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Recent Health System Reforms: Sustainability Measures or a Push to Privatization?

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Matter Commented On: Recent health policy changes in Alberta

Health care costs are undoubtedly a pressing policy issue, with Alberta spending an estimated $7658 per person in 2019. Since the election, the UCP has taken various steps to aggressively contain health spending. While reducing the deficit is a laudable goal, recent changes may save little money and could worsen the health of Albertans and undermine the public health care system.

Cuts to Health Services

A substantial body of evidence shows that health is not only determined by access to health care services but by the social determinants of health, which are the social and economic factors that influence health. This includes things like education, housing, and a sufficient income to purchase necessities like food and heat. Recent budgetary changes not only target the health care system but the social determinants of health. For example, the UCP government made cuts to the Assured Income for the Severely Handicapped program (AISH) by de-linking monthly payments with inflation. As the cost of goods and services increase with inflation, these individuals, who often struggle to make ends meet on a very modest budget, will be increasingly unable to pay for food, heat, and rent. A lack of access to the social determinants of health not only exacerbates health inequities but fails to prevent morbidity and mortality, leading individuals to require health care services.

The UCP's recent budget will also reduce drug benefits for seniors relative to 2019-2020 spending. Although the government has yet to release details, they have announced income-tested deductibles for beneficiaries with higher incomes. The government also terminated coverage for dependants under the age of 65. Many Canadians report not taking prescriptions or taking steps to make them last longer (such as skipping doses) due to their cost. As demonstrated by studies examining cost-sharing for medication, pushing drug expenses onto seniors will likely increase cost-related non-adherence. Studies also show that a failure to take prescribed medication results in increased adverse events and greater use of more expensive health care services like emergency rooms (see e.g. here and here).

One of Kenney's election promises was "to do things more efficiently without affecting front-line services." However, recently announced government cuts will cause approximately 400 auxiliary nurses and 750 registered nurses and registered psychiatric nurses to lose their jobs. Given the key role that nurses play in providing primary care and preventive services, the health

of Albertans will likely suffer as a result of these cuts. Rather than conceptualizing primary care as merely a cost, the government ought to look at it as an investment in a healthy and productive workforce.

The UCP has also taken steps to reduce physician fees, which represent about 15% of health spending in Canada. Although the contract between the government and physicians was not set to expire until the end of March, the province allowed contract negotiations to break down prematurely and unilaterally imposed new reimbursement rules. After significant outcry, the province agreed to resume talks on Sunday.

Unless the province reaches a new agreement with doctors in the next three weeks, the existing rules will freeze the current budget, with no room for increases due to inflation or to account for Alberta's aging population. It will also impose several additional measures designed to curb fees. For example, the province will only pay for doctors to see a certain number of patients per day and salary top-ups, which were used to recruit doctors, will be terminated.

One of the most contentious changes in this new agreement relates to billing for complex patients. Currently, doctors bill $41 for each visit plus an additional $18 if the visit exceeds 15 minutes. Once changes are phased in, visits will have to be 25 minutes long to be eligible for this additional fee. This change could affect some of the most vulnerable patients. For example, psychiatrists are concerned that mental health issues cannot be adequately covered in a short consultation and that doctors could stay away from treating complex patients entirely. Similarly, patients with several medical conditions may not have all their health concerns addressed in a single visit, despite the fact that these co-morbidities interact with one another and must be treated holistically. When patients do not have access to community-based care for complex medical issues, more expensive hospital visits could increase. These changes may also affect the number of doctors in Alberta. For example, there are reports of doctors closing their practices and medical residents accepting positions outside of the province as a result of the recent changes.

A Shift to Two-Tier Care?

According to wait times data from the Canadian Institute for Health Information, Alberta is within five percent of the Canadian average for elective procedures with benchmarks, apart from cataract surgery. However, some Albertans are still waiting longer than medically recommended. For example, only 70% of Albertans are receiving a hip replacement within the recommended 182 days. On Thursday, the province announced a wait times initiative that includes a plan to invest $100 million in operating rooms, to schedule surgeries at underutilized hospitals (in locations such as High River and Canmore), and to contract with private surgical clinics to treat public patients. The initiative is projected to reduce Alberta's surgical wait times to an average of four months, resulting in an additional 80,000 surgeries by 2022-23.

Although the government has yet to release details on its wait times initiative, there are several potential concerns. For example, it did not address equity issues associated with patient travel, which will likely disparately affect those with lower incomes and those who lack social supports. Similarly, the announcement contained few details on the use of private surgical facilities. Both

international evidence and the limited available Canadian evidence show that private facilities generally cost more and raise quality and safety issues. For example, Longhurst, Cohen, and McGregor highlight four problems with private delivery of public health care services. First, they are more expensive as a result of higher administrative costs, the need to return profits to investors, and the costs incurred to create and enforce regulations pertaining to private providers. Second, there are quality problems that are often attributable to lower staffing levels. Third, a conflict of interest leading to inappropriate care can arise when physicians have a financial stake in private facilities. Fourth, private facilities can destabilize the public health care system.

Alberta's own history with privatization has not always been successful. In 2004, a private facility (the Health Resource Centre) received a contract from the regional health authority to provide 2500 public patients with orthopedic surgeries. Despite being allotted the least complicated cases, these procedures cost significantly more than they would have cost within the public system. On average, procedures were about $500 more at the private facility than the public counterpart. Ultimately, Alberta Health Services spent millions of dollars attempting to keep this facility in operation and acted as its receiver before it declared bankruptcy.

In its recent announcement, Alberta stated that its approach to private clinics is modelled on Saskatchewan's Surgical Initiative. However, that program involved a considerable public investment in private facilities. Specifically, from 2009 to 2014, Saskatchewan invested $176 million in this initiative and spent another $60.5 million on operating costs in 2015. When these public funds were withdrawn, wait times steadily climbed. Although it is not clear whether Alberta will similarly invest in private facilities, evidence suggests that it would receive better return on investment by committing these funds to public hospitals.

Alberta's budget also includes a $164 million investment in the Affordable Supportive Living Initiative. Under this program, the government will subsidize the construction and operation of private designated supportive living (DSL) spaces. This infusion of funds responds to a recent review of Alberta Health Services by Ernst & Young, which recommended moving 1300 seniors who are currently living in long-term care to DSL, where they will receive a lower level of care, since DSL facilities are not subject to the same nurse staffing requirements. Privatizing senior care is concerning, given that public facilities have been consistently shown to provide higher quality care than their for-profit counterparts (see e.g. here, here, and here). This recent reform may foreshadow further privatization in senior care, given that the Ernst & Young report also recommended that Alberta Health Services reconsider long-term care "facility ownership in cases where private delivery may be more efficient and appropriate."

The cuts to physician reimbursement may also push Alberta towards privatization. If doctors find it increasingly fiscally unsustainable to practice within the public system, they may choose to opt out entirely and to treat private patients. In some provinces, such as Ontario, even if doctors opt out of the public system, they cannot bill their private patients more than they would receive on the public fee schedule (*Commitment to the Future of Medicare Act, 2004*, SO 2004, c 5, s 10). In other words, there is a significant disincentive to opt out, given that it would be no more profitable than treating a steady stream of publicly-insured patients. Because Alberta has no such disincentive, doctors who are not adequately paid in the public system could opt to treat private

patients (*Alberta Health Care Insurance Act*, RSA 2000, c A-20). Although very few Alberta doctors have opted out of the public system to date, this has been a problem in Quebec since the province abolished "accessory fees", which were user fees for insured services levied by doctors in contravention of the *Canada Health Act*, RSC 1985, c C-6.

Between reducing the number of nurses, alienating doctors, and shifting care to private facilities, the government has significantly undercut the public health care system. Failing to maintain a robust public health care system may weaken support for Medicare, further pushing Alberta towards a two-tier system. Alberta is not alone in grappling with the appropriate balance between public and private health care services. For example, Saskatchewan is currently embroiled in a dispute with the federal government over private MRIs that breach the *Canada Health Act*, and there is ongoing litigation in British Columbia in which a doctor is trying to dismantle the public health care system through the legalization of extra billing and private health insurance for insured services. Depending on the outcome of these challenges to public Medicare, Canada could see a dramatic shift from a system that is based on medical need to one that is based on ability to pay.

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