

Response to Proposed Bill 11 Regulations

Jointly submitted by:

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Alberta Union of Provincial Employees (AUPE)
Canadian Union of Public Employees (CUPE)
Health Sciences Association of Alberta (HSAA)
United Nurses of Alberta (UNA)

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I. Introduction

It is with a great deal of reluctance - and even trepidation - that we submit this brief regarding the proposed regulations for the government's so-called Health Care Protection Act.

Our reluctance is not difficult to understand. After all, this round of consultation comes after most of the important decisions have been made regarding Bill 11. Why are we being consulted only now that the Bill has passed? Where were the consultations last in the fall, winter or spring? And if the government is really so interested in "listening to the people" why didn't they withdraw the Bill when it was clear that so many Albertans opposed it?

To make matters worse, we've been given a miniscule timeline - less than two weeks - to respond. In Saskatchewan, after they passed a law seeking to more rigorously regulate the role of private clinics, the government took three years to consider the regulations. Three years! They took this time because they knew they were dealing with the future of Canadians most cherished public program - and they wanted to make sure they got things right.

But here in Alberta, we apparently are throwing caution to the wind. We are not spending three years on the regulations - we are barely spending three weeks. This mad rush to finish the regulation is also being done in the middle of summer when many key stakeholders are away and the public is paying less attention. Taken together with the government's earlier refusal to really listen to the views of Albertans, this leaves us all feeling extremely suspicious that this round of "consultations" is nothing more than a formality - a cynical public relations exercise.

There are even some people within our organizations that worry that by participating in the consultation process we are actually being manipulated. They fear that the government will point to our participation as "proof" that a wide cross-section of Albertans have been consulted and that, therefore, Bill 11 now has a stamp of approval from the public.

In our eyes this is a very legitimate concern - especially given the government's track record of manipulating the results of previous summits and public roundtables. Many of us still remember what happened during and after the government's Health Summit. The vast majority of delegate attending that meeting concluded that privatized, two-tier health care should be

avoided at all costs. But, as we all know now, the government decided to proceed with privatization anyway.

So before we get into any discussion of the regulations, we feel it is important to set the record straight: the Alberta Federation of Labour and the health care unions of Alberta do not now and have never supported Bill 11, the government's so-called Health Care Protection Act. Our participation in this consultation should not be misconstrued as support for either the law or the regulations.

We have opposed Bill 11 from the beginning and continue to oppose it today. We believe strongly that it represents a serious threat to the future of public health care in Alberta. In our minds, no amount of regulatory gymnastics or legislative tweaking will make Bill 11 a good law.

Our first choice would be to see Bill 11 repealed altogether. But given this government's stubborn - some would say rabid and dangerous - commitment to privatization at any cost and experimentation with discredited private health care models, we recognize that the chances of the law being withdrawn or repealed are slim.

It is with this reality in mind that we have reluctantly agreed to participate in the consultation process. We will comment on the regulations, not because we support them or the law upon which they are based, but because we are trying to make the best of a bad situation.

II. What's wrong with the regulations?

Most of our concerns with the regulations flow directly from problems with the Bill itself - as we have mentioned, we feel the Bill is fundamentally flawed and dangerous. And no amount of regulation, no matter how well intentioned, will change that basic fact.

But even if the Bill was a good one - which it most certainly is not - the proposed regulations that have been forwarded to us leave a lot to be desired.

In our brief we will go through the regulations point-by-point, outlining our concerns and making suggestions for improvement. In each section, we will summarize our understanding of the regulations, present our concerns and provide recommendations for change.

This will take up the bulk of our presentation. But in addition to talking about the problems with what's in the regulations, we will also spend some time discussing what's not. With this in mind, the final section of our brief will be devoted to a discussion of what's missing from the regulations and how the government should go about plugging the holes.

III. Ownership

The first major section of the regulation deals primarily with ownership issues. This section defines "distributing" and "non-distributing" corporations. These definitions are apparently needed so the government can better understand the ownership structures of the companies holding healthcare contracts with the various regional health authorities. Companies with

different ownership structures face different requirements under the regulation when it comes to things like filing financial reports and transferring ownership. The regulation also lays out the basic information that both distributing and non-distributing corporations must file with the Minister (names, addresses, etc.). It also stipulates when a "transfer" has occurred.

Shortcomings:

No Guidelines for Transfer: The section of the regulation dealing with ownership issues goes into painful detail about the difference between distributing and non-distributing corporations. It also goes into minute detail when it comes to explaining the kinds of basic personal and business information that must be provided on forms for the Minister's records. But - despite all this attention to detail in some areas - other questions are almost completely glossed over. For example, the regulation gives no direction or guideline for the Minister to determine when to approve or not approve a transfer of ownership. The sections only require that information be submitted. There are no requirements for approval. Will all transfers be approved without question as long as all the paperwork is filled out properly? That seems to be the case.

No Foreign Ownership Restrictions: Another issue that is glaringly absent from the regulation is the issue of foreign ownership. During the debate over Bill 11, many Albertans expressed fear that the Bill would allow large private health firms - especially those based in the United States - to set up shop in Canada. The provincial government could have used the regulations to ease these fears by restricting the ownership of "approved surgical facilities" to Canadians - but they did not. In fact, the regulation contains no restrictions whatsoever on who may own a private hospital. Supporters of Bill 11 may argue that such restrictions would contravene provisions of international trade agreements like NAFTA. But if Canada's health sector is protected under the so-called "NAFTA carve-out" as government spokespeople have claimed it is, then foreign ownership restrictions would be permissible. These kind of rules - if included in the regulation - would go a long way towards easing the fears of people who feel Bill 11 is the "Trojan Horse" that will lead to the Americanization of Alberta's health care system.

No requirement for full disclosure: When applying for approval, the regulations state that individuals or corporations seeking to operate private surgical facility must provide basic personal and financial information - such as name, business address etc. In our opinion, this is not enough. Albertans deserve to know as much as possible about the companies that are being hired to provide core Medicare services - services which, after all, will be paid for with tax dollars. With this in mind, applicants should be required to fully disclose their ownership structure and ties with other business and corporate entities. In particular, information should be collected about whether or not the applicant is owned by or is a subsidiary of any other corporation. Albertans deserve to know if contracts are being awarded to subsidiaries of large American health companies or companies owned by friends of the government. The lax disclosure rules outlined in the regulation would make it far too easy for companies to misrepresent themselves.

IV. Major and Minor Surgical Procedures

The government's Health Care Protection Act begins by saying that private hospitals will be banned in Alberta. This is strong language - but also misleading. In subsequent sections, the Act goes on to say that certain surgical procedures will be allowed to be performed in private facilities. However these new centres for surgical treatment will not be called hospitals - they will be called "approved surgical facilities".

So while the government is technically banning private hospitals they are in effect creating a whole new tier of health care facilities that in many ways will resemble hospitals. Significantly, almost all of these new facilities will be privately owned and operated for profit. Given this reality, the big question becomes: what medical procedures will these private hospitals - or rather "treatment facilities" - be allowed to perform? Which elements of our public system are going to be farmed out to these private contractors?

The Act itself doesn't answer these important questions directly. The most we get is a promise in Section 2(2) that "major" surgical procedures will be restricted to public hospitals. But what constitutes a major surgical procedure?

Unfortunately that Act is extremely vague on this point. That's why we looked to the regulations hoping for more detail. Happily, the regulations put at least some meat on the bones laid out in the Act. For example, the regulations provide a reasonably detailed definition of what constitutes major and minor dental surgery. According to this portion of the regulations - which were drafted with the help of the Alberta Dental Association - major dental surgery includes anything with substantial risk of hemorrhage or airway compromise, concurrent care or entry into the thoracic cavity or cranium. A list of oral surgical procedures that are considered minor is also attached to the regulations (Schedule 1).

Significantly, all the rules regarding dental surgery are written directly into the regulation. This is not the case when it comes to the much more contentious area of medical surgery. Instead of spelling out the rules in this area, the regulation defers to the non-elected professional association that regulates the medical profession in Alberta - the College of Physicians and Surgeons. In particular, it authorizes the College to define for itself what constitutes major and minor surgery.

So what does the College have to say on this important issue? Under the College's by-laws - which have recently been amended at the request of the government - major surgery is defined as any procedure involving surgical access to the cranium (skull), thoracic cavity (chest) or retro-peritoneal space (behind the "gut"). A surgical procedure is also considered "major" if it would require a patient's vital signs to be monitored after recovery from anesthetic.

But the College didn't stop with a simple explanation of the difference between major and minor surgery. It also developed a list (Section 42 [2] of the College's by-laws) of procedures it says can be performed in so-called non-hospital treatment facilities. This list includes the following procedures: abortions; hernia repairs; orthopedic surgery; skin grafts and cosmetic surgery; almost all diagnostic services including MRIs; and any other procedure that would not require patient stays of longer than 12 hours (this would presumably include eye surgery).

Essentially what the Act, regulations and College's by-laws do is create a third tier of health services in Alberta, one that falls between the public hospital (where "major" surgical procedures are performed) and the doctor's office (where "minor" procedures can be performed). Unlike the public hospital sector, this new tier will be privately-owned and operated on a for-profit basis. Of course, much of this is not new. The "third tier" has actually been emerging for years with active encouragement from the Klein government - the Gimbel eye clinics in Edmonton and Calgary and the Health Resources Centre (HRC) in Calgary being the most obvious examples. So these regulations don't establish something entirely new - but they do formalize a new group of for-profit medical facilities that most Albertans are still not sure they really want.

Passing the Buck to the College: As we have mentioned, neither the Act nor the regulations define what constitutes major and minor medical surgery - this responsibility has been left to the College of Physicians and Surgeons. The problem with this is that it leaves a wide range of important public policy decisions - decisions which lie at the very heart of the Act - in the hands of a body that is neither publicly elected nor publicly accountable. It's true that the College has traditionally been responsible for establishing rules regarding safety and operational standards for medical facilities. But, with these regulations, the College is being asked to do far more than determine whether certain health facilities are up to standard - they are being asked to determine which procedure should or should not be hived-off from the public system. It is our contention that these kinds of decisions are inherently political - and, as a result - should be made by duly elected political leaders, not the appointed board members of an association that has no public accountability. In our opinion, asking the College to make the decision about what is major and minor surgery - and hence which service can or can't be contracted to the private sector - is an abdication of responsibility on the part of the government.

Limited Control Over Decisions of College: Another problem related to the role of the College of Physicians and Surgeons has to do with amendments, additions and revisions. When it comes to things like the rules regarding dental surgery, only the government will be able to make changes. That's because those rules are written directly into the regulation. But in the case of medical surgical procedures, the regulations simply defer to the by-laws of the College of Physicians and Surgeons. If the College changes its by-laws - as it does from time to time - the effect of the regulations and the Act may also be changed. Some members of the College may even be in a conflict of interest position. Already, a number of College board members have personal financial interests in private surgery and diagnostic clinics. What's to stop these College members from pushing for by-law changes that would expand the range of services that can be contracted to private clinics? By not writing the rules directly into the regulations, the government is vesting too much power in a group that may not always have the best interests of the public at heart.

Silence on Overnight Stays: There is absolutely no doubt that Bill 11 was one of the most contentious pieces of legislation ever introduced by a government in Alberta. The public outcry it engendered was truly unprecedented. For the thousands of Albertans who opposed the Bill, one of the biggest issues was the question of "overnight stays." More specifically, many people

were opposed to the government's plan to let so-called "approved surgical facilities" perform procedures that would require keeping patients overnight. Unfortunately for those who shared this concern, Bill 11 did exactly that - it gave the green light for overnight stays. However, that's as far as the government went. According to the Act, overnight stays are legal - but it doesn't define exactly which procedures require overnight stays or which of those overnight procedures can be performed in private surgical clinics. We in the labour movement were hoping that the regulations would shine some light on this problem - but we were disappointed. Like the Act, the regulations pass the buck to the College of Physicians and Surgeons - and the College so far has nothing to say. So on one of the biggest issues raised by the thousands of opponents of Bill 11, the government and the College are still leaving the public in the dark. This is unacceptable. How can the government expect "stakeholders" - like the health care unions - to sign off on the regulations while such a central question has been left unresolved?

Bad Fit between Act and College By-laws: Another problem with the College's by-laws regarding private surgical clinics is that they go beyond the scope of the Act. The Act is written very carefully to deal exclusively with surgical facilities and surgical procedures. But the College by-laws (Section 45.2) provide a framework for private clinics to offer diagnostic and laboratory services - as well as surgical services. The College by-laws don't even use the same terminology as the Act - for example, they talk about "diagnostic and treatment facilities" instead of "approved surgical facilities." This would not necessarily be a problem if the College's by-laws were meant to stand alone - but they're not. The by-laws are supposed to fit seamlessly with the Act and provide a core piece of the regulations. Given this fact, it simply is not acceptable that they don't mesh well. The by-laws and the regulation are supposed to make things clearer when it comes to defining major and minor surgeries and listing which procedures can be performed in private hospitals - but as they are currently worded they only confuse matters.

V. Enhanced Medical Goods

Aside from the rules regarding major and minor surgery, the most important part of the Bill 11 regulation deals with the sale of so-called "enhanced goods and services." According to the Act, an enhanced medical good or service is a good or service that "exceeds what would normally be used in a particular case in accordance with generally accepted medical practice." Put more simply - patients going to private surgical clinics will be given the choice of receiving a standard Medicare-insured service ("I'll take the Chevy") or receiving a higher-standard service that is not fully insured by Medicare ("I'll take the Cadillac")

The regulation goes on to say that the government will pay for a portion of the enhanced service equal to the cost of the Medicare-insured standard service upon which the enhanced service offers an "improvement". Beyond this basic fee, the patient must pay the difference between the standard service and the enhanced service plus an "administration fee" of 15 per cent. These extra fees can only be charged if the good or service being sold is listed in Schedule 2 of the regulation. So far, however, only two enhanced goods and no enhanced services are listed.

In addition to providing definitions and rules regarding fees, the regulation also lays out the process that must be followed by the operators of private clinics before and after selling an enhanced good or service. For example, the regulation requires doctors working in private clinics to explain the difference between the standard and enhanced service. The regulation also details the paperwork that must be completed before an enhanced good or service is provided. And it explains how patients can go about changing their minds if they agree to an enhanced service then later decide not to have it done. Finally, the regulation details the records that must be kept after an enhanced good or service is sold.

Shortcomings:

Ignoring the Persuasive Power of Physicians: The regulation does make some efforts to protect the interests of patients as "consumers." But in our view, it does not adequately address the issue of "subtle coercion". The sections are written as if the agreement to purchase an enhanced good or service is a contract between two equals, not between an expert doctor and a vulnerable patient needing care. The truth is that patients almost always defer to the recommendations of their doctors. So if a doctor says that purchasing an "enhanced" good or service makes sense, most patients will purchase that good or service - regardless of how necessary it really is. No amount of regulation will redress this fundamental power imbalance. The only way to completely avoid this kind of coercion is to ban doctors from selling "extras."

Warping the Doctor-Patient Relationship: In our view, the sale of enhanced goods and services is not only bad for patients - i.e. they may end up buying things they don't really need - it is also bad for doctors and other medical practitioners. That's because doctors need to develop a trusting relationship with their patients - a relationship that puts the welfare of the patients first. But if the doctor becomes both a salesman and a caregiver, that relationship of trust is undermined. Patients will always be wondering if their doctor is really concerned about them or about making another "sale." On other side, doctors will no longer be able to focus exclusively on patient care - they will also be thinking about making money. Patients will no longer be just patients - they will also become opportunities for profit "maximization." Once again, the only way to avoid this kind erosion in the doctor-patient relationship is to ban the sale of enhanced goods and services.

Who decides what's an enhanced good or service? The listing of only two enhancements is suspicious. If it stays that way, then no other enhanced good or service could be charged to patients. However, the probable outcome is that cabinet will slowly add to the list over time. There is a serious problem with this: how do members of the cabinet decide what types of goods and services should be placed on the list? The regulation says that the cabinet may expand the list - but it says nothing about how that should be accomplished. Government officials have said the cabinet, before expanding the list, will consider advice from medical professionals, academics and other concerned individuals and groups (this latter category would presumably include the operators of private clinics pushing for more services to be added to the list). In our opinion, this is simply not good enough. We need to put a much more rigorous process in place. Most importantly, someone in government needs to be asking the

tough questions about goods and services that are being proposed for the "enhanced" list. For example, the cabinet should be required to ask questions like the following: if a service is not medically necessary, why should we encourage doctors to sell it? And if a service is medically necessary - i.e. if it does make sense to offer a particular medical good or service - then why isn't it covered by Medicare? If the cabinet is not required to ask these kinds of tough questions before approving items for the list of enhanced goods and services, then we run the risk of creating a convoluted and haphazard patchwork of healthcare that doesn't serve anyone's interests.

Problems with policing: In the regulation, there is plenty of talk about the paperwork that needs to be filled out before an enhanced good or service can be sold. There is also plenty of talk about the reporting process that private clinics will have to submit to and even the fines that clinic operators could face if they violate the regulations. But curiously there is no discussion of how violations will be policed and enforced. Will there be spot checks of patient records? Or will the system be entirely complaint-driven? The regulation doesn't say - and this worries us. If the government is really concerned about protecting patients, then more thought has to be given to inspection. What will probably be needed is a special investigation unit that would conduct random interviews with patients and spot checks of facilities to see if people are being hoodwinked into buying services they don't really need

Problems with consent: The regulation says that patients must give written consent before being given an enhanced good or service - except in "emergency" situations. Unfortunately, the regulation never spells out what constitutes an "emergency." It's hard to imagine a situation where an enhanced good or service would be necessary to save a person's life in an emergency situation (after all, the enhanced service is by definition medically unnecessary). Besides, under the government's own rules, private surgical facilities should not be handling emergencies - that's the responsibility of public hospitals. If an emergency develops, patients should be sent to public hospitals immediately - not plied with "enhanced" services when they are unable to give informed consent.

VI. Designations

Under the Act, a businessperson or corporation seeking to establish a for-profit "approved surgical facility" must jump through three hoops. First, they must sign a contract with a regional health authority to provide a certain service or set of services that would otherwise be delivered through the public system. Second, they must satisfy the College of Physicians and Surgeons that the new surgical facility meets accepted professional standards. Finally, plans for all proposed private surgical facilities must go before the Minister of Health. After reviewing an application the Minister will decide whether or not to designate the proposed facility as an "approved surgical facility." Under the Act and the regulations, this last process is referred to as "designation."

When deciding which facilities and contracts to approve, the Minister is required under section 8(3) of the Act to consider whether or not the proposed service meets a "current and on-going

need" and has no "adverse impact" on the public health system. If the minister is not satisfied that a proposed contract meets these requirements, he can reject it. Under the regulations, he also has the power to rescind, amend or reinstate existing facility designations when "circumstances warrant".

Shortcomings:

Protector of the Public or Rubber Stamp? The Act sets up the Minister of Health as the final authority when it comes to the approval of for-profit surgical centres. The Minister, in turn, is supposed to make his decision based on criteria outlined in the Act and regulations. For example, under section 8(3) of the Act, the minister is supposed to determine whether proposed private facilities conform with the Canada Health Act; meet a demonstrated need; and do not represent a threat to the existing public system. These rules are supposed to reassure people that the public system is being safeguarded. But there's a serious problem with the process - the rules are weak. How exactly is the Minister supposed to decide if a private facility will provide a "public benefit"? How does he decide whether or not there is a "current and on-going need"? How exactly does he determine that a private facility will not have an "adverse impact" on the public system? Most importantly, how does the Minister decide between meeting "demonstrated needs" by contracting out services or increasing resources for the existing public system?

Unfortunately, neither the Act nor the Regulations provide clear answers to these questions. Despite all the fancy language - the reality is that approvals will be granted at the discretion of the Minister. In our opinion, this situation is simply not acceptable. It's not enough for the Minister to argue that there will be a public benefit just because he says there will be. And it's not acceptable for the Minister simply dismiss concerns about adverse impacts on the public system. Instead, the Minister should be required to provide proof in support of his decisions. The regulations should spell out clearly how the conditions for approval need to be met. And the Minister should be required to publicly disclose his rationale - and his proof - whenever a new private surgical facility is approved.

Getting a handle on "internal capacity": When considering an application for a private surgical facility, one of the things that RHAs - and presumably the Minister - are supposed to consider is "internal capacity." In other words, the RHAs are supposed to ask themselves if they have the capacity (i.e. beds, staffing etc.) to provide the service in the public sector. For supporters of the public system, this may sound reassuring. But according to an "assessment criteria" document circulated by the government on July 24, 2000, "internal capacity" is only one of many things that RHAs are asked to look at before signing contracts with private providers. In fact, if an RHA is convinced that a contract meets the test under section 8(3) of the Act - a test which is extremely weak, as we have already argued - then they can go ahead, even if there is existing "internal capacity."

Another related problem is that the regulation provides no guidelines for determining "internal capacity." What's missing is a formal and objective auditing process designed to reveal the true

internal capacity of the public system. Before even considering a private contract, RHAs should be required to put together an inventory of all their closed hospital beds and moth-balled operating rooms. Comprehensive lists of staff resources should also be compiled and made public. Without these kinds of detailed inventories, neither the RHAs nor the Minister will be able to make informed decisions about internal capacity.

Ignoring the Public Option: As we have seen, both the Act and the regulation spell out the process for approving private surgical facilities - supposedly to fill gaps in the service provided by the public system. But nowhere does the Act or the regulations talk about the more obvious option: expanding the public system to fill the gaps itself. Presumably, the government will be spending new money to pay for the private facilities. The question that needs to be asked is - why shouldn't that money be spent in the public system? If there is a gap in service, why can the public system be fortified to fill it? Everything about Bill 11 and its regulations suggest that the government is ignoring the obvious public options.

Failure to Perform: One of the problems with contracting out in general is that private operators will often promise the moon in order to win a contract - and then fail to deliver once have an agreement locked in place. That's why many contracts include language regarding performance expectations. Under these types of agreements, if a contractor falls to perform, his contract can be cancelled. In the case of the government's private health care Act, however, the regulations say almost nothing about the termination of contracts. The Minister is clearly given the power to rescind agreements, but nothing is said about the circumstances that would lead to such action. Again, the decision is made at the discretion of the Minister. And again, we think that isn't good enough. What's needed is a clear process outlining performance expectations (even performance guarantees) for the operators of private surgical facilities. If they don't live up to the letter of their contracts - and if it turns out that their service does end up having an "adverse impact" on the public system - then their designation should be immediately revoked and their contracts cancelled.

VII. Reporting

The regulation lays out monthly and yearly reporting requirements for approved surgical facilities. The requirements roughly parallel those that apply to public hospitals. In addition to requiring private facilities to file basic reports on things like caseloads and service mix, the regulation also requires reporting of "significant mishaps".

Shortcomings:

Not Enough Information: The regulation says that approved surgical facilities must file monthly and yearly reports similar to the reports filed by public hospitals. The regulation even refers to specific reporting protocols designed for public hospitals and says they must also be followed by private facilities. But in our opinion, this doesn't go far enough. We believe a private operator should be required to provide a greater level of information than a public hospital - because information in public facilities is inherently more accessible. A greater burden should

also be placed on private facilities simply because they are unproven and are not directly accountable to the public. The government - and the public in general - need as much information as possible to assess whether or not these new private facilities are providing a "public benefit" or weakening the foundations of Medicare.

What if they don't report?: The regulations describe the kind of information that private facilities will have to gather and submit to the government on a monthly and yearly basis. But it says nothing about what happens if private companies simply don't comply. Failure to submit a report has no penalty under the regulation.

Confusion over "significant mishaps": The regulation says that private facilities must report all "significant mishaps." But a definition of this term is not provided. Once again, responsibility is passed off to the College of Physicians and Surgeons. We think the definition of "significant mishap" should be written directly into the regulation.

Oh, the irony!: The government has repeatedly said that the private facilities that will be approved under Bill 11 are not hospitals. Yet these facilities are being asked to follow the same reporting protocols as public hospitals. This raises an interesting question. If private surgical facilities are not hospitals themselves, why is it appropriate for them to use reporting protocols designed for hospitals? Could it be that these new "approved surgical facilities" are more like hospitals than the government would like to admit?

VIII. Premier's Advisory Council

While the sections dealing with major and minor surgeries and the sale of enhanced goods and services are probably the most important part of the regulation, the section dealing with the Premier's Advisory Council is probably the most laughable. The regulation stipulates the number of members who will sit on the Council. It also talks about the appointment process and term of appointments. But it provides no insight into the role and function of the Council. What will this Council do? What will its mandate be? How will it go about reporting? Neither the Act nor the regulations provide answers to these obvious questions.

Observers can be forgiven for viewing the council as yet another publicly-financed resting place for loyal friends of the government. That's probably the best-case scenario. The worst-case scenario is that the council is being set up as proxy for public input that can be easily controlled by the government. The public may continue calling for greater restrictions on private health care - as they did so strenuously during the debate over Bill 11 - but the Council may argue that greater privatization is "in the Public interest." This would give the government the kind of cover it needs to proceed with the private health plans it so obviously supports - but which are opposed by the majority of Albertans. In the end the Council may simply be a ready-made scapegoat - i.e. "Don't blame us, the Council made us do!"

This scenario may never play out - and the Council may end up simply being another trough for

retired government hacks. But suspicions about the Council will continue unless its role is more clearly defined.

IX. Missing Items

As we have seen, the Bill 11 regulations are riddled with problems. In our view, there are serious short-comings in almost every section of the document. But the problems don't stop with the wording of individual sections and clauses - the regulation is just as notable for what it doesn't say as what it does. Here is a list of key issues that we feel deserve attention - but were not touched on in the regulations.

Rights of Health Care Workers: One of the probable outcomes of Bill 11 is that many services that are currently provided in the public health system will end up being contracted out to the private sector. This obviously raises concerns for patients and taxpayers. But it also has serious implications for health care workers. Presumably, if a service is privatized, many of the displaced public sector workers will find new employment with the private sector contractor (or contractors). This is what happened when the provincial government decided to contract-out the bulk of medical laboratory services a few years ago. But what happens to the wages earned by these workers when they are transferred to the private sector? What happens to their pensions and entitlements related to things like vacation and sick leave? Will their new employers recognize their years of service - or will they all be forced to start at square one?

Unfortunately, neither the Act nor the regulations answer any of these questions. This is particularly disturbing given the experience of laboratory workers who found their jobs shifted from the public to the private sector. As a result of that transfer, most of effected workers lost the protection that had been provided by their collective agreements. In many cases, the conditions of their employment were radically changed. And, in the case of Calgary laboratory workers, they also lost their pension plan - which most workers had been paying into for years. Given this experience, it is almost unconscionable that the government has failed to include any provisions in its regulations aimed at protecting the rights of displaced workers. What's clearly needed is language guaranteeing successor rights for unions - so that collective agreements follow health care workers from the public sector to the private sector. Provisions also need to be included in the regulations that would specifically protect these workers' pensions. If the government is really serious when it talks about the "important role played by health care workers", then these kinds of measures are the least that should be done.

Conflict of Interest: One of the biggest concerns raised by opponents of Bill 11 had to do with the question of conflict of interest. Critics rightly pointed out that by creating a new multi-million dollar market for medical services, the government is opening the door for all kinds of questionable business behaviour. The serious nature of the problem has been particularly evident in Calgary, where many decision-makers involved with the Calgary Regional Health Authority also own private surgical clinics - clinics that profit handsomely from contracts with the Authority. The government clearly recognizes that the potential for conflict of interest exists under the Act - but surprisingly the regulations set out no conflict of interest guidelines for the contracting out of services. Instead, the responsibility for developing rules is farmed out

to the RHAs (who, as we have seen, may have an interest in creating the weakest rules possible) and the College of Physicians and Surgeons (whose board includes a number of doctors who are the owners or part-owners of private surgical clinics). The province has drafted a list of criteria that RHAs are supposed to consider when putting together their conflict of interest rules - but they are only guidelines. This raises a serious question. Why hasn't the government written its own rules? Why have they passed the buck to bodies that could be accused of being in conflict of interest positions themselves? Clearly what's needed in this situation is clear direction from the government. There should be a strongly worded set of rules regarding conflict of interest that apply to all RHAs equally. and those rules should be written directly into the regulations.

Liability Concerns: Another issue that is missed in the regulation is the issue of liability. If a procedure is botched in a private surgical facility will the owner of that facility be liable for legal damages - or will that responsibility be passed along to taxpayers because of the facility's contract with the RHA? And what about employees of the private clinics? Will they have liability coverage from the RHA - or will be on their own? The government needs to provide answers to these questions.

Inadequate financial reporting: A final item that is missed in the regulations has to do with financial reporting. Under the various sections of the regulations, contractors are required to release certain types of information about things like ownership and treatment outcomes. But there is no requirement for detailed financial reporting from owners of facilities. All that is available to the public is the contract between the facility and the RHA. In our view, this is not enough. The owner should be required to disclose detailed statements outlining exactly how taxpayers money is being used. How much is being spent on equipment? How much is going to management salaries? How much is being set aside as profits for the owners? How much is being spent on front-line service? Given that private clinics will be financed largely by tax dollars and public sector contracts, Alberta taxpayers deserve answers to these questions. Unfortunately, this kind of information won't be available - and Albertans won't know if they're really getting their money's worth - unless the government includes much more rigorous requirements for financial reporting in its regulations.

X. Conclusions

After reviewing the proposed Bill 11 regulations, the health care unions of Alberta are more convinced than ever that the government's scheme to privatize health services in the province is both flawed and dangerous. We feel the government has failed to adequately address serious concerns related to things like conflict of interest, foreign ownership, financial accountability and the rights of health care workers - workers who inevitably will be displaced by privatization.

Even more importantly, we feel the government has failed to provide a compelling rationale for its privatization plan. Why should public money be spent on private facilities when it could be put to equal - or better - use in the public system? Why should doctors be allowed to sell goods and services that are not medically necessary? And if those services are indeed medically necessary, why aren't they covered by Medicare? Unfortunately, Albertans are still waiting for

answers to these crucial questions.

To date, the Klein government has ignored the legitimate concerns of Albertans and turned a deaf ear on those who have been asking "why?" In fact, despite numerous opportunities, the government has been unable or unwilling to produce evidence proving that its private health scheme will either save money or shorten waiting lists for medical services.

On the contrary, all the available evidence suggests that privatization will weaken Medicare. In the United States, free-market medicine has resulted in a system that is both hugely expensive and grossly unfair. The Americans spend twice as much per person on health care as Canadians - yet 45 million Americans still have no health coverage and another 50 million have inadequate coverage. Is that the kind of system we want here in Alberta?

But, we don't have to go to another country to find evidence that casts doubt on the government's private health plan. In Calgary for the past three years 100 per cent of cataract procedures have been contracted out to private clinics - in exactly the same way that Bill 11 envisions other medical procedures being farmed out to "approved surgical facilities."

And what has been the result of this three-year experiment? Contrary to the predictions of government officials and the promises of the owners of private clinics, the waiting lists got longer, not shorter. In fact, the waiting periods for cataract procedures are now nearly twice as long in Calgary as in cities like Edmonton and Lethbridge where the vast majority of procedures are still done in the public system. To make matters worse, per procedure costs - costs which are borne by the taxpayer - are also higher in the private clinics than in public hospitals.

Premier Klein and others in the government have shrugged off the Calgary experience with cataract surgery. They say that things will improve and they ask Albertans to trust them. Well, we in the Alberta health care unions think the stakes are too high to simply "trust" the government. Medicare is Canada's most cherished social program. It makes us a better country in which to live and it even makes us more competitive economically. We simply cannot afford to gamble with the future of such an important program.

Given the fact that the government has still been unable to produce evidence in support of its privatization scheme and the fact both the Act and the regulations are so full of holes, we in the health care unions strongly urge the government to pull back. The regulations should be torn up and the Act repealed. To do anything else would be reckless and irresponsible. The time has come for the government to finally listen to the majority of Albertans who never wanted the law in the first place. The government should do the right thing. And that means discarding its ideologically-driven experiment with private health care and, instead, fortifying and protecting the public system - it's simply too good to lose.

XI. Recommendations

General

1.1 We recommend that Bill 11 be repealed. It represents a serious threat to the future of public health care in Alberta.

1.2 We recommend that a section be added to the regulations that would grant successor rights for unions in cases where a public health service is contracted out to the private sector.

1.3 We recommend that steps be taken to protect the pensions and other benefits of workers whose jobs are effected by contracting out under the Health Care Protection Act.

1.4 We recommend that the government develop it's own list of strongly-worded conflict of interest rules. These rules should be written directly into the regulations so they apply equally to all Regional health Authorities.

1.5 We recommend that the regulations be amended to deal with the issue of legal liability.

1.6 We recommend that sections be added to the regulations that would require the operators of approved surgical facilities to fully disclose all financial information regarding the use of taxpayers' money.

Ownership

2.1 We recommend that the regulations be re-written to provide clear guidelines for the approval of ownership transfers.

2.2 We recommend that the regulations include a clause restricting the ownership of "approved surgical facilities" to Canadians or Canadian-owned corporations.

2.3 We recommend that all applicants for designation (or transfer of designation) be required to fully disclose their ownership structure and ties with other business and corporate entities. In particular, information should be collected about whether or not the applicant is owned by or is a subsidiary of any other corporation.

Major and Minor Surgical Procedures

3.1 We recommend that the rules and definitions regarding major and minor medical surgery be drafted by the government (as opposed to the College of Physicians and Surgeons) and be included directly in the regulations (as opposed to the College by-laws).

3.2 We recommend that approved surgical facilities not be allowed to perform any procedure that cannot already be performed in a doctor's office. All other procedures should be restricted to public hospitals.

3.3 We recommend that more detailed regulations be written to deal with the question of overnight stays. In particular, we recommend that approved surgical facilities be prohibited

from performing medical procedures that require patients to stay in care for more than 12 hours.

Enhanced Medical Goods and Services

4.1 We recommend that doctors be prohibited from selling patients any good or service that is not deemed medically necessary or which is not fully insured by Medicare.

4.2 We recommend that the government draft clear guideline explaining how to decide whether a new medical good or service should be fully insured by Medicare or placed on the list of enhanced goods and services.

4.3 We recommend that the government establish a process for ensuring compliance with all rules regarding the sale of enhanced services. In particular, we advocate the creation of a special investigation unit that would conduct random interviews with patients and spot checks of facilities to see if people are being coerced into buying services they don't really need or want.

4.4 We recommend that the government more clearly define what constitutes an "emergency" for the purposes of the sections of the regulation dealing with consent and the sale of enhanced services.

Designation

5.1 We recommend that the Minister be required to provide proof in support of his decisions regarding the designation of approved surgical facilities. He should be required to demonstrate clearly and publicly why the service could not be provided in the public system.

5.2 We recommend that the regulations outline a formal and objective auditing process designed to reveal the true "internal capacity" of the public system.

5.3 We recommend that the regulation include a section requiring the Minister to rescind the designation of surgical facilities if those facilities do not meet specific performance expectations or if it can be demonstrated that they represent a real threat to the public health care system.

Reporting

6.1 We recommend that special medical reporting protocols be developed for approved surgical facilities and included in the regulations. These protocols should be even more rigorous than the protocols in place for public hospitals.

6.2 We recommend that clear guidelines and penalties be developed and written into the regulation regarding what should be done in cases where approved surgical facilities fail to comply with required reporting protocols.

6.3 We recommend that the government develop its own definition of "significant mishap" and write it directly into the regulation.

Premier's Advisory Council

7.1 We recommend that the role and mandate of the Premier's Advisory Council be clearly outlined in the regulations.