

**HEALTH SERVICES  
PREFERENTIAL ACCESS INQUIRY  
ALBERTA**



**VOLUME 2:  
RESEARCH AND EXPERT OPINIONS**





Health Services Preferential Access Inquiry – Alberta

The Hon. John Z. Vertes, Commissioner

Volume 2: Research and Expert Opinions

August 2013

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## Introduction

This research volume contains the reports and papers commissioned by the inquiry to help inform its work. The first section contains the expert reports of Professor William Lahey and Mr. J.L. Saunders. These reports provided the background for their expert testimony on December 3, 2012. The reports were entered as exhibits 11 (Lahey) and 12 (Saunders) at inquiry hearings.

Professor Lahey's report, *The Legislative Framework Governing Access to Health Services that are "Insured Health Services" under the Canada Health Act and "Insured Services" under the Legislation of Alberta*, examines federal and provincial laws governing health care in Canada. Mr. Saunders' report, *How Healthcare is Delivered in Alberta*, reviews the organization of health care services in Alberta. Mr. Saunders' report is reproduced without the substantial appendices that were attached to his original report. Readers can see these appendices by examining exhibit 12 online.

The second section of this volume contains the research papers produced by six experts who testified on February 26 and 27, 2013. These papers are assembled in a single document marked exhibit 149. The papers respond to seven questions posed to each expert by the inquiry research branch. The seven questions are as follows:

1. What is "preferential access" to health care?
    - a. Is there a common definition?
  2. Is there a difference between "proper preferential access" and "improper preferential access"?
  3. In your opinion, what would be examples of "proper" preferential access to health care?
    - a. Is there harm to the public care system associated with "proper" preferential access to health care?
    - b. In your opinion, what is the nature of that harm?
    - c. Is that harm acceptable from an ethical or practical perspective?
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4. In your opinion, what would be examples of “improper” preferential access to health care?
    - a. Is there harm to the public care system associated with “improper” preferential access to health care?
    - b. In your opinion, what is the nature of that harm?
    - c. Is that harm acceptable from an ethical or practical perspective?
  
  5. Which of the following would you characterize as “proper” or “improper” access to health care and why?
    - a. Physician advocacy.
    - b. Physician use of emergency OR [Operating Room] slots to book patients for surgeries.
    - c. Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list.
    - d. Hospital or medical staff obtaining flu shots before the general public.
    - e. Professional athletes and their families obtaining flu shots or medical treatment before the general public.
    - f. A physician arranging for a friend or family member to be seen quickly.
    - g. Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem).
  
  6. Are you aware of any safeguards which currently exist in the health care system to prevent “improper” preferential access?
    - a. If so, do you believe such safeguards to be effective, and why?
  
  7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent improper preferential access?
    - a. What changes would you recommend, and why?
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A literature review performed by Dr. Nishan Sharma of the University of Calgary research and innovation centre, known as W21C, forms section three of this volume. The paper, *Academic Literature Review of Preferential Access to Health Care in Canada*, is a review of the academic literature on preferential access to health care as it pertains to the Canadian system. Referencing peer-reviewed journal articles that are applicable to the Canadian context, this review helps define what preferential access or “queue-jumping” means in the Canadian health care system from an academic point of view.

The final section contains the *Renal Dialysis Rimbey Support Group Report*, produced by Dr. John Church. The Commissioner had invited the Group to make a formal written submission. This report was entered as exhibit 152 during hearings on February 27, 2013. The report focuses on the financial, safety and health costs associated with the travel necessary for residents of one rural community to receive dialysis services.

The opinions expressed in each paper are those of the author(s) alone and do not necessarily reflect the position of the inquiry. The documents contained in this volume are reproduced in the form in which they were presented to the inquiry and have not been substantially edited by inquiry staff

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**The Legislative Framework Governing Access to Health  
Services that are “Insured Health Services” under the  
*Canada Health Act* and “Insured Services” under the  
Legislation of Alberta**

**Professor William Lahey**

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## 1. Expert Reports

(a) **The Legislative Framework Governing Access to Health Services that are “Insured Health Services” under the *Canada Health Act* and “Insured Services” under the Legislation of Alberta**

**Professor William Lahey**

### EXECUTIVE SUMMARY

In every province and territory, Canadians have a statutory entitlement to receive medical (and some dental) services and hospital services that are determined to be medically necessary at public expense without charges at the point-of-service.

This entitlement is designed to ensure that Canadians have access to these services on the basis of relative need rather than on the basis of relative wealth. It therefore ensures a significant measure of equality of access, particularly among the residents of each province or territory, to most medical and hospital services. In a nutshell, this system is what is called Medicare.

The existence of Medicare as a quasi-national program depends upon the *Canada Health Act*. The function of the *Canada Health Act* is to establish the criteria and conditions of eligibility that each province or territory must satisfy to receive their full share of the annual cash contributions to health-care spending, called the Canada Health Transfer, that the federal government decides to make to the provinces and territories. These eligibility criteria and conditions apply to the design and functioning of the health-care insurance plan that the Act says each province and territory must have.

Pursuant to the *Canada Health Act*, a provincial health-care insurance plan must meet the five “program criteria” of:

- 1) public administration;
  - 2) comprehensiveness;
  - 3) universality;
  - 4) portability; and
-

## 5) accessibility (“the Five Criteria”).

In addition, in respect to the health services that the plan insures, extra-billing and user charges must not be permitted under the plan.

The overall effect of the *Canada Health Act* is that each province or territory that wants its full share of the Canada Health Transfer has to establish a health-care insurance plan that is administered by a public authority accountable to the provincial or territorial government and that pays 100% (more or less) of the cost of a comprehensive range of medical and hospital services whenever they are provided, with limited exceptions, to any resident of the province or territory.

The clear exceptions in the legislation occur where medically necessary services are provided to injured workers entitled to the service under workers’ compensation legislation, to members of the Canadian Forces, to federal inmates, or to provincial or territorial residents who have not met the residency requirement of three months or less set by the province or territory. The result of the exceptions is that these individuals either pay for medical services, or medical services are provided to them through a program other than the provincial health-care insurance plan.

The more uncertain exceptions relate to services that may or may not be “medically necessary” and therefore might arguably fall outside of the *Canada Health Act*. This uncertainty has applied to certain diagnostic services when provided outside of a hospital.

Alberta has a legislative framework that creates the health-care insurance plan required by the *Canada Health Act*. Alberta has created two separate health-care insurance plans.

The first, the Alberta Health Care Insurance Plan, covers medical services. This plan is established and operated under the *Alberta Health Care Insurance Act* and its regulations. The second plan, the Hospitalization Benefits Plan, covers hospital services. The Hospitalization Benefits Plan is established and operated under Part 3 of Alberta’s *Hospitals Act*.

Both of these Plans are consistent with each other in entitling Albertans to access without any charge at the point-of-service to what is defined in Alberta as medical and hospital services that are medically

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necessary, subject to the exceptions provided for in the *Canada Health Act*.

Like all other provinces, except one, Alberta goes further than is required by the *Canada Health Act* in seeking to ensure that these services are for the most part only available through the Alberta Health Care Insurance Plan and the Hospitalization Benefits Plan.

The *Alberta Health Care Insurance Act* accomplishes this goal by requiring physicians who wish to provide any of these services for private payment to opt out of the Alberta Health Care Insurance Plan and to forego all reimbursement under that Plan. In addition, Alberta, like a number of other provinces, prohibits the selling or purchase of private insurance for services available under the Alberta Health Care Insurance Plan and the Hospitalization Benefits Plan.

Alberta's "Medicare legislation" includes the *Health Care Protection Act*. This Act creates a regulatory framework for the operation of private surgical clinics that stresses consistency with the *Canada Health Act*. It authorizes the establishment, with Ministerial approval, of designated surgical facilities that can, like public hospitals, provide insured and uninsured surgical services as well as "enhanced medical goods and services".

When the designated surgical clinics provide insured surgical services, they do so under a minister-approved agreement with Alberta Health Services (or a predecessor regional health board) under which the cost of the service is paid for by the public system. Designated clinics also provide uninsured surgical services and enhanced medical goods and services for payment by the patient or a third-party payer other than Alberta's two health-care insurance plans.

The *Health Care Protection Act* also contains a number of distinct but overlapping provisions that are intended to prevent preferential access to services that should be delivered as insured services. In particular, section 3 of the *Health Care Protection Act* contains an express prohibition on queue jumping.

The following summary is intended to provide a general overview of the key elements of the primary pieces of legislation which govern Medicare in Alberta:

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*The Canada Health Act:*

- Seeks to ensure that Canadians have universal and reasonable access on uniform terms and conditions to a comprehensive range of physician and hospital services on the basis of need and without regard to individual ability to pay;
  - Authorizes the federal government to make health transfers to provinces and territories that are determined by the federal government to have a health care insurance plan, or plans, that comply with the *Canada Health Act*;
  - Establishes the criteria and conditions which each province and territory must satisfy to receive its full annual share of the Canada Health Transfer;
  - Requires each province and territory to establish and maintain a health care insurance plan for medically necessary hospital services and medically required physician services, including some dental-surgical services, which meets five program criteria: public administration; comprehensiveness; universality; portability; and accessibility;
  - Requires each province and territory to prevent extra-billing and user charges under its health care insurance plan (or plans);
  - Authorizes the federal government to withhold or reduce cash transfers otherwise payable in the event of failure by a province or territory to comply with one or more of the program criteria and requires the federal government, where extra-billing or user charges are permitted, to deduct the total amount charged to patients from transfers otherwise payable;
  - Leaves the critical phrases “medically necessary” and “medically required” undefined, giving each province and territory significant latitude to determine the services that it will fund as medically necessary or required;
  - Excludes hospital and physician services provided under workers’ compensation legislation or to members of the Canadian Forces, federal inmates and non-residents of a province; and
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- Deals with how hospital/physician services are to be funded, not with how services are to be delivered, leaving service delivery choices to provinces and territories.

*The Alberta Health Care Insurance Act:*

- Establishes entitlement for all residents of Alberta (as defined) to basic health services, which are defined to include the services that Alberta insures as medically necessary physician and dental-surgical services, called “insured services”;
- In accordance with the *Canada Health Act*, establishes the Alberta Health Care Insurance Plan, which is Alberta’s health care insurance plan for the services that Alberta insures as medically required physician services and dental-surgical services;
- Excludes services provided under workers’ compensation legislation or to members of the Canadian Forces, federal inmates and non-residents of Alberta;
- Expressly prohibits extra-billing and the charging of other fees in respect of insured services by physicians and dentists who are “opted-in” to the Alberta Health Care Insurance Plan; and
- Deems physicians and dentists to be opted-in to the Alberta Health Care Insurance Plan and discourages “opting out” by: requiring physicians to publicly do so for all purposes; prohibiting payments to physicians and reimbursement of patients for services received from opted-out providers in most circumstances; and prohibiting private insurance for services covered by the Plan.

*The Alberta Hospitals Act:*

- Establishes entitlement for all residents of Alberta (as defined) to medically necessary hospital services, called “insured services”;
  - In accordance with the *Canada Health Act*, establishes the Hospitalization Benefits Plan, which is Alberta’s health care insurance plan for medically necessary hospital services;
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- Excludes hospital services provided under workers' compensation legislation or to members of the Canadian Forces, federal inmates and non-residents of Alberta;
- In respect of insured services, prohibits the charging of user-charges or fees; and
- Prohibits private insurance for services covered by the Hospitalization Benefits Plan.

The *Health Care Protection Act*:

- Prohibits the provision of surgical services except in a public hospital or in an approved surgical facility;
  - Prohibits the provision of major surgical services except in a public hospital;
  - Establishes a legislative framework for purchase and provision of insured and uninsured surgical services;
  - Differentiates between insured services (for which patients cannot be charged) and "enhanced medical goods or services" (which can be purchased by patients either with or independently of insured services);
  - Subject to the limitation that major surgical services must be provided in a public hospital and the other requirements of the Act:
    - permits designated surgical facilities to provide insured surgical services (under agreements with Alberta Health Services that are approved by the Minister of Health), uninsured surgical services and enhanced medical goods and services;
    - permits accredited surgical facilities that are not designated to provide uninsured surgical services that require less than 12 hours of medically supervised post-operative care and enhanced medical goods and services; and
  - Contains various provisions, including a prohibition of queue jumping, that are intended to ensure that access to insured surgical services is in accordance with the *Canada Health Act*
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and the underlying objective of the *Canada Health Act*, which is access based on need without regard to ability to pay.

## 1. Introduction

### *a) Overview of Canadian Medicare*

Across Canada, Canadians are generally entitled under the laws of their province or territory of residence to receive three categories of health service without being charged for the service: (1) medically required services provided by a physician; (2) medically necessary services provided by a hospital; and (3) surgical-dental services that are medically or dentally required if performed in a hospital where the service is one that must be provided in a hospital.<sup>1</sup>

The health services that fall into these three categories are generally called “insured health services”.<sup>2</sup>

Legislation in every province and territory provides for remuneration of the physician (or dental surgeon) or the funding of the hospital that delivers these services by a publicly administered health insurance plan that is funded either by (a) general government tax revenue or (b) by a combination of general tax revenue and a dedicated health premium paid separately from taxes by provincial residents.<sup>3</sup>

The starting point in this Canada-wide legislative consistency is the *Canada Health Act*.<sup>4</sup> This federal legislation entitles every province and territory that maintains the legislative framework described above to its share of the cash transfers that the federal government annually makes to the provinces and territories in respect of the expense the provinces and territories incur in funding health care, including by paying 100% of the cost of what the *Canada Health Act* defines as “insured health services”.

The annual transfer provides a significant financial incentive to the provinces to comply with the *Canada Health Act*, notwithstanding that

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<sup>1</sup> *Canada Health Act*, RSC 1985, c C-6 [CHA] at s 2. See Appendix A for a full list of relevant sections of the *Canada Health Act* discussed in this report.

<sup>2</sup> *Ibid.*

<sup>3</sup> See *CHA Report*, *infra* note 15 at Chapter 3.

<sup>4</sup> *CHA*, *supra* note 1.

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the Act is not written, and could not be written for constitutional reasons, to be legally enforceable against the provinces.

It is estimated that in 2012, provincial and territorial government health expenditures will reach \$135 billion. Spending on health care is one of the largest budget items for all provinces. As a percentage of provincial expenditure it ranges from 30.1% in Quebec to 47.9% in Nova Scotia. On a per capita basis, it ranges from \$4,606 annually per person in Alberta (second highest) to \$3,513 annually per person in Quebec (the lowest).<sup>5</sup>

In a nutshell, this is what Canadians know as Medicare, a quasi-national program that is available to citizens because of the legislation of their province or territory of residence, but that ultimately also rests on the federal *Canada Health Act*. It seeks to ensure general access to necessary physician and hospital services (as well as some dental services) by eliminating the role that each individual's wealth would otherwise play in determining their ability to access these services.

Therefore, to the significant degree that relative access to these services would otherwise depend on each person's financial capacity, Medicare seeks to ensure equality of access to the health services it encompasses.

At the same time, Medicare protects individuals and families from the financial stress that many would otherwise face if they were required to pay with personal resources for some or all of the expensive services that Medicare covers.

### ***b) Variance of Scope of Medicare Among the Provinces***

Even though Medicare has a clear national dimension, the scope of Medicare varies among the provinces and territories. Provinces and territories differ as to how they apply the key concepts of "medical necessity" (in relation to hospital services) and "medically required" (in relation to physician services). This means that Medicare encompasses more (or fewer) health services in some provinces and territories than in others. Physician and hospital services that are excluded from Medicare are generally services that Canadians pay for out-of-pocket or with private health insurance, typically associated with employment.

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<sup>5</sup> See Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2012" (2012), online: <[www.ciha.ca](http://www.ciha.ca)>.

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In addition, for the physician and hospital services that are treated as an insured service within Medicare in all or most provinces and territories, the service may for practical reasons be more readily available in some than in others. For example, one province may be able for fiscal capacity or other reasons to make certain services more available to its residents than another province can. For similar kinds of practical reasons, there is also variation in access to insured services within provinces, including between people who live in rural and urban communities.

While these variations in what Medicare includes and in how it operates do exist, it is important to keep them in the perspective of the bigger picture, which is that Medicare makes most of the services provided by doctors and hospitals available to most Canadians without personal expense.

There is more extensive variation among provinces and territories on their funding of health services not included in Medicare. These services include home care, long-term care, most of dental care, various kinds of therapy provided by care providers other than doctors, and prescription drugs, except when they are provided in hospital.

Provinces and territories fund these services to varying degrees or not at all, depending on their health policy priorities and fiscal capacity. The funding that is provided is often subject to cost-sharing (through deductibles, co-pays or user fees) that is inapplicable to services funded within Medicare. In many cases, funding or the amount of funding that is provided for these services depends on whether the patient or user of the service is a child, senior citizen or has a low income. The *Canada Health Act* has no applicability to the decisions which provinces make about public funding for the services not included in Medicare.<sup>6</sup>

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<sup>6</sup> Some of these services are what the *Canada Health Act* calls “extended health care services”, which are defined to mean nursing home intermediate care service, adult residential care service, home care service and ambulatory health care service: *CHA*, *supra* note 1, s 2. The requirement that the provinces and territories provide information to the federal Minister of Health and that they give recognition to the Canada Health Transfer in public documents and advertising or promotional material applies to extended health care services, but the Five Criteria and the requirement to prevent extra-billing and user charges do not.

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## 2. The Legislative Framework of Medicare

### a) *The Canada Health Act*

#### i) *What Does the Canada Health Act Do?*

The subject matter of the *Canada Health Act*<sup>7</sup> is the federal government's annual distribution of the cash portion of the Canada Health Transfer (the "CHT") to the provinces and territories.<sup>8</sup>

The CHT is the federal contribution to provincial and territorial spending on health care. It consists of tax points (i.e. taxing room) that the federal government permanently transferred to the provinces in the 1970s and a cash portion that is distributed among the provinces and territories on an annual basis according to a formula established by the federal government, with or without discussions with the provinces and territories. The total amount of funding distributed each year is also determined by the federal government, again, with or without discussions with the provinces and territories. These decisions about the size of the CHT and the formula for its distribution are not made under the *Canada Health Act* but through federal budgetary legislation.

What the *Canada Health Act* does do is establish the criteria and conditions that each province must satisfy in order to receive their full share of the CHT available under federal budgetary legislation.<sup>9</sup> At a high level, the Act specifies the circumstances in which the federal government must pay a province or a territory its full share of the CHT; the circumstances in which it has the discretion to reduce or withhold the cash portion of the CHT otherwise payable to a province or territory; and the circumstances in which it must apply deductions to the share of the cash portion of the CHT otherwise payable to a province or territory.<sup>10</sup>

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<sup>7</sup> *CHA*, *supra* note 1.

<sup>8</sup> Although the *Canada Health Act* only refers to the provinces, it is administered by the federal government as also applicable to the territories.

<sup>9</sup> *Ibid.*, ss 7-13.

<sup>10</sup> *Ibid.*

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***ii) Provincial & Territorial Entitlement to the CHT & Authority to Reduce the Transfer***

Under the *Canada Health Act*, a province or territory is entitled to its full share of the CHT when it has:

- a) established and maintained a “health care insurance plan” that satisfies the Five Criteria of public administration, comprehensiveness, universality, portability, and accessibility;<sup>11</sup>
- b) provided the Minister of Health with information as prescribed by Regulation on its compliance with the Act, including the Five Criteria, and given recognition to the CHT in public documents and advertising and promotional material;<sup>12</sup> and
- c) not permitted extra-billing by physicians (or by dentists providing covered surgical-dental services) or user charges (generally called user fees in the literature) under its health-care insurance plan.<sup>13</sup>

The *Canada Health Act* gives the federal government discretionary authority to reduce or to withhold the CHT payment that otherwise would be payable to a province or territory where it determines that the health-care insurance plan of the province or territory does not meet one or more of the Five Criteria. The federal government is also entitled to exercise this discretion upon failure of the province or territory either to provide the Minister of Health with the information prescribed by Regulation or to give recognition to the CHT in public documents or advertising or promotional material.<sup>14</sup>

This authority to reduce or withhold the CHT is conferred on the Governor in Council and can only be exercised after the Minister of Health has consulted with the provinces or territories in question.<sup>15</sup>

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<sup>11</sup> *Ibid*, s 7.

<sup>12</sup> *Ibid*, s 13.

<sup>13</sup> *Ibid*, ss 18 & 19.

<sup>14</sup> *Ibid*, ss 14-17.

<sup>15</sup> *Ibid*. Since April of 2002, interpretation and administration of the *Canada Health Act* is also subject to a Dispute Avoidance and Resolution Process which was agreed to between the federal government and all provinces and territories except Quebec, as set out in a letter from then-federal Minister of Health Anne McLellan to her provincial and territorial counterparts. The letter is an annex to the annual report that Health Canada issues on the *Canada Health Act*: see Health Canada, *Canada Health Act Annual Report 2010-2011*, (Ottawa, Health

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The authority has never been used to reduce or withhold the transfers otherwise payable to a province or territory.<sup>16</sup>

***iii) Extra Billing, User Fees & Impact on Canada Health Transfer***

Should a province or territory permit patients to be extra-billed (by physicians or by dentists providing covered dental-surgical services) or to be charged user charges for insured services, the *Canada Health Act* requires the total of the amounts charged to patients to be deducted from the CHT contribution otherwise payable.<sup>17</sup> Deductions under these provisions have been applied to the federal contribution paid to various provinces on a number of occasions.<sup>18</sup>

Extra-billing means charging a fee in addition to the compensation for providing a service that the physician recovers from the health care insurance plan.<sup>19</sup> User charges are any other fee charged to a patient that is not recoverable from the applicable provincial or territorial health care insurance plan.<sup>20</sup>

It has been stated that the prohibition of extra-billing and user fees that the *Canada Health Act* indirectly imposes on physicians and hospitals constitutes the truly unique element of Canada's approach to the public funding of essential health services.<sup>21</sup> Other countries publicly fund general access to the physician and hospital services that are encompassed by the *Canada Health Act*. But none go as far as Canada does in trying to make public funding the sole and exclusive source of funding for these services by "banning" extra-billing and user fees in the provision of these services.

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Canada, 2012) [*CHA Report*].

<sup>16</sup> *Ibid* at 6.

<sup>17</sup> *CHA*, *supra* note 1, ss 18, 19 & 20.

<sup>18</sup> *CHA*, Report, *supra* note 15 at 10-2.

<sup>19</sup> *CHA*, *supra* note 1, s 2.

<sup>20</sup> *Ibid*.

<sup>21</sup> Colleen M Flood, "The Anatomy of Medicare" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 2d ed (Markham, ON: Butterworth's, 2002) at 27.

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***iv) What Provinces and Territories Must Do to Satisfy the Canada Health Act***

Leaving aside the annual reporting and recognition requirements, it follows from the above summary of the *Canada Health Act* that the eligibility of a province or territory for its full share of the cash portion of the CHT comes down to two questions:

- a) does it maintain a “health care insurance plan” that meets the Five Criteria?, and
- b) does it prevent extra-billing and the charging of user fees in respect of the services that are insured under that plan?

Taken together, the Five Criteria require each province and territory to establish a publicly managed single-payer system of health care funding under which the provincial or territorial government – or an agency that is accountable to it – pays the full cost of universal access to a comprehensive range of medical and hospital services.

The criteria that are most directly related to the question of access to services and the objective of equality of access are public administration, comprehensiveness, universality, and accessibility. Portability is also important to access and increasingly so in a highly mobile society, but primarily as an adjunct to the access that is guaranteed by the other four criteria.

The following discussion will therefore focus primarily on public administration, comprehensiveness, universality, and accessibility, while touching more briefly on portability.

***A) Criterion #1: Public Administration***

The criterion of public administration is fundamental to the single-payer model of health care insurance that is envisaged by the *Canada Health Act*. It requires the health care insurance plan of provinces and territories to be administered and operated on a non-profit basis by a public authority that is appointed or designated by, and is responsible to, the government of the province or territory.<sup>22</sup> In

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<sup>22</sup> *CHA*, *supra* note 1, s 8.

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most jurisdictions, including Alberta, the designated authority is the minister of health, i.e., Alberta's Minister of Health.

The requirement for public administration ensures political accountability for administration and operation of health care insurance plans. More to the point, it requires the provinces and territories to be accountable for establishing and maintaining plans that directly fund medical and hospital services instead of plans that subsidize the purchase of private insurance, which could be insurance on differential terms reflecting factors such as age, gender, occupation and health status.<sup>23</sup> In this respect, the public administration criterion works with the universality and the accessibility criteria, both of which require insurance to be provided on "uniform terms and conditions".<sup>24</sup>

In conjunction with the requirement of universal coverage under the universality criteria, the public administration criterion ensures that each health care insurance plan functions as a centralized payer for all of the services that the plan is required to include under the criteria of comprehensiveness. This avoids the cost of multiple administrative structures and was intended to contribute to cost control by giving governments, as single-payers, greater bargaining power with providers. It also ensures that everyone in a province or territory, with certain limited exceptions, depends on the same third-party funder to pay for most of the physician and hospital services they require.

There is a limit to how far the *Canada Health Act* goes in requiring the provinces and territories to insure their residents for medical and hospital services through a single publicly administered plan. The *Canada Health Act* does not require prohibition of private insurance that covers services included in the public plan. Six provinces, including Alberta,<sup>25</sup> have nevertheless prohibited such insurance, presumably to ensure that public health care insurance plans

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<sup>23</sup> Odette Madore, *Current Issue Review – The Canada Health Act: Overview and Options* (Ottawa: Library of Parliament – Parliamentary Information and Research Service, 2005) at 6 [Madore].

<sup>24</sup> *CHA*, *supra* note 1, ss 10 & 12.

<sup>25</sup> *Alberta Health Care Insurance Act*, RSA 2000, c A-20, s 26(2) [*A-HCIA*]; and *Hospitals Act*, RSA 2000, c H-12, s 44 [*HA*].

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are truly the single and exclusive payer for the services they encompass.<sup>26</sup>

### ***B) Criterion #2: Comprehensiveness***

Comprehensiveness requires the health care insurance plan of a province or territory to insure “all insured health services rendered by hospitals, medical practitioners or dentists”.<sup>27</sup>

The *Canada Health Act* defines “insured health services” as “hospital services, physician services and surgical-dental services provided to insured persons”.<sup>28</sup> Each of these terms is in turn defined.

For services provided by hospitals and physicians, the net effect of the definitions can be summarized as follows: comprehensiveness requires a health-care insurance plan to insure all the services provided by hospitals that are “medically necessary” and all services provided by physicians that are “medically required” when they are provided (with some exceptions) to persons lawfully in Canada who are residents of the province or territory.

In summary then, the meaning of comprehensiveness depends on the meaning of “insured health services” and of “insured persons”. Each of these key phrases will be discussed separately, keeping in mind that comprehensiveness depends on their combined effect.

### ***I. Definition of “Insured Health Services”***

Given that the services that hospitals and physicians provide are generally those that are medically necessary or required, the general intent of the *Canada Health Act* is clear: it is to require health care

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<sup>26</sup> Colleen M Flood & Tom Archibald, “The illegality of private health care in Canada” (2001) 164:4 CMAJ 825 at 825, 828-829 [Flood & Archibald]. The Quebec version of this prohibition was found to be contrary to the *Quebec Charter of Human Rights and Freedoms* by the Supreme Court of Canada where the public system was found by the Court to be failing to provide the level of access to services that was required by the *Charter’s* right to personal inviolability (equivalent to the right to security of the person under the *Canadian Charter of Rights and Freedoms*): *Chaoulli v Quebec (Attorney General)*, [2005] 1 SCR 791. Quebec has subsequently reinstated the prohibition while excluding certain insured services from its scope and stipulating that private insurance, where it is permitted, must cover not only the cost of the insured service but also of preoperative, postoperative, rehabilitative and home care support services; *Health Insurance Act*, RSQ, c A-29, s 15.

<sup>27</sup> *CHA*, *supra* note 1, s 9.

<sup>28</sup> *Ibid*, s 2.

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insurance plans to fund most of the services provided by hospitals and physicians as “insured health services”. The criterion is, after all, the criterion of *comprehensiveness*.

It is critical to note however that the *Canada Health Act* does not define the operative concepts of “medically necessary” or “medically required”.

This omission provides latitude for the health care insurance plan(s) of each province and territory to determine the boundary between hospital and physician services that are deemed to be or not to be medically necessary or required.

This latitude can result in delays in funding for new services or new ways of providing services as medical technology evolves. It can be used to refuse to fund services that have been characterized as “emergent services”.<sup>29</sup> It has been used to “de-list” procedures which were at one time funded as medically necessary.<sup>30</sup> It has been used to refuse to fund services that are deemed to be purely aesthetic or associated with lifestyle choices or a desire for an enhancement of some area of physical functioning, such as fertility.<sup>31</sup> It can also be used to refuse to fund treatment options that are regarded as in excess of what is truly needed by the patient to address their condition. For example, where a patient needs a hip replacement it will be clear that an artificial hip is medically necessary, but it may not be clear that he or she needs the most expensive artificial hip on the market.

#### **a) *Workers’ Compensation Benefits and “Insured Health Services”***

The definition of “insured health services” excludes health services that a person is entitled to receive under federal or provincial

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<sup>29</sup> *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, [2004] 3 SCR 657.

<sup>30</sup> A dated but indicative table of the kinds of services that have been “de-insured”, mostly in the 1990s, can be found in Odette Madore, *supra* note 23 at 15. The services that have been de-listed in one or more provinces include minor procedures, such as wart or ear wax removal, and more significant procedures such as treatments for infertility. See M Giacomi, J Hurley & G Stoddart, “The many meanings of deinsuring a health service: the case of in vitro fertilization in Ontario” (2000) 50 *Social Science & Medicine* 1485-1500.

<sup>31</sup> *Cameron v Nova Scotia Attorney General* (1999), 177 DLR 611 (NSCA).

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workers' compensation legislation.<sup>32</sup> This is a carry-over from the predecessor legislation to the *Canada Health Act*.<sup>33</sup> The rationale for this exclusion was that people who needed medical care to address workplace injuries or illness would not need public health care insurance because they already would have access to the care they needed through the medical benefits they would be entitled to receive under workers' compensation legislation.

The exclusion of workers' compensation services means that compliance with the *Canada Health Act* is not jeopardized if injured workers receive access to medical or hospital services that would, but for the exclusion, fall under the definition of insured health services on terms and conditions that are different from those that determine the access to the same services under the health care insurance plan of a province or territory. This has become controversial because of the concern of some that workers' compensation boards are purchasing faster access for injured workers to services such as orthopedic surgery that other Canadians receive through Medicare by waiting their turn.

In 2002, Commissioner Romanow characterized the exclusion of services provided to injured workers as one of the "grey areas around the issue of private for-profit delivery" and expressed agreement with those who thought this should "be redressed in a modernized *Canada Health Act*".<sup>34</sup>

### ***b) Diagnostic Services and "Insured Health Services"***

Medicare was intended to include diagnostic procedures: the hospital services portion of Medicare was originally established under the *Hospital Insurance and Diagnostic Services Act*.<sup>35</sup>

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<sup>32</sup> *CHA*, *supra* note 1, s 2.

<sup>33</sup> *Hospital Insurance and Diagnostic Services Act*, SC 1957, c 28, s 2(g) [*HIDSA*]; and the *Medical Care Act*, SC, 1966, s 2(e).

<sup>34</sup> Commission on the Future of Health Care in Canada, Roy J Romanow, Commissioner, *Building on Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 7-8 & 64-65 [*Romanow Report*].

<sup>35</sup> *HIDSA*, *supra* note 33.

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Under the *Canada Health Act*, the definition of insured health services includes “hospital services” and diagnostic procedures are among the services listed under the definition of “hospital services”.<sup>36</sup> But like all other services on that list, diagnostic procedures are considered a hospital service if they are provided to a hospital patient.

The definition of insured health services also includes physician services, which are defined simply to include “any medically required services rendered by medical practitioners”.

There is no express mention of diagnostic services, or of other kinds of hospital services, in the definition of insured health service.

After the adoption of the *Canada Health Act* in 1984, developments in medical technology allowed diagnostic procedures as well as a range of surgical procedures to be delivered outside of hospitals, specifically in private clinics. The absence of a specific reference to diagnostic procedures in the definition of insured health services resulted in divergent views as to whether diagnostic procedures provided in a private clinic were outside of the *Canada Health Act*. A similar divergence of views can exist with respect to certain surgical services, but there has been a particular focus on the question of how the *Canada Health Act* applies to diagnostic procedures.

Health Canada has taken to view that those diagnostic procedures that are delivered as insured services must be treated as insured services for all purposes, whether they are delivered in a hospital or a clinic. This was clarified in 1995 when then-federal Health Minister Diane Marleau wrote to provincial and territorial ministers of health to advise that she would make deductions from the health transfers of jurisdictions that allowed private clinics that were funded to provide insured services to charge “facility fees” (i.e. “user charges”) to the patients who received those services (“the Marleau Letter”).<sup>37</sup> At the time of the Marleau Letter diagnostic services paid for by the health care insurance plans of several provinces were among the services for which private clinics were charging facility fees.

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<sup>36</sup> *CHA*, *supra* note 1, s 2.

<sup>37</sup> *CHA Report*, *supra* note 15 at Annex B, 171-173.

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Health Canada subsequently proceeded to make deductions from federal transfers until it was satisfied that the provinces in question had acted to eliminate the offending facility fees. The Marleau Letter continues to be cited by Health Canada as a policy statement that reflects the federal position on the *Canada Health Act*.<sup>38</sup>

The Marleau Letter did not deal with diagnostic procedures purchased by or on behalf of patients outside of Medicare. This can happen in two situations. In the first situation, the procedure is not thought to be strictly necessary from a medical point of view but the patient wants and is willing to pay for it nevertheless. This is a scenario that is more likely with some kinds of diagnostic procedures than it will be with other kinds of medical procedures. In the second situation, the procedure is medically necessary and therefore available through the public system, but the patient is prepared and able to pay for it personally, usually to get it faster than he or she can get it in the public system. In that situation, the argument for regarding the service as being outside of the *Canada Health Act* is that the patient is paying to have the service more quickly than the public system, given factors such as prevailing waiting lists and clinical prioritization decisions, deems it to be medically necessary.

Where the service is provided on the basis that it is being provided before it has become medically necessary, a question arises as to whether access to a necessary diagnostic procedure is being determined by differences in the personal ability to pay for it. In both situations, there is a concern that privately funded access to a diagnostic procedure can result in preferential access in the public system to the treatments that the diagnostic procedure may reveal are indicated.

These concerns were raised by Health Canada with various provinces between 2000 and 2005.<sup>39</sup> In 2002, they led Commissioner Romanow to make two recommendations: amendment of the *Canada Health Act* to explicitly include diagnostic services in the definition of insured health services; and a significant investment in the capacity

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<sup>38</sup> *Ibid* at 7.

<sup>39</sup> Madore, *supra* note 23 at 8-11.

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of the public system to provide timely diagnostic procedures.<sup>40</sup> The recommended change to the Act has not been made.

## ***II. Definition of “Insured Persons”***

Comprehensiveness requires a health-care insurance plan to insure medically necessary (or required) services when they are provided to a person who is an “insured person”.<sup>41</sup>

### ***a) Residents of a Province***

Subject to important exceptions discussed below, the *Canada Health Act* defines an insured person as “a resident of the province”.<sup>42</sup>

The *Canada Health Act* goes on to define “resident” as a person “lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province”.<sup>43</sup> The limitation of the definition to persons “lawfully entitled to be or to remain in Canada” means, for example, that provinces and territories can insure those waiting for a determination of their refugee claim, but are not obliged to do so.

### ***b) Excluded Persons: Members of Canadian Forces, Federal Inmates, Non-Residents***

The definition of “insured person” expressly excludes members of the Canadian Forces, federal inmates and persons who have not completed the waiting period of three months or less that the province or territory may require before allowing a person who moves to the province or territory to become an insured person.<sup>44</sup>

Until recently, members of the RCMP were also excluded, but this exclusion was recently removed from the Act.<sup>45</sup> The result presumably is that members of the RCMP will now be insured persons under the health-care insurance plan of the province or territory in which they are a resident.

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<sup>40</sup> *Romanow Report*, *supra* note 34 at 6-9, 59-60, 64-65 & 71-72.

<sup>41</sup> *CHA*, *supra* note 1, ss 9 & 2.

<sup>42</sup> *Ibid*, s 2.

<sup>43</sup> *Ibid*.

<sup>44</sup> *Ibid*.

<sup>45</sup> SC 2012, c 19, s 377.

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The rationale for the exclusion of members of the Canadian Forces and federal inmates (and until recently, RCMP members) is that they are provided health care by or at the expense of the federal government. Their exclusion from Medicare is therefore based on a similar rationale as the exclusion of services provided through workers' compensation benefits.

The situation of people moving from one province to another will be similar. These people will generally be insured persons under the health care insurance plan of their province or territory of origin during the period of three months or less that their new province or territory requires them to wait before enrolling them in its health-care insurance plan.

Here, the comprehensiveness criterion works with the portability criterion.<sup>46</sup> In general terms, the latter says that provincial and territorial health-care insurance plans must not impose minimum residency requirements in excess of three months. It also says that plans must provide for the payment of the cost of insured health services provided to their residents by another province or territory when their residents are visitors to the other province or territory or have moved to another province or territory and receive insured health services during the minimum residency requirement of that province or territory.<sup>47</sup>

The exclusion of certain categories of persons from the definition of insured person means that the level and terms of access to medical and hospital services that is provided to these persons is irrelevant to provincial or territorial compliance with the *Canada Health Act*.

It also means that the eligibility of a province or territory for funding under the *Canada Health Act* is not jeopardized if physicians or hospitals directly charge persons in these limited categories for medically necessary hospital or physician services. Practically speaking, these charges will be paid by the federal government in the case of members of the Canadian Forces and federal inmates. They may or may not be paid by a third-party payer in the case of new arrivals to Canada or in the case of visitors if the visitor is from outside

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<sup>46</sup> *CHA*, *supra* note 1, s 11.

<sup>47</sup> *Ibid*, s 11(2).

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Canada or is from within Canada seeking elective insured health services that they could have received in their home province.<sup>48</sup>

***c) First Nation and Inuit Canadians are not Excluded***

Finally, because the federal government is heavily involved in funding or in funding and providing certain health-care services to First Nation and Inuit Canadians, it should be noted that these Canadians are not excluded from the definition of insured person under the *Canada Health Act*.<sup>49</sup>

The contrary impression may be created by the range of health-care services that the federal government funds or funds and provides for these Canadians, which includes primary care and emergency services in remote and isolated communities; community-based public health and health promotion programs on First Nation reserves and in Inuit communities; and a non-insured health benefits program that covers spending on dental, drug and vision care. However, the reality is that First Nation and Inuit Canadians are residents of their provinces or territories who are not excluded from the definition of insured person found in the *Canada Health Act*. As such, they are persons who must be insured by the health care insurance plans of their provinces or territories of residence.

***C) Criterion #3: Universality***

To satisfy the universality criterion, the health care insurance plan of a province or territory “must entitle one hundred per cent of the insured persons of the province (or territory) to the insured health services provided for by the plan on uniform terms and conditions”.<sup>50</sup> “Insured person” has the same meaning under universality as under comprehensiveness: every resident of the

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<sup>48</sup> Subsection 11(2) of the *Canada Health Act* says that the portability criterion is not contravened where a province or territory makes payment for the cost of an elective service received in another province or territorial conditional on its prior consent to the provision of the service in the other province or territory where the service is available on substantially similar terms in the province or territory.

<sup>49</sup> *Ibid*, s 2.

<sup>50</sup> *Ibid*, s 10.

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province or territory who does not fall into one of the limited categories of exclusion.<sup>51</sup>

The universality criterion does two things: it says that all of the people within the definition of “insured person” must be insured and it says that they must all be insured “on uniform terms and conditions”.<sup>52</sup> The requirement of coverage on “uniform terms and conditions” means that different premiums or different eligibility requirements cannot be imposed to reflect differences in factors such as age, gender, occupation, or health status.

The rationale of the universality criterion is to ensure general equality of access, to the extent that it depends on ability to pay, to the services that a health-care plan is required to fund in order to satisfy the comprehensiveness criteria. The standard of equal access implied is, however, a provincial or territorial one and not a national one: the requirement is entitlement on uniform terms and conditions among “one hundred percent of the insured persons *of the province (or territory)*”.<sup>53</sup>

The universality criterion, like all the others, applies to the health-care insurance plan of a province and not to its health-care system. Accordingly, what it requires is entitlement on uniform terms and conditions insofar as this can be accomplished by a single-payer system of health-care insurance that is operated by or on behalf of the government of each province or territory.

#### ***D) Criterion #4: Accessibility***

The accessibility criterion has a number of distinct elements relating to the processes and mechanisms that health care insurance plans must follow to compensate physicians and fund hospitals.

For example, it requires provinces and territories to pay “reasonable compensation” to physicians and dentists and says that this requirement is deemed to be complied with where the province (or territory) and its physicians and dentists (through their representative organizations) have agreed to negotiate compensation for provision of insured

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<sup>51</sup> *Ibid*, s 2.

<sup>52</sup> *Ibid*, s 10.

<sup>53</sup> *Ibid*.

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services and to settle compensation disputes through conciliation or binding arbitration.<sup>54</sup>

The more general requirement under the accessibility criterion is that the health care insurance plan of a province or territory “must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges or otherwise, reasonable access to those services by insured persons”.<sup>55</sup>

Accessibility thus comes into play where universality leaves off: it repeats the requirement for uniform terms and conditions of access but adds that the access must also be “reasonable”.

What reasonableness means in this context is not defined. Given, however, that medical necessity is the basis on which a service becomes a service that must be insured, it would seem that the reasonableness of access to those services would also depend on what is medically necessary. Guidance might also be taken from section 3 of the *Canada Health Act*, which states that “the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada”.<sup>56</sup>

It should also be recognized that the accessibility criterion is not the only part of the *Canada Health Act* that addresses accessibility. The Act as a whole is about accessibility to medically necessary (or required) medical and hospital services. In many ways, the most rigorous “accessibility” feature of the *Canada Health Act* is not the criterion itself but the requirement under section 18 that provinces and territories not allow extra-billing and under section 19 that they not allow user charges.

The accessibility criterion is written in general terms to potentially reference whatever impedes or precludes reasonable access to insured services, “either directly or indirectly whether by charges or otherwise”.<sup>57</sup> But, like the Five Criteria in general, accessibility is a criterion that must be satisfied by the health care insurance plan of

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<sup>54</sup> *Ibid*, s 12(2).

<sup>55</sup> *Ibid*, s 12(1)(a).

<sup>56</sup> *Ibid*, s 3.

<sup>57</sup> *Ibid*, s 12(1)(a).

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a province or territory, not by health care delivery within the province or territory.

### ***v) Public Financing, Public and Private Delivery***

The *Canada Health Act* deals with the question of how the provision of hospital and physician (and some dental) services is funded rather than with the question of how these services are delivered. Therefore, it can be said that compliance with the Act requires public financing of the services it encompasses but not public delivery of those services.<sup>58</sup>

From time to time, the administration of the *Canada Health Act* has suggested that the federal government regards the accessibility criteria (and the comprehensiveness criteria) as potentially extending into general health care system design and administration, particularly in relation to the role of private clinics. But the more general federal pattern has been to focus on the design and functioning of provincial health care insurance plans. This focus aligns with the interpretive approach outlined in a letter sent to provincial and territorial health ministers in 1985 by then-federal Health Minister Jake Epp, which is still cited as applicable to the interpretation of the *Canada Health Act* by Health Canada.<sup>59</sup>

## **3. Alberta Legislation**

### ***a) The Alberta Health Care Insurance Act and the Hospitals Act***

The Alberta version of the health care insurance plan that is required by the *Canada Health Act* is partly established under the *Alberta Health Care Insurance Act*<sup>60</sup> (the “A-HCIA”) and partly established under the *Alberta Hospitals Act*.<sup>61</sup>

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<sup>58</sup> William Lahey, “Medicare and the Law: Contours of an Evolving Relationship” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: Lexis Nexis, 2011).

<sup>59</sup> CHA Report, *supra* note 15 at Annex B, 165-170.

<sup>60</sup> A-HCIA, *supra* note 25. See Appendix A for a full list of relevant sections of the *Alberta Health Care Insurance Act* discussed in this report.

<sup>61</sup> HA, *supra* note 25. See Appendix A for a full list of relevant sections of the *Hospital Act* discussed in this report.

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The *A-HCIA* implements the single-payer system with respect to physician services and dental-surgical services, while the *Hospitals Act* does so in respect of hospital services. Both statutes have to be read in conjunction with the *Health Care Protection Act*,<sup>62</sup> which deals with the funding and delivery of insured and uninsured surgical services and with the role in the provision of these services of private surgical facilities.

The *A-HCIA* establishes the Alberta Health Care Insurance Plan.<sup>63</sup> It stipulates that the Minister who is determined under the *Government Organization Act*<sup>64</sup> to be the Minister responsible for the Act is the public authority responsible for the administration and operation of the Plan.<sup>65</sup> This Minister is the Minister of Alberta Health and Wellness. The Minister is required by the *A-HCIA* to operate the Plan on a non-profit basis.<sup>66</sup>

The *Hospitals Act*<sup>67</sup> establishes the Hospitalization Benefits Plan. This Plan is administered by the Minister responsible for the *Hospitals Act*, which under regulations made under the *Government Organization Act*<sup>68</sup> is again the Minister of Alberta Health and Wellness.

Taken together, these provisions of the *A-HCIA* and of the *Hospitals Act* address the public administration criterion for medical and hospital services.

Both Plans apply to residents of Alberta. “Resident of Alberta” is defined in both the *A-HCIA* and in the *Hospitals Act* as it is in the *Canada Health Act*: a person “entitled by law to reside in Canada who makes the person’s home and is ordinarily present in Alberta, but does not include a tourist, transient or visitor to Alberta”.<sup>69</sup> Under both

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<sup>62</sup> *Health Care Protection Act*, RSA 2000, c H-1 [A-HCPA]. See Appendix A for a full list of relevant sections of the *Health Care Protection Act* discussed in this report.

<sup>63</sup> *A-HCIA*, *supra* note 25, s 3(1).

<sup>64</sup> *Ibid*, s 1(o). *Government Organization Act*, RSA 2000, c G-10 [GOA]. *Designation and Transfer of Responsibility Regulation*, AR 80/2012, s 9 [DTRR].

<sup>65</sup> *A-HCIA*, *supra* note 25, s 3(3).

<sup>66</sup> *Ibid*, s 3(1).

<sup>67</sup> *HA*, *supra* note 25 at Part 3, ss 36-47.

<sup>68</sup> *GOA* and *DTRR*, *supra* note 64.

<sup>69</sup> *A-HCIA*, *supra* note 25, s 1(x); and *HA*, *supra* note 25, s 1(p). The applicability of the Plan established by the *A-HCIA* to residents of Alberta (as defined) is found in sections 3 and 4 of the Act. The applicability of the Plan established

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Acts, a resident is not entitled to benefits if they have not completed the waiting period prescribed by regulations.<sup>70</sup>

Under the *A-HCIA*, a resident is also not entitled to receive benefits if they are a member of the Canadian Forces, a member of the RCMP, or a federal inmate.<sup>71</sup> It would appear that the same exclusions apply under the *Hospitals Act*, either under an Agreement that was made between Alberta and Canada in 1980 that is referenced in the Act and/or under sub-section 4(2) of the *Hospitalization Benefits Regulation*, which says, in effect, that services a resident is entitled to receive under “any statute of the Parliament of Canada” are not insured services.<sup>72</sup> The exclusion of members of the RCMP will presumably be revoked to reflect the recent amendment to the *Canada Health Act*, mentioned above, which repeals the exclusion of members of the RCMP from the definition of insured person.

The scope of the services included in the Alberta Health Care Insurance Plan under the *A-HCIA* is broader than the physician and dental-surgical services that are encompassed by the *Canada Health Act*. The function of the Plan is to “provide benefits for basic health services to all residents of Alberta”.<sup>73</sup> “Basic health services” are then defined to include “insured services” and dental surgical services as specified in the regulations, plus optometric services, chiropractic services, podiatrist services, and “services classified as basic services by the regulations”.<sup>74</sup>

Insured services are, in turn, defined to mean “all services provided by physicians that are medically required”, dental surgical services that are specified in the regulations, and “other services that are declared by regulation to be insured services”.<sup>75</sup> As contemplated in the *Canada Health Act*, the definition excludes services that a person is entitled to receive under workers’ compensation legislation.<sup>76</sup>

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by the *HA* to residents of Alberta (as defined) is set out in section 38 of the *HA*.

<sup>70</sup> *A-HCIA*, *supra* note 25, ss 4(3)(d) & 16(e); and *HA*, *supra* note 25, s 43(g).

<sup>71</sup> *A-HCIA*, *supra* note 25, s 4(3).

<sup>72</sup> *HA*, *supra* note 25, s 38(1)(c). *Hospitalization Benefits Regulation*, AR 244/1990 at s 4(2) [HBR].

<sup>73</sup> *A-HCIA*, *supra* note 25, s 3(1).

<sup>74</sup> *Ibid*, s 1(b).

<sup>75</sup> *Ibid*, s 1(n).

<sup>76</sup> *CHA*, *supra* note 1, s 2.

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The responsibility of the Minister to pay benefits under the *A-HCIA* is broader than that of the Alberta Health Care Insurance Plan. The Minister is to pay benefits in respect of “health services”, a concept which includes basic services, and thus insured services, but also “optional health services” (to be specified in regulations) and “extended health services”, which are services specified in regulations for people who are or have a partner over 65 or who are in receipt of a widow’s pension.<sup>77</sup> By contrast, the responsibility of the Health Care Insurance Plan is to “provide benefits for basic health services”.

Careful attention must therefore be paid to whether specific provisions of the *A-HCIA* are applicable to:

- a) all health services (which includes all basic services and all insured services);
- b) all basic services (which includes all insured services); or
- c) only to insured services.

For example, the provisions of the Act that prohibit extra-billing and user charges apply only to insured services and not to the other services that are funded as basic services or as health services. In contrast, the exclusion of the Members of the Canadian Forces, federal inmates and persons who have not completed the residency requirement applies to all health services.

What matters from a *Canada Health Act* perspective is whether the Plan satisfies the requirements of the *Canada Health Act* in respect of medically required physician and medically required dental-surgical services that have to be provided in a hospital.

The effect of the *A-HCIA* in placing the physician services that are to be publicly funded on “uniform terms and conditions” into the broader category of “basic health care services” may be to emphasize that the services that are insured in accordance with the *Canada Health Act* are those that are truly necessary. They do not include all services that physicians may safely and ethically be able to offer

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<sup>77</sup> *A-HCIA*, *supra* note 25, s 1(m).

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and that people may desire in addition to those that are strictly necessary.<sup>78</sup>

Under the *Hospitals Act*, insured services are those listed in the list of services found in that Act's definition of "standard ward hospitalization".<sup>79</sup> This list is supplemented by a more specific list of insured hospital services that is found in the *Hospitalization Benefits Regulation*.<sup>80</sup>

The more general list found in the *Hospitals Act* maps closely onto the list of services that are included in the definition of hospital services found in the *Canada Health Act*.<sup>81</sup> The differences again reflect the emphasis that the Alberta legislative framework seems to place on the necessity of the services. For example, while the *Canada Health Act* lists "nursing services", the *Hospitals Act* lists "necessary nursing services".<sup>82</sup> Like the definition of insured services under the *Alberta Health Care Insurance Act*, the *Hospitals Act* definition excludes services that residents of Alberta are entitled to receive under workers' compensation legislation.<sup>83</sup>

Alberta legislation complies with the *Canada Health Act* in prohibiting extra-billing and user fees. Under the *Hospitals Act* and the *Hospitalization Benefits Regulation*, the prohibition of user fees is done by clear implication: every resident of Alberta is entitled to receive insured hospital services. The Regulations then itemize the fees that hospitals can charge without conferring any authority to charge fees for the provision of what are defined as insured services.<sup>84</sup>

Under the *A-HCIA*, physicians and dentists may not, in the provision of insured services, charge or collect from any person (i.e. the patient or a third-party insurer) "an amount in addition to the benefits payable by the Minister for those insured services".<sup>85</sup> The *A-HCIA* also prohibits the charging or collecting "by any person" of an amount as a condition for receiving an insured service or for goods and

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<sup>78</sup> *Ibid*, s 1(b).

<sup>79</sup> *HA*, *supra* note 25, s 36(j).

<sup>80</sup> *HBR*, *supra* note 72, s 4(1).

<sup>81</sup> *CHA*, *supra* note 1, s 1.

<sup>82</sup> *Ibid* and *HA*, *supra* note 25, s 36(j)(ii).

<sup>83</sup> *Ibid*, s 38(1)(b).

<sup>84</sup> *Ibid*, s 37(1); and *HBR*, *supra* note 72, s 4.

<sup>85</sup> *A-HCIA*, *supra* note 25, s 9(1).

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services that are provided as a condition of receiving an insured service.<sup>86</sup>

*i) Opting Out*

Under the *A-HCIA*, the payment of benefits for insured services depends on the physician or dentist who provides the service being “opted in” to the Plan.<sup>87</sup> No physician or dentist and no resident may receive the payment of benefits under the Plan in respect of insured services unless the physician or dentist was opted in to the Plan when the services were provided.<sup>88</sup> The prohibition on extra-billing only applies to physicians or dentists who are “opted in” to the Alberta Health Care Insurance Plan.

Members of both professions are deemed by the Act to have “opted in” but the legislation provides procedures by which they can opt out and directly charge patients for the provision of services that they would otherwise be compensated to provide by the Plan.<sup>89</sup>

The opting out process operates at the level of the Plan as a whole, not at the level of specific insured services or persons or at the level of categories of insured services or persons. The result is that where a physician or dentist “opts out”, the dentist or physician forgoes all opportunity to provide services for remuneration under the Plan and their patients forgo the opportunity to receive benefits under the Plan for any services received.

To ensure clarity on this point between providers and their patients, the *A-HCIA* says that where the patient of an opted out physician or dentist is entitled to receive benefits under the Plan, the physician or dentist must tell the patient before they provide the service that they have opted out and that this will mean that the patient will not be eligible to receive those benefits.<sup>90</sup>

The only exception is where an insured service is provided by an opted out physician or dentist on an emergency basis.

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<sup>86</sup> *Ibid*, s 11(a) & (b).

<sup>87</sup> *Ibid*, s 6(1).

<sup>88</sup> *Ibid*, s 6(2).

<sup>89</sup> *Ibid*, ss 7(1) & 8(1).

<sup>90</sup> *Ibid*, ss 7(4)(b) & 8(4)(b).

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In light of these provisions, it can be said that under Alberta legislation it is open to Alberta doctors and dentists to make services that are available to all Albertans on uniform terms and conditions through Medicare available on different and possibly preferential terms to Albertans who are able and prepared to pay for services on this basis.

Alberta's legislation also contains provisions that recognize that a person entitled to be an insured person may choose not to participate in Medicare. A provision of the *A-HCIA* reads as follows: "Nothing in this Act or the regulations is to be construed to prevent any resident who does not desire to claim or receive benefits for health services provided to the resident or resident's dependents from assuming the responsibility for the payment of those costs".<sup>91</sup> Similarly, a provision in the *Hospital Act* says, "Nothing in this Part [Part 3, which establishes the Hospitalization Benefits Plan] is to be construed to prevent a person who does not desire to receive insured services as provided pursuant to this Part from assuming the entire responsibility for the payment of the costs of the person's hospital services".<sup>92</sup>

At the same time, it is clear that Alberta's legislation is designed to discourage doctors and dentists from opting out of Medicare. As indicated above, they must opt out on a global basis and thereby forego all remuneration under the Health Care Insurance Plan.

The disincentive for "going private" that the opting out requirement creates for physicians may be reinforced in Alberta (and in other provinces) by the way the opting out procedure is structured. The physician who opts out must place a notice to that effect in a general circulation newspaper.<sup>93</sup>

The disincentive is also reinforced by provisions that seem clearly designed to limit the market available to opted out physicians. For example, as noted earlier, the *A-HCIA*, like the health-care insurance legislation of a number of provinces, contains a provision that prohibits insurers from entering into contracts that provide residents with prepaid basic health services or with indemnification "for all or

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<sup>91</sup> *Ibid*, s (21)(2).

<sup>92</sup> *HA*, *supra* note 25, s 40.

<sup>93</sup> *Ibid*, s 8(3)(b).

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part of the cost of any basic health services or extended health services”.<sup>94</sup> Given the definition of “basic health services”, this prohibition applies to what the *A-HCIA* defines as insured health services.<sup>95</sup>

In these respects, Alberta legislation is consistent with that in place in other provinces. With the exception of Newfoundland and Labrador, all provinces require physicians either to opt in or out of their health care insurance plan and all apply restrictions on opted out physicians that are intended to discourage physicians from making that choice. This legislative consistency has been interpreted at a national level as being designed to permit private purchase of insured medical and hospital services, while discouraging and inhibiting the growth of a private market for those services.<sup>96</sup> This seems to be the effect produced in Alberta: the most recent annual report of Health Canada on the *Canada Health Act* says: “As of March 31, 2011, there were zero opted out physicians in [Alberta]”.<sup>97</sup>

There would seem to be at least two interrelated policy rationales for discouraging opting out by the providers of insured services. The first would be to minimize the extent to which those who have access to insured physician services through Medicare have preferential access to those services outside of Medicare. This rationale aligns with the concern of the *Canada Health Act* and of Alberta legislation with access to medical and hospital services on “uniform terms and conditions”.

The second policy rationale would be to ensure that physician resources are overwhelmingly dedicated to making medical and hospital services available through Medicare on “uniform terms and conditions”. This rationale aligns with the concern of the *Canada Health Act* and of Alberta legislation to ensure that access on uniform terms and conditions is reasonable.

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<sup>94</sup> *Ibid*, s 26(2).

<sup>95</sup> A parallel provision is found in section 44 of the *HA*, *supra* note 25.

<sup>96</sup> Flood & Archibald, *supra* note 26.

<sup>97</sup> *CHA Report*, *supra* note 15 at 96.

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## **b) The Health Care Protection Act**

Alberta's legislative framework includes the *Health Care Protection Act*.<sup>98</sup> This Act establishes a legislative framework for the provision of surgical services that operates in conjunction with the broader legislative frameworks set up by the *A-HCIA* and the *Hospitals Act*.

The preamble to the *Health Care Protection Act* states that, “the Government of Alberta is committed to the principles of universality, comprehensiveness, accessibility, portability and public administration, as described in the *Canada Health Act*”.<sup>99</sup> The preamble also says that “the Government of Alberta is committed to ensuring that no person who is entitled to an insured surgical service be required to pay for that service or be given priority for that service by reason of the payment of money or other valuable consideration”.<sup>100</sup> The *Health Care Protection Act* also contains a number of operational provisions, including a prohibition of queue jumping, that are intended to maintain equality of access in respect of insured surgical services.<sup>101</sup>

The *Health Care Protection Act* applies the distinction between insured services (for which patients cannot be charged) and uninsured services (for which patients can be charged) that is found in the *A-HCIA* to surgical services. It also introduces a new distinction between insured services and “enhanced medical goods or services” which can be purchased by patients with, or independently of, insured services.<sup>102</sup>

The Act also establishes a process for approval of the establishment of non-hospital surgical facilities and for the regulation of their ongoing operation.

In general terms, subject to the limitation that major surgical services can only be provided in public hospitals and to other requirements discussed below, the *Health Care Protection Act* says that insured surgical services, uninsured surgical services and enhanced medical goods or services (along with non-medical goods and services) can be delivered under the same funding rules either in public hospitals or in

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<sup>98</sup> *A-HCPA*, *supra* note 62.

<sup>99</sup> *Ibid* at Preamble.

<sup>100</sup> *Ibid*.

<sup>101</sup> *Ibid*, s 1-4.

<sup>102</sup> *Ibid*, s 5(1) & ss 29(f) & (i).

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surgical facilities (clinics) that are accredited by the College of Physicians and Surgeons of Alberta and designated by the Minister of Health and Wellness.

Overall, the expressed intent of the *Health Care Protection Act* is to ensure that access to insured surgical services in a delivery system that includes private clinics is in accordance with the *Canada Health Act*.

### ***i) How the Health Care Protection Act Works***

The *Health Care Protection Act* provides for the establishment, operation and continuing regulation of private surgical clinics, called surgical facilities. It draws a distinction between such facilities and hospitals by prohibiting the operation of private hospitals in Alberta.

The Act limits the range of surgical services that can be provided in surgical facilities by saying that no major surgical service may be provided except in a public hospital and by defining “surgical facility” to mean “a facility whose primary function is to provide a limited range of surgical services”.<sup>103</sup> The Act leaves responsibility for determining the services that are major surgical services to the College of Physicians and Surgeons of Alberta, exercising their by-law-making authority under the *Health Professions Act*.<sup>104</sup>

The Act requires all surgical facilities to be approved. It establishes two levels or classes of approved facility: (a) those that are accredited by the College of Physicians and Surgeons (or by the dental facilities accreditation committee in the case of dental surgical facilities), and (b) those that are both accredited by the College and also designated by the Minister of Health and Wellness. The latter are called “designated surgical facilities”.<sup>105</sup>

Only surgical facilities that are “designated” can provide insured surgical services. Insured surgical services are defined as surgical

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<sup>103</sup> *Ibid*, s 5(1) & ss 29(f) & (i).

<sup>104</sup> *Health Professions Act*, RSA 2000 c H-7 at Schedule 21; *Health Care Protection Regulations*, AR 208/2000, ss 2 & 3. See also the College of Physicians and Surgeons of Alberta, *By-Law: Addendum No. 1-12* (Edmonton: 1 January 2012) at section 36.

<sup>105</sup> *A-HCPA*, *supra* note 62, s 29(e).

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services provided in “circumstances under which a benefit is payable” under the *A-HCIA*.<sup>106</sup>

The authority of designated surgical facilities to provide insured surgical services is subject to the limitation that no surgical facility can provide major surgical services. It is also subject to the requirement that the facility has an agreement with a health authority to provide facility services in respect of the provision of insured services on behalf of and for payment from the authority. Such agreements must be approved by the Minister of Health and Wellness. Under the consolidation of regional health authorities that took place in 2008, there is now only one health authority in Alberta – Alberta Health Services.<sup>107</sup>

Designated surgical services can also provide uninsured surgical services. These are defined as services provided in “circumstances under which no benefit is payable under the *Alberta Health Care Insurance Act*”.<sup>108</sup>

Uninsured surgical facilities are sub-divided into two categories: (a) uninsured in-patient surgical services, and (b) uninsured day surgical services.

The basic difference between these two categories of uninsured service is that uninsured in-patient surgical services are those requiring “a medically supervised post-operative period of care exceeding 12 hours” whereas uninsured day surgical services are those that require no or a shorter period of medically supervised

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<sup>106</sup> *Ibid*, s 29(i).

<sup>107</sup> In 2008, Alberta’s Minister of Health and Wellness adopted several Ministerial Orders under the *Regional Health Authorities Act*, RSA 2000, c R-10, that “de-established” all of the previously existing regional health authorities and transferred their responsibilities, assets, contracts, liabilities, and employment relationships to one province-wide health authority that is called Alberta Health Services; see MO #93/2008, online: <<http://www.health.alberta.ca/documents/MO-93-2008-AHSB.pdf>>.

<sup>108</sup> *A-HCPA*, *supra* note 62, s 29(s). Under the *A-HCIA*, the line between insured and uninsured services is drawn in detail in the *Alberta Health Care Insurance Regulation* (which lists services that are not considered to be basic services and therefore cannot be insured services under the *A-HCIA*) and the *Medical Benefits Regulation* (which establishes the benefits payable for insured medical services). Both regulations operate under the governing concept of medical necessity as set out in the *A-HCIA* in accordance with the *Canada Health Act*.

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post-operative care.<sup>109</sup> Surgical facilities that are accredited by the College of Physicians and Surgeons, but not “designated” by the Minister of Health and Wellness, can provide uninsured day surgical services, but not uninsured in-patient surgical services.

Both kinds of surgical facilities (as well as public hospitals) can provide “enhanced medical goods and services”. These are defined as, “medical goods and services that exceed what would normally be used *in a particular case* in accordance with generally accepted medical practices”.<sup>110</sup> These are uninsured services for which patients can be charged. The legislative establishment or recognition of this category of medical services reinforces the implication of the language used in the *Alberta Health Care Insurance Act* – that insured services are *basic* health care services. The other significant aspect of the definition is that the italicized words imply that the decision of what is enhanced and therefore uninsured gets made on a case-by-case basis, largely by treating physicians.<sup>111</sup>

In summary, subject to the overriding rule that major surgical services can only be provided in a public hospital and the approval and other requirements set out in the Act, the system created by the *Health Care Protection Act* can be described as follows:

- Uninsured day surgery can be provided in a public hospital or an approved surgical facility, meaning either a facility that is accredited by the College of Physicians and Surgeons or a designated surgical facility that is both accredited by the College and designated (approved) by the Minister;
- Uninsured in-patient surgical services can be provided in a public hospital or a designated surgical facility;
- Insured surgical services can be provided in a public hospital or in a designated surgical facility if the facility has an agreement to provide such services with Alberta Health Services that has been approved by the Minister of Health and Wellness; and

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<sup>109</sup> *A-HCPA*, *supra* note 62, s 29(s)(ii).

<sup>110</sup> *Ibid*, s 29(f) [emphasis added].

<sup>111</sup> Timothy A Caulfield, Colleen M Flood & Barbara von Tigerstrom, “Comment: Bill 11, *Health Care Protection Act*” (2000) 9:1 Health Law Review 22-27.

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- Enhanced medical goods and services, as well as non-medical goods and services, can be provided in public hospitals and in both kinds of surgical facilities.

#### ***iv) Medicare Protection Provisions in the Health Care Protection Act***

When adopted, the *Health Care Protection Act* gave rise to a number of concerns about its implications for Medicare.<sup>112</sup> For example, there was concern it would encourage the growth of a private clinic sector that would compete with the public sector for medical and other health human resources, thus reducing the capacity of the public sector to provide reasonable access on uniform terms and conditions to a comprehensive range of medical and hospital services. Another concern was that the availability of both insured services and enhanced medical goods and services from designated surgical facilities would result in necessary medical services being distributed as enhanced medical goods and services and, therefore, outside of the *Canada Health Act* and its principle of equal access based on relative need.

The *Health Care Protection Act* contains a number of provisions to guard against these and related concerns. Some of these provisions deal directly with the risk that the Act will operate inconsistently with the *Canada Health Act* and its underlying policy objectives and others address this risk more indirectly.

One of the direct provisions says that the Minister is not to approve an agreement between a health authority and a designated surgical facility for the provision of insured surgical services by the facility unless satisfied of a number of factors. The Minister must, for example, be satisfied that the provision of the insured services by the facility “would be consistent with the *Canada Health Act*”<sup>113</sup> and would not have “an adverse impact on the publicly funded and publicly administered health system in Alberta”.<sup>114</sup>

The Minister must also be satisfied that there is a current and ongoing need for the services to be provided by the facility.<sup>115</sup> In addition, the

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<sup>112</sup> Sujit Choudhry, “Bill 11, the *Canada Health Act* and the Social Union: The Need for Institutions” (2003) 38:1 Osgoode Hall Law Journal 39.

<sup>113</sup> *A-HCPA*, *supra* note 62, s 8(3)(a).

<sup>114</sup> *Ibid*, s 8(3)(c).

<sup>115</sup> *Ibid*, s 8(3)(b).

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Minister must be satisfied that the proposed agreement has made provision for monitoring physician compliance with the *Health Professions Act*, College by-laws, and ethical codes and standards of practice “as they relate to conflict of interest and other ethical issues”.<sup>116</sup>

The *Health Care Protection Act* also contains a number of specific prohibitions that deal directly with behaviours or practices that could result in preferential access to insured surgical services. Specifically, it prohibits:

- queue-jumping by prohibiting anyone (including a public hospital or those working in a public hospital) from accepting money or other valuable consideration, or paying for or accepting payment for an enhanced medical good or service or non-medical goods and services, or providing an uninsured service, for the purpose of giving any person a priority for receipt of an insured surgical service;<sup>117</sup>
- designated surgical facilities providing an insured service from charging the patient an amount for facility services that is additional to the amount that the facility receives for those services under its regional health board agreement;<sup>118</sup>
- surgical facilities (and public hospitals) from charging for enhanced medical goods and services or non-medical goods and services that are provided in connection with the provision of an insured service unless the facility (or the hospital) explains the enhanced or non-medical goods or services and gets the patient’s agreement in writing to accept and to pay for the services;<sup>119</sup> and
- the charging of fees for enhanced medical goods and services greater than the cost of the service plus a reasonable allowance for administration.<sup>120</sup>

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<sup>116</sup> *Ibid*, s 8(3)(g).

<sup>117</sup> *Ibid*, s 3.

<sup>118</sup> *Ibid*, s 4(b).

<sup>119</sup> *Ibid*, s 5(3)(a), (b) & (c). In the case of enhanced medical goods and services, the explanation must cover the reason for the service, the price of the service, and that the service is not part of the medically required service.

<sup>120</sup> *Ibid*, s 5(2).

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The prohibition on queue-jumping is similar to the prohibition on queue jumping found in the general health insurance legislation of at least one other province.<sup>121</sup>

The prohibition on facility fees extends the prohibition on user fees from the public hospital sector to the surgical facilities sector. The “price cap” on enhanced medical goods and services limits the extent of the financial incentive to encourage patients to purchase such services.

More indirectly, the prohibition against the provision of major surgical services in surgical facilities may function as a broader and more structural protection against the concern that the *Health Care Protection Act* could adversely affect access to insured services in the publicly funded system. This prohibition protects public safety. But by limiting the scale of the surgical facilities sector, it may also play a role in limiting the resources that the sector can draw from the public sector. The same comment applies to the definition of a surgical facility as “a facility whose primary function is to provide a limited range of surgical services”.<sup>122</sup> Of course, the impact of these provisions greatly depends on how “major surgical service” is defined in the by-laws that the independent College of Physicians and Surgeons is authorized to adopt under the *Health Professions Act*.<sup>123</sup>

In summary, the *Health Care Protection Act* contains a number of provisions that tackle concerns about its compatibility with the *Canada Health Act* and its underlying policy objectives from multiple directions.

## CONCLUSION

The *Canada Health Act* and Alberta legislation that establish two health care insurance plans are designed to ensure that Albertans, with some limited exceptions, have access to medically necessary medical and hospital services under “uniform terms and conditions”.

<sup>121</sup> *Health Professions Act*, RSA 2000, c H-7. See also College of Physicians and Surgeons of Alberta, *By-Law: Addendum No. 1-12* (1 January 2012) section 36.

<sup>122</sup> *A-HCPA*, *supra* note 62, s 29(q).

<sup>123</sup> *Health Professions Act*, RSA 2000, c H-7. See also College of Physicians and Surgeons of Alberta, *By-Law: Addendum No. 1-12* (1 January 2012) section 36.

Specifically, the legislation and the two health care insurance plans are designed to ensure that these uniform terms and conditions have nothing to do with ability to pay or with the range of factors that a system of private health care insurance would take into account in determining eligibility for coverage and individual premiums.

Medical or hospital services provided as a benefit under workers' compensation legislation or to members of the Canadian Forces, federal inmates or new residents of Alberta are excluded from this framework. For the most part, the rationale for these exclusions is that people in each of these categories will receive access to medical and hospital services from other sources of public funds. This assumption will not apply to some of those excluded on grounds of residency. For some of those to whom the assumption is applicable, exclusion from Alberta's two health insurance plans can mean that the consistency of the terms and conditions under which they receive access to those under which others receive the service as an insured service is not relevant to compliance with the *Canada Health Act*.

Changes in medical technology that have made it possible to provide sophisticated kinds of diagnostic services outside of hospitals have created a difference in views as to when diagnostic services are and are not subject to the *Canada Health Act*.

Alberta has recognized the reality that changes in medical technology have also made it possible for certain surgical services to be provided outside of hospitals by establishing a legislative framework for the operation of private surgical facilities. This framework stresses consistency with the *Canada Health Act* and its core policy objectives of universal and reasonable access on uniform terms and conditions to all insured services.

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## LEGISLATIVE APPENDIX

### *i) Canada Health Act (RSC 1985, c C-6)*

#### INTERPRETATION

##### **2. In this Act,**

“extended health care services” means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

- (a) nursing home intermediate care service,
- (b) adult residential care service,
- (c) home care service, and
- (d) ambulatory health care service;

“extra-billing” means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

“health care insurance plan” means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

“insured health services” means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

“insured person” means, in relation to a province, a resident of the province other than

- (a) a member of the Canadian Forces,
  - (b) [Repealed, 2012, c. 19, s. 377],
  - (c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or
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- (d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

“user charge” means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

## **CANADIAN HEALTH CARE POLICY**

### **Primary objective of Canadian health care policy**

**3.** It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

## **PROGRAM CRITERIA**

### **Program criteria**

**7.** In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

- (a) public administration;
- (b) comprehensiveness;
- (c) universality;
- (d) portability; and
- (e) accessibility.

### **Public administration**

**8. (1)** In order to satisfy the criterion respecting public administration,

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- (a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;
- (b) the public authority must be responsible to the provincial government for that administration and operation; and
- (c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

### **Comprehensiveness**

**9.** In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

### **Universality**

**10.** In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

### **Portability**

**11. (1)** In order to satisfy the criterion respecting portability, the health care insurance plan of a province

- (a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;
  - (b) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that
    - (i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which
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the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

- (ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and
- (c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

### **Requirement for consent for elective insured health services permitted**

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

### **Definition of "elective insured health services"**

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

### **Accessibility**

**12. (1)** In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

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- (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;
- (b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
- (c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and
- (d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

### **Order reducing or withholding contribution**

**15. (1)** Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

- (a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or
- (b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

### **EXTRA-BILLING AND USER CHARGES**

#### **Extra-billing**

**18.** In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

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**User charges**

**19. (1)** In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

**Deduction for extra-billing**

**20. (1)** Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

**Deduction for user charges**

**(2)** Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

**(ii) Alberta Health Care Insurance Act (RSA 2000, c A-20)****Definitions**

**1.** In this Act,

(b) “basic health services” means

- (i) insured services,
  - (ii) those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations but are not within the definition of insured services,
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- (iii) optometric services,
  - (iv) chiropractic services,
  - (v) services and appliances provided by a podiatrist,
  - (vi) services classified as basic health services by the regulations;
  - (k) “extended health services” means those goods and services or classes of goods and services that are specified in the regulations and provided to a resident or the resident’s dependants under section 3(2);
  - (m) “health services” means basic health services, optional health services and extended health services;
  - (n) “insured services” means
    - (i) all services provided by physicians that are medically required,
    - (ii) those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations, and
    - (iii) any other services that are declared to be insured services pursuant to section 2, but does not include any services that a person is eligible for and entitled to under any Act of the Parliament of Canada or under the *Workers’ Compensation Act* or any law of any jurisdiction outside Alberta relating to workers’ compensation;
  - (x) “resident” or “resident of Alberta” means a person lawfully entitled to be or to remain in Canada, who makes the person’s home and is ordinarily present in Alberta and any other person deemed by the regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.
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**Part 1****Health Care Insurance****Operation of Plan**

**3(1)** The Minister shall, in accordance with this Act and the regulations, administer and operate on a non-profit basis a plan to provide benefits for basic health services to all residents of Alberta.

**Coverage under Plan**

**4(1)** Subject to this Act and the regulations, the Minister shall pay benefits in respect of health services provided to residents.

**(2)** All claims for benefits are subject to assessment and approval by the Minister and the amount of the benefits to be paid and the person to whom the benefits are to be paid shall be determined in accordance with the regulations.

**(3)** A resident is not entitled to the payment of benefits in respect of health services provided to the resident if the resident is

- (a) a member of the Canadian Forces,
- (b) a member of the Royal Canadian Mounted Police who is appointed to a rank in it,
- (c) a person serving a term of imprisonment in a penitentiary as defined in the *Corrections and Conditional Release Act* (Canada), or
- (d) a resident who has not completed the waiting period prescribed by the regulations.

**(4)** The Minister may withhold payment of benefits for health services until the Minister is satisfied that the person was a resident at the time the services were provided.

**(5)** For the purposes of subsection (4), a certificate of registration under the *Health Insurance Premiums Act* is proof, in the absence of evidence to the contrary, that the person is a resident if the certificate was in effect at the time the service was provided to that person.

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**Payment of benefits**

**6(1)** No physician or dentist may receive the payment of benefits from the Minister for insured services provided in Alberta to a resident unless the physician or dentist was opted into the Plan when the insured services were provided.

**(2)** No resident may receive the payment of benefits from the Minister for insured services provided in Alberta to the resident by a physician or dentist unless the physician or dentist who provided the insured services was opted into the Plan when the insured services were provided.

**(3)** Notwithstanding subsections (1) and (2), the Minister may pay benefits for insured services provided in Alberta to a resident by a physician or dentist who was opted out of the Plan if the insured services were provided in an emergency.

**Opting in and out by physicians**

**8(1)** Subject to this section, every physician is deemed to have opted into the Plan.

**(2)** A physician may opt out of the Plan by

- (a) notifying the Minister in writing indicating the effective date of the opting out,
- (b) publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practices, and
- (c) posting a notice of the proposed opting out in a part of the physician's office to which patients have access at least 180 days prior to the effective date of the opting out.

**(3)** A physician who has not previously practiced in Alberta may opt out of the Plan prior to commencing practice by

- (a) notifying the Minister in writing indicating the date on which the physician will commence opted-out practice, and
  - (b) publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician intends to practice.
-

**(4)** A physician who has opted out of the Plan shall

- (a) post a notice in a part of the physician's office to which patients have access advising patients of the physician's opted-out status, and
- (b) ensure that each patient is advised in person of the physician's opted-out status before any service is provided to the patient.

**Extra billing**

**9(1)** No physician or dentist who is opted into the Plan who provides insured services to a person shall charge or collect from any person an amount in addition to the benefits payable by the Minister for those insured services.

**Other prohibited fees**

**11(1)** No person shall charge or collect from any person

- (a) an amount for any goods or services that are provided as a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan, or
- (b) an amount the payment of which is a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan where the amount is in addition to the benefits payable by the Minister for the insured service.

**(2)** Subsection (1) does not prohibit the charging or collecting of an amount paid for non-insured health or pharmaceutical goods or services where the charging or collecting of that amount is not otherwise prohibited under this Act or the *Hospitals Act* and a physician or dentist reasonably determines that it is necessary to provide the non-insured health or pharmaceutical goods or services before the insured service is provided.

**Prohibition on receiving benefits**

**12(1)** A physician or dentist who is opted into the Plan and provides insured services to a person in circumstances where the physician or dentist knows or ought reasonably to know that the person is being

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charged an amount in contravention of section 11 shall not receive the payment of benefits from the Minister for those insured services.

(2) Section 9(2) applies where a physician or dentist contravenes subsection (1).

### **Minister's right to recover amounts**

**13(1)** If a physician or dentist

- (a) in contravention of section 9 or 10, receives an amount in addition to the benefits payable by the Minister, or
- (b) receives the payment of benefits in contravention of section 12, the Minister may act under subsection (2).

(2) If subsection (1) applies, the Minister may recover the additional amount and the benefits in a case referred to in subsection (1)(a), or the benefits in a case referred to in subsection (1)(b), by one or more of the following means:

- (a) by withholding those amounts from any benefits payable to the physician or dentist;
- (b) by civil action as though those amounts were a debt owing to the Crown in right of Alberta;
- (c) pursuant to any agreement between the Minister and the physician or dentist that provides for the repayment of those amounts.

(3) The Minister shall reimburse a person in respect of whom benefits may be paid for any amounts recovered under this section that were paid by the person and have not been previously reimbursed.

### **Duty to advise**

**15(1)** Prior to providing insured services in Alberta to a resident in respect of whom benefits may be paid, a physician or dentist who is opted out of the Plan shall advise the resident of that fact and that the resident is not entitled to be reimbursed from the Plan for the cost of any insured services provided by the physician or dentist.

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(2) This section does not apply when the insured services are provided in an emergency.

**(iii) Hospitals Act (RSA 2000, c. H-12)**

**Definitions**

1. In this Act,

(p) “resident of Alberta” means a person entitled by law to reside in Canada who makes the person’s home and is ordinarily present in Alberta, but does not include a tourist, transient or visitor to Alberta.

**Part 3**

**Hospitalization Benefits Plan**

**Definitions**

36. In this Part,

- (h) “insured services” means the hospital services the operating costs of which will be provided for under this Part;
- (j) “standard ward hospitalization” means the following services to in-patients:
- (i) accommodation and meals at the standard or public ward level;
  - (ii) necessary nursing services;
  - (iii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretation, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability;
  - (iv) drugs, biologicals and related preparations when administered in a hospital, as specified in the Agreement;
  - (v) use of operating room, case room and anaesthetic
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facilities, including necessary equipment and supplies, where available;

- (vi) routine surgical supplies;
- (vii) use of radiotherapy facilities, where available;
- (viii) use of physical therapy facilities, where available;
- (ix) services rendered by persons who receive remuneration for those services from the hospital.

### **Insured services**

**37(1)** The insured services to be provided under this Part shall be those furnished

- (a) by an approved hospital of the patient's choice, and
- (b) by any other institutions or persons that are prescribed in the regulations.

**(2)** The insured services to be provided under this Part shall include

- (a) standard ward hospitalization in an approved hospital, and
- (b) any other goods and services that are prescribed in the regulations.

### **Entitlement to insured services**

**38(1)** Subject to the following exclusions, a resident of Alberta is entitled to receive insured services under this Part except when, in respect of those services,

- (a) the resident is or could be entitled to hospital services from another province or territory that has entered into a hospitalization plan with the Government of Canada under the *Canada Act*,
  - (b) the resident is entitled to receive hospital services pursuant to any workers' compensation statute of any province or territory,
-

- (c) the resident is entitled to receive hospital services under any statute of Canada or of any province or territory of Canada, as specified in the Agreement, or
- (d) the resident is declared, pursuant to Part 2, to be not in need of hospital services.

### **Payment for insured services**

**40** Nothing in this Part is to be construed to prevent a person who does not desire to receive insured services as provided pursuant to this Part from assuming the entire responsibility for the payment of the costs of the person's hospital services.

*(iv) Health Care Protection Act (RSA 2000, c H-1)*

#### **Part 1**

### **Protection of Publicly Funded Health Care**

#### **Operation of private hospitals prohibited**

**1** No person shall operate a private hospital in Alberta.

#### **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.

**(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.

#### **Queue-jumping prohibited**

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**3** No person shall

- (a) give or accept any money or other valuable consideration,
- (b) pay for or accept payment for enhanced medical goods or services or non-medical goods or services, or
- (c) provide an uninsured surgical service for the purpose of giving any person priority for the receipt of an insured surgical service.

**Facility services****4** Where a person receives an insured surgical service at a designated surgical facility,

- (a) the operator of the surgical facility shall provide facility services to the person, and
- (b) no person shall charge or collect any amount in respect of the provision of facility services that is in addition to the amount that is payable for the facility services by the health authority under an agreement referred to in section 8.

**Provision of goods or services****5(1)** No person shall require a person who receives an insured surgical service at a public hospital or a designated surgical facility to pay for

- (a) enhanced medical goods or services, or
- (b) non-medical goods or services,

that are provided in connection with the provision of the insured surgical service or that arise out of the stay at the public hospital or designated surgical facility, unless subsections (3) and (4) have been complied with.

**(2)** No person shall charge or collect a rate for enhanced medical goods or services that is greater than cost plus a reasonable allowance for administration.

**(3)** Before any enhanced medical goods or services are provided to a person,

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- (a) the nature of the enhanced medical goods or services being offered and the charges for them must be fully explained to the person,
  - (b) the person must be presented with a statement signed by the physician or dentist who will be providing the insured surgical service that
    - (i) explains the nature of the enhanced medical goods or services to be provided,
    - (ii) explains why the physician or dentist is offering the enhanced medical goods or services,
    - (iii) explains that the enhanced medical goods or services are not part of the medically required service,
    - (iv) sets out the charges for the enhanced medical goods or services, and
    - (v) meets any other requirements of the regulations, and
  - (a) the person must have agreed in writing to accept and pay for the enhanced medical goods or services.
- (4)** Before any non-medical goods or services are provided to a person, the nature of the goods or services and the charges for them must be fully explained to the person and the person must have agreed in writing to accept and pay for the goods or services.
- (5)** A person who has agreed to accept and pay for enhanced medical goods or services or non-medical goods or services may, in accordance with the regulations, rescind the agreement before the goods or services are provided.
- (6)** Where a person is provided
- (a) with an enhanced medical good or service because the public hospital or designated surgical facility does not have available the medical good or service that would normally be used in accordance with generally accepted medical practice, or
  - (b) with a private or semi-private room because the public hospital or designated surgical facility does not have standard ward accommodation available,
-

the person is not responsible for the extra cost of having the enhanced medical good or service or the private or semi-private room provided.

### **Conditions of operation**

**7** No person shall operate a surgical facility at which insured surgical services are provided unless

- (a) the surgical facility is accredited as required by section 11(1)(b),
- (b) the operator of the surgical facility has an agreement with a health authority that the Minister has approved under section 8, and
- (c) the surgical facility is designated under this Division.

### **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.

**(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),
  - (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,
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- (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.

**Designation of facility**

**15(1)** On considering the proposal and the following factors, the Minister may by order designate the surgical facility as a surgical facility for the purposes of this Division:

- (a) whether the provision of the uninsured in-patient surgical services as contemplated in the proposal would have an adverse impact on the publicly funded and publicly administered health system in Alberta or impair the government's ability to comply with the *Canada Health Act* (Canada);
- (b) whether the public interest would be served by the designation of the surgical facility;
- (c) any other factors the Minister considers appropriate.

**(2)** The Minister shall not designate the surgical facility unless the Minister is satisfied that the surgical facility is accredited to provide the uninsured in-patient surgical services referred to in the proposal, or that it will be accredited before any such services are provided.

**(3)** A designation must describe the uninsured in-patient surgical services that the designated surgical facility is authorized to provide.

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**Disclosure requirement**

**17** Where a person receives an uninsured surgical service at a public hospital or an approved surgical facility in circumstances under which that person is expected to pay for the uninsured surgical service, no person shall require that person to pay for the uninsured surgical service or for any facility services unless, before the uninsured surgical service is provided, the nature of the uninsured surgical service and facility services to be provided and the charges for them are fully explained to the person and the person agrees in writing to accept and pay for them.

**Part 5****Definitions**

**29** In this Act,

- (a) “approved surgical facility” means a designated surgical facility and a surgical facility referred to in section 16;
  - (b) “designated surgical facility” means a surgical facility that is designated under Part 2, Division 1 or 2, as the context requires;
  - (c) “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;
  - (d) “facility services” means any of the following services that are medically necessary and are directly related to the provision of a surgical service at an approved surgical facility:
    - (i) standard ward accommodation, or a semi-private or private room where the patient’s condition requires it;
    - (ii) meals;
    - (iii) necessary nursing services, including private nursing care where ordered by the attending physician or dentist;
    - (iv) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
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- (v) drugs, biologicals and related preparations when administered in the surgical facility;
  - (vi) use of operating room, case room and anesthetic facilities, including necessary equipment and supplies;
  - (vii) use of physical therapy services;
  - (viii) use of surgical equipment and supplies;
  - (ix) medical goods or services consistent with generally accepted medical practice in the particular case;
  - (x) transportation by ambulance or commercial vehicle of a patient from the surgical facility to an approved hospital under the Hospitals Act, a nursing home, a mental health facility or another surgical facility;
  - (xi) other services provided by persons who receive remuneration for providing the services directly or indirectly from the operator of the surgical facility;
  - (xii) any other service that is presented in the regulations;
- (e) “health authority” means a regional health authority;
  - (f) “insured surgical service” means 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*;
  - (g) “private hospital” means 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.
  - (h) “public hospital” means
    - (i) a hospital that is established by or under, or the establishment or operation of which is governed by, the *Hospitals Act*, the *Regional Health Authorities Act* or the *Workers’ Compensation Act*, or
    - (ii) a hospital that is established by the Government of Alberta or the Government of Canada.
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**(v) Hospitals Act, Hospitalization Benefits Regulation, Alta  
Reg 244/1990****Insured services**

**4(1)** The following goods and services, in addition to standard ward hospitalization, are included in insured services under Part 3 of the Act:

- (a) to in-patients,
  - (i) a semi-private or private room, where a patient's medical condition makes it necessary;
  - (ii) private nursing care for a patient where ordered by the attending physician and approved in accordance with the hospital's by-laws;
  - (iii) subject to subsection (2)(f) and (g), drugs, biologicals and related preparations when administered in a hospital, unless they are enhanced goods and services referred to in section 5.2;
  - (iv) pacemakers, steelplates, pins, joint prostheses, valve implants and any other goods approved by the Minister, unless they are enhanced goods and services referred to in section 5.2;
  - (v) transportation in Alberta, whether by ambulance or other commercial vehicle, to transport a patient in the circumstances described in section 6;
  - (vi) goods and services included in an approved hospital program or a specific program but not included in subclauses (i) to (v), unless they are enhanced goods and services referred to in section 5.2;
  - (vii) enhanced goods or services provided under section 5.2(2);
- (b) to out-patients, any medically necessary goods and services that may be provided on an out-patient basis, including goods used in a medical procedure but excluding goods provided to a patient for use after discharge from an approved hospital or facility.

**(2)** The following services are not insured services:

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- (a) examinations required for the use of third parties, except as otherwise directed by the Minister;
  - (b) services that a resident is eligible to receive under a statute of any other province, any Act of Alberta relating to workers' compensation or any statute of the Parliament of Canada, including:
    - (i) the Aeronautics Act (Canada),
    - (ii) the Civilian War Pensions and Allowances Act (Canada),
    - (iii) the Government Employees Compensation Act (Canada),
    - (iv) the Merchant Seamen Compensation Act (Canada),
    - (v) the National Defence Act (Canada),
    - (vi) the Pension Act (Canada),
    - (vii) the Royal Canadian Mounted Police Act (Canada), and
    - (viii) the Veterans Rehabilitation Act (Canada);
  - (c) services that a resident is entitled to receive under the Alberta Health Care Insurance Act, unless approved by the Minister;
  - (d) services that a patient is declared not to be in need of pursuant to section 31 of the Act;
    - (i) those services provided by the board in connection with non-insured health services that are referred to in section 5.1;
    - (ii) enhanced goods and services referred to in section 5.2(1);
  - (e) laboratory and x-ray services performed in a facility not approved by the Minister;
    - (i) services provided by a facility outside of Canada (other than services provided in the case of an emergency) without the prior approval of the Minister, unless the Minister directs otherwise;
  - (f) any drugs, biologicals and related preparations that are not considered necessary for the proper treatment of patients
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- (i) by the pharmacy-therapeutic committee of any hospital,
  - (ii) by the joint pharmacy-therapeutic committee of The Alberta Medical Association, The Alberta Pharmaceutical Association and the Alberta Hospital Association in respect of any hospital having a rated capacity of
    - (A) fewer than 180 beds, or
    - (B) 180 beds or more if, in the opinion of that committee, this view represents the majority of the hospital pharmacy-therapeutic committees or the practising physicians in the geographic area of Alberta in which the hospital is located;
  - (g) any drugs, biologicals and related preparations that, in the opinion of that joint committee, have not been proven by experimental or clinical trials to be satisfactory for general use in hospitals.
- (3)** Notwithstanding subsection (2)(g), the joint committee may recommend limited experimental or clinical trials under close supervision in order to determine whether or not materials referred to in that clause should be approved for general use in hospitals.
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## How Health Care is Delivered in Alberta

J.L. Saunders

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## **(b) How Health Care is Delivered in Alberta**

**J.L. Saunders**

### **Scope**

This paper will briefly review the organization of health services in Alberta. It will summarize the legislated accountabilities and policies of the Alberta Government and Alberta Health Services as they relate to the subject of preferential access to publically funded health care services in Alberta. It will also comment on the role of physicians in the health care system and their roles related to the patient referral processes. The current patient wait list initiatives and the publically-funded and fee-based options Albertans have to access health care services will also be reviewed.

The *Canada Health Act* and the relationship between federal and provincial legislation in health care delivery has been summarized by Professor Lahey in his submission to the Inquiry and will not be repeated here.

The intent of this paper is to provide an overview of how the health care system is organized in Alberta, for the purpose of assisting the Public Inquiry. It is not intended to be an exhaustive review of health care delivery in Alberta.

### **1. Summary of Government and Health System Legislated Accountabilities**

The roles and responsibilities of the Alberta government and Alberta Health Services (including AHS medical staff) are defined in provincial government acts and regulations. A brief review of these relationships will assist in understanding the accountabilities for setting appropriate policies, communicating expectations and monitoring compliance to assure equitable access to health services in Alberta.

#### **1.1 Minister of Health**

The Minister of Health (“the Minister”) sets overall direction, priorities and expectations, including standards, for the provincial health system. The Minister develops the planning, policy, legislative and standards framework within which health authorities plan and deliver services. The Minister also monitors the overall health of Albertans, the factors

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that affect health, and assesses the overall performance of the health system.<sup>1</sup>

The provincial government, through the Minister, sets provincial policy on matters to ensure that the government's expectations are met.

### **1.2 Alberta Health Services (“AHS”)**

Alberta Health Services, through its Board (“the AHS Board”), reports to the Minister.<sup>2</sup> The Minister appoints each member of the AHS Board. Board members hold office for a specified term or until removed earlier, at the discretion of the Minister.<sup>3</sup>

Regional health authorities (meaning Alberta Health Services at this time) have responsibilities conferred on them by the Legislative Assembly, primarily through the *Regional Health Authorities Act*.

Regional health authorities also have responsibilities under the *Hospitals Act* respecting the operation of hospital programs, the *Nursing Homes Act* respecting the operation of nursing home programs, the *Mental Health Act* respecting the admission, detention, administration and treatment and control of mental health patients, the *Public Health Act* respecting home care and the prevention of communicable diseases and health hazards, and the *Government Accountability Act* respecting the preparation of business plans and annual reports.<sup>4</sup>

The AHS Board is responsible for governing the AHS organization and its operating entities. The AHS Board provides vision, direction and leadership to the organization to ensure that its mandate is achieved. It governs the AHS organization by establishing policies and bylaws. It is the responsibility of management and staff to implement the policies and bylaws developed by the AHS Board.<sup>5</sup>

Subject to any limitations of its authority imposed by legislation and regulations, the AHS Board has full control of AHS facilities and has

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<sup>1</sup> Appendix A, *Health Authority Accountability in Alberta's Health System*, Page 2, 3.

<sup>2</sup> Appendix B, *Organization Chart, Ministry of Health and Wellness, Annual Report 2010-11*, Page 8.

<sup>3</sup> Appendix C, *Alberta Health Services Board, 2008, M.O. #93/2008*, Page 5.

<sup>4</sup> Appendix A, *Health Authority Accountability in Alberta's Health System*, Page 3.

<sup>5</sup> Appendix A, *Health Authority Accountability in Alberta's Health System*, Page 3.

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absolute and final authority in respect of all matters pertaining to the operations of its hospitals.<sup>6</sup>

In further detail, AHS is responsible to:

- (i) promote and protect the health of the population in the health region (province of Alberta) and work toward the prevention of disease and injury;
- (ii) assess on an ongoing basis the health needs of the health region;
- (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly;
- (iv) ensure that reasonable access to quality health services is provided in and through the health region; and
- (v) 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.

AHS has final authority in the health region, subject to the *Regional Authorities Act* and Regulations, in respect of the matters referred to in clauses (i) through (v) above.<sup>7</sup>

### **1.3 Alberta Health Services and Covenant Health<sup>8</sup> Medical Staff**

The AHS, Covenant Health and their medical staff, together with their medical and administrative officers, are responsible for the provision and quality of care within these organizations. The details of these responsibilities are described in a number of documents including the Medical Staff Bylaws and Medical Staff Regulations of the respective organizations and the *Alberta Hospitals Act*. For example, the medical staff is responsible for:

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<sup>6</sup> Appendix D, the *Alberta Hospitals Act*, RSA 2000, Chapter H-12, s. 10(1) and 10 (2).

<sup>7</sup> Appendix E, *Regional Health Authorities Act*, RSA 2000, Chapter R-10, s. 5.5.

<sup>8</sup> Covenant Health is an Alberta-based Catholic organization which provides acute care, continuing care, assisted living, hospice, rehabilitation, respite care and seniors housing in 12 communities throughout Alberta, operating approximately 946 acute care beds and 1,368 continuing care beds [Appendix H: Excerpt from Covenant Health Website] Covenant Health delivers these services under contract to AHS.

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- the quality of the professional services provided by the medical staff;
- reviewing the professional practices of the medical staff;
- improvement of the care of patients under the care of the medical staff; and
- the clinical and scientific work of the medical staff.<sup>9</sup>

## **2. Governance of the Health Care System in Alberta**

While the government department responsible for the oversight of the health system changed names several times over the years from Alberta Social Services and Community Health to Alberta Hospitals and Medical (1975), to Alberta Health (1988) and to Alberta Health and Wellness (1994), no major changes were made in the roles, responsibilities or accountabilities of government or the health organizations prior to 1994.

As noted in the previous section, the provincial Government is responsible for setting provincial health policy and funding levels. The appointed health care Board(s) are accountable for, among other duties, operating their facilities and meeting provincial expectations for quality, access and operating budgets.

The following is a brief review of the major changes that have taken place in the governance of the health organizations in Alberta over the past 18 years.

### **2.1 *Seventeen (17) Regional Health Authorities – 1994***

In May 1994 there were a total of 193 health care Boards in Alberta: 128 acute care hospital boards, 25 public health boards and 40 long term care boards.<sup>10</sup>

On June 24, 1994, under the authority of the Alberta *Regional Health Authorities Act*, the Minister announced that the number of health care Boards would be reduced from 193 to 17 new health region Boards. In

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<sup>9</sup> Appendix D, *the Alberta Hospitals Act, RSA 2000, Chapter H-12, Page 10.*

<sup>10</sup> Appendix F, *Government of Alberta News Release, "One Provincial Board to Govern Alberta's Health System", May 15, 2008, Page 3.*

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addition, the Alberta Cancer Board and the Alberta Mental Health Board would remain in place with province-wide responsibilities.

The purpose of the change was to increase efficiency of the health system.

### ***2.2 Nine (9) Health Regions – 2003***

The number of health regions was further reduced from 17 health regions to 9 on April 1, 2003. The Alberta Cancer Board and the Alberta Mental Health Board remained in place for a total of 11 health care entities.

This change enabled the boundaries of the large and medium sized health regions to be expanded to include smaller rural health regions whose populations were accessing and depending on health services from the larger regions. For example, the Headwaters Health Region (High River area south of Calgary) was merged into the Calgary Health Region and the West View Health Region (west of Edmonton out to Jasper) was merged into Capital Health.

The decision to make the 2003 changes was based on the idea that fewer health regions with more resources, larger budgets and responsibility for managing health services for larger catchment areas and service populations would achieve efficiencies within the system. The greater scope was expected to streamline government interaction with the health system and to improve the effective management of the health regions, quality of care, standardization of policies and procedures and coordination of services.

### ***2.3 One (1) Province-Wide Health Region – 2008***

The Minister announced on May 15, 2008 that Alberta would be moving to one provincial governance Board which would be tasked with co-ordinating the delivery of health services across the province.

Alberta Health Services (AHS) brought together 12 formerly separate health entities in the province: nine geographically based health authorities<sup>11</sup> and three provincial entities – the Alberta Mental Health

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<sup>11</sup> Chinook Regional Health Authority, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health, Capital Health, Aspen Regional Health Authority, Peace Country Health and Northern Lights Health Region.

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Board, the Alberta Alcohol and Drug Abuse Commission (AADAC) and the Alberta Cancer Board.<sup>12</sup> Prior to the creation of AHS, the Mental Health and Cancer Boards reported to the Minister of Health while AADAC reported to the (then) Department of Health and Wellness.<sup>13</sup> Ground ambulance service was added to the responsibilities of AHS on May 30, 2008.<sup>14</sup>

One further change in the governance of the Alberta health system in 2008 was the integration of Covenant Health into a contractual working relationship with AHS. Prior to 2008, Covenant Health (then Caritas Health) had a working relationship with the (former) Capital Health Region. In 2008, it was agreed that Covenant Health would continue to operate with its own Board but that it would sign a formal cooperation and services agreement with AHS that would define funding, health care services, policy and relationship agreements.<sup>15</sup>

In a May 15, 2008 news release, the Minister stated that:

the first priority in the health action plan is to improve the way health care is administered in this province....Moving to one provincial governance board will ensure a more streamlined system for patients and health professionals across the province.<sup>16</sup>

The news release goes on to state that the new governance model is intended to strengthen a provincial approach to managing health care services, including surgical access, long term care, chronic disease management, addictions and mental health services as well as health workforce and access to primary care.<sup>17</sup>

Feedback from both executive and medical managers who were working in the health system in 2008 reinforces the advantages of one provincial vision, mission and statement of priorities. The creation of AHS allowed medical and health system standards, benchmarks, quality, data collection and reporting to go to a provincial level and

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<sup>12</sup> *Alberta Health Services Annual Report, April 1, 2008 – March 31, 2009, Page 4.*

<sup>13</sup> The Department of Health and Wellness is now known as the Department of Health.

<sup>14</sup> *Appendix G, Alberta Health Services Annual Report, April 1, 2008 – March 31, 2009, Page 6.*

<sup>15</sup> *Appendix I, AHS Board Meeting Minutes, December 2, 2010, Page 7-8.*

<sup>16</sup> *Appendix F, Government of Alberta News Release, "One Provincial Board to Govern Alberta's Health System", May 15, 2008, Page 3.*

<sup>17</sup> *Appendix J, Government of Alberta News Release Backgrounder, dated May 3, 2011, Page 1.*

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further enhanced the opportunities to reduce administrative and back-office expenses.

A copy of the AHS executive organization chart as of October 31, 2012 is attached to this report.<sup>18</sup> AHS continues to evolve as an organization. Changes in 2011, for example, included some realignment of positions and responsibilities in the executive structure, introducing a shared administrative/medical decision making model, dividing the province into 5 zones<sup>19</sup> and delegating authority and accountability for a greater scope of decision making at the zone level. The zones were intended to create a clear, patient-focused “line of sight” between the decisions that need to be made and the people who need to make them.<sup>20</sup>

Another change for the health system was the approval of a first-ever 5-year funding commitment for health. The Minister’s message in the 2010-11 Annual Report states: “The funding commitment provides 6 per cent operating increases in each of the first 3 years, and 4.5 per cent increases in each of the final 2 years. This 5-year funding – the first of its kind in Canada – provides AHS with a stable, predictable funding platform to enhance long-range planning.”<sup>21</sup>

### **3. Ways Albertans Can Access Primary Health Care Services and Specialists**

It is important to understand the options that Albertans have to gain entry into both primary and specialty health care services. The below is not a comprehensive statement of all of the possible ways that Albertans can gain access to primary care and specialists. Rather, it is intended to provide the Inquiry with a general understanding of the more common ways that Albertans access these services.

#### ***3.1 First Point of Contact – Access to Primary Care***

There are a number of options for accessing primary health services in Alberta. Four of the most common are:

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<sup>18</sup> Appendix K, AHS Organizational Chart as of October 31, 2012.

<sup>19</sup> Appendix L, Map of AHS Zones.

<sup>20</sup> Appendix J, Government of Alberta News Release Backgrounder, Page 1.

<sup>21</sup> Appendix M, Health and Wellness Annual Report, 2010–11, Page 5.

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1. General Practitioners' ("GPs") offices. This could include a sole practitioner, group practice or a care delivery service organized through a Primary Care Network (a group of networked family doctors working with other health care professionals such as nurses, dietitians, pharmacists, etc. to provide care to a defined group of patients);<sup>22</sup>
2. Walk-in clinics;
3. Urgent Care Centers and Advanced Ambulatory Care Centers (most often located within a regional health center, they provide extended hour access for unexpected, but non-life-threatening health concerns, which require same day treatment); or
4. Hospital emergency departments ("EDs").

If the GP or ED physician determines that a patient requires care that is beyond that physician's training or expertise, the patient is referred to a medical specialist (medicine, surgery, mental health, etc.).<sup>23</sup>

When patients arrive at an emergency department they are prioritized and then treated according to the urgency of care they require. AHS uses the Canadian Triage and Acuity Scale ("CTAS") to assess patients triaged at Emergency Departments and Urgent Care facilities.<sup>24</sup> The CTAS scale is based on an acuity level between 1 and 5. Patients requiring immediate intervention and possibly resuscitation are assessed as CTAS level 1. CTAS 2 (emergent) and CTAS 3 (urgent) categories represent patients needing more timely attention than those categorized as CTAS 4 (less urgent) and CTAS 5 (non-urgent).

### **3.2 Access to a Specialist**

Discussions about access to health services often relate to wait times from GP to Specialist and from Specialist to treatment. These are areas of concern for patients, government and AHS.

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<sup>22</sup> Appendix N, description of the Primary Care Initiative and AHS website, "Your Health Care Options".

<sup>23</sup> Appendix O, College of Physicians and Surgeons of Alberta, Standards of Practice, The Referral Consultation Process, Standard 6.

<sup>24</sup> Appendix P, AHS document titled: "How Busy Are Our Emergency Departments".

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While there are exceptions, typically patients access Specialist care through a referral from a GP, an ED physician or another Specialist.

There are generally two ways to refer a patient to a Specialist:

1. Direct referral to a specific Specialist; and
2. Referral to a group of Specialists through a Central Booking Office.

### ***3.2.1 Direct Referral to a Specific Specialist***

The most common form of referral is direct to a specific Specialist with whom the GP, ED physician or another Specialist has a working relationship. In the normal process, the referring physician will write a referral letter to the Specialist which summarizes the patient's history, medical symptoms, etc. The referring physician may classify the patient as routine, semi-urgent or urgent (or similar wording) and provide medical information to validate the classification. What the GP/ED physician says and the urgency that the referring physician expresses to the Specialist may act as one influencing factor for the Specialist in deciding how soon the Specialist will schedule an appointment for the patient.<sup>25</sup> Some Specialists have designated classification systems where GPs are required to fill out special forms that may be unique to that Specialist.

Some GPs may be more effective than others at assessing patients prior to referral, summarizing required medical information and cultivating relationships with Specialists. The effectiveness of the GP can impact the wait time for a patient to see a Specialist. For example, a phone call from the GP to the Specialist asking them to watch for a specific referral that the GP is concerned about, together with a detailed patient assessment summarizing the medical evidence may encourage the Specialist to review the patient file more quickly.

Specialists are expected to evaluate a patient's acuity and to assess the relative priority for treatment compared to other patients who are waiting for treatment on the Specialists' waiting list.

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<sup>25</sup> *Appendix O, College of Physicians and Surgeons of Alberta, Standards of Practice, The Referral Consultation Process, Standard 6.*

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### ***3.2.2 Referral to a group of Specialists through a Central Booking Office***

To achieve AHS's objectives of improving access and reducing wait times<sup>26</sup> some options have been developed related to referrals to some Specialists and speciality clinics, particularly within certain AHS Zones.

For those Specialists who agree to accept referrals through a Central Booking Office, the GP or Specialist referring to them will submit the patient's referral information to a group of Specialists as opposed to one specific Specialist. The Central Booking Office will then review the referral and will assign a Specialist within their group based on factors such as workload (next available on the list), particular skills, etc.

At the national level there are some new strategies for priority standardization in some of the specialities. One example is the Paediatric Canadian Access Targets for Surgery ("P-CATS"). One of the differentiating factors with this project is that the P-CATS are diagnosis-based, in contrast to many adult surgical access targets, which are procedure-based. Standardization across surgical subspecialties and hospitals allows for national and hospital-specific analyses, comparisons and benchmarking, since each patient with a given diagnosis will also have the same priority level. In addition, this standardization allows operating room resources to be managed across surgical subspecialties.<sup>27</sup>

The Central Booking Office concept is in the early stages of development. It is intended to offer advantages such as: better coordination of Specialist workloads, more efficient patient flow, standardizing treatment-specific priority-setting criteria and reduction of waiting times. Some Specialist groups, with the support of AHS in some cases, are working together on the development of alternate central booking options. Examples of the speciality services where central booking options may be in the development stages include: Orthopaedics, Gastrointestinal, Neurology, Endocrinology, Rheumatology and Cardiology.

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<sup>26</sup> Appendix Q, AHS Health Plan and Business Plan, 2012–2015, Page 22.

<sup>27</sup> Appendix R, P-CATS Report, November 5, 2008, Page 3.

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## **4. Fee-Based Options to Access Health Services**

As thoroughly canvassed by Prof. Lahey, the *Canada Health Act* prohibits extra-billing by physicians<sup>28</sup> and user charges for any medical and related service that is defined as an insured service within the province's health care insurance plan. There are still, however, a number of options whereby Albertans can legally pay for certain health services.

### **4.1 Uninsured Health Services**

Medical services that are not publically insured within the Alberta Health Care Insurance Plan (i.e. non-essential cosmetic surgery, etc.) can be legally purchased. Fees for uninsured medical services can include charges for the physician and charges for the facility (facility fee) in which the service is provided.

### **4.2 No Fee Code**

Those medical services that do not have a fee code in Alberta can be legally purchased from a licensed vendor even if they are also available free of charge within the public system. Examples of this type of service are: MRIs, CT scans and ultrasounds. To access these services on a user-pay basis the patient obtains a referral from a GP or Specialist, schedules an appointment with a radiology group offering such services and pays a fee to have the investigative procedure done, often within 1 or 2 weeks. The wait in the publically funded system can be (but is not always) longer.

### **4.3 Private Preventative Health and Wellness Groups and Executive Health Groups**

There are "wellness" related health service organizations in Alberta which, in exchange for an annual fee and sometimes an additional service fee, entitle "members" to a range of health-related consultations and not-medically-required services. Some programs offer "round the clock" or "24/7" access to a GP.

### **4.4 Private Medical and Surgical Clinics in Canada**

As noted in Professor Lahey's report, the *Canada Health Act* is open to interpretation by each of the provinces and territories. The result is that

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<sup>28</sup> Or by dentists providing publically insured surgical-dental services.

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there are some differences in the scope of insured services across Canada.

Based on an internet search for “*private medical clinics in Canada*” it appears that Alberta’s private clinics do not offer as extensive a range of user-pay surgical interventions as the private clinics in some other provinces, particularly British Columbia and Ontario. Albertans may therefore be able to pay for some insured surgical services in other Canadian provinces that they cannot purchase in Alberta. For example, some private surgical facilities in other provinces offer knee, elbow, hand and shoulder arthroscopy surgeries on a user-pay basis, whereas private medical clinics in Alberta do not appear to offer these services.

#### **4.5 *Private Hospitals and Medical/Surgical Clinics in Other Countries***

Any Albertan with the will and financial means can travel to the United States or another country to buy whatever medical or surgical services they may need. There are a number of companies now offering private catastrophic health insurance which covers U.S. treatment for Canadians who suffer certain illnesses. There are also companies offering medical tourism options.

In Alberta, a physician or dentist may make an application to the Out-of-Country Health Services Committee on behalf of an Albertan for funding to cover costs of treatment which may not be available in Canada. If the application is not successful, the patient must personally pay costs if he or she wishes to access the services.

### **5. How Physicians are Paid and Who They Work For**

Most doctors practicing in Alberta practice medicine either in individual or group practices of varying size and make-up.

#### **5.1 *Fee for Service***

Most doctors are paid on a fee-for-service basis paid directly from Alberta Health through the Alberta Health Care Insurance Plan.<sup>29</sup>

The medical fee-for-service schedule is negotiated by Alberta Health and the Alberta Medical Association.

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<sup>29</sup> *Appendix S, Practicing Medicine in Alberta, October 2012, Page 5.*

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Most physicians in Alberta establish themselves as private, incorporated businesses of some form. Physicians are normally independent contractors rather than employees, except for those physicians who are full or part time employees of the government, Alberta Health Services or any other company from which they receive a salary in their personal names.

In addition to fee-for-service, physicians in Alberta may also be eligible to receive additional compensation through a number of other payment arrangements which are set out below.

### ***5.2 Alternate Relationship Plans (“ARPs”)***

The aim of the ARP program is to develop compensation strategies – other than fee-for-service – to remunerate physicians for providing defined program services. There are 3 types of ARPs:

- academic (compensation for teaching and research in addition to clinical responsibilities);
- clinical (compensation for clinical service based on annual, sessional or capitation models, each of which have different funding models); and
- contractual (compensation for defined responsibilities).<sup>30</sup>

Compensation for physicians working in some on-call specialty rosters and/or as hospitalists (in-hospital paid physicians) may also fit into this category.

### ***5.3 Primary Care Networks and Family Care Clinics***

Primary Care Networks (“PCN’s) are networks of doctors that create multi-disciplinary care teams. Originating in 2003, Alberta now has 40 networks with almost 2,500 doctors and about 600 full-time-equivalent professionals in other disciplines. In a PCN, a team of health professionals led by family doctors delivers and co-ordinates health services, with the objective of better collaboration, more timely referrals and more comprehensive care.

A PCN can be one clinic with many family doctors and other health professionals (i.e. nurse practitioners, dieticians, pharmacists, social

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<sup>30</sup> Appendix U, *Alternate Relationship Plans*.

workers and mental health workers) or many family doctors and other health professionals in several clinics in the area.<sup>31</sup> Some physicians may receive sessional fees as a part of their compensation.<sup>32</sup>

Family Care Clinics, a new approach introduced in early 2012, provide direct access to a variety of health professionals on a team, and to other community and support services.<sup>33</sup> Again, some physicians may receive sessional fees as a part of their compensation.

#### ***5.4 Physician Workforce Service Subsidies***

Where it is determined by AHS that physicians in a specific specialty or subspecialty are required to deliver a service but are not able to earn adequate compensation due to factors such as volume or time required per patient, AHS may pay a physician a subsidy in addition to what the physician is able to bill on a fee-for-service basis.

#### ***5.5 Salary***

A small percentage of physicians are paid a salary (and benefits) by AHS, Covenant Health or the government for their administrative and/or clinical services. Examples of physicians who may be on part or full time salary include medical administration, public health, public sector laboratory pathologists, clinical associates, cancer specialists and geriatricians.

#### ***5.6 Other Public and Private Payors/Payers***

Examples of physicians who may receive remuneration from sources other than government (fee-for-service) or AHS could include payments from groups who are defined in legislation as eligible to pay for insured services. Examples include: workers' compensation and the Canadian Forces. In addition, physicians are paid directly by a patient or their insurer for uninsured health services or by exempt groups such as automobile insurance companies.

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<sup>31</sup> *Appendix V, AHS, What is a Primary Care Network, 2010.*

<sup>32</sup> Sessional fees refers to paying physicians for "sessions" of work related to specific tasks. These fees are usually based on an hourly rate. For example, psychiatrists, where considerable time is spent in team consultation or in direct patient consultation where the amount of time required with the patient may be very disproportionate to the fee paid on a fee-for-service basis. Another example is emergency physicians – many emergency departments now offer physicians a guaranteed sessional fee for working as the doctor on duty, regardless of the number of patients seen.

<sup>33</sup> *Appendix Q, What is primary health care?*

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### **5.7 Clinical Privileges in AHS**

Physicians who wish to care for patients within AHS must apply for and receive an AHS and, where required, Covenant Health Medical Staff Appointment, and approval for specified clinical privileges.

Clinical privileges within AHS are defined in the Alberta Health Services Medical Staff Bylaws as:

The delineation of the Procedures that may be performed by a Practitioner; the sites of Clinical Activity in which a Practitioner may perform Procedures or provide care to Patients; and the AHS Programs and Professional Services that are available to a Practitioner in order to provide care to Patients.<sup>34</sup>

## **6. AHS Medical Staff Bylaws**

The AHS Medical Staff Bylaws and the Medical Staff Rules govern the Physicians, Dentists, Oral and Maxillofacial Surgeons and Podiatrists who provide medical care to Patients and the Scientist Leaders who provide medical administrative leadership, in relation to an AHS Medical Staff Appointment. They establish and describe, in addition to other terms:

...the responsibilities of the Medical Staff and AHS to each other for the organization and conduct of the Medical Staff, and in particular the processes relating to Medical Staff Appointments and delineation of Clinical Privileges.<sup>35</sup>

The Bylaws contain general statements about responsibilities and accountabilities such as: “The medical staff and AHS share joint responsibility and accountability for the provision of health services in a patient-centered system.”<sup>36</sup> In addition the Bylaws state:

Practitioners shall be governed by the AHS values of respect, accountability, transparency and engagement, AHS policies and by the AHS Code of Conduct. Practitioners shall also be

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<sup>34</sup> *Appendix W, Alberta Health Services Medical Staff Bylaws, Effective February 28, 2011, Page 4.*

<sup>35</sup> *Ibid., Page 10.*

<sup>36</sup> *Ibid., Section 4.0.1, Page 37.*

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governed by the relevant Professional Code of Conduct, and the respective code of ethics of the relevant profession.<sup>37</sup>

## **7. Covenant Health Medical Staff Bylaws**

Covenant Health maintains a parallel set of Medical Staff Bylaws which are integrated with and aligned to the AHS Medical Bylaws.

## **8. Tracking Wait Times in Alberta**

AHS is tracking, benchmarking and reporting the wait times for a number of programs and services. A summary of these reports is published in the Alberta Health Services Health Plan and Business

Plan, 2012-2015.<sup>38</sup> Examples of some of the wait times that are benchmarked by AHS include:

- Cardiac Surgery
- Hip Replacement Surgery
- Knee Replacement Surgery
- Cataract Surgery
- Cancer Treatment
- Emergency Department Length of Stay
- Children's Mental Health
- Wait in Community for Continuing Care Placement
- Wait in Acute/Sub-Acute Care for Continuing Care Placement.

The new Alberta Wait Time Reporting System was launched on the (then) Alberta Health and Wellness website in May 2011. The website shows wait time information on surgical procedures and diagnostic tests, including MRI scans and cancer services as reported by Alberta specialists and facilities. The site allows Albertans to search wait times

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<sup>37</sup> *Ibid.*, Section 4.0.6, Page 37.

<sup>38</sup> Appendix X, "Improve Access and Reduce Wait Times", Alberta Health Services Health Plan and Business Plan 2012-2015, Section 3.1, Pages 25-31.

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by procedure, by specialist and by facility, and indicates wait times trends over the most recent 13-month period.<sup>39</sup>

Alberta Health also publically reports the benchmarked wait times for hip replacement, knee replacement and cataract surgery, plus wait times for continuing care.<sup>40</sup>

## **9. Federal Government, AHS and Covenant Health Policy on Preferential Access to Health Care in Alberta**

Health Canada is required to publish an annual report for each fiscal year on the extent to which provincial and territorial health care insurance plans have satisfied the criteria and the condition for payment under the *Canada Health Act*.<sup>41</sup> Similarly, Alberta Health also publishes an annual report which contains the Minister's accountability statement, the audited consolidated financial statements of the ministry and a comparison of actual performance results to desired results set out in the ministry business plan.

### **9.1 Alberta Health Services Policy Regarding Preferential Access**

The AHS website appears to contain two items related to preferential access to health care:

1. A June 11, 2009 memorandum to the AHS executive team signed by then CEO Dr. Stephen Duckett on the issue of preferential access ("the Duckett Memo") directed that any requests for Preferential or Expedited Care be referred to Dr. Duckett,<sup>42</sup> and
2. The policy statement that was attached to the Duckett Memo and that is currently posted on the AHS website<sup>43</sup> ("the AHS Policy"). This document was prepared by Dr. D. W. Megran (Senior Physician Executive) on May 10, 2009.

The AHS Policy states that:

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<sup>39</sup> Appendix Y, *Health and Wellness Annual Report 2011-2012*, Page 21.

<sup>40</sup> Appendix Z, *Health and Wellness Annual Report 2011-2012*, Pages 10, 11.

<sup>41</sup> Health Canada Website.

<sup>42</sup> Appendix AA, *the Duckett Memo*, June 11, 2009.

<sup>43</sup> Appendix BB, *AHS Policy – Requests for Preferential or Expedited Care*.

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Providing preferential and/or expedited care based on societal status or personal relationship to health care executive or officials, rather than on medical indications and accepted prioritization pathways for care, creates conflict-of-interest for the organization and an ethical dilemma or the health care executive or official receiving a request to do so.

By its very nature, such a scenario: represents “queue-jumping,” a practice that a public health care organization cannot defend or support; delays or otherwise adversely affects the care of other persons awaiting or requiring care, especially when the organization has limited and inadequate capacity or resources; implies that not all individuals in society are considered “equal,” or are entitled to equal treatment; suggests that the organization’s current norms of care do not meet acceptable standards; exposes the organization to negative public and/or media opinion.

The policy also provides an AHS definition of preferential access, as follows:

Preferential or expedited care includes, but is not limited to care that is:

- rendered more quickly than medically indicated or required
- rendered more quickly than the current norm of the organization
- of a higher quality and/or is more extensive/ “thorough” than the currently provided norm of the organization
- offered at a lower cost than is the current norm (i.e. for services or equipment that are non-insured or must be purchased by the patient).

The author understands that AHS currently has a more comprehensive policy on preferential access under development.

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## **9.2 Covenant Health Policy Regarding Preferential Access**

Covenant Health has developed and implemented its own policies addressing special requests for care and access to care, including patient requests for a specific provider. The Covenant Health policy<sup>44</sup> gives direction to staff asked to accommodate a special request stating:

It is the responsibility of staff who have been asked to accommodate a special request to respond to the requester, investigate whether the possibility exists to meet the request without compromising clinical judgment or personal/professional reputation, and to clearly communicate and document the rationale for the decision. It is not acceptable to ignore the request, nor is it expected that every request must be, or should be, honoured. In all cases, a prudential judgment must be made in keeping with the mission, values and ethical principles of Covenant Health.

Accommodating a special request that may result in another patient/resident being medically disadvantaged and seriously harmed is prohibited.

The Covenant Health policy goes on to state:

...it is unethical and wrong to allocate resources to an individual of influence or celebrity status when someone else may be disadvantaged or harmed.

## **10. College of Physicians and Surgeons of Alberta: Policy**

The College of Physicians and Surgeons of Alberta (“CPSA”) regulates the practice of medicine in Alberta. As a professional body governed by the *Alberta Health Professions Act*, CPSA, among other responsibilities, guides professional conduct and ethical behavior of physicians.<sup>45</sup>

Physician behavior in Alberta is governed through CPSA Standards of Practice and the Code of Ethics and requires a high standard of

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<sup>44</sup> Appendix FF, Covenant Health Policy, Accommodating Special Requests, Policy No. VII-B-5, December 1, 2010.

<sup>45</sup> Appendix CC - CPSA website, *Introduction to the College, Lines of Business*.

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compliance to each, in order to maintain a licence to practice medicine in Alberta.

Within the Standards of Practice, the most relevant section relating to preferential access to the health system is Standard 6, *The Referral Consultation Process*,<sup>46</sup> which provides various standards that physicians are expected to abide by when they are considering referring a patient to a specialist for treatment. While these standards are requirements for physician-to-patient and GP-to-Specialist communication, the CPSA does not have a specific reference in its Standards of Practice related to preferential access to health services.

### **11. Access to Health Services is a Top Priority**

The *Canada Health Act Annual Report for 2010-2011* states that the most prominent concerns with respect to compliance under the *Canada Health Act* remained patient charges and queue jumping for medically necessary health services at private clinics.<sup>47</sup> A similar level of concern was voiced in a 2010 Health Quality Council of Alberta survey of Albertans which concluded: “From the public’s perspective access – the ease of obtaining health care services – continues to be the most important factor associated with their overall satisfaction with health care services received.”<sup>48</sup>

### **12. Summary**

It is hoped that this summary will provide general context for the Inquiry as it examines the subject of proper or improper preferential access to health care in Alberta.

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<sup>46</sup> Appendix O, CPSA Standard 6, The Referral Consultation Process.

<sup>47</sup> Appendix DD, *Canada Health Act Annual Report, 2010–2011*, Page 2.

<sup>48</sup> Appendix EE, *HQCA Satisfaction and Experience with Health Care Services: A survey of Albertans 2010*, Page 3.

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## 2. Research Panel Papers

### (a) Submission: Contextual Ethical Analysis

**Dr. Lynette Reid**

#### Summary

Canada's healthcare system constitutes a significant expenditure of public resources in pursuit of a crucial public good – a shared standard of healthcare for all – with little accountability for performance in either equity or efficiency. Our healthcare system performs so poorly on a number of measures, including access,<sup>1</sup> that insiders to the system often call on personal relationships to bypass the queues that other Canadians experience, by facilitating access for themselves and their families, colleagues and their families, and prominent public figures.<sup>2</sup> Similarly, independent insurers (workers' compensation and motor vehicle) that stand outside medicare, acutely conscious of the costs they would incur from our healthcare system's inefficiencies, pay a premium for expedited access for their patients.<sup>3</sup> Such queue-jumping is not inevitable: in particular, it is not common where the most scarce and/or crucial resources (such as in transplant medicine, pediatric oncology) are managed on ethically and medically appropriate criteria such that the public trust is maintained. It is possible to organize care rationally. The culture of trading favours removes one important

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<sup>1</sup> Commonwealth Fund. *Mirror Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*; 2010 Update [cited 2013, Feb 15]. Available from:

[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jun/1400\\_Davis\\_Mirror\\_Mirror\\_on\\_the\\_wall\\_2010.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf).

<sup>2</sup> Anecdotally reported, documented in the media Jaimet K. Top Doctor admits to queue jump. *The National Post*; 2007, 2 December [cited 2013, Feb 15]. Available from: <http://www.nationalpost.com/news/story.html?id=141706>, and documented by research in: Alter DA, Basinski AS, Naylor CD. A survey of provider experiences and perceptions of preferential access to cardiovascular care in Ontario, Canada. *Ann Intern Med* 1998, Oct 1;129(7):567-72.

<sup>3</sup> Davidson A. Under the radar: Stealth development of two-tier healthcare in Canada. *Health Policy* 2006, Jul;2(1):25-33; 1; Gildiner A. The organization of decision-making and the dynamics of policy drift: A Canadian health sector example. *Social Policy & Administration* 2007;41(5):505-24; Gildiner A. Measuring shrinkage in the welfare state: Forms of privatization in a Canadian health-care sector. *Canadian Journal of Political Science* 2006;39(01):53-75; Hurley J, Pasic D, Lavis JN, Culyer AJ, Mustard C, Gnam W. Parallel payers and preferred access: How Canada's workers' compensation boards expedite care for injured and ill workers. *Health Pap* 2008;8(3):6-14.

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incentive for insiders to do so: they can simply bypass the deficiencies of the system that the Canadian public must endure. Furthermore, entrenched interests and the organizational challenges posed by physician autonomy – which extends far beyond autonomy in clinical decision-making to autonomy in the management of public resources through private practice – keep us from achieving the goals of the *Canada Health Act*.

Assessing what constitutes ethical resource stewardship and improper preferential access in Canadian healthcare involves navigating a complex terrain, both in terms of ethics and in terms of the organization of care. In my submission, I sketch out the relevant ethical considerations and tradeoffs, and highlight specific practice contexts worthy of further attention and analysis.

***A summary of my conclusions is as follows:***

**Preferential access** is *differential access* to any of a comprehensive set of medically necessary healthcare services, where that differential access is ***based on medically and/or ethically inappropriate criteria***. Preferential access may occur ***whether access is formally or informally organized***. There are other forms of inequitable differential access: “preferential” access implies the subset of inequitable access in which there is a ***conscious granting of access*** to one person rather than another with equal or greater need. Poor coordination and organization of care, broader social and structural factors, and conflicting program goals among public healthcare systems may also cause inequitable differential access. Although some kinds of differential access are not deliberate but are “side-effects” of other policy choices or structural constraints, in some cases, these are sufficiently blatant in their effects to be considered ***de facto preferential access***.

There is no common definition of preferential access: some consider preferential access to consist only in access resulting from corruption, fraud, and conflict of interest; some define the term in relation to specific violations of the accessibility principle (7(e)) of the *Canada Health Act*.<sup>4</sup> However, the goals of equity and efficiency (using resources – fairly – to meet medical need) are broadly shared values in healthcare, and many people and institutions acting at the micro, meso,

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<sup>4</sup> *Canada Health Act*. R.S.C., 1985, c. C-6. [Cited 2013, Feb 15]. Available from: <http://laws-lois.justice.gc.ca/eng/acts/C-6/FullText.html>.

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and macro levels strive to attain these goals.<sup>5</sup> Therefore preferential access as access that violates mechanisms adopted to promote health equity may also be identified outside the scope of the CHA.

We can distinguish “proper” considerations that may generate differential care or access to care, including medically appropriate criteria, the promotion of equity, the responsibility to take into account the individuality and cultural specificity of patients. Another appropriate consideration is that of reasonable policy tradeoffs arrived at through accountable, transparent, and/or democratic processes, given that the pursuit of equity as an absolute value could conceivably consume unlimited resources and render society incapable of meeting other needs (education, etc.).<sup>6</sup> Examples of “proper” differential access include ethical processes of resource allocation, ethical advocacy, patient-centred and culturally competent care and some instances of differential access resulting from policy tradeoffs expressed in the boundaries of universal coverage (extended and excluded services or excluded persons in the CHA).

“Improper” preferential access occurs where corruption, bribery, influence trading, conflict of interest, extra-billing or similar practices, and in-group privilege lead to differential and inequitable access to publicly funded care. Furthermore, “improper” preferential access can occur as the inadvertent but foreseeable results of policy choices, as well as what might be described as a dereliction of duties on the part of those who control access to public resources: duties of performance and accountability to the funders and beneficiaries of public healthcare (the Canadian public). Examples commonly believed to fit the description of “improper preferential access” include queue-jumping, gaming the system, and extra-billing; examples that I believe also fit this description include “professional courtesies” and other forms of preferential access for healthcare insiders and public figures, the “second tier” that has arisen in care funded by workers’ compensation boards (WCBs), and the ongoing absence of appropriate accountability on the part of the medical profession for the control physicians exercise

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<sup>5</sup> See for example Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health [Internet]. Copenhagen: World Health Organization Regional Office for Europe; 2006 [cited 2013, Jan 2]. Available from: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0010/74737/E89383.pdf](http://www.euro.who.int/_data/assets/pdf_file/0010/74737/E89383.pdf).

<sup>6</sup> Norheim OF, Asada Y. The ideal of equal health revisited: Definitions and measures of inequity in health should be better integrated with theories of distributive justice. *Int J Equity Health* 2009;8:40.

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over substantial expenditures from the public purse. In each of these cases, specific factors have led to *de facto* preferential access: the “historical accommodation” of Canadian medicare that protects physician autonomy at great cost to the taxpayer and patient; personal and group loyalty in a widespread (but not universal) culture of insider privilege; policy decisions that count the social costs of injury to some citizens (WCB-insured workers) while ignoring the social cost of injury and disability of others (the self-employed, informal caregivers, students, the retired, etc.), and that are inconsistent with policy decisions taken in other practice areas to enforce the prohibition on extra-billing.

### **What is “preferential access” to health care?**

I will define and discuss “preferential access” with reference to a number of ethical principles, including principally that of equity in health and healthcare. (See Table 1 for overview of key relevant ethical concepts.)

I take the *Canada Health Act* as a defining framework for public healthcare in Canada. Although the CHA does not use the term “equity,” the principles of universal (§7(b)) access to a comprehensive set of medically necessary physician and hospital-based services (§7(c)) without financial or other barriers (§7(e)) is understood to be addressing the goal of equity in access.

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**Table 1**

<b>Key Ethical Concepts:</b>	
<b>Health Equity</b>	Three commonly given definitions: Equal access for all to the opportunity for the best achievable health; access to healthcare based on medical need alone; absence of systematic and avoidable health disparities between groups. May be in relation to access, utilization, quality, or outcomes.
<b>Integrity</b>	Behaviour (individual or institutional) consistent with accepted principles.
<b>Other social values that may guide or place limits on pursuit of health equity:</b>	
<b>Loyalty and Solidarity</b>	Specific responsibilities to individuals or groups based on roles and relationships.
<b>Liberty</b>	An equal right to individual liberty consistent with equal liberty for all places limits on means for achieving common goals, and imposes obligations to foster the conditions of liberty for all.
<b>Other needs or desires for welfare/flourishing</b>	Achieving health equity may interfere with our ability to achieve other social priorities, such as education, economic development, the arts, etc.
<b>Social Justice</b>	Goals of social inclusion in relation to the marginalized or restitution in relation to colonial history may inform the judgment of fairness in distribution or provide a rationale for differential care.

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**Health equity**, a form of **distributive justice**, is not the only value at stake in preferential access. Other values support health equity, or shape how we go about the goal of health equity. Norms of **integrity** (in relation to resisting corruption and conflict of interest) are relevant, as are norms of **loyalty**, such as personal loyalty (to friends, family), loyalty (fiduciary duty) to individual patients or to a group of patients, professional or institutional solidarity, and social solidarity.<sup>7</sup> Conflicts between personal loyalty and broader social fairness exist wherever there are processes meant to apply equally to all; some dilemmas relating to preferential access take this form. **Other social values or needs**, including values relating to **individual liberty**, may limit the lengths to which we go in order actually to achieve health equity. For example, healthcare in Canada is comparatively expensive but performs comparatively poorly on many measures.<sup>8</sup> The extent to which we should focus on addressing our poor performance on equity rather than our poor performance on access, quality, or other measures is an important question for priority setting.

Margaret Whitehead famously defined health inequity in the following terms:

The term 'inequity' has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust.<sup>9</sup>

Whitehead contends that what is considered unfair and unjust is a matter of discussion within a particular social context.<sup>10</sup> Equity may be considered in relation to **access**, **utilization**, or **quality** of care, and it may focus on opportunity or on **outcomes**.

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<sup>7</sup> See extensive history of the value of social solidarity in the distribution of “de-commodified goods” in the welfare state: Stjernø S. *Solidarity in Europe: The history of an idea*. Cambridge: Cambridge University Press; 2009.

<sup>8</sup> Commonwealth Fund, op. cit. note 1.

<sup>9</sup> Whitehead M. The concepts and principles of equity and health. *Int J Health Serv* 1992;22(3):429-45. See also Anand S, Peter F, Sen A. *Public health, ethics, and equity*. Oxford; New York: Oxford University Press; 2004 for a selection of recent discussions of the philosophical grounding and application of health equity.

<sup>10</sup> While granting that what is considered fair and unfair will differ from time to time and place to place, Whitehead contends that health behaviours that are freely chosen, and genetic or other causes of disease that cannot be altered, do not in themselves result in health inequities.

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It is important to note that, despite admitted indeterminacies in the concept of equity<sup>11</sup> and the reality of competing values, the goal of health equity is broadly shared internationally, across healthcare systems with different mixes of public and private pay and delivery; similarly, at the national level, equity and its supporting values guide various actors in healthcare, not just the scope of the CHA.

With these values in mind, I will now define preferential access (“queue-jumping”) in two contexts – where formal queues exist and where queues do not exist – and distinguish and identify inequities in access without queue-jumping.

### ***Queue-jumping – where queues exist***

Where a health resource is a public good, and it is limited or scarce, and the consequences of access for morbidity and mortality are significant, we typically guide its distribution through organized and transparent processes of resource allocation. An example is allocation of solid organs for transplantation. The resource is publicly funded and provided on a volunteer and “gift” basis by the public; the need of a patient awaiting transplant is substantial and consequences of not receiving the resource are significant. All transplant services operate under formal allocation processes guided by explicit principles. The details of the particular allocation rules we adopt and how strongly we weight each in decision-making is a local discussion, as Whitehead suggested in her definition, and may vary from province to province or from program to program. An overview of candidate principles is contained in Persad et al.<sup>12</sup> and summarized here (with adaptations) in Table 2. Despite local variations in criteria chosen, the commitment to equity in such circumstances is broadly shared, and accountability is strong.

With varying degrees of commitment, effort, and success, Canadian healthcare providers in other areas of practice have organized systems

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<sup>11</sup> As seen in Table 1, equity may be defined primarily in terms of an aspiration for the best achievable health for all (based on the Universal Declaration of Human Rights), access based on medical need alone (Delamothe T. Universality, equity, and quality of care. *BMJ* 2008, Jun 7;336(7656):1278-81), or in terms of comparisons between socially advantaged and disadvantaged groups (Marmot MG. Policy making with health equity at its heart. *JAMA* 2012, May 16;307(19):2033-4).

<sup>12</sup> Persad G, Wertheimer A, Emanuel EJ. Principles for allocation of scarce medical interventions. *Lancet* 2009, Jan 31;373(9661):423-31. My table differs slightly in its analysis.

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for triage and allocation for scarce or limited resources in healthcare.<sup>13</sup> Where there are explicit processes of resource allocation, these typically involve wait times for patients. Where there are queues, there are cases where people seek to bypass these fair systems, whether for themselves, their associates, or prominent persons.<sup>14</sup> This may happen through outright bribery and corruption, or through exploiting personal influence.

**Where fair wait lists exist, “preferential access” is access based on personal resources or influence rather than on medical need, as judged according to agreed-upon processes of resource allocation.**

There are first-order and second-order reasons for taking action against the manipulation of fair wait lists: to promote the values of equity that they embody, and to preserve the integrity of the system, that is, to *prevent corruption and control the effects of conflict of interest* on the part of those with insider access or the ability to influence these fair processes. This, in turn, helps secure public trust.

Survey data indicating that half of Canadians state they would call on associates to jump queues if they could<sup>15</sup> is often presented as indication that Canadians are not deeply committed to equity or fair access, despite 95% verbally affirming such a commitment. The data could also simply suggest that the normal ethical tension between self-interest or personal loyalty and (impersonal) fair processes exists in healthcare as in all areas of human moral life. Faced with dilemmas between fairness and loyalty, we may choose personally or socially to abandon fairness in favour of a free-for-all of personal advantage-seeking, or we may reinforce fairness with personal consequences for its violation, to better align self-interest/loyalty with fairness. Such choices are extensively explored in game-theoretic analyses of social ethics, and, of course, they form one substantial basis of our legal

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<sup>13</sup> For instance, an extensive literature documents the organization of access to cardiac surgery in Canadian centres, e.g. Ray AA, Buth KJ, Sullivan JA, Johnstone DE, Hirsch GM. Waiting for cardiac surgery: Results of a risk-stratified queuing process. *Circulation* 2001, Sep 18;104(90001):I-92-I-98.

<sup>14</sup> I will use the term “associates” throughout as shorthand for friends, family, colleagues, and iterations of those relationships (family of colleagues, for example).

<sup>15</sup> Friedman SM, Schofield L, Tirkos S. Do as I say, not as I do: A survey of public impressions of queue-jumping and preferential access. *European Journal of Emergency Medicine* 2007;14(5):260-4.

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system. The fact that people would break a rule if they could get away with it does not in itself vitiate a rule.

**Table 2 – Ethical Criteria for Resource Allocation**

<b>Equal Rights</b>	1. Equal respect for human dignity and vulnerability.
<b>Medical Criteria</b>	2. Distribution based on maximizing potential medical benefit. 3. Distribution based on responsibility to alleviate suffering.
<b>Social Criteria</b>	4. Social justice, based on responsibilities to identify and alleviate injustices and compensate for lack of voice/power. 5. Social worth, evidence-based and tied to health, security, and/or economic needs of society. 6. Social value, status-based or tied to particular conceptions of greater or lesser human value.  Ethical access to healthcare will involve balancing these different values. The last value is rarely, if ever, an ethically justifiable as a criteria for access.

### ***Queue-jumping – without queues***

For much of Canadian healthcare, there are no such processes of fair and transparent resource allocation.<sup>16</sup> In these less organized areas, across all of medically necessary hospital and physician services, the concept of preferential access also applies. Where there is no organized queue to be jumped, there may still be queue-jumping, in the sense of bypassing the “ordinary” (disorganized) means of access to care.

<sup>16</sup> Flood CM. *Just medicare: What's in, what's out, how we decide*. Toronto: University of Toronto Press; 2006.

The growth of extra-billing in the 70s and 80s created a situation in which those with private means could access services to which those unable to pay could not.<sup>17</sup> While “queuing” did not frame the issue in the 80s, in contemporary terms, extra-billing equates to payment to jump a queue. The CHA was put in place to deal with physician practices that create financial barriers to access to care – or, put another way, practices that create financial means for patients to expedite their access to care.

The political will to meet the requirements of the CHA varies from province to province, as do the legal and regulatory mechanisms employed. Provinces may ensure compliance through specific legislation,<sup>18</sup> and/or through legislation and regulations primarily directed at the provincial health insurer, or at hospitals and other healthcare facilities. Physicians’ provincial regulatory colleges also play a part in setting and enforcing guidelines that help healthcare providers meet these standards. British Columbia, Alberta, Ontario, and Quebec are jurisdictions where we have seen the public pressuring regulators to enforce the principles of the CHA.

The identification and ethical evaluation of preferential access is less straight-forward where there are no organized and fair wait lists. Where there is no shared understanding of fair access, the line between advocacy and queue-jumping is difficult to determine: it may be that the “normal” system for securing access to care is to call in favours. Furthermore, it is one thing to ask a person to sacrifice personal loyalty (or self-interest) to fairness where there are fair processes, and more difficult to expect such a sacrifice to an unfair process in the context of inadequate access for all.<sup>19</sup> In a “free for all” of players seeking advantage for themselves and their associates, it may be exceedingly difficult to gauge the boundaries of ethical advocacy.

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<sup>17</sup> More technically, the provinces must regulate the practice of medicine such that there not be “financial or other” barriers (7(e)) to a comprehensive (7(b)) and universal (7(c)) package of medically necessary hospital and physician services, on penalty of foregoing healthcare funding from the federal government.

<sup>18</sup> As, for example, in *Ontario’s Commitment to the Future of Medicare Act, 2004*, SO2004, c5, s. 17(1) [Cited 2013, Feb 15]. Available from: <http://canlii.ca/t/kv43>.

<sup>19</sup> An example of the argument that personal loyalty may trump fair process in access to healthcare is Browne A, Browne K. Morality, prudential rationality, and cheating. *Camb Q Healthc Ethics* 2007;16(1):53-62.

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Nonetheless, despite the lack of organized queues, basing access to any part of a comprehensive package of medically necessary hospital and physician services on ability to pay is prohibited under the *Canada Health Act*,<sup>20</sup> and so we identify extra billing and equivalent practices as forms of preferential access. Although this is not preferential access in the sense of bribery, corruption, or conflict of interest on the part of the provider, it is preferential access in relation to the broad policy goal of *ensuring universality and accessibility* of public healthcare in Canada, and it is legally proscribed for services and persons covered by the CHA. It is important to note that there are services not covered by the CHA that are similarly governed by norms of equity (e.g. Public Health programs), such that forms of preferential access may similarly be identified in areas not covered by the CHA.

**Table 3 – “Public Healthcare” in Canada**

**Publicly funded but not within the scope of the CHA;** may purchase services from public system or from persons or institutions who also provide services in the public system:

- Public Health (health protection, promotion, and prevention services, typically delivered outside of hospitals and often not by physicians)
- Federal programs that are substitutive or that fund extended benefits for particular populations (First Nations and Inuit Health; (formerly, refugee health, RCMP); Armed Forces; Inmates)
- Provincial pharmacare, home care, longterm care programs; may be universal or needs-tested
- Provincial motor vehicle insurance (MVI), in some provinces

**Privately funded but operating under a public mandate;** may purchase services from the public system or from persons who also provide services to the public system:

- Private MVI in some provinces
- Provincial workers’ compensation (WCB)

<sup>20</sup> Leaving aside opted out physicians and the provisions for and controls on them (and on insurance) that vary across the provinces. Flood CM, Archibald T. The illegality of private health care in Canada. *CMAJ* 2001, Mar 20;164(6):825-30.

**Table 4****Key Definition and Related Concepts**

- **Preferential access** is *differential access* to any of a comprehensive set of medically necessary healthcare services, where that differential access is *based on medically and/or ethically inappropriate criteria*.
- Access based on criteria that are medically and/or ethically inappropriate is *one form of inequitable differential access* (the application of medically appropriate criteria is necessary but not sufficient for equity in access; there is differential and inequitable access that is not “preferential”).
- “Preferential” access implies a *conscious granting of access* to one person over another. Other mechanisms (poor coordination and organization of care, structural factors, conflicting program goals within public healthcare) may also cause inequitable differential access.
- Preferential access may occur *whether access is formally or informally organized*.
- Some instances of inequitable differential access that result from structural features of Canadian healthcare, while they are “side-effects” of other policy choices and not deliberate acts of preference for one patient over another, are sufficiently blatant and similar in their effects to be considered *de-facto preferential access*.

***Inequities with neither queues nor queue-jumping***

There are many kinds of inequities in access, utilization, and quality that would not be described as “preferential access” because they result from structural factors or from acts of omission rather than commission. They may be unintended consequences of the organization of a service or location: a hospital is built closer to some people than others, creating inequalities in access to emergency care; such unintended inequalities may even reach the threshold of being inequities, if the inequality is unfair and remediable.

It may be that, in Canada, problems of access for everyone and problems of inadvertent or structural inequities both outstrip in their impact the problem of preferential access, where that is understood as deliberate actions to grant access to one person over another with equal or greater need.

### Is there a common definition?

No, there is not a common definition. Different candidate definitions may focus on the goal of *controlling corruption* in business and public affairs, or on the principles of the *Canada Health Act* and its mechanisms, or more broadly on the shared ethical commitment of the profession and of health systems to *health equity*, which may apply to services publicly or privately funded, or publicly or privately provided, inside or outside of the medicare basket.

Preferential access to public healthcare may include, be related to, or be distinguished from the following (see Table 5 for summary):

1. Differential and deliberately expedited access based on **corruption**: bribery, influence peddling, and rent-seeking;
  2. Differential and deliberately expedited access based on **conflict of interest and status, influence, and unspoken expectations** that insiders to the system, their associates, and public personalities enjoy special treatment;
  3. Differential and deliberately expedited access based on “**professional courtesy**” or other forms of special consideration for insiders to the system or their close associates;
  4. Differential and equitable access or treatment based on **ethically-appropriate advocacy**;
  5. Differential treatment based on **culturally competent patient-centred care**;
  6. Physician billing practices that are or are equivalent in their effects to **extra-billing**, insofar as this may or may not be successfully controlled by provincial governments and regulators, in light of their responsibilities to meet the requirements of the *Canada Health Act*;
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7. Differential access that arises **from individual and arbitrary management of wait lists** for essential services without transparent criteria and processes;
  8. Differential access based in **ethical processes of resource allocation and wait list management**;
  9. Differential and sometimes expedited access to services to **“extended” and excluded healthcare services**<sup>21</sup> under the CHA, whether these services are publicly or privately funded, and whether the provinces intend or do not intend to deliver these services under the principles of universality and accessibility;
  10. Differential and sometimes expedited access based on **differential status** of persons under the CHA,<sup>22</sup> given its exclusions and the responsibilities of other public and private payers for their care;
  11. Differential and sometimes expedited access based on an **absence of transparent, accountable resource allocation processes** throughout Canadian healthcare;
  12. Differential access based on **broad structural issues**: geography, language and literacy, social determinants of health, and so on.

### **Is there a difference between “proper preferential access” and “improper preferential access”?**

The choice is a semantic one, between reserving “preferential access” for preferential access that instantiates corruption and/or threatens health equity, or using “preferential access” for both equitable access delivered with integrity and corrupt/inequitable differential access, while qualifying the latter with “improper.”

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<sup>21</sup> Extended services are nursing home care, adult residential care, home care, and ambulatory care. Excluded services are any healthcare services and products delivered by healthcare professionals other than physicians outside of the hospital setting, e.g. physiotherapy, and other care by healthcare professionals, pharmaceuticals in the community. The category of excluded services also includes non-medically necessary hospital- and physician-delivered care: cosmetic surgery, laser eye surgery, assisted reproduction, etc.

<sup>22</sup> I.e. care for those covered by workers’ compensation, for inmates, for members of the Armed Forces, and for those who do not yet meet the residency requirements in a Canadian province.

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I prefer the first option for its ethical clarity: we should think in terms of a goal of access based on medical and ethical criteria, delivered with integrity, and reserve “preferential access” for access that in some way violates the principles of equity and integrity. If equitable access based on medical need is labeled “preferential access,” then it would be “proper preferential access.” This is not, however, useful language: on these terms, all healthcare should be delivered “preferentially,” insofar as it should always be delivered in accordance with people’s differing kinds and levels of medical needs.

**Table 5**

**Forms of Differential and Preferential Access:**

1. Corruption (bribery, influence peddling, and rent-seeking).
2. Status, influence, conflict of interest.
3. “Professional courtesy”.
4. Ethical advocacy.
5. Culturally competent patient-centred care.
6. Extra-billing and similar practices.
7. Arbitrary variation in management of wait lists.
8. Ethical processes of resource allocation and wait list management.
9. “Extended” healthcare services under the CHA.
10. Differential status of persons under CHA.
11. Absence of transparent and accountable resource allocation.
12. Structural issues.

**In your opinion, what would be examples of “proper” preferential access to health care?**

I would consider some items in Table 5 list to be “proper” differential or expedited access, specifically:

4. Ethical advocacy;

5. Culturally competent patient-centred care;
8. Differential access based in ethical processes of resource allocation and wait list management;
9. Some instances and aspects of differential access to extended and excluded healthcare services;
10. Some instances and aspects of differential access based on differential status of persons under the CHA.

What renders these “proper” is that they incorporate medically appropriate criteria (4, 8, 9), promote equity (4, 5, 8), take into account the individuality and cultural specificity of patients (4, 5), and/or represent reasonable tradeoffs arrived at through accountable (8), transparent, and/or democratic processes (9, 10).

**Is there harm to the public health care system associated with “proper” preferential access to health care? In your opinion, what is the nature of that harm? Is that harm acceptable from an ethical or practical perspective?**

In answering these questions, I will focus on harms and ethical trade-offs in general, and on items in my list that are not addressed in separate questions by the Inquiry below.

Ethical processes of **resource allocation and wait list management** (8) involve making difficult choices in which different possible values for prioritizing access to care must be weighed (e.g. medical need, medical benefit, alleviation of suffering, social vulnerability, social value, equal regard for human dignity, etc.; see Table 2). Such ethical processes *enhance the efficiency and equity* of the system, enabling us to dedicate resources to areas of greatest need or greatest potential benefit. They also contribute to making the system *worthy of public trust*, insofar as the criteria they employ are fair. They may even *enhance trust* particularly when adoption and application of the criteria involve transparent and inclusive processes.

Each particular principle for prioritizing access has its own potential for harm: ethical choices involve tradeoffs in which competing values may be modified or threatened.<sup>23</sup> In specific instances, conscious resource

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<sup>23</sup> Persad et al., op. cit., note 12, summarizes the downside of each possible allocation rule.

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allocation and wait list management itself may involve *resources that are disproportionate to the benefits to equity or efficiency gained* by any access system more elaborate than “first come, first served.” Such systems may *incur opportunity costs*. For example, while triage based on urgency at an Emergency Department is universal, triage at the point of access to primary care is not commonly performed: any patient calling for an appointment receives the next available appointment that suits their schedule, with informal flexibility for urgency. Furthermore, fair processes run the *risk of inflexibility* where more flexible processes, including a scope for the exercise of professional autonomy, might be argued to better serve the needs of patient-centred care. For example, formalizing the first-come, first-served access for primary care may degrade equity by imposing inflexibility on providers who may perhaps be trusted to appropriately exercise their professional autonomy in the service of meeting patients’ needs.

These possible harms must be taken seriously in organizing systems of access. They are not reasons for rejecting wholesale formal access controls. While some may argue that “muddling through” is the best method of resource allocation for patients in light of the above concerns,<sup>24</sup> the majority view, which I share, is that deliberate and transparent processes of resource allocation are preferable.

I will discuss **ethical advocacy** (4) below in the specific questions from the Inquiry. Ethical advocacy is action to ensure that patients receive the care that is due to them based on their medical needs. Patients are more than their illnesses: their individual values and context, including culturally influenced beliefs and practices, enter into and must be taken into account in the healthcare encounter. **Culturally competent patient-centred care** (5) is similar to ethical advocacy in that it involves action by healthcare providers and systems to attend to individual patients’ needs, defined by the individual’s unique perspective on the world and the cultural influences that may shape that perspective.<sup>25</sup> Such differences do not typically equate to differences in

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<sup>24</sup> Mechanic D. Muddling through elegantly: Finding the proper balance in rationing. *Health Aff (Millwood)* 1997, Sep 1;16(5):83-92.

<sup>25</sup> Examples of the considerations relevant to healthcare delivery that may be culturally influenced include rituals relating to birth and death, dietary restrictions, treatment restrictions and preferences, and appropriate involvement of family in decision-making. A family meeting with 20 present to support the patient and the legal substitute decision-maker may be more time-consuming for the team than a family meeting with one substitute decision-maker, but requiring that all patients and families fit the “autonomous

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access, but they may involve greater expenditure of resources to achieve the same access.

There are ethical and medical rationales for such customization in care related both to efficiencies (*removing barriers to appropriate care* to prevent future morbidity and mortality) and values such as respect and *social inclusion*,<sup>26</sup> goals broadly consistent with and supportive of *equity*. In some cases, these values are enforced by law (e.g. bilingual services in NB) or legal precedent (sign interpretation for hard of hearing patients).

Social inclusion is an on-going public discussion, with debate centered around the goals described above and what some consider to be potential harms, such as whether the goal of social inclusion may oblige us to endorse oppressive values, whether the expense of individualization and inclusion may be in some instances unacceptably high, whether we may paradoxically foster social division by policy mechanisms aimed at inclusion.

Both ethical advocacy and culturally competent patient-centred care involve grey areas and the exercise of individual professional discretion, and are sensitive to the degree that patients and groups are able to advocate for themselves. That is, having permitted a scope for these values, they may be implemented imperfectly and may be subject to abuse or manipulation.

Differential access at the **boundaries of medicare – to services excluded** from the CHA (9) and differential access based on **status** under the CHA (10) – raise broad and complex issues. In and of themselves, they may constitute differential access without necessarily constituting or leading to preferential access.

Some of these services are nonetheless **publicly funded** (see Table 3). Some of these publicly funded or publicly mandated services, although outside the CHA, nonetheless are delivered by provinces on terms that

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patient” model with a single substitute decision maker would be placing an access restriction on some Canadians and not others, i.e. a requirement that you must abandon your family’s and culture’s practices of familial decision-making.

<sup>26</sup> See Kymlicka W. *Liberalism, community, and culture*. Oxford: Oxford University Press; 1991 and Taylor C. The politics of recognition. *New Contexts of Canadian Criticism* 1994:98-131 for Canadian discussions (liberal and communitarian) of the grounds for social inclusion.

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**aspire to fulfill the spirit of the CHA or the spirit of equity.** For example, provinces have acted to remove incentives to more expensive (hospital-based and physician-provided) care where other care locations and providers may be less expensive and more appropriate to patient needs. To do this, they cover home care, nursing home care, and nurse-provided care on terms and conditions equivalent to the CHA terms and conditions, or terms that are designed to promote equity but are not uniform. Another example is public health, including vaccination and health promotion activities, which is delivered historically with a strong commitment to equity and may fit some but not all principles of the CHA. Provincial pharmacare programs, similarly, may be means tested instead of universal, while still publicly funded and guided broadly by principles of equity. In all these areas, the principle of uniform terms and conditions may be sacrificed in order to target resources at areas of greatest need, and income-dependent co-payments may be tolerated. Despite their status as excluded or extended services under the CHA, there may be queue-jumping that we must attend to as closely as we attend to queue-jumping for CHA-covered services.<sup>27</sup>

At the boundaries of medicare, it may be unclear whether an exclusion serves a particular policy goal or is an accident of history. For example, the need for cost containment in light of other priorities for public funding dictates limits to healthcare coverage: it is generally thought that we could not cover pharmaceutical and devices in the community, longterm care, and home care on the terms of the CHA (universal access on uniform terms and conditions) at taxation levels acceptable to the electorate without encroaching unacceptably on the provinces' other funding priorities, such as education, infrastructure, and security. Furthermore, some excluded services relate to enhancement and to prevention: individual liberty argues in favour of not interfering with the rights of some to pursue these areas where there is not a broad social consensus to support all to pursue them equitably. Other more specific policy goals, such as the historic bargain of workers

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<sup>27</sup> Longterm care in some provinces is managed on a single-wait list access (e.g. NB, NS), while in other provinces there are simply two tiers of longterm care and private payers receive officially sanctioned preferential access (e.g. PEI). Preferential access may arise from variable enforcement of facilities licensing laws (direct access, private pay non-nursing home facilities may offer expedited access to a level of care that ought to bring them under the umbrella of nursing home regulations and single-wait list access and so rule out that expedited access) or application of resident selection criteria (preferentially accepting private pay residents, a practice that would be vulnerable to complaint on human rights grounds).

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compensation (trading coverage and financial accountability for employers with unsafe worksites with the workers' right to sue), or the relationship of First Nations and Inuit people with the federal government, or the separate system for coverage of prisoners, may be seen as serving particular policy goals, or as the result of convenience at the time of the founding of medicare. Medicare did not seek to provide coverage where coverage was already in place.

The need for cost containment, the historical process of policy development, the necessary limits of coverage, and the liberty of individuals to choose care beyond the universal package, where available, create forms of "proper" differential access. Those who can pay may have access to drugs, to home care and assisted living options that have a substantial impact on morbidity and mortality, while those who cannot, wait on wait lists until they deteriorate to a point where they require more substantial, covered care.

The two-tier systems in Canadian healthcare resulting from limitations in coverage of the CHA do cause known harms. They are to some extent transparent and accountable, and chosen by political processes. I would join with those who advocate that we make different policy choices as a society in some of these areas, particularly in pharmacare. Nonetheless, they do represent proper democratic policy choices.

**In your opinion, what would be examples of "improper" preferential access to health care?**

I would consider some items in Table 5 list to be "improper" differential or expedited access, specifically:

1. Corruption (bribery, influence peddling, and rent-seeking).
  2. Status, influence, conflict of interest.
  3. "Professional courtesy".
  6. Extra-billing and similar practices.
  7. Some instances of arbitrary variation in the management of wait lists.
  9. Some instances of the interface between "extended" and covered healthcare services under the CHA.
  10. Some instances of differential status of persons under CHA.
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**A note about the absence of transparent and accountable measures of resource allocation (11) and about structural inequities (12):**

While differential access that arises from the absence of good resource allocation procedures in Canada<sup>28</sup> and differential access based on structural issues such as social determinants of health are not “proper,” these are even broader and more structural issues than the ones I identify as constituting “*de facto* preferential access.”

The absence of transparent and accountable processes of resource allocation, for example, results in imbalances between funding of stigmatized and valorized conditions, so a person with schizophrenia receives substantially worse care for schizophrenia than a person with a myocardial infarction receives for myocardial infarction (rather than differential access for two patients with the same condition to the same treatment).<sup>29</sup> Arguably, such inequities in Canadian healthcare cause more suffering and injustice than the more local inequities in access that this submission and Inquiry are concerned with. Indeed, the global conversation is now concerned with inequity in relation to the social determinants of health<sup>30</sup> and inequities in relation to corruption, conflict of interest, and favour-trading are not much discussed. We are under a broad ethical obligation to address these broader inequities when we can, and there is no doubt that Canada can do better in these areas. The achievement of medicare has, arguably again, left us complacent, while the disorganization of our system has also left us relatively powerless to address these issues.

**Is there harm to the public health care system associated with “improper” preferential access to health care? In your opinion, what is the nature of that harm? Is that harm acceptable from an ethical or practical perspective?**

In answering these questions, I will focus on general harms and ethical tradeoffs, and on items on my list that are not addressed in separate questions below from the Inquiry.

Preferential access based on corruption (1) is improper, and its harms include *violation of the public trust, misuse of office, and the*

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<sup>28</sup> Flood CM. *Just Medicare: What's in, what's out, how we decide*. Toronto: University of Toronto Press; 2006.

<sup>29</sup> Starfield B. The hidden inequity in health care. *Int J Equity Health* 2011;10:15.

<sup>30</sup> Marmot MG. Policy making with health equity at its heart. *JAMA* 2012, May 16;307(19):2033-4.

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*diversion of resources* from those in medical need to those with resources, influence, and a willingness to trade on them unethically and illegally to ensure their own needs are met. It is probably unnecessary to add that there are no arguments, apart from ethical nihilism, to the effect that these harms are acceptable. However, as with all wrongdoing, total eradication is impractical and may require excessively intrusive means, violating principles of *liberty* and threatening other priorities for use of resources.

I believe access expedited by **status, influence, and conflict of interest** (2) to be equally unacceptable and harmful in terms of trust, use of office, and diversion of resources; when the exchange is less blatant and material than in (1), we may enter into grey areas. Insofar as personal and professional loyalty may be positive values in some contexts, some instances of requests or pressures for preferential access based on status, influence, and conflict of interest may pose genuine dilemmas for healthcare providers juggling different roles, loyalties, and relationships.

I believe, while acknowledging it is a matter for discussion, that so-called **professional courtesy** (3) and other forms of preferential access for insiders to the system are also improper preferential access, and are not substantially different from access offered on the basis of influence or conflict of interest (2). I will discuss these below in answer to specific questions from the inquiry.

Preferential access based on **extra-billing** (6), which the CHA outlaws via the pressure it places on provinces, is improper, causing harm in the form of violation of the principles of universality and accessibility, potentially depriving individuals of medically necessary care and so contributing to suffering and death, and placing a financial burden on individuals in need of healthcare with attendant social harms of the sort that medicare was designed to prevent.

I will argue in relation to the boundaries of medicare (8) and (9) that the CHA fails to control all instances where the interface between public and private care (or among public systems) creates preferential access (potentially troubling practices summarized in Table 6).

I consider differential and *de facto* preferential access based on **individual and arbitrary management of wait lists** (7) to be improper. That is not to say that in a single instance an individual

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physician should be held culpable for how they manage wait lists; lack of coordinated and conscious management of wait lists aimed at the public good is not the same thing as giving individual patients expedited access through corruption and influence peddling or through less conscious but still professionally culpable conflict of interest. The public has (apparently) accepted since the adoption of medicare that care should be delivered in such a disorganized fashion. This is a particular feature of Canada's healthcare system: Physicians enjoy considerable professional autonomy while they are, in effect, managing a public resource. This individual and arbitrary variation in management of access to services could even be considered as officially tolerated and sanctioned.

Nonetheless, access to surgery is determined by which primary care physician one happens to see, who in turn may happen to have a good referring relation with a particular surgeon, who in turn may happen to have the most claim on OR time due to seniority: this is not preferential access in the narrow sense outlined above (corruption; violation of CHA), but it is differential and inequitable access that I would argue professionals have the responsibility to foresee and address.<sup>31</sup> I consider it to be an on-going dereliction of a professional ethical duty and of accountability to the taxpayer and beneficiaries of the system to steward public resources in a responsible fashion. Neither the responsibilities of provinces, health districts and individual hospitals, nor the responsibilities of individual physicians and of group practices, can be ignored in crafting a solution: Canada is one of only two countries in a recent Commonwealth Fund survey where physician payment is independent of hospital budgets.<sup>32</sup> All relevant parties should, in my opinion, be placed under stronger legal/policy obligations, to organize care to meet medical need – for both equity and efficiency.

The disorganization of access, apart from constituting a failure in accountability to the public, also creates the context for more culpable instances of preferential access. For example, referring relationships may be with private facilities that offer CHA-covered care bundled

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<sup>31</sup> It may be a factor in the relative challenges in achieving equity in specialist services: see Starfield, *op. cit.*, note 29.

<sup>32</sup> The other is the US. See Squires et al. *International profiles of health care systems*, 2012 [Internet]. New York: The Commonwealth Fund; 2012 [cited 2013, Feb 15], p. 9. Available from: <http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Nov/International-Profiles-of-Health-Care-Systems-2012.aspx>.

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with other services, and in a context of broad professional autonomy, referring practices may include preferential booking for those referred from such facilities offered bundled services over those referred from practices focused on CHA-covered care. Another example is the way in which access in some areas may be so poorly organized that fair, equitable advocacy cannot be distinguished from “calling in favours.”

**Table 6**

**Examples of *potential or actual* spillover effects on access and equity for services outside the boundaries of medicare**

- Private access to diagnostic imaging and lab services resulting in expedited access to public care;
- “Tray fees” and other practices of billing patients for services or supplies necessary for the delivery of medically necessary services;
- Private surgical facilities billing the provincial plan but requiring extended stays not funded by the provincial plan;
- Medically necessary surgery, billing the provincial plan or not billing the plan, using devices not funded by the hospital or provincial insurer;
- Chemotherapy with drugs not on the hospital or provincial formulary;
- Other methods of bundling medically necessary and extended/excluded services;
- Expedited access by premium payment for patients covered by WCB and MVI;
- Differential and preferential referring relationships, which may be with practices bundling basic and excluded services.

***Services and persons not covered***

At the boundaries of CHA coverage (**extended and excluded services, and excluded persons** (9-10)) there are practices that would constitute or resemble extra billing (6), and cause the similar harms, but that are

in my opinion inadequately controlled and constitute forms of preferential access.

Separate systems may be warranted by policy goals, as in the WCB system, but potential harms exist: they include that the *separate system may offer worse access and care* than the more broadly shared public system (a concern in prison health and in First Nations and Inuit health, even while the package of care may be larger, i.e. include extended benefits), and that the *separate system may offer expedited access* in relation to the public system, i.e. forms of preferential access to public healthcare that are currently tolerated or sanctioned but that I would consider “improper.” Where there are separate and private systems, potential harms are that expedited access to private care should in effect expedite access to public resources, and that the close integration of public and private services should create *de facto* means of preferential access for those able to afford to access integrated services where the core services covered under CHA or other programs guided by similar values are not accessible.<sup>33</sup>

Some harms of the separate system may be acceptable in relation to the necessity of weighing the policy goals outlined above. In some cases, crafting regulation to prevent spillover effects (see Table 6) for access to the (CHA-governed) public system may not be possible.

In some instances, separate public or private systems exacerbate resource limitations and, in particular, health human resource limitations in the public system, degrading access to CHA services for all, but not necessarily creating preferential access (apart from, by definition, the preferential access to the non-CHA services). Certainly, wait times for diagnosis of macular degeneration or cataract surgery are affected by the amount of time a limited number of providers are spending in private practice doing procedures that are not covered as they are considered to be “enhancement” services or not to offer a favourable cost-utility balance. I know of no evidence whether public provision of privately funded chemotherapy (expensive drugs covered by private insurance but not hospital formularies) creates similar pressures on access for all. It behooves the system to attend to these affects – to incentives to health human resources to exit the public

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<sup>33</sup> The harms and purported benefits are discussed in the collection Hurley et al, op. cit., note 3.

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system – and we do so in various ways,<sup>34</sup> but some of these practices are unavoidable given goals of cost containment and respect for liberty.

However, such practices may constitute preferential access, and be avoidable through clear regulation, in cases such as the following:

- A CHA-covered *procedure* with a non-hospital or provincial insurer-funded *drug or device* is re-interpreted as a non-CHA-covered procedure, and providers bill privately, at a premium, and offer preferential access, when this practice is designed to circumvent a particular province's mixture of laws on direct patient billing (is it permitted and is it restricted to the same reimbursement that the province offers?) and status disincentives (may the patient claim back the portion covered by the province?).
- A non-CHA-covered procedure that addresses the same medical problem as a CHA-covered procedure is billed privately, at a premium, and patients who elect that service are offered preferential access.<sup>35</sup>

Some practices would be simple to regulate and others more difficult.

### ***Bundling of covered and not-covered services***

Another form of preferential access that may occur at the boundaries of medicare is where services that are medically necessary hospital-based or physician-delivered services are bundled with extended or excluded services (or bundled with services for persons not covered under the CHA), and then access to the CHA-covered care is available only to those purchasing the whole package.

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<sup>34</sup> Canadian provinces approach the policy goal of de-incentivizing exit from the public system in local and piecemeal ways, sometimes with no legal restrictions, simply relying on the lack of a market (NL) and in other provinces with various restrictions on insurance and billing that resist the growth of this sector. (Flood & Archibald, op. cit., note 20.) This functions more or less adequately at a global level to prevent the widespread development of financial barriers to covered services, but it has permitted the growth of financial barriers to care in certain areas.

<sup>35</sup> In both cases, the problem of access is exacerbated by the same physician offering both services, as s/he has an intrinsic interest in steering patients towards selecting the premium service and away from the publicly funded one.

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This is widely forbidden by the regulatory colleges when it takes the form of “boutique medicine,” which is where a physician practice charges a kind of retainer fee to be accepted as a patient. In the case of boutique practices, the regulatory colleges have placed requirements around it to prevent financial or other barriers to access.<sup>36</sup> physicians must unbundle services so that patients can access CHA services independently of paying for other services; physicians must consider the ability of the patient to pay; physicians must not refuse access to patients who do not buy the extended services, and, most crucially for our purposes, ***physicians may not charge a fee for being available to provide a CHA-covered service or for providing such a service in an expedited fashion, as these practices would be considered extra-billing.***

The regulatory colleges are less clear about the acceptability of similar access barriers in other contexts, such as rehab and sports medicine (I know of no comprehensive overview of such practice models and specialty areas).

In fact, for separate (public) coverage of WCB patients, the explicit policy decision was that, ***while a given surgery may be medically necessary, a given surgery within 6 weeks may not be medically necessary, and so it may be paid at a premium to give physicians and facilities incentive to expedite that surgery.***

I agree with the regulatory colleges’ interpretation that paying for expedited access to covered services is impermissible, and reject the WCB/MVI interpretation, which sets the stage for a form of ***officially sanctioned but improper preferential access*** – queue-jumping by WCB-covered patients (and, under the interpretation, other large insurers such as MVI).

In addition, contracts with the WCB and MVI companies are typically the bread and butter of clinical practices that offer bundled CHA and

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<sup>36</sup> See, for example, College of Physicians and Surgeons of Alberta. Standard 18: Charging for uninsured services. Standards of practice. Edmonton AB: CPSA; 2010 [cited 2012, Nov 25]. Available from: [http://www.cpsa.ab.ca/Libraries/Res\\_Standards\\_of\\_Practice/CPSA\\_Standards\\_of\\_Practice\\_Consolidated\\_Version.pdf](http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf); College of Physicians and Surgeons of Ontario. Block fees and uninsured services. Toronto: CPSO [cited 2012, Nov 25]. Available from: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1612>.

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non-CHA services, and such clinics may then also offer "executive healthcare" or employee wellness packages.

Neither the CHA nor the regulatory colleges address the restrictions on access that such clinics present (a separate issue apart from referring relationships relating to these clinics as outlined above). There are at least two dimensions here. One is whether a clinic with such a business model in itself represents a violation of the CHA, and how this could be defined and regulated given that physicians may, in general, control their own practice balance of covered and non-covered services. In addition, such clinics typically perform screening that exceeds what is recommended in practice guidelines, and this has an impact on efficiency and on equity for the public system, as excessive screening leads to excessive use of resources for over-treatment and faster access for those excessively screened.

The CHA envisions eliminating financial barriers to access to care by prohibiting physicians from adding extra fees to what they bill the provincial insurer. It does not envision or adequately control for making access conditional on bundling of insured and non-insured services.<sup>37</sup>

**In your opinion, would you characterize the following examples as “proper” or “improper” access to health care? [Explain with reasons where applicable]**

***Physician Advocacy? Is this a good thing? Why or why not?***

Physicians have a responsibility to advocate appropriately for their patients, to ensure that they receive the services they need and to which they are entitled. This is enshrined in the CanMEDS Health Advocate

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<sup>37</sup> I believe this issue will only grow as interprofessional team care in the community grows – a desirable development – and this moves more and more care out of the overview of the CHA. It becomes a matter for provincial government policy, facilities licensing regulations, primary care reform models, and health district planning whether the core principles of the CHA hold across new care models, which may involve the delivery of medically necessary care by pharmacists and nurse practitioners, for example, whose practice in the community is not covered by the CHA. Developments in this area are likely to be marked by the federal-provincial wrangling that too often replaces effective healthcare planning in Canada. A modernized CHA or modernized provincial policy would, in my view, make explicit the policy goals of universal access to a comprehensive set of medically necessary care on uniform terms and conditions without financial or other barriers, without the antiquated restriction to physicians and hospitals.

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role,<sup>38</sup> in common law,<sup>39</sup> and in professional ethics. They have a responsibility to distinguish this from “queue-jumping” or “gaming the system.”<sup>40</sup> One touchstone to distinguish advocacy and queue-jumping is the responsibility to advocate equally or equitably for all patients, or to focus advocacy in areas of greatest need (for the most vulnerable patients).<sup>41</sup>

***Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list?***

I consider this to be improper preferential access, based on insider privilege.

It may be rationalized by those who engage in the practice by the social value of physicians or hospital workers, considering “social value” as a possible principle of ethical resource allocation.

There are well-known concerns about social value as a criterion for allocation of scarce medical resources. Social value is to a large extent in the eye of the beholder. Fair judgments of social value are costly and intrusive.

There are situations where allocation based on social value is contemplated, in particular, in military triage or in public health emergencies, where the viability of the system to meet the threat creating the shortage is dependent on human resources, and these human resources are themselves at a heightened risk from the threat. Insofar as resources in question are particularly scarce and consequential in such situations, the judgment of social value must be tightly tied to the social need to meet the immediate urgent situation and the particular role of persons in meeting that need.

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<sup>38</sup> RCPSC. The CanMEDS 2005 Physician Competency Framework: Better standards, better physicians, better care. Ottawa: Royal College of Physicians and Surgeons of Canada, 2005.

<sup>39</sup> Sibbald B. Is scarcity of resources a valid legal defence? CMAJ 2000, Mar 21;162(6):880.

<sup>40</sup> Van Rosendaal GM. Queue jumping: Social justice and the doctor-patient relationship. Can Fam Physician 2006, Dec;52(12):1525-6, 1527-8; Cunningham N, Reid L, Macswain S, Clarke JR. Ethics in radiology: Wait lists queue jumping. Can Assoc Radiol J 2012, Aug 4.

<sup>41</sup> A useful discussion of the balancing act in clinical practice is Menzel P. Allocation of scarce resources. In: Rhodes R, Francis LP, Silvers A, editors. The Blackwell Guide to Medical Ethics. Oxford: Blackwell Publishing; 2007.

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In the kind of case envisaged by this question, it does not inspire public trust that this judgment of social value is made in the situation where the same parties control access to the resources and judge themselves to be especially socially worthy to receive them. Healthcare workers may not be the best judges of whether their role in society is more essential than those of police officers or teachers or transportation workers or home-makers providing substantial unpaid care for children, parents, and other community members.

The idea that healthcare access depends on the superhuman endurance of a single physician who never falls ill is a fading ideal. The idea that enduring a painful hip or missing work while on a wait list is worse for a physician than for other people is dubious. The idea that healthcare workers may suffer greater anxiety at the unknown does not seem evidence-based; even if it were, management of anxiety is not commonly proposed as a fair principle of resource allocation.

Such practices may be rationalized as preserving and facilitating working and referring relationships, as examples of professional solidarity and appropriate team behaviour. I believe there are ways to enhance working relationships while basing them on a shared ethical commitment to equitable access based on medical need.

I consider such practices to be examples of professional solidarity overtaking social solidarity: healthcare workers acting to privilege fellow insiders to the system over serving the public equitably. The pressure to preserve professional solidarity at the expense of patients is a troubling phenomenon posing well-known challenges for self-regulation, which ostensibly protects the public and also faces limits posted by insider solidarity.<sup>42</sup>

An argument in favour of healthcare providers adopting a perspective of **social (rather than professional) solidarity** is that when insiders to the system experience the consequences of how the system works, those with (relative) power and influence are appropriately motivated to remedy access and quality problems; allowing insiders to exit the

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<sup>42</sup> A recent contribution to the literature discussing this problem is DesRoches CM, Rao SR, Fromson JA, Birnbaum RJ, Iezzoni L, Vogeli C, Campbell EG. Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. *JAMA* 2010;304(2):187-93.

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public queue is likely to exacerbate the problems of the public system.<sup>43</sup>

***Hospital or medical staff obtaining flu shots before the general public?***

I will distinguish a scarce vaccine for a pandemic outbreak from seasonal flu shots.

In the case of resource allocation decisions in a situation of a public health emergency, allocation would be based on medical need/prevention of harm. In a given outbreak, it may be appropriate for those who experience exposure to a given risk while providing essential services related to managing that risk to receive preferential access. This would be an instance of ***ethically appropriate resource allocation*** based on evidence-based social value.

Some argue that a principle of ***reciprocity*** for service should also be in play. I am not in favour of mixing reciprocity and medical need: there are ways of expressing public appreciation that do not interfere with the distribution of healthcare based on medical need. This is an area of active debate and discussion.

Where scarce resources are allocated on the basis of social need (or society's medical needs), a careful, transparent, and multi-dimensional assessment should be made to ensure that a fair judgment is made about who is at risk (e.g. are teachers or transit workers also highly exposed?) and who is essential (e.g. are hospital housekeeping staff also essential workers?), and who is not (e.g. is an administrator who works offsite during an outbreak especially at risk?).

Outside of the pandemic context, seasonal flu vaccines are not typically in short supply, and they may be delivered by physician services and/or by public health and/or employer-based programs. That is, these are services delivered at the ***boundaries of medicare***, within and/or outside of the CHA, with its specific conditions of universal access on uniform terms and conditions without financial and other barriers. Within a context of sufficient supply and diverse delivery models it may not be worth the trouble to formalize allocation processes. A given service

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<sup>43</sup> This argument about quality incentives created by universal services is generally credited to Richard Titmuss: Titmuss RM, Abel-Smith B, Titmuss K. *The philosophy of welfare: Selected writings of Richard M. Titmuss*. London: Allen & Unwin; 1987.

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even if outside of medicare may have general principles and a culture of equity that may apply to this as to all its services. A shared standard set by the CHA cannot be assumed in this area; a general culture and specific approach designed to achieve equity must be set by explicit program policy.

***Professional athletes and their families obtaining flu shots or medical treatment before the general public access?***

I cannot imagine any ethically justifiable resource allocation rule by which professional athletes and their families would receive expedited or preferential access. Even if one were to defend and follow a general rule giving preferential access to those who occupy an elevated social role or exhibit a form of “human excellence,” I can see no reason why athletes would be selected as more worthy than other accomplished individuals or benefactors of humanity with large (or small) fan bases.

I can only speculate on practical and sociological reasons why this question would arise. Physicians and other healthcare providers, given their social location, may be particularly impressed by professional athletes, and so more likely to recognize and give expedited access to a goalie rather than a respected elder from a First Nations community, or a world class violinist, or a prominent physicist, or a great tattoo artist (examples chosen to highlight diversity in judgments of social value).

***A physician arranging for a friend or family member to be seen quickly?***

This is prevalent and widely tolerated in Canada. Although “professional courtesy” is officially considered to be a matter of after-hours appointments (see the Inquiry’s further questions below), one might reasonably wonder about the extent to which professional courtesy takes the form of after-hours appointments and to which extent it involves expedited care during normal business hours.

Professional courtesy involves ethical harm. Like access to diagnostic imaging, preferential access to a consult creates upstream inequities in access (to the next stage of services). It seems unlikely that the same physician who is unable to resist a request for an expedited appointment could resist the similar pressure for special consideration in making a referral.

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An argument in favour of the acceptability of the practice is that our healthcare system is so badly organized that it is particularly unreasonable to expect fairness to lay a stronger claim than personal loyalty.

I consider it to be another example of improper preferential access based on insider status. My greatest concern about the practice is in relation to the value of social solidarity: widespread use of personal connections to expedited access for insiders and persons of influence contributes to a system in which those with influence exit the public queue and hence have little incentive to advocate to improve the situation.

***Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?***

I understand this to be prevalent and widely tolerated in Canada. I consider it, again, to be highly problematic in terms of the public trust, conflict of interest, equity, and solidarity.

Hospitals more or less aggressively fund-raise from former patients. There is nothing wrong with fundraising, but hospitals should want to zealously guard against the appearance that treatment depends on a quid pro quo in the form of donations, in light of their stewardship of substantial resources dedicated to a public good and funded by the taxpayer, and their dependence on public trust. Refusing and being seen to refuse to consider preferential access for donors and philanthropists would be one way of guarding against such an appearance.

What “depending on the nature of the problem” means here is unclear to me. Preferential access for trivial problems and preferential access for serious problems are both problematic.

This is another dilemma where personal relationships of loyalty and gratitude come in tension with fairness and equity.

Again, the principle of solidarity would especially suggest that those with power and voice, who are in the best position to address shortcomings of the system – such as donors – should not be offered a view of the system that hides its blemishes.

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**Are you aware of any safeguards which currently exist in the health care system to prevent “improper” preferential access? If so, do you believe such safeguards to be effective and why?**

Well-managed wait lists (ethical criteria and transparent administration) discourage some forms of seeking and granting preferential access. The public can be reasonably confident that their needs will be met in a timely and fair fashion, and so the incentive to seek expedited access is moderated, while healthcare providers are better equipped to resist requests for special access, because they have the assurance that the system is a fair one that ensures appropriate care.

Where such a process is transparent – e.g. a group of cardiologists meets to determine priority access to bypass surgery, or an interprofessional committee meets to determine wait list order for scarce organs according to established and evidence-based criteria – there is less potential for individual wrongdoing than there is where wait lists are at the discretion of individuals within the system.

Regulations on the part of provincial insurers and regulatory college guidelines covering practices that constitute or are relevantly similar to extra-billing are sometimes effective.

Legislation against bribery and influence peddling for public office holders may be effective in controlling some kinds of requests for special access.

Transparent processes such as the application of clear eligibility criteria for safety net coverage (e.g. pharmacare) and the process of transparent and independent health technology assessment (for drugs for provincial or hospital formulary) contribute to preventing improper preferential access to programs and to specific goods and services.

**Do you believe that there are changes that can be made to the existing health care system to avoid or prevent “improper” preferential access? What changes would you recommend and why?**

Each of these areas is deserving of close analysis, but I make a few comments here about limitations to current mechanisms, and desirable directions of change.

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Leadership by the regulatory colleges in defining improper preferential access, as well as institutional policies that clarify healthcare providers' commitment to solidarity with the Canadian public and prohibit preferential access of insiders to the resources they control, could make substantial contributions to addressing this issue.

Self-regulation, however, is an imperfect means to address the tendency of a privileged insider group to give itself additional privileges. It is exceedingly unlikely that, for example, physicians will come forward and report on fellow physicians for giving preferential access to other physicians, or that these practices would be transparent to the public. (This is long-recognized as a problem for self-regulation in general.)

Public and transparent processes of priority setting throughout Canadian healthcare, replacing the *de facto* determination of resource allocation by mechanisms such as non-transparent physician fee negotiations,<sup>44</sup> and the further development of fair and centrally managed wait lists, would contribute to a fair system in which the rules of access could be considered just and worthy of upholding. Again, without transparency beyond the immediate care providers, organized wait lists can leave untouched the tendency of those within healthcare to give people like themselves expedited access.

As physicians operate for the most part as private business entities delivering publicly funded healthcare services with a significant degree of professional autonomy, the use of their position to secure preferential access for themselves, their friends, their associates, and other people who impress them, may not be understood or treated legally as equivalent to a public official's or public employee's use of his or her position to sway access to the public goods over which they have influence – which would be a clear breach of public trust. Indeed, practices of “professional courtesy” are a conscious hearkening back to the days where physician practice was purely a private business affair.

This specific mix of public funding and private delivery in physician services in Canadian healthcare contributes to the sense that access is theirs to grant. Perhaps legislative frameworks focusing on the crime of using a public office to secure personal advantage, rather than focusing on using any office or influence, public or private, to secure personal

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<sup>44</sup> Flood CM. *Just Medicare: What's in, what's out, how we decide*. Toronto; Buffalo, N.Y.: University of Toronto Press; 2006.

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access to a public resource, also contribute. Furthermore, existing legislation may effectively address explicit requests for favours, but not so clearly address unspoken expectations about preferential access, where the “benefit” traded may simply be avoiding an uncomfortable conversation, enjoying the pleasure of expressing personal loyalty towards associates or gratitude towards benefactors, or facilitating collegial referring relationships aimed at the good of one’s own patients.

Legislative or policy changes that provide greater transparency and public accountability on the part of Canadian physicians in their role as *de facto* managers of public resources, whatever their official employment status as private business persons, would contribute to more equitable access and clarity in the grey areas between corruption, conflict of interest, and professional autonomy.

Facilities and hospitals (and their accreditation bodies and regulatory frameworks) can also address these issues. For example, they should support staff in achieving equitable access by showing strong ethical and organizational leadership in relation to the expectations of special access by benefactors and public figures.

***Emergency Department Care: Providing high profile people with a separate waiting area away from the general public***

A special waiting area is technically an instance of preferential treatment or consideration, but not preferential access to care. Like a private room that can be purchased for a premium, it does not necessarily mean that a person will be cared for better or faster.

The issue here is less one of queue-jumping and more one of the ethos of the institution. Even in jurisdictions with multi-tier care, pressures to deliver luxury care constitute a problem in the inefficiencies they present and the pressure they put on resources that could be used to care for other patients.<sup>45</sup>

An equitable approach at the level of the institution to this policy question would involve questioning who is defined as needing privacy and why (what about the privacy needs of victims or alleged perpetrators of crimes, of people under threat of intimate partner

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<sup>45</sup> Donohoe M. Luxury primary care, academic medical centers, and the erosion of science and professional ethics. *J Gen Intern Med* 2004, Jan;19(1):90-4.

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violence?), while distinguishing preference and privilege from medical and social need. Learning about the privacy needs of an individual prominent patient can sensitize an institution to the gaps in its privacy practices, such as patient boards with names and room numbers in public access areas, that have significance for all patients.

***Emergency Department Care: Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff***

I consider this to be the same as other kinds of problematic insider access as has been discussed under several headings. Those who would advocate for the acceptability of “professional courtesy” would be hard-pressed to extend those arguments to preferential access to ED care, as there is no such thing as after hours access that does not bump other patients.

***Emergency Department Care: Physicians asking their own patients to go to the ED to receive elective procedures***

I am uncertain whether the envisaged scenario is simply one of inefficiency in the organization of the hospital services (presumably admissions for elective surgeries can be handled with less conflict for acute care needs if they are not handled by the ED), or an actual way for people to jump the queue for elective procedures.

It may be in a given area that there is a clinical threshold between a procedure being elective and urgent, and as patients are on the wait list for elective procedures, their acuity may change and they cross this threshold. For patients experiencing such a worsening to present to emergency may be the appropriate care pathway. Encouraging patients reluctant to do so may be an appropriate form of ***advocacy***.

Coaching patients who do not meet such a threshold to present to emergency with the right story to trigger urgent treatment would be ***gaming the system***, and a form of ***queue-jumping***.

In some areas of care, access may be so poorly organized that physicians have few options to secure appropriate care for patients, and what one physician considers advocacy another considers gaming the system.

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***Physicians: Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends***

This may either describe “professional courtesy” for an associate, or it may be a practice of accommodation for individualized, medically appropriate patient-centred patient care (for example, making special arrangements for a patient with autistic spectrum disorder who is distressed by a busy waiting room).

Where this is a question of professional courtesy, in addition to my answers above in relation to expedited access based on insider status, I add the following considerations:

An after-hours appointment may be “in addition” to the regular patient load, but is nonetheless a publicly-funded service; while some argue that no patients are harmed by being “bumped” when the appointment is after hours (ignoring follow-on effects), nonetheless access to a public resource is preferentially granted to associates.

Alternately, physicians granting appointments based on professional courtesy may elect not to charge (in this case, not to bill the provincial insurer) for such treatment. (This is what the Code of Ethics recommends for emergency care for self or close family members.)

***Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office***

This captures diverse phenomena, ranging from acts prohibited by the Code of Ethics (non-emergent care of close family), to a version of what is sometimes discussed in the literature as “curbside” or “hallway consults.”

**First, treating close family except on an emergency basis is prohibited by the Code of Ethics.** The prohibition serves a number of professional, personal, and ethical goals. The close relationship may interfere with unbiased medical judgment, whether by swaying the provider towards imagining the worst or towards denying the gravity of a situation. Any close relationship that would garner access to care is *ipso facto* a form of conflict of interest that may drive care providers to provide disproportionate attention to their friend or family over other patients for whom they have responsibilities. The role conflict affects

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the other side of the equation as well: the role of patient or of family member is an equally important role, and one of great personal value within the individual's narrative or family context, and may be sacrificed to the medical role. It is also likely that historical prohibitions on billing for care to family members where it is provided on an urgent basis is a recognition that close relationships create a greater potential for abuse of billing privileges, i.e. a danger zone for corruption.

**Second, curbside consults**, in the sense of an informal consult about one's own or a patient's medical condition, also known as curbside consults, **are a complex phenomenon**. In the context of ordinary care for a patient who is not a close associate, the physician receiving a request for a curbside consult must weigh the reason for the request (Does the patient or consulting physician have a legitimate or illegitimate reason to try to keep the consult off the record?). The risk of harm and legal liability assumed by undertaking care outside of a clear physician-patient relationship and with what may be inadequate instruments and information must be considered. On the other side, one's responsibilities to participate in a collaborative learning community and avoid excessively conservative risk management must also be considered.<sup>46</sup>

In the context of care for self and families, the question arises whether foregoing the physician-patient relationship for informal consultation constitutes an adequate form of self-care: the practice of consulting informally rather than pursuing care through a consistent physician-patient relationship is discouraged.<sup>47</sup>

All examples in this area must be contextualized: we live in an era where, as "activated patients," we seek information from multiple sources to enhance our health. We ask friends and family with experience with a condition for advice, and similarly we ask friends

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<sup>46</sup> Leavitt FJ, Peleg R, Peleg A. Informal medicine: Ethical analysis. *J Med Ethics* 2005, Dec;31(12):689-92; Perley CM. Physician use of the curbside consultation to address information needs: Report on a collective case study. *J Med Libr Assoc* 2006, Apr;94(2):137-44.

<sup>47</sup> Roberts LW, Warner TD, Carter D, Frank E, Ganzini L, Lyketos C. Caring for medical students as patients: Access to services and care-seeking practices of 1,027 students at nine medical schools. Collaborative research group on medical student healthcare. *Acad Med* 2000, Mar;75(3):272-7; Walter JK, Lang CW, Ross LF. When physicians forego the doctor-patient relationship, should they elect to self-prescribe or curbside? An empirical and ethical analysis. *J Med Ethics* 2010, Jan;36(1):19-23.

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and families who are healthcare providers with experience in care provision.

Healthcare providers, in the process of socialization to their profession, learn to set and communicate boundaries in such conversations. This is often discussed in relation to good patient care (the risk of informal second opinions without good information and under the influence of personal relationships that may bias clinical thinking) and self-care (the need for “time off” the physician role).

***Private Health Care Facilities: Do membership based private health care facilities constitute an example of preferential access?***

Where these facilities deliver extended or excluded services under the CHA, there is nothing to prevent health professionals from operating and patients from joining membership-based facilities that provide, for example, physiotherapy, massage therapy, nutritional counselling, chiropractic care.

Given the room left by the CHA for extensive diagnostic workups by physicians and for diagnostic imaging and other kinds of testing to be done by private pay, these practices create the potential for created expedited access to the public system. Potentially problematic practices are reviewed above in Table 6.

Boutique medicine, in the form of a membership-fee-based physician practice, is an area of policy concern in some provinces, particularly where market conditions support the development of such models.

Regulatory colleges have typically, and appropriately in my view, clarified that where a funding for a service falls under the CHA, offering access or expedited access to this service based on the payment of a fee is a form of improper preferential access, in specific, a form of extra-billing. They have also clarified that services offered bundled must also be available unbundled, and patients may not be excluded from a physician’s practice for refusing to pay for bundled services.<sup>48</sup> Enforcement varies from jurisdiction to jurisdiction.

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<sup>48</sup> See, for example, College of Physicians and Surgeons of Alberta. Standard 18: Charging for uninsured services. Standards of practice [Internet]. Edmonton AB: CPSA; 2010 [cited 2012, Nov 25]. Available from:

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While regulatory colleges have been clarifying that physicians may not establish such boutique practices, I do not believe they have adequately characterized and regulated multi-disciplinary and corporate practices where physicians may provide a limited set of services and only to patients of that membership based facility. Does the responsibility not to create financial or other barriers to care follow the physician into that multidisciplinary setting and compel it to adopt a certain access model, or may the physician split their time between practicing in such a setting and in the public setting, as they may do for a range of non-insured services (e.g. cosmetic surgery)?

I believe that we have blatant double standards in this area, and that it will be challenging to regulate this effectively under the framework of Canadian medicare.

***MLAs or their Staff: Providing advice to their constituents about wait times, alternate care options etc.; Requesting special consideration for a constituent by communicating directly with a health care provider***

In general, as suggested above, one can distinguish ethically acceptable advocacy in terms of navigation and sharing of information from ethically unacceptable advocacy such as calling in special favours or exercising personal or political pressure. It would be difficult to imagine a scenario where direct communication from a political figure to a healthcare provider would be anything but the latter. The MLA who wants to advocate for patients should advocate for decent treatment of patients as a class, not for special treatment of specific patients.

***Senior Hospital or Health Authority Officials: Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient***

This is similar to the questions about a separate waiting room in the ED: they are less questions of equity in access and more of equity in experience of care. Someone in a private room is not necessarily receiving faster medical care or a higher standard of medical care.

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[http://www.cpsa.ab.ca/Libraries/Res\\_Standards\\_of\\_Practice/CPSA\\_Standards\\_of\\_Practice\\_Consolidated\\_Version.pdf](http://www.cpsa.ab.ca/Libraries/Res_Standards_of_Practice/CPSA_Standards_of_Practice_Consolidated_Version.pdf); College of Physicians and Surgeons of Ontario. Block fees and uninsured services [Internet]. Toronto: CPSO [cited 2012, Nov 25]. Available from: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1612>.

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In hospitals, patients may and do purchase private rooms where this is medically possible.

All patients have needs of privacy and confidentiality. A high profile patient may make this clear to providers and institutions, but equally an “ordinary” patient who is threatened by an ex-spouse (for example) has privacy needs that may not be met by common hospital practices.

***Calling front line staff to make them “aware” that a VIP patient is in the hospital or in the system***

It would be irresponsible to make such a call without a defined and stated goal; front-line staff would reasonably conclude they are being asked to deliver special treatment.

If a patient who would cause disruption in terms of media interest, law enforcement, or security needs is entering the hospital, then communicating this may be important, but accompanied by specific instructions or policies as to the nature of the concerns and accommodations to be undertaken.

If the provision of care in a particular area is so inadequate that administrators feel it is not appropriate for or not desirable to be seen as the norm by VIP patients, then this is a signal for much broader action.

I discussed above the responsibilities to provide patient-centred and culturally sensitive care. It is important to distinguish the responsibility to accommodate a patient’s “special needs” in a sense that promotes health equity from the desire to accommodate a patient’s “special needs” when this is a cynical label for the requests of VIPs for extra or expedited care. The former promotes health equity and the latter promotes health inequity.

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## (b) Preferential Access to Health Care Services in Alberta, An Opinion

**Dr. John Church**

### Overview

The issue of preferential access to health care is nested within the larger issue of access to health care. In Canada, access to health care is prescribed by federal legislation, the *Canada Health Act*, and also through individual provincial and territorial legislation. The *Canada Health Act* prescribes that all insured persons have “**reasonable access**” to healthcare facilities and that hospitals and physicians are reasonably compensated for providing this access. The Act also prescribes that access to publicly funded health care will be determined by “**medical necessity**.” In practice, physicians determine medical necessity based on their recognized expertise. The gatekeeper role is sanctioned by the state on behalf of its citizens. The key point here is that physicians make decisions about who will access health care, what type of health care and when that health care will be accessed based on criteria related to the severity of illness, not the ability to pay or other “non-medical” criteria.

In practice, physicians have a professional obligation/responsibility to advocate for the best health care for their patients. This includes attempting to gain access to appropriate health care in a **timely** fashion based on professional judgment about the severity of the illness and what is medically required to resolve the issue. Individual family physicians develop professional relationships with individual medical specialists based on a number of factors including professional reputation, availability and geography. Thus, family physician A may develop a relationship with medical specialist B and will tend to refer patients routinely to that specialist. Family physicians will have a back up plan for referral to an alternate medical specialist should the usual specialist referral not be available. Family physicians also develop similar relationships with other occupations such as physiotherapists.

Within this context, individual physicians can gain access to health care for *their* patients through a variety of avenues, depending on their connectivity to different parts of the healthcare system. The key point here is that the motivation of the physician is to advocate on behalf of

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**their** patient for access to *medically necessary* health care based on *severity of illness* as determined by professional judgment.

Even under normal circumstances, there may be variability in access based on the nature of the way in which individual physicians discharge their responsibility. Variation may occur as a result of a number of factors including the availability of the family physician and/or the specialist and the severity of the illness compared to other patients being seen by the family physician or the specialist. Thus, a form of preferential access may and does occur based on how individual physicians exercise their clinical judgment, navigate the system, and based on severity of illness and availability of resources such as diagnostic imaging and hospital beds. This form of preferential access is commonly recognized as acceptable and is foundational to the healthcare system in Canada. International evidence is clear that this approach to allocating health care produces better results than other possible alternatives.

A second form of preferential access relates to the notion of professional courtesy<sup>1</sup>, a time-honoured practice of referring family members to other physicians in exchange for the same courtesy. This stems from the ethical requirement of not treating one's own family members and the professional desire to build bonds among individual practitioners.

Taking the above as representing what would normally be considered as acceptable access, are there additional, non-medical criteria that might be applied in determining when preferential access to health care is appropriate? One circumstance in which preferential access to medical health care might be warranted would be for workers deemed as providing an *essential service*. Included in this category might be health care providers (doctors, nurses, other core medical providers), emergency service providers (EMTs and firefighters), law enforcement (police) and senior politicians (PM, premiers and cabinet ministers).

This sort of preferential access would be particularly important during times of recognized collective crisis (pandemics, war or terrorism or catastrophic natural disasters). An argument might also be made that immediate family members of certain essential service workers (e.g.

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<sup>1</sup> Professional courtesy is not unique to medicine. It is a practice common to many occupational groups ranging from lawyers to mechanics.

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medical specialists) also be granted preferential access, especially if the illness of the family member is severe enough to prevent the essential service provider from discharging their normal professional responsibilities. Again, during times of crisis, this would be particularly important.

Criteria that might be used to determine when preferential access might be appropriate for essential service workers might include: the nature of the service being provided (how essential is the service?); the context under which preferential access is being sought (e.g. pandemic); the consequences of denying preferential access (e.g. denial or delay in accessing essential services by other members of the public possibly resulting in injury or death).

### **The Questions:**

Keeping the above discussion in mind, we now turn to a discussion of the seven questions raised by the Inquiry.

1. At the current time, there is no common definition of preferential access. We know from research that access to health care is affected by a variety of factors including socio-demographic status, and ethnicity. In short, some individuals are better able to access health care than others, although in Canada, ability to pay has been eliminated for core medical services. Having said this, the only clear definition that exists at this point relates to *appropriate access*. This definition revolves around the concepts of medical necessity and severity of illness as determined by physicians.
2. Without a clear definition, determining “proper preferential access” and “improper preferential access” revolves primarily around the definition and criteria assigned to appropriate access as defined through the *Canada Health Act* and other provincial legislation or regulations. However, most if not all of this revolves around the interpretation of physicians based on professional judgment. At the very least, under the existing legislative framework, access to publicly funded health care that violates the principles of the *Canada Health Act* would constitute inappropriate preferential access (e.g. queue jumping). So, access to health care for reasons other than medical necessity as determined by a physician or other designated health care provider and/or access to publicly funded

health care based on ability to pay would constitute inappropriate preferential access. The one caveat to this principle might relate to certain categories of workers deemed essential as described above.

3. “Proper” preferential access to health care might include anything deemed by a physician or other duly designated health care provider to be medically necessary based on the severity of illness. Making this determination should be based on clearly established clinical criteria that meet professional quality assurance requirements. The potential harm associated with this approach to accessing health care is that some patients receive preferential access to health care over others. However, the criteria used for making this determination are both ethical and practical.
4. “Improper” preferential access would refer to access to health care based on criteria other than medical necessity and severity of illness based on recognized professional clinical judgment. So, accessing health care through “threat, influence or favour” would be considered improper. Interestingly enough, the small amount of research that has been done in the Canadian context suggests that while supporting this notion in principle, a minority (not socio-demographic specific) of the public-at-large is willing to pursue preferential access to health care based on criteria other than professional clinical judgment. Other very limited research within the Canadian context suggests that politically connected individuals are more likely to receive preferential treatment than other members of the public.  
The harm in allowing preferential access to health care is that it undermines the principles of the *Canada Health Act* and ultimately undermines public confidence in the healthcare system.
5. i) As discussed above, physicians have a professional obligation/responsibility to advocate on behalf of their patients for appropriate access to medically necessary services. The recognition of the expertise of physicians in determining what constitutes disease and how best to treat it has been broadly acknowledged by Canadian society for over 100 years. The granting of self-regulation to Organized Medicine by Canadian governments is formal recognition of the collective



trust that Canadians place in the capacity of physicians to represent their best interests in decision making about health care. Unless the knowledge base underlying health care alters significantly, it would be difficult to envision a superior means of advocating for patients, although discussions about which professions are qualified to exercise clinical judgment in this role are ongoing.

ii) Physician use of emergency OR slots to book patients in for surgeries represents one of the practical means by which physicians advocate on behalf of their patients for appropriate access to health care. The practice has emerged largely because of increasing wait times for access to certain medical procedures. Whether this is “proper” or “improper” depends on one’s perspective. From the point of view of the physician fulfilling their professional responsibility, it is proper because it expedites the process of getting **their** patient in for appropriate health care. From the perspective of the system administrator, it increases the volume of patients being seen in emergency rooms and contributes to increased wait times at this point of access to the system. The underlying issue of wait times is discussed further below.

iii) As discussed above, allowing a physician or other health care provider to obtain an MRI faster than spending time on a waiting list is probably appropriate when failing to do so might adversely affect the provision of health care to other patients. One can imagine a circumstance in which a heart surgeon is unable to perform heart surgeries because of a deteriorating hip. In this case, diagnosing and treating the heart surgeon as quickly as possible is in the best interests of everyone. However, not all circumstances merit the same consideration for expedited health care.

Another category of workers currently receives preferential access because of coverage through Workers’ Compensation Boards. Because these services are financed separately from public-financed services they create a parallel but institutionalized pathway for preferential access to health care services. The appropriateness of this access is a subject of debate. As with other categories of workers, the case needs to be made about the relative societal benefits of expedited access to healthcare services.

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- iv) Hospital and medical staff who are deemed essential workers should obtain flu shots prior to the general public. The definition of “essential” should consider the collective benefit of providing this sort of preferential access. Not all hospital and medical staff are a *priori* essential.
- v) Professional athletes and their families do not meet any reasonable definition of an essential worker as described above. Thus, preferential access to publicly funded health care by these individuals would be generally considered as inappropriate.
- vi) A physician arranging for a friend or family member to be seen quickly might constitute part of the tradition of professional courtesy. Regardless of the personal relationship, if the decision is not based on objective clinical judgment about medical necessity and severity of illness, then it might be considered inappropriate. As discussed above (#4), limited research suggested that a minority of the population (not socio-demographic specific) is willing to pursue this avenue in order to expedite the process of accessing health care.
- vii) As discussed above, certain categories of politicians (e.g. PM, premiers and cabinet ministers) might ethically and practically be considered essential workers. Preferential access would depend on the severity of the illness and the context within which the request was being made (e.g. national/provincial crisis). Financial donors and philanthropists do not constitute essential workers by any reasonable definition and therefore do not merit consideration for preferential access.

#### **Additional Sub-Questions**

- viii) Providing priority access in the emergency room for doctors, nurses, AHS staff and/or family members, or a physician’s patients, accompanied by a physician, nurse or AHS staff would only be appropriate if clear criteria for medical necessity and severity of illness relative to other patients in the emergency room at the time were met. Alternatively, if failure to provide such preferential access would prevent an essential worker from carrying out their
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duties and place other members of the public in danger (as discussed above), then preferential access would be justified.

ix) Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on weekends would not be justified except as discussed below (x). Doing so might call into question the lack of availability of the physician to all patients during non-scheduled office hours. A physician might offer a home visit or on-call service to all patients after hours to ensure equal access.

x) Physicians writing prescriptions or providing medical services for friends, family or medical colleagues outside of regular office hours might be allowable as a professional courtesy as long as it does not compromise availability of care for regular patients. Within reason, a physician's private time is his/her own. However, providing medical care to a family member may constitute a breach of the medical code of ethics.

xi) Recently, a number of private companies have begun to offer comprehensive health care packages to individuals based on an annual membership fee. These arrangements have been the subject of ongoing monitoring as potential violations of the *Canada Health Act*. It has been alleged that some of these companies in Alberta have engaged in queue-jumping for certain advanced diagnostic testing provided through the publicly funded system. If these allegations are demonstrated to be true, then it would constitute inappropriate preferential access. Depending on the circumstances, it might also constitute medical conflict of interest and be in violation of the *Canada Health Act*. The only caveat here would be if the access provided was based on clearly demonstrated medical necessity and severity of illness relative to all other patients waiting for the same diagnostic test at the same location.

xii) An MLA or political staffer providing advice to their constituents about waits, alternative care or other health care options would not be considered as inappropriate preferential access. Providing this sort of information on other government services is an important part of the legitimate role performed by MLAs. Also, AHS and Alberta Health provide various online resources for determining the length of wait times for

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various surgical procedures and also for access to emergency care. Increasing emphasis is now being placed on making this sort of information more readily available to the public.

xiii) An MLA or political staffer contacting a health provider to request expedited access for a constituent would be inappropriate unless justified through demonstrated medical necessity and severity of illness criteria relative to all other patients awaiting access at the same facility.

xiv) Providing high profile individuals with special treatment, such as a separate waiting area, private room, anonymity or a “heads up” call from senior management to front-line staff, would constitute inappropriate preferential access. The only exception to this would be if failure to make these arrangements might pose a clear safety risk for the individual, other patients, other members of the public and health providers, or otherwise disrupt the efficient provision of health care services.

6. In 2009, Alberta Health Services issued guidelines relating to dealing with requests for preferential or expedited health care. While the guidelines served as a useful starting point for identifying the issue, they did not prescribe an appropriate response with sufficient transparency. Referring the matter directly to “the President and Chief Executive Officer of Alberta Health Services” and/or providing “advice as to how to most effectively access and navigate the provincial health care system” might still be construed by the public as facilitating preferential access to health care.
  7. Based on the discussion provided in this opinion, changes need to be made in the way preferential access to health care is addressed. These changes include developing the following:
    - clear guidelines and protocols (including compliance tracking) for the application of the concepts of medical necessity and severity of illness;
    - a definition of appropriate and inappropriate preferential access, and related criteria;
    - a definition of essential workers and related criteria;
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- a transparent, clear and effective process for administering these definitions and criteria; and
- a transparent, clear and effective process for determining wrongdoing, including whistleblower protection and serious penalties for demonstrated wrongdoing.

### **Concluding Thoughts**

The issue of preferential access to health care in Alberta has arisen primarily because of publicly unacceptable wait times for access to health care services. If wait times were at an acceptable level, then presumably efforts to gain preferential access would no longer be necessary. Therefore, efforts to reduce wait times to acceptable levels must continue regardless of appropriately addressing the specific issue of preferential access. Addressing the issue of preferential access now is essential because it potentially violates the *Canada Health Act* and undermines confidence in the publicly funded health care system.

Having said this, efforts to address wait times have tended to be focused fairly narrowly on developing administrative and clinical solutions to dealing with wait lists and surgical management. Far less attention has been directed toward the broader organization of the continuum of health care and its impact on access to services. Even less attention has been focused on the role that prevention of injury and disease might play in reducing wait times. We know that injury rates in Alberta are high relative to other jurisdictions; we know that with an aging population we are facing more complexity in illness; we know that chronic diseases such as obesity are on the rise, especially among younger populations; and yet we are not devoting sufficient resources to address these contributing factors to current and future demand pressures on the system. Failure to get serious about these broader population trends will almost certainly mean that demand pressures on the system will not decrease. In turn, this will lead to continuing unacceptable wait times and a continuing pressure for preferential access.

Dealing with the issue of preferential access to health care represents treating a symptom related to a larger disease. If serious strategies to address the larger disease are not developed and implemented, the symptom will likely continue in some form.

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**Recommendations**

1. Develop clear guidelines and protocols (including compliance tracking) for the application of the concepts of medical necessity and severity of illness.
  2. Develop a clear definition of appropriate and inappropriate preferential access.
  3. Develop a definition of what constitutes an essential worker.
  4. Develop a transparent and fair process for administering these definitions.
  5. Develop a transparent and fair process for determining wrongdoing, including serious penalties.
  6. Develop effective whistleblower protection.
  7. Develop effective strategies to address wait times.
  8. Develop a comprehensive and **well-resourced** wellness strategy.
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## (c) Responses to Preferential Access Questions

**Dr. David Alter**

### LIST OF QUESTIONS TO BE ANSWERED BY EXPERTS

#### 1. What is “preferential access” to health care?

I am unaware of any uniform definition of preferential access. However, within the Canadian context of universal health care, our previous study (“A Survey of Provider Experiences and Perceptions of Preferential Access to Cardiovascular Care in Ontario, Canada”, David A. Alter, MD; Antoni S.H. Basinski, MD, PhD; and C. David Naylor, MD, DPhil, *Ann Intern Med.* 1 October 1998;129(7):567-57) defined preferential access as incidents which result in unreasonable access to medically necessary services that allows for either more expeditious or wider use of services based on perceived socioeconomic status or for other non-medical reasons (family of staff, VIP, socioeconomic status etc.).

##### *i) Is there a common definition?*

Not that I am aware of.

#### 2. Is there a difference between “proper preferential access” and “improper preferential access”?

The distinction between proper and improper preferential access in part depends on how one interprets the appropriateness of access equity. Accordingly, I will begin by referencing the definition of the *Canada Health Act*, and bold some key phrases:

“Canada's national health insurance program, often referred to as "Medicare", is designed to ensure that all residents have **reasonable access to medically necessary hospital and physician services**, on a **prepaid basis**. Instead of having a single national plan, we have a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. Framed by the *Canada Health Act*, the principles governing our health care system are **symbols of the underlying Canadian values** of equity and solidarity.”

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The definition of preferential access is therefore open to considerable debate, and hinges on a few key issues or phrases as highlighted above: (1) “reasonability”; (2) “pre-paid payment”; (3) medical necessity; and (4)...framing the symbolic Canadian values of equity and solidarity. I will begin with the fourth issue first. I am not sure that symbolic goals are enforceable, definable, or indeed, an underlying Canadian value. While few would question the importance of many of the strong social policies that govern our country (and specifically, Medicare), I am not certain how such principles are to be interpreted within the *Canada Health Act*.

Do the symbols that underlie Canadian values truly reflect equity? There are many examples to the contrary. For instance, income expectations are not equal. Similarly, primary priorities of Canadian taxation policy solutions are not necessarily hinged on income redistribution strategies to improve equity. Do we, in Canada, discourage free-markets? Do parallel private systems not exist within other social programs like education? Does public-funding towards social programs for education cover all religious preferences? etc.

So, in reality, Canadian values, as observed by actual behaviours and policies do not necessarily reflect “equity” per se. In my opinion, the fourth issue of equity is actually one of the weakest arguments when debating the appropriateness or inappropriateness of preferential access. I am not a bioethicist, but equity alone seems unreasonable to be used to define or evaluate the presence or absence of “proper” or “improper” preferential access. Rather, preferential access must be evaluated within the context of the other issues specified within the *Canada Health Act*.

In distinct contrast to the issue of equity, is the issue of pre-paid payments. Out-of-pocket payment for Medicare-covered services would be considered illegal (at least in Ontario). Consequently, pre-paid payments from first-payers in order to expedite access would, by definition, be “improper”. However, there are circumstances where third-party payments are not illegal. Accordingly, legal third party payments used to expedite access and circumvent long waiting-lists do occur. An example might include a professional sports team and access to MRIs. In my opinion, as long as this is legal, such preferential access is not improper.

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The remaining issues pertain to issues of “medical necessity” and “reasonable access”. In my opinion, the crux here is that all patients in need of service should receive “reasonable access” to the service in question. So, any access afforded to individuals who are not in need of service, or preferential access for some resulting in unreasonable access delays for others in need of service would be considered “improper”. The challenge here, however, is that such a supposition assumes that “medical necessity” and “reasonable access” are quantifiable. For many (if not most) procedures/services, such terms have neither been quantified nor defined explicitly. Medical necessity may, in theory, involve an array of symptoms or signs. Examples include the following: An asymptomatic patient in need of service for screening; a highly symptomatic patient in need of Medicare services for symptom-control; and those who experience mental or psychosocial distress as a result of illness, symptoms, or screening. All such examples could be considered as “medically necessary”. How then do we prioritize these medically necessary, but highly variable indications? And, who decides?

For waiting-times to be considered “reasonable”, one presumes there must be standards for waiting-time acceptability. One might logically assume that waiting-time acceptability be defined in accordance to an agreed upon definition of medical necessity. For this to occur, one would assume that there must be an organizational process in place which prioritizes and delivers services in accordance to such acceptable waiting-times. While national wait-list strategies have attempted to set standards for waiting-times for selected services, few waiting-lists are explicitly managed in accordance to need. Without such mechanisms in place, “preferential access” will exist and is challenging to define operationally and prevent.

The distinctions between “proper” and “improper” preferential access remain unclear and ambiguous. The assessment of whether preferential access is “proper” or “improper” likely necessitates some legal and ethical conceptual framework. The former (legal) is fairly easily discerned. The latter (ethics) is more difficult, in part because ethics will vary by stakeholder groups. From a societal perspective, an improper example of preferential access may be a circumstance where an individual jumps several places in the queue despite objectively having similar disease severity as others who wait. Is that unethical? Not necessarily, for several reasons: First, it assumes that there is an explicit prioritization system in place within the queue that takes into

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account all clinical and potentially important non-clinical (e.g., distance and capacity) factors. Second, it assumes that the queue is organized in such a way that there is no flexibility in movement and that pushes and pulls are impervious and impenetrable within the management of the waiting lists. This is likely an unrealistic assumption. Third, it assumes that patient's clinical status and priorities remain static, and that medical personnel and system managers don't or can't respond to non-clinical extraneous factors that place added pressures or expectations to expedite care. Fourth, it assumes that the objectives and goals of an individual are always aligned with that of the system. Such is not always the case, especially since patients (and their families) self-advocate for care. Moreover, health care providers, public health advocates promote appropriate health-seeking behaviours. Reconciling differences between the needs of the individual and the needs of the system are challenging. Finally, no two individuals will experience the symptoms and/or psychosocial impact of disease. Accordingly, no two patients are entirely equal with regards to symptoms, experiences perceived, and its psychosocial impacts on health status and quality of life.

The example of a patient who is waiting to be seen in a busy fracture clinic, who then, after waiting hours, tries to self-advocate and expedite his/her own care because of non-clinical issues, such as his/her fear of missing his/her scheduled transportation with Wheel-Trans (a publicly-funded transportation service for those with disability) serves to exemplify the complexity of a queue. Is providing preferential expedited care for transportations reasons wrong? Is it inappropriate for patients to self-advocate? Who judges what is and what is not a valid reason to push ahead and receive preferential access? Do we really believe that we can prevent such pushes and pulls?

In reality, no queue is organized as a lineup. There are always circumstances, some of which are resource-based, while others administrative or personal, which will result in some patients being serviced ahead of others, even where clinical severity can be measured, and be deemed objectively comparable.

### **3. In your opinion, what would be examples of “proper” preferential access to health care?**

It is my opinion that preferential access is “proper” because it reflects reality. In our survey of preferential access, we noted that over 80% of

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Ontario physicians acknowledged having been personally involved in cases where preferential access for patients occurred. The issue in my opinion is not one of preferential access appropriateness or equity, but rather one that ensures that all patients in need of medical services receive reasonable access to such services without user fees or out-of-pocket payment. While access equity may be an aspiring goal of Medicare, it is neither realistic nor practical. Indeed, a “proper” preferential access circumstance might include virtually any example of self-advocacy. If patients advocate on behalf of their own health (which is something we as practitioners encourage), then is it not appropriate that they advocate for the best access that will improve their own health?

I also believe that preferential access based on personal connections is not necessarily improper. A patient who is sick who tries to expedite his/her care by involving a personal friend/doctor to advocate for them is not necessarily improper for the reasons discussed above. Is there evidence that people who push the system actually receive preferential access? In our survey above, health care providers made special note of “squeaky wheels” who often receive preferential access. It is not coincidental that “squeaky wheels” often receive preferential access to other services outside of our health care system. Is this “improper”? Why would we not expect that such societal patterns that result in individuals seeking expedited services outside of medical care not filter into their seeking behaviours within our health care system? Who should stop this? And why?

Finally, one can argue that in reality, our society already has multiple tiers and inequities. For example, urban patients will receive preferential access to services than that of their rural counterparts who experience longer waiting-times and less frequent services. Is this improper? No. Might this mean that more services are required to care for rural patients? Yes.

***i) Is there harm to the public health care system associated with “proper” preferential access to health care?***

Harm to public health care system originating from proper preferential access might be expected to occur when access to services are particularly constrained and where patients may experience adverse outcomes as a result of delay or an underuse of services.

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***ii) In your opinion, what is the nature of that harm?***

Death, re-hospitalization, symptoms (e.g., pain limiting mobility), quality of life. There may also be the issue of perceptions of bias for individuals receiving and not receiving preferential access. While speculative, for some, there may be an expectation or sense of entitlement for preferential access. For others not receiving preferential access, people could feel a sense of partiality, unfairness, or bitterness if they knew that others of similar severity received services more expeditiously.

***iii) Is that harm acceptable from an ethical or practical perspective?***

In my opinion, when harm manifests in adverse clinical events, then the harm from preferential access is not acceptable. However, from a practical standpoint, I'm not sure that harm results from inequity itself. While there is evidence that access inequalities to health care may impact on health outcomes, these circumstances usually occur at extremes of care – for example, patients who are in critical need of a cardiac procedure who, for one reason or another do not receive any such service whatsoever, and consequently, succumb to their disease. One might reasonably hypothesize that the relationship between variations in access and outcomes become weaker among populations who are less ill or sick. Moreover, there is little or no evidence to suggest that health is deleteriously affected by the occurrence of preferential access itself. Simple differences in waiting-times may only impact on the health status of selected individuals within the population – namely those who are critically ill, and/or those for whom service delays are so excessive that delays lead to significant exposure to adverse events. For many of these individuals, symptoms may change and worsen while waiting. Invariably, patients whose symptoms status worsen while waiting in the queue for a particular service should serve as an “alarm” and in turn trigger more expeditious care. Currently, waiting lists are not sufficiently organized to even monitor, service, and prioritize according to clinical need, let alone changing clinical needs.

Perhaps one may argue that the issue of “inequity” itself is unacceptable when there is a public expectation that health care delivery is (or should be) equitable. Should this expectation be reinforced by governments, media etc., then perhaps from an ethical

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perspective, herein lies the exception where inequity itself is unacceptable and harmful (particularly in a publicly-funded system which is ostensibly funded by the tax-payer). However, in the absence of such expectations, then inequity itself is not, in my opinion, an example of “harm”.

#### **4. In your opinion, what would be examples of “improper” preferential access to health care?**

Any circumstances which are illegal. For example, financial gains from “under the table” payments to expedite medical services would be an example of “improper” preferential access. As suggested above, patients who experience delays as a result of preferential access and consequently, experience adverse clinical events resulting from significant delays would be an example of “improper” preferential access. Finally, from an ethical standpoint, improper preferential access could exist from a societal perspective should public expectations, as reinforced by governments and health policy stakeholders, suggest that access to medical services be equal when in fact it is not.

##### ***i) Is there harm to the public health care system associated with “improper” preferential access to health care?***

Improper preferential access from illegal payments has logical harm to the public health care system and to society as a whole. Harm to the public health care system can also occur when patients experience adverse events as a result of service delay as a direct consequence of preferential access.

##### ***ii) In your opinion, what is the nature of that harm?***

Suboptimal health outcomes from those adversely affected by excessive service delays.

##### ***iii) Is that harm acceptable from an ethical or practical perspective?***

No.

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**5. In your opinion, would you characterize the following examples as “proper” or “improper” access to health care? [Explain with reasons where applicable]**

***i) Physician advocacy? Is this a good thing? Why or why not?***

“Proper.” Physicians should be advocates for their patients.

***ii) Physician use of emergency OR slots to book patients in for surgeries?***

“Proper maybe.” I do think there is an implicit unfairness should the patient’s level of clinical severity be far lower than their more urgent counterpart, and that delays incurred through the use of emergency OR slots might realistically result in adverse outcome events in others due to “access delays”.

***iii) Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list?***

“Not improper.” But, it depends on the perspective stakeholder. If a non-physician or non-hospital worker knew that his/her spot was altered because of a physician or hospital worker, one can certainly understand that that individual might be justifiably upset. However, from a system perspective, such preferential treatment represents a reality. Accordingly, it is the system which must “factor in” and consider such circumstances so that waiting-lists still have the flexibility to adequately service the queue despite the presence of preferential access for some.

***iv) Hospital or medical staff obtaining flu shots before the general public?***

“Proper.” Front-line workers at increased risk for exposure.

***v) Professional athletes and their families obtaining flu shots or medical treatment before the general public?***

One might argue that professional athletes are at high risk due to public exposure from travel and occupation. That said, professional athletes are not at higher risk for influenza-related complications than other populations such as the elderly, those who are immune-compromised, and/or those with multiple chronic diseases. Accordingly, from a

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medical appropriateness standpoint (more so than a preferential access standpoint), I think that professional athletes should not trump high-risk populations when obtaining flu shots. Certainly in the setting of flu vaccine shortages, I do not think that it would be proper for athletes to receive flu shots prior to high-risk populations. However, when compared with the general public, one might argue that they are at higher occupational risk from influenza than the general public.

***vi) A physician arranging for a friend or family member to be seen quickly?***

I think it's a reality of society - therefore not improper - but it depends on the service and the way in which that service delivery is organized. In the absence of explicit management criteria, for instance, I think the issue is not one of equity. Indeed, the issue is not so different from physicians who advocate for preferential services on behalf of their colleagues. These are natural social phenomena, and advocating for family and friends are natural for our society. However, in circumstances where patients are formally wait-listed in accordance to medical need, and someone usurps this because of preferential access, then the issue becomes problematic. When patient outcomes are adversely affected by delays that result from preferential access, then it should signal that resources may be too constrained and limited to the point that it doesn't allow for sufficient flexibility of movement and pushes/pulls that results from self-advocating or advocating on behalf of others (due to personal relationships or otherwise).

***vii) Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?***

I suppose it's perhaps hypocritical and disingenuous to state that preferential access should not be allowed for politicians and others, when I've stated that it is not improper for preferential access to be provided to physicians. However, there is a sense that people in public service using their political influence to self-advocate for, or advocate on behalf of others, expedited medical care access seems troubling (i.e., since politicians in theory are servicing the public good and in such circumstances would be using their position for personal gain with the consequences of added-strain to a health care system funded by the public-payer). That being said, once again, it's a reality. I have tended to politicians who received "red-carpet" access and care. I have

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accepted that it was the reality. The same holds true for donors and philanthropists.

**ADDENDUM QUESTION 5:**

*In your opinion, would you characterize the following examples of access to care as:*

- *Preferential access or not preferential access;*
- *If you determine it to be preferential, is it “proper” or “improper?” Please explain, briefly, the reasoning behind your opinion.*

**Emergency Department Care**

***Providing high profile people with a separate waiting area away from the general public***

No. In my opinion, waiting areas are not directly related to the provision of health care services. I would view separate waiting areas in a similarly to private rooms, which are often covered under personal or third-party payer insurance. That being said, I’m not sure how “high profile people” would be identified and characterized. Therefore, operationalization of separate waiting areas could be challenging.

***Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff***

If the question here relates to priority access to care for doctors, nurses or AHS staff, then I would characterize this as preferential access, as discussed in answers to question 5 iii. Alternatively, if the question here relates more specifically to the issue of accompaniment by doctors, nurses, or AHS staff, then I would not necessarily characterize this as preferential access, since accompaniment can simply serve as supportive roles for their colleagues (similarly to any personal supportive roles in health care settings), and does not necessarily imply that doctors, nurses or AHS staff who accompany other health professionals in the ED are expediting access to care. If access to care were being expedited, then this would be an issue analogous to 5 iii,

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and consistent with preferential access. The line of reasoning follows the previous responses given.

Where doctors, nurses or AHS staff uses their influence to expedite emergency room care, then such actions could be deemed as either “proper” or “improper”, depending upon the acuity of the patient in question, the general acuity of the other patients in the ED and ED capacity during the time of presentation. For example, a physician who accompanies his/her colleague to ED with an acute myocardial infarction and attempts to expedite care may not be inappropriate, because this would be seen as a life-threatening high acuity situation. However, a physician who tries to expedite access to ED services for a colleague who is experiencing knee discomfort and is otherwise of low acuity may be inappropriate, depending on the acuity of other patients and the availability of ED staff.

As in other examples of preferential access, colleagues do tend to help colleagues when medical issues arise. This may apply to the ED as well, and as long as other patients are not adversely harmed by the expedited access, I would view this as proper preferential access. In contrast, in circumstances where physician’s influence is used to expedite ED access for colleagues of low acuity levels thereby resulting in excessive treatment delays and adverse outcomes in patients whose acuity levels are higher, this would, in my opinion exemplify improper preferential access.

***Physicians asking their own patients to go to the ED to receive elective procedures***

This may or may not represent preferential access, depending on the clinical scenario, the rationale for referral, and procedure in question. This scenario seems may be better addressed under issues of referral appropriateness more so than preferential access. A physician who advises patients to go to the ED for non-emergent or non-urgent matters may be more indicative of inappropriate care than preferential access per se. Moreover, a physician referral to the ED does not necessarily imply that a patient will be given preferential access. The ED triage process tends to be variable, and the degree to which outside physicians may have influence on this ED triage process will also vary widely. ED triage processes may also filter-out elective from more urgent cases, and referring physicians may be implicitly taking such considerations into account when referring patients into ED.

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Beyond inappropriate referral patterns, there may be other mitigating circumstances that necessitate physician referrals to ED for elective procedures. For example, physicians may send their patients to ED because of diagnostic ambiguity. While the procedure in question may be “elective”, the patient’s clinical status may be complex, necessitating more comprehensive assessment. Other factors may include geographical challenges, which limit the ability to manage patients in communities without referrals to ED even for more elective procedures (e.g., remote rural communities). Moreover, even though patients may not be acutely ill, they may be sufficiently symptomatic and in need of temporizing or definitive surgical management for quality of life issues. Furthermore, not all elective procedures are similar; not all procedures have uniform “elective” definitions.

Some physicians may feel that utilizing the ED for non-urgent procedures may be justified in selected cases. Let us examine the extreme hypothetical example of an in-grown toe nail. Most would contend that in-grown toe nails constitute “elective” rather than “urgent procedures” (should a procedure be needed at all). Yet, questions still remain. Might there ever be a circumstance whereby in-grown toe nails require more timely intervention (e.g., infection)? What degree of symptoms would justify an in-grown toe nail from being managed in the ED? Finally, what if patients themselves advocate for ED or expedited services? In such circumstances, physicians may feel obliged to refer patients to the ED. In our study of preferential access discussed in question 1, physicians acknowledged that patient pressure was a driver or determinant of preferential access, in that physicians were responding to patient pressure.

## **Physicians**

### ***Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends***

This depends upon the physician’s usual practice schedule and the clinical circumstances of the patient. Physicians usually have flexibility in their schedules to “slot” patients in on a case-by-case basis. Such decisions are entirely discretionary and left up to the physician. If a patient is sick and is in need of medical attention, then the opening up of slots would not be considered “preferential access” because in such circumstances, expedited access is being provided in accordance to

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clinical necessity. If the “opening up of slots” were done selectively based on personal connection (e.g., family members, friends, VIPs, or others of influence), then such scenarios would be considered examples of preferential access. However, if care were still appropriate, then, as discussed elsewhere, such circumstances would in my opinion represent examples of “proper” preferential access. “Proper”, in that care was still medically justified at some level.

***Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office***

This represents preferential access. It is only “proper” if the prescriptions themselves reflect appropriate management. Physicians who write prescriptions for family, friends or colleagues outside of their medical office may not have had the time, medical equipment, or the ability to objectively diagnose or evaluate clinical conditions accurately or appropriately. In such circumstances, prescribing medications can be inappropriate (if not dangerous), and might accordingly exemplify “improper” preferential access. The assessment of written prescriptions also depends on the management in question. For example, prescribing a family member or friend an antibiotic in response to a rapid-positive strep screen for throat infections is very different than prescribing a family member or friend narcotics or benzodiazepines.

**Private Health Care Facilities**

***Do membership based private health care facilities constitute an example of preferential access?***

Yes. These would often constitute third-party payer (e.g., employer/insurance) health care. Where legal, these would in my opinion, exemplify proper preferential access.

**MLAs or their Staff**

***Providing advice to their constituents about wait times, alternate care options etc.***

No. Every patient should be given advice about wait-times and alternate care options. Where available, such information is often publicly accessible. Patients themselves should seek-out such information. Accordingly, providing advice about wait times or

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alternate care options does not in my opinion exemplify preferential access, unless, such information was not otherwise publicly accessible.

***Requesting special consideration for a constituent by communicating directly with a health care provider***

This depends upon the usual practice style of the physician. In theory, most physicians may do this routinely for their patients irrespective of personal connections or VIP status of the patient. Where physicians reserve such communication only to patients for whom there is a personal connection/VIP status, then this would be considered preferential access. If the special consideration is medically justifiable, then it is an example of “proper” preferential access.

**Senior Hospital or Health Authority Officials**

***Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient***

In my opinion, this would constitute “proper” preferential access. Anonymity may be important for a variety of reasons (confidentiality, distraction, etc.). Moreover, there are already precedents whereby private rooms are covered under third-party or first-party parallel private plans (e.g., Blue Cross). Finally, neither private rooms nor anonymity directly impacts on medical care per se (although, as discussed elsewhere, access to medical care will generally be more expedient as well).

***Calling front line staff to make them “aware” that a VIP patient is in the hospital or in the system***

I think this would exemplify preferential access. Given that these are front line staff, they are likely involved directly in the management of patients. “Awareness” among such staff, may (and almost certainly will) have effects on the evaluation and management of such patients. These circumstances would exemplify “proper” preferential access as long as the care being provided to the VIP is appropriate, and the outcomes of non-VIP patients are not being adversely affected by the expeditious care being provided to the VIP.

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## **6. Are you aware of any safeguards which currently exist in the health care system to prevent “improper” preferential access?**

Aside from the legal implications associated with improper payments, system safeguards to prevent improper preferential access would be three-fold: (a) ensuring that access to a service in question does not become too constrained that it cannot deal with the realistic pushes/pulls that are to exist and remain in society. Ensuring sufficient capacity will not eliminate or prevent preferential access. However, it will ensure that those in need can still receive services when preferential access does occur. (b) Explicit management systems that prioritize patients according to clinical necessity. Currently, there are rare examples of services (e.g., bypass surgery waiting lists in Ontario) that assign recommended waiting times in accordance to clinical severity. The broader implementation of explicit waiting-list management systems/formalized queues could not only help prioritize patients in accordance to clinical need, but could also facilitate system tracking and surveillance of waiting-times and outcomes, to ensure that those individuals in need are receiving service without excessive delays. (c) Demand-side initiatives that discourage the utilization of services that are not required based on appropriateness criteria. These admittedly are harder to implement. However, the assignment of appropriateness criteria/indications when patients are referred for services will at the very least allow for better system tracking.

### ***i) If so, do you believe such safeguards to be effective and why?***

The goal here would not necessarily be one designed to eliminate or prevent preferential access for the sake of equity. But rather, to prevent or mitigate adverse outcomes resulting from excessive waiting-time delays. Ensuring that there is sufficient supply/capacity for service, ensuring that there are recommended maximum waiting-times that are assigned based on clinical need, and ensuring that referrals for service are justifiable based on appropriateness criteria will minimize or manage the adverse consequences that may arise as a result of preferential access. System monitoring and tracking will ensure that no patient is waiting excessively for service.

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**7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent “improper” preferential access?**

Yes. Discussed above.

***What changes would you recommend and why?***

As discussed above. I view this as a system management issue more so than a societal ethical issue. Preferential access will occur. It is a reality. As with other programs in society, health care is multi-tiered. While health equity is a goal in our society, I don't believe Medicare is predicated on access equity. Regional inequalities in the distribution of services will create different access opportunities for different individuals. Interpersonal relationships and other societal values (that aren't necessarily predicated on egalitarianism) will filter into health care delivery. Clinical symptoms may be experienced and/or perceived differently between individuals. Inequities and inequalities will exist; such are the realities in Canada. The goals therefore are to ensure that the system can handle such inequalities to mitigate the repercussions and consequences of access inequalities on the health and outcomes of individuals in Canada. Supply-side initiatives, demand-side initiatives, and formalized waiting-list management systems will help safe-guard against adverse effects in the queue by ensuring timely access to services in accordance to patient need, regardless of whether some get serviced quicker than others.

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## **(d) Responses to Expert Questions**

### **Dr. Brian Goldman**

#### **1. What is “preferential access” to health care?**

##### *1) Is there a common definition?*

This is a crucial question to the Inquiry. From my examination of the medical literature plus my recollections of conversations with mentors and colleagues over more than thirty years, I am not aware of a common definition. Looking at the medical literature, the common elements to the definition include preferred access to and utilization of medical services for different patients of equivalent medical need based on factors other than medical need.

In my view, preferential access may be deliberate; or may be due not to deliberate intent but to observational factors. Such factors include age, sex, education and socioeconomic background.

For example, in a prospective observational cohort study of more than two thousand patients with acute myocardial infarction admitted to fifty-three hospitals across Ontario, Alter and colleagues found that more affluent or better educated patients were more likely to undergo coronary angiography, receive cardiac rehabilitation, or be followed up by a cardiologist than were patients in lower socioeconomic strata.

In my opinion, since it is not considered intentional, preferential access of this sort has been studied extensively. With preferential access or queue-jumping by design or intent, this is not the case. This is reflected in the number of citations on PubMed. Using the search terms ‘preferential access’ and ‘health care’, I found seventy-two articles; using the search terms ‘queue jumping’ and ‘health care’, I found just three articles.

In an article entitled ‘Ethics in Radiology: Wait Lists Queue Jumping’, Cunningham and colleagues write: “At present, there are few resources available to Canadian radiologists and radiology training programs to facilitate this learning.”

In their survey on queue jumping published in 2007 in the European Journal of Emergency Medicine, Friedman and colleagues defined

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queue jumping as the provision of preferential access to medical care for reasons other than medical need.

To my knowledge, the above definition has not been accepted widely. I would suggest that there is no universally recognized definition for the deliberate provision of preferential access based on factors other than medical need because such activity is considered unethical because it offends the concept of social justice.

In blog entry entitled ‘Queue Jumping, Standards of Practice and Budgets’, Dr. Trevor Theman, Registrar of the College of Physicians and Surgeons of Alberta, incorporated many of the elements of a formal definition of preferential access when he wrote the following:

It calls into question the whole notion of queue jumping and its definition, and the very real question of what definition will the inquiry accept and use. I note that the Cabinet order creating this inquiry states, in the preamble, that access to publicly funded health services is properly based on patient need and the relative acuity of a patient’s condition and that it is improper to gain access to publicly funded health services through threat, influence or favour.

In my opinion, the inquiry would do well to establish a definition of queue jumping that encompasses the following dimensions:

- Preferential access to publicly funded services;
- Based on factors other than medical need (for example, overt reward such as money, power, or influence or expectation of same);
- Offends the principle of social justice by correspondingly delaying or denying access to another individual of equal or perhaps even greater medical need.

## **2. Is there a difference between “proper preferential access” and “improper preferential access”?**

In my opinion, the distinction is open to considerable variations in interpretation. In medicine, there is universal acceptance of the notion of preferential access based on medical need. There are many tangible examples of this in medicine. For instance, in emergency medicine,

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using the Canadian Triage Acuity Scale (CTAS), patients are triaged into one of five categories based on the acuity of their illness or injury and the immediacy of the threat to life or limb. These are arranged in descending order of medical need. CTAS Level 1 patients – examples include Cardiac/Respiratory arrest, major trauma, and shock states – need to be seen immediately, regardless of when they arrive in the ED. CTAS Level 2 patients – examples include those with altered mental status, head injuries, severe trauma, heart attacks – need to be seen within 15 minutes of arrival. By contrast, CTAS Level 5 patients – examples include sore throat, upper respiratory infection and mild abdominal pain – need to be seen within 120 minutes eighty per cent of the time.

I would define proper preferential access as that provided based on legitimate medical need. I would define improper preferential access as that occurs by intent of the patient or an individual who arranges that access on the patient's behalf or because of passive factors discussed above (e.g. age, gender, level of education, social status, and the knowledge and experience of the patient's care providers).

### **3. In your opinion, what would be examples of “proper” preferential access to health care?**

Examples of “proper” preferential access to health care include:

- immediate access to angioplasty or bypass to patients with acute coronary syndrome;
- organ transplant access in order of need based on consensus criteria;
- priority assessment in the ED of agitated patients out of concern for the disruptive effect of such patients on work flow and emergency personnel;
- separation of ED patients into major, ambulatory and rapid assessment zone (RAZ) categories so as to improve overall efficiency and throughput.

**Is there harm to the public care system associated with “proper” preferential access to health care?**

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Of course there is. In general, preferential access operates on a 'one patient at a time' basis and with little if any regard for the impact of said access on the integrity of the system. The fact that there are wait times for everything from MRIs to joint replacement therapy demonstrates the potential for adverse effect on the system. In terms of patients requiring extraordinary levels of care, right now, the system can tolerate one patient at a time requiring thrombolytic therapy for a stroke or a ventilator for a patient with an exacerbation of chronic obstructive pulmonary disease. However, a large number of patients requiring these services can quickly overwhelm the system. It is for this reasons that notions of medical futility (the provision of life prolonging treatment without hope of returning the patient to a reasonable quality of life) are gaining attention in any discussion of the future of publicly-funded health care. The coming 'boomer tsunami' will likely test the system's ability to provide "proper" preferential access.

**In your opinion, what is the nature of that harm?**

There are two kinds of harm. The first is direct harm to patients who have to wait longer for treatment because of others who are deemed to have preferential access because of a legitimate need as currently defined. Patients who don't meet the test of "proper" preferential access wait longer and as a result suffer reduced quality of life if not an overt threat to their health. The second type of harm is to the system. The more patients needing "proper" preferential access, the less predictable the demands upon the system and therefore the less efficiently it runs.

**Is that harm acceptable from an ethical or practical perspective?**

From a practical perspective, the harm described above is acceptable because a publicly funded system does not possess infinite resources and therefore cannot be all things to all people at all times. From an ethical perspective, it can be argued that the harm caused by "proper" preferential access is not acceptable. In 2010, I hosted a town hall meeting at George Street United Church in which bioethicists Dr. Lionel

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Rubinoff mused about an emerging concept among bioethicists. Notions of patient autonomy tend to predominate discussions of whether or not to offer life-prolonging or death-delaying treatments. Rubinoff said that as members of society, patients must balance autonomy with justice. He said bioethicists are beginning to discuss the idea that patients should have a duty to refuse death-delaying treatments that are widely considered to be futile, especially in tough economic times in which resources are finite.

#### **4. In your opinion, what would be examples of “improper” preferential access to health care?**

- Any instance in which a health care provider or employee with access to the booking system for health services gives preferential access to a publicly-funded health care service in return for a payment of cash or gifts.
  - Any instance in which a health care provider or employee with access to the booking system for health care barter preferential access to publicly-funded health care in return for services and/or discounts.
  - Any instances in which a ‘VIP’ receives preferential access to publicly-funded health care for no reason other than the fact they are famous.
  - Any instance in which a health care provider or employee with access to the booking system for health care services offers a ‘VIP’ preferential access to publicly-funded health care services in return for the possibility of receiving a favour or favours at some point in the future.
  - Exception: In my opinion a VIP who provides major support to a particular health facility should obtain preferential access to publicly-funded health care services provided by that facility because a) his or her financial support provides a net benefit to the health care system and b) it would be petty and churlish not to provide such services in that situation.
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**i) Is there harm to the public health care system associated with “improper” preferential access to health care?**

Yes.

**ii) In your opinion, what is the nature of that harm?**

Improper access harms patients treated in a publicly-funded health care system by lengthening wait lists. Improper access harms the system by reducing efficiency, by undermining public confidence in a publicly-funded system and by reinforcing such behaviour.

**iii) Is that harm acceptable from an ethical or practical perspective?**

From an ethical perspective, improper access is unacceptable because it offends the true purpose of publicly-funded health care, which is to provide health care to the public regardless of ability to pay. Permitting wealthy and individual patients to obtain improper preferential access turns access to decision making in health care into a commodity that can be sold or bartered to the highest bidder. Improper access to publicly-funded health care undermines the concept of social justice and also undermines social cohesiveness. Left unchecked, it can lead directly to evolution of publicly-funded health care into a two-tiered system. From a practical perspective, improper access is unacceptable if it reduces access to the system by patients who do not use or have recourse to improper means. That results in longer wait times which can lead to greater morbidity which in turn puts even greater stress on the system.

**5. Which of the following would you characterize as “proper” or “improper” access to health care and why?**

**Physician advocacy?**

In my opinion, physician advocacy is an example of “proper” access to health care. Advocacy can be patient-centred, clinical, administrative or legislative. Advocacy is considered a core value of the practice of medicine. There are calls for advocacy training in medical education. Advocacy based on

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evidence is always proper. Advocacy that is based on emotion rather than evidence may lead to improper access. The phrase “the squeaky wheel gets the grease” comes immediately to mind. However, in this case, the fault lies not with the physician advocate but rather the system that permits advocacy without evidence-based merit.

### **Physician use of emergency OR slots to book patients for surgeries?**

If such a practice necessitates postponing emergent cases, then such access would be improper. However, if it’s a case of “use it or lose it”, then one can argue that such a practice while not proper makes appropriate use of the system based upon the administrative context.

### **Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list?**

This is the Canadian equivalent of “professional courtesy”. In countries such as the United States – where health care is an out of pocket expense – professional courtesy generally refers to the provision of medical services free of charge or at reduced rates. As recently as 1993, surveys indicated that almost all American physicians extended professional courtesy to colleagues. Although not formally defined as such, professional courtesy in Canada has come to mean physicians and other health professionals offering preferred or faster access to medical services than the lay public would ordinarily receive. It would be up to the inquiry in Alberta to decide whether such access is improper or not. Some consider it improper. Others say such preferred access is proper for two reasons. First, it alleviates the added apprehension of health care workers given their knowledge of the worst case scenarios of presenting complaints. Second, the faster a health care worker is seen and treated, the faster that worker can return to productive work, which is a net benefit to the health care system. The argument often stated anecdotally by health professionals – “in a publicly-funded system, faster access is the only thing we can offer each other” – is based on emotion and tribalism and is clearly an example of improper access. It

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would be well worthwhile to do a survey to determine the scale of professional courtesy in Canada.

**Hospital or medical staff obtaining flu shots before the general public?**

This is clearly an example of “proper” access to health care. Studies have shown that higher rates of immunization among health professionals lead to lower rates of flu and lower rates of mortality among residents of long term care facilities and lower rates of flu transmission in hospital. It also leads to lower rates of absenteeism in the health care system. For all of these reasons, preferred access to flu shots is a net benefit to the health care system.

**Professional athletes and their families obtaining flu shots or medical treatment before the general public?**

This is clearly an example of “improper” access to health care. There is no net benefit to the health care system or the public from such a practice. If allowing it to occur inconveniences or delays other patients, then one can argue the practice is unethical.

**A physician arranging for a friend or family member to be seen quickly?**

This is an example of “improper” access because doing so clearly causes others with illnesses of equal or even greater severity to wait longer simply because they have no such advantage.

**Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?**

This is clearly an example of “improper” access because it confers advantageous access based on fame, power or money. As I said above, one could make an exception for donors if their contributions provide a net benefit to the health care system.

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## Additional Scenarios

*In your opinion, would you characterize the following examples of access to care as:*

- *Preferential access or not preferential access;*
- *If you determine it to be preferential, is it “proper” or “improper?”*

*Please explain, briefly, the reasoning behind your opinion.*

### Emergency Department Care

- **Providing high profile people with a separate waiting area away from the general public.**

This is an example of improper preferential access because in a single payer publicly funded system, access to ED services of any kind should be based solely on medical need. Although a separate waiting area per se would not necessarily convey superior treatment, such an entity would undermine social justice by creating a perception that by being in a separate waiting area, high profile people would receive preferential access.

- **Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff.**

This is clearly an example preferential access. The issue is whether or not it is improper. In the United States, where medical services are not free of charge, there is a long and unchallenged tradition of professional courtesy in which colleagues receive care free of charge or at reduced rate. Given the long tradition of professional courtesy, in my opinion, it would be churlish to deny physicians the right to provide special access to colleagues they work with and esteemed colleagues in the medical community at large. One can argue that there is a net benefit to society if such preferential access results in a colleague returning to work faster. However, this would be of no relevance in the case of

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retired colleagues. In my opinion, the same courtesy should be extended to immediate family members of the colleague. Although this opinion may offend some and may be tacit approval of a social injustice, in my opinion, we must create rules that take human nature into account. For example, my father has been admitted to the hospital where I work on three occasions in the past two years. The staff that have cared for my father were unfailingly courteous and helpful to him and to me. I have no doubt the fact I am a colleague played a role in this. Were that courtesy to change to an attitude of contempt or condescension (as in “You know the rules, Brian. Fair is fair.”), it would probably affect my ongoing relationship with those colleagues.

- **Physicians asking their own patients to go to the ED to receive elective procedures.**

This is a grey area. The answer depends on how ill the patient is. If by elective, you mean that the need for the procedure is in no way an emergency, then asking the patient to go to the ED to receive it sooner is an example of improper preferential access because it’s gaming the system – knowing that ED staff are largely unable for medical legal reasons to declare a patient a non-emergency and send them home. What makes this a grey area is that all too often, the patient sent to the ED to have a test or a procedure done sooner needs it sooner. Looked at another way, studies show that people who come to the ED need care. Very few ED visits are out and out unnecessary. The larger issue in this instance is that often, the larger problem is lack of comprehensive primary care – which necessitates ED visits for care that should be available elsewhere.

## **Physicians**

- **Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends.**

This is not preferential access unless the practice is used on a habitual basis to funnel preferred access patients into the

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system. The answer therefore depends on the circumstances. I have met many consultants who make room to see an urgent referral by seeing them in off hours. As well, one could argue that the consultant who sees patients in their office quickly by slotting them into off hours is preserving the integrity of the system by not slotting such patients into normal working hours. Physicians must retain the option to manage their own time.

- **Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office.**

The writing of prescriptions and the providing of medical care for immediate family members outside of emergencies is a form of conduct that is governed by specific provisions of regulated health professions legislation. If prescribing under such circumstances is considered improper, then it is my view that there is no need to give an opinion as to proper or improper preferential access. The providing of prescriptions and medical care for friends and colleagues is likely a form of preferential access since it is less likely to be made available to patients who are neither friends nor colleagues. However, in my opinion, there is not enough information provided in the premise to this section to judge whether such preferential access is proper or improper.

### **Private Health Care Facilities**

- **Do membership based private health care facilities constitute an example of preferential access?**

Such memberships likely provide preferential access. One could argue that such preferential access is proper since it is limited to non-insured services such as massage therapy and access to a registered dietician. However, from interviews that I did for a radio show on concierge medicine, it's clear to me that part of the service provided by the physician in return for a membership includes privileged access to the physician via phone or email during out of office hours. If the physician has completely opted out of provincial Medicare, then such access

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would be considered neither preferential nor improper. However, were the physician to bill both the patient and the province, doing both would in my opinion blur the boundaries between public and private services. As such, it would be highly likely that at some point in the course of care, the patient would be receiving improper preferential access.

### **MLAs or their Staff**

- **Providing advice to their constituents about wait times, alternate care options etc.**

The answer depends on how they get the information they share. If the information were available freely, then such a practice would not be preferential and would in any case be proper.

- **Requesting special consideration for a constituent by communicating directly with a health care provider.**

In my opinion, such requests are what MLAs do on behalf of their constituents, and are neither preferential nor improper. That said, if a health minister or a legislative secretary with direct responsibility for health care were to do the same thing, in my opinion, doing so would, if successful, lead to improper preferential access. This is because the person being asked to provide special consideration might reasonably consider the request an order with consequences if disobeyed.

### **Senior Hospital or Health Authority Officials**

- **Requesting special arrangements (e.g. private room, anonymity etc.) for a VIP or high profile patient.**

If successful, this would certainly be an example of preferential access that would in my opinion be improper. This is because the person being asked to provide special consideration might reasonably consider the request an order with consequences if disobeyed.

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- **Calling front line staff to make them “aware” that a VIP patient is in the hospital or in the system.**  
In my opinion, this form of communication is the same as an out and out request, since the person receiving the call would in all likelihood understand that the purpose of the call is to make certain the VIP patient receives preferential access. If that were the only deciding factor, then the preferential access would be improper because it would in all likelihood bump a more medically deserving patient down the list.

**6. Are you aware of any safeguards which currently exist in the health care system to prevent “improper” preferential access?**

I’m not aware of any such safeguards. Given the ready acceptance of the advocacy role of physicians, it would be very difficult to tease out improper from proper advocacy without asking the advocate a lot of intrusive questions.

**7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent “improper” preferential access?**

It should be possible to discourage “improper” access through educational campaigns aimed at the general public and the health professions. Such a campaign could utilize radio, television and print ads to demonstrate examples of improper access and to discourage the practice.

System changes could also be put into place to discourage health care providers from trying to game the system. For example, placing an explicit message discouraging “improper” access on a diagnostic imaging order form or request for consultation may be effective. Putting in place a system to screen out attempts to obtain “improper” access might also be effective.

The main caveat of such initiatives is that their success may only be short-lived.

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**(e) Response to List of Questions to be Answered by  
Experts**

**Pam Whitnack**

***1. What is ‘preferential access’ to health care?***

Dictionaries define ‘preferential’ as giving advantage or a priority. Hence, ‘preferential access’ would describe a situation where an individual is given advantage or a priority in access to health care services.

There are a variety of definitions of the term ‘preferential access’.

It is often described as queue jumping where an individual receives the service more quickly than others on a waiting list. However, some would consider preferential access to describe an advantage available due to geographic proximity or economic circumstance. Other considerations are factors such as ethnic diversity, language barriers and gender inequality. Services provided to Workers’ Compensation Board clients and uniformed groups such as the RCMP may also be considered preferential.

The issue most commonly arises with respect to access to scarce resources.

***2. Is there a difference between ‘proper preferential access’ and ‘improper preferential access’?***

The term proper ‘preferential access’ may be used to describe preference given on the basis of clinical need or urgency. Medical judgment is the basis used to establish this priority.

‘Improper preferential access’ describes priority given to an individual with less clinical need because of some other action such as a financial incentive, or the exertion of influence, threat or offer of a favour.

***3. In your opinion, what would be examples of ‘proper preferential access’ to health care?***

‘Proper preferential access’ is appropriate treatment of individuals with greater clinical need. Geographic location provides an advantage of quicker access to some services, however this is largely unavoidable.

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***i) Is there harm to the public health care system associated with 'proper' preferential access to health care?***

There may be harm, in that it is impossible to assess the relative clinical need of individuals across a system with so many patients, providers and range of assessment skill. In a complex system, it is likely to be imperfect.

***ii) In your opinion, what is that nature of that harm?***

Harm would result in the impact on other individuals waiting for service. Even though their clinical need may not be as great at the time, their condition may deteriorate while waiting longer for service. This impacts not only the suffering of the individual, but also potentially the acuity and resource impact of their eventual treatment.

With respect to geographic advantage, some rural areas have potentially greater access to basic and primary care services, yet may be disadvantaged with respect to their access to tertiary services.

***iii) Is that harm acceptable from an ethical or practical perspective?***

While the harm associated with 'proper preferential access' may not be acceptable from an ethical perspective, from a practical perspective, solutions bring into question the allocation of scarce resources.

***4. In your opinion, what would be examples of 'improper preferential access' to health care?***

Examples of 'improper preferential access' to health care would include: payment made to a provider in an effort to receive a service more quickly; providing service to a friend without regard to the urgency; providing service more quickly because of the public profile of the individual.

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***i) Is there harm to the public health care system associated with ‘improper’ preferential access to health care?***

The harm to the system arises in that all individuals are not treated equally. Those that may have a greater clinical need have their treatment delayed in favour of someone with a greater advantage.

However, how can the system adjudicate given the complexity of the system? Specialist physicians and services have varying waitlists. This combined with different assessment skills and clinical judgment may cause individuals to seek a second opinion from a service with a shorter waiting list. Is this ‘improper’ preferential access if the clinical need exists? Because resources for many services are scarce, individuals try to navigate the system by whatever means are available to them.

***ii) In your opinion, what is the nature of that harm?***

The risk to the health of an individual with greater need is the harm.

While waiting longer than necessary, health can deteriorate, sometimes with drastic consequences.

***iii) Is that harm acceptable from an ethical or practical perspective?***

The harm is not acceptable from an ethical perspective as the system has an obligation to offer service to those most in need. From a practical perspective, delayed service may mean that an individual requires a higher level of service than they may otherwise require if treated more promptly.

***5. In your opinion, would you characterize the following examples as ‘proper’ or ‘improper access’ to health care? [Explain with reasons where applicable]***

***i) Physician advocacy? Is this a good thing? Why or why not?***

It is quite appropriate for physicians to advocate for their patients if the basis for the advocacy is clinical need. However, there is always the possibility this advocacy may be interpreted as a means to influence resource allocation within the health care system. Examples of clinical

need can include need to shorten wait lists for cancer surgery or to establish a colonoscopy program. In these circumstances, the physician is advocating for a program to serve a group of patients to the benefit of many individuals. Other examples though, may be advocacy to establish a program in a location that may not have the necessary supports from a quality and safety perspective, yet the physician advocates for the program on the basis of improving access generally. This latter situation can result in inefficient allocation of resources.

***ii) Physician use of emergency OR slots to book patients in for surgeries?***

The issue in this example is the appropriate use of OR time. Emergency slots should be used for emergencies. If the time slots are unused by emergencies, it is appropriate for the physician to use those times to treat his patients with the highest clinical need. This raises the question of course, about how one would actually have those patients available for surgery! Physicians understandably wish to make the best use of the available OR time. It is very difficult to assess the relative clinical need of the patients and thus very difficult to define as ‘improper’ preferential access.

***iii) Allowing a physician or hospital worker to obtain an MRI faster than spending time on a waiting list?***

In my opinion, this is an example of ‘improper preferential access’ if it is planned. However, there are occasions when patients who are booked for procedures cancel their bookings or do not show. On those occasions, what is the process? Does the department try to contact people on the wait list to come in on short notice? Or, is it more convenient to call a health care worker or physician who needs the procedure because of their proximity? I believe the high cost equipment should be used most efficiently, however every effort should be made to fill gaps created by cancellations from the priority waiting list.

***iv) Hospital or medical staff obtaining flu shots before the general public?***

In my opinion, this is ‘proper preferential access’. The health of the public is best protected through immunization of caregivers so they do not adversely affect the health of others.

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***v) Professional athletes and their families obtaining flu shots or medical treatment before the general public?***

My view is this is an example of ‘improper’ access to health care. There is no reason for this group to receive service ahead of the general public. There may be an economic benefit to society if professional athletes are able to play their sport, but there is no clinical reason for this to occur.

***vi) A physician arranging for a friend or family member to be seen quickly?***

In my opinion, this is ‘improper preferential access’. This example implies the friend or family member requires access to specialty services of some sort. The clinical need may be very high, yet ethically, the individual should follow the same path as others who are competing for access to scarce resources.

However, if waiting lists were reduced, the physician would not be called upon to respond to these requests with the same frequency.

This example is very difficult to assess since the person who the physician is assisting may have a high clinical need. The physician may be a skilled navigator of the system, but that does not negate the possible urgency of the friend or family member’s condition.

***vii) Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem)?***

Emergency departments have a triage system that should be used for all patients regardless of social status. However, there may be a need to provide extra supports to ensure confidentiality for higher profile individuals.

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**6. Are you aware of any safeguards which currently exist in the health care system to prevent 'improper preferential access' effective?**

***i) If so, do you believe such safeguards to be effective and why?***

I am not aware of any documented safeguards. There was a request by the CEO of Alberta Health Services for staff to refer any requests for preferential access to him. This was effective in providing staff with a buffer and allows requests to be considered at a higher administrative level.

**7. Do you believe that there are changes that can be made to the existing health care system to avoid or prevent improper preferential access?**

***i) What changes would you recommend and why?***

It is very difficult to establish specific rules and processes in a complex system that relies heavily on clinical judgment as the 'gatekeeper' for access. Creation of another bureaucratic process is unlikely to help.

Perhaps consideration can be given to strengthening the values and policies within the system. Greater awareness of the importance of universal access based on clinical need would provide reassurance to the public as well as reinforcement for providers to avoid circumstances that create 'improper' preferential access.

The Government of Alberta has introduced Bill 4, *The Public Interest Disclosure (Whistleblower Protection) Act* to the legislature. Though it will apply to the public service including Alberta Health Services and is expected to be enacted next spring, I am uncertain if this will apply to cases of 'improper' preferential access, but it does refer to situations of gross mismanagement of funds or acts that pose a danger to the public or the environment. Again, the system does not need to be encumbered by lengthy investigative processes, yet this existence of a deterrent may be helpful.

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### **Addendum to Question #5:**

*In your opinion, would you characterize the following examples of access to care as:*

- *Preferential access or not preferential access;*
- *If you determine it to be preferential, is it “proper” or “improper”?*

*Please explain, briefly, the reasoning behind your opinion.*

### **Emergency Department Care**

#### ***Providing high profile people with a separate waiting area away from the general public***

Provision of a separate waiting area is not preferential access, it is a means to protect the privacy and confidentiality for the individual. This would be preferential if the person receives treatment ahead of another with less need; or if another person who does not have a high profile were displaced from the available private space to accommodate the ‘VIP’.

#### ***Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff***

Priority of access should be based on clinical need. Just because someone is a doctor, nurse or AHS staff or accompanied by them does not mean that their clinical condition is not urgent. However, if they are treated with a higher priority than someone of less clinical need, then this is an example of ‘improper preferential access’.

#### ***Physicians asking their patients to go to the ED to receive elective procedures***

If the patient is sent to the ED to circumvent another scheduling process, then this may be an example of ‘improper preferential access’ as the example speaks of an elective procedure. However, there may be some reason that the physician believes there is a degree of urgency for the procedure that warrants a process other than traditional access. This again raises the question of fair means to adjudicate.

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## **Physicians**

### ***Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends***

A physician is responsible for the management of their own office practice. If they choose to see patients during extended hours, that is their choice. Presumably, they would be making those decisions based on the urgency of the patient's condition, and would not be 'improper' access.

### ***Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office***

Physicians practice in accordance with Code of Ethics and Guidelines as set out by the College of Physicians and Surgeons. This would provide the framework for treating individuals with whom they may have a personal relationship. Within that framework, if a physician chooses to write prescriptions or provide medical care outside of their office, they would make the decision with respect to the clinical need and act accordingly. In some cases this may constitute improper access, but is difficult to adjudicate.

## **Private Health Care Facilities**

### ***Do membership based private health care facilities constitute an example of preferential access?***

This depends on the benefits provided through membership. If I am promised an appointment the same day, this is available through the public system in many physician practices, so there is nothing preferential.

If I have paid for a membership that provides me with fast access to a private MRI when needed as part of my 'benefits', then I am not impacting the public system. This is no different than my ability to pay for a private MRI without the benefit of membership.

However, if I am promised faster access to publically funded services where I am placed in the queue ahead of someone with greater clinical need, then this is an example of improper preferential access.

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## **MLAs or their Staff**

### ***Providing advice to their constituents about wait times, alternate care options etc.***

The health system is large, complex and difficult for many people to navigate. It is not improper for MLAs or their staff to provide information and advice to their constituents.

### ***Requesting special consideration for a constituent by communicating directly with a health care provider***

The MLA or their staff may wish to advocate on behalf of an individual based on perceived need. However, it is very difficult for any lay person to assess clinical need. Requests should not be made to front line staff, as this may be perceived as the MLA exerting influence or an attempt to gain preferential access for the constituent. The current position of AHS is such requests are referred to the CEO for consideration.

## **Senior Hospital or Health Authority Officials**

### ***Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient***

All individuals have the right to expect their privacy and confidentiality will be maintained. Every effort should be made to provide this protection for VIPs, high profile individuals and their families.

A means to avoid special requests from senior hospital or health authority officials may be to provide staff in the ED with a policy or guideline that outlines what is expected in such a situation. Situations may arise where no private space is available, or it is occupied by a person with higher clinical need. In these cases, it may be impossible to provide the additional privacy to the VIP or high profile individual.

That said, it does not mean that the VIP or high profile individual should receive faster treatment, but rather a private place to wait in the queue. Faster treatment would be an example of improper preferential access.

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Ms. Pam Whitnack

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***Calling front line staff to make them 'aware' that a VIP patient is in the hospital or in the system***

This is not an example of preferential access unless there is an expectation of some special treatment.

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**(f) Response to Questions of Access****Dr. Owen Heisler****What is “preferential access” to health care? Is there a common definition?**

There is no common definition not just of preferential access but health care itself. If we consider health in its proper perspective (as per the World Health Organization) health extends beyond disease management to the wider social and spiritual aspects of health. Just as hospitals and physicians are important to health care, of equal if not greater importance are housing and income disparities within society. Such discussion is beyond what is under consideration here which I will take to be the health care system that is funded through the Alberta Government Department of Health. The concept of access is layered on this definition as the nature of both the system itself and the access to said system are extremely complex, layered in culture, politics, history and societal paradigms reflecting the social contract that exists in Canada.

Governments generate revenue through taxation. They utilize this global revenue to provide services for individual members of their society. There is a limit to how much is available for public goods corresponding to decisions on, and societal tolerance for, taxation levels. Not everyone who pays into the ‘system’ receives access to the entire scope of care they might desire. Not everyone who benefits from services contributes financially to the revenue base funding services. Different societies have different levels of taxation, different levels of government involvement in providing public goods and different value laden strategies in making decisions about allocation of public funds. Decisions on allocation of the public purse are expected by the public and the press to be made in a manner consistent with the ethical framework of the population providing the resources. Given resources are scarce (or there would be no need for allocation), those making the decisions will be held to task by the public for the choices they made as when allocating resources to one stakeholder group there will invariably be other groups who receive less than they wanted – the opportunity cost.

For resource allocation one usually considers three different kinds of allocation – macro, meso and micro. The macro allocation issue would

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be the larger issues faced by government in deciding how much of their global budget goes to 'health' compared to 'education' for example. These are global overarching decisions. Macro allocation decisions in Canada tend towards a modified egalitarian approach elevating health care to a basic right as opposed to the libertarian approach in the United States that considers health care more a commodity (see Appendix A). The meso allocation issues are those 'in between' decisions and are often hospital or region based. An example of a meso allocation issue would be whether a hospital with a given global allocation of resources (macro allocation already done) chose to spend its limited resources on a new orthopedic program or an integrated medical-surgical program for obesity. On a meso level, balancing acute health care interventions and preventative strategies is a pressing challenge in a resource limited environment. The decision as to which individual gets the hip operation within the orthopedic program would be a micro allocation issue. It would appear from the questions that have been proposed it is these micro allocation decisions which are the primary focus of this inquiry and further comments will concentrate on these decisions.

The questions that are being asked in this inquiry are framed as what is 'proper' or 'improper', what is 'right' and 'wrong' in regards to health care access – the subject of normative ethics. These micro allocation questions mean we must touch on the normative ethical paradigms of health care delivery in the Canadian context (see Appendix B). The challenge is when individuals say something is 'ethically' or 'morally' right this typically relates to their own unique perspective (most often shared within their local culture) which itself is often inconsistent as it is not unusual for individuals to flip flop on paradigms. As new technologies develop we see an increasing (apparently insatiable) demand fast outstripping society's ability to provide. This is reflected by increasing wait times and queues for limited resources. The question becomes how to allocate resources not just for individuals but, more importantly, to prevent implosion of the system for the entire society. Equality for everyone (egalitarianism) versus rule oriented distribution (libertarianism) and rights versus obligations become topics of hot debate. Conflicts arise. What is the right balance between advocating for individual patients and advocating for the rights of an entire population and which paradigm should be used?

Physicians in the Canadian environment are a group that deserve special attention given that it has been estimated that 70% of the health care costs can be directly traced back to a decision made or influenced

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by a physician. Appealing to ‘professionalism’ as a reason for physicians to participate in allocation decisions does not recognize the paradigm conflict between their fiduciary responsibilities and managing population needs. The challenge is that professionalism, if not the classical fiduciary physician-patient relationship, is, like health care itself, also not clearly defined (see Appendix B).

### **Is there a difference between “proper preferential access” and “improper preferential access”?**

When resources are limited there should ideally be a well-defined, agreed upon, transparent algorithm outlining strategies as to how resources (both rights and obligations) should be shared amongst a population. In such an algorithm there should evolve a hierarchy as to who goes first, who goes second and so forth – such a list would outline a relativity we call ‘preference’ (which may be positive or negative depending if above or below another in the ranking). Distributing resources in accordance with such a distribution process would be ‘proper preferential access’. One would expect such an algorithm would be determined in a fair and just manner reflecting the modified egalitarian approach characteristic of the Canadian population (after John Rawls as outlined in Appendix A) and that the algorithm would have imbedded rules that cover not only the original placing of groups/individuals but also rules that outline when an individual/group would be ‘fairly’ moved on the distribution algorithm reflective of changing context. In other words the ‘access to care algorithm’ must not be immutable and fixed but a living process responsive to agreed upon initial and ongoing criteria. It would be in those circumstances where individuals/groups have care outside of the ranking lists arising from such rules that one would consider this to be ‘improper preferential access’.

### **In your opinion, what would be examples of “proper” preferential access to health care?**

Any list one would derive on preferential access would be debated at length with great difficulties to gain consensus since allocation decisions are so context sensitive and reflective of the decision maker’s orientation to the issues at hand. Further, clinical judgement dramatically varies between different practitioners, also related to their individual context and orientation. Some of the micro allocation

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criteria (and this list is not inclusive nor presented in a ranked fashion) that might be considered in addressing access would include:

- Clinical criteria – As an example, in the Operating Room unscheduled cases are often prioritized utilizing an “E” system with E1 cases to be done in one hour, E4 within 4 hours and so forth. An E1 case might include such things as a patient with an actively bleeding stab wound that needs operative control or a laboring patient with a poor tracing indicating the baby might be at risk. Both would be done before an appendectomy labelled as an E4-6 which itself would be done before repairing a fractured bone which had been labelled an E24 by the orthopedic surgeon managing the case.
  - Pathophysiological criteria – If a patient has a cancer that has a recognized “Halstedian” progression wherein the earlier the cancer is treated, the better the outcome, management of this cancer should receive priority over processes that carry less risk. As another example, when deciding which of two patients with hernias should be treated first, a younger patient with a symptomatic defect more susceptible to incarceration would be treated prior to an elderly, sedentary patient with a broad based asymptomatic hernia.
  - Social criteria – In deciding when to schedule a patient, consideration of the availability of social supports should be considered. This might include the patient’s responsibilities of care for others (such as supporting another family member) or alternatively the availability of other support for the individual during their time of need (such as a mother-in-law availability to come and help care for a young family when the wife is being scheduled for a cholecystectomy). This would respect patient autonomy reflecting how access to services impacts their life; these factors are often poorly documented and tightly held such that the weight they attach to an individual’s decision to access services is not always understood or appreciated by others external to this decision.
  - Elasticity of supply – It is not unusual for resources to be available in unpredictable manners, not easily available again. This often results in time pressures which necessitate best efforts to use the resource in a fixed time interval. One example would be in the operating room. Cases are scheduled each day
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based on average time to complete a case. This means some days when cases will take longer than planned, not all the booked cases will be completed while at other times when cases take less time than planned there will be available time left at the end of the day (this may also occur if a case is cancelled). Spaces in the OR left available in this manner are like airline seats in that all the resources are already paid for and available (anesthesia time, nursing time, etc.) and to have this time available later costs more than using the time now.

Accordingly, efforts are taken to fill this time. Depending upon the availability of patients and surgeons this can be a scramble which does not necessarily reflect on the urgency of patient need. However, not using the time and opportunity from a system perspective would be a poor overall use of resources.

- Resource constraints – Access to one part of the system may depend upon joint availability of other resources. As an example, a cardiovascular case may need to be scheduled depending upon availability of a post-operative ICU bed. Although national efforts are made to ensure the highest priority case is offered the next available transplant organ, one of the considerations needs to be the timeliness of being able to provide the transplant itself which will often result in significant rescheduling of previously scheduled cases in the OR for example.
  - Commensurality – Commensurality is the ethical principle that distinguishes equality and equity. In public health consideration for example, the access to resources should be commensurate with risk of exposure. Hospital staff working in environments with high exposure to the flu virus should be vaccinated early as they are taking on more risk. Further (similar to putting your mask on first in an airplane prior to helping others), vaccinating care workers and others responsible for public services is a consideration in ensuring maximal total population access to services.
  - Access for the “Poor” – First, to be clear, this is not confined to an economic definition of poor but poor in the broadest sense. This is the basis of deontological ethics, the ‘walking a mile in somebody else’s shoes’. I am referring to what Rawls calls life’s ‘undeserved lottery’ a concept that is very strongly
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represented in feminist ethics. In our society there are those who are in unfortunate circumstances, sometimes as a result of externalities, sometimes as a result of how society itself is structured. Lasting societies can often be measured by how they treat their most vulnerable and disadvantaged and this must be considered in regards to access. Another variant to consider here would be disease processes wherein even though there has been no demonstrated survival benefit with earlier treatment there is recognized angst and emotional stress by having the disease untreated – surgical treatment of breast cancer falls into such a category.

- Professional Courtesy – In medicine the stories of individuals ‘going the extra mile’ are replete – individuals who stay on their own time to support patients, individuals who give of their time and energy to serve patients, individuals who truly treat health care as a calling as much as an occupation. I saw it in practice. I considered it professionalism. Further, health care is so much better if the treating team is truly a team and not a collection of individuals. It is likely a truism that the only way a health care system can put ‘patients first’ is by those embedded in health care administration of said system to put ‘providers first’.

Accordingly, I believe that there is a place to provide some degree of increased access to those working within the health care professions – not just physicians but all providers. In society as a whole, if my next door neighbor is a plumber, he might help me on the weekend. In the rest of society this might be looked at as a ‘black market’ in economic terms. The challenge for health care in the Canadian context is that payment for services comes from the public purse. However, especially if the provision of professional courtesy service ‘expands’ the total pool of potential services I do not believe this is unreasonable as one of but many variables to consider. If a physician sees an additional patient after usual office hours and this does not impact access for the rest of the patients this should be a consideration. The ethical principle here would be physician autonomy that would have to be balanced against societal non-maleficence.

Having shared my sentiment it is important to recognize this is an issue of great debate and significant historical context. The concept stems from the time of Hippocrates and was first

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designed to discourage physicians not to self-treat or treat their families. There was a suggestion that professional courtesy also built teams and fostered better camaraderie amongst physicians. The American Medical Association in their first Code of Ethics (1847) made the reciprocal treatment of physicians and their families an ethical responsibility. This ‘professional courtesy’ reflected on forgiving payment for services but was silent on ease of access, not an issue at the time. (At that time, physicians often came from lower social classes and struggled in a very competitive market place so that many physicians could not afford care.) Thomas Percival’s classic 1803 treatise on medical ethics actually suggested not only physicians but also the clergy should receive such ‘professional courtesy’ suggesting both did work that reflected benevolence in economically challenging circumstances. The Canadian Medical Association has similarly struggled with professional courtesy, an excellent example of which is provided in an article by Goldman that captures the disparate but impassioned points of view in the mid 1980’s (Goldman B. Professional courtesy: my colleagues will no longer be my brothers. CMAJ 1985; 132:422-8.) Until the revision in 1996, the Canadian Medical Association Code of Ethics retained an article indicating charging a fee to a physician or their family was contrary to the Code of Ethics (Article 43 in the 1990 Code of Ethics). The American Medical Association in their current Code of Ethics states in 6.13 that “While professional courtesy is a long standing tradition of the medical profession, it is not an ethical requirement.” An excellent summative article in the New England Journal of Medicine suggested at the time the article was written, 96% of physicians in the United States offered professional courtesy, defined as providing free or discounted health care to physicians and their families (Levy M, et al. Professional courtesy – current practices and attitudes. NEJM 1993; 329(22):1627-31.) The authors also suggested 92% of the physician respondents indicated it was an honor to treat a colleague. However, in the conclusion of the article the authors suggested there were ethical reasons to prohibit professional courtesy, especially since physicians were no longer unable to pay for care and there were so many Americans who could not afford health care or had limited access to it. At that time and increasingly so since, there are increasing legal requirements in

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the United States making it legally forbidden to forgive co-payments which further complicate this debate.

Paradoxically, there would be a concern that any such ‘professional courtesy’ may in fact lead to inferior health care for physicians and their families. Physicians would by the nature of their practice see low incidence events often enough to potentially lead to over-investigation which may in turn lead to worse outcomes (Bayes Theorem). Thus, though usually framed as an ethical issue of autonomy and justice there could be an argument from a beneficence point of view that professional courtesy is not justified (very similar to the argument made that routine breast examination at the time of annual examination is no longer recommended given that the effects of over-investigation and over-treatment that result lead to worsened outcomes)

- Macro-Economic Considerations – Though we are considering micro allocation criteria, it is important to remember that the macro and meso allocation decisions also reflect on individual choices. As an example, in rural communities, health care is a major economic driver of the local economies which in turn increases the total health of the community by providing income and jobs. This needs to be considered in determining location of facilities. For example, having a long term care facility in a rural area where it may not potentially be optimally matched to population needs, might allow access to human care resources (underemployed nurses for example) and sustain this local economy. This might also bring into the picture distribution in society of ‘obligations’ rather than just ‘rights’ when we consider how far away from their ‘home community’ an individual should consider when accessing services.

There are wide overarching rules that everyone would agree to in their ‘black and white’ state. A choice to allocate the next OR space between someone recently stabbed and bleeding to death OR a patient who has been scheduled for several months for a non-life threatening condition would seem obvious to all. The challenge for all of these decisions is that ultimately there will be ‘grey areas’ that require consideration of the many other factors involved in the context of the decision. Further, it is also important to reflect transparently and non-

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judgmentally on the motivations and paradigms imbedded in the choices made by all decision makers in their allocation choices.

**In your opinion, what would be examples of “improper” preferential access to health care?**

I look to Aristotle who advanced the concept that a virtue is not one end of a dichotomous scale with a virtue demonstrating one extreme and a vice on the other end. The reality is that a virtue is the ‘golden mean’ between its two associated vices of either excess or deficiency. As an example, the virtue of bravery is between the vice of deficiency (cowardliness) and the vice of excess (foolhardiness). Likewise in the examples that I have indicated above in regards to what might be considered ‘proper’ access, each can be taken to the extreme of either too much or not enough which would then constitute ‘improper’ access to health care. As an example, if I use the category that I indicated was access to the ‘poor’, if the entire health care system concentrated on this group it would create unfair restriction to other groups whereas if this group was ignored we would deteriorate towards an entirely utilitarian ethic of health care allocation – both would be improper. The challenge in our system has to be developing the right balance between the myriad of considerations that need to be considered in allocating resources.

I will also add one other category here that deserves special attention. I will categorize this as the ‘squeaky wheel’ consideration. This would include a wide array of presentations. One example would be what has become characterized as ‘defensive medicine’ where a test or procedure is done not because it is indicated but rather because of underlying medico-legal considerations. The challenge with this relates to the at times forgotten reality that all tests are not perfectly accurate with understood rates of false positives and false negatives. With rare diseases, the challenge is that the rate of false positives approaches a rate where the risks of intervention outweigh potential benefits for the net disadvantage of a population – not to say anything about total costs to the system.

The other concerning component of the squeaky wheel would be political interventions – either formally through the political system or informally through what might perhaps be best characterized the ‘connected’. Most would agree that preferential access to a health care intervention purely because of advocacy by such a mechanism is not

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acceptable. However, here too there are grey areas. Sometimes, this is the only way that an unrecognized need comes to the attention of the system given the knowledge of the individual in need of care. This is navigation in the system. This would be good. However, it would not be good if, after consideration of all other factors, it is purely the relationship with the political champion that forms consideration for priority access. An interesting consideration here is perhaps best demonstrated by the decision to give Mickey Mantle a liver transplant. Although Mr. Mantle was a poor candidate for a liver transplant, he did receive one of the few organs that were available. Of interest however is a reflection that the publicity of Mr. Mantle receiving the transplant actually increased the number of donors which in turn increased the total pool of organs resulting in a net benefit to those in need. This might be considered positive, especially in a utilitarian ethical paradigm.

**In your opinion, would you characterize the following examples as “proper” or “improper” access to health care?**

- i. Physician advocacy – It is imbedded in the Hippocratic Oath and in the fiduciary nature of the patient-physician relationship that the physician is to be an advocate for their patients. This is the same relationship expected in the legal profession. It would be the standard to which physicians would be judged in the legal system. The choice of a physician NOT to provide a test to a given patient would not consider an acceptable defense that other patients needed the test more when *a posteriori* the test would have made a difference. Changes in physician advocacy would necessitate changes in not only the physician-patient relationship but also the tort system. Physician advocacy is therefore good. The challenge is how to apply a ‘gate keeper’ to this behavior when there are multiple advocates for scarce resources. Individual physicians as advocates for their patients cannot be expected to serve this population need and we need to look at alternatives. The challenge is when physician advocacy crosses the boundary of fairness so that it becomes a ‘win’ to get the resource as opposed to fairly advocating for needs of their patients. If physicians are advocating not for their patient needs but rather solely for their economic or power advantage this has crossed a line, especially if advocacy is artificially couched in patient need.
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- ii. Physician use of emergency OR slots to book patients in for surgeries – Emergencies occur and are unpredictable in regards to volume and timing. Ideally, time should be available in an OR schedule for such cases. There also needs to be a fair mechanism of stratifying emergency cases so that those most in need of care are prioritized. This is completely appropriate. There will be times when emergency slots are available but there are no ‘emergency’ cases in need of the slotted time. In this instance the OR time (including time of staff and anesthesiologists) is available and already ‘paid for’, not to be available again. In this situation, filling the time with other, non-emergent cases makes good economic sense. If the time is not used the total waiting time will increase. Thus it is appropriate to use these slots to book patients for surgery and availability becomes an important consideration for using the time. One must also be thoughtful of administrative time in scheduling as it might be more timely and possible to fill the time with a patient not already in the queue rather than moving the whole queue up. Filling the time with patient X might make much more sense than moving A to the available time, B to A’s time slot, C to B’s time slot and so forth. There are often multiple social reasons that make sudden movements in time difficult to accomplish in the short term that would not make this manageable. There is another challenge with this scheduling that occurs when the patient most in need of an available emergency OR time is available but their surgeon is not (perhaps because he/she is in their office) – this brings in the consideration of having another surgeon available to provide the care. This is becoming very common in the orthopedic surgery environment but not in all environments and adds another layer of complexity in regards to how to best manage, especially when the physician and patient already have a pre-existing fiduciary relationship. This becomes extremely challenging to manage as it brings in patient and physician autonomy against beneficence and justice.
- iii. Allowing a physician or hospital worker to obtain an MRI faster than spending time on the waiting list? – Most would agree that all other things being equal, priority access on this basis as a sole consideration is not reasonable in a publically funded system. However, there are many other considerations that apply. The same argument as above applies in that a time slot
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that becomes available in the short term should be filled – at times this urgent availability might actually be a physician or hospital worker who happens to be in the hospital at the time the slot becomes available. If the reason to schedule an MRI for a health care worker is directly related to their health care position the principle of commensurality would suggest this should be considered. If for example, they hurt their back providing patient care in the system it might be considered whereas if they hurt their back playing sports outside of the system one might not give this as much weight. The other consideration is the need of the whole system. For example, if several nurses are off work awaiting an MRI and this absence from work means that service will not be available as a direct result of their absence, it might be reasonable to give some weight to giving them preferential access (all other things being equal) to ensure that the system maximizes its potential. A further example of this could be seen in the prioritization lists that were considered during the H1N1 epidemic where prioritization of care to essential service workers such as health care providers, fire fighters and the police service was a consideration.

- iv. Hospital or medical staff obtaining flu shots before the general public – In this instance I believe this is right most of the time. Hospital and medical staff would be expected to have greater exposure to the flu virus related to their work in environments with expected higher concentrations of individuals with high viral loads. As well, if the hospital and medical staff contract the flu there are fewer resources to manage those in the population who get the flu. Finally there is a concept of ‘herd immunity’ where having more people immunized decreases the spread of the flu in care environments. For all these reasons, I think it appropriate the flu shots consider these groups with greater priority.
  - v. Professional athletes and their families obtaining flu shots or medical treatment before the general public – If the vaccine supply is significantly limited (which is very unusual) the answer would be no. This was witnessed during the H1N1 vaccination program where a hockey team did receive preferential access. The public indicated this was not acceptable and in the context of the severely restricted supply of vaccine such access cannot be justified. However, vaccine
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is usually available and our challenge is more getting the population immunized. If the same thing happened this year (hockey team immunized early) where there is no shortage of the vaccine this may actually be very positive in that we have a shamefully low rate of immunization in our province and it would be hoped that positive public media attention of a hockey team getting the vaccination may actually increase immunization in the public. It is all in the context of the multitude of factors one has to weigh into the decision. If we could be certain that the total number of people getting immunized in a population increases because of the potential positive message that this priority immunization provides (perhaps as a quid pro quo in that the professional athletes would publically promote immunization for this preferred status) then the positive overall population outcome might very well justify this strategy.

The question of medical treatment for professional athletes needs to always consider the clinical context of the presenting complaint of the professional athlete in that injuries that occur as a result of the circumstances that professional athletes are subjected to often demand more urgent assessment because of the immediate risk of the injury and potential future injuries because of the environment in which they compete. Sports injuries and their management has become a separate branch of medicine because of this complexity which is often not considered in determining this access. The access has to be related to clinical need and risk. To add to the complexity of this discussion is the expansion to an even broader discussion as it relates to what type and kind of support a society should provide to its 'elite' athletes who represent our country at international events – when is the outcome for the good of the individual and when is it for the good of a society?

- vi. A physician arranging for a friend or family member to be seen quickly – The question would be how this person receives this 'quick' visit. If the visit is an 'expansion of supply' in that it is an additional visit at the end of an office for example, is this any different than a plumber fixing the toilet for his sister or friend? This does relate to the rightful autonomy of physicians within a society to be able to have some control of their environment. A corollary of this question is whether a physician (excluding
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emergent reasons) has to see every patient that presents to them. The challenge is when a patient in the queue to see the physician is cancelled or deferred because of this preferential access which is potentially more problematic and relates to the context of patient need (beneficence and non-maleficence) balanced with physician autonomy.

- vii. Politicians/donors/philanthropists being seen in emergency without waiting (depending on the nature of the problem) – The moral argument might be that since this group has been involved in increasing the size of the health care ‘pie’ by the decisions they have made in the past or might make in the future this would entitle them to preferential access as without these additional resources less total resources would be available so the overall net good outweighs this individual behavior. This is a utilitarian argument and I am not swayed by this argument. I believe this kind of preferential access is not justified in the Canadian system. The politicians/donors/philanthropists have both rights and, equally as important, obligations related to their positioning. We should be striving to provide a system that provides optimal care to all. Ultimately such a desired system will result in decisions to optimize resources for health care, be it through political decisions, donations or philanthropic efforts. Any preferential allocation via the politician/donor/philanthropist route also has the risk that the next investment in health care is made to reflect the personal wish of an individual rather than reflect on the most pressing needs of the population. Of all the questions that were asked in this section, this is the one that I have seen asked all too often and which I am most troubled by.

**Are you aware of any safeguards which currently exist in the health care system to prevent “improper” preferential access effective?**

1. Media – the media is a powerful means of oversight by shining lights on issues of concern in resource allocation. The challenge is that the media tends to look at individual rather than population outcomes which can create challenges of its own. Unusual events make for much better news stories than public health campaigns which also risk skewing public expectations. Another challenge is that confidentiality of individual patient
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decision making criteria may prevent full disclosure of the clinical scenario and risks.

2. Regulatory Colleges, especially the College of Physicians and Surgeons of Alberta (CPSA) given the preponderance of physician involvement in micro allocation decisions. The CPSA has a robust process to evaluate complaints and concerns about physician behavior and this oversight role needs to be complemented by increasing promotion of adoption of standards of care. The CPSA has a legislative framework that incorporates members of the public in reviewing troubling cases that adds value to the process.
  3. Underlying virtue ethic of health care providers. At the end of the day the vast majority of physicians make these allocation decisions responsibly and collaboratively each and every day. This is the ‘virtue ethic’ of physician behavior since the time of Hippocrates. We do not have robust enough data and information systems in the present environment to develop a system to replace this.
  4. Increasing emphasis on booking protocols to rationalize resource use. An excellent system developed in Ontario (often referred to as pCATS) for pediatric surgical patients and spread across the country (*Can J Surg.* 2011 Apr; 54(2):107-10 presented as an abstract at <http://www.ncbi.nlm.nih.gov/pubmed/21443828>) is an excellent example of the power of these targets. Alberta is currently working with BC to develop similar targets in the adult world. This needs to continue.
  5. Increasing involvement of physicians in administrative roles. In several jurisdictions development of dyadic leadership models have evolved. The hope is that greater engagement of physicians in roles such as these will lead to more robust gate-keeper rules and roles.
  6. *Health Professions Act* (HPA) has better defined professional roles, scopes of practice and complaint mechanisms that in their entirety have the potential to provide more transparent and just oversight.
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**Do you believe that there are changes that can be made to the existing health care system to avoid or prevent “improper” preferential access?**

1. Greater differentiation and transparency between macro and micro allocation decision makers in the system. The Ministry should concentrate their efforts to macro allocation decisions and strategy, deferring meso and micro allocation decisions (tactics and operations) to Alberta Health Services or its equivalent.
  2. Increasing emphasis and implementation of Standards of Practice. There are existing and evolving standards of practice guidelines that need to be more widely implemented and adhered to.
  3. Continuing work and implementation of pCATS and similar such scheduling tools.
  4. Ongoing dialogue and development of priority tools. One of the most developed of these is the Western Canadian Wait List (WCWL) project (<http://www.wcwl.ca/>) that is most mature in its development of ophthalmology priority tools. This project involved wide discussion and engagement to help inform these standards.
  5. Rationalization and optimization of physician leadership dyad models. These are very costly administrative modes that need to be optimally applied. The challenge with physician dyads is to clearly define roles of the various partners and ensure that the physician role reflects the need for increasing adoption of standards of care and quality of care initiatives and is complementary and not duplicative of administrative roles currently in place.
  6. Comprehensive and transparent outcome data. While we have much process data we do not necessarily have robust and defensible outcome data. In this instance the challenge is a bit of data is likely just as dangerous as no data as the outcomes will not be properly risk stratified. As an example of where this is a challenge we might look at publishing outcome measures on the web for surgeons. If, for example, I am a general surgeon and my hernia recurrence rates were to be published I may very well choose never to operate on a smoker again as
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they have higher recurrence rates. There are often many other reasons why a patient may not do well and unless ALL this information is transparently captured one runs the risk of making decisions on incomplete data that may actually adversely affect those most in need of care.

7. Review of the *Health Professions Act* (HPA) to ensure it has the mandate and role for each of the Professions to have valuable oversight of their members. This must include transparency and involvement of the general public. The HPA was a beneficial step forward but I would suggest needs refinement based on the initial experience of the last few years. It is my understanding there is some discussion of reviewing this Act in the next few years and I would strongly encourage this as the HPA needs to ensure there are forums for this discussion.
  8. There must be defined overview of booking systems within individual institutions that incorporate the input and feedback from all the health care team involved in the system. In my clinical practice there had been a mechanism to review any emergency cases that were booked as an emergency within the hospital when there were concerns. This should exist in all hospitals for all services. This should look not only at emergency cases but also scheduled cases.
  9. Over the last many years resources have been prioritized towards the ‘big 5’ as first defined in the late 1990’s by the Federal Government with funding (hip/knee replacement, coronary artery bypass, cataracts, and MRI/CT). We measure how many of these we have done (quantitative data) rather than whether we have made a true difference on outcome. We need to develop more robust systems to determine we have truly made a difference in outcome of patients rather than just measure numbers of procedures done. For example, when it comes to hip and knee replacement, do we have it right that we are concentrating on these procedures rather than perhaps allocating greater resources on prevention? This is likely best captured in an excellent article by Dr. Michael Porter in a 2010 New England Journal of Medicine article titled “What is value in health care?” where he emphasizes we need to consider value as dependent on results or outcomes achieved, not inputs. The questions need to be asked in a wide, transparent forum outside of decisions made by governments in the past.
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10. Political emphasis needs to shift to the “Triple Aim” described by the Institute for Healthcare Improvement which concentrates on patient experience of care, improving the health of populations and reducing the per capita cost RATHER than wait times in one part of the system – an emphasis akin to pushing in a bulge in a balloon with bulges occurring in often unexpected places. We need to concentrate on ensuring we provide the right care at the right place by the right provider and times will look after themselves. Unless the system can take the broader approach concentrating on marginal costs health will remain a political juggernaut in the realm of politicians rather than health care providers. This will take political will and skill.

**DISCLAIMER:** The above represent my personal opinion only and not that of any previous or current employer. Prior to completion of this document I did have a leadership role in Alberta Health Services and near the end of the completion of this document I did assume a role with the College of Physicians and Surgeons of Alberta. Much of this information is imbedded in the Fellowship paper I presented to the Canadian College of Health Leaders and I have copied some of this information directly. The entire paper is available at [http://www.cchl-ccls.ca/assets/FellowProjects/OwenHeisler\\_FellowshipProject.pdf](http://www.cchl-ccls.ca/assets/FellowProjects/OwenHeisler_FellowshipProject.pdf).

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## **Appendix A: Macro-Allocation Resource Allocation Ethical Frameworks**

Classically for a macro allocation decision the major concern relates to concepts around distributive justice – how do we ‘justly’ distribute both rights and obligations within a society? The two basic models to consider are libertarianism and egalitarianism. While libertarianism would be most closely represented by the health care system in the United States, a modified egalitarian approach would be closest to the health care system in Canada.

Libertarianism argues that the only thing we owe to each other in society is non-interference; individuals acting in this freedom framework will maximize their personal goods and consequentially increase the ‘value’ of society. Maximization of civil liberties in this model does not consider health a basic civil liberty but rather a commodity.

The egalitarian approach to allocation of health care resources recognizes health as a basic right of the human condition with basic health an intrinsic civil liberty. Egalitarians argue that, in the principle of justice and fairness, the resources of all of society need to be equally distributed as a basic envelope of health services to all individuals in society to maintain the health of all individuals. Egalitarians believe the development of a more healthy population is the only way to ensure individuals can maximize their potential and in so doing increase the ‘value’ of society.

A total egalitarian approach argues for completely equal distribution of all resources while a modified egalitarian approach argues for equitable distribution, differentiating equity from equality. Much of this thinking is based upon the work of John Rawls and further elucidated in the health care environment by Norman Daniels. Given the Canadian environment where the ethical framework of Rawls has become so prominent it is worth looking at the Rawlsian ethic in greater depth.

Rawls’ theories were clearly based in a deontological approach stressing the importance of normative principles of intention. He looked for universal fundamental principles that could be applied to individuals to facilitate harmoniously living together as a society. The principle of greatest concern to Rawls was the principle of justice. He

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concluded that we ought to decide what is right and wrong human conduct based upon fairness as the most important aspect of justice. Justice as fairness became the basic tenet of Rawls' approach. He advanced two principles that he believed were integral to justice. The first is that each individual in society has an equal right to the most extensive liberty possible compatible with an equal similar liberty for everyone in society. Second, Rawls suggested for a society to function properly there are reasons permitting inequalities of liberties between individuals. These inequalities might exist because of a necessity to provide greater benefits to fulfill a need to attract individuals to certain jobs or positions. A very basic example would be in distribution of food - should a one hundred pound sedentary retired individual be allocated an identical amount of food as a two hundred and fifty pound laborer? Equality would say yes while equity would say no. Differences also exist as part of human nature, realities Rawls referred to as life's undeserved lottery. Rawls' principle flowing from this line of reasoning was that where inequalities exist, they have to be open to all and ultimately work out to the advantage of everyone. It is the burden of proof of those with the greater liberties to demonstrate their greater advantage is for the good of all of society. Rawls did not dispute there are examples when society itself sets these inequalities, as for example the theological/religious rationalization for a caste system.

In his arguments Rawls was most concerned with functions of a society and made an unstated assumption that all individuals in society are 'context' free with each individual having an equal 'deserve' to everything society offers. He further assumed equal opportunity for all individuals to have equal access to liberties presuming all persons are rational with roughly similar needs and interests. Rawls believed offices in society must be available to everyone. In such an environment each individual should be able to look at his/her situation with a 'veil of ignorance' and accept that given the situation leading to inequalities, the reason for any difference would be robust enough that he/she would accept either the 'advantaged' or 'disadvantaged' position, understanding any existing difference was for the good of society. Flowing from this 'veil of uncertainty' Rawls argued each individual would be wary of proposing governing principles which gave him/her a peculiar advantage for fear that in the future this same principle, if unfair, might be applied against him/her. This would leave no easy way for anyone to win special, unwarranted advantage for himself/herself. Persons engaged in such a just practice would be able

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to face one another honestly with mutual acknowledgement and respect.

This ‘fair play’, Rawls argued, needed to be recognized in society beside the complementary principles of fidelity and gratitude. All three principles imply constraints on self-interest that are essential to society where realization of aspirations of others is at times required for the maximal benefit of all. Rawls was very clear to clarify he was not suggesting his theory was utilitarianism which he characterized as welfare economics. Rawls acknowledged that at times the outcome from a utilitarian perspective and his perspective might look the same. The difference, he argued, related to the intention that led to the outcome. In utilitarianism any differences in liberties are administrative and have the potential to relate to ‘accidents’ of education or upbringing. The resultant inequalities of liberty are assessed on the basis of diminishing marginal utility and are entirely teleological (outcome) based. For Rawls, his conception of justice as fairness was entirely duty based. He was clear to differentiate ‘unintended’ positions in society based on life’s lottery from those relating to free choice. An example of the differences in the two approaches would be the treatment of disabled individuals – for a utilitarian, allocating few resources to this group might lead to algebraic maximization in society whereas for Rawls this is an unintended positioning and the question back to society would be what would a given individual have expected had he/she been born into this situation. Different outcome!

The fundamental moral concept of justice as fairness arises directly from the reciprocal relations of persons. If a claim of uneven distribution of liberties were not in accordance entirely with principles, Rawls, similar to Kant, would argue there would be no moral value in granting this position. The arguments for and against slavery demonstrate how this concept is applied. Whereas utilitarians might assess the advantages of the slaveholder compared to the disadvantages to slaves and society, from the perspective of Rawls, any potential gains of the slaveholder cannot be considered at all as the absence of societal gain already dismisses the argument.

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## **Appendix B: Micro-Allocation Resource Allocation Ethical Frameworks**

When considering micro allocation decisions the questions from an ethical perspective become normative questions of right or wrong, good or bad. The four basic ethical/moral theories addressing such questions are utilitarian, deontological (Kantian), virtue (Aristotelian) and feminist. All four theories are concerned with normative concepts of right/wrong and what we 'should' do when considering options to come to a right and just decision. Of these theories, one (utilitarian) looks at consequences, one (deontological) to motivation, one on the actor (virtue) and one towards context (feminist).

Utilitarianism as originally proposed by Bentham and Mills and expanded by many others over the years is consequence driven. The rightness of an action relates entirely to an algebraic determination of the production of overall happiness. The correct act is that act which maximizes happiness no matter what it takes to get to this point – the end justifies the means. In its pure form, all outcomes are known and can be measured and actions are entirely impartial. Major concerns with this 'act utilitarianism' is the realization that optimal outcome will invariably be realized with a strategy of maximally disadvantaging a small group in society for the 'greater good'. Three major concerns with a pure utilitarian approach are disadvantaging a few for the advantage of the majority, acceptance of acts that many would consider inherently wrong such as torturing innocent people, and the promotion of individuals acting only for their own good (free riders). These concerns prompted some utilitarians to develop an alternative known as 'rule utilitarianism'. In rule utilitarianism the rightness of an individual action is not related to its *direct* consequences but rather the *universal outcome* should this individual action become the general rule for behavior. Rule utilitarianism is thus more concerned with the kinds of acts that are done, at the same time still arguing that these kinds of acts be evaluated on their ability to promote maximal overall happiness. Whether or not the ideal world this supposes can exist and whether for a true utilitarian this rule utilitarianism does not revert to act utilitarianism remains contested.

Deontological ethics, in direct opposition to utilitarian ethics, argues that adherence to duty, rather than consequences, is most important in analyzing the rightness of an action. Immanuel Kant, who first

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advanced this moral theory, proposed that actions are right when they satisfy the “categorical imperative”. He suggested general rules or ‘maxims’ be considered when evaluating the rightness or wrongness of actions and that these maxims should adhere to one of three formulations of this categorical imperative. The three formulations are 1) maxims should be able to become universal laws, 2) maxims consider treating humanity as an end and never only a means and 3) maxims treat others as autonomous agents. Whereas a utilitarian would justify telling a ‘white lie’ this does not exist for a Kantian since lying could never become a universal law. Deontological ethics are based on four basic principles of beneficence (the Golden Rule - do good), non-maleficence (the Silver rule - don’t do bad), autonomy and justice. One of the challenges for deontological ethics is what to do when adherence to discreet principles collide. In the health care environment, should a patient’s right to autonomy trump what would be the most beneficial treatment plan for the individual? This lack of consideration for context, emphasis on consideration only of rational autonomous beings (discounting non-humans and cognitively impaired for example) and variable formulation of maxims has challenged the Kantian deontological moral theory.

Whereas both Utilitarians and Kantians examine actions, virtue (Aristotelian) ethics consider the actor. Kant specifically indicated that if an individual performs an action within his/her character this is not to be even considered a moral action. Aristotle, the founder of virtue theory, proposed that it is/was consideration of this very character that is in fact paramount. The actor is more important than the action. Aristotle proposed primary importance is development of virtuous people. Virtuous people will ‘naturally’ do the right things and we do not need to consider their actions since all actions will be natural outcomes of their character. Being virtuous is a learned behavior that can be taught but requires considerable practice. If a virtue is considered the ‘golden mean’ between two vices, virtuous individuals consider alternatives, deliberate about them and, as a result of their training, voluntarily choose the correct action based upon the nature of humans to aim for *eudemonia*. Eudemonia represents the state of happiness and well being that, according to Aristotle, is fixed in human nature. It is concern with this concept of what is natural that remains debated in Aristotelian ethics. The lack of direction in evaluating both actions and the progress towards being virtuous are other difficulties with Aristotelian virtue ethics.

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Feminist ethics arose because of concerns that classical moral theories not only did not consider gender but, more globally, did not address oppression in all its forms. The lens of the feminine gender is proposed more revealing than the more masculine humanist perspective reflecting experiences and intuitions of women that emphasize caring, friendship and relationships. The context of an act is vitally important and acts should not be universalized (as per Kant) or simply outcome summed irrespective of whose happiness and the nature of the happiness (as per utilitarianism). In feminist ethics there is greater emphasis on justice than the absolute nature of autonomy imbedded in previous theories. Similar to virtue ethics there is an absence of rules and/or calculations for making individual decisions.

Health care ethics until the mid-1950's were based on a virtue ethic emphasizing the care provider more than the specifics of decisions being made – the actor rather than the act. This theory promoted the virtue of training competent physicians, nurses and other health care providers who would then make good decisions; it is the theory underlying paternalistic attitudes of physicians in the past that are still seen at times today. This is the basic ethical paradigm that underlies the Hippocratic Oath and the fiduciary nature of the physician-patient relationship. In the middle of the twentieth century health care evolved towards a principle based deontological ethic concerned more with beneficence, non-maleficence, autonomy and justice. Imbedded in and influencing both these paradigms were utilitarian ethics promoting strategies to maximize happiness - always a major consideration especially when considering equitable rather than equal distribution of scarce resources.

Physician-patient relationships over the last half-century have demonstrated a decrease in paternalism creating an increasing 'challenge' from the physician perspective to balance what a physician 'knows' is best for the patient and what the patient 'wants' (if and when there might be a conflict). Physicians are increasingly, and with some distress, being asked not only to ensure that the patient in front of them has optimal care but simultaneously to ensure fair population access to limited resources by acting as gatekeepers to an increasingly expensive technological environment of scarcity. When lawyers are asked to leave their fiduciary advocacy role they become judges – physicians have not historically been granted the same 'changing of hats'. A legal environment that is perceived to demand primacy to the fiduciary

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responsibility for physicians magnifies this picture of existential conflict.

When physicians are asked to assist management with allocation decisions of resources to populations the basic orientation of physicians towards individuals creates ethical dilemmas. As medicine becomes progressively more technology based physicians often feel compelled to respond to allocation decisions for new, most often expensive technologies on the basis of not just what is *good* but what is *best* for their individual patient. In being asked to make determinations of resource utilization, physicians should ideally evaluate the marginal value of interventions in an environment where outcomes are uncertain. For example, when only one CT scan is available should a physician order a seventh scan on a patient where it might be expected to add just a bit of value or the first scan for a different patient where one might assume the scan could add potentially more value? Given the answer to these questions can only be determined *a posteriori* once both scans are completed, these *a priori* decisions become doubly difficult when evaluative criteria invariably consider developments beyond the time frame during which the decision must be made. To add further to this challenge is an environment where there is often significant marketing pressure by pharmaceutical companies and medical equipment manufacturers who are promoting their interventions and a public who are exposed to both advertising and anecdotes in an increasingly networked, internet-worked environment.

What is the right balance between advocating for individual patients and advocating for the rights of an entire population? Codes of ethics equally stress both the importance of the wellbeing of an individual patient and the importance of looking after the whole of society. Rather than providing direction when there are ethical conflicts, these codes support both sides of the debate equally. This means these codes are usually not helpful in managing conflicts that inevitably arise in allocation decisions when different principles clash or the needs of the population and the individual are at odds. The codes in fact can lead to greater polarization as tools to capture the moral high ground in conflict situations.

Another way to characterize this paradigm conflict can be captured in a two-by-two diagram. On one axis we can consider the two major competing ethical perspectives – deontological versus virtue/utilitarian. On the other axis will be whether one is considering applying the

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ethical framework to an individual or a population. Each of the four resulting approaches can be characterized in the diagram. The following paradigms exist:

	<b>Utilitarian/Virtue (Outcomes Based)</b>	<b>Deontological (Duty Based)</b>
<b>Individual</b>	Hippocratic	Respect for Persons
<b>Population</b>	Social Utility	Social Justice

In this framework, physicians classically have been positioned in the upper left box reflecting their fiduciary relationship to individual patients. It might be suggested elected officials (funding agencies) gravitate towards the bottom left box – maximum outcome for a population usually means the best chance of getting elected. The challenge with this box reflects a reality that the way to maximize outcome for a large group is to significantly disadvantage a small minority group. The media would likely be best represented in the top right hand corner. The challenge here is that the way to optimize this paradigm is to limit what is provided to only those things that can be provided to all. Further, the challenge is that if one, for example, develops a policy which results in avoidance to ten of a potential bad outcome while at the same time directly creating a negative outcome to one (net happiness of  $10 - 1 = 9$ ), since we cannot identify the ten who did better (nothing bad happened) and can easily identify the one having a negative outcome the policy is doomed to failure. This is a reflection of the power narratives and stories are given in health care communication. It has been said health care communication is the slave of the anecdote. Although a powerful communication tool, this communication style can be a significant impediment to introduction of evidence based protocols and initiatives that are more population than individual based. We have no way to measure and identify individuals who were prevented an adverse outcome so when ‘bad side effects’ are identified we do not have the balancing patient where harm was averted.

It should be the goal of all health care leaders, especially physicians, to ensure that we all strive together to be where we need to be - the

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bottom right - social justice. The challenge is the multitude of ethical frameworks involved in the transition to this framework for physicians. When considering asking physicians to provide principle based direction on distribution of resources to a population, one must consider the multitude of demands placed on the physicians in a very complex health care environment by those advocating for social utility (government) and those advocating for rights of individuals (media). Appealing to ‘professionalism’ as a reason for physicians to participate in these difficult decisions does not recognize the paradigm change involved when fiduciary responsibilities conflict with managing needs for a population. The other challenge is that professionalism, if not the classical fiduciary physician-patient relationship, is not clearly defined leading to a great deal of ambiguity. Appealing to professionalism and ethics to advance physician participation in population initiatives, while a powerful strategy, must therefore be respectful of a wide view when utilized. It often is not.

## Supplementary Questions – February 2013

*In your opinion, would you characterize the following examples of access to care as:*

- *Preferential access or not preferential access;*
- *If you determine it to be preferential, is it “proper” or “improper?”*

*Please explain, briefly, the reasoning behind your opinion.*

### **S1 – Emergency Department Care**

*Providing high profile people with a separate waiting area away from the general public;*

**Preferential Access – Improper** – Emergency Departments should rightly be reserved for emergent needs and not as a replacement for care in the community. There are often separate waiting areas for pediatric patients; with time there may need to be separate areas for bariatric patients. At times if there are significant infective diseases (such as H1N1) segregating potentially highly infectious patients may be considered. All these are for patient comfort and needs. However, segregating because of the profile of the patient would be improper.

There is no ethical principle that would support this. The issue might for example be a ‘star’ hockey player concerned he might be approached by other waiting patients – from my perspective this would be one of the unfortunate obligations that are associated with the privileges attendant with the high profile.

***Providing priority access to care for doctors, nurses or AHS staff and/or family members accompanied by doctors, nurses or AHS staff;***

**Preferential Access – Improper** – When I recently presented to the ED with back pain, I waited my turn (5 hours). I would expect the same of others. It is incumbent on all health care workers to appropriately utilize the emergency department and work within the system to ensure that the ED is appropriately utilized for emergency and urgent care – not as a way to facilitate more rapid access to care. This is unfortunately the behavior of many (entire population and not just health care workers) in which case ED’s evolve as a surrogate for care that is best provided outside of this acute environment. As a professional courtesy a physician may choose to see patients in their office with ‘priority access’ as a reflection of their autonomous choice (discussed below) but this does not extend to community resources such as emergency departments. An ED needs to be considered a community resource that provides care almost exclusively on the basis of urgency of need.

***Physicians asking their own patients to go to the ED to receive elective procedures;***

**Not Preferential Access** – The challenge here is the word ‘elective’ that should be removed from this conversation. There should be only scheduled and emergent. Physicians advocate for their patient’s needs. If a patient requires services that cannot be reasonably and appropriately obtained in a scheduled manner, utilizing the ED for all such patients (and not just a privileged few) might eventually be their only choice.

This is a system issue. As an example, in an attempt to hit ‘targets’ in the ED, one strategy is increasing ED access to diagnostic services and procedures to facilitate quick throughput in the ED. With scarce and fixed resources, this leads to fewer resources available for patients waiting for these same services in the community. The ensuing vicious

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cycle continues wherein patients in the community wait longer and longer so that they eventually have no choice but to go to the ED where they get the service which in turn increases community waits even further. The unfortunate logical conclusion to such a process would be all care would be provided in the ED – not good care.

This question is not the ethical decision of a physician to access services or procedures in the ED but rather the resource allocation decisions that are made within the system. The system has a responsibility to allocate resources in a manner that the needs of ALL populations (and not just those in the ED) are considered. Physicians choosing to access what is available for their patients is not unethical. They are making the best decision they can balancing beneficence and non-maleficence. The question as to the ethical decisions in regards to the fair distribution of resources across the continuum is not so solid.

## **S2 – Physicians**

***Responding to requests to see patients in their office quickly by slotting them in before or after normal office hours or on the weekends;***

**Preferential Access – Not Improper** – This would respect the autonomy of the physician. There are currently no limitations as to where a physician can practice or the scope of his/her practice. In the past there had been direction that new graduates not practice in busy metropolitan environments – these were struck down in the courts. There have been previous attempts to control where physicians practice to better match physician supply and patient demand. In the same vein many physician practice ‘boutique’ medicine that may not reflect the needs of the population. This has always been a challenge in the Canadian system where the costs of physician education have historically been heavily subsidized by the public purse in the absence of clear deliverables by the physicians that graduate and benefit from this system.

The number of hours any physician works is not mandated – some work few hours, some work extraordinarily long hours. (There are concerns that seeing too many patients and too few patients may reflect a decreased quality of care but there has been no limitations imposed on any of the above.) Accordingly, in this environment where physicians have the right to control their own hours – if they choose to

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see someone outside of regular hours as a matter of professional courtesy this would be their autonomous right to do so. The proviso remains that once physicians have entered into a 'contract' to see a patient by having booked that patient into their offices, they cannot discard this contract to see someone else preferentially unless there is a defensible clinical need that demands such rescheduling. There is an ethical responsibility to manage this patient population as well.

It is recognized that the payment for such expanded service comes from the public purse. However, there is currently no restriction on the number of patients seen by any physician. No physician has a limitation as to the number of patients they can see and one of the arguments for a fee for service model is to maximally provide service. In the absence of such limitation, it is not germane to the argument the payment source since the payment for such a patient does not interfere with the ability to see another patient.

***Physicians writing prescriptions or providing medical care for friends, family or colleagues outside of their medical office;***

**Not Preferential Access** – Firstly, it is unethical for physicians to provide care to their families except under emergent conditions (Code of Ethics #20). Otherwise, it would be the autonomous choice of the physician where care is provided for all the patients they see. Physicians in the past did house calls and many continue to provide such service to their patients. If this care is provided to friends, colleagues or patients, the key is that the care is appropriate for the needs of the patient and there is appropriate care provided.

**S3 – Private Health Care Facilities**

***Do membership based private health care facilities constitute an example of preferential access?***

**Preferential Access – Consistent with Current Norms** – In Alberta, 30% of health care costs are not covered by the public purse – the greatest cost is pharmaceuticals but other professional services such as physiotherapy also fit into this category. The Canadian system does not universally provide access to all health services so the ability to pay does make a difference. I knew in practice there were patients who would not be able to afford prescriptions so did not get similar care based on their ability to pay. Public policy has indicated that in the

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current environment there is not a willingness to include these services in the public purse as it would require additional taxation.

We as a society need to determine what constitutes a reasonable basket of services that we will provide to all members of our population. This is a conversation that will need to be had very soon. It is impossible given the growth of technology and ‘personalized treatment’ such as individualized chemotherapy for society moving forward to cover the costs of all possible treatments. An example would be a recent novel treatment for CF that is estimated to cost \$300,000 per patient per year treated. My personal thought is that at some time this ‘basic basket’ must be transparently defined. Perhaps, as part of such a discussion, inclusion of an insurance mechanism to manage the remainder of potential services might be considered. Society could decide if the cost of insurance coverage for vulnerable populations would be something they would consider providing. However, this is not the case now and society does have preferential access to non-insured services.

Private health care facilities have indicated that the membership fees they charge is for ‘non-insured’ services and not for access to insured services such as physician fees. The membership fee is therefore an example of preferential access to these non-insured services. It is no worse than what currently exists.

It is the personal decision of individuals if this health care allocation is proper or improper. My personal opinion would favor improper as I have outlined above – this improper determination however relates to the universal rather than the particular in this situation.

#### **S4 – MLAs or their Staff**

##### ***Providing advice to their constituents about wait times, alternate care options etc.;***

**Not Preferential Access** – This is reasonable. Many people do not know how to access the health care system. This is not preferential access as this service would/should be available to the entire population.

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***Requesting special consideration for a constituent by communicating directly with a health care provider;***

**Preferential Access – Improper** – There is no natural or expected relationship between an MLA and the health care provider. Such a request would suggest there would be an inappropriate *quid pro quo* implied which would be wrong.

**S5 – Senior Hospital or Health Authority Officials**

***Requesting special arrangements (eg: private room, anonymity etc.) for a VIP or high profile patient;***

**Not Preferential Access** – I am assuming the care here relates to ‘special’ services outside of direct health care. Private rooms are already in the category of non-insured services. Anonymity is something that the general public does not typically need or want. Having said that there are instances when any individual may benefit from anonymity such as might exist for a patient on a psychiatry ward where direct contact with a member of the public may be detrimental to their own health. I think services such as private rooms and anonymity would not be unreasonable as long as other patients with contextually sensitive ‘special’ needs are likewise considered.

***Calling front line staff to make them “aware” that a VIP patient is in the hospital or in the system.***

**Not Preferential Access** – I would reflect back on the recent suicide in the UK of a nurse who was looking after a VIP committing suicide. VIPs bring an interest and entourage that impede not only their care but those of others in the same ward. I do think that front line staffs being aware is very reasonable so they can appropriately respond to events or comments in this context. There should not be a problem sharing such information to make the staff aware.

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# Academic Literature Review of Preferential Access to Health Care in Canada

Dr. Nishan Sharma

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### **3. Academic Literature Review of Preferential Access to Health Care in Canada**

**Dr. Nishan Sharma**

#### **Preface**

In the introduction to his book “Chronic Condition”, Jeffrey Simpson declares that “Canadians embrace their public health-care system, Medicare, more passionately than any other public program”. Simpson goes on to assert that Medicare’s foundation is equity. Perhaps implicitly, this includes an understanding that access to services, while not necessarily equal, is equitable – with “highest need” being the key determinant of who gets what service and when.

On the matter of equality, differences in access to a variety of health care services for Canadians are well described. Many differences relate to issues such as geography, where the concept of fairness is necessarily dominated by reasonable pragmatism. For example, every community in Canada does not have a trauma surgery team; therefore a significant number of Canadians will have unequal access to potentially life-saving care. Few would argue that positioning such teams in regions with high density or volume is unfair to citizens in other regions.

This review, commissioned by the Health Services Preferential Access Inquiry in Alberta, attempts to focus on the understanding of differences in access that may carry a perception of inequity or unfairness for Canadians. For purposes of this document, these differences in access are referred to as “preferential access”.

The author acknowledges that “highest need”, fairness and pragmatism often have a large subjective element, and that the perception of these concepts, and therefore the notion of preferential access, will necessarily vary amongst individuals and groups.

#### **Executive Summary**

- This report is a review of the academic literature on the topic of preferential access to healthcare as it pertains to the Canadian system. Referencing peer-reviewed journal articles that are applicable to the Canadian context, this review helps define
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what preferential access or “queue jumping” means in the Canadian healthcare system from an academic point of view.

- There are few studies that examine the topic of preferential access in the Canadian healthcare system. The academic literature regarding preferential access does not provide empirical, objective data on the practice, but focuses primarily on more subjective, survey-based and case-based data.
  - The literature suggests that preferential access to healthcare in Canada may occur:
    - As a result of patient socioeconomic status, whereby preferential access is gained by those with greater means.
    - Through the factors involved in creating, managing and accessing waitlists that are subject to interventions that promote either preferential access or equitable improvements to access.
    - Through variation in the criteria and processes used by physicians to generate referrals to specialty physicians.
    - When physicians practice “professional courtesies”.
    - When patients are prioritized through their affiliation with particular organizations.
    - When patients are prioritized based on being deemed “very important people”.
    - When “two-tiered” healthcare systems allow patients quicker access to care when they are able to pay for service.
  - While some authors question whether it is even advisable to try and address preferential access, there are others who suggest that there are educational, legislative and functional strategies that can help mitigate the practice. These strategies are outlined in this report.
  - Academic research in the fields of medicine, law, business and sociology must continue in order to grow the understanding of what impact preferential access has on Canadian society.
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## **1. The Context of this Report**

This report, commissioned by the Health Services Preferential Access Inquiry in Alberta, is a review of the academic literature on the topic of preferential access to healthcare as it pertains to the Canadian system. Referencing primarily medical, peer-reviewed journal articles and excluding popular press/media pieces on the topic, this review helps define what preferential access or “queue jumping” means in the Canadian healthcare system from an academic point of view. Given a lack of objective data on the prevalence of the practice in Canada, this report does not address the impact of preferential access and the harm it may cause, but does outline where the healthcare system may be vulnerable to queue jumping. This report also reviews the case made in the literature as to whether preferential access can be mitigated, and outlines strategies that may be employed to reduce queue jumping.

## **2. Literature Search Methodology**

After consulting with W21C colleagues on the scope of the topic, search terms for “preferential access” were modified and then expanded through guidance from a Research Librarian in the Faculty of Medicine at the University of Calgary. In addition to medical literature databases, searches were conducted in business, legal and sociology archives. The key terms listed in Table 1 (below) were then used to retrieve potentially relevant papers from the academic literature databases listed in Table 2. For each potentially relevant article found, “find similar citations” (based on key terms) and “cited by” (linking to other articles referencing the potentially relevant paper) functions were used to further expand the search. Finally, after reviewing the search results, additional papers were retrieved based on references listed in relevant articles.

### ***2.1 Literature Search Results***

The search terms used in Table 1 yielded a total of just under 700 articles potentially relevant to the topic of preferential access to healthcare. Relevance and potential relevance was based on the judgment of the report’s sole author. Of the potentially relevant articles, more than 70% came from medical databases. The Canadian business literature and legal databases yielded no relevant papers.

A scan of the potentially relevant articles resulted in a total of 37 articles downloaded for in-depth review. The literature cited in these yielded an

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additional 15 articles for in-depth reading, for a total of 52 relevant articles.

**Table 1** - Terms used to search databases for review of preferential access to healthcare. Note: Due to the general usage of these terms, searches were paired with the terms “healthcare” and “Canada” where applicable to limit results to more relevant articles.

Term	Related Terms
Preferential access	
Queue jumping	
Waiting lists	Wait list, wait listing
Health services accessibility	
Resource allocation	Health care rationing
Professional courtesy	
Fee-for-service	

**Table 2** - Scientific and peer-reviewed literature databases searched for review of preferential access to healthcare.

Database Name	Domain
MEDLINE	medicine
PubMed	medicine
Index to Canadian Legal Literature	law
CBCA Complete	business
CINAHL	nursing and allied health
Google Scholar	general

### 3. Defining the Issue

Describing what *preferential* access means, and whether the practice occurs in the healthcare system, requires an explanation of what access to healthcare means in Canada. That is, by understanding what fair access is, one can begin to discuss what is unfair.

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### **3.1 Defining Access**

The *Canada Health Act* defines the principles and standards to which provincial and territorial health insurance programs must conform in order to receive transfer payments from the federal government for healthcare (Department of Justice Canada 1985). Provinces and territories must adhere to conditions under the headings of public administration, universality, comprehensiveness, portability, (and most important here) accessibility. Specifically, the *Canada Health Act* states “the health care insurance plan of a province must entitle one hundred percent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions...” (Department of Justice Canada 1985). The general terms of the Act have led to discussion of what “access to care” might mean (e.g. Baltzan 1999), but as Cunningham et al. (2012) note “the principles of the *Canada Health Act* include that health care not be impeded by social or financial factors”.

### **3.2 Defining Preferential Access**

This report equates preferential access with the term “queue jumping”, which is defined by Friedman, Schofield & Tirkos 2007 as “the favorable placement or prioritization of a patient in a waiting list for reasons other than medical need”.

Whether it is varying definitions or criteria to establish “medical need”, or practices in the healthcare system that go against the principles of providing care to the sickest patient first, there are a number of ways that individuals may obtain preferential (read: unfair) access to healthcare. These circumstances are described below.

## **4. Preferential Access to Canadian Healthcare**

Given the definition of fair and “unfair” practices, there are seven themes that cover the preferential access to Canadian healthcare debate in the literature. Various authors have made cases that preferential access exists and occurs:

- As a result of patient socioeconomic status, whereby preferential access is gained by those with greater means.
  - Through manipulation of the criteria that are used to evaluate patients and generate waitlists for healthcare.
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- Through variation in the criteria used by physicians to generate referrals to specialty physicians.
- When physicians practice “professional courtesy”.
- When patients are prioritized through their affiliation with particular organizations.
- When patients are prioritized based on being deemed “very important people”.
- When “two-tiered” healthcare systems allow patients quicker access to care when they are able to pay for service.

These themes are explored below.

#### **4.1 Socioeconomic Disparities**

Various studies in the academic literature attempt to answer the question of whether Canadians with higher socioeconomic status have greater access to doctors and healthcare service than Canadians with lower socioeconomic status.

It is important to note, as Chan & Austin (2003) explain, that these studies “cannot measure true access, defined as the ability to obtain an appropriate service given a health need, but do[es] examine utilization”. That is, these studies are based on how individuals of varying social status and income levels use the Canadian healthcare system (after the fact); not, for example, how individuals with lesser status or means may be blocked from accessing the system (before the fact).

If the question is put forward as “Do Canadians with greater socioeconomic status have preferential access to healthcare?” or conversely “Do Canadians with lower socioeconomic status have a decreased ability to access healthcare?”, researchers have drawn conclusions on either side of the debate.

##### **4.1.1 Studies that say “Yes”**

There are numerous studies that suggest that the Canadian healthcare system is similar to systems in the United States, United Kingdom, Spain and Sweden, where health services researchers have generated evidence that socioeconomic factors affect utilization of clinical services (Alter, Basinski, & Naylor 1998).

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Alter and colleagues (1999) conducted a study on hospital admissions for Ontario residents who had experienced acute myocardial infarctions over a three-year period. The authors controlled for a number of variables (including patient age, sex, severity of disease, specialty of the attending physician, and characteristics of the hospital, among others) and inferred patients' income levels from the median incomes of their residential neighbourhoods according to the 1996 Canadian census. From their analyses, the researchers drew a number of conclusions, two of which were:

- a) Those patients with myocardial infarction who lived in higher-income neighborhoods were significantly more likely to undergo treatment through angiography than patients in lower-income neighbourhoods.
- b) Those patients with myocardial infarction who lived in higher-income neighbourhoods had shorter wait times for angiography than patients in lower-income neighborhoods.

Their conclusions suggest that the lower the median income level in the neighbourhood that the patient lived, the less likely the patient was to undergo treatment, and the longer the wait time was to receive treatment. Alter et al. (1999) write “although more affluent neighborhoods tended to have a greater concentration of specialized services, inequitable distribution of hospital resources did not account entirely for the effects of socioeconomic status on access to procedures and on outcome after acute myocardial infarction”. In a follow-up commentary, David Alter suggests that managed waitlists “may be subjected to biases that will tend to favor the socially affluent or those who are best connected with either managing physicians or with the system itself” (2003).

Another study by Alter and colleagues (2004) backs up previous findings and adds another socioeconomic variable (education) to the equation. Data collected through telephone interviews with 2,256 patients, 30 days post-discharge from one of 53 hospitals across Ontario suggested that patients with higher incomes and higher education levels were significantly more likely to have been referred for coronary angiography, cardiac rehabilitation, and to a cardiologist than those with lower incomes and levels of education.

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In another study focusing on access to specialist healthcare service, Haider and colleagues (2006) reported that the proportion of patients seeing a dermatologist (through referral) within two years of a diagnosis of a skin disorder increased from 17% in the lowest socioeconomic status category, to 24% in the highest socioeconomic category.

A study by Chan & Austin (2003) also suggests a “modest” positive correlation between preferential access to specialists and high-income earners. By accounting for the fact that individuals with low socioeconomic status have more illnesses, the authors proposed that high-income earners were receiving preferential access to specialist healthcare given their lower disease burden.

#### ***4.1.2 Studies that say “No”***

For those studies above that suggest that those with higher socioeconomic status receive preferential access to healthcare, there are other studies that refute this conclusion.

Murray Finkelstein (2001) analyzed responses to a Canadian Population Health Survey for mean per capita expenditures on physician care and the probability of referral to a specialist, in relation to income and self-reported health status. After adjusting for health status (i.e., accounting for the fact that individuals of lower socioeconomic status have more illnesses), Finkelstein concluded that utilization of physicians’ services was based on need, and *not* on income.

In a study by Pilote and colleagues (2007), the authors examined data from all patients admitted to acute care hospitals with acute myocardial infarction in three Canadian provinces over a five or six year period (n = 145,882). They found no associations between socioeconomic variables and access to cardiac medications or invasive cardiac procedures.

#### ***4.1.3 Low Socioeconomic Status is Associated with Fewer Visits to Specialists***

McIssac, Goel & Naylor (1997) also did an analysis of an Ontario Health Survey for a possible association between socioeconomic status, need for medical care and the number of visits to general practitioners and specialists. In examining the responses of over 45,000 respondents

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16 years of age or older, the researchers did not find an association between education or household income and the use of physician services (at least one visit per year). However, McIssac, Goel & Naylor (1997) did conclude that high income persons were *less* likely to have made six or more visits to a general practitioner in one year, and were *more* likely to have made at least one visit to a specialist, than low income persons.

Similar to McIssac, Goel & Naylor (1997), Veugelers & Yip (2003) studied survey data to evaluate whether universal healthcare coverage reduced socioeconomic disparities in health in Nova Scotia. Acknowledging their greater disease burden, Veugelers & Yip (2003) also found comparatively higher use of general practitioner services and lower use of specialist doctor services amongst those with a lower socioeconomic status.

## **4.2 Waitlists**

When demand for services outstrips supply, a system must be created to allow fair access based on prioritization of the need for service. In terms of Canadian healthcare, the system involves wait listing. This section of the report looks at the literature that pertains to waitlists, and the factors involved in creating, managing and accessing waitlists that are subject to interventions that promote either preferential access or equitable improvements to access.

### **4.2.1 The Existence of Waitlists**

Waitlists and wait listing are common topics in the healthcare literature. On the need for waitlists, Naylor (1991) suggests, “[d]elayed care with prioritization according to need is theoretically more equitable than overt denial of access on the basis of income or insurance coverage”. Alter, Basinski & Naylor (1998) summarize the opposing viewpoints on waitlists, their existence in the healthcare system, and the idea of universally fair access to healthcare in Canada. One side points to them as impossible to manage fairly, and will suggest that as long as waitlists exist, the idea of universal access to healthcare itself is illusionary. On the other side of the argument, proponents say without them patients are not even in the system, and that waitlists are only created *after* a potential patient has accessed the system.

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#### ***4.2.2 The Existence of Queue Jumping***

Alter, Basinski & Naylor (1998) conducted a landmark survey to determine Ontario health care providers' perceptions and experiences of preferential access to cardiovascular services on the basis of factors other than clinical need. The study asked all practicing cardiologists, cardiac surgeons, and hospital chief executives, plus a random sample of internists and family practitioners (total 788 respondents) in Ontario about their beliefs towards, and experiences with preferential access. With their results, the authors sought to understand what "preferential access" actually meant to their study population.

Alter, Basinski & Naylor's (1998) most significant finding was that over 80% of responding physicians, and 53% of hospital chiefs admitted to have been personally involved in managing a patient who had received preferential access on the basis of factors other than medical need. Other significant observations from the study:

- More than 80% cited pressure from referring and consulting physicians, or patients and their relatives, as potential causes of preferential access.
  - Eighty-eight percent indicated that personal connections to treating physicians were likely to play a role in preferential access.
  - Factors that contributed to increased pressure to grant preferential access included knowledge of the risks of delayed care, and the patient's propensity to litigate.
  - Seventy-one percent believed that preferential access came into play if the patient had community standing such that it would be advantageous to the hospital if the patient were pleased.
  - Ninety-three percent agreed that preferential access was more likely granted to physicians and their families.
  - Over 80% agreed that preferential access was more likely for public figures (entertainers, professional athletes, media members, politicians).
  - In an area where write-ins were permitted, respondents also included patients enrolled in research protocols and patients
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under intolerable stress due to waiting were taken into account in instances of preferential access.

### ***4.2.3 The Difficult Task of Managing Waitlists***

Alter, Basinski & Naylor's (1998) survey results and conclusions argue that preferential access is a real phenomenon. A few studies suggest why waitlist management is a difficult task. On the topic of why anyone should be concerned with organizing and managing waitlists, Lewis et al. (2000) writes "The main reason is fairness and equity ... those with the greatest need for the intervention should be served first, if all else is equal. The probability that tens of thousands of individual, uncoordinated decisions, taken in a large, complex and diverse system will combine to yield fairness for all is vanishingly low".

Focusing on access to cardiac rehabilitation, Dafoe et al. (2006) suggest that failure to refer eligible patients, strength of endorsement for cardiac rehabilitation by physicians, lag time between cardiac event and referral, geographic issues, scheduling limitations, and capacity issues all contribute to the variation seen in waitlists for cardiac rehabilitation programs across Canada. The paper also suggests wait time benchmarks that may be considered standards for generating waitlists to reduce the disparities.

Lewis et al. (2000) were extremely critical in their paper on the state of waiting list information and management systems in Canada, describing them as "woefully inadequate". The paper argues that some factors that may be considered in managing a waitlist, including employment status, time on a waiting list and age are not scientific variables, making them difficult to argue for or against. Lewis and colleagues (2000) also discuss other variables that (could) go into managing wait lists and add to the difficulty of managing them: cost of the intervention, interest-group pressures, political perceptions of need, unstandardized concepts and terms, and the meaning and value of waiting time.

In Sanmartin and colleagues' (2000) paper, the authors suggest that another significant problem when considering waitlist management are differences in measurement approaches. One can find different interpretations of the same data for some fundamental aspects of waitlists, such as when a waiting list starts (e.g., first visit to family doctor? time when facility is booked?), how long waiting time actually

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is, reporting statistics (e.g., mean waiting time? median? proportion waiting for a certain period?), and irregular auditing procedures.

### ***4.3 Disparities in the Referral Process***

Typically, access to specialist doctors and procedures occurs through primary care physicians, and the referral process. As referrals are received, specialists prioritize the incoming patient to place them on a waitlist based on the information coming from the referring physician.

The referral process is multi-faceted, with many variables for a family practitioner to consider before recommending a patient to a specialist (e.g., Can the patient be treated without seeing a specialist? How urgently is specialist attention required? Which specialist should be considered – the “best” with the long waitlist, or an unknown?). Making a referral also highlights the struggle between advocating for your patient versus proper use of the system (e.g., If I don’t say this case is urgent, will my patient be made to wait longer?) (Van Rosendaal 2006).

The many variables involved make the referral process a non-standardized practice. Chan & Austin (2003) present a number of factors that influence specialist referral rates, each encompassing a range of values that change over time:

- patient-related factors – age, gender, socioeconomic status, expectations, need, demands.
- community type.
- specialist supply.
- physician-related factors – age, gender, training, workload, practice patterns, skill, confidence, time to assess patient.
- disease – presence, severity.

From the perspective of the specialist, gastroenterologist Van Rosendaal (2006) explains the difficulty of receiving referrals and prioritizing patients: “We regularly receive information regarding referred patients that overstates the severity of symptoms or that reports ‘alarm symptoms’ that are entirely absent on evaluation. Assessment of patients with less than urgent problems delays evaluation and treatment of patients with serious symptoms who truly require urgent care”.

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Even when a healthcare system attempts to formalize the system of scoring and ranking patients for referral the process can be undermined by some doctors circumventing the system. New Zealand created the “clinical priority assessment criteria (CPAC)” in an attempt to standardize waitlists for elective surgery across the country. Variation in the way CPAC were being used in score construction and in the influence of the score on access to surgery led the researcher to conclude that the tool “did not provide a transparent and equitable method of determining access to surgery” (McLeod et al. 2004).

#### ***4.4 Professional Courtesy***

Professional courtesy is a custom with deep roots in medical practice, and is described as healthcare workers (primarily physicians) providing free or discounted service, and/or last-minute or after hours care, to other healthcare workers and their families (Levy et al. 1993). Originally intended so that physicians would not treat themselves or their own families, professional courtesy has been criticized as providing certain individuals with preferential access to healthcare (Bass & Wolfson 1980).

##### ***4.4.1 The Evolution of Professional Courtesy***

A number of scholars point to the Hippocratic Oath as the root of professional courtesy, where it reads “I swear to reckon him who taught me the art equally dear to me as my parents, to share my substance with him and relieve his necessities as required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it without fee or stipulation” (Bass & Wolfson 1980). In its first code of ethics, published in 1847, the American Medical Association included professional courtesy as an ethical obligation: “All practitioners of medicine, their wives, and their children while under the paternal care, are entitled to the gratuitous services of any one or more of the faculty residing near them, whose assistance may be desired” (although the current code does not mention it) (American Medical Association 1847; Levy et al. 1993).

In Canada, professional courtesy is a recognized practice that has been debated at provincial colleges and the Canadian Medical Association. With no resolution, the practice has been debated as being a custom, a tradition, or a moral imperative which should be enshrined in the Canadian Medical Association code of ethics (Goldman 1985). Levy et

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al. (1993) suggest that, at least in the United States, medical associations have failed to provide physicians with proper guidelines for addressing this important issue.

#### ***4.4.2 Opinions on Professional Courtesy***

A study by Levy and colleagues (1993), based on a survey of American Medical Association-listed physicians from 12 direct-care specialties, suggests that most physicians had a positive attitude toward professional courtesy:

- Over 90% of 2,224 respondents agree with the statement “I consider it an honor to care for other physicians”.
- Just under 80% agreed that “professional courtesy solidifies bonds between physicians”.
- Over 60% agreed that “giving professional courtesy is sound business practice”.

#### ***4.5 Preferential Access to Workers’ Compensation Board***

DeCloet (1998) outlines the special circumstances where individuals eligible for Workers’ Compensation (WC) in British Columbia can gain access to healthcare services such as surgery with shorter wait times than those not covered by WC. In British Columbia, the Workers’ Compensation Board (WCB) pre-purchases surgery time from hospitals. WC claimants have their names put into prepaid spots on the waitlist for surgery. The practice is cited by the WCB as being cheaper than having patients draw compensation while waiting in the public system’s queue. The WCB in British Columbia has even purchased services in neighbouring Alberta to meet the needs of its list of claimants. Critics of the practice suggest that if everyone is not eligible for these held and paid-for spots on treatment lists, it should be deemed preferential access.

#### ***4.6 The VIP (Very Important Patient)***

As the case is put forward by Friedman, Schofield & Tirkos (2007), “the mayor, a visiting dignitary, or the spouse of a seven-figure benefactor is not commonly found waiting among the homeless and the intoxicated in the emergency department waiting room”. Whether fair or not, there are instances when certain individuals are moved to the head of the queue due to their status or position, such as during the

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assassination attempts of Ronald Reagan or Pope John Paul II (Smith & Shesser 1988). Smith & Shesser (1988) published a paper on handling (as they have termed it) the “Code Purple”, outlining what measures should take place for the handing of VIPs, and how these measures may disrupt the normal process of care. These occurrences are often accepted to be “for the greater good”, but when the interpretation of who is a “VIP” becomes questionable, attempts at this type of queue jumping become subject of complaint and are even cited as breaches of the Criminal Code (Cunningham et al. 2012).

#### **4.7 *The Two-Tiered Care Debate***

The idea of preferential access to healthcare is inextricably tied to the concept of a two- or multi-tiered healthcare system, where those with means can “step out of the public queue” and pay for services at a private healthcare facility. Some have argued that the Canadian healthcare system cannot currently be considered a single-tiered system. For example the case of *Chaoulli v. Quebec*, that challenges the legality of prohibiting private medical insurance in the face of long wait times, brought the debate of the single-tiered system to national attention (Marchildon 2005).

Although a multi-tiered system must be acknowledged as a means by which preferential access to healthcare may be obtained, the topic is of such grand scale that it is considered beyond the scope of this review. The two- or multi-tiered system has been considered in various studies already cited in this report, and two instances are only cited here for this reason.

In Alter and colleagues’ (2004) survey of acute myocardial infarction patients (referenced in Section 4.1.1 above), 20% stated that they favored allowing private care for anyone who was willing to pay. In addition when respondents were asked about their own willingness to pay for service, the proportion of those in favor of out-of-pocket payments for more expedient or a wider selection of treatment or hospital services increased to 25% (Alter et al. 2004).

In Friedman, Schofield & Tirkos’ study (2007) (referenced in Sections 4.4.2 and 4.6), the authors note that legislation passed in Ontario in 2004 as Bill 8 sought to address instances of preferential access by stating that “the legislation closed legislative loopholes that allowed queue-jumping”. Ontario, however, is just one jurisdiction in Canada.

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Not all areas of the country have attempted to pass such legislation, leaving the possibility of queue jumping in other areas of Canada.

## **5. Is it Realistic to Eliminate Preferential Access?**

Before presenting ways in which preferential access could be mitigated (below in Section 6), this portion of the review explores the opinions in the literature as to how difficult a task it might be. As this report describes, the incidences and opportunities for preferential access are myriad. There are a number of arguments in the literature that suggest that eliminating preferential access altogether may be virtually impossible. Chan & Austin (2003) suggest, “The small amount of preferential access for the socioeconomic elite is perhaps unavoidable, and on the whole, Canada’s policy-makers may be reassured that their health care system is doing a reasonably good job at offering equitable access to care to all its citizens”.

### ***5.1 The Problem of Finding the Evidence***

As stated at the beginning of this review, the scientific study-based literature gathering empirical evidence of preferential access to healthcare in Canada is limited. Even as the popular media highlight well-publicized incidents of individuals “jumping the queue”, the academic literature does not provide any evidence-based proof of preferential access that might be targeted by anti-queue jumping measures. The studies cited that fit within the scope of this review are based on surveys, opinion and subjective data. At this point, it would be difficult to design and implement a means to limit preferential access that could be backed up with “before and after” and data to confirm the efficacy of the strategy.

### ***5.2 Patients Seeking Preferential Access***

Despite publicly upholding the values of a fair, equal and just healthcare system for all Canadians, being a patient in the system can change the perspective of some individuals. Patients and their families will go to new lengths to ensure timely care for themselves or their loved ones. As Friedman, Schofield & Tirkos (2007) write with respect to their findings from a survey of random households, “There was broad consensus for allowing people to jump ahead in queue for reasons of medical necessity, but not for reasons of status. When responding to questions relating to personal practice – both past and

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hypothetical – participants, however, volunteered some readiness to undermine principles of accessibility”.

In a survey given to 668 random households in the Toronto area, Friedman, Schofield & Tirkos (2007) reported that despite overwhelmingly advocating equal access based on need, approximately half of the total respondents (n = 101) surveyed “would call a friend who is a doctor, works for a doctor, or is a hospital administrator” to improve a position on a waiting list. In their Canadian study (outlined above in Section 4.1.1), Alter and colleagues (1999) found that almost 10% of the variation in patient waiting times was found to be explained not by clinical factors but by the hospital affiliation of the referring physician. Quoting Shortt’s (1999) comments on the Alter et al study, “From the patient’s point of view, ‘who you know’ turns out to be disconcertingly important” when accessing healthcare.

Using Friedman, Schofield & Tirkos’ (2007) term, “undermining principles of accessibility” might also include threatening legal action (Alter, Basinski & Naylor 1998), taking advantage of high socioeconomic status (Alter 2003; Alter et al. 2004), or capitalizing on grey areas and jumping into prepaid spots on waiting lists (DeCloet 1998) to gain preferential access to healthcare.

### **5.3 A Complex System with Many Access Points**

Healthcare in Canada is a multi-faceted, complex, and often non-standardized system that offers many points of entry for patients. Every province has its own healthcare insurance system and its own processes for patients to access and pay for service. It is hard to picture a legislation designed to limit or eliminate preferential access that would be applicable to every province and jurisdiction in Canada. Also, Cunningham et al. (2012) point out that the *Canada Health Act* (on which legislation might be based) relates to provincial health insurance plans and the general organization of insured services, not individual physician practice. Add to the problem of creating legislation: a) the number of ways a physician may run her/his practice, b) the options for diagnosing and referring a patient (Chan & Austin 2003), and c) the number of factors to be considered in prioritizing a patient for a waitlist (Shortt 1999; Lewis et al. 2000); there may be just too many holes to plug to eliminate preferential access.

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### **5.4 Is the Problem Worth Addressing?**

There are studies in the literature that question how much effort should be put into trying to eliminate preferential access, given that without empirical evidence the impact of the practice is unknown. In Lasser, Himmelstein & Woolhandler's (2006) study comparing access to care and health status in the United States versus Canada, the authors suggested that long waiting times led to an unmet health need for only a "small percentage" (3.5%) of Canadians. In the same article, the authors offer the opinion that perhaps "Canada's far lower health spending compromises aspects of care that affect satisfaction but not health outcomes" (Lasser, Himmelstein & Woolhandler 2006). Sanmartin et al. (2000) reported from their study that government respondents insisted that waiting-list problems are neither serious nor worsening, whereas all other respondents maintained the opposite. Unfortunately, both sentiments must be considered opinions without knowing the scope of the problem.

## **6. Strategies to Mitigate Preferential Access**

Even as the previous Section of this review highlighted the fact that there is little empirical evidence of the impact of queue jumping, it is also a fact that preferential access to healthcare does occur. This portion of the review presents the strategies suggested in the academic literature that might be used to combat preferential access.

### **6.1 Develop Ethical Guidelines**

Alter, Basinski & Naylor (1998), Van Rosendaal (2006) and Cunningham et al. (2012) make suggestions addressing medical ethics to address the problem of preferential access. Alter, Basinski & Naylor (1998) call for the development and implementation of "ethical guidelines that define and circumscribe preferential access". Van Rosendaal (2006) calls for physicians to "uphold the ethical principle of justice" in their work, reminding doctors that their responsibility is not limited to the individual patient, but extends to the population as a whole. Van Rosendaal's comments are with respect to physicians who provide inaccurate information in letters of referral sent to specialists, in order to prioritize the referring doctor's patient on a waitlist. Cunningham et al. (2012) offer their article "Ethics in Radiology: Wait Lists Queue Jumping" as a resource for educators to "stimulate discussion of ethical issues about wait lists and queue jumping with

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residents”, and offer their decision-making scenarios and framework as a resource for practicing radiologists interested in ethics.

### ***6.2 Educate, Inform, & Provide Feedback***

Education is offered as a basic strategy to limit preferential access. Alter, Basinski & Naylor (1998) suggest that medical students and postgrad trainees be taught generally about preferential access, while Van Rosendaal (2006) more specifically suggests that students learn how to better manage their practice with populations of patients in mind. Van Rosendaal (2006) also calls upon those who develop wait-list strategies to listen to feedback from the Canadian family physician – those practitioners who are most often the point of access to the healthcare system.

### ***6.3 Greater Transparency in the Referral Process***

The referral process (discussed in Section 4.3 above) largely falls under the purview of the physician, not the patient. Specifically, the physician is often the sole decision-maker when deciding what specialist the patient will wait to see. Without the knowledge to make informed decisions, Lewis et al. (2000) note that “A patient may languish on a particular physician’s waiting list for a long time without ever knowing that another physician could provide the needed service much sooner”. Public information regarding the wait times for particular physicians able to provide the same treatment would remove the mystery from the referral process (Lewis et al. 2000). Patients may be less tempted to jump the queue if they know the queue is shorter somewhere else.

### ***6.4 Increase Healthcare Funding***

Although it may be the most controversial strategy, Alter, Basinski & Naylor (1998) do suggest that more generous funding for healthcare would speed up service, thereby reducing the temptation for patients to seek preferential access. More targeted spending, focusing on socially or geographically disadvantaged patients, may also decrease the temptation to queue jump (Alter, Basinski & Naylor 1998). Van Rosendaal (2006) encourages physician organizations to pressure governments to ensure that healthcare resources are sufficient.

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### ***6.5 Develop Standards and Tools for Prioritization of Care***

Lewis et al. (2000) suggest that developing tools for a) the individual physician, to prioritize patients using consistent criteria within her/his practice; and b) groups of physicians to prioritize patients on pooled lists would lead to better waitlist management and fairer, standardized access to care. Van Rosendaal (2006) similarly calls for “effective and equitable” strategies to prioritize patients’ access to care. MacLeod et al. (2004), however, have discussed how the implementation of just such a tool, namely the clinical priority assessment criteria for elective surgery across New Zealand, has been problematic (as discussed in Section 4.3 above).

Even before creating tools, Lewis et al. (2000) lament the dearth of good information systems based on standardized concepts and terms that may provide the data for prioritization tools. Sanmartin et al. (2000) join Lewis et al. (2000) in arguing that a universal (Canadian) definition of fundamental concepts, such as when a waiting list actually starts, needs to be established to be able to collect good data for information systems.

Finally, once waitlists are generated based on standardized data, tools and protocols, they must be managed properly. Lewis and colleagues (2000) argue that good management of waitlists:

- Would identify people at risk while subject to excessive waits.
- Would ensure that patients are reassessed when their condition changes.
- Would remove those whose clinical condition improves, who have decided to forgo the procedures, who die, who move out of the jurisdiction, etc.
- Should track outcomes to allow for continuous refinement of the criteria and weights used to prioritize patients.

### **Limitations of the Review**

The literature on the topic of preferential access to healthcare in Canada may be subject to publication bias and researchers’ reluctance to publish negative results. Also, a number of the significant studies referenced in this report are limited to a small number of authors, focusing on one area of healthcare – cardiovascular care. It is unclear as

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to what extent their findings are generalizable to other health services. Finally, the author has interpreted studies from non-Canadian jurisdictions (particularly the United States) as applying to the Canadian context. These interpretations must be taken with the major differences in how healthcare is structured and delivered outside of Canada in mind.

## **Conclusions**

Though there is no empirical, objective data on the impact of preferential access to healthcare in Canada, the practice does occur. Though not abundant, there are studies in the academic literature that examine how queue jumping may be facilitated by a healthcare system that provides better access to those with greater socioeconomic means. There is also research on the non-standardized systems that are used for generating and maintaining waitlists, or processing referrals to specialists that can create opportunities for preferential access. There are the special circumstances surrounding professional courtesy, Workers' Compensation claims, and "very important patients" that are deemed by other researchers as examples of preferential access. Finally, there are various jurisdictions in Canada that permit individuals to "step out of the public queue" and pay for healthcare services at private facilities with shorter wait times.

While some investigators question whether it is even advisable to try and address preferential access, there are others who suggest that there are educational, legislative and functional strategies that can help mitigate the practice.

Like the Canadian healthcare system itself, preferential access is a complex topic. Academic research in the fields of medicine, law, business and sociology must continue in order for us to grow our understanding of what impact preferential access has on Canadian society, and how we might reduce that impact in the future.

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## **Renal Dialysis Rimbey Support Group Report**

**Dr. John Church**

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## **4. Renal Dialysis Rimbey Support Group Report**

**Dr. John Church**

### **Executive Summary**

#### ***Rimbey and Area Dialysis Support Group Submission to the Alberta Health Services Preferential Access Inquiry***

As part of the Alberta Health Services Preferential Access Inquiry, the Rimbey and Area Dialysis Support Group were asked to make a formal written submission. The written submission focuses on the financial, safety and health costs associated with travelling to Red Deer to receive dialysis services. The formal submission will be presented to the Inquiry in Calgary on February 27, 2013.

#### ***Rural Canada***

Research and government reports on rural health care over the past two decades have emphasized a growing gap between Canadian rural and urban communities when accessing healthcare services. In addition to enjoying poorer health status and facing increased health risks, rural Canadians are confronted with a healthcare system that is not designed to serve their needs. In a nutshell, urban Canadians receive preferential access to health care.

#### ***Alberta's Rural Development Strategy***

Announced in 2005, A Place to Grow, Alberta's Rural Development Strategy, committed the provincial government to strive to: ensure that people in rural Alberta have access to quality public services; and, adapt and adjust programs and measures to take into account the unique aspects of rural communities. Included in this strategy is making sure people in rural Alberta have access to quality health services, recognizing the role rural health regions can play in health renewal, and providing opportunities to develop the economic potential of health care services.

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### ***Alberta Health Services***

Alberta Health Services is responsible for the delivery of health services to all Albertans according to the following guiding principles: local leadership and decision-making; focusing and fine-tuning our efforts to see the health system through the eyes of patients and communities; eliminating bureaucracy; and, valuing, trusting and respecting our staff, physicians and volunteers. Currently, Alberta Health Services has developed options for bringing dialysis services to rural communities. So far, they have refused to consider these options for Rimbey despite requests from local leaders.

### ***The Rimbey Situation***

Rimbey residents' costs are five times as much to access the same dialysis services as residents living in Red Deer. They travel over 1000 hours per month, use their own vehicles for transportation, and travel on statistically dangerous highways. Collision rates on these highways are 60 percent above the provincial average. In the last several years, one patient has been killed, one has been seriously injured and others have had near misses while driving back and forth between Rimbey and Red Deer. Rimbey residents are literally risking their lives to access dialysis services in Red Deer. Other rural Alberta communities are facing similar challenges. Meanwhile, dialysis patients in urban centres, such as Red Deer, have access to subsidized public transit options that provide door-to-door transportation and some of the largest urban areas in Alberta are provided with convenient access to services in neighbourhood shopping centres.

The Rimbey group has been trying for five years to get Alberta Health Services to recognize the life threatening challenges to accessing dialysis services that they face. While Alberta Health Services has refused to bring dialysis services into the community, Rimbey has a relatively new hospital that could accommodate a dialysis unit. Medical and nursing staff who currently provide dialysis services in Red Deer have indicated that they could support a dialysis unit in Rimbey. Other options, such as mobile dialysis and storefront services currently being used by Alberta Health Services, might also be used to bring dialysis services to Rimbey.

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### ***Recommendations***

1. In partnership with the Rimbey and Area Renal Dialysis Support Group, Alberta Health Services and the Northern Alberta Renal Program develop a detailed case illustrating costs/benefits for all options available to Rimbey and area renal dialysis patients, consistent with the principals of the CHA, the Alberta Health Services mission "to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans" and the goals and objectives of the Alberta rural development strategy.
2. In partnership with the Rimbey and Area Renal Dialysis Support Group, and other rural communities, Alberta Health Services and the Northern Alberta Renal Program, establish strategies to address effectively and equitably the needs of rural dialysis patients in Rimbey and other rural communities in Alberta.
3. In partnership with the Rimbey and Area Renal Dialysis Support Group, and other rural communities, Alberta Health Services and the Northern Alberta Renal Program, ensure public availability of relevant information and transparency in decision-making and resource allocation for dialysis services. Albertans want to know how decisions are being made, and that decisions are open and fair. Involving rural communities in a meaningful way and carefully considering their quality of life when making decisions about their health and the health care services they receive is a key part of a patient-focused approach to health care.

### **Background**

On October 11, 2012, Rimbey and Area Renal Dialysis Support Group submitted a request to Mr. Justice John Z. Vertes, Commissioner of the Health Services Preferential Access Inquiry called by the Province of Alberta, asking for an opportunity to make an appearance at the Inquiry to present a request for funding to support appearance at the Inquiry. On November 7, 2012 we made an oral submission to the Inquiry and subsequently were advised that we should more formally document our concerns and submit this to the Inquiry. We wish to express our appreciation for being given the privilege of appearing on October 11,

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and respectfully present the submission of the Rimbey and Area Renal Dialysis Support Group.

### ***Canada Health Act***

Section 3 of the *Canada Health Act* states that “the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada” [*Canada Health Act*, RSC 1985]. The *Canada Health Act* deals with how hospital and physician services are funded, and leaves how services are to be delivered to the provinces and territories. However, the Act does “seek to ensure that Canadians have universal and reasonable access on uniform terms and conditions to a range of physician and hospital services on the basis of need and without regard to individual ability to pay.”<sup>1</sup> “Therefore, to the significant degree that relative access to these services would otherwise depend on each person’s financial capacity, Medicare seeks to ensure equality of access to the health services it encompasses.”<sup>2</sup> It is understood that for practical reasons a service may be more available in some areas than others, resulting in some variation in access including variation between people who live in rural and urban communities. However, under the universality criterion, the rationale is to ensure general equality of access to the services funded by a health care plan on uniform terms and conditions. In conjunction with the universality criterion, the accessibility criterion repeats the requirement for uniform terms and condition, and adds that access must also be “reasonable”. While reasonableness has not been defined, referring to the overall objective of health care policy to promote and restore physical and mental wellbeing of residents of Canada, rural residents face an additional burden when attempting to access healthcare services under uniform terms and conditions. In the case of access to dialysis services in Alberta, rural residents can face significantly greater financial barriers than urban residents when attempting to access the same services. The *Canada Health Act* was designed to ensure that Canadians had equitable access to services, that is, that Canadians with the same medical condition, needing to access the same medical service would have comparable access to these services without financial barriers. Clearly, in the case presented below,

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<sup>1</sup> Lahey, W. The Legislative Framework Governing Access to Health Services that are “Insured Health Services” under the *Canada Health Act* and “Insured Services” under the Legislation of Alberta, A Report to the Health Service Preferential Access Inquiry of the Province of Alberta, November 2012, p.4 .

<sup>2</sup> *Ibid*, p.8.

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Rimbey and area dialysis patients do not have comparable access to medically necessary services without financial barriers. In addition, they face life-threatening transportation barriers. Comparable patients in urban settings are not faced with comparable costs or transportation safety barriers and appear to enjoy preferential access to publicly funded dialysis services.

### **Rural Health Care in Canada**

Rural Canada is diverse both geographically and economically. Rural communities are unique in their characteristics, values and employment. In Alberta, rural economies may include activities related to agriculture, oil and gas, forestry, mining, and tourism. A number of reports in Canada have identified issues related to the health care of rural Canadians.<sup>3 4 5 6</sup>

- Canada may have a good health care system with good health outcomes, but this is not the reality for Canadians living in smaller or more isolated communities. Canadians living in rural and remote communities spoke to the Commission on the Future of Health Care in Canada (the Romanow Commission) of the need for good health and good access to health care because it is essential not only to sustain their own quality of life, but the quality of life in their communities.
- The health status of rural residents is lower than urban residents. Rural residents have lower health status than urban residents, higher overall mortality rates and shorter life expectancies, as well as higher rates of long-term disability and chronic illness. Rural Canadians are limited to a smaller range of health providers. The most serious problem for residents of rural and remote areas is access to

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<sup>3</sup> The Future of Rural Healthcare (2001). Society of Rural Physicians of Canada, Submission to The Commission on the Future of Health Care in Canada. <http://www.srpc.ca/PDF/srpc-submission.pdf>.

<sup>4</sup> Building on Values: The Future of Health Care in Canada, Final Report, Commission on the Future of Health Care in Canada, Government of Canada, November 2002, Chapter 7. <http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>.

<sup>5</sup> Rural Canada: Access to Health Care (2002). Ottawa: Economics Division. 23 p. 4,6. <http://publications.gc.ca/Collection-R/LoPBdP/BP/prb0245-e.htm>.

<sup>6</sup> Government of Canada (October 2002). Senate Standing Committee on Social Affairs, Science and Technology. The Health of Canadians: The Federal Role. <http://www.parl.gc.ca/Content/SEN/Committee/372/soci/rep/repoct02vo16-e.htm>.

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the health care services they need closer to their own communities. The chronically ill and infirm elderly are at particular risk and often have to move away from their friends, families and homes. Rural seniors play a significant role in sustaining rural communities. They populate volunteer groups that provide many valuable services for rural communities. They also provide support for younger working parents who may have few options for childcare in rural settings. When forced to move away, not only is this community capacity lost, the capacity and health of the individuals may be negatively affected by being separated from their communities and their families.

- If rural residents require more specialized care they must travel longer distances and incur additional expenses that are not fully reimbursed. During some parts of the year, travel may be impossible due to weather conditions leading to poor health outcomes.
- One of the biggest barriers is the organization of the health care system “in a highly centralised manner better suited to countries with dense populations and short distances.”<sup>7</sup>
- “When centralised policies do not fit rural realities, as they so often do not, the rural side is swept under the carpet.”<sup>8</sup> The centralization of health services and rural hospital closures has had a severe impact on rural residents. Widespread closure of rural hospitals in some provinces has had serious consequences for local residents.
- Urban planning has dominated the planning of rural health care programs, to the detriment of rural populations. The predominance of urban approaches meets the needs of large hospitals in major urban centres, but doesn’t meet the needs of rural communities.
- Primary care reform is the mantra of health care analysts and consultants. It is perceived as “in the box” thinking.

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<sup>7</sup> The Future of Rural Healthcare, Society of Rural Physicians of Canada, Submission to The Commission on the Future of Health Care in Canada, p.8. <http://www.srpc.ca/PDF/srpc-submission.pdf>.

<sup>8</sup> The Future of Rural Healthcare, Society of Rural Physicians of Canada, Submission to The Commission on the Future of Health Care in Canada p.8. <http://www.srpc.ca/PDF/srpc-submission.pdf>.

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“Few have understood that it is hard to put the round peg of rural health into that box.”<sup>9</sup> The concept of primary and specialist care reflects a division of labour that occurs in the big cities. In rural areas, specialist care is often non-existent. To receive such care, patients often must travel significant distances on a frequent basis at their own expense. Even access to primary care can be limited because of shortages of family physicians in rural areas.

- As seniors get older, their cognitive abilities may diminish. Eventually, many will have their driving privileges reduced or eliminated completely. As the population ages, younger seniors (65-80) increasingly may be driving older seniors (>85), or spouses may be co-pilots when travelling to medical appointments. Public transportation options in rural areas are limited or non-existent. Seniors who must travel into urban centres for medical appointments have fewer options than seniors in urban centres.

In their submission to the Romanow Commission, the Society of Rural Physicians of Canada in discussing barriers to change concluded, “what is needed in general, in our opinion, is for rural health care to be treated not as a difficult child of the present system, but as a distinct entity, with its own specific challenges and solutions.”<sup>10</sup> As was identified over a decade ago by Dr. John Wooton, “if there is two-tiered medicine in Canada, it's not rich and poor, it's urban versus rural.”<sup>11</sup>

### **Alberta's Rural Development Strategy**

A Place to Grow, Alberta's Rural Development Strategy developed in 2005, committed the provincial government to strive to:

- Ensure that people in rural Alberta have access to quality public services.
- Adapt and adjust programs and measures to take into account the unique aspects of rural communities.

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<sup>9</sup> *Ibid.*, p.5.

<sup>10</sup> *Ibid.*, p.9.

<sup>11</sup> Dr. John Wooton, "New Office to Focus on Rural Health Issues," *Farm Family Health*, Vol. 7, No. 1, Spring 1999.

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- Encourage innovation in rural Alberta and promote innovative and creative solutions to the current challenges in rural Alberta.
- Foster learning in rural Alberta by making sure new opportunities are available for rural Albertans to learn, adapt and develop new knowledge and skills essential for economic development.
- Promote and expand rural Alberta's vital role in Alberta's competitive advantage in the global marketplace.
- Make rural Alberta a key part of the appeal that makes our province the best place to live, work and visit.

The Strategy outlines objectives and actions to be taken to strengthen and sustain rural communities, including:

- **Community capacity, quality of life and infrastructure** – ensuring that rural communities have the capacity, the quality of life, and the infrastructure necessary to remain vibrant and attractive places to live, work and visit.
- **Health care** – making sure people in rural Alberta have access to quality health services, recognizing the role rural health regions can play in health renewal, and providing opportunities to develop the economic potential of health care services.

Priority actions identified included:

- **Building community capacity.**
- **Improving access to health care:** “Steps will be taken to make better use of the capacity in rural hospitals and health regions to improve access for people in rural and urban communities and to build the economic potential of health services in rural communities.”

The economic potential alluded to in the Alberta Rural Development Strategy refers to the traditional role of hospitals in rural communities as a source of employment and income for local communities. The presence of hospital services is also a draw for new commercial and

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industrial development. While this presence was diminished when regional health boards were introduced, the development of new hospital facilities in rural communities such as Rimbey has created new opportunities for economic growth.

As identified in Alberta's Rural Development Strategy, rural communities tend to have a higher proportion of seniors. While not all renal dialysis patients are seniors, most are in the adult population, individuals who play important roles in rural communities providing support to families and friends, volunteering in community activities and projects, and sharing their talents with their communities. These individuals have a strong attachment to their communities and would prefer to continue living in their communities as they age, helping to preserve the rural way of life, instead of having to move to an urban centre.

If rural patients cannot gain adequate access to non-emergent and frequently required healthcare services such as renal dialysis they face the prospect of having to sell their homes and move to an urban centre, as has been the case for numerous rural families. Having to leave their communities and community networks imposes not only a financial cost, but also a social cost on individuals, their families, their friends and their community. In cases where one partner dies after relocation to an urban setting, the other partner is often isolated because of lost connections to their rural community.

Alberta rural communities are also deprived of the social capital that these individuals bring through their knowledge and skills. In the case of the Town of Rimbey, over 500 seniors contribute to voluntary organizations including local churches, school lunch programs, the library, the museum, the seniors centre and the handi-van.

### **Patient-Centred Care**

In recent years, the concept of patient-centred care has begun to reshape health care. The Canadian Medical Association, the Canadian College of Physicians and Surgeons and provincial/territorial governments have all embraced the concept.<sup>12 13 14 15 16 17</sup> At its

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<sup>12</sup> Canadian Medical Association (2007), Putting Patients First®: Patient-Centred Collaborative Care A Discussion Paper.  
<http://fhs.mcmaster.ca/surgery/documents/CollaborativeCareBackgrounderRevised.pdf>.

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essence, patient-centred care means focusing on the needs and preferences of patients rather than the needs and preferences of health providers or health organizations. Thus, designing health service delivery based on provider preferences and centralized urban planning models may not be appropriate for serving rural populations. In fact it may reflect decisions that focus on the needs of health managers and providers (system-centric) rather than patients.

### **Alberta Health Services**

The mission of Alberta Health Services (AHS) is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. AHS is responsible for the delivery of health services to all Albertans according to the following guiding principles:

- Local leadership and decision-making.
- Focusing and fine-tuning our efforts to see the health system through the eyes of patients and communities.
- Eliminating bureaucracy.
- Valuing, trusting and respecting our staff, physicians and volunteers.<sup>18</sup>

### **Kidney Disease and Diabetes in Alberta**

Nearly 38,000 Canadians were living with kidney failure in 2009 – more than triple the number (11,000) living with the disease in 1990.<sup>19</sup>

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<sup>13</sup> College of Family Physicians of Canada (2009). Patient-Centred Primary Care in Canada: Bring It On Home. Discussion Paper. [http://www.cfpc.ca/uploadedFiles/Resources/Resource\\_Items/Bring20it20on20Home20FINAL20ENGLISH.pdf](http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Bring20it20on20Home20FINAL20ENGLISH.pdf).

<sup>14</sup> Patients' Association of Canada. What Patient Centred Care Really Means. <http://patientsassociation.ca/video/don-berwick-what-patient-centred-care-really-means>.

<sup>15</sup> Government of British Columbia, A New Era for Patient-Centred Health Care. [http://www.health.gov.bc.ca/socsec/pdf/new\\_era\\_sustain.pdf](http://www.health.gov.bc.ca/socsec/pdf/new_era_sustain.pdf).

<sup>16</sup> Government of Saskatchewan. Patient and Family Centred Care. <http://www.health.gov.sk.ca/pfcc>.

<sup>17</sup> Focus on patient-centred care highlights need for reforms. *Globe and Mail*. Nov 9, 2011. <http://www.theglobeandmail.com/partners/focus-on-patient-centred-care-highlights-need-for-reforms/article4252728/>.

<sup>18</sup> AHS (2012). Fine-Tuning Alberta's Health System. <http://www.albertahealthservices.ca/7502.asp>.

<sup>19</sup> Alberta Health Services (2012). Local renal program marks 50th anniversary of milestone. December 19, 2012. <http://www.albertahealthservices.ca/7746.asp>.

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Kidney diseases can occur for a variety of reasons including: infections, such as polycystic kidney disease (an inherited genetic disorder), pyelonephritis, and glomerulonephritis (inflammation of blood vessels), or a kidney problem you were born with; a narrowed or blocked renal artery (carries blood to the kidneys); long-term use of medicines that can damage the kidneys e.g. non-steroidal anti-inflammatory drugs (NSAIDs), such as Advil and Celebrex. Diabetes and high blood pressure are also common causes of chronic kidney disease.<sup>20</sup>

Diabetes is a chronic disease that is “a large and growing problem in Alberta.”<sup>21</sup> Over the past two decades the number of Albertans with diabetes has increased 2.5 times. “Diabetes is most prevalent in the aging population, who tend to have additional health problems that subsequently increase the burden on Alberta’s health care system.”<sup>22</sup> Many individuals with diabetes go on to develop kidney disease.

Patients who are diagnosed with diabetes require ongoing and long-term treatment. In 2009, the incidence of diabetes (number of new cases) identified in Alberta was more than double the incidence in 1995. Albertans with diabetes are twice as likely to die annually as those without diabetes.

In 2009, the rate of End Stage Renal Disease (ESRD) in Alberta was 12 times greater in patients with diabetes. Between 1997 and 2007, the number of patients with end-stage renal disease for diabetes patients increased from 39 percent to 56 percent. Diabetes patients over the age of 75 are most likely to develop ESRD and are increasing at the greatest rate.<sup>23</sup>

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<sup>20</sup> Government of Alberta (2013). Health Information and Tools: Health A-Z. <https://myhealth.alberta.ca/Pages/default.aspx>.

<sup>21</sup> Johnson, J.A. and Balko, S.U. (2011). "Epidemiological Trends of Diabetes in Alberta" (Chapter 2). Alberta Diabetes Atlas 2011, 13.

<http://www.albertadiabetes.ca/documents/AtlasWeb.pdf>.

<sup>22</sup> Johnson, J.A. and Balko, S.U. (2011). "Epidemiological Trends of Diabetes in Alberta" (Chapter 2). Alberta Diabetes Atlas 2011, 13.

<http://www.albertadiabetes.ca/documents/AtlasWeb.pdf>.

<sup>23</sup> Klarenbach, S. et al. (2011). "Diabetes and Kidney Disease in Alberta" (Chapter 8). Alberta Diabetes Atlas. <http://www.albertadiabetes.ca/documents/AtlasWeb.pdf>.

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**Options for Treatment of ESRD (End Stage Renal Disease)<sup>24</sup>**

A variety of options have been developed for the treatment of ESRD. However, many of these options are not feasible for all patients, especially those who have diminished physical or cognitive capacity due to aging and those with complex health issues.

**Hemodialysis:** Hemodialysis is a process used to clean and filter the blood to remove harmful wastes and extra salt and fluids. It also filters out excess potassium, sodium and chloride. This filtering or cleansing process is what a healthy kidney would normally do. Hemodialysis uses a mechanical filter, a dialyzer, to clean the blood. This connects to a machine through which the blood travels by IV tube during treatment. Once the blood passes through the machine and is cleaned, it flows back into the body through an IV tube. Most people require three 4-hour treatments every week. Patients must be under the care of a Nephrologist (kidney specialist) to undergo hemodialysis. Referral to a Nephrologist is through a General Practitioner or an Emergency Room. Hemodialysis can be done either at home or at a location outside of the home. Home dialysis requires the participation of a second individual to assist the patient and requires special training. When performed outside the home, hemodialysis involves trained professionals such as nurses and doctors. The possible complications associated with rapid changes in the body's fluid and chemical balance during treatment include: muscle cramps and hypotension. Hypotension, which is a sudden drop in blood pressure, can cause feelings of weakness, dizziness, nausea or death.

**Home Dialysis:** This form of hemodialysis often requires home renovations to accommodate the storing of equipment and supplies. A specific physical layout is required to accommodate the treatment. As mentioned above, a friend or family member, or hired aide is required to assist with home dialysis. Both the patient and the friend/family member/aide require specialized training. This training requires the patient and their assistant to relocate at their own expense to Edmonton for a period of six weeks. Driving back and forth every day for six weeks is just not feasible. The benefits of home dialysis are: an increased sense of control and independence; avoidance of travel associated with treatment; and, treatment during hours that are

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<sup>24</sup> Kostadurus. A. "End-Stage Renal Disease: Choosing a treatment that is right for you." <http://www.kidneydoctor.com/esrd.htm>.

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convenient to the patient. The challenges associated with home dialysis include: the cost and inconvenience of retrofitting existing space; the stress placed on friends/family members; the additional training; and the distance from trained medical personnel in the event of an emergency.

***Hemodialysis Outside of the Home:*** This form of dialysis might take place in several locations: health facility; specially equipped mobile facility (bus); or a specially equipped, storefront facility. What all of these options have in common is that there are trained medical personnel on hand to administer treatment and that the patient must travel outside of the home to receive the treatment. The benefits of receiving treatment in these settings include: presence of trained medical professionals; and, interaction with other patients.

The challenges of receiving treatment in these settings include: travelling outside of the home for treatment; and lack of control over the schedule.

***Peritoneal Dialysis:*** This form of dialysis uses the lining of the abdomen to filter impurities from the blood. A cleansing solution (dialysate) travels through an IV tube to the abdomen. Various fluids and waste pass through the blood vessels of the abdomen and into the dialysate. After several hours, the dialysate is drained from the abdomen taking the impurities with it. New dialysate is pumped into the abdomen and the process is repeated. This process may occur either with or without a machine.

Continuous Ambulatory Peritoneal Dialysis (CAPD), when performed without a machine, the patient has an external plastic bag attached to a catheter inserted in the abdomen. After several hours the solution is drained from the abdomen back into the bag and the bag is emptied. New dialysate is then placed in the bag and reintroduced into the abdominal wall. While being worn, the bag is hidden underneath clothing. The process is repeated three to four times a day. The benefit of this form of treatment is that it does not require a partner to assist. Possible complications to this form of treatment include: infection where the catheter is inserted into the abdomen; problems connecting and disconnecting the bag; and, fever and stomach pain.

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Continuous Cyclic Peritoneal Dialysis (CCPD) uses a machine to fill and drain the dialysate. The process can occur at night while the patient is sleeping and takes 10-12 hours.

Intermittent Peritoneal Dialysis (IPD) uses the same machine as CCPD. While it can be done at home, it usually takes place in a health care facility and takes longer than CCPD. As with CAPD, infection at the catheter insertion point is a potential complication.

***Kidney Transplant:*** Ultimately, replacement of the diseased kidney with a healthy kidney is desirable. In order for this to occur, a compatible donor kidney must be found. This might come from a living or deceased donor. The current demand for kidneys for transplantation significantly exceeds availability across Canada.

Possible complications from this procedure include rejection by the body of the new kidney. Anti-rejection drugs are used to reduce the chances of rejection. Kidneys from living relatives are less likely to be rejected than kidneys from unrelated cadavers. Long-term use of anti-rejection drugs can cause liver and kidney damage.

### **Access Barriers to Renal Dialysis Services for Rural Alberta Residents**

The Northern Alberta Renal Program now helps more than 1,100 patients at 22 sites in the central and northern parts of the province.<sup>25</sup> However, residents of rural communities who require regular and frequent access to renal dialysis are not having their needs provided for under the same terms as urban patients. For example, patients of Rimbey and nearby centres must travel to Red Deer, three times a week, a 170 km round trip each time they require a dialysis treatment. Other rural Alberta communities such as Lac La Biche face similar challenges. At certain times during the winter, adverse weather conditions require the closure of rural primary and secondary roads.<sup>26</sup>

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<sup>25</sup> U of A hospital marks 50th anniversary of first dialysis.  
[http://www.cbc.ca/news/canada/edmonton/story/2012/12/19/edmonton-dialysis-50th-anniversary-university-alberta.html?cmp=rss&utm\\_source=dlvr.it&utm\\_medium=twitter](http://www.cbc.ca/news/canada/edmonton/story/2012/12/19/edmonton-dialysis-50th-anniversary-university-alberta.html?cmp=rss&utm_source=dlvr.it&utm_medium=twitter).

<sup>26</sup> Emily Mertz. "Lac La Biche dialysis patients demanding better health care." Global Edmonton. Friday, August 24, 2012.  
<http://www.globaltvedmonton.com/lac+la+biche+dialysis+patients+demanding+better+health+care/6442703037/story.html>.

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The impact of geography and transportation of patients in rural areas creates barriers (including significant health risks) and impedes access to needed health services. In addition to the burden of travelling for treatment, Rimbey and area patients can sometimes be diverted from Red Deer to other facilities like Rocky Mountain House or Wetaskiwin when patient volumes in Red Deer reach capacity, creating further disruption in their lives.

Transportation is vital for access to health services, particularly in rural areas where distances are greater, road conditions can be highly variable, and access to alternative modes of transportation is less prevalent and significantly more expensive. Regardless of weather or road conditions, patients requiring renal dialysis must make the journey – foregoing such treatments is not an option.

Rural patients carry not only the burden of their condition but also the material, physical, emotional and financial stress of having to travel longer distances on hazardous roads to access treatment on a very frequent basis, a burden experienced to a much lesser degree by urban residents accessing the same services.

### **Transportation Accident Risk**

According to Alberta Transportation, “the majority of fatal crashes (69.8%) occurred in rural Alberta” between 2006 and 2010, although the number of vehicle accidents increased by 2 percent during 2009-2010 period.<sup>27 28 29 30 31</sup> During this period, a total of 13 fatal vehicle accidents occurred on the highways in and around Rimbey (Chart 1). It is these highways that Rimbey dialysis patients must use to access dialysis services in Red Deer three or four times per week.

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<sup>27</sup> Alberta Transportation. Alberta Collision Statistics, 2006.

<http://www.transportation.alberta.ca/Content/docType47/Production/2006AR.pdf>

<sup>28</sup> Alberta Transportation. Alberta Collision Statistics, 2007.

<http://www.transportation.alberta.ca/Content/docType47/Production/2007AR.pdf>

<sup>29</sup> Alberta Transportation. Alberta Collision Statistics, 2008.

<http://www.transportation.alberta.ca/Content/docType47/Production/2008AR.pdf>

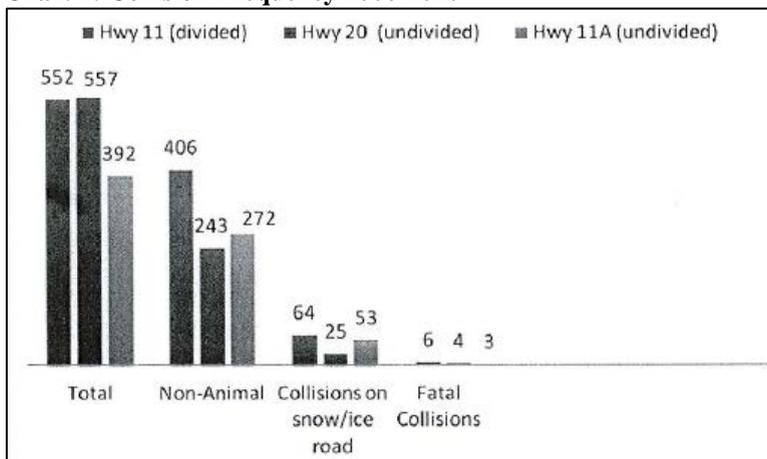
<sup>30</sup> Alberta Transportation. Alberta Collision Statistics, 2009.

<http://www.transportation.alberta.ca/Content/docType47/Production/2009AR.pdf>

<sup>31</sup> Alberta Transportation. Alberta Collision Statistics, 2010.

<http://www.transportation.alberta.ca/Content/docType47/Production/AR2010.pdf>

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**Chart 1: Collision Frequency 2006-2010**

Source: Alberta Transportation, Personal Correspondence, November 27, 2012.

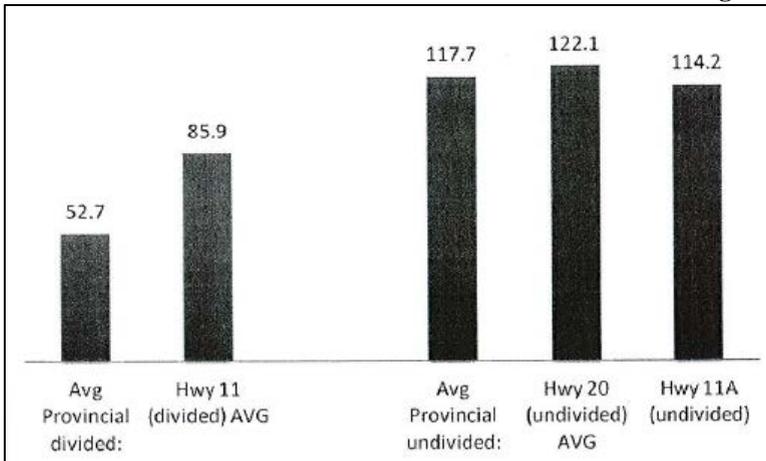
One of these deaths involved a patient returning to Rimbey after dialysis treatment in Red Deer. An elderly lady driving home after a long day for dialysis treatment in Red Deer had an accident. Complications from her weakened condition contributed to her death. Her son, who also requires dialysis, faces problems getting to Red Deer as his father now has to close his business four times a week to run his son into Red Deer for treatment. Thus, family members and friends who assist rural dialysis patients often pay a financial cost as well as suffer a personal loss (See Attachment 1).

A second patient was in a non-fatal accident that resulted in a broken hip and an extended (four month) stay in hospital. This cost the health care system \$193,320. Following this accident, he was no longer able to drive to Red Deer and he and his wife ended up leaving their home by Rimbey and moving to Red Deer, leaving the community where they had lived for many years.<sup>32</sup> As previously discussed, relocating to an urban setting in these circumstances often leads to social isolation and declining quality of life.

<sup>32</sup> Alberta Health, Personal Correspondence, November 22, 2012.

Many have travelled at numerous times during the winter months when people were being advised not to travel on the roads. Travel was “not recommended” but they had to take chances.

**Chart 2: Collision rates/100 Million Vehicle Kms 5 Year Average**



Source: Alberta Transportation, Personal Correspondence, November 27, 2012.

As Chart 2 indicates, the collision rate on Highway 11 between 2006 and 2010 was 60 percent above the provincial average. The collision rate on Highway 20 was above the provincial average during this time period. Both highways are subject to high traffic volumes associated with the oilfield servicing industry, agriculture and seasonal tourism.

**Table 1: Typical Dialysis Patient Day**

	<b>Rural Patient (Rimbey and Area Patients)</b>	<b>Urban Patient (Red Deer Patients)</b>
<b>Time Commitment</b>	10 hours per treatment	6 hours (5 hours in hospital)
<b>Human Resources</b>	Rural patients <i>should</i> be accompanied by a second individual to treatments to act as a driver	Urban patients do not have this requirement if they access the Transit Action Bus or other local public transit
<b>Transportation (Extra KM on average per year)</b>	Distance: 300 KM/week x 4 = 1,200/month x 12 = 14,400/KM extra per year  Personal vehicle with driver (20 hours x 3 times/week x 4 times/month x 12 times/year = 2880 hours.	Extra Distance: N/A  Personal vehicle, or Handi-Bus, taxi, or city bus
<b>Average Extra Costs / Year</b>	Vehicle wear-and-tear:  Other vehicle expenses - \$1,800/yr (estimate)	Handi-Bus: 3 trips/week x 4 @ \$35/month x 12 months = \$420 Taxi: variable Srs. City bus: \$56/month x 12 = \$672



	<p>Gas: (\$85/fill x 5 fills per month @ 3 trips/week = \$425/month x 12 = \$5,100/year)</p> <p>With 75% for dialysis use = \$3,825</p> <p>Parking: \$33/month x 12 = \$396/year</p> <p>Travel cost: \$5,625/year</p> <p>Meals: 2 people x \$8.50 = \$17.00 x 2 per trip = \$34/day and 3 days/week = \$102/week = \$408/month x 12 months = \$4,896/year</p> <p>Cost to required driver: If working, three full days of lost wages per week.</p> <p><b>Total: \$10,521 (average estimate)</b></p>	<p>Gas: N/A - not on ongoing basis</p> <p>Parking: when being dropped off.</p> <p>Meals: N/A as can eat at home both before and after treatment or 1 x \$8.50 x 3 x 4 x 12 = \$1,224</p> <p>Cost to required driver: If working two hours per day for 3 days of lost wages, or none if dialysis occurs in the evenings.</p> <p><b>Total: \$1,896 (estimate)</b></p>
<p><b>Travel Risks</b></p>	<p>Rural driving conditions and associated traffic fatality rate</p>	<p>N/A</p>

## **A Typical Dialysis Patient Day**

A typical patient day for a Rimbey and area dialysis patient (Table 1) lasts approximately 10 hours. This includes between 4–6 hours of treatment, plus 2 hours travel time and 2 hours for preparation and meals. As the information provided in the preceding charts on transportation indicates, driving the roads between Rimbey and Red Deer involves a risk that is well above the provincial average. In fact, as described above, patients have been involved in serious accidents resulting in significant injury and death as a result of driving to Red Deer to receive dialysis treatment. In addition to the significant transportation risk experienced by Rimbey and area dialysis patients en route to and from treatment in Red Deer, Rimbey and area patients also experience significant financial costs compared to Red Deer patients receiving the same care at the same AHS facility. Table 1 (previous page) compares the various direct costs to Rimbey and area patients compared to patients living in Red Deer. Rimbey and area dialysis patients pay at least five times as much in out-of-pocket expenses as comparable patients living in Red Deer.

## **Options for Treatment for Alberta Rural Dialysis Patients**

### ***In-Centre Dialysis***

The current option for dialysis patients from Rimbey and surrounding communities is to travel to Red Deer three times a week for dialysis treatments at the Red Deer Hospital, a 170 km round trip each time. A typical trip includes 4-6 hours of treatment, plus time for travel, preparation and meals (10 hours/day average). As previously discussed, driving the roads between Rimbey and Red Deer involves a demonstrated risk of accidents and adverse weather conditions that impose a burden in addition to a patient's medical condition. Patients experience significant financial costs, which are not reimbursable, in addition to the impact on family, friends or volunteers who must accompany them to treatments.

The Rimbey and Area Renal Dialysis Support Group has been trying for five years to get a dialysis unit in the Rimbey Hospital and Care Centre that was opened three years ago. The Rimbey Hospital and Care Centre has a 23 bed Acute Care Medical Unit and an 11 bed Emergency Department. The Seniors Health Care Centre has 84 beds. Rimbey can accommodate improved service and it would benefit area

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patients financially and eliminate much of the danger, stress and cost associated with the constant travel to and from Red Deer. By offering this service, the community would be using the health facility in an efficient way, and it would lessen the load on the Red Deer Hospital and other treatment centres.

Providing the service in the Rimbey Hospital would also fit with the priority actions of the Alberta Rural Development Strategy (described above). Dr. Kym Jim, who is a nephrologist in Red Deer and cares for many Rimbey and area patients, has offered to provide medical support for a dialysis unit. A number of the nursing staff currently working in the Red Deer dialysis unit have also offered to staff a unit in Rimbey. This option is currently being offered to other Alberta rural communities with similar challenges to accessing dialysis services.<sup>33</sup>

### ***Mobile Dialysis Treatments (satellite)***

Alberta has been innovative in utilizing mobile dialysis units to provide dialysis treatments to rural residents in northern and central Alberta. Recognizing that the health care system can't establish fixed dialysis units in every local centre, mobile units are seen as being a cost-effective way to bring renal dialysis to communities in need. Nurses and specially trained drivers staff the unit as it moves from community to community. Having a mobile unit can be cost effective as it is docking at a local centre, usually a hospital, to connect to water, sewage and electricity. Mobile units are capable of treating six patients on board, and connecting them with doctors in Edmonton via satellite. Such innovation enables patients to be treated locally, saving them considerable time, money, and the stresses of having to travel.

While several rural communities have been provided with a mobile dialysis unit that provides treatment to patients in their communities, Rimbey has not been offered this option.<sup>34</sup> Issues with staffing and equipment breakdown may not make this an optimal solution,<sup>35</sup> but it

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<sup>33</sup> McKinley, R. "Cadow to have full-time dialysis." Lac La Biche. Mar 27, 2012. <http://www.lacalabichepost.com/article/20120327/LLB0801/303279963/0/LLB>.

<sup>34</sup> Ramsay, C. "Medical milestone marked at University of Alberta hospital". Wednesday, December 19, 2012.

<http://www.globaltvedmonton.com/Pages/Story.aspx?id=6442775760>.

<sup>35</sup> Dubois, S. "Dialysis bus stops working for over a week." Lac La Biche Post. Jan 11, 2011.

<http://www.lacalabichepost.com/article/20110111/LLB0801/301119964/-1/llb/dialysis-bus-stops-working-for-over-a-week>.

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may still be an option worth exploring to address the needs of rural communities in west central Alberta.

### ***Store-Front Dialysis (satellite unit)***

Two dialysis units have been established in shopping centres in Calgary that provide easier access for patients there, saving parking expenses and enabling anyone accompanying the patient to do their errands or shopping.<sup>36</sup> Rimbey could accommodate this in existing commercial or community space.

### ***Home Dialysis***

As previously discussed, home dialysis is another option available to individuals living with renal disease. This can include:

- Dialysis done 3 times a week similar to in-centre hemodialysis, but done at home.
- Short daily sessions.
- Nocturnal hemodialysis.

Each has its advantages and disadvantages. It may be less expensive overall for the health system, due to savings on staffing (e.g. nursing). While home dialysis allows for more control over schedules and greater life satisfaction for patients, there are costs associated with this option and:

- Home dialysis may not be suitable for all patients.
- Training is required over a period of weeks in order to properly operate equipment and dialyze successfully. Currently rural patients and an individual who will supervise the home dialysis must travel into urban centres for training. Training takes six weeks. The patient must pay for travel and accommodation expenses, which can be a significant cost.
- Introducing dialysis into the home will impact everyone in the home, for good and bad.

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<sup>36</sup> Alberta Health Services (2013). Northland Village Mall: Programs and Services. <http://www.albertahealthservices.ca/services.asp?pid=facility&rid=1009760>.

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- Space is needed for the dialysis machine and supplies, often requiring renovations to the home which can be costly and are not reimbursable.
- There may be increased utility costs. Supply management may require time during business hours e.g. to receive deliveries, to drop off blood draws.
- Technical support is at a distance, and in emergency situations, patients must call 911 and wait for a response. The response time in rural areas is also much greater than in urban centres.

One Rimbey patient who chose this option was left with \$15,000 in renovation expenses that could not be claimed on income tax. The Northern Alberta Renal Dialysis Program only reimburses for \$1,500 in one-time renovation expenses. The patient must then shoulder all further maintenance and renovation requirements. This constitutes cost shifting from the taxpayer to the individual, a form of privatization.

### ***Telehealth***

Telehealth refers to the use of information and communications technologies in health care and can have the potential to improve the health and health care of people living in rural areas. Teledialysis has been implemented in Saskatchewan, Newfoundland and Ontario to provide dialysis treatment to patients living in rural or remote communities. It saves patients the associated costs of traveling, and provides them with the care they need where they live. With an aging population, telemedicine is seen as a useful tool in helping to monitor and manage chronic diseases. In Newfoundland, local clinics around the province offer dialysis, and patients come in for treatment three times a week. The mobile Telehealth unit is moved from bed to bed while the patients are being treated and they meet with the doctors over the telephone while they are being treated. Saskatchewan has nine Telehealth sites that offer a variety of clinics including renal dialysis. In Ontario, connection has been established with the nephrology group at the London Health Sciences Centre using the Ontario Telemedicine Network (OTN) to utilize the concept of a virtual clinic.

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### **Response to Rimbey Dialysis Challenges**

The Rimbey and Area Renal Dialysis Support Group has attempted to work with the local MLAs and the Alberta Health Services, Northern Alberta Renal Program (N.A.R.P.) to get a unit established in the Rimbey Hospital and Care Centre. To date, these efforts have received the following responses:

- Can't have a dialysis unit in Rimbey because it is in the wrong postal code. Since at least six patients are required, there are not enough with the actual Rimbey postal code. Surrounding area postal codes were ignored.
- There was room in the new hospital; then there was no room in the hospital.
- When the minimum patient requirement was met, the Rimbey and Area Renal Dialysis Support Group was provided with a map with circles on it. At first they fell outside the circles so qualified, but at a later date were provided with a different map with larger circles and told that they were within a circle so didn't qualify for a unit.
- Since they were within a 100 km radius from the Red Deer dialysis unit, they were too close.
- Subsequently, Rimbey was told that it would never have a renal dialysis unit as long as Red Deer was not at capacity. Recent information suggests that the Red Deer dialysis unit has reached capacity and plans are in place to expand it.

### **Conclusions**

The *Canada Health Act* is intended “to ensure that Canadians have universal and reasonable access on uniform terms and conditions to a comprehensive range of physician and hospital services on the basis of need and without regard to individual ability to pay.”<sup>37</sup> Research over the past two decades has identified clearly a growing gap between rural and urban Canadians in access to healthcare services. The Rimbey and area dialysis case described in this document provides a good example of the growing inequality in reasonable access to healthcare services for rural residents in Canada.

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<sup>37</sup> *Canada Health Act*, s12 (1) (a).

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Diabetes and ESRD are significant and growing health issues in Alberta. Rural and elderly Albertans are disproportionately affected by these medical conditions. Alberta is a leader in the treatment of diabetes and ESRD. Ongoing research for the Alberta Diabetes Surveillance System has recommended that government “enhance access to allied health professional primary care providers, particularly in rural and non-metro health zones”<sup>38</sup> and “ensure an adequate supply of primary care providers and access to all diabetes services in all areas of Alberta.”<sup>39</sup>

Currently, there are options available through Alberta Health Services for the treatment of ESRD outside of urban hospital settings and in rural communities. Satellite renal dialysis occurs in mobile buses, in-home self-care, and through store-front facilities in shopping malls. A number of rural communities currently access renal dialysis through a fully equipped mobile bus that travels to their community and connects to water and power infrastructure through local hospital facilities. However, Rimbey is not one of these communities. Residents in one Calgary neighbourhood access dialysis services conveniently through a store-front facility in a shopping mall.<sup>40 41</sup>

Currently, Rimbey and area dialysis patients travel over 1,000 hours/month; use their own vehicles for transportation; enlist a volunteer to drive them when possible; travel on statistically dangerous roads; and pay more than five times as much as urban residents to receive the same healthcare service. As already noted, Rimbey and area dialysis patients have been seriously injured, nearly killed or killed while travelling to and from dialysis appointments in Red Deer (see Attachment 1). Urban Alberta residents have access to door-to-door public transit if they choose.

Overall, rural residents receiving renal dialysis in Alberta are subject to cost shifting, a form of privatization. In addition, urban dialysis patients receive preferential access to dialysis services because rural dialysis

<sup>38</sup> ADSS (2011). "Key Findings and Policy Options" (chapter 13). Alberta Diabetes Atlas, 217. <http://www.albertadiabetes.ca/documents/AtlasWeb.pdf>.

<sup>39</sup> ADSS (2011). "Key Findings and Policy Options" (chapter 13). Alberta Diabetes Atlas, 218.

<http://www.albertadiabetes.ca/documents/AtlasWeb.pdf>.

<sup>40</sup> Alberta Health Services (2013). Northland Village Mall: Programs and Services. <http://www.albertahealthservices.ca/services.asp?pid=facility&rid=1009760>.

<sup>41</sup> Alberta Health Services (2013). Northland Village Mall: Programs and Services. <http://www.albertahealthservices.ca/services.asp?pid=facility&rid=1009760>.

patients pay significantly more than comparable urban patients to receive the same service and are sometimes diverted to other urban centres for treatment when they cannot be accommodated in the larger urban centre.

All of the above seems to be contrary to the *Canada Health Act*, the Alberta Health Services mission statement, current research on diabetes services in Alberta, and the Alberta Rural Development Strategy that has clearly indicated that rural hospitals should be used to ensure rural Albertans have access to quality health care. Rural hospitals are also seen as a source of economic development, offering employment to local residents and building community capacity and sustainability.

Although Rimbey has a relatively new hospital that could accommodate either an in-centre dialysis unit or a mobile facility, a storefront operation could be accommodated in the downtown and the existing Red Deer renal dialysis unit medical staff (nurses and nephrologist) is supportive of providing services in Rimbey, to date these options have been rejected by N.A.R.P. and Alberta Health Services.

Given the demonstrated safety concerns and financial barriers currently faced by Rimbey and area dialysis patients, is the access they receive to renal dialysis services *reasonable* relative to comparable patients within 70 kilometres of them receiving the same services, or do urban residents within the same geographic area, with the same medical conditions, seeking access to the same services, receive preferential access? How does this fit with the guiding principles of Alberta Health Services?

## **Recommendations**

The following recommendations are based on the evidence presented in this document and are consistent with Alberta Health Services guiding principles:<sup>42</sup>

1. In partnership with the Rimbey and Area Renal Dialysis Support Group, Alberta Health Services and the Northern Alberta Renal Program develop a detailed case illustrating costs/benefits for all options available to Rimbey and area renal

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<sup>42</sup> AHS (2012). "Fine Tuning Alberta's Health System."  
<http://www.albertahealthservices.ca/7502.asp>.

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dialysis patients, consistent with the principles of the CHA, the Alberta Health Services mission “to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans” and the goals and objectives of the Alberta rural development strategy.

2. In partnership with the Rimbey and Area Renal Dialysis Support Group, other rural communities, Alberta Health Services and the Northern Alberta Renal Program, establish strategies to address effectively and equitably the needs of rural dialysis patients in Rimbey and other rural communities in Alberta.
3. In partnership with the Rimbey Area Renal Dialysis Support Group, other rural communities, Alberta Health Services and the Northern Alberta Renal Program, ensure public availability of relevant information and transparency in decision making and resource allocation for dialysis services. Albertans want to know how decisions are being made, and that decisions are open and fair. Involving rural communities in a meaningful way and carefully considering their quality of life when making decisions about their health and the health care services they receive is a key part of a patient-focused approach to health care.

### **Attachment 1: Examples of the Barriers Faced by Rural Dialysis Patients**

Some examples illustrating the nature of the challenges faced by some rural residents who must drive quite a distance into an urban centre to access medically necessary dialysis services are provided below. These examples are based on true stories provided by rural Albertans. There are many stories like this. Names have been changed to protect privacy.

#### ***Example 1: The Near Miss***

The roads in the winter are unpredictable. One night after dialysis Jack and Mary had good roads to Sylvan Lake. Then all of a sudden we came over a hill and hit black ice. The traffic was slowed to 30 kph. Jack looked back and saw a tanker truck directly behind them starting to come alongside of them. At first they thought the truck was trying to pass which would have been very dangerous because there were five vehicles ahead of them. Then Mary realized the truck wasn't trying to

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pass them, just trying to miss them and slow down. After the truck was able to slow down, it pulled over and stopped. Jack and Mary did not see the truck pull out again before they were out of sight. Jack and Mary consider themselves lucky that the trucker was such a good driver.

### ***Example 2: The Accident and Lengthy Hospital Stay***

In December 2010 one rural dialysis patient Gerry had an accident coming home from dialysis. It was storming, roads were ice and snow covered and it was still snowing and blowing. Gerry couldn't control the car and it hit the ditch. Luckily a truck came along and phoned the ambulance. This accident resulted in a broken hip and part of one arm and almost a four-month stay in hospital. Based on an average cost/day for a hospital stay in Alberta, the cost of the four month hospital stay cost the Alberta taxpayer (120 days X \$1,611 per typical day) \$193,320. It is almost 2 years later and Gerry cannot walk without a walker. In September of 2011, Gerry and his spouse Jean left their home in rural Alberta to move to Red Deer after driving the road between Rimbey and Red Deer for over 10 years. There is also an added cost to this. They now have double payments on all utilities, taxes and insurance.

### ***Example 3: Travelling for Dialysis Can Kill***

Heather who had been driving her son Jim from outside of Rimbey for dialysis into Red Deer four times a week for ten years, and had herself recently (one year ago) become a dialysis patient, was in a car accident on her way home from her own dialysis treatment. Due to complications from injuries that occurred during the accident, Heather died. Her husband Bill now drives Jim to Red Deer for dialysis. Because Bill owns and operates a business, he must shut down his business at least 16 hours per week. He drives his son into Red Deer, drops him off, drives back to his business outside of Rimbey and then returns to pick up his son from dialysis at the end of the day.

### ***Example 4: Depression Caused by Leaving Home***

Charlie, who was born and raised on his farm, married, raised his children and spent his entire life there, needed dialysis. For the first few years of seven years relatives drove him to and from Red Deer. Later he stayed with a friend in Red Deer during the "poor travel" winter months. Finally he felt he was infringing on family and friends too

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much and moved into Red Deer, leaving behind his beloved farm and friends and community, trying to get a ride out to the countryside on the odd weekend. Even that came to an end. Charlie died away from the farm he built, and the community he loved and contributed to so much.

There are many other stories and testimonials including deciding to miss a dialysis treatment altogether because travelling is just too treacherous and stressful, but missing a treatment is also a gamble for many needing dialysis.

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