Alberta Doctors' Digest

Keeping a cool eye on politicians: Alberta’s health care at a crossroads

I thought the UCP might recover by the next election if the economy rebounded and the provincial debt could be seen as manageable – despite the damage done in rural Alberta by the party’s aggressive attacks on rural and city family doctors. Apologies given in the legislature, while welcome, also accentuated a lack of political canniness. Lump this with increasing governmental centralization, a politically clumsy handling of the pandemic in the summer and other peccadilloes, and re-election chances are slipping.

ZOOM-weary? Bad for large gatherings like the House of Commons but good for small board meetings where you know the people. And excellent for early morning rounds and lectures. On October 15, this year, I Zoom-attended a 7:30 a.m. lecture – the Gordon MacDonald Memorial Lecture. This year it was given by Dr. Lorian Hardcastle, a lawyer and associate professor in the Faculty of Law at the University of Calgary with a joint appointment in community health sciences in Calgary’s Cumming School of Medicine. She has publications in public health law, health systems and other areas.

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Dr. Hardcastle contends that we’re at an important, yet concerning time in our profession’s relationship with government, patients and the law. She tackled a number of areas.

The recent “agreement”

For the recent tentative agreement with Alberta Health (rejected by AMA members in March 2021), there was minimal consultation with the profession. The ministry took an unnecessarily aggressive negotiating approach (as Dr. Christine Molnar can attest to) in a seemingly frantic effort to cut costs. The issue of billing number restrictions was tabled for later. Billing number restrictions have been eschewed by other provinces because of “unexpected” (though entirely predictable) consequences such as retaining rural medical staff. The Ernst & Young report had some fair suggestions, but others were destabilizing – micro-management of family doctors’ practices was daft, pushing them away from devoting more time for complex cases and promoting a six patients/hour production line. Then the pandemic hit. Given the massive costs of the pandemic, the projected savings from the Ernst & Young report seem trivial now. But, like my basement beetles, the ministry will be back when the weather warms.

"Alberta's Healthcare at a Crossroads" was a presentation deserving wider dissemination as an accurate, pithy review of current issues facing the AMA and all doctors – and likely problems forthcoming during 2022. (Photo credit: Pixabay.com)

The role of corporations

In *Bill 30* legalese, corporations are "persons." Commercial companies are now paying physicians for clinical services. This may well increase costs by duplication rather than reduce them. These companies cater to the younger worried-well and indulge in upselling health store nostrums (e.g. "Vitamin X is *good* for you – it boosts your immunity") and online counselling. Virtual care has opened a Pandora's box with Telus/ Babylon's My Care, the President's Choice Health App ("Earn Optimum points") and the dermatologist's delight, Mecca (with Dr. Gwyneth Paltrow's Goop), leading the way. These companies conceivably might be interested in profit. Unaddressed are quality issues like lack of care continuity, over-prescribing, privacy and up-selling online. Machine intelligence ("your symptom check-list") is a problem with inappropriate recommendations. Government has been slow to regulate these – no doubt because it's difficult. Predictably, there has been no updated information on the usage or costs to the taxpayer of Babylon's My Health and others.

The role of private delivery

Government has intimated that some 30% of surgeries will be done in private facilities by 2023 – largely necessary due to the pandemic's delaying of routine procedures. But the plan may be to double that number eventually, though there has been little professional, let alone public, discussion. Remember the government contribution of $200 million towards a private ENT facility in Edmonton and the grant to a First Nations company (fashionably styled "in partnership with First Nations") to explore the development of private projects. Private units (whether surgical or medical) will, quite reasonably, try to select routine cases by nature of their limited immediate access to other specialists and equipment. Staffing costs eat into profits. Payments from Alberta Health should reflect case complexity – though this definition is a difficult nut to crack.

Then there is the limited supply of specialists: will their attendance in a private facility deprive public hospitals of their skills? Time contracts for professionals can deter but are notoriously difficult to enforce. Some specialties (e.g., anesthetists) may be harder to replace, and quality assurance questions remain: is there lower overall care quality in

some private/semi-private long-term care facilities? But quality care in some public long-term care facilities is nothing to crow about. Governmental consideration of these annoying details has been minimal, although the College of Physicians & Surgeons of Alberta will still have oversight (but vide infra).

Private financing

At their October 2020 conference, the UCP supported (slim 52.7% approval) “the option of a privately funded and privately managed health care system” (Policy 11.) This is the “perpetual Zombie Question” according to the much-loved BC economist Robert Evans (no, Robert, this Zombie is very much alive given the long wait-times now in the public system). In BC, Brian Day (founder of Cambie Surgical Centre) lost his challenge advocating for private insurance, though the judge agreed that delay to treatment time may violate “security of person” in the Constitution. Day’s case led to the longest judicial report in Canadian history – bed-time reading of 880 pages! The case is now in the BC Court of Appeal, and $32 million in transfer payments to BC have been withheld by the federal government under the *Canada Health Act*. New Brunswick also had funds withheld for private abortion services.

These new active private facilities set up due to COVID will likely continue post-COVID. The strange federal rule that as an Albertan you can visit BC (or other provinces) and have a private procedure without losing federal funding (but not in your home province) and vice-versa for BC and other provincial residents needs repealing. But if federal funding for private procedures done locally is lost, the clamour for private insurance for provincially-covered procedures will grow.

Private radiology is now available (and much used) in most provinces, but from December 2022 there will be federal claw-backs. A battle is brewing there, especially in light of the federal government’s further incursion into health care with calls for national pharmacare and fully-covered dentistry – although with “new economics” baloney, deficit spending and the Central Bank’s “quantitative easing” wheeze (which has “no effect on inflation” according to an ex-Bank governor) one of these may be possible.

Government control

There has been significant intrusion of the provincial government in areas previously self-managed. The independent Health Quality Council formerly reporting to the legislature (like, for example, the privacy commissioner and auditor-general) now reports to the minister of health. The College of Physicians & Surgeons of Alberta, a body widely admired in Canada for its independence from government pressure, will now have a council with 50% government appointees (previously 25%.) This may lead to some mistrust with the medical profession. Licensing and discipline could possibly become a bureaucracy of government – God help us!

Scopes of practice may be modified to contain costs. In-camera quality assurance discussions, previously privileged and confidential, to improve the goal of actually achieving quality improvement rather than having participants reluctant to admit anything untoward happened, may wither. Regulation has two sides – the BC experience with increased regulation of long-term care homes has resulted in nursing staff taking time from patient-care to fill lengthy forms which few read. Real problems can become a casualty of form-filling.

Public health

A review is likely on the role of public health. The Alberta chief medical officer is an advisor to the government. She makes regulations with legal standing but does not take final decisions despite regulations going out under her signature. This has been a challenging role to play for Dr. Hinshaw, balancing the effects of lockdowns and public health measures against the deleterious effects of the pandemic on delayed surgeries, cancelled transplants, delayed medical consultations (e.g. the cancer diagnosis incidence in 2020-21 dropped by over 20%), opiate overdose deaths, children's education, mental health, domestic violence and the overall economy. She must be able to speak freely. She will have been under intense pressure from MLAs and government ministers with more objectives than just the health of the population. It may be better for her and the Alberta population to report to the legislature like the privacy commissioner and auditor-general rather than the minister of health.

"No government ever voluntarily reduces itself in size. Government programs, once launched, never disappear. Actually, a government bureau is the nearest thing to eternal life we'll ever see on this earth!" – Ronald Reagan.

So we have seen an increased centralization of government control over health care by provincial and federal governments with an increase in pace of change and an aggressive style in negotiations. This may be justified if costs must be urgently contained but may not have been the best politics by risking destabilization of the health care system with the background of a pandemic starting in February 2020.

Politics in Alberta has been (dare I say it) a bit amateurish. They could learn from Churchill, who sarcastically said about London smog: "It's just the weather." On realizing he was wrong, he immediately visited the hospitals full of respiratory cases and recanted. His popularity rebounded. No senior Alberta minister (to my knowledge) visited rural health centers to talk to rural physicians.

You can hear Dr. Hardcastle's talk here. Go to Videos from Rounds October 2021: "Alberta's Healthcare at a Cross-roads." (Note: access to AHS web portal is required).

Editor's note: The views, perspectives and opinions in this article are solely the author's and do not necessarily represent those of the AMA.

Acknowledgement: Dr. Hardcastle kindly reviewed this column, correcting inaccuracies. Interpretation of her lecture is that of the writer.

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