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report

Bill 30 (Alberta) and Potential Implications for Public Health Care in Canada

By Andrew Longhurst

July 28, 2020

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Biography

Andrew Longhurst, MA, is a health policy researcher and analyst with the Health Sciences Association of BC (an affiliate of the National Union of Public and General Employees) and PhD student in the Department of Geography at Simon Fraser University. In 2020, Andrew was awarded a Joseph-Armand Bombardier Doctoral Scholarship from the Social Sciences and Humanities Research Council of Canada to research market-oriented health care reform in Canada and internationally. He served as senior advisor to the BC Ministry of Health's Primary and Community Care Research Initiative in 2019. He has authored numerous publications on health care topics including, *Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership* (with M. Cohen and M. McGregor.

Please note that for ease of understanding the amendments to the legislation, we have included the deletions and additions, highlighted in red, in the excerpts included in the document.

BACKGROUND

In December 2019, the Alberta government announced initial plans for the "Alberta Surgical Initiative" with a focus on contracting out publicly funded surgeries. In February 2020, the government-commissioned Ernst & Young review of Alberta Health Services (AHS) recommended contracting out surgeries, including those that require an overnight stay or longer.[1] This significant recommendation received little attention: "Alberta Health could consider reviewing the criteria for delivery of procedures in non-hospital surgical facilities to identify opportunities to deliver additional services, including potential (sic) those that require overnight stays."[2] With the exception of several other recommendations, the Alberta government accepted all the recommendations from the review, making it clear that it favours moving in this direction and transforming the role of private surgical clinics into hospital-like facilities performing low-risk and more complex surgeries requiring more than 12-hour stays.[3]

The government announced in the spring budget that it would spend $400 million on contracting out surgeries to private surgical facilities, and invest $100 million in public sector operating rooms.[4] The government committed to doubling the number of contracted-out surgeries over three years – from 15% to 30% of total surgeries province-wide. This represents a significant shift of surgeries from the public sector, and a very significant amount of public funding flowing to the for-profit surgical sector.

On July 6, 2020, Bill 30 (Health Statutes Amendment Act) was introduced in the Alberta Legislature. As of July 24, it is currently in second reading. Bill 30 amends seven acts and repeals two acts.[5] Only consequential amendments to the Alberta Health Care

Insurance Act, Health Care Protection Act, Health Quality Council of Alberta Act, Health Professions Act, and Regional Health Authorities Act that relate to health care privatization and health system governance are addressed in this report. Bill 30 amendments come into force upon proclamation, with several exceptions.

According to Premier Jason Kenney, Bill 30 will:

> […] make it easier for chartered surgical facilities to work with us and AHS to provide publicly funded surgeries to people who need them. […] The proposed amendments here in Bill 30 would reduce barriers and administrative burdens so that new chartered surgical facilities can more easily open, reducing surgical wait times for cataracts among other surgeries. Now, of course, strong oversight of these facilities would be maintained, and the College of Physicians and Surgeons of Alberta would continue to accredit these facilities to ensure that they provide

[1] For an analysis, see Alison McIntosh (2020, Feb. 13), Review of AHS a pro-privatization attack on workers, *Parkland Blog*, The Parkland Institute.
[2] Ernst & Young (2019), *Alberta Health Services Performance Review: Final Report*, page 108.
[3] Paige Parsons (2020, Feb. 27), Budget 2020: Health budget sees doubling of private clinic surgeries, deductibles on seniors drug plan, *CBC News*.
[4] CTV Calgary (2020, March 4), Province details $500 million plan for utilizing private clinics to reduce surgical wait times.
[5] Government of Alberta (2020, July 6), Improving public health care (accessed July 21, 2020).

safe, quality procedures. The current process for chartered surgical facilities to open and contract with AHS can take as much as two years.[6]

Law professors Lorian Hardcastle (University of Calgary) and Ubaka Ogbogu (University of Alberta) have stated that Bill 30 "opens up the health care system to increased privatization[,] […] deepens the rift between doctors and the province, [and] could be a mere stepping stone toward two-tier health care in Alberta."[7] This echoes concerns raised by Friends of Medicare, an Alberta-based non-profit organization that advocates for improving and defending public health care.[8]

Health Care Protection Act

In 2000, the Health Care Protection Act, enacted by the Klein government, introduced the most expansive legislative framework to legitimize, regulate, and encourage for-profit surgical delivery.[9] This Act introduced the private "surgical facility", distinguished between "major" and "minor" surgical services, and defined "facility services" that are "medically necessary and directly related the provision of a surgical service" in private surgical facilities.

In a significant departure from the Canada Health Act, the Health Care Protection Act explicitly blurred the distinction between *funding* and *delivery* of health care services by creating private surgical facilities whereby private-pay ("uninsured") services from opted-out physicians may be performed in the same facilities that have contracts with government to provide publicly funded ("insured") services at no cost to patients.[10] As legal scholar Marie-Claude Prémont noted in her 2002 paper for the Romanow Commission, "what the Alberta statute creates, then is a plan for subsidizing the for-profit surgical facility with public health care funds" through "the co-existence of insured and uninsured services in the same [private facility]."[11] The object of this Act "is to ensure the profitability of the for-profit surgical facility with the assistance of a constant

[6] Alberta, Legislative Assembly, *Hansard*, 30th Leg, 2nd Sess, Day 40 (July 7, 2020) at 1783 (Hon. J. Kenney).
[7] Lorian Hardcastle and Ubaka Ogbogu (2020, July 16), Opinion: Alberta's Bill 30 is a gateway to privatization and cronyism, *Edmonton Journal*.
[8] Friends of Medicare, Friends of Medicare initial statement on Bill 30, website accessed July 22, 2020.
[9] Marie-Claude Prémont (2002), *The Canada Health Act and the Future of Health Care Systems in Canada*, Discussion Paper No. 4., Commission on the Future of Health Care in Canada: The Romanow Commission, pages 12-14.
[10] "Insured surgical service" is defined under the Health Care Protection Act as "a surgical service that is provided by a physician, or by a dentist in the field of oral and maxillofacial surgery, in circumstances under which a benefit is payable under the Alberta Health Care Insurance Act." "Uninsured day surgical service" is a "surgical service that is provided by a physician, and does not require a medically supervised post-operative period of care exceeding 12 hours, and is provided in circumstances under which no benefit is payable under the Alberta Health Care Insurance Act." "Uninsured in-patient surgical service" is defined as "a surgical service that is provided by a physician, and requires a medically supervised post-operative period of care exceeding 12 hours, and is provided in circumstances under which no benefit is payable under the Alberta Health Care Insurance Act." See
[11] Marie-Claude Prémont (2002), *The Canada Health Act and the Future of Health Care Systems in Canada*, Discussion Paper No. 4., Commission on the Future of Health Care in Canada: The Romanow Commission, page 13. These definitions are not amended by Bill 30. See Health Care Protection Act, RSA 2000, s. 29.

flow of public health dollars."[12] Bill 30 significantly expands this pre-existing legislation. The issue of for-profit facilities requiring a more stable revenue stream is one the central issues that has come to light in the Cambie Surgeries Corporation litigation led by Dr. Brian Day (CEO of the for-profit Cambie clinic in Vancouver).

Physician Remuneration and the Alberta Medical Association (AMA)

In all provinces, physician remuneration is negotiated between provincial medical associations and government through the provincial Physician Master Agreement (or its equivalent). Changing the payment relationship between physicians and government is central to the Bill 30 reforms which will provide corporations the ability to employ or subcontract physicians outside of the terms and rates negotiated in the Physician Master Agreement. This is an attempt to undermine the role of the AMA as the solely recognized bargaining agent for physicians in Alberta.

Although fee-for-service payment has long been recognized as one of the most significant barriers to team-based care, optimizing scope of practice for other health professionals, maintaining a cost-efficient public system, and introducing evidence-based public-sector improvements,[13] the Alberta government is using this shift in payment as cover. It is true that younger physicians, especially family doctors, genuinely want alternatives to fee-for-service,[14] but the Alberta government's goal here is to drive its political agenda, entrench for-profit delivery, and undermine the role of the AMA.

CONSEQUENTIAL AMENDMENTS[15]

Alberta Health Care Insurance Act

Remuneration of practitioners
20 The Minister may enter into agreements or ~~arrangements~~ establish arrangements for the payment of benefits on a basis other than a fee for service basis.

This amendment clarifies and extends the Minister's power to "enter into agreements or establish arrangements" with physicians directly (rather than via the Physician Master Agreement) and third-party entities, namely private corporations, that provide health

[12] Marie-Claude Prémont (2002), *The Canada Health Act and the Future of Health Care Systems in Canada*, Discussion Paper No. 4., Commission on the Future of Health Care in Canada: The Romanow Commission, page 13.
[13] Andrew Longhurst (2019), How (and how much) doctors are paid: why it matters, *Policy Note*, Canadian Centre for Policy Alternatives, BC Office; Andrew Longhurst, Marcy Cohen, and Margaret McGregor (2016), *Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership*, Canadian Centre for Policy Alternatives, BC Office; Hugh M. Grant and Jeremiah Hurley (2013), *Unhealthy Pressure: How Physician Pay Puts the Squeeze on Health-Care Budgets*, The School of Public Policy, University of Calgary; Marcy Cohen (2014), *How Can We Create a Cost-Effective System of Primary and Community Care Built Around Interdisciplinary Teams? CCPA Submission to the Select Standing Committee on Health*, Canadian Centre for Policy Alternatives, BC Office.
[14] Vanessa Brcic, Margaret J. McGregor, Janusz Kaczorowski, Shafik Dharamsi, and Serena Verma (2012), Practice and payment preferences of newly practising family physicians in British Columbians, *Can Fam Physicians 58*: e275-281. See also: Canadian Foundation for Healthcare Improvement (2010), *Myth: Most physicians prefer fee-for-service payments*.
[15] Red text indicates amendments.

care services and employ or have agreements with physicians to provide publicly insured health care services. Under these arrangements, physicians are to be paid directly by that third party (not directly by the public plan/government) and through non-fee-for-service remuneration. This explicitly opens the door for government to entrench corporate primary and community care clinics, and virtual care platforms, such as Telus Health for its Babylon doctor consultation app, through public contracts, despite widespread criticism by physicians and health policy researchers.[16]

However, this amendment must be read in relation to the introduction of the 20.1(1) language below.

Remuneration to other person
20.1(1) A person may submit a claim to the Minister in accordance with this section for a benefit for an insured service provided by a physician if
(a) the Minister has, in accordance with section 20, entered into an agreement or established an arrangement with the person for the payment of benefits for the insured service on a basis other than a fee for service basis,
(b) the person employs or has entered into a service agreement with the physician to provide the insured service, and
(c) the physician was opted into the Plan when the insured service was provided.
(2) For the purposes of subsection (1) a "person" does not include an individual or a professional corporation.
(3) If a claim is submitted to the Minister in accordance with subsection (1),
(a) the payment of a benefit by the Minister to the person who submitted the claim discharges the Minister's duty with respect to the payment of that benefit to the physician who delivered the insured service,
(b) the physician who delivered the insured service is not eligible to submit a claim to the Minister for a benefit for the insured service, and
(c) no physician shall claim or receive the payment of a benefit from the Minister with respect to the insured service.
[…]

Minister not liable
20.2 The Minister is not liable in respect of
(a) any provision of an agreement referred to in section 20.1(1)(b), or
(b) any breach, termination or act done or omitted to be done by a party to an agreement referred to in section 20.1(1)(b).

The proposed sections 20.1 and 20.2 arguably represent the most significant change in how physician remuneration is structured in Canada – specifically how physicians may be paid via corporate structures and not directly by government. The proposed section 20.1(1) grants new power to "a person" to directly "submit a claim" to the public plan.

[16] Lorian Hardcastle and Ubaka Ogbogu (2020, March 26), Opinion: Alberta's virtual health care app plagued with problems, *Edmonton Journal*; Rita McCracken, Andrew Longhurst, Damien Contandriopoulos, and Ruth Lavergne (2019, Nov. 14), Opinion: Virtual walk-in clinics undermine primary care, *Vancouver Sun*.

These new "persons" under the proposed 20.1(2) "do not include an individual or a professional corporation." In other words, this refers to private corporations, and in theory, may include non-profit societies. But within the context of this government's broader political agenda, this should be understood as a way of giving the Health Minister the power to contract with corporations, and for corporations to directly bill the public plan for services provided by physicians (who may be employed or subcontracted by the corporation). In an unprecedented legislative move for Canadian medicare, this language severs the direct remuneration relationship between government (the public payer) and physicians. Physician remuneration by these persons – i.e., corporations – will be determined by that corporation and not the Physician Master Agreement negotiated between government and the AMA. The proposed section 20.2 means that government is not liable for the contractual agreements that these "persons" (i.e., corporations) and physicians enter into. In effect, any remuneration disputes must be dealt with between the two parties.

Health Care Protection Act

Bill 30 amends the Health Care Protection Act to be consistent with the Alberta Health Care Insurance Act in granting power to the Health Minister to contract with corporations for the provision of publicly funded (insured) services. The Alberta Health Care Insurance Act governs how physicians, and now corporations, may directly bill government for insured services contracted out by government. The Health Care Protection Act governs the approval and regulation of for-profit facilities, providing both insured and uninsured medical services (by physicians opted-out of the public plan), and the powers that the Health Minister has to approve agreements/contracts with private sector facilities. Bill 30 renames the "Health Care Protection Act" as the "Health Facilities Act".[17]

Provision of surgical services

2(1) No physician shall provide a surgical service in Alberta, and no dentist shall provide an insured surgical service in Alberta, except in

(a) a public hospital, ~~or~~

(b) ~~an approved surgical facility.~~ a chartered surgical facility, or

(c) a surgical facility referred to in section 16.

(2) No physician or dentist shall provide a major surgical service, as described

(a) in the bylaws under Schedule 21 of the Health Professions Act, in the case of a physician, or

(b) in the regulations under section 25(1)(b), in the case of a dentist, in Alberta, except in a public hospital.

[17] This note refers to the legislation as the Health Care Protection Act, not the proposed amended title.

The above amendments introduce the "chartered surgical facility" as a new class of surgical facility into legislation, which under Bill 30, will be distinguished from "a surgical facility referred to in section 16." "Chartered surgical facility" is defined in the amended definitions as "a surgical facility that is designated under Part 2, Division 1 or 2, as the context requires."[18] This definition provides the Minister with broad powers to designate chartered surgical facilities "as the context requires". Until the regulations are made public, it is not known what is contemplated here. "A surgical facility referred to in section 16" refers to the current surgical facilities that have been accredited and are already operating.

Based on the Ernst & Young recommendation accepted by the government and the plan to double the number of outsourced surgeries, it is reasonable to assume that "chartered surgical facilities" may be used as a stepping stone to a for-profit hospital that provides a more comprehensive range of hospital-like services necessary for longer stays, more complex procedures, and higher acuity patients. That said, the Health Care Protection Act explicitly prohibits the operation of a "private hospital" which is defined as "an acute care facility that provides emergency, diagnostic, surgical and medical services, and admits patients for medically supervised stays exceeding 12 hours, but does not include a public hospital."[19] Section 2(2) restricts "major surgical services" to public hospitals. These important sections are not amended in Bill 30; however, the College of Physicians and Surgeons has the power under the Health Professions Act to use its bylaws to "[describe] the services that are major surgical services and minor surgical services for the purposes of section 2(2) and 29(r) of the Health Care Protection Act."[20]

Therefore, with the government's Bill 30 amendments to the Health Professions Act, which will change the composition of the College of Physicians and Surgeons governing council (allowing for government to appoint 50% of the College board with "public members"), it is foreseeable that the definitions of major and minor surgical services could be easily changed in a manner that does not require legislative amendment (and public scrutiny).

Despite language that prohibits the operation of "private hospitals" in Alberta, the government could use increased control over the College of Physicians and Surgeons to make changes to the definitions of major and minor surgical services, thereby significantly increasing the types of procedures that may be considered minor surgeries. This direction would seem to be consistent with the AHS's Request for Expressions of

[18] Bill 30 (Health Statutes Amendment Act, 2020), s. 2(3)(b), page 10.
[19] Health Care Protection Act, RSA 2000, s. 29(m).
[20] Health Professions Act, RSA 2000, Schedule 21, s. 8.7(i).

Interest process that closed earlier this year which identifies specific procedures and volumes,[21] but states a desire in determining market interest in other procedures and increased volumes: “AHS has identified the […] specific procedures for potential expansion, but is also interested in understanding the market capacity in procedures not listed[.]”[22]

Approval of agreement

8(1) A health authority that wishes to enter into an agreement with an operator of a surgical facility for the purpose of providing facility services that are required in connection with the provision of insured surgical services shall provide the Minister with a copy of the proposed agreement for the Minister’s approval.

(1.1) The Minister or person designated by the Minister shall assess the proposed agreement with respect to the following factors:

(a) access to insured surgical services in Alberta;

(b) quality of care;

(c) cost effectiveness and other economic considerations in Alberta;

(d) any other factors the Minister considers appropriate.

(2) The Minister may

(a) refuse to approve a proposed agreement, or

(b) approve a proposed agreement, subject to any terms or conditions that the Minister considers appropriate.

(3) The Minister shall not approve a proposed agreement unless ~~the Minister is satisfied~~

~~(a) that the provision of insured surgical services as contemplated under the proposed agreement would be~~

~~consistent with the principles of the Canada Health Act (Canada),~~

(a) the Minister is satisfied

~~(b) that there is a current need and that there will likely be an ongoing need in the geographical area to be served for the provision of insured surgical services as contemplated under the proposed agreement,~~

~~(c) that the provision of the insured surgical services as contemplated under the proposed agreement would not have~~

~~an adverse impact on the publicly funded and publicly administered health system in Alberta,~~

~~(d) that there is an expected public benefit in providing the insured surgical services as contemplated under the~~

~~proposed agreement, considering factors such as~~

~~(i) access to such services,~~

~~(ii) quality of service,~~

~~(iii) flexibility,~~

~~(iv) the efficient use of existing capacity, and~~

~~(v) cost effectiveness and other economic considerations,~~

[21] The potential procedures identified for expansion are in the areas of gynecology, general surgery, ophthalmology, orthopedics, urology.

[22] Alberta Health Services, Request for Expression of Interest for the Provision of Non-Hospital Surgical Facilities Services, RFEOI #AHS-2020-1184, release date January 31, 2020, accessed May 12, 2020, at: http://www.purchasingconnection.ca/.

~~(e) that the health authority has an acceptable business plan in respect of the proposed agreement showing how the health authority will pay for the facility services to be provided,~~
~~(f) that the proposed agreement indicates performance expectations and related performance measures for the~~
~~insured surgical services and facility services to be provided, and~~
~~(g) that the proposed agreement contains provisions showing how physicians' compliance with the following, as they relate to conflict of interest and other ethical issues in respect of the operation of the facility, will be monitored:~~
~~(i) the Health Professions Act and regulations under that Act;~~
~~(ii) the bylaws of the College of Physicians and Surgeons of Alberta;~~
~~(iii) the code of ethics and standards of practice adopted by the council of the College of Physicians and Surgeons of~~
~~Alberta under the Health Professions Act.~~
(i) that the provision of insured surgical services as contemplated under the proposed agreement would
be consistent with the principles of the *Canada Health Act* (Canada),
(ii) that the proposed agreement indicates performance expectations and related performance measures for the insured surgical services and facility services to be provided, and
(iii) that the proposed agreement contains provisions showing how physicians' compliance with the
following, as they relate to conflict of interest and other ethical issues in respect of the operation of the
facility, will be monitored:
(A) the *Health Professions Act* and regulations under that Act;
(B) the bylaws of the College of Physicians and Surgeons of Alberta;
(C) the code of ethics and standards of practice adopted by the council of the College of Physicians and Surgeons of Alberta under the *Health Professions Act*, and
(b) the Minister has considered the assessment referred to in subsection (1.1).

Section 8 governs the conditions and requirements for AHS to enter into an agreement with a private surgical facility to provide publicly funded services. AHS may not enter into agreements without the Minister's approval, which does not change with Bill 30.

However, the criteria that the Minister must use to assess the proposed agreement will be significantly amended. Important language protecting public delivery will be repealed:

- Language that requires the Minister to determine "that there is a current need and that there will likely be an ongoing need in the geographical area to be served for the provision of insured surgical services as contemplated under the proposed agreement" is to be repealed.[23]
- The subsection requiring that contracting not have an adverse impact on the public system is to be repealed: "the Minister shall not approve a proposed agreement unless the Minister is satisfied that the provision of insured surgical services as

[23] Health Care Protection Act, RSA 2000, s. 8(3)(b).

contemplated under the proposed agreement would not have an adverse impact on the publicly funded and publicly administered health system in Alberta."[24] The subsection requiring the Minister to only approve contracting out if they are satisfied that there is "efficient use of existing capacity" will also be repealed.[25]

- The subsection requiring AHS to have "an acceptable business plan in respect of the proposed agreement showing how the health authority will pay for the facility services to be provided" will be repealed.[26] An "acceptable business plan" would necessarily require that AHS perform a cost analysis to demonstrate how contracting out is more cost-effective than delivering those services in-house.

Designation of facility
11(1) Where the Minister
(a) approves a proposed agreement, and
(b) is satisfied that the surgical facility at which the insured surgical services will be provided is accredited to provide those insured surgical services or will be accredited before any such services are provided, the Minister shall ~~by order~~ in writing designate the surgical facility as a surgical facility for the purposes of this Division.
[…]

Amendments to section 11(1) will no longer require the designation of surgical facilities to be made by ministerial order, which means that they do not need to be made public.

Withdrawal of, changes to, designation
18(1) Where the Minister is of the opinion that, since the granting of a designation in respect of a surgical facility, circumstances have changed with respect to any of the factors referred to in section 8(3) or 15(1) in a material and substantial way, the Minister shall give a written notice of intent under subsection (2) to the operator of the designated surgical facility.
(2) A notice of intent must
(a) set out in detail the nature of the change in circumstances under subsection (1) that gave rise to the notice of intent, and
(b) advise the operator of the Minister's intention to withdraw the designation of the surgical facility or amend the
designation to delete one or more of the surgical services that the designated surgical facility is authorized to provide
unless, within 60 days after receipt of the notice of intent, the operator establishes to the Minister's satisfaction that
(i) the concerns raised in the notice of intent have been addressed or will be addressed, or
(ii) the concerns raised in the notice of intent are not founded or do not warrant withdrawing or amending the designation.

[24] Health Care Protection Act, RSA 2000, s. 8(3)(c).
[25] Health Care Protection Act, RSA 2000, s. 8(3)(d)(iv).
[26] Health Care Protection Act, RSA 2000, s. 8(3)(e).

(3) During the 60-day period referred to in subsection (2) the Minister and the operator shall attempt to resolve the concerns in the notice of intent.
(4) If
(a) the Minister is not satisfied as set out in subsection (2)(b), or
(b) the Minister is of the opinion that, after reasonable attempts at resolution of the concerns under subsection (3), the concerns will not be resolved within the 60-day period, the Minister shall ~~by order~~ in writing withdraw the designation of the surgical facility or amend the designation to delete one or more of the surgical services that the designated surgical facility is authorized to provide.
[…]

In addition to removing public scrutiny in designating a facility, section 18(4) is amended so that a ministerial order will no longer be required to withdraw or make changes to the designation of a surgical facility, meaning that any change would no longer be made public. If, for example, adverse events, patient safety issues, or other problems emerge requiring government intervention, these issues would be addressed in private between the Minister and the facility, and would not be on the public record.

Health Professions Act

The Health Professions Act governs the professional regulatory colleges, including the College of Physicians and Surgeons, that have the responsibility to regulate health professionals and protect the public interest. The Health Professions Act section 12(1) is amended to require that 50% of the voting members of the governing body ("council"), complaint review committee or hearing of all professional regulatory colleges must be public members, and appointed by government.[27] While there is movement internationally towards greater public involvement in health system governance (including professional regulation) in order to ensure that the public interest is served, these changes within the current political context are intended to consolidate government power and reduce the independence of the regulatory colleges. When enacted, this change will take effect on April 1, 2021.

Health Quality Council of Alberta Act

A number of consequential amendments will be made to this Act, which serve to increase the Health Minister's powers over the Health Quality Council of Alberta (HQCA). The HQCA is the province's health care quality improvement organization with a mandate to monitor and engage in activities that improve the quality of health care services. The work of the HQCA is similar to other quality improvement organizations in other provinces whereby the organization is mandated to work with government, health authorities, health care providers, patients and the public. Alberta, Ontario, and Saskatchewan have the most well-developed quality councils in Canada, which are respected for their independence from political intervention.

[27] Bill 30 (Health Statutes Amendment Act, 2020), s. 2, page 18.

Specifically, Bill 30:

- Creates the new requirement that an "approved plan" must be approved by the Health Minister and "must be submitted in the form and manner required by the Minister, contain the information required by the Minister, and be submitted to the Minister within the time set by the Minister." Moreover, "[o]n reviewing the plan, the Minister may approve it or may require the Council to make changes in it and resubmit the plan for approval."[28]
- Reduces the powers of the HQCA from a leadership to an assistive role: "shall undertake the following activities in co-operation with health authorities" to the HQCA "assist[ing] in" a list of activities that are reduced under Bill 30. The power of the HQCA to, "in co-operation with health authorities […] measure, monitor and assess patient safety and health service quality" is repealed.[29]
- Grants the power to appoint the HQCA board to the Health Minister instead of the Lieutenant Governor in Council.[30]
- Adds new language that the HQCA board shall give the Deputy Minister (or designate) notice of all meetings of the board and all meeting materials, and that the Deputy Minister (or designate) may attend all meetings but will not having voting rights.[31]
- Requires that the HQCA submits its annual report on activities and financial statement to the Health Minister rather than the Legislature.[32]

In sum, Bill 30 amendments undermine the independence of the HQCA from political interference by the Minister and government. The changes centralize power in the Health Minister to approve and alter the HQCA's work.

University of Alberta law professor Ubaka Ogbogu resigned from the board of the HQCA due to Bill 30 amendments and the loss of the organization's independence from government, which will no longer report to the Legislature but to the Health Minister.[33]

Regional Health Authorities Act

The Regional Health Authorities Act governs the establishment of health regions and the responsibilities of Alberta Health Services (AHS) as the single health authority. Bill 30 amends this Act in several important ways:

- Subsection 5(b) is repealed in which AHS "has final authority in the health region in respect of the matters" that follow: "promote and protect the health of the population […], access on an ongoing basis the health needs of the health region, determine priorities in the provision of health services in the health region and allocate resources accordingly, ensure that reasonable access to quality health services is

[28] Bill 30 (Health Statutes Amendment Act, 2020), s. 5(2)(a)(a), s. 5(12), pages 20, 24.
[29] Bill 30 (Health Statutes Amendment Act, 2020), s. 5(4), page 21.
[30] Bill 30 (Health Statutes Amendment Act, 2020), s. 5(5), page 21.
[31] Bill 30 (Health Statutes Amendment Act, 2020), s. 5(6), page 22.
[32] Bill 30 (Health Statutes Amendment Act, 2020), s. 5(17), page 25.
[33] Global News (2020, July 20), Edmonton-based board member quits HQCA in protest over Bill 30. See University of Alberta law professor Ubaka Ogbogu's resignation letter from the HQCA due to the loss of the its independence.

provided in and through the health region, and promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region."[34] This deletion undermines the authority of AHS in health care services planning and delivery and centralizes ministerial power.

- The Minister now has the power by ministerial order to establish an "accountability framework" which sets out reporting requirements for AHS.[35]
- A concerning new section "Agreements for planning and provision of services" is added to the Act which suggests that AHS may be required by the Minister to enter into agreements with a "person for the purposes of carrying out its responsibilities" to plan for the provision of (contracting of), and direct delivery of, health services, and in order to conform with any accountability framework that the Minister establishes.[36] This language opens the door for the Minister to require, through an accountability framework, that AHS contract with a private corporation/consultancy in order to perform its responsibilities and meet ministerial expectations. For example, this language could be used to undermine the public administration of Alberta's health system and the public servants working within AHS by requiring that AHS contract with private sector consultants. This direction would be consistent with the recommendations and direction contained in the Ernst & Young AHS review, and would make AHS look more like the National Health Service in England, which contracts most service delivery. Hollowing out NHS England's internal health policy and service planning expertise, by downsizing the public service and contracting with private sector consultants, has been used by successive governments to privatize the English NHS.[37]

DISCUSSION

Much has yet to be clarified based on the regulations (yet to be publicly released), but the legislation provides an expansive legal template for major privatization of acute care and primary and community care services. Bill 30 provides language that may be used to weaken AHS's public administration of the provincial health system and role in direct service delivery. It also undermines the Alberta Medical Association as the sole recognized bargaining agent for physicians, and also undermines the important independent roles of the Health Quality Council of Alberta and the professional regulatory colleges. With BC, Alberta, Saskatchewan, and Manitoba moving simultaneously to outsource surgeries, the concern is that market will become large enough to attract much larger corporate players like for-profit US or English hospital chains to enter the market.

[34] Bill 30 (Health Statutes Amendment Act, 2020), s. 11(4), page 30.
[35] Bill 30 (Health Statutes Amendment Act, 2020), s. 11(5), page 30.
[36] Bill 30 (Health Statutes Amendment Act, 2020), s. 11(4), page 30.
[37] Allyson Pollock (2006), *NHS plc: The Privatization of Our Health Care*, New York: Verso.

Will Bill 30 increase contracting out of publicly funded surgeries in Alberta?
In and of itself, Bill 30 does not increase contracting out of publicly funded surgeries, but the creation of "chartered surgical facilities" will likely expedite the process of approving for-profit facilities to receive AHS contracts. The Alberta government has committed to doubling the number of surgeries performed in private facilities, from 15% to 30% of total surgeries provincially. Amendments to the Alberta Health Care Insurance Act and Health Care Protection Act open the door to corporations contracting directly with government for publicly insured health care services in which these corporations may subcontract or employ physicians (and non-physician health care professionals) based on remuneration negotiated directly with these health care personnel. These changes are likely to encourage greater investor-owned corporate involvement as it means that corporations will have much greater control over their labour costs (by negotiating remuneration directly with physicians as well as non-physician staff).

The weight of the academic evidence and experience in Canada and internationally shows that private, for-profit delivery of surgeries is more expensive, lower quality and less safe, can lead to more clinically unnecessary surgeries, and can destabilize the public system.[38]

What are possible implications for health human resources in Alberta (including physicians/surgeons and unionized health care workers)?
Bill 30 provides new contractual mechanisms for public funds to be used to contract out publicly funded services, and pull limited health human resources into the private sector, often through financial incentives, reduced workload, predictable hours, and a less complex patient population. Health care providers can't be in two places at once, and even if providers work in both the public and private sectors, it will make it much more difficult to increase public hospital capacity, which is likely to complicate efforts working down the COVID-19 surgery backlog and reducing wait times over the immediate and longer term (thereby eroding public trust in the public system).[39]

However, much will depend on the regulations, the outcome of the current RFP process, and the final contracts between AHS and contracted private facilities. If the Alberta government purposefully provides generous contracts to private facilities so that these facilities can attract physicians and surgeons to work in these facilities by paying higher than the negotiated AMA fee-for-service rates, these facilities may successfully pull limited health human resources from the public to the private sector. The market for surgical services delivery in Alberta (like all provinces) does not operate as a competitive market, and it is likely that the RFP process will return bids that ensure that private facilities are able to pay physicians/surgeons at the AMA fee-for-service rates or higher, thereby encouraging them to focus their time in the private sector.

[38] Andrew Longhurst, Marcy Cohen, and Margaret McGregor (2016), *Reducing Surgical Wait Times: The Case for Public Innovation and Provincial Leadership*, Canadian Centre for Policy Alternatives, BC Office.
[39] Ibid., pp. 21-22.

If the Alberta government is serious about increasing contracted-out surgeries to 30% of total provincial volume, the government may find that it must reduce AHS capacity in order to limit work opportunities for physicians/surgeons and unionized health care professionals, thereby encouraging them to shift from the public to the private sector. In some medical and surgical specialities, private facilities may have fewer challenges attracting providers due to limited work opportunities in public hospitals. Finally, the absence of a new Physician Master Agreement could have the effect of encouraging physicians and surgeons to work for private, for-profit facilities.

Will Bill 30 lead to for-profit hospitals in Alberta?

Bill 30 significantly expands the legislative framework necessary to establish for-profit hospitals in Alberta (and Canada). This direction is consistent with the recommendation made in the December 2019 Ernst & Young review of Alberta Health Services to contract out surgeries that require an overnight stay or longer. As previously mentioned, Section 1 of the Health Care Protection Act states that "no person shall operate a private hospital in Alberta" which is defined as "an acute care facility that provides emergency, diagnostic, surgical and medical services, and admits patients for medically supervised stays exceeding 12 hours, but does not include a public hospital."[40] While Bill 30 does not appear to make all the necessary changes to sanction full-blown for-profit hospitals, there are two complicating factors.

First, there remains an important legal question as to whether the Section 1 prohibition carries any weight. The same legislation creates a regulatory framework (Health Care Protection Act, Part 2, Division 2) for "uninsured in-patient surgical services" which are defined as requiring more than a 12-hour stay (contrary to Section 1 which prohibits more than 12-hour stays). In other words, the Act seems to contradict itself.

Second, privatization of this nature is typically advanced in an incremental manner, and depends on generating serious market interest first. We can, however, be certain that once a larger for-profit surgical delivery sector develops in Alberta (the government's plan to double the total share of outsourced surgeries from 15% to 30% will facilitate this), these companies and investors will lobby for increased contracts which will necessarily require allowing more complex surgeries with longer stays to be contracted out.

Bill 30 clarifies that the government intends to create a market for much greater contracting out of surgical and hospital-like services. The regulations for "chartered surgical facilities" and the current RFP process (to conclude in fall 2020) will provide much more insight into how quickly this government wants to expand the role of for-profit surgical and acute care delivery. As the class of "chartered surgical facilities" has been crafted to be broad, the government can develop these new facilities in a manner that suits the corporations *after* the conclusion of the RFP process – without public scrutiny.

[40] Health Care Protection Act, RSA 2000, s. 1 and 29(m).

Does Bill 30 introduce private financing/two-tier health care for medically necessary services in contravention of the Canada Health Act?

Bill 30 appears to be consistent with the Canada Health Act and maintains the language in the Alberta Health Care Insurance Act that requires physicians to opt out of the public plan if they want to provide uninsured medical services by charging patients directly for medically necessary care. However, practice has shown that provinces do not consistently enforce provincial legislation that upholds the Canada Health Act.[41] And this is how the Cambie Surgeries Corporation (led by Dr. Brian Day, CEO of the for-profit Cambie clinic in Vancouver) constitutional challenge came about: the BC government audited Day's clinics and found evidence of unlawful billing practices, and so the plaintiffs, led by Day, launched the Charter challenge to strike down the laws that uphold public health care in BC.[42]

What is especially worrisome about Bill 30 and the pre-existing legislative framework established by the Health Care Protection Act is that the Minister can, under Division 2, designate surgical facilities that provide "uninsured in-patient surgical services" that "[require] a medically supervised post-operative period of care exceeding 12 hours."[43] This means that surgical facilities may be designated to provide both insured and uninsured services under the same roof, and Bill 30 provides greater opportunities for these for-profit facilities to cross-subsidize using public health care dollars via contracted-out insured services.

As noted in the background section, the Health Care Protection Act already blurred the distinction between *funding* (insured services under the public plan versus uninsured services on a private-pay basis) and *delivery*, and Bill 30 provides greater flexibility for facilities to maximize revenue/profits through both the public purse and charging patients directly. With the amendments to the Alberta Health Care Insurance Act, whereby physicians enter into contractual agreements with corporations in order to be paid, it removes government from more direct responsibility or oversight of the billing practices that may be employed. It also creates confusion for patients who may be referred to a private facility by the health authority to receive a publicly funded procedure but find themselves in a facility where they may be upsold "enhanced medical goods or services" by the opted-in physician or offered faster medically necessary treatment by an opted-out physician within the same facility.[44] The blurring of insured and uninsured health care service *funding* and *delivery*, and the introduction of corporations subcontracting physicians in Bill 30 raises significant conflict of interest concerns and implications for the Canada Health Act.

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[41] Kathy Tomlinson (2017, June 10), Some doctors are charging both government and patients privately in illegal double-dipping practice, *The Globe and Mail*; Kathy Tomlinson and Eric Andrew-Gee (2017, June 12), Canadian patients, advocates speak out about illegal doctor double-billing, *The Globe and Mail*.

[42] Val Avery (2019, Dec. 3), As Brian Day's court case ends, future of health care hangs in the balance, *The Tyee*.

[43] Health Care Protection Act, RSA 2000, s. 13-16.

[44] Under the Health Care Protection Act, "enhanced medical goods or services" "means medical goods or services that exceed what would normally be used in a particular case in accordance with generally accepted medical practice."

Finally, this analysis does not contemplate the significance of Bill 30 in relation to the Cambie Surgeries Corporation litigation. However, should the plaintiffs, led by Brian Day, be successful with some or all of their claims, Alberta would have the most well-developed legislative framework to encourage and legitimize profit-making opportunities through both public health care dollars and private payment. It could potentially facilitate the fairly rapid movement of physicians and other health care workers from the public to private sector as these corporations would have significantly increased abilities to generate revenue from insured and uninsured services, and compensate these professionals in a manner necessary to recruit them.

What are the implications of Bill 30 for other provinces and Canadian medicare, more generally?

Alberta already had one of the most expansive legislative frameworks for contracting out publicly funded surgeries in for-profit facilities prior to Bill 30 (via the Health Care Protection Act enacted in 2000). However, Bill 30 is a decisive shift to greater for-profit involvement in the provision of publicly funded health care services. In essence, it further develops a legislative framework that will enable the erosion of publicly delivered surgeries and other acute care services (including laboratory, diagnostic imaging, nursing, and rehabilitation services) from the public to the private sector.

Bill 30 raises many questions that will not be resolved until the regulations regarding "chartered surgical facilities" are made public. However, Bill 30 – coupled with government statements to contract out 30% of surgeries and the Ernst & Young recommendation to extend the length of stay in the private sector – clarify the government's intent to establish a legislative framework that encourages the development of a larger market for surgical services (and necessary "facility services" including diagnostics, nursing, rehabilitation, and support services).

While questions remain about the ultimate direction the Alberta government plans to pursue regarding contracting out more complex surgeries requiring longer stays (and what chartered surgical facilities will look like), the clear political commitment to outsource 30% of total surgeries significantly increases the risk of well-capitalized corporations, specifically international hospital chains, getting a foothold in delivering publicly funded acute care in Canada. At a minimum, it could mean that some of the larger for-profit surgical corporations, including Calgary-based Surgical Centres Inc., will see considerable growth considering that all western provinces are turning to for-profit facilities to work down the COVID-19 surgery backlog. Once entrenched in the health care system, these providers are likely to form industry associations to lobby government for more contracts and oppose more stringent regulations. We need only look to the for-profit seniors care industry as an example. We can also expect the for-profit industry to align itself with advocates for two-tier health care.

Even with Bill 30 amendments coming into force, these shifts may not occur immediately. However, Bill 30 serves as a signal to for-profit actors, potentially international hospital chains, that Alberta is committed to their involvement in publicly funded service delivery and increasing profit-making potential by allowing corporations to subcontract physicians and develop complex business practices and cross-subsidization of insured and uninsured services. Initially, the market may be dominated by a mix of investor-owned corporations, but mainly entrepreneurial physicians/surgeons who currently own and operate private facilities and may be the first to submit bids to provide expanded contracted services. Contracted seniors' care provides evidence of this trend, with a shift from small proprietors to investor-owned chains over time.

Bill 30 offers a regulatory environment that provides greater certainty to private investors and protection of business interests. These measures will be necessary to attract private capital to make long-term investments in building and operating health care facilities – whether surgical/acute care facilities, primary care clinics or diagnostic and rehabilitation services. The consequential amendments to the Alberta Health Care Insurance Act and the Health Care Protection Act, in particular – and the broader legislative framework enabled by Bill 30 – provide a template for other provinces seeking to significantly expand the role of the for-profit sector in the delivery of surgical services. Bill 30 sets the stage for a for-profit hospital sector in Canada.

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