continued to see these facilities and the physicians and investors who owned them as key to future health reform and limited public expenditures.

For the CRHA, the stated attraction of this model of contracting with private business appears to be a concept promoted by private entrepreneurs that private capital is *free* money which allows the Region to *save* money by avoiding up front capital costs and building these costs into operating contracts. In return, private investors are rewarded with access to a captive clientele of publicly paid patients for the sale of *complementary* and non-insured services - which they also contend are often paid by the public system inappropriately. Being able to offer such services and products through private sales (due to increased private capacity) is promoted as a way of keeping valued services available to the public, while enabling the province or Region to reduce the number of *core* or publicly paid services - which these private suppliers claim they can provide at a lower cost in primarily non-unionized settings.¹ By enabling both physicians opted into the provincial plan and private facilities with public contracts to market upgraded or alternative services and timelier access to payers excluded from coverage by the provincial plan, claims are made that access to physician and facility services covered by the provincial plan will increase.²

As a consequence of the success of these arguments with administrators and politicians, both willing and unwilling physicians and patients soon found themselves directed to a growing number of private surgery centres to both provide and receive medical services.³

By May of 1998, there were almost 50 accredited private surgical facilities in Alberta; 26 providing medical anesthesia exclusively for routine dental work and dental surgery and 23 providing anesthesia for a range of surgical specialties, including seven (7) multi-purpose surgery centres in Calgary and one (1) in Edmonton.⁴ The higher number of multi-purpose private day

¹The attraction to politicians appears to be promises that the private health sector will attract investment dollars and create jobs - although this may be deceiving. Most such jobs are low-paying, temporary, part time or casual and the same amount of money is often simply redistributed from health workers to physicians and investors. Other in-demand workers are simply drawn from the same pool upon which public facilities rely.

² Many of these arguments were also used by Health Care of Australia (HCoA), a large multinational corporation owned by Mayne Nickless (which according to their literature has "led Australia and the world in the privatization of public facilities",) at the time they were attempting to persuade the Headwaters Health Authority to allow them to purchase and/or take over management of the Canmore hospital in 1997.

³ According to Dr. John Yates of the Health Services Management Centre in Birmingham, England and author of a 1994 book on waiting lists, the differential access between public and privately offered services in England is "staggering" and has been increasing as the private sector has grown. Public waiting lists are much longer than those reported by the Fraser Institute in Canada. In 1994, it took an average of 2 weeks in the private sector and 25 weeks in the public sector to see an orthopedic surgeon. (personal communication)

⁴ Surgeries currently contracted to the CRHA include arthroscopies, myringotomies, repair of deviated septum, hernia repairs, surgeries on hands and feet, varicose veins, removal of growths, surgical repair of fractures, etc. (CRHA documentation).

surgery available in Calgary appears to be due to the early entry of clinics run by anesthetists in 1988. (Refer to Figures 2,3,4) Although the first private surgery clinics were started by a few surgical specialists looking to expand their own practices, the investment in private surgery clinics by anesthetists may have led to more acceptance by surgeons who had been previously reluctant to leave the confines of a public hospital out of safety considerations.

From Private Clinics to Private Hospitals

In a climate of growing demoralization due to deteriorating working conditions from a combination of budget cuts and massive reorganization, two former public hospitals in Calgary which had been declared surplus in 1994 continued to present enticing opportunities to local physician entrepreneurs and investors. A probable genuine shortage of surgical time for some practitioners and a lack of skilled nursing and rehabilitation services following surgery were negatively affecting opportunities for income and patient access. These centrally located hospital facilities had been originally built and equipped with public money and were available for a fraction of what it would cost to build a new facility.

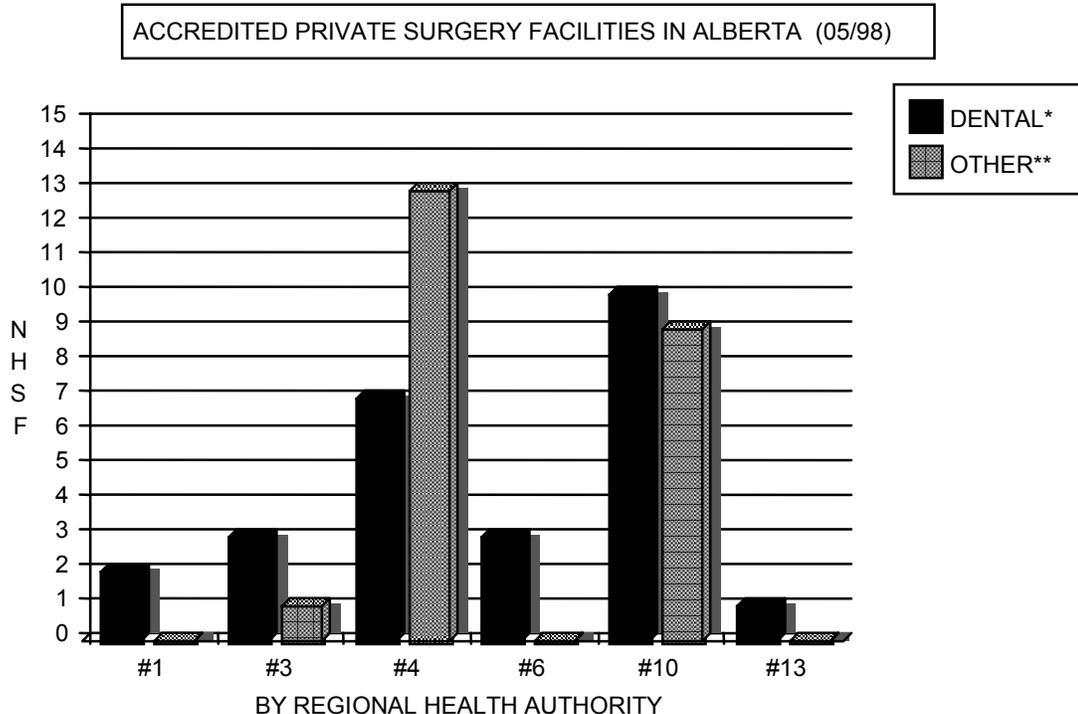
In the Spring of 1997, many Albertans watched nervously as a group of high profile Calgary investors with close ties to both the Regional Health Authority, the provincial government and private investors decided to push the margins of the existing private envelope. These individuals included the former Chief Operating Officer of the CRHA, the husband of a local conservative MLA, the Chief of Orthopedics in a local hospital, a high profile Calgary businessman, the head of a chain of recently established private rehabilitation clinics, and a former Dean of Medicine whose current stated area of expertise is venture capital acquisition. Their company, Health Resources Group Inc.(HRG), leased a floor of the former Grace Hospital (which had been regularly upgraded by the province, but was still owned by the Salvation Army) and aggressively pursued private venture capital to fund renovations. Their intent was to offer major surgeries previously restricted to “approved” general hospitals for which patients would require inpatient care and overnight stays.

According to an HRG Business Plan, this corporate entity planned on providing a range of acute-care hospital services for a number of potential markets which it felt could be cultivated or carved out. Suggested surgical procedures included joint replacements, back surgery and ligament repairs as well as a controversial and complication prone weight loss surgery.¹ Suggested markets included out-of-country patients, Albertans who have opted out of the provincial plan, individuals whose medical expenses are paid directly by federal government programs (e.g. RCMP and Treaty Indians) or provincially *legislated* workers compensation

¹ Taxpayers bear the financial consequences of these riskier surgeries in private settings because Alberta Health pays all except the first \$1000 dollars of all opted in doctors’ malpractice insurance premiums which range from \$1000 to \$30,000/year. Excerpts from HRG Business Plan in separate Appendix.

Figure 2

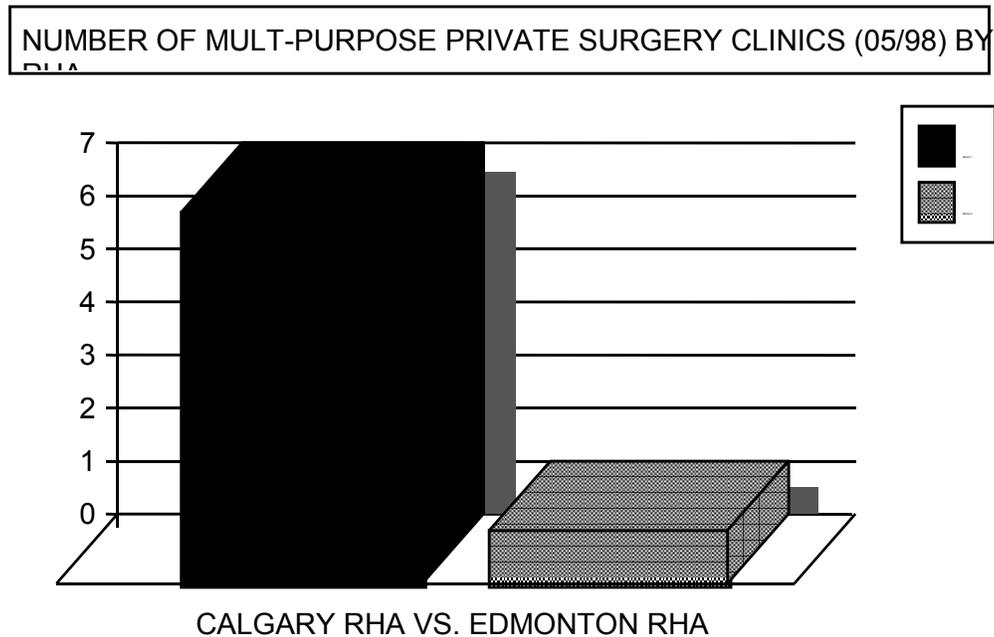
BREAKDOWN OF PRIVATE DAY SURGERY CLINICS IN ALBERTA BY TYPE OF SURGERIES to MAY/98



- #1 Chinook, #3 Headwaters, #4 Calgary, #6 David Thompson, #10 Edmonton, #13 Mistahia
- Based on data available from the College of Physicians and Surgeons of Alberta for accredited “non hospital surgical facilities” (NHSF) current to May 21, 1998.
- By May 1998 there were 49 NHSF compared to 36 in 1993, 20 in 1988 and 4 in 1980. Breakdown: 26 exclusively for medical anesthesia for dental surgery and 23 for all other types of surgery, which may include dental.
 - 7 ophthalmology only (5 Edmonton/2 Calgary)
 - 2 abortion (1 Edmonton/1 Calgary)
 - 3 dermatology (1 Edmonton/2 Calgary)
 - 8 multi-purpose anesthesia facilities (1 Edmonton/ 7 Calgary)
 - 3 plastics (1 Banff/1 Edmonton/1 Calgary)
- Procedures provided in multi-purpose clinics include orthopedic, general surgery, ear nose and throat, urology, gynecology, podiatry, etc.

Figure 3

COMPARISON MULTI-PURPOSE CLINICS CALGARY AND EDMONTON 1998



The above chart is based on data provided by the College of Physicians and Surgeons and reflects the situation in Alberta as of May 21, 1998. “Other” includes single purpose dermatology, ophthalmology and plastic surgery clinics as well as clinics providing sites for at least two specialties. Some provide facilities for up to 8 different specialties. Multi-purpose clinics are listed below. **Two are currently situated in former public hospitals.***

MULTI-PURPOSE PRIVATE SURGERY CLINICS IN CALGARY (1998)

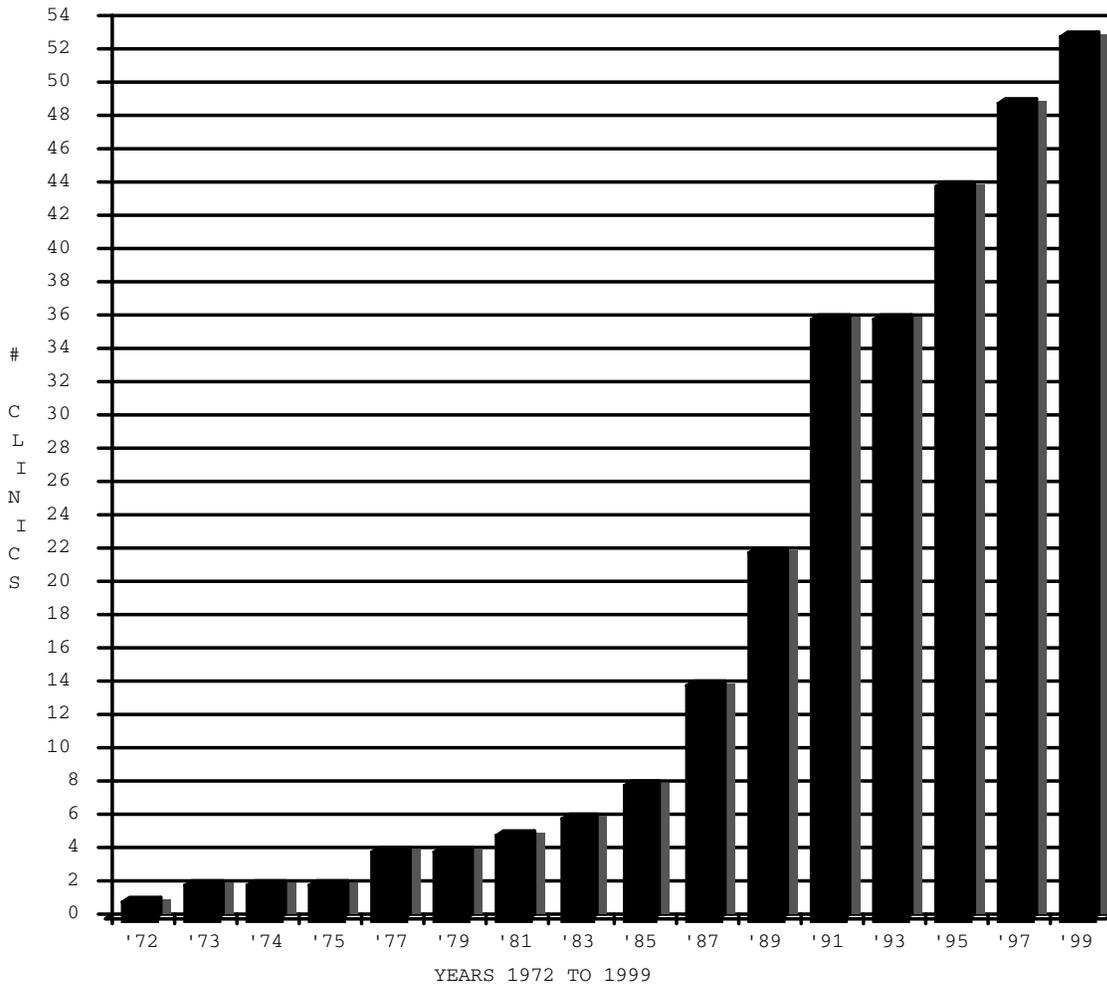
Royal View Surgi-Centre
Surgi-Centres/ Southport
Surgi-Centres/Foothills
Surgi-Centres/Rockyview
Rocky Mountain Surgical Centre
Holy Cross Surgery Centre (previous “Bow River”)*
Health Resources Centre *

MULTI-PURPOSE PRIVATE SURGERY CLINICS IN EDMONTON (1998)

Coronation Day Surgery (multi-purpose)
(Surgi-Centres Inc. opened a multi-purpose surgery clinic in Edmonton in 1999)

Figure 4

GROWTH OF NON HOSPITAL SURGICAL FACILITIES (NHSF) OR PRIVATE SURGERY “CLINICS” IN ALBERTA (TO NOVEMBER, 1999)



Graph is based on available accreditation data for Non-Hospital Surgical Facilities from College of Physicians and Surgeons of Alberta and interviews with private clinic managers.

It incorporates openings and closings.

- Facilities are currently limited to day surgery
- Two are located in former public hospital premises.
- One is currently seeking accreditation for major surgery and inpatient services

programs excluded from required provincial plan coverage in the CHA. Out-of-province patients had also proven to be a lucrative market for some private day surgery facilities here in Alberta. Health Resources Group also anticipated it could fill a growing gap in public capacity by contracting with the Regional Health Authority.

Finally, it appears as though HRG planned to market the idea of allowing physicians opted into the provincial Medicare plan having the opportunity to provide the same procedures in privately owned hospital type facilities to Alberta residents *outside* the Medicare plan as long as a third party paid. According to the circulated HRG Business Plan (1997), disability insurers, employer benefit plans and other unspecified third party insurers are *not* prohibited from “assuming the lead” to pay for services if the third party has a contract with the private facility. Given past interpretations of the *Canada Health Act* and restrictions on private insurance coverage for Medicare services in existing *provincial* legislation in Alberta, it is difficult to understand how this conclusion was reached - or how it will be nuanced. Once renovations were complete, HRG received accreditation to perform day surgeries from the College (August 14th, 1997) while they set in motion an unprecedented application to be accredited for the provision of traditional acute care inpatient hospital services and more complex surgeries requiring overnight stays.

The Workers’ Compensation Board Takes the Bait and Jumps the Queue

Given the growing expense of wage replacement for injured workers due to delays for surgical procedures related to the new limitations of the public system, the Alberta Workers Compensation Board (WCB) was the first to officially jump at the opportunity identified by HRG to pay higher prices for fast-tracked surgery at the new facility.¹

Up until this time, both the federal programs and the WCB had used and paid public facilities and opted-in physicians at the same general rates negotiated by the provincial plan. In fact, physician offices had historically billed Alberta Health for services to injured workers and the WCB reimbursed Alberta Health. According to Alberta Health, “approved” public hospitals have historically directly billed federal programs and the WCB the same rates charged to other provincial plans. These rates are identified in regularly updated provincial Ministerial Orders (#23) referencing the rates set by a joint Federal/Provincial Coordinating Committee on Reciprocity. With all publicly paid or publicly legislated health plans paying about the same price to suppliers, Canadians had managed to avoid the rapid inflation found in countries where multiple payers are forced to continually up the ante or lose access to timely care and skilled specialists for individuals covered by one plan or another.

Even before HRG opened its doors, many Alberta employers, who are obliged through provincial legislation to foot the cost of workers’ compensation programs, had been putting

¹ The purchasing of expedited surgical services from private clinics in British Columbia by the WCB program there erupted into a major battle between the Departments of Labor and Health at about the same time.

pressure the Alberta WCB to reduce its expenditures. The WCB's response had been to hire a specialist from the U.S. and introduce new strategies similar to those used in U.S. managed care organizations to limit claims, increase pressure on physicians to provide more timely care and purchase aggressive rehabilitation services at new facilities owned by private business interests. In fact, one of the directors of HRG was also the head of such a facility in Calgary. By the time HRG had opened, the Alberta WCB had already begun requiring physicians to bill the WCB directly in order to be compensated. This was seen as a way to increase the responsiveness of physicians to WCB requests for documentation and avoid long-standing disputes with Alberta Health over the allocation of billings related to pre-existing conditions.

The WCB also introduced bonus payments for surgeons who fast-tracked surgery for its clients. Initially, the WCB put out a Request for Proposals (RFP) to the well established private surgery sector in Calgary for a bulk contract for a specified number of expedited and frequently required surgeries and completely bypassed the public hospital sector. After an outcry by healthcare unions, public interest groups, and concerns expressed by the Alberta Medical Association that the loss of so many privately paid surgeries from public hospitals would have a negative impact on already stretched hospital budgets, the WCB decided to change tactics. They announced they were increasing the amount they would pay to both private and public facilities by up to 500% as an incentive to get clients treated quickly. These figures included a built-in 20% profit margin in recognition of the needs of third party investors in private facilities. The choice of the facility was to be left up to the worker and the surgeon who could also receive a bonus for expedited care.¹

The Public and the Profession Draw a Line in the Sand

The decision by the Alberta WCB to pay higher fees for fast-tracked service and HRG's plans to expand into inpatient care seemed to galvanize a number of groups and ordinary citizens. Up until now, most Albertans had been too busy with rapid changes in their own workplaces due to major changes in many industries, to pay much attention to the confusing world of health system restructuring.

The public had been told that new health reforms would bring improved coordination of medical care, more patient friendly treatment options and reduced costs. Yet many patients, particularly those with complex problems or chronic conditions, were finding that assessments were fraught with delays and poorly coordinated. Treatment choices covered by the provincial plan seemed to be dwindling. Families were more reliant on employer benefit plans, deductions for these plans were rising, and it was becoming more common to dip into credit to pay for needed care. Some families were even forced to ask for charity to pay for medical expenses. Something had obviously gone wrong!

¹ "Private hospital (HRG) targets WCB biz", EJ, Mr 18'97, "AMA worries private hospital may weaken health system", EJ, My 24'97, "WCB letting injured workers opt to be treated in private facilities" EJ, N14'97

This rapid growth of private facilities, commercial advertising, new charges and growing discrepancies in the availability and quality of care for those with generous employer plans and those without such plans all seemed to be linked. Line-ups to see certain specialists were lengthy. Yet if an individual was willing to pay for heavily advertised non-insured procedures, many of these same specialists seemed to be readily available. Reports from other countries questioning the wisdom of allowing increased private care had started to occasionally filter through the daily newspapers.¹ Some critics were expressing doubts about the ability of provincial governments to pull health services back into the public realm due to International Trade Agreements related to protecting private business interests.

Many Alberta farm families, small businesses and the newly self-employed in home based businesses (as a consequence of layoffs, downsizing and contracting-out) were began to worry that they would be the ones most likely to end up at the back of increasingly lengthy public queues for medical procedures. Calgarians waiting for services in the gutted public hospital sector saw the takeover of the former Grace Hospital by private business interests as particularly offensive. The planned opening of a private hospital providing inpatient acute care services rapidly became the battleground over the direction of health reforms and the increasing privatization of health services.

Initially there seemed little to impede implementation of HRG's plans. There was a complete gap in legislation and little enthusiasm by the provincial government for putting any restrictions on private business of any kind. This was accompanied by continued government claims that the expansion of private medical care would be the only way to save the public health system and provide desperate people with needed care.

When HRG applied to the College for accreditation to provide major surgeries and inpatient care, a flurry of correspondence among the Alberta Minister of Health, the College, and Health Canada attempted to clarify how the situation could, and should, be managed. The provincial government insisted it had no responsibility for the regulation of *any* private health facilities - despite the fact that at the time the *Medical Professions Act (1975)* which gave regulatory control to the College was passed, private medical facilities were primarily small professional corporations. No investor owned hospitals existed or were even envisioned. In fact, construction of acute care hospitals had been restricted to those approved by the Minister. Even the provincial *Workers Compensation Act* gave Cabinet the authority to approve or disapprove construction of facilities by the Workers' Compensation Board as well as the power to control the prices paid by the WCB to suppliers.

An August 1997 briefing note to the Minister of Health, Halvar Jonson, from a senior staff member identified his political dilemma: "The Minister has also indicated publicly that he will monitor the activities of HRG to ensure there is not a negative impact on the public healthcare system. However, there is no present legislation which would allow the Minister to disestablish a

¹ "Private care no cure, British say: a London hospital offers queue-jumping to the affluent but its CEO doesn't recommend the plan to Canada", G & M, JI 24'97,

"American health-care giant under siege: business practices of Columbia/HCA focus of probes", EJ, International, O 3'97,

"Home care test a failure: public sector regains service", Winnipeg Free Press, D 5'97

private facility if the Minister were to find the facility negatively impacting the public system”.¹ Critics also suggested the Minister would have no way of determining such information given the current lack of senior staff resources in the Department.

The situation came to a head in a Council meeting of the College of Physicians and Surgeons on December 1, 1997. Many representatives of public interest groups, concerned citizens and local media reporters were in attendance. In response to unprecedented public input to the College Council Members, the Council passed a motion. It acknowledged the College’s mandate to assure the safety of services provided in private facilities but went on to deny HRG’s application to expand its activities until more public discussion and political direction on this matter could occur.²

Bill 37

In response to the College’s decision and calls by public interest groups for legislation to stop the opening of Canada’s first for-profit traditional acute care hospital, the provincial government hastily drafted a Bill which would give the Minister of Health the power to approve or disapprove a new and undefined type of medical facility called a “treatment facility”. While the Health Minister insisted this Bill would provide a responsible mechanism to control the growth of for-profit facilities and potentially limit the scope of their activities, the Premier went on record noting the Bill could also enhance opportunities for private facilities, particularly private hospitals.³

Many interested parties across Canada were carefully watching these proceedings. Private health interests across the country and internationally had been pressing for greater opportunities for access to both public and private healthcare dollars in many provinces. The expansion of HRG into inpatient care would set a precedent that would make it difficult to stop existing private surgery centres in other provinces from expanding into inpatient care and offering a wide array of old and new services¹ - particularly for the worried well.

¹Documentation received in Freedom of Information request by the CAC (Alberta).

² “ MDs must decide: When is a hospital not a hospital?”, EJ, D4’97, “ Private clinic loses bid for overnight care: Regulator wants more public debate over for-profit medicine in Alberta”, EJ, D6’97, “ No overnight stays at private hospital -gov’t”, EJ, D11’97

³ “ Proposed changes may open door to private hospitals, Klein says (Bill 37)” EJ, Ja 30’98. While Bill 37 had the same general thrust as Independent Health Facilities Legislation in Ontario and Saskatchewan, the lack of specifics, the lack of public scrutiny and input into decisions, the power given the Minister and the comments of the Premier did not provide the assurances the public were seeking. Although an Alberta Health Press Release (Nov. 10,1998) indicated that no private “treatment facility” or private hospital would be allowed to provide publicly insured surgical services also provided by public hospitals to insured Canadians, a subsequent review by a government appointed panel of experts found that there were major flaws in the Bill which would have limited its ability to fulfill this publicly identified purpose (Blue Ribbon Panel Report, 1999) and answers to questions posed to government representatives at a meeting with public interest groups appeared to contradict these statements.

“Wellness” appears to have become a wonderful marketing tool for private sales of medical procedures. For example, in one of HRG’s presentations to the College, attended by members of the public and the media, a representative of HRG said there wasn’t a physician in Alberta who didn’t have time for private medicine. He went on to say that many surgeons in Calgary did not have enough work because of the lack of operating time in public facilities. Another representative pointed out the “great potential” for marketing privately paid arthroscopies of *healthy knee joints* (inserting a metal scope into a joint) *in order to predict how long the joint will stay healthy*. Despite the risk of complications such procedures may pose, this was described as a potentially valuable service to amateur sports enthusiasts and “consumers interested in wellness”. Later, in response to specific questions by Council members about the company’s willingness to perform a risky surgical procedure which a number of other doctors may have refused to do, HRG indicated that the company would be willing to do any surgery on anyone, citing their belief that it was a matter of patient “choice”- as long as the individual was willing to pay.² One can see how difficult it may become in the future, particularly if there is a complete blurring between public and private boundaries due to reliance on the same physician and site of care, to differentiate between a truly informed choice about the risks and benefits of a procedure related to medical need and company marketing or professional suggestion driven by financial imperatives.

Public outcry throughout Alberta resulted in Bill 37 being reluctantly deferred to the Fall 1998 sitting of the Legislature where continued public pressure resulted in another deferral and review by a “Blue Ribbon Panel” of experts in the Spring of 1999. No legislative action has been taken since the Panel’s report was released. In the Fall of 1999, the government announced its intention to once again bring in similar legislation in the Spring Sitting to facilitate contracting out major surgeries and inpatient care to private hospitals in order to “relieve the suffering of Albertans” waiting for care.

Despite the College’s initial stand that the provincial government be forced to take responsibility for any private hospitals in Alberta, the implied threat of a lawsuit by HRG led the College to proceed with the development of standards for private hospitals – just in case. These facilities were euphemistically called “Long Stay Non Hospital Surgical Facilities”. During the delay, an on-site hotel service with amenities was introduced in vacant hospital rooms at HRG for patients to recuperate from surgery and receive nursing care as long as it wasn’t considered “medically required”.

Meanwhile, the proposed expansion of the range of activities allowed in private medical facilities proved to be a powerful bargaining chip in negotiations between Alberta Health and the Alberta Medical Association during 1999 for a new fee schedule. A number of specialists threatened to opt out of the provincial health plan if their demands for increased fees for specific services were not met. The potential availability of a private hospital with the capacity to support a wide range of medical procedures would mean these specialists would no longer be dependent on

¹ These include the King’s Centre in Toronto, the Cambie Surgical Centre in British Columbia and two private corporations in Quebec reportedly proceeding with plans similar to Health Resources Group.

² Personal notes from College meeting verified by notes from other observers.

public hospitals. There were also proposals floated to allow physicians to opt out of the provincial plan on a procedure by procedure basis. This would enable them to continue to bill the public plan the negotiated fee for some procedures which required complex public hospital services but charge higher fees in private facilities for simpler but high-demand procedures.¹

Cataract Surgery Comes Full Circle

While the government, the public, and health professionals were all busy debating the merits of the HRG plans to expand their scope of activities, the Huang brothers, two Calgary doctors who had opened a private surgery clinic in 1991, created a consortium (Enterprise Universal Inc.) to quietly buy up the other surplus Calgary hospital, the Holy Cross. They moved their clinic across town. By March of 1998, the newly established “Holy Cross Surgery Centre” had expanded to provide cataract procedures on contract to the Region. At the same time, all foot surgery was consolidated in one private surgical centre. Dr. Mark Zivot, the RHA chief of podiatry also noted that the region had elected to contract with one specific *multi-purpose* facility for foot surgery rather than have physicians work out of several private centres. He was quoted saying that having all foot surgeons under one roof would make it easier to monitor the quality of surgery and the effectiveness of specific procedures as well as improve cost effectiveness.²

Remarkably, after years of argument in favor of multiple smaller free-standing facilities in order to decrease costs and increase access, the Calgary Health Authority and private companies were reinventing traditional hospitals by centralizing practitioners and multiple services under one roof in order to maximize coordination, efficiency, quality - *and* private profits.³

A significant portion of the cataract surgeries performed in Calgary had now come full circle back to a hospital type facility. The only difference was that many decisions about these procedures and activities were now firmly planted in the hands of private investors who had purchased a former public hospital facility (upgraded, and maintained by taxpayers’ dollars) for a reported fire sale price of 4.5 million dollars.

¹ “ Klein defends lifting cap on doctors’ fees: ‘You’ve done your part’ he says”, Mr 9’97, “Calgary surgeons want out of medicare”, EJ, D19’97, “ Docs resume talks as deadline looms: physicians threaten to cut working hours”, EJ, Mr 22’98, “Doctors turn down \$10, 800-a-year raise, EJ, Mr 15’98.

² “Holy Cross building open for day surgery”, CH, Mr 24’98

³ **Update 2003. The Holy Cross now has also obtained a contract with the Region for long term care beds. Long term care beds in Alberta are increasingly being used for sub-acute care formerly provided in acute care hospitals.**

21. Consumer Reality Check (1998)

Throughout the year of debate and discussion on the potential impact of private hospitals in Alberta, supporters continually pointed to the overwhelming success and acceptance by Albertans of the provision of cataract surgery in private clinics as evidence of the merits of their case. Yet many Albertans had mixed feelings about cataract clinics and no one seemed to have any real information on the impact of the growth of these clinics on the cost, quality and accessibility of cataract surgery, public plan coverage or the value for money provided by these clinics. In the Spring of 1998, in the midst of the HRG debate, the Alberta Chapter of Consumers' Association of Canada (CAC) decided to take one more look at the options and choices faced by Albertans in need of cataract surgery.

CONSUMER ACCESS TO CATARACT SURGERY SURVEY (1998)

During May and June of 1998, representatives of the Consumers' Association of Canada (Alberta) posing as a relative of a prospective cataract patient, contacted the offices of 48 Alberta ophthalmologists previously identified through a variety of sources as routinely performing cataract surgery. Questions on the current waiting time for cataract surgery, the soonest available appointment, the site of surgery, the existence of additional charges and information on any optional enhancements were directed to the receptionist answering the phone. While staff in some offices/clinics appeared to be prepared to answer such questions (particularly in Calgary), others provided tentative answers and advised callers they would have to wait to speak to the surgeon at the time of his assessment for details. Two clinics (5 surgeons) required callers to leave their name and number to be contacted later. A second call was made to one third of the offices surveyed. Some responses varied slightly.

The results were collated using the initial response. Surveyors also requested that available printed information on upgraded lens implants being offered or promoted be sent out.*

Surgeons performing cataract surgery are located in Lethbridge (3), Medicine Hat (3), Calgary (23), Red Deer (1), Edmonton (15) Sherwood Park (2) and Grande Prairie (1). At least 2 Edmonton surgeons also travel to neighboring RHAs to do surgery. According to information provided by offices surveyed, cataract surgeries were also regularly performed in Wetaskiwin, Lloydminster, Camrose, Leduc, Westlock, Lamont, Stony Plain, and Fort Saskatchewan.²

* The most frequently sent out materials were various lens manufacturers' pamphlets. In some Regions, the foldable implant was simply not used by surgeons (RHA #2 -Medicine Hat, RHA #6 - Red Deer). In others it was frequently used and routinely covered at no cost to patients (RHA-#1 - Lethbridge, RHA #12 - Lamont/Ft. Saskatchewan). In Calgary , Edmonton and neighboring RHAs serviced by Edmonton surgeons only rare public coverage appeared to exist. Conflicting information suggests some of these neighboring RHAs may provide higher levels of coverage than Edmonton. Private sales of "foldable" lens implants appeared to be most actively promoted in Calgary, although information provided by staff and surgeons during assessment may differ.

Based on information provided to surveyors, Albertans with an identified need for cataract surgery could expect to encounter a variety of waiting times and charges. One of most interested findings to emerge was the contrast between three large Regional Health Authorities in Alberta with high volumes of recipients of cataract surgery over the age of 50 between 1994/95 to 1996/97 and three very different models of delivery. ¹

In the Chinook Region (Lethbridge), all cataract procedures were performed in public hospitals. In the Calgary Region, all cataract procedures were contracted out to privately owned day surgery facilities – with a few exceptions related to other complicating disease conditions. In the Edmonton Region, the majority of procedures were performed in public hospitals with about 20% contracted out to private facilities. The Calgary Region had the most identified cataract surgeons per population (1 to 37,000) while Edmonton had the lowest (1 to 51,000). The Chinook Region fell between with one cataract surgeon per 49,000 population.

A comparison of the findings in these different settings can be found in Tables 5 and 6.

Table 5

**WAITING TIMES FOR FULLY INSURED CATARACT SURGERY
IN 3 DIFFERENT DELIVERY MODELS (1998) ***

- In Calgary, Albertans could find minimum waits ranging from 1 to 40 weeks¹
- In Edmonton, Albertans could find minimum waits ranging from 2 to 8 weeks
- In Lethbridge, Albertans could find minimum waits ranging from 1 to 8 weeks

- In Calgary, Albertans could expect an “average” wait of 16 to 24 weeks²
- 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

- Calculations are for fully insured cataract surgery. .Not included are: one surgeon on leave; two offices where receptionist refused to give a waiting time until assessed by surgeon; one office where payment for an upgraded lens appeared to be required; the shorter wait identified by one clinic with 3 surgeons if the patient opted to pay privately for an enhanced lens package in order to obtain faster service.

¹This describes the range of lowest identified wait times for surgery by cataract surgeons’ offices.

² Average wait reflects an average of minimum and maximum wait identified by office staff when a range was given - usually described as next availability of bookings for operating room time. If no range was given, the single number was calculated in both low and high range of averages.

¹ Based on volumes of cataract procedures by RHA of the recipient by year, a document provided by the Calgary Regional Health Authority to the Alberta Council on Aging.

Table 6

EXTRA PATIENT CHARGES IN 3 REGIONAL HEALTH AUTHORITIES IN ALBERTA WITH 3 DIFFERENT DELIVERY MODELS (1998)*

*Following a decision to proceed with surgery, patients of 24 out of the 48 eye surgeons could face a decision whether or not to pay an additional fee for an *enhanced* service which included a “foldable” or “soft” surgical lens implant in lieu of a standard or traditional “rigid” implant.*

In Calgary, where 100% of publicly insured cataract surgeries are performed in private clinics:

- 18 out of 23 surgeons’ offices surveyed offered this option
- prices ranged from \$250 to \$750 dollars per eye
- the most common charge was \$400 dollars or \$800 dollars for both eyes
- some offices indicated the majority of patients chose this option (e.g. 70%)

In Edmonton, where 80% of publicly insured cataract surgeries are performed in public hospitals and 20% are performed in private clinics

- 6 of 15 surgeons’ offices surveyed offered this option
- prices ranged from \$250 - \$425 dollars per eye
- the most common charge was \$250 dollars or \$500 dollars for both eyes

In Lethbridge, 100% of publicly insured cataract surgeries are performed in public hospitals

- 0 out of 3 surgeons’ offices surveyed offered this option
- foldable cataract lens implants were routinely provided to patients at no cost.
- these implants are purchased by the Region for “substantially less than \$100 per lens”

* These findings are graphed in Figure 5

Comments provided to CAC researchers demonstrated a wide variation in opinion about the value of these implants and the pressures that may be applied to prospective patients either by staff or surgeons. (Refer to Illustration 17)

**INFORMATION PROVIDED TO PROSPECTIVE CATARACT PATIENTS
ON SURGICAL IMPLANTS (1998)**

The following comments were provided by cataract surgeons' office staff in response to the question: "Are there any charges or additional costs?" and probes for information.

1. *"There is no charge unless she is interested in the new technology which is a soft lens. The doctor folds it to insert it. The incision is smaller and there is less chance for infection."*
2. *"It's supposed to have a shorter healing time due to a small incision, but the doctor does a very small incision already so he sees no need. There is no pain in either case, but we do have it available for \$250 dollars."*
3. *"No charge, unless she wants the full health package. It costs \$750 dollars per eye. This includes a foldable lens which means a smaller incision. The doctor can't guarantee there will be no stitches with the rigid or basic lens. It also heals faster by about two weeks and there is less trauma to the eye. If you choose the standard or rigid lens the wait is 10-18 months. The wait for the soft lens is 6-10 months. (Why the difference?) It's less popular."*
4. *"Yes, we recommend the foldable lens at \$350 dollars. It's a much smaller incision, it heals faster, and there are generally no stitches."*
5. *"He sometimes recommends foldable lenses for individuals if they have certain conditions, but it makes no difference in your eyesight and stitches don't hurt."*
6. *"If the patient's preference is a soft lens, it's smaller and the eyesight is clear. Patients sometimes develop a covering on the eye which needs to be removed and this happens less with the soft lens - 1% vs. 15%. The price is \$400 dollars"*
7. *"The doctor sticks with the rigid lens. He has some concerns about the long term results with the foldable lens. He currently has very good results from cataract surgery and believes people have better vision with the rigid"*
8. *"The cost is \$400 dollars. It provides a better angle to do the surgery. Patients also only need drops rather than an injection. It should have fewer complications as well."*

SUMMARY OF FINDINGS OF CONSUMER GROUP SURVEY OF ACCESS TO CATARACT SURGERY IN ALBERTA (1998)

In locations where there was more reliance on private for-profit facilities to deliver publicly insured cataract surgeries and an optional privately paid second tier, Albertans were more likely to experience:

- longer waits for cataract surgery
- more frequent out-of-pocket patient charges for physician recommended care
- higher out-of-pocket charges for physician recommended care
- less value for money from suppliers and the public plan
- decreased choice of cataract surgeons based on ability to pay
- questionable compliance by surgeons with professional codes of conduct

Compliance with Professional Code of Conduct

Inquiries by the consumer group indicated that these lens implants being sold to patients for \$250 to \$750 dollars wholesaled for around \$150 to \$200 dollars to individual surgeon's offices, depending on the manufacturer and other special arrangements.

Given that most legal jurisdictions have some type of restriction on the sale of products by licensed medical practitioners in order to avoid circumstances where opportunities for additional income may influence professional judgment, the CAC attempted to determine if such limitations existed in Alberta. It discovered that the seemingly excessive mark-up on these implants appeared to be a violation of the *Conflict of Interest Guidelines* of the College of Physicians and Surgeons of Alberta. These Guidelines were created to prevent licensed physicians from taking advantage of their power over patients in order to benefit financially from the sale of unnecessary, expensive or inappropriate products. According to a College official, Dr. Bryan Ward, charges for products had historically been limited to a small administrative mark-up of around 15%, although this could vary depending on the particular circumstances.

On November 16, 1998, the Board of the Alberta Chapter of Consumers' Association of Canada filed a complaint with the College of Physicians and Surgeons of Alberta under the *Medical Professions Act*. They requested an investigation of the 16 cataract surgeons whose offices had identified charges of \$300 dollars or more for access to an upgraded lens implant.

Although the Consumers' Association Board felt that any charges for enhanced implants were inappropriate, no complaints were laid against the other eight surgeons who offered this implant at less than \$300 dollars. It was felt these physicians were at least acting in the spirit of the *Conflict of Interest Guidelines* by keeping mark-ups on this product to a minimum.

The Board also filed a complaint with the Minister of Health charging violation of the Alberta Health Policy on *Enhanced Goods and Services* by a privately owned surgical clinic in Calgary with 3 surgeons. This clinic had offered consumer group surveyors a shorter wait if the enhanced lens implant was purchased. A major influence on the organization's decision to file complaints was a particular disturbing call received by the association early in November 1998. (Illustration 19)

Illustration 19

A CONSUMER NIGHTMARE . . . the story of Mr. X (1998)

Mr. X, 74, was referred to a cataract surgeon by his optometrist whom he trusted. His eyesight was failing badly and both eyes were affected. "I was worried about driving my grandkids around in the car." When he went to his appointment, the surgeon gave him written information about a "foldable" lens implant and told him the choice of purchasing it at \$250 per eye was up to him. Mr. X had not anticipated this and was a little shocked. He didn't expect to have to pay an extra \$500 for a medical procedure covered by Medicare. Mr. X also didn't feel he had the expertise to make such a judgment, so he asked the surgeon what he would do - and took the doctor's advice to pay the extra. Besides, Mr. X didn't want to risk delaying his surgery. It was scheduled only a few weeks away and his payment had to clear the bank at least two weeks before his date of surgery.

Once he got home, Mr. X started talking to acquaintances who had undergone the same surgery with the standard lens implant and were very satisfied with the outcomes. He began to wonder about the wisdom of his choice, particularly since he was facing a big increase in property taxes and his income was limited. Mr. X. tried to find more information without much success. He did find out there were actually many different types of rigid and foldable lens implants and that opinions among surgeons varied. He didn't want to see another doctor and delay his surgery, so he called the surgeon's office.

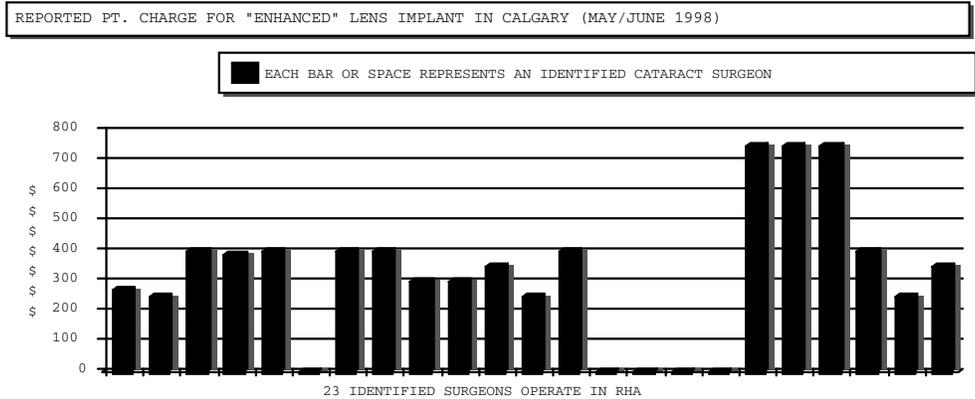
Given his impending surgery and his inability to speak with the surgeon directly, he told the receptionist he had been reconsidering his decision. He acknowledged that it may be too late but requested that she get a message through to the surgeon that *if* both types of implants were going to be available on the day of his surgery, he'd like another chance to speak with the doctor before the operation. He wanted to see if he really needed to spend the money and *exactly* how much of a difference using this implant would reduce his risk of complications.

At 10 p.m., just as he was going to bed the night before his surgery, the surgeon called. With no opportunity for discussion, Mr. X was brusquely advised that since he obviously had so little faith in the surgeon's advice, he must not consider him competent. Therefore the surgeon was canceling his surgery and referring him to someone else to wait for another appointment and surgery date. Mr. X. was frightened and angry. He eventually went to the other surgeon, was advised that the "foldable" lens would provide better vision (e.g. less chance of surgically induced astigmatism) and *less chance of certain complications leading to a possible loss of vision*. Mr. X paid his \$500 and proceeded with the surgery.

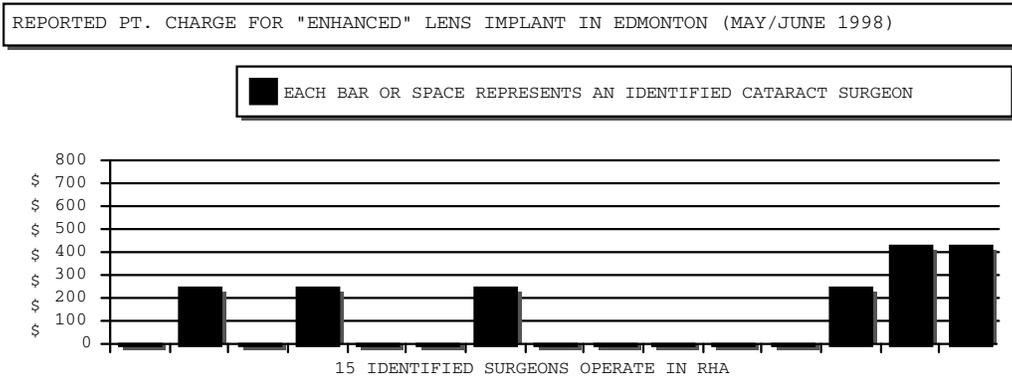
Figure 5

**Prices for Access to “Upgraded” or “Enhanced” Surgical Implants
in 3 High Volume RHAs in Alberta (June 1998)**

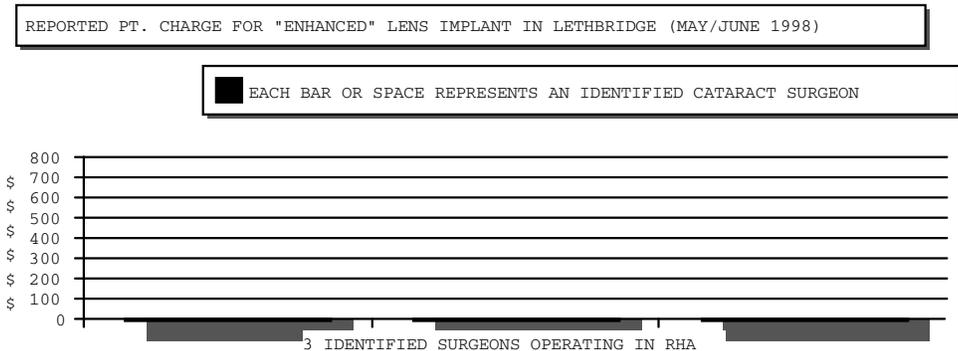
100% OF CATARACT SURGERY IS CONTRACTED TO PRIVATE CLINICS (CALGARY)



80% OF CATARACT SURGERY IN PUBLIC HOSPITALS & 20% PRIVATE (EDMONTON)



100% OF CATARACT SURGERY PERFORMED IN PUBLIC HOSPITALS (LETHBRIDGE)



22. A Snapshot of Accountability for Commercial Medicine in Alberta

Provincial Government Accountability

In a recently published Alberta Health handbook for citizens on *Accountability in Health: Roles and Responsibilities*, it states “to be accountable, a person must have been assigned responsibilities that he or she is expected to perform.” It also goes on to say “the Minister of Health and Wellness has the ultimate responsibility for the overall quality of the health system in the province” and “through legislation, policy and standards, the Minister provides overall direction to the health system.”

The Response of the Provincial Government to Consumer Group Allegations of a Violation of Alberta Health Policy on “Enhanced Goods and Services”

In response to the letter of complaint sent to the Minister of Health by the Consumers’ Association regarding the promotion of fast-tracked surgery which had been identified during three separate calls over a three month period, the Minister, Halvar Jonson, simply restated the policy. “The purchaser of the enhanced services must not be allowed faster access to medically required services than those patients who chose not to purchase the enhancements; nor must the promotion of enhanced services imply that patients will get faster access”. Although the evidence upon which the complaint was made was originally misconstrued by the Ministry to be complaints by patients, subsequent communication clarified that the complaint was based on the promotion of faster access by surgeon’s staff over the telephone to CAC researchers. In a letter dated May 11th, 1999, the Minister advised that because the complaint was not coming from someone who had actually paid for faster service, the Ministry was unable to investigate.

Decision of Alberta Health Re: Allegation of Breach of Policy

“ Alberta Health subsequently sought legal counsel to determine the strength of its position in pursuing an investigation of the Centre without complainants willing to come forward. The legal opinion obtained indicated that, without the co-operation of the actual complainants, Alberta Health is not in a position to pursue an individual investigation. . . at this time. Alberta Health was further advised that the pursuit of an investigation based solely on the testimony of two CAC employees was not a viable option.” (Letter from Alberta Health to Larry Phillips, President, Consumers’ Association dated May 17th, 1999)

In short, someone who has already been victimized is the only complainant the province will recognize. Unlike other consumer markets (e.g. car dealers, manufacturers, department stores), the reporting and provision of evidence by independent third parties regarding the violation of Alberta Health rules of marketplace conduct related to representation and promotion will not be investigated.

Author’s Update 2003: The same clinic was captured making this offer of expedited surgery on tape by the Editor of the Calgary Sun in 2000, “Calling for Health Answers”, Licia Corbella, Calgary Sun, March 5, 2000

Professional Regulatory Body Accountability

The Alberta government has adamantly maintained over the past few years that the authority and responsibility for regulating both private medicine and private medical facilities (and businesses) rests with the delegated professional regulatory body for licensed medical practitioners in Alberta - the College of Physicians and Surgeons of Alberta (CPSA).

In the handbook on *Accountability*, professional regulatory bodies are identified as being accountable to “review the performance of their members, set requirements for ongoing practice and conduct of their members and disciplining members who don’t meet professional standards.” The motto on the stationary of the College of Physicians and Surgeons of Alberta reads “to serve the public and guide the medical profession”. The legislated mandate of the College is to protect the interests of the public.

The Response of the College of Physicians and Surgeons of Alberta to Consumer Group Allegations of Violations of Professional Codes of Conduct

On May 31, 1999, the CAC received a response from the College to its complaint filed on November 16th, 1998 alleging violations of the College’s *Conflict of Interest Policy* by sixteen cataract surgeons related to patient charges for upgraded cataract lens implants.

In a detailed letter from Dr. Theman, Assistant Registrar, the College advised the consumer group that it had conducted an investigation of all identified surgeons. Based on supporting documentation from the surgeons, the College identified “ although some are cheaper and some are more expensive, *the typical lens costs \$150 to \$200 dollars and that is price paid by virtually all of these physicians.*” The letter went on to say that all physicians had provided the College with a cost accounting of additional costs incurred related to the private sale of these surgical implants which generally included items such as:

- the cost of the lens
- the purchase order
- the cost of credit card billing
- counseling time
- increased staff time
- corneal topography or mapping, including the cost of the machine and the cost of interpretation
- surgical instrumentation specific to the use of the foldable lens
- provision of patient instructions, solar shields or sunglasses, medications and a container to hold these materials
- the cost of the damaged implant, which must be replaced
- bad debts

Based on their investigation, the College felt that that all surgeons contacted had been able to provide sufficient evidence to support these costs as legitimate expenses - thus indicating that the amount charged to patients did not result in any additional profits or income flowing which could influence a practitioner’s recommendation. Furthermore, upon review of its *Conflict of Interest*

Policy, the College concluded there was no policy in place suggesting that 10-15% was a reasonable mark-up on products.

Dr. Theman then went on to comment that Dr. Shutt, Chief of Ophthalmology for the Capital Health Authority (which does *not* cover this upgraded implant except in a limited number of cases when patients have other mitigating conditions) had identified there *are* significant medical advantages to use of the foldable implant. He also relayed comments from one cataract surgeon who “found it interesting that the concern of Consumers’ Association of Canada is more about costs rather than whether or not the procedures is of benefit”. Finally, he noted that “ many of the ophthalmologists expressed grave concerns about the motivation behind your complaint and indeed about the College’s willingness to investigate this matter”.

In conclusion the College found:

1. “The provision of a foldable or otherwise “enhanced” intraocular lens was an optional service, not medically necessary. All patients had the option to have a standard intraocular lens placed after cataract extraction.
2. There is wide access to cataract surgery, with great variability in the price charged to patients for the enhanced lens, from effectively no markup to \$750 dollars. Patients therefore have a wide choice in cost and provider.
3. All the physicians were able to attribute their costs. While all physicians attributed the costs in a similar manner, there remained significant variability indicating that there was no price fixing or collusion. This point is important, and is made more strongly by your own data, which confirms tremendous price variability and therefore a lack of price-fixing or collusion.”

The final decision of the College is documented in the Illustration below.¹

Illustration 20

**The Decision of the College of Physicians and Surgeons of Alberta
Re: Allegations of Violation of *Conflict of Interest* Policy**

“ In short, we believe that consumers have a broad choice of provider, a wide choice in cost, and variability in the enhanced services which they may purchase. The College is satisfied that none of these physicians has violated the ethical principles as stated in our Conflict of Interest policy.”

Excerpt from letter to Mr. Larry Phillips, CAC President from
College of Physicians and Surgeons of Alberta, May 31, 1999

It is difficult to reconcile these responses from the Minister and the College with information provided in the *Accountability* handbook. In particular, the discrepancies in interpretation of written policies between the consumer group which deals with the interpretation of regulations on a daily basis and the legislated governing bodies seems remarkable - as does the failure of both to even address the identified concerns fully.

The lack of a meaningful response to these complaints, the lack of public knowledge rules of conduct for medical practices and private clinics, along with the traditional patient fears of alienating a physician on whom they depend demonstrate some of the challenges facing Albertans in an increasingly commercialized medical marketplace. It also demonstrates the reason why such markets are so difficult and expensive to regulate in the public interest.

When it comes to consumer protection from misleading or coercive marketplace practices, the resolution of payment or terms of coverage disputes, product guarantees and other business practices, the only recourse is through complaints to the College of Physicians and Surgeons or Alberta government administrators. There appears to be no protection from anti-competitive practices such as the linkage between the price of an upgraded implant and professional service rendered by a surgeon or the overwhelming barriers encountered by patients attempting to realistically evaluate the tradeoffs among different implants.

Given this seeming lack of interest in monitoring or challenging private clinics or physician practices over their activities, it is clearly a case of *Caveat Emptor* or “Buyer Beware” for vulnerable Albertans in an increasingly commercialized medical environment. Unfortunately, the buyer of medical services has little recourse but to place their trust in the advice of professional suppliers of this high stakes service - unlike other economic markets.

Between the Lines

A closer consideration of the written responses of the College and Alberta Health to the problems faced by cataract patients with the emergence of direct sales of upgraded surgical implants (related to the provision of a publicly insured medical procedure) demonstrates the far reaching ramifications of an expansion of this practice.

Private sales of medical products & services related to an insured service
shift the accountability for safety, quality and cost

The choice of surgical implants and supplies has historically been based on input from surgeons and specially trained institutional purchasers because these products are essentially the tools of skilled and knowledgeable surgeons. *Shifting responsibility for this decision to patients allows surgeons and administrators to avoid accountability for the safety, quality and cost of products used in the provision of a medical procedure - and the outcomes of the procedure.*

Envisioning the actual mechanics of just how prospective cataract patients could make an informed choice as a “sovereign” consumer on the safety, quality and price of a product as unfamiliar as a surgical implant - the value of which depends on a professional assessment of the patient’s unique condition - demonstrates the inappropriateness of direct sales of such products.

On what past experiences or reliable third party information would a patient make a choice about the various materials used in implants, the variations in stabilizing arms, the risks and benefits? Are there numerous outlets to compare price and quality? Will these implants soon be available at Future Shop along with an optional five year extended warranties? What if a surgeon doesn't like the type a patient chooses, particularly since the choice affects the particular surgical technique employed and the surgeon's comfort level? Can it be returned? Can a patient buy an implant from one surgeon for a lower price and have another perform the surgery? Is this wise?

Some of the surgeons from across Canada interviewed by the author, including some who liked and often used various types of "foldable" implants, pointed out that although there appear to be some definite benefits, long term studies are not complete. There are also numerous clinical trade offs with each type of commonly used implant and each type of commonly used anesthetic. The most frequently mentioned benefit of these foldable implants was a reduced (but not eliminated) rate of clouding of the eye post surgery called a "secondary cataract". This requires a minor painless office procedure with a special laser when it occurs. Others felt the rigid lens provides clearer vision because of the manufacturing process. Many noted that the technical skill of the surgeon could make more of a difference than the type of implant used. Patients have *no* access to this information.

On top of this conflicting information, the real dilemma for patients making a decision about such an unfamiliar product with such perceived high stakes is the palpable fear created by the thought of shouldering the blame and guilt should complications arise after surgery if one has disregarded the surgeon's advice. There are significant differences between a patient wanting to participate in decisions about treatment choices such as surgery versus medication versus watchful waiting, based on personal circumstances, treatment requirements, past history and desired outcomes - and a situation in which one is suddenly confronted with a complex decision regarding the choice of surgical supplies which surgeons cannot agree on.

Private sales of products and services related to publicly insured services
increases costs and creates longer waits

There are significant disincentives and added costs and consequences for both patients and the public plan inherent in this model of purchasing surgical supplies - including lengthening waiting lists for assessments, treatment and surgery.

The type of foldable lens implant offered and price is essentially "tied" to the choice of surgeon, but patients are not routinely advised of the type suitable for their eye or preferred by the surgeon prior to an initial assessment. Furthermore, the availability of these implants is often tied to the purchase of other goods or services which may be considered less valuable by patients thus driving up the price of the product even more. In order for a patient to obtain the necessary assessments and recommendations on various options to make a reasonably informed choice, multiple appointments would be required. If such visits are billed to the provincial health plan, the public purse pays for these additional visits. If patients are billed directly, it creates financial disincentives for making an informed choice. Information provided to the College indicates increased physician counseling and staff time is necessary and attributed to the cost of the

implant. It is reasonable to assume this additional time must add to the doctor's workload and affect the overall availability of eye surgeons - for assessments, treatments, other surgeries and on-call services.

Private sales of products and services related to publicly insured services provides poor value for money

If, as the College states, the sale of these surgical implants did not result in any profits or additional income flowing to surgeons or clinics over and above the actual expense of providing the product, *the cost of providing these implants to patients through retail sales is two to seven times more expensive than providing them to everyone within the public plan at wholesale prices.*

Realistically speaking, there are few families who would not attempt to find the money to pay for a product which they perceive to be necessary to assure safety, comfort and the best outcomes for a surgical procedure - even at the cost of other necessities of daily life. This is reflected in the information provided by one surgeon's office in Calgary. The receptionist volunteered that over 70% of patients paid extra for the enhanced lens. In the summer of 1999, the CAC office also received a call from a partially disabled woman whose completely disabled husband had been advised that he needed cataract surgery on both eyes. The surgeon recommended upgraded implants that would cost a total of \$500 dollars for both eyes. Since they lived on a monthly pension income of \$800 dollars, purchasing these implants would have to come at the price of falling behind in rent and telephone payments and cutting back on groceries. Her bluntly worded question was "What are his chances of going blind without them? Is it 1 out of 10, 1 out of 100 or 1 out of 10,000?"

Finally, if such private sales associated with insured services continue to exist and proliferate, families of ordinary means will feel it necessary to purchase additional private insurance coverage to cover such gaps and protect themselves from unexpected expenses. With private insurance products, the administrative costs and profit margins as well as these higher prices are ultimately added into premiums.

This method of payment for surgical implants in Alberta by individual private sales appears to provide incredibly poor value for Albertans' health care dollars.

The Equivalent of Consumer Product Testing in the Medical Marketplace

Just prior to publication of this report, the Alberta Heritage Foundation for Medical Research (AHFMR) released a technology assessment paper on the safety, efficacy and effectiveness of three different broad classifications of intraocular lens implants (IOLs). It was based on the composition of the implant: rigid polymethyl methacrylate (PMMA), foldable silicone, and foldable acrylic lenses.

This evaluation was done in response to a formal written request by the Consumers' Association of Canada (Alberta) in January 1998 in order to evaluate the claims being made and assist patients in making such complex decisions. "Technology Assessment" involves evaluating a product or procedure based on all methodologically sound available literature and studies.

Illustration 21

Excerpts from Summary of AHFMR Technology Assessment of Intraocular Lens Implants

“Many designs of intraocular lens implants (IOL) are available. They differ in their refractive indices, water content, surface properties, clarity and mechanical strength. They are either rigid or foldable and the cost per lens can range from \$50 to \$700. Controversy remains about the ideal lens to implant in regards to safety, effectiveness and costs. . . . A large number of the IOL products are available and their safety and effectiveness are functions of a complex interaction between the lens and the surgical procedure. . . . Overall, there appears to be little good quality information (or studies) to guide ophthalmologists, consumers and funders in their choice of the most appropriate type of IOL. . . . The choice seems to depend mostly on the surgeon’s preferences, training, expertise (appropriate placement of a lens in the capsular bag) and availability (coverage by Health Ministry and purchasing choices by Regional Health Authorities).”

Technology Assessment on Intraocular Lens Implants
Technology Assessment Unit
Alberta Heritage Foundation for Medical Research, 1999

Unfortunately, there were no clear answers. In fact, the findings of the AHFMR would support the view that surgical implants used in cataract surgery are a highly unsuitable and inappropriate product for direct purchase by consumers.

23. Evaluating the Canary in the Mine Shaft: A Postmortem

Proponents of increased contracting out to private business to provide publicly insured health services and the addition of new sources of private income for suppliers claim this model will offer greater convenience, greater choice, greater flexibility and better access to new valuable technologies. Based on an examination of the experience of Albertans over the past 20 years, it seems clear these claims are deceptively misleading. Benefits are marginal or fleeting at best and need to be weighed against the overall detrimental effects of this model on the cost, quality and accessibility of medically necessary care - and increased financial burdens on families, employers and taxpayers. The historic benefits of the “Canadian model” of health payment and delivery documented in national and international research find themselves echoed in the experiences of Albertans requiring cataract surgery. The benefits associated with the Canadian model are:

- universal availability of care and coverage
- lower prices and good value for money
- wide choice of practitioners and sites of care
- coverage of a comprehensive basket of services and historic high standards
- no financial barriers to insured services at time of need
- minimal paperwork to obtain coverage or make a claim
- low administrative and regulatory costs

The overwhelming evidence in this report indicates that Alberta’s forays with increased reliance on private delivery and private payment have already negatively impacted these highly valued features. This report began with a metaphor of a canary in a mine shaft: the canary representing the quality, cost and accessibility of medical care: the mine shaft being the new (increasingly privatized) environment in which Alberta cataract patients have found themselves. The findings in this report suggest the bird has been asphyxiated. Let’s explore the cause of death.

1. Private delivery and private payment ultimately walk hand in hand.

Roemer’s Economic Law (which describes a dysfunctional market dynamic unique to health care whereby supply dictates demand) is alive and well in Alberta. The uncontrolled proliferation of private clinics in the 1980s and early 1990s led to rapid increases in the volume of billings to the physician fee-for-service budget in the public plan. These pressures eventually led to a reduction in the number and type of services covered by the plan and/or the quality and timeliness of public cataract surgery for many patients. By 1992, one third (1/3) of Alberta patients were paying additional fees (over and above the professional fees paid by Alberta Health) in order to access physician recommended cataract surgery. As the number of private clinics grew they sought new sources of income. *This led to the aggressive marketing and sales of experimental technologies and pressure to remove benefits from Medicare in order to create new private markets to maintain the financial viability of these clinics and increase income opportunities for professionals and investors. Many fearful Albertans are now paying additional private insurance premiums to try and protect themselves from growing gaps in public health plan coverage for delisted services.*

2. Claimed savings from private delivery are deceptive and misleading.

There is *no* evidence that increased reliance on private business reduces the price of services to the public plan except through a corresponding loss of quality or access or the addition of “tied” private sales of related goods or services to a captive market. Over the past decade cataract patients in Alberta have paid up to \$1275 per eye on top of the amount paid by the public plan in order to recover real or perceived deficits in publicly insured services such as timeliness or quality. Current patient charges for access to an “enhanced” implant for cataract surgery range from \$250 to \$750 dollars per eye. *This has resulted in a substantially higher price to obtain the originally desired “consumer product”, thus defeating the originally stated purpose of contracting out to private business. (i.e. lower costs)*

3. More private delivery leads to longer public waits and less choice.

The ability of physicians opted into the provincial health plan to earn substantially more through private sales of upgraded or non-insured services in private facilities decreases the availability of these skilled practitioners to the public plan and public facilities. It also leads to a shortage of physicians willing to spend their time providing lower paying public procedures or dealing with more seriously ill or complex patients. It does not shorten public waiting lists. Instead, it leads to longer waits for public care and reduces patient choice of practitioner and site of care *within* the public plan. A 1994 survey found that fully paid cataract surgery was readily available from surgeons who worked exclusively in public hospitals. Significantly longer waits for fully paid surgery in public hospitals were only encountered by patients whose surgeons also offered a choice of paying extra fees out of pocket for a shorter wait in a private clinic. A 1998 survey (following the introduction of contracting-out public surgeries to private clinics) found that patients in *Regions with private clinics providing cataract surgery on contract had less choice of cataract surgeons whose recommendations for care related to cataract surgery were entirely paid by the public plan.*

4. Increased private delivery can adversely affect public plan quality.

New opportunities for private sales of medical products can marginally speed the introduction of new innovations into practice. It can also lead to the premature adoption of expensive and poorly evaluated products that may not provide substantial benefits *or* unnecessarily delay public plan coverage of a genuine advancement in order to maintain the attractiveness of private facilities to patients. *Cataract surgeons in RHAs that contract with private clinics advised administrators that “foldable” implants do not provide a substantial medical benefit for most patients and should not be publicly paid. Yet many of these same surgeons advise patients in their offices that these implants do provide substantial medical benefits and encourage patients to purchase them privately.* In Calgary, where 100% of publicly insured cataract surgery is contracted out to private clinics, patients must pay an average fee of \$400 dollars (up to \$750) for an optional “foldable” implant in order to obtain what is promoted to be better and/or safer care. In Lethbridge and Lamont where all cataract surgery is performed in a public hospital and there are no contracted private clinics, these foldable implants are routinely provided at no cost to patients for a wholesale price of less than \$100 dollars.

5. Contracting out health services decreases flexibility and public scrutiny

Contracting to private business interests for the provision of publicly paid medical care has a number of hidden risks and costs. This includes the loss of flexibility due to legal contract obligations, increased dependency on privately controlled suppliers in an essentially non-competitive environment, and loss of the ability of the public to scrutinize and evaluate providers or hold plan administrators accountable. It may also reduce future options of bringing public health plan services back in-house due to International Trade Agreements. Details of public contracts and outcomes with private surgery facilities performing cataract surgery are considered commercially confidential. Even RHAs are restricted from sharing such information with each other. *This means that the real impact of contracting out on the marginal cost, quality, and safety benefits associated with adequate volumes, quality and consistency of staffing and adequate oversight cannot be properly evaluated.*

6. Public contracts subsidize the private commercial health industry.

The infusion of public money to private business interests cross-subsidizes non-insured commercial sales. Many complications from non-insured surgeries wind up in public facilities being treated at public expense. Public contracts attract new private investors. This leads to the unnecessary and expensive duplication of facilities and underutilized equipment. The number of all types of private surgery clinics in Alberta rose from 4 in 1980 to 20 in 1988, 36 in 1993 and 49 in 1998. The range and scope of activities and size of facilities also increased over this time. Six new private eye surgery clinics opened between 1990 and 1993. *The destruction of public hospital capacity and legislation to facilitate contracting out in 1994 served as a public bail-out of investors in private clinics who were suffering from dropping volumes and income due to the rapid expansion of new competitors for a limited pool of money over the previous decade.*

7. Most investment in private clinics is driven by opportunism - not need.

Small private facilities targeting underserved geographic areas or marginal groups with special unmet needs and which exist simply to fill gaps in local services at the lowest possible cost to ensure accessibility may provide an important safety valve and good value for money – but are rare. Most suppliers and commercial interests target large urban markets and services with a good potential for marketing low overhead, high volume procedures with good returns and opportunities for related sales - often to the detriment of other needed services. *There are no private eye surgery clinics outside the major urban centres of Edmonton and Calgary.*

8. More private delivery leads to more marketing & increased demand.

The use of medical procedures and products is not just driven by self-identified need. It can also be driven by suggestion and by commercial marketing strategies that downplay risks or limitations and highlight potential benefits of procedures in order to maximize volumes. There are no warranties in medicine. Standards of practice set in the private sector drive expectations of the public system - regardless of merit or risk. Calls to the Alberta Chapter of the Consumers' Association of Canada indicate that increased volumes of cataract surgery have

been stimulated by the identification of clinically insignificant cataracts through “free screenings” by private clinics and expensive advertising. *This has led to increased billings for eye exams and cataract surgeries in Alberta, increased public and private expense, and an increase in time consuming and potentially unnecessary tests and treatments for Albertans.*

9. Increased commercial marketing limits the ability of administrators and the public to realistically evaluate need and value.

Pressure from the continual expansion and marketing of commercial suppliers makes it difficult for the public and plan administrators to separate propaganda from real need and value. This limits the ability of public administrators to allocate resources wisely. It also decreases public confidence in the public system. Dramatic decreases or increases in public funding are blunt instruments that do not address need or appropriateness of care. The drastic cuts to the Alberta Health budget in 1993/94 led to scarce resources being diverted to administrative costs related to restructuring to the detriment of patient care. It also created new income opportunities for private suppliers as previously insured services/products were unbundled and higher uncapped fees for these services were shifted to patients. *This led to greater media coverage and subsequent pressure for funding for those procedures where private suppliers and facilities stand to gain the most (e.g. cataract surgery, MRIs), rather than the full range of highly valued and possibly even more urgently needed health services.*

10. Private health interests can negatively influence public decision-making.

The problems associated with contracting out the provision of publicly paid medical care to private business and the introduction of private payment alternatives in other countries have now been well documented. This information *should* have filtered through to key decision-makers, yet there have been few adjustments in the original course set for health reform in Alberta. In fact, these “solutions” continue to be advocated. Why? A number of medical practitioners and business investors with strong political affiliations and economic interests in commercial health ventures have jockeyed themselves into positions of private and public trust in Alberta. This has enabled these individuals to have access to privileged information and opportunities to influence key decision-makers to the detriment of the public health system and their peers. *The influence of these parties has led to the creative use of language to disguise the intent of many commercial interests. Examples include the constant re-labeling of patient charges for cataract surgery at private clinics as “extra-billing”, then “facility fees, and finally “enhanced services’, the introduction of core and complementary services, and calling a legislatively restricted private hospital a “long stay non hospital surgical facility”.*

11. The greater the number and size of private suppliers, the greater the need for expensive monitoring and regulation.

The objective of investors is to sell more (not less) services and products in order to recoup and increase returns - not act as stewards for the wise use of public money. The greater the private investment in bricks and mortar, equipment, supplies, repayment of debt and advertising, the more products they have to sell. Even well intentioned suppliers can soon rationalize inappropriate behaviors when they face the

loss of a major financial investment or see new lucrative opportunities and there are no obstacles put in their way. In an environment where commercial values and behaviors are rewarded, an increasing number of otherwise public interest minded health professionals begin to embrace such values and emulate these behaviors. The visible success of one Alberta cataract surgeon increasing his volumes, public billings and private income through the use of a private surgery clinic led to other surgeons also opening private clinics. The success of sales of upgraded implants to patients at private clinics led to surgeons working primarily in public hospitals selling these same implants to patients for extra fees. The ownership and control of private clinics is also changing from individual practitioners to large corporate entities answerable to third party investors and shareholders. (e.g. Gimbel Vision International, Surgical Centres Inc., Health Resources Group Inc.) *Given the response to complaints filed by the Consumers' Association of Canada (Alberta), neither the College of Physicians and Surgeons nor Alberta Health have any effective mechanisms to protect individual consumers or monitor and control activities in the rapidly growing commercial environment for health care in Alberta. These will need to be developed at taxpayers' expense.*

12. The public system has to fail in order for the private to succeed.

Private business interests often promote misinformation in order to achieve their ends. An example is the frequent claim in the early 1990s of routine 2 years waits for cataract surgery in public hospitals. This drove many Albertans into unnecessarily paying higher prices at private clinics when many skilled surgeons had waiting lists under 2 months. The claim that "Alberta could save millions" by contracting to private clinics also appears to have been false. The early buy-in by Alberta politicians to these deceptive claims led to drastic budget cuts and administrative chaos in 1994. It created a very dysfunctional public system. It also led to many demoralized health professionals seeking greater autonomy and financial rewards in private settings to replace elusive professional job satisfaction in public settings - which may account for a reported shortage of some specialists and anesthetists. The destruction of hospital capacity and a decision not to fund or appropriately staff existing community owned (public) facilities has led to a loss of confidence by many Albertans in the public health plan and public facilities. *The Alberta government is proposing a plan to allow investor driven private hospital type facilities to provide previously restricted major surgeries and inpatient care on contract to Regional Health Authorities "to relieve the suffering of Albertans" - even if it costs the public plan (and patients) more.*

23. CONCLUSION & RECOMMENDATIONS

Instead of being the *solution* to rising costs, longer waits and less than ideal patient care, increased reliance on private business and the introduction of new sources of private payment has been the *cause* of many of these problems. While a limited number of small private initiatives may provide a safety valve and source of innovation, the more public plans rely on facilities and agencies owned and controlled by private business interests and the more costs are shifted outside the plan, the greater these problems will become.

Remarkably, this seemingly inverse cause and effect relationship is analogous to a well documented phenomenon in the practice of medicine whereby the overuse of tests and aggressive treatment for mild or temporary conditions can lead to debilitating side-effects or life threatening complications which are far worse than the original problem. This phenomenon is one important reason why many health professionals and citizen groups around the world consider medicine ill suited to a commercial environment. The increased marketing of potentially hazardous medical goods and services in such environments leads to more casual use of tests and treatments. This is not only more expensive. It also increases the opportunities for causing unnecessary harm.

Based on the evidence documented in this report, it seems clear that increased reliance on private business to deliver services and the introduction of new private payers for medically necessary care will not control prices, ensure adequate distribution or assure an acceptable level of safety and choice for Canadians. Nor will it enhance the sustainability of the provincial health plans that make up Medicare or the total costs of care to families and communities.

By not applying the same terms and conditions of public plan payment to services shifted from hospital to non-hospital settings (and back again) - and not keeping service delivery predominately in the hands of designated in-house community oriented organizations— the Canadian healthcare system will lose its historic price and quality controls. It will also lose its simplicity of use and flexibility. In fact, this is already occurring.

Families and society at large will face higher prices for both publicly and privately paid care to the detriment of other sectors of the economy. Public administrative and regulatory costs will rise as new opportunities are created for self-interested suppliers, large commercial interests, third party investors and private insurers to exert increasing control and demands. There will be longer waiting lists for public care, less quality, and less choice.

The challenge facing Canadians policy makers and the Canadian public is that most of the problems encountered by individuals seeking medical care today are primarily related to the nature of modern medicine and medical markets - *not* the nature of Medicare. However, it will be an even greater challenge to protect citizens' interests in the midst of an explosion in new information, medical and genetic technologies until this new model of increased reliance on private market strategies and private payment for medical care is firmly rejected.

A NEW DIRECTION

12 RECOMMENDATIONS TO CONTROL

THE COST OF HEALTH CARE SERVICES TO THE COMMUNITY AND IMPROVE THE SAFETY, QUALITY, TIMELINESS AND ACCESSIBILITY OF MEDICAL CARE

1. Identify a credible public body to determine the dollar value of health care expenditures that have been shifted from provincial health plan coverage to private payers, including lost or replaced income waiting for tests and treatment since 1980 or 1985. This should include costs shifted to employers sponsored supplemental health and disability benefit plans, workers' compensation programs, out-of-pocket expenditures and private home, life, health and auto insurance premiums.
2. Determine how best to shift this money back into the public health system in a fair and equitable manner in order to maximize price controls and timely access. This shift is how Canadian Medicare was originally created. It is a success story which can be built upon.
3. Begin a deliberate effort to shift the ownership and control of facilities and agencies providing publicly insured services in the community from private investor-owned corporations to a controlled number of government approved and community driven non-profit facilities and agencies (run by voluntary service organizations or local public boards). These should be globally funded organizations, not fee-for-service, and publicly accountable. Limit and regulate existing private clinics.
4. Limit the opportunities for physicians enrolled in the provincial health plan to provide privately paid services, including prohibiting private direct sales of products and services related to a publicly insured service. Restrict other public or publicly legislated third parties such as workers' compensation plans or federal in-house plans from paying higher fees to public or private facilities or practitioners. Maintain restrictions on private insurance coverage.
5. Restrict the scope, size and circumstances of physicians' investment in private health ventures in order to avoid conflicts that may adversely affect patient care. The public does not want to have to worry about conflicts-of-interest in administration. Patients should not have to be wary and on guard for a sales pitch when seeking vital medical advice.
6. End the use of strategies which have been fueling the rapid growth of commercial activities and third party investors in health care and driven up costs to the community such as: a) delisting services, quality, or timeliness from the provincial plan, b) providing generous access to public money and captive public patients, and c) introducing new direct purchasers of medical services such workers' compensation plans and insurers. Bring severed services back into the Plan. Provide appropriate coverage of new technologies and assistive devices.

7. Apply the Principles of the *Canada Health Act* (as identified in the policy and legal interpretation by Federal Minister, Diane Marleau, on Jan 6th, 1995) to the full range of diagnostic, treatment, recovery and rehabilitation services moved outside hospital settings. Being a “payer of first resort” for the comprehensive range of services required to recover from an episode of illness or manage a chronic condition, regardless of the setting where services are delivered, is the best way to maximize flexibility, choice and value for money.

8. Ensure quality and compassion within the public plan and equal public plan coverage of an insured procedure regardless of the location of delivery.

9. Increase public access to information on decisions and supporting rationale regarding plan coverage and issues related to the development, cost, evaluation, regulation and marketing of medical services and products. Ensure adequate appeal processes are in place for individuals. Ensure adequate numbers of public representatives to represent the interests of plan members are involved in oversight and decision-making committees.

10. Legislate that any significant changes to the terms and conditions of coverage or delivery of services provided by public health plans require prior written notice to plan members, public hearings, and intervention opportunities for academic based researchers, workers, employers and citizen groups. Any evaluations of proposed changes should consider *and* publicly disclose the anticipated impact on the *overall* cost, quality, accessibility of health care to the community as a whole, the future sustainability of public health plans, and any additional administrative and regulatory costs which may be borne by taxpayers. It should not just measure the impact on the budget of one government department or health plan.

11. Reduce the unnecessary additional costs of administering multiple assessment, treatment and payment streams (e.g. workers’ compensation) by bringing direct payment of public programs under one roof. It makes little economic sense to force Canadians to rely on separate systems depending on where, when or how an injury or illness occurs.

12. If changes are not made to the current model of increasing reliance on private business interests and the outsourcing of publicly insured services, significant taxpayer dollars will need to be raised or shifted in order to invest heavily in consumer and taxpayer protection. This will be necessary due to the problems associated with an increase in commercial activities by investor-driven suppliers of health services and private insurance products. Adequate legislative, regulatory and judicial resources will be required to monitor, control and ensure effective remedies to deal with issues such as tied selling, anti-competitive practices and environments, self dealing, and contract obligations. Additional money will also need to be directed to dealing with misleading advertising and marketing practices and public and private costs related to harm done from inappropriate medical treatment.

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