

# **Report on Core Framework Health Care Legislation**

**Alberta Federation of Labour  
July 2010**

**Gwen J. Gray, Q.C.  
Chivers Carpenter  
Barristers & Solicitors  
101, 10426 81 Avenue  
Edmonton, Alberta  
T6E 1X5**



# **Report on Core Framework Health Care Legislation**

**Alberta Federation of Labour  
July 2010**

**Gwen J. Gray, Q.C.  
Chivers Carpenter  
Barristers & Solicitors  
101, 10426 81 Avenue  
Edmonton, Alberta  
T6E 1X5**



## **Executive Summary**

### **Provincial Responsibilities:**

In providing health care to their citizens, provincial governments in Canada are responsible for four key functions:

- establishing, administering and funding of provincial health care insurance plans;
- organizing the delivery of publicly-funded health care services to their citizens;
- establishing and enforcing standards for the delivery of all health care services; and,
- preventing the growth of a parallel private for-profit health care system.

### **Role of the Federal Government:**

The Government of Canada, as a funder of health care services, imposes standards through the *Canada Health Act* (“CHA”) to ensure that federal spending on health care supports publicly administered, comprehensive, universal, portable and accessible provincial health care insurance plans. The *CHA* imposed financial penalties on provinces that permit extra billing for insured services. The *Act* does not prevent the delivery of publicly-funded health care services through for-profit service providers.

### **Consultations on New *Alberta Health Act*:**

The Minister of Health and Wellness is currently consulting Albertans on a new *Alberta Health Act* ("AHA") following a review of health legislation by the Minister's Advisory Committee on Health.

The legislative model proposed by the Minister's Advisory Committee on Health for the new AHA is the model used in the *Drug Program Act*, S.A. 2009, c. D-17.5 (not yet proclaimed). The *Drug Program Act* is enabling legislation, which permits the Minister to establish a drug program for the purpose of providing funding for, or providing, drugs, services and approved drugs (s. 2). The *Drug Program Act* then permits the Minister to make regulations which will determine all of the details of the plan, including who is covered for what kind of drug coverage, amounts of co-payments and deductibles. The *Drug Program Act* puts most of the power to decide the future of Albertans' drug coverage in the regulations, not the legislation or statute itself.

The key difference between a statute and a regulation is that a statute is approved by the Legislative Assembly following debate before it becomes law, where a regulation is not. If the *Drug Program Act* is accepted as the model for the new AHA, Alberta's health care legislation will contain no details of the core health care framework. All details will be left to the Minister's discretion and will not subject to debate in the Legislative Assembly. Further, the Minister can change the regulations at any time without notice and without debate. This model offers no assurances that delivery of insured services using public funding will be organized in a manner that preserves delivery of health care on a non-profit model, or that appropriate standards for health and health services in Alberta will be established and enforced.

**Purpose of this Report:**

Unfortunately, the Minister of Health is seeking consultation on the new *AHA* without circulating a draft of the proposed *AHA*. As a result, for the purposes of this report, we will identify how Alberta's existing health care legislation complies with the *CHA*; how it organizes the delivery of publicly-funded health care services; how it establishes and enforces standards for health care in Alberta; and how it restricts the growth of private for-profit system of health care.

Key legislative provisions restricting the growth of private for-profit delivery of health care include:

- Section 6 of the *Alberta Health Care Insurance Act* which prohibits doctors, dentists and patients who opt out of the Alberta Health Care Insurance Plan from receiving payment from the Plan for medical services;
- Section 26 of the *Alberta Health Care Insurance Act* which prohibits the sale of private medical insurance for medical services that are insured under the *Act*;
- Section 44 of the *Hospitals Act* which prohibits the sale of private insurance for hospital services insured under the *Hospitals Act*;
- Section 25 of the *Health Insurance Premiums Act* which prohibits residents who opt out of Alberta Health Care Insurance Plan and Hospitalization Benefits Plan from receiving benefits under either Plan.

The core framework is comprised by several pieces of legislation and their regulations: the *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20, the *Hospitals Act*, R.S.A. 2000, c. H-12, the *Health Care Protection Act*, R.S.A. 2000, c. H-1, the *Health Insurance Premiums Act*, R.S.A. 2000, c. H-6 and the *Nursing Homes Act*, R.S.A. 2000, c. N-7. In addition, the Report identifies the key elements of the *Public Health Act*, R.S.A. 2000, c. P-37, the *Mental Health Act*, R.S.A. 2000, c. M-13 and the *Emergency Health Services Act*, S.A. 2008, c. E-6.6, all of which the Minister's Advisory Committee on Health recommended be considered for inclusion in the new *Alberta Health Act*.

### **Key Concerns:**

The key concerns identified in this Report are as follows:

- Alberta has a bare-bones health care insurance system which covers only hospital services, physician services and surgical-dental services, and limited podiatry and optometric services. Drugs, dental care, regular optometric care, physiotherapy, chiropractic, and other medical services are not covered by the publicly-funded plan.
- Alberta permits publicly-funded health care services to be delivered through for-profit service providers under contract with Alberta Health Services ("AHS") with limited financial oversight or public reporting.
- Alberta has largely abandoned its role in establishing and enforcing standards for the delivery of health care through for-profit service providers. This role has been

assigned to the College of Physician and Surgeons of Alberta, resulting in reduced public oversight.

- The model proposed for the *Alberta Health Act* will decrease the role of the Legislative Assembly in shaping the legislative framework for health care in Alberta. Under the “enabling framework” model, Cabinet and/or the Minister of Health could implement major changes to the health care system without debate or review by the Legislative Assembly.

### **Conclusion:**

It is not possible to comment on whether the new *AHA* will result in improvements to the health care system in Alberta. There are, however, several reasons for citizens to be skeptical.

- The Alberta Government has not committed to expanding coverage of the health care insurance plan to include medical services that currently are uninsured.
- Alberta continues to allow insured health care services to be delivered through for-profit Non-Hospital Surgical Facilities, even in the wake of the bankruptcy proceedings relating to Calgary’s Health Resource Centre (“HRC”), a private surgery clinic owned by Network Health Inc. The bankruptcy exposed the vulnerability of the for-profit delivery model which, without additional funding from AHS, could have resulted in the cancellation or postponement of surgeries for Alberta citizens.

- There are no indications in the Minister's Advisory Committee Report that Government intends to reclaim its ability to set and enforce standards for the provision of health care in the for-profit sector.
- The legislative model proposed by the Minister's Advisory Committee, reduces the ability of citizens to have input into health care legislation by eliminating debate in the Legislative Assembly over key components of the plan.

All of these factors would lead one to conclude that the proposal to implement a new *AHA* to replace the existing core framework of health care legislation is either ill-conceived or designed to conceal Government's plans to significantly alter the existing health care system.





## Table of Contents

<b>I. Introduction:</b>	<b>3</b>
<b>II. Key Elements – What the <i>Canada Health Act</i> Requires:</b>	<b>4</b>
<b>A. Public Administration</b>	<b>5</b>
<b>B. Comprehensive</b>	<b>5</b>
<b>C. Universality</b>	<b>7</b>
<b>D. Portability</b>	<b>7</b>
<b>E. Accessibility</b>	<b>8</b>
<b>F. Ministerial Reporting</b>	<b>9</b>
<b>III. Alberta's Core Health Care Legislative Framework</b>	<b>9</b>
<b>A. <i>Alberta Health Care Insurance Act</i></b>	<b>9</b>
(i) Public Administration	9
(ii) Comprehensiveness	11
Additional Services:	13
Conclusion on Comprehensiveness for Physician and Dental Services	14
(iii) Universality	15
(iv) Portability	16
(v) Accessibility	19
(vi) Other provisions	22
<b>B. Hospitals Act</b>	<b>23</b>
(i) Compliance with <i>CHA</i>	24
(a) Public Administration	24
(b) Comprehensive	25
Facilities Covered:	26
Benefits provided:	27
Costs not covered:	29
(c) Universality	30
(d) Portability	31
(e) Accessibility	33
(ii) Hospital Standards	35
(iii) Hospital Foundations	36
(iv) Recovery of Costs related to Personal Injury	36
<b>C. Health Care Protection Act</b>	<b>37</b>
(i) Compliance with <i>CHA</i>	37

(a) Public Administration.....	37
(b) Comprehensiveness.....	42
(c) Universality .....	42
(d) Portability .....	43
(e) Accessibility .....	44
(ii) Hospital Standards for NHSF .....	45
(iii) Conclusions on <i>HCPA</i> .....	48
<b>D. Health Insurance Premiums Act .....</b>	<b>49</b>
<b>E. Nursing Home Act.....</b>	<b>50</b>
Mixed model of delivery.....	50
Funding .....	51
Eligibility for Nursing Home Care .....	51
Basic Care .....	52
Standards of Care.....	52
Inspection and Enforcement .....	53
Conclusion .....	54
<b>IV. Secondary Health Care Legislative Framework .....</b>	<b>54</b>
<b>A. Public Health Act .....</b>	<b>54</b>
<b>B. Mental Health Act .....</b>	<b>55</b>
<b>C. Emergency Health Services Act.....</b>	<b>55</b>
<b>V. “Drug Program Act” Model of Health Care Legislation .....</b>	<b>57</b>
<b>VI. Patient Rights .....</b>	<b>59</b>
<b>Conclusions: .....</b>	<b>60</b>

## **I. Introduction:**

This report identifies the key elements of the core health care framework which the Minister's Advisory Committee on Health proposes to amalgamate into the new *Alberta Health Act* ("AHA"). By "key elements" we refer to those legislative provisions that:

- (1) protect and ensure publicly funded health care in accordance with the principles set out in the *Canada Health Act*, R.S.C. 1985, c. C-6;
- (2) set out the methods of delivering publicly-funded health care services to their citizens
- (3) establish and enforce standards for the delivery of all health care services, and
- (4) restrict the growth of a parallel for-profit health care system.

The "core health care framework" considered by the Committee includes the following statutes and their regulations:

- *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20;
- *Hospitals Act*, R.S.A. 2000, c. H-12;
- *Health Care Protection Act*, R.S.A. 2000, c. H-1;
- *Health Insurance Premiums Act*, R.S.A. 2000, c. H-6; and,
- *Nursing Homes Act*, R.S.A. 2000, c. N-7

This report will also set out significant aspects contained in the secondary legislation which the Minister's Advisory Committee recommended be consolidated, at least in part, in the proposed *AHA*. The secondary legislation includes:

- *Public Health Act*, R.S.A. 2000, c. P-37
- *Mental Health Act*, R.S.A. 2000, c. M-13
- *Emergency Health Services Act*, S.A. 2008, c. E-6.6

Our report will address the Advisory Committee's proposal to structure the proposed *AHA* as an "enabling framework" for the health system, adopting the legislative model of the proposed *Drug Program Act*, S.A. 2009, c. D-17.5 (awaiting proclamation).

Finally, the report will address patient rights issues arising out of the *Chaoulli* case.

## **II. Key Elements – What the *Canada Health Act* Requires:**

In Canada, constitutional authority over the provision of medical services rests with provincial governments. The federal government, however, pays for part of the costs of the public system through federal-provincial transfers. The *Canada Health Act* ("CHA") was enacted to ensure that Government of Canada spending on health care supports publicly administered, comprehensive, universal, portable and accessible provincial health care insurance plans (the "plans"). It achieves this goal by setting out the manner in which the plans must satisfy the criteria of (1) public administration; (2) comprehensiveness; (3) universality; (4) portability; and, (5) accessibility. If the plans do not meet the standards set for each criteria, federal funding of provincial health care is reduced.

It is important to note that the *Canada Health Act* itself does not contain any disincentives that would discourage private for-profit delivery of publicly funded medical services. Nor does it contain incentives that would discourage physicians from working outside of the public system or working in both systems. The federal government's ability to restrict the growth of a parallel for-profit health care system is also constitutionally limited by its inability to regulate the sale of private medical insurance.

#### **A. Public Administration**

Under the *CHA*, in order to satisfy the “public administration” requirement, the plans must:

- be administered and operated on a non-profit basis by a public authority (s. 8(1)(a));
- the public authority must be responsible to the provincial government for that administration and operation (s. 8(1)(b)); and,
- the public authority must be subject to financial audits by the provincial auditor (s. 8(1)(c)).

#### **B. Comprehensive**

To satisfy the “comprehensive” requirement, the plans 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” (s. 9). Provinces have flexibility to insure services above and beyond the basic services required to be insured under the *CHA*.

“Insured health services” are defined as meaning “hospital services, physician services and surgical-dental services provided to insured persons,” excluding care that is provided under workers’ compensations laws (s. 2).

“Hospital services” are defined in the *CHA* as meaning medically necessary services provided to in-patients or out-patients at a hospital, including the following:

- accommodations and meals;
- nursing services;
- laboratory, radiological and other diagnostic procedures and interpretations;
- drugs, biologicals and related preparations when administered in a hospital;
- use of operating room, case room and anaesthetic facilities, including equipment and supplies;
- medical and surgical equipment and supplies;
- use of radiotherapy facilities;
- use of physiotherapy facilities; and,
- services provided by persons who receive remuneration therefor from the hospital

(s. 2).

“Hospitals” are defined as “a facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care” except mental hospitals, nursing home intermediate care service, adult residential care service or comparable services for children (s. 2).

“Physician services” are defined as meaning “any medically required services rendered by medical practitioners” (s. 2).

“Surgical-medical services” are defined as meaning “any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures” (s. 2).

### **C. Universality**

To satisfy the “universality” requirement, the plans must provide 100% of the insured persons of the province with the insured services on uniform terms and conditions (s. 10).

An “insured person” is a resident of a province and not a member of the RCMP, Canadian Forces or person who is an inmate in a federal penitentiary. Up to a three (3) month waiting period is permitted before a new resident is covered by the plans (s. 2).

### **D. Portability**

The “portability” criterion requires plans not to impose a minimum period of residency in excess of three months as a waiting period for plan coverage (s. 11(1)(a)). It also requires plans to pay the costs of a resident obtaining insured health services in another province at rates set by the other province (s. 11(1)(b)(i)). Out-of-country insured health services must be paid at rates that would have been paid in the province in comparable circumstances (s. 11(1)(b)(ii)). The plans must also cover the costs of insured health

services during the three month waiting period when a person changes provincial residency (s. 11(1)(c)).

#### **E. Accessibility**

To satisfy the accessibility requirement, plans must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude reasonable access to those services by insured persons, whether directly or indirectly by charges made or otherwise (s. 12(1)(a)).

The plans must also provide for:

- payment for insured services in accordance with a tariff or system of payment authorized by law;
- reasonable compensation for all insured health services rendered by medical practitioners or dentists; and,
- payment of amounts to hospitals in respect of insured health services.

In provinces where extra billing is not permitted, the requirement to provide reasonable compensation for all insured health services is met if the province agrees with associations representing doctors and dentists to negotiate rates and to settle disputes relating to compensation through, at the option of the medical associations, conciliation or binding arbitration. Such agreements must also provide that the decision of an arbitration panel cannot be altered except through an Act of the legislature of the province (s. 12(2)(a), (b) and (c)).

Extra billing by medical practitioners and dentists and user fee charges are discouraged under the *CHA* by deducting the amounts of extra billings and/or user charges from the cash contributions paid to the province in question (ss. 18 to 21).

#### **F. Ministerial Reporting**

Each fiscal year, the federal Minister of Health must report to Parliament on provincial compliance with the requirements of the *CHA*. The reports are available on Health Canada's website.

### **III. Alberta's Core Health Care Legislative Framework**

#### **A. *Alberta Health Care Insurance Act***

The *Alberta Health Care Insurance Act* ("*AHCIA*") establishes the health care insurance plan for Alberta with respect to the provision of physician and dental services. The *AHCIA* sets out the mechanism for establishing and operating the plan and for complying with many of the requirements of the *CHA*. It also sets out the main mechanisms that restrict the growth of a parallel for-profit health care system.

The key legislative provisions for ensuring that the five principles set out in the *CHA* are met and for restricting the growth of a parallel for-profit system are as follows:

##### **(i) Public Administration**

- **Non-profit basis by a public authority (*CHA*, s. 8(1)(a))**

Subsection 3(1) of the *AHCIA* requires the designated Minister (usually the Minister of Health and Wellness) to administer and operate the plan on a non-profit basis to provide benefits for basic health services to all residents of Alberta.

- **Public authority responsible to provincial government (*CHA*, s. 8(1)(b))**

The Minister is designated as the public authority responsible for the administration and operation of the plan (s. 3(3)).

- **Finances subject to audit by Provincial Auditor (*CHA*, s. 8(1)(c))**

The third element required under the “public administration principle” set out in the *CHA* requires the public authority to be subject to audits of its accounts by the provincial auditor. This requirement is met by Alberta through the *Auditor General Act* which authorizes the Auditor General of Alberta to audit the records of each government department.

However, the bulk of the Department of Health and Wellness’s budget is provided to Alberta Health Services (“AHS”) for the operation of the health care system. Under the *Regional Health Authorities Act*, AHS is required to appoint an auditor if the Minister has not designated the Auditor General of Alberta as the official auditor of AHS. It appears that, in the past, the Auditor General of Alberta has conducted audits of the Regional Health Authorities. In addition, AHS is required to provide the Minister with its budgetary documents under the *Government Accountability Act*, R.S.A. 2000, c. G-7.

(ii) **Comprehensiveness**

- **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 (CHA, s. 9)**

The *AHCIA* pays benefits for health services that are provided by physicians, dentists and some ancillary health care professionals. It does not address the provision of hospital care, which is dealt with in the *Hospitals Act*, R.S.A. 2000, c. H-12, the *Hospitalization Benefits Regulation*, AR 244/1990, the *Health Care Protection Act*, RSA 2000, c. H-1 and the *Health Care Protection Regulation*, AR 208/2000.

- **Insure medically required services rendered by medical practitioners (CHA, ss. 2 & 9)**

Subsection 4(1) of the *AHCIA* requires the Minister to pay benefits in respect of health services provided to residents subject to the provisions of the *AHCIA* and regulations.

The term “health services” is defined as meaning “basic health services, optional health services and extended health services” (s. 1(m)).

“Basic health services” are defined to include “insured services” (s. 1(b)). With respect to insured physician services, the *AHCIA* complies with the *CHA* by defining “insured services” as including “all services provided by physicians that are medically required” (s. 1(n)).

The *Medical Benefits Regulation*, AR 84/2006, establishes the benefits payable to physicians for the provision of insured medical services. The rates are negotiated between Government and the Alberta Medical Association and are set out in the Schedule of Medical Benefits (SOMB).

The *Alberta Health Care Insurance Regulation*, AR 76/2006 (as amended) defines the services which are not considered basic or extended health services (s. 12(2)), which include medical-legal services, advice by telephone except as permitted in the SOMB, transportation services (i.e. ambulance), 3<sup>rd</sup> party examinations, and services for which the resident is eligible to receive funding under another statute (i.e. *Hospitals Act*, WCB, etc.).

- **Insure medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures (*CHA*, ss. 2 & 9)**

With respect to insured dental services, the *AHCIA* defines “insured services” to include

- those services that are provided by a dentist in the field of oral and maxillofacial surgery and are specified in the regulations (s. 1(n)).

The dental services for which benefits are paid are set out in the *Oral and Maxillofacial Surgery Benefits Regulation*, AR 86/2006. In its 2008-2009 *Canada Health Act* Report, Health Canada reports that “in Alberta, a dentist may perform a small number of insured surgical-dental services” (p. 149). However, the Report does not conclude that Alberta is not in compliance with the requirements of the *CHA* with respect to dental benefits.

**Additional Services:**

- **Where the law of the province so permits, similar or additional services rendered by other health care practitioners (*CHA*, s. 9)**

Under s. 2 of *AHCIA*, Government may by regulation declare that any “basic health services” to be insured services. This provision allows Government to expand the scope of health care insurance coverage beyond physician and dental surgery.

Currently, some podiatric services and surgeries are included in coverage under the plan. Podiatric surgery benefits, as set out in the *Podiatric Surgery Benefits Regulation*, AR 202/2007 (as amended), are declared “insured benefits.” Other podiatric services to a maximum of \$250/year are provided under the *Podiatric Benefits Regulation*, AR 87/2006.

Some optometric benefits are provided under the *Optometric Benefits Regulation*, AR 202/2007 (as amended). Children and seniors are provided with coverage for eye examinations (Part 2). Other citizens are provided with coverage for an initial visit and follow up visit on an annual basis for specific medical conditions related to eye health (Part 3).

Chiropractic services benefit regulations were repealed effective July 1, 2009 by the *Chiropractic Benefits Repeal Regulation*, AR 174/2009.

Under subsection 3(2) of the *AHCIA*, the Minister is required to provide extended health services benefits to seniors, their dependents and widows receiving a Widow's Pension. Under the *Extended Health Services Benefits Regulation*, AR 83/2006, dental, denturist, and optician goods and services are provided to widows and their dependents receiving a Widow's Pension under the *Widow's Pension Act*, RSA 2000, c. W-7. Extended health services are provided through the provision of Blue Cross coverage without premiums for seniors and persons receiving a Widow's Pension.

### **Conclusion on Comprehensiveness for Physician and Dental Services**

The *AHCIA* provides the same definition for physician services as provided in the *CHA*. Dental services are defined somewhat differently, but the Alberta practice appears to comply with the requirements of the *CHA*. Extended health services are guaranteed for seniors and persons receiving Widow's Pensions. Few additional services, other than those provided by physicians and dental surgeons, are covered as "insured services." Under the existing legislation, Government has the ability to expand the scope of the health care insurance plan to include other medical services. No legislative change would be required to significantly expand coverage.

Rather than expand services that are covered by the plan, Government has recently reduced coverage by de-listing chiropractic services and sex reassignment surgery. Both reductions provide examples of the dangers of allowing the scope of insured services to be defined through regulation and not statute. Government was able to alter plan coverage without approval from the Legislative Assembly.

(iii) **Universality**

- **The health care insurance plan must entitle 100% of the insured persons of the province to the insured health services on uniform terms and conditions (*CHA*, s. 10)**

Section 4 of the *AHCIA* provides for payment of “health services benefits,” which include “insured services”, for all residents, except those who are members of the Canadian Forces, members of the RCMP, imprisoned in a federal penitentiary, or have not completed the waiting time for residency as set out in the regulations. Newcomers to Alberta from other provinces are eligible for coverage on the first day of the third month that they reside in Alberta. The waiting period is established under the regulations to the *Health Insurance Premiums Act*, R.S.A. 2000, c. H-6.

Resident is defined in s. 1(x) as 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.”

Coverage is provided to a resident and their dependents. “Dependents” is defined to include a spouse, an unmarried child under the age of 21 who is wholly dependent on the resident, an unmarried child less than 25 years of age who is in full-time attendance at an accredited educational institute, and an unmarried child 21 years or older who is wholly dependent by reason of mental or physical infirmity (*AHCI Reg. 76/2006*, s. 2).

Temporary absences of up to 12 months to reside elsewhere in Canada or up to 6 months to reside outside of Canada do not affect eligibility for benefits (*AHCIA*, s. 5(2) and *AHCI Reg.* 76/2006, s. 3). The Minister can extend the period of temporary absence (*AHCI Reg.* 76/2006, s. 3(2)). Children born to parents who are temporarily absent from Alberta are deemed to be residents of Alberta (*AHCI Reg.* 76/2006).

Persons who are ordinarily resident outside of Canada are deemed to be residents of Alberta for entitlement to the plan if they are: (a) in Alberta under a work assignment, contract or arrangement; (b) in full-time attendance as a student at an accredited educational institution in Alberta; or, (c) a dependent of a person referred to in (a) provided they have been lawfully admitted to Canada, established residence in Alberta, and intend to stay for 12 or more consecutive months (*AHCI Reg.* AR 76/2006, s. 5).

Dependents of a resident who is in Canada on a vacation or visit of not more than 12 months, or who is in full-time attendance as a student at an accredited educational institute with the intention of becoming a permanent resident of Alberta on the conclusion of the vacation, visit or schooling, is deemed to be a resident of Alberta for the purposes of obtaining health benefits (*AHCI Reg.* 76/2006, s. 7(2)).

**(iv) Portability**

- **No waiting period in excess of three months**

The Lieutenant Governor in Council is authorized to make regulations setting the waiting period for benefits for a new Alberta resident under s. 16(e) of the *AHCIA*. However, it appears that the actual regulation providing for waiting periods of 2 months for Canadians is made under the *Health Insurance Premiums Regulation*, AR 217/1981, s. 21. Under this *Regulation*, newcomers to Canada must apply for registration within 3 months after arriving and their coverage is effective on the date of becoming a resident of Alberta.

- **Must provide for payment of costs of insured health services for a resident who is temporarily absent from the province: (a) at the rate set by the other province or as agreed between the provinces when the resident remains in Canada; or, (b) payment at the rate that would have been paid in the province for similar services taking into account the size of the hospital, standards of service and other relevant factors when the resident is outside of Canada**

Payment for insured services for residents who are temporarily absent from Alberta is required under s. 5(2) of the *AHCIA*. Where there is a medical reciprocal agreement between the provinces in question, the province providing the benefits pays for the insured service and then bills Alberta. The rates paid are the rates required according to the rules established for payment of benefits in the other province or territory, and at the rates established by that province or territory (*Medical Benefits Regulation*, AR 84/2006, s. 4(2)).

Where payment of an insured service is not claimed under a medical reciprocal agreement, if the insured medical services are insured services under legislation in the other province or territory, the benefits are payable according to the rules established for payment in that province or territory. If the insured service is not insured in the other province or territory, Alberta pays the lesser of the rates contained in Alberta's SOMB or the amount charged (*Medical Benefit Regulation*, AR 84/2006, s. 4(3)).

No benefit is payable for out of province care if the service is not an insured medical service in Alberta or are claimed under a medical reciprocal agreement (*Medical Benefit Regulation*, AR 84/2006, s. 4(4)).

The Minister is authorized to make payments to a physician or hospital in Alberta for the provision of insured services provided to a resident of another province where the Province of Alberta and the other province have entered into a reciprocal agreement (*AHCI Reg. 76/2006*, s. 17). Alberta has reciprocal agreements with all provinces except Quebec.

Payment for insured services for residents who are temporarily absent from Canada is set out in s. 5 of the *Medical Benefits Regulation*, AR 84/2006 and the *Claims for Benefits Regulation*, AR 81/2006, s. 8. Payment for benefits for insured medical services provided to a resident of Alberta by a physician outside of Canada is limited to the lesser of the amount claimed and the rates set out in Alberta's SOMB. No payment is required for services that are not "insured services" in Alberta. If, as a result of one particular

illness or accident, a resident obtains health services over a period of more than 3 months outside Alberta, the Minister can request information why continued out-of-province care is required.

- **Must provide for payment of insured services for persons permanently leaving the province for the waiting period in the new province, on the same basis as if they had not ceased to be residents**

The requirement to continue benefits for residents who are permanently leaving Alberta for another Canadian residence is set out in s. 5(1) of the *AHClA*. The coverage period is set at 2 months, which period can be extended in certain circumstances (*AHCl Reg.* 76/2006, s. 8(1)).

For Alberta residents who leave Canada permanently, the coverage period is set at the discretion of the Minister at one, two or three months (*AHCl Reg.* 76/2006, s. 8(5)).

**(v) Accessibility**

- **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**

The *AHClA* requires physicians and dentists to opt into the plan in order to be entitled to receive payments for the provision of insured services from the plan (ss. 6, 7). Physicians and dentists who opt out of the plan have to inform the Minister and post notices for their

patients (s. 8). Doctors and dentists who opt out of the plan do not receive payment from the plan for their services (s. 6(1)). Instead, they have to collect fees for their services directly from their patients. Patients who receive services from “opted out” physicians or dentists cannot seek reimbursement from the plan for the cost of those services (s. 6(2)) unless the services were provided in an emergency (s. 6(3)). These provisions are essential for restricting the growth of a parallel for-profit health system. The *AHCA* prevents public subsidization of private medical services by not permitting payment from the plan to either the patient or the physician or dentist in relation to services provided by opted out physicians or dentists.

No physician or dentist who has opted into the plan is entitled to extra bill the patient for any services rendered (s. 9). According the Canada Health Act Annual Report, 2008-2009, 100% of physicians and dentists in Alberta had opted into the plan (p. 149). The ban on extra billing enables the Province of Alberta to receive full federal funding for health care. If extra billing is permitted, the amount of the federal transfer would be reduced as specified in the *CHA*.

Premiums for insured health care benefits were eliminated effective January 1, 2009 (*Health Insurance Premiums Regulation*, AR 217/81, s. 1.1 (as amended)). Any financial barriers resulting from premium payments have been eliminated.

- **Must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province**

Section 4 of the *AHCIA* requires the Minister to pay benefits in respect of all health services provided to residents. Section 17 of the Act permits the Minister to make regulations respecting the rates to be paid for health services. Those rates are set out in the Schedule of Medical Benefits, which is authorized under s. 3 of the *Medical Benefits Regulation*, AR 84/2006 and which is subject to negotiation between Government, AHS and the Alberta Medical Association.

Insured health services are provided under *AHCIA* by physicians on a fee-for-service or on an alternative relationship plan (*AHCIA*, s. 20). The current funding agreement allows doctors to be paid through three different alternative relationship plans: (a) a basket of services provided over a defined period of time for a specified volume of work or group of patients; (b) payment based on time; or, (c) an amount of money per patient over a set period of time.

- **Must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists**

In Alberta, the Minister is empowered to negotiate an agreement with the Alberta Medical Association, which agreement may provide for the submission of differences to binding arbitration (*AHCIA*, s. 40). The Minister, AHS and the AMA have entered into agreements concerning physician fees and the goods and services which will be compensated by the Plan. Alberta also prohibits extra billing by physicians and dentists who opt into the Plan. As a result, under s. 12(2) of the *CHA*, Alberta is deemed to have complied with the requirement to provide “reasonable compensation.”

**(vi) Other provisions**

- **Relationship between physician and patient**

Section 21 of the *AHCIA* preserves the patient's right of choice of medical practitioner and the physician's and dentist's right to accept or refuse patients. Subsection 21(2) permits residents to opt out of the Plan (i.e. patients can pay the costs of health care directly).

- **Restrictions on private health insurance**

Section 26 of the *AHCIA* prohibits an insurer from issuing insurance policies for basic health services or extended health services. This is a key provision for restricting the growth of private for-profit health care. The provision prohibits the purchase of private medical insurance by wealthier Albertans to cover the provision of services that are insured under the *AHCIA*. The ban on sale of private medical insurance to cover services that are provided through *AHCIA* is essential for ensuring the health of the public system. It prevents the diversion of doctors, surgeons and other health care resources from the public system to the private, for-profit system.

- **Optional Health Services**

Section 30 of the *AHCIA* permits the Lieutenant Governor in Council to enact regulations authorizing the Minister to issue contracts of insurance to residents providing optional health services, fixing subscription rates and providing subsidies for subscriptions.

Section 41 of the *AHCLA* specifically authorizes the Minister to enter into an agreement with the ABC Benefits Corporation to insure health services that are not basic health services or extended health services. The Minister has enacted the *Blue Cross Agreement Regulation*, AR 77/2006, whereby residents can apply for non-group Blue Cross coverage for optional health services. The Minister must enroll Alberta seniors and their dependents and recipients of Widow's Pensions and their dependants in the Government Blue Cross plan without premium (*Blue Cross Agreement Reg.* AR 77/2006, ss. 10, 11). The ABC Benefits Corporation is a non-profit corporation established through legislation.

- **Insured Services under other Statutes**

Section 44 of the *AHCLA* provides residents of Alberta with entitlement to receive without charge insured services that are provided under the *Mental Health Act*, the *Public Health Act* and any other Act under which insured services are provided.

## **B. Hospitals Act**

The *Hospitals Act*, R.S.A. 2000, c. H-12 provides for the establishment and operation of approved hospitals in Alberta, including non-regional health authority hospitals, and for the hospitalization benefits plan. It also contains other provisions dealing with Hospital Foundations and the Crown's rights to recover health costs.

For our purposes, I will first review the hospitalization benefits plan set out in Part 3 of the *Hospitals Act* in the framework of the requirements of the *CHA*.

(i) **Compliance with *CHA***

(a) **Public Administration**

- **be administered and operated on a non-profit basis by a public authority (s. 8(1)(a));**
- **the public authority must be responsible to the provincial government for that administration and operation (s. 8(1)(b)); and,**
- **the public authority must be subject to financial audits by the provincial auditor (s. 8(1)(c)).**

The *Hospitals Act* does not contain explicit language requiring the Minister to administer and operate the hospitalization benefits plan on a non-profit basis, nor does the *Act* ensure Ministerial and Government responsibility for the plan. Section 41 does require the Government of Alberta to share approved hospitals' operating costs with patients. This *Act* must be considered in the context of the *Health Care Protection Act*, which prohibits the establishment of full-service, for-profit hospitals. In this context, the various Acts do provide for payment of insured hospital services, as required by the *CHA*, but they also permit the establishment of "for profit" delivery of some surgical procedures.

Section 43 of the *Hospitals Act* enables the Minister to make regulations concerning the operation of the hospitalization benefits plan. The *Hospitalization Benefits Regulation*, AR 244/1990 (as amended) provides details of the calculation of hospital operating costs and the mechanisms for approving capital cost projects.

The auditing requirement of the *CHA* would be met by the audit of Alberta Health and Wellness pursuant to the *Auditor General Act*. For approved hospitals that are not owned by AHS, s. 4 of the *Hospitals Act* allows them or AHS to request a plan for fiscal and operational integration between the hospital and AHS. Approved hospitals that are not owned by AHS are referred to as “voluntary” hospitals. They operate under service agreements with AHS.

**(b) Comprehensive**

- **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 (*CHA*, s. 9);**
- **“Hospital” includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include a hospital or institution primarily for the mentally disordered, or a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children (*CHA*, s. 2);**
- **“Hospital services” means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,**
  - (a) accommodation and meals at the standard or public ward level and**

**preferred accommodation if medically required,**

**(b) nursing service,**

**(c) laboratory, radiological and other diagnostic procedures, together  
with the necessary interpretations,**

**(d) drugs, biologicals and related preparations when administered in the  
hospital,**

**(e) use of operating room, case room and anaesthetic facilities, including  
necessary equipment and supplies,**

**(f) medical and surgical equipment and supplies,**

**(g) use of radiotherapy facilities,**

**(h) use of physiotherapy facilities, and**

**(i) services provided by persons who receive remuneration therefor from  
the hospital,**

**but does not include services that are excluded by the regulations**

**(CHA, s. 2).**

Facilities Covered:

Section 37(1) of the *Hospitals Act* provides that the insured services to be provided by the Plan “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.”

Section 14 of the *Hospitalization Benefits Regulation*, AR 244/1990, permits the Minister to “make contracts with hospitals, other than approved hospitals, situated in Alberta to

provide insured services to residents.” In the *Hospitals Act*, “hospital” is defined as “an institution operated for the care of diseased, injured, sick or mentally disordered people” (s. 1(h)). No institution, however, can call itself a “hospital” unless it is an approved hospital under the *Act* or a hospital owned by the Crown (i.e. Alberta or Canada) (*Hospitals Act*, s. 47). Section 14 then allows Government to contract with institutions that fall within the definition of “hospital” and opens the door for private for-profit “non-hospital surgical facilities” where insured hospital services are provided through for-profit surgical facilities.

Subsections 43(a) and (c) of the *Hospitals Act* enable the Lieutenant Governor in Council to make regulations prescribing the basis on which the Minister may make contracts for the provision of insured services with non-approved hospitals, and prescribing the institutions and persons who can provide insured services.

Section 15 of the Regulation permits the Minister to make payments under the plan for insured services provided by the operator of an “approved facility.” An “approved facility” is one approved by the Minister (*Hospitalization Benefits Regulation*, AR 244/1990, s. 1(d)). Under the *CHA*, the “approved facilities” would fall within the definition of “hospital.” Hence, if insured services are provided by “for profit” approved facilities, any form of extra billing will be clawed back under *CHA*.

Benefits provided:

Section 37(2) of the *Hospitals Act* provides that the insured services to be provided by the hospitalization benefit plan shall include standard ward hospitalization in an approved hospital and any other goods and services prescribed in the regulations.

Section 36(j) defines “standard ward hospitalization” in a manner very similar to the definition of “hospital services” in the *CHA*.

Section 4(1) of the *Hospitalization Benefits Regulation*, AR 244/1990, sets out a list of services included in insured services for both in-patients and out-patients, in addition to standard ward hospitalization. The list is more generic in some circumstances than the list contained in the definition set out above in the *CHA*, for instance, s. 4(1)(vi) of the Regulation refers to “goods and services included in an approved hospital program or a specific program.”

In other circumstances, the list is more specific, providing for, for instance, private nursing care for a patient where it is ordered by the attending physician and authorized by the hospital’s by-laws (s. 4(1)(a)(i)), pace-makers, steelplates, pins, joint prostheses, valve implants, and any other goods approved by the Minister (s. 4(1)(a)(iv)), and inter-facility ambulance transfers (*AHCI Reg.*, s. 4(1)(a)(v) and s. 6).

Section 4(2) of the *Regulation* lists the services that are not insured under the plan. The services listed primarily relate to services that are paid for under some other statute, or relate to third party examinations. Section 4(2)(e.1) lists as uninsured “services provided

by a facility outside of Canada (other than services provided in the case of an emergency) without prior approval of the Minister, unless the Minister directs otherwise.” The list also excludes drugs, biologicals and related preparations that are not considered necessary for the patient’s treatment as determined by the pharmacy-therapeutic committee of the hospital, or the AMA, APA and AHA with respect to smaller hospitals. Similarly, drugs, biologicals and related preparations that have not been approved by experimental or clinical trials are excluded unless they are offered as part of a clinical trial (*AHCI Reg.*, s. 4(2)(g) and 4(3)).

Costs not covered:

Hospitals are allowed to charge patients for the following services:

- (a) in a general hospital, preferred accommodations charges (i.e. semi-private or private rooms) at rates set by the regional health authority if the preferred accommodation is requested by the patient and is not medically required (*AHCI Reg.*, s. 1(c) and 1(7));
- (b) in auxiliary hospitals, where the patient is more or less a permanent resident, but not for the purpose of receiving palliative care or sub-acute care, the accommodation charges for standard ward, semi-private or private accommodation at rates prescribed under the *Nursing Homes Act Operation Regulation*, AR 258/85, s. 5(1)(d) and 5(1.1));
- (c) in general hospitals, patients assessed as requiring auxiliary hospital or nursing home level care can be charged the same accommodation rates as prescribed in the *Nursing Home Operation Regulation*, AR 258/85 s. 1(8));

(d) physician services that are not insured under the *AHCIA* (s. 5.1(1)); and,

(e) enhanced goods and services requested by a patient, but not medically required at rates set by the regional health authority (*AHCI Reg.*, s. 5.2).

(c)           **Universality**

- **The health care insurance plan must entitle 100% of the insured persons of the province to the insured health services on uniform terms and conditions (*CHA*, s. 10)**

Residents of Alberta are entitled to receive the insured services unless (a) they are covered by another hospitalization plan in Canada; (b) they are covered by WCB; or (c) they are entitled to coverage under a federal or territorial statute (*Hospitals Act*, s. 38(1)).

“Resident of Alberta” is defined as “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” (*Hospitals Act*, s. 1(p)).

Registration under the *Health Insurance Premiums Act*, R.S.A. 2000, c. H-6, provides proof of residency (*Hospitals Act*, s. 38(3)).

The definition of “temporarily absent from Alberta” for the purpose of determining residency under the hospitalization benefits plan is the same as the definition contained in

the *AHCIA (Hospital Benefits Reg.*, AR 244/1990, s. 1(1)(gg) and 1(2)). The period of absence can be extended by the Minister in unforeseen and extenuating circumstances (*Hospital Benefits Reg.*, AR 244/1990, s. 1(6)).

Students from outside of Canada who are in full-time attendance at an accredited educational institution in Alberta and who intend to remain in Alberta for 12 consecutive months are deemed to be residents of Alberta.

Unmarried children of Alberta residents under 25 years of age who are in full-time attendance at an accredited educational institute maintain their entitlement to benefits as “dependents.”

No one can be refused admission to an approved hospital or the provision of services in an emergency by reason only of the fact that they are not entitled to receive insured services (*Hospital Act*, s. 38(4)).

**(d) Portability**

- **No waiting period in excess of three months**

The *Hospitalization Benefits Regulation*, AR 244/1990, requires residents to register for hospitalization benefits and to present their registration card to hospital authorities on their admission to a hospital (s. 2).

Registration takes place under the provisions of the *Health Insurance Premiums Act*, R.S.A. 2000, c. H-6 and the *Health Insurance Premiums Regulation*, AR 217/1981, s. 21. Newcomers to Alberta from other provinces must register by the first day of fourth month of their residency in Alberta, and their coverage is effective on the first day of the 3<sup>rd</sup> month. Persons coming from outside of Canada must register within 3 months of becoming a resident and the effective date of registration is the date the person became a resident of Alberta.

- **Must provide for payment of costs of insured health services for a resident who is temporarily absent from the province: (a) at the rate set by the other province or as agreed between the provinces when the resident remains in Canada; or, (b) payment at the rate that would have been paid in the province for similar services taking into account the size of the hospital, standards of service and other relevant factors when the resident is outside of Canada**

The *Hospitals Act*, s. 43(d) enables the Lieutenant Governor in Council to make regulations respecting the amounts payable in respect to hospital services provided to Alberta residents in other provinces and territories of Canada and outside of Canada.

The payment terms are essentially the same as provided under the *AHCI Regulation* set out above. For in-Canada services, the Province pays the rates set by the health insurance plan of the province providing the service. For out-of-country services, the rates paid are those that would be paid in Alberta taking into account the size, standards of service and

type of hospitals and other relevant factors (*Hospitalization Benefits Regulation*, AR 244/90, s. 16).

- **Must provide for payment of insured services for persons permanently leaving the province for the waiting period in the new province, on the same basis as if they had not ceased to be residents**

The same rules apply for residents of Alberta who take up residency in another province of Canada as were set out in the *AHCI Regulation*, AR 76/2006. Coverage continues during the waiting period of two months (*Hospitalization Benefits Regulation*, AR 244/90, s. 16(1)).

(e) **Accessibility**

- **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**

As indicated above, premiums for insured health care benefits were eliminated effective January 1, 2009 (*Health Insurance Premiums Regulation*, AR 217/81, s. 1.1 (as amended)).

The *Hospitals Act* does allow hospitals to charge for “enhanced services.” Charges for “enhanced services” have been criticized by the Consumers’ Association of Canada (Alberta) (the “CAC”) in a presentation to the Senate Standing Committee (Edmonton

2002). CAC reported that in the period from 1980 to 1986, the Province allowed surgeons and anesthesiologists in private surgical clinics to extra bill patients for insured surgical services. From 1986 to 1996, the extra billing fees were renamed “facility fees” but they remained at approximately the same level as the original extra billing. From 1996 to 2000, the private surgical clinics offered “enhanced” services (foldable or enhanced cataract lens implants) at roughly the same charge as the original extra billing. Finally, Alberta Health covered the costs of the “enhanced” lenses in all regions at wholesale prices (considerably less than the prices charged by the private clinics). Enhanced services are discussed more fully under the *Health Care Protection Act*, R.S.A. 2000, c. H-1.

- **Must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province**

The *Hospitals Act* requires the Province to pay the operating costs of approved hospitals, which the Province can share with patients. It also permits the Province to provide payments for approved capital costs (*Hospitals Act*, s. 43(j) and *Hospitalization Benefits Regulation*, AR 244/90, ss. 20 to 23). Part I of the *Act* sets out provisions for integrating the operations, financing, and management of non-regional health authority hospitals into a health region through plans for hospital facilities. There are approximately 24 approved “voluntary” acute care and auxiliary care hospitals in Alberta, all of which receive provincial funding. The voluntary approved hospitals are primarily operated on a non-profit basis by religious organizations. Currently, they work under service agreements with AHS.

With respect to non-approved hospitals and approved facilities, the rates paid for the provision of insured services is set by agreement between Government and the hospital or approved facilities. (*Hospitalization Benefits Regulation*, AR 244/90, ss. 14 & 15).

With certain exceptions, insurers are not permitted to offer contracts of insurance covering insured benefits (*Hospitals Act*, s. 44). The exceptions relate to the renewal of private insurance in effect on July 1, 1961 and for individuals who opt out of *AHCIA* benefits and *Hospital Act* benefits in accordance with s. 25 of the *Health Insurance Premiums Act*. Section 25 of the *Health Insurance Premiums Act* does permit residents and their dependants to file a declaration with the Minister that they elect to be outside of both benefit plans. However, insurance for standard ward hospitalization is not permitted to be issued to residents who opt out of hospitalization benefits for the costs of authorized charges for standard ward hospitalization. The exception to the ban on hospitalization benefit insurance then would be limited to: (a) those residents who opt out of hospitalization benefits; and (b) benefits that do not include standard ward hospitalization. Opted-out patients are personally and solely liable for the costs of insured hospital services (*Health Insurance Premiums Act*, s. 25(6)). Again, the ban on private insurance is an important mechanism for preventing the growth of private for-profit health services in Alberta.

## **(ii) Hospital Standards**

Part II of the Act sets out the standards for the operation of approved hospitals. These provisions deal with the governance structure of the hospitals, their by-laws, medical staff by-laws, and procedures for granting and removing physician privileges, and the obligations of hospitals to keep records of medical treatments. The legislation also requires reporting to the Minister and enables the Minister to investigate the management and affairs of a hospital. The Lieutenant Governor in Council is also given broad enabling powers to enact regulations dealing with approvals for new hospitals and setting standards of service, admission policies, health care education programs, rules for the disposal of human tissues, privileges of medical staff, etc. The Minister determines, by order, which hospitals offer a standard of service that qualifies them as “approved hospitals.” The *Operation of Approved Hospitals Regulation*, AR 247/90, sets out detailed requirements for the operation of approved hospitals in Alberta.

**(iii) Hospital Foundations**

Part 4 of the Act deals with the establishment and operation of Hospital Foundations, non-profit arms of approved hospitals.

**(iv) Recovery of Costs related to Personal Injury**

Part 5 of the Act deals with the Crown’s right to recover health costs for personal injuries suffered by a patient as a result of a wrongful act or omission of a wrongdoer. Typically, this Part governs the Crown’s recovery of medical costs resulting from personal injuries suffered in automobile accidents. This is the mechanism used to shift the medical cost

burden of automobile accidents from the public health system to the automobile insurance system.

### **C. Health Care Protection Act**

The *Health Care Protection Act*, R.S.A. 2000, c. H-1 (“*HCPA*”) begins with a preamble that confirms Alberta’s commitment to the principles of the *CHA* and to the principle that no Alberta resident should be required to pay for an insured surgical service or be given priority for that service by reason of any payment.

#### **(i) Compliance with *CHA***

##### **(a) Public Administration**

- **Non-profit basis by a public authority (*CHA*, s. 8(1)(a))**

The *HCPA* declares that “no person shall operate a private hospital in Alberta” (s. 1).

The Act then goes on to limit the provision of insured surgical services to: (a) a public hospital; or, (b) an approved surgical facility (i.e. a private surgical facility) (s. 2(1)).

Physicians and dentists are required to provide major surgical services in public hospitals only. “Major” surgical service is defined for physicians as one “described in the bylaws under the *Medical Profession Act*” (s. 2(2)(a)). These bylaws are set by the College of Physicians and Surgeons. Although the College’s bylaws are subject to government approval, the Government of Alberta has essentially abandoned its responsibility for determining what surgical services must be provided in a public (i.e. approved) hospital.

The term “private hospital” is defined as an acute care facility that provides emergency, diagnostic, surgical and medical services and admits patients for medically supervised stays exceeding 12 hours (s. 29(m)). The term “public hospital” is defined as a hospital established under the *Hospitals Act*, the *Regional Health Authorities Act* or the *Workers’ Compensation Act* and hospitals owned by the federal and provincial Crowns (s. 29(n)).

Despite its opening preamble and legislative prohibition on private hospitals, the *HPCA* allows for private, for-profit surgical facilities, which are called “non-hospital surgical facilities” or “NHSF.” These facilities fall within the definition of “hospital” as set out in the *CHA* (i.e. “a facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care”). The only “private” hospital prohibited by the *HPCA* is a full-service hospital that provides emergency services as well as other acute care services.

The level of government funding for insured services performed by the NHSF is determined by agreement between AHS and the NHSF. Typically, the NHSF are paid a service fee based on the procedures performed. These fees are in addition to the charges that are made by the physicians and surgeons under *AHCIA*.

“Facility services” are defined to include the types of services that are required to be included in insured hospital services under the *CHA* (*HCPA*, s. 29(g)). That is, the NHSF cannot bill patients for the items that would be provided in a public hospital.

Under the *HCPA*, both NHSF and public hospitals are permitted to charge patients fees for enhanced medical goods or services and for non-medical goods and services, at cost plus a reasonable allowance for administration, provided they comply with s. 5(3) of the *HCPA* and s. 6 of the *Health Care Protection Regulation*, AR 208/2000 related to disclosure and consent of the patient.

While the *AHCI* Plan remains a “non-profit plan operated by the public authority,” the use of NHSF to provide insured services clearly reduces the capacity of the public system to provide the same services. It introduces a profit model into the delivery of hospital services. A similar model is also used in Alberta with respect to the provision of diagnostic services.

By allowing “for profit” delivery of publicly funded surgical services, the Government has set up a system that encourages physicians to establish NHSF to compete with approved hospitals. Doctors who own NHSF have a financial incentive to perform work in their NHSF, not in approved hospitals, and there is an obvious concern that they will divert patients from the public system to their NHSF. The elimination of eye surgery from Calgary approved hospitals is one example of how the “for profit” system harms the capacity of approved hospitals to provide a full range of insured services.

- **Public authority responsible to provincial government (*CHA*, s. 8(1)(b))**

The Minister is required to approve all NHSF agreements (s.8). In doing so, the Minister is required to be satisfied that:

- the private provision of the insured service is consistent with the principles of the *CHA*;
- there is a current need, and there likely will be an ongoing need in the geographical area to be served, for the provision of the insured service as contemplated in the agreement;
- there is an expected public benefit considering such factors as access to service, quality of service, flexibility, efficient use of existing capacity and cost effectiveness and other economic factors;
- the health authority has an acceptable business plan showing how it proposes to pay for the NHSF;
- the agreement indicates performance expectations and related performance measures for insured surgical services and facility services to be provided; and,
- the agreement contains provisions showing how physicians' compliance with the *Medical Profession Act* and bylaws as they relate to conflict of interest and other ethical issues will be monitored.

Unlike payments made under *AHCIA* or the *Hospitals Act*, both of which are determined by the Minister or Cabinet through the processes set out in the respective statutes, public payments made under the *HCPA* to NHSF are determined by AHS and the NHSF operators by agreement. AHS remains responsible to Government for its expenditures and is a public authority. NHSF, however, are not public authorities and are not responsible to the provincial government. Hence, although they receive public funds to

provide insured hospital services, they have no legislated obligation to provide detailed financial statements to government or to AHS.

The financial health of a NHSF has a direct bearing on its ability to provide insured services, as was evident in the recent bankruptcy of Calgary's Health Resource Centre, owned by Network Health Inc., a NHSF which provides hip and knee surgeries. In a complex legal proceeding, the Government of Alberta applied to intervene in the bankruptcy and had a trustee appointed in order to prevent the winding up of the service through the bankruptcy proceedings. As AHS represented to the Court, "[i]f Network had ceased operations, surgeries would be disrupted, highly-skilled employees would be left jobless and physicians would be left without facilities in which to operate" (*AHS v. Network Health Inc.*, 2010 ABQB 373 at p. 7). As a result of the proceedings, AHS took over the secured debt owed by Network Health Inc. to CIBC and assured the landlord of the NHSF that AHS would pay rent on the facilities until January 31, 2011. In the meantime, the Government is scrambling to complete construction of its own facilities. The Network proceedings demonstrate the expense and vulnerability of operating a health care system using private facilities.

Although the terms of the contracts between AHS and NHSF are made available to the public, there is no mechanism to determine if the contractual payments are reasonable as no detailed financial information is required to be disclosed, including matters such as the salaries paid to corporate officers, etc.

- **Finances subject to audit by Provincial Auditor (*CHA*, s. 8(1)(c))**

Section 16 of the *Health Care Protection Regulation*, AR 208/2000, requires a NHSF to report on an annual basis the number of insured surgical services provided by the facility, and a summary of the enhanced medical goods or services provided, along with the revenues received for the enhanced goods or services. Otherwise, NHSF are only subject to financial audit if there is an auditing requirement in the contract between the NHSF and AHS. When for-profit entities are permitted to provide significant insured surgical services, it would seem reasonable to require those entities to establish their financial well-being on an on-going basis according to sound accounting practices. In addition, the public should be aware of the financial costs of using NHSF compared to the costs of delivering the same services through the publicly funded system of approved hospitals.

**(b) Comprehensiveness**

- **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 (*CHA*, s. 9)**

The hospitalization benefits plan applies to the insured services provided by NHSF, that is, those procedures which would be covered if performed at a public hospital will also be covered at the NHSF.

**(c) Universality**

- **The health care insurance plan must entitle 100% of the insured persons of the province to the insured health services on uniform terms and conditions (*CHA*, s. 10)**

The *HCPA* prohibits queue jumping based on the payment of money, payment for enhanced services, or provision of an uninsured service for the purpose of giving a person priority for the receipt of insured surgical service (*HCPA*, s. 3). NHSF are also prohibited from charging for facility services where a person receives an insured service (*HCPA*, s. 4).

The *HCPA* sets rules for the charging for enhanced services and non-medical goods and services at both public hospitals and NHSF. The rules require disclosure of information to the consumer and consumer consent (*HCPA*, s. 5 and *HCPA Reg.*, AR 208/2000).

The Legislation does not provide consumers with the right to insist on the provision of a surgical procedure in a public hospital, as opposed to a NHSF. Although all surgeons are paid for their services under the *AHCIA*, they can elect to provide the service through a for-profit NHSF.

#### **(d) Portability**

The Agreements entered into between AHS and NHSF contain provisions requiring the operator of the NHSF to comply in all respects with the provisions of the *CHA*, which

would entitle persons registered under the *Health Insurance Premiums Act* to insured services.

**(e) Accessibility**

- **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**

In its 2002 Report to the Senate Committee, the Consumers Association of Canada documented the history of extra-billing, facility charges and enhanced service fees in the NHSF sector. The Report provides examples of how patients were coerced into agreeing to enhanced services. Although the *HCPA* and Regulations require disclosure and consent for such services, and allow for the rescission of an agreement to pay for the services, these provisions may not overcome the imbalance of power and knowledge that exists between patient and surgeon.

- **Must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province**

The “system of payment authorized by law” is a contractual system. The *HCPA* requires AHS to publish contracts entered into with NHSF and to disclose contractual prices. Unlike the SOMB system used to reimburse physicians for their services where all physicians are paid the same rates for the same services, AHS has attempted to use competitive market forces to determine the price it will pay for the insured surgical services. For instance, when AHS announced the second last round of increases in eye

surgeries, it issued requests for proposals and initially accepted only four NHSF to provide the services. Other NHSF were required to transfer their patients to the services chosen by AHS. This competitive approach to the provision of insured services put the existence of the other NHSF at risk, and caused considerable physician backlash against AHS's attempts to start a bidding war among NHSF. The instability of such a system cannot bode well for the delivery of publicly funded health care.

- **Must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists**

Medical practitioners and dentists performing surgeries at NHSF still receive payment from the *AHCIA* in accordance with the SOMB negotiated between Government and the Alberta Medical Association. As indicated above, the "facility services" paid for by AHS pursuant to the agreements with NHSF are not negotiated through the AMA. The basis on which the payments are negotiated is not set out in the *HCPA* or the *Regulation*.

Profit margins are unknown. Unlike public facilities, a NHSF is not required to publically disclose its financial records. In these circumstances, it is difficult to know if the compensation paid is "reasonable" compensation.

## **(ii) Hospital Standards for NHSF**

Normally, public hospitals are accredited through Accreditation Canada, a non-profit organization with extensive and lengthy experience in assessing the quality of health care institutions and programs. Approved hospitals in Alberta are also subject to the requirements of the *Hospitals Act* and Regulations with respect to their operations.

Even within this regulatory framework, there have been recent examples of significant standards compliance problems in the provision of hospital services, i.e. the 2007 MRSA outbreak in a voluntary hospital, St. Joseph's Hospital in Vegreville, and the re-use of single use syringes in various Alberta hospitals. While Government has the authority to set and enforce standards in such areas as infection control, it tends to rely on hospitals and the regulated medical professions to determine and enforce those standards.

NHSF are required to be accredited by the College of Physicians and Surgeons and the standards applicable to them are set and enforced by the College. The College of Physicians and Surgeons of Alberta is the regulatory body in charge of doctors. It is comprised of members elected by the medical profession with some public members appointed by Government. The College does inspect NHSF, however, there does not appear to be any significant public reporting of the results of the investigations. For instance, in its 2009 Annual Report on Accreditation Programs, the College reported that it had inspected 12 NHSF in 2009. It further noted that there were 111 "reportable incidents" in 2009 in the NHSF sector. A "reportable incident" is a death within the facility or within 10 days of the procedure; transfers from the facility to a hospital; unexpected admissions to hospital within 10 days of the procedure; clusters of infection; and, any procedure performed on the wrong patient, site or side. There does not appear to be any public reporting by the College of the type of incidents, the location of the incident, the follow-up required or the like. Although public funds are used to pay for the NHSF, the public interest does not seem to have been taken into account in the manner

that Government has chosen to establish standards for this sector or enforce those standards.

Through its service agreements with NHSF, AHS does have contractual provisions that permit it to hold the NHSF to acceptable standards of practice and to inspect the facility. Ultimately, however, the only enforcement mechanism for breach of standards would be a termination of the service agreement.

The Alberta government has effectively taken itself out of the business of regulating health care standards in a significant portion of the health services industry.

It is unknown if the health outcomes of the current NHSF services are equal to, better or worse than services provided through approved hospitals. A recent report by the Parkland Institute entitled “The New Alberta Health Act: Risks and Opportunities” refers to academic studies in other jurisdictions which establish that outcomes in for profit health care institutions are not equal to the services provided by not for profit institutions. In this regard, it would seem essential for the public to be informed as to the health care outcomes of NHSF compared to those in approved hospitals and for the health care consumer to have a choice as to the manner of service delivery.

Part 3 of the *HCPA* empowers the council of the Colleges to report to the Minister on accreditation issues. The Minister is empowered to obtain injunctions to prevent violations of the *Act*. The Minister is also empowered to make inquiries into the

management and affairs of a designated surgical facility after its designation has been withdrawn. The Minister also has broad powers to visit and inspect surgical facilities and examine their records to ensure compliance with the *Act*, *Regulation* and *Agreements*. The Lieutenant Governor in Council is empowered to make extensive regulations governing the operation of NHSF. To date, however, the regulation of NHSF has been left to the College of Physician and Surgeons.

### **(iii) Conclusions on *HCPA***

As we argued above, the *HCPA* allows for a significant erosion of the publicly administered health care system in Alberta by permitting “for profit” delivery of insured services. NHSF currently exist in the areas of anaesthetic dentistry service, anaesthetic podiatry service, brain injury services, cardiac rehabilitation services, colon cancer screening, ophthalmology service, oral and maxillofacial services, orthopedic services, pregnancy termination, vestibular lab services, dermatology services, otolaryngology services, and plastic surgery.

In its submission to the Minister’s Advisory Committee on Health, the Calgary Chamber of Commerce urged Government to repeal the *HCPA* in total thereby allowing for the expansion of the for-profit delivery of health care, including the development of for-profit full-service hospitals and the elimination of Government oversight of for-profit facilities. The Chamber’s proposals would result in the expansion of private for-profit delivery of all health services, with little, if any, government oversight. Clearly, under the Chamber’s approach, the public system would be eroded.

Government has a legislative responsibility to establish and enforce standards for all hospital services, including those provided through for-profit surgical facilities. As past incidents, such as the MRSA incident in Vegreville, demonstrate, the Government of Alberta needs to expand its capacity to set and enforce health care standards through routine inspections and public reporting.

**D. Health Insurance Premiums Act**

The *Health Insurance Premiums Act*, R.S.A. 2000, c. H-6 (“*HIPA*”) and the *Health Insurance Premiums Regulation*, AR 217/81, deal primarily with the collection of health care premiums, which were eliminated effective January 1, 2009. However, the *Act* remains relevant with respect to registration and subsidies for non-group Blue Cross coverage.

Section 2 of the *Act* enables the Lieutenant Governor in Council to enact regulations authorizing the Minister to grant subsidies. This power remains important with respect to subsidization of non-group Blue Cross premiums, which are provided for in ss. 5 to 7. Section 8.3 of the *Regulation* waives the Blue Cross premiums for registrants over 65 years of age and their spouses, and for persons receiving benefits under the *Widow's Pension Act*.

Section 22 of the *HIPA* requires a resident to register himself/herself and dependents with the Minister. Dependents include (a) spouse; (b) unmarried wholly dependent child up to

age 21; (c) unmarried wholly dependent student up to age 25; and, (d) unmarried child 21 years or older who is dependent by reason of mental or physical infirmity (Reg. s. 1(2)(b.1)). Registration for persons arriving from other parts of Canada is effective the first day of the third month following the date they became a resident (HIPA Reg. s. 21(1)). Non-Canadians must apply within 3 months after their date of arrival, and their coverage is effective as of the date of their arrival in Alberta (HIPA Reg., s. 21(2)).

Alberta residents are permitted under s. 25 of the *HIPA* to opt out of the AHCI plan and hospitalization insurance plan by filing a declaration with the Minister. If a declaration is filed, the resident and his or her dependents no longer qualify for plan benefits and are responsible for payment of their own health services.

## **E. Nursing Home Act**

### Mixed model of delivery

The *Nursing Home Act*, R.S.A. 2000, c. N-7 ("*NHA*") is one of the statutes that the Minister's Advisory Committee on Health is proposing to sweep into the new *AHA*. The *NHA* permits AHS to enter into contracts with persons who operate nursing homes for the purpose of providing nursing home care to eligible residents. The contract terms are set out in a schedule to the *Nursing Homes General Regulation*, AR 232/85. Aside from publicly owned nursing homes, only nursing home operators who have a contract with AHS can use the term "nursing home" to describe their facilities (*NHA*, s. 21). Nursing homes are operated by AHS, voluntary non-profit organizations and for-profit organizations.

### Funding

Nursing homes are funded by accommodation charges paid by residents and direct government funding through AHS. Section 10 of the *NHA* requires benefits to be paid to nursing home operators in respect of eligible residents in an amount and manner set by regulation. The rates are set by the Minister and include payment for operating and capital costs (*Nursing Homes Operation Regulation*, AR 258/85, s. 2).

Accommodation charges paid by residents are set at the rate of \$44.50/day for standard ward accommodation; \$47/day for semi-private accommodation; and \$54.25/day for private accommodation (*Nursing Homes Operation Regulation*, AR 258/85, s. 3).

### Eligibility for Nursing Home Care

Residents of Alberta who have been found by an assessment committee to require nursing home care, and who have resided in Alberta for the year immediately preceding the application for benefits, if the person has been a resident of Canada for a period of at least 10 years, or 3 consecutive years at any time preceding the application are eligible for nursing home care benefits. Benefits are not paid if nursing home care is provided in accordance with another statute (i.e. WCB, Department of Veterans' Affairs) (*NHA*, s. 9(3)).

The procedures for assessing the level of care required by a resident are set out in the *Nursing Homes Operation Regulation*, AR 258/85, ss. 6 and 7. Assessment committees

are established by AHS. Once a person has been assessed as requiring nursing home care, the operator of a nursing home is required to accept the person if the operator has an open bed (s. 5).

### Basic Care

The basic care required to be provided by a nursing home includes accommodation and meals, facilities services, necessary nursing services, personal services, therapeutic and special diets as required, drugs and medications specified by the Minister, routine dressings, and life enrichment services (*Nursing Homes General Regulation*, AR 232/85, s. 2). The Minister can approve other programs in addition to the basic services.

### Standards of Care

The Minister is enabled to make regulations governing the operation and staffing of nursing homes and the standards applicable to nursing homes under s. 24 of the *NHA*. Section 4(2) of the *Nursing Homes General Regulations* incorporates the Continuing Care Health Service Standards and the Long-term Care Accommodation Standards into contracts entered into between AHS and nursing home operators.

In addition, the *Nursing Homes Operations Regulation*, AR 258/85, contains extensive provisions with respect to the composition of nursing home staff (s. 12), the role of the director of nursing (s. 13), staffing requirements for nurses (s.14), food service personnel, including dietitians (s. 15), life enhancement personnel (s. 16), and in-service education staff (s. 16).

Each nursing home is required to have a medical advisor (*Nursing Homes Operations Regulation*, AR 258/85, s. 18), and to require each resident be under the care of a physician (s. 19).

The *Regulation* also prohibits the administration of medications and drugs without a physician's order, and requires a nursing home to have an arrangement with a pharmacist to provide emergency pharmaceutical services (ss. 20 & 21).

Section 23 of the *Nursing Homes Operations Regulation* sets out general standards relating to the operation of nursing homes.

#### Inspection and Enforcement

The Minister can authorize the inspection of a nursing home to ensure the health, safety or well-being of residents, and compliance with the *Act* and regulations (*NHA*, s. 12). If the inspection reveals non-compliance with the *Act* or regulations, the Minister can order the operator to prepare a correction plan and submit it for approval to the Minister (s. 13).

The Minister has the power to order the cancellation or suspension of a nursing home contract if the Minister is of the opinion that there is non-compliance with the *Act* or regulations, or an act or omission that has or will prejudicially affected the health, well-being or safety of the residents (s. 14). A review process is established under s. 15 to allow an operator to appeal the Minister's order. The board of review can recommend that the Ministerial order be confirmed, cancelled or varied. The Minister may also

appoint an official administrator to operate the nursing home in the event the operator is not in compliance with the Act or regulations (s. 16). The Minister's Orders under these provisions may be appealed to the Court of Queen's Bench.

### Conclusion

The legislative and regulatory framework for nursing homes in Alberta is concise and well-developed. It could be used as a model for drafting detailed standards legislation for hospital and other medical services. The Auditor General, however, noted in his 2005 Report that the legislative and regulatory requirements were inadequately enforced.

## **IV. Secondary Health Care Legislative Framework**

### **A. Public Health Act**

The *Public Health Act*, R.S.A. 2000, c. P-37, establishes the office of the Chief Medical Officer for the Province and empowers the Chief Medical Officer to have general oversight over communicable diseases, public health emergencies, and the inspection of public and private facilities related to health hazards. Immunization services are provided to children under this *Act*. AHS is primarily designated with responsibility for implementing and carrying out the work previously performed by Medical Health Officers under the *Act*. There is an extensive list of regulations and health standards governing a variety of discrete public health issues, i.e. from food regulations to tattooing health standards. The regulations and standards appear to be designed to allow citizens easy access to the regulations and standards which may apply to their workplace or business.

## **B. Mental Health Act**

The *Mental Health Act*, R.S.A. 2000, c. M-13, provides the legislative and regulatory framework for detaining individuals under admission certificates for mental health examination and treatments and for issuing mental health warrants. It provides for appeals of mental health detention and treatment orders to a review panel, and establishes mental health advocates. Mental health services are delivered as insured services by AHS.

## **C. Emergency Health Services Act**

The *Emergency Health Services Act*, S. A. 2008, c. E-6.6, requires AHS to provide emergency ambulance services in Alberta. “Emergency health services” are defined to include dispatch services as well as the regular assessment, stabilization, treatment and transportation of patients (*EHSa*, s. 1(k)). AHS is permitted to contract out both aspects of these services with Ministerial approval (*EHSa*, s. 6).

Currently, AHS operates the system through multiple streams, including direct and contracted delivery of ambulance services and inter-hospital transfers, and direct and contracted delivery of dispatch services. The provincial flight co-ordination centre and air ambulance services, formerly operated directly by Alberta Health and Wellness, transferred to AHS on April 2, 2010. The Shock Trauma Air Rescue Society (“STARS”) operates outside of AHS, although part of its funding comes from AHS.

Part 3 of the *EHSA* provides for a system of licensing ambulance operators.

Part 4 sets out the duties of ambulance attendants and provides them with legal authority to enter premises without warrants. Section 18 in Part 4 prohibits the operation of an ambulance service except under agreement with AHS.

Part 5 deals with Ministerial oversight of ambulance services, including the ability to inspect a service and recommend the suspension or removal of an ambulance operator's license. Part 6 provides an appeal mechanism for operators whose licenses are suspended. Part 7 provides for fines for violations of the Act.

Part 8 enables the Lieutenant Governor in Council to make regulations defining "first response operations" and determining the use of such operations and the standards to be applied to such operations (*EHSA*, s. 47). Section 48 of the Act enables the Minister to enact extensive regulations governing the operation of ambulance services. The Minister is also empowered to arrange for additional ambulance services in any area of the province, and to impose service requirements, standards, protocols and guidelines for AHS and any ambulance operators to follow (s. 44). The Minister has established the Ambulance Vehicle Standards Code, *Licensing and Ambulance Maintenance Regulation*, *Staff Vehicle and Equipment Regulation* and Ambulance Equipment and Supplies Standards.

Ambulance services, except for inter-hospital transfers, are not insured services under the AHCI Plan.

## **V. “Drug Program Act” Model of Health Care Legislation**

The legislative model proposed by the Minister’s Advisory Committee on Health for the “Alberta Health Act” is the model used in the *Drug Program Act*, S. A. 2009, c. D-17.5 (not yet proclaimed). The *Drug Program Act* is enabling legislation, which permits the Minister to establish a drug program for the purpose of providing funding for, or providing, drugs, services and approved drugs (s. 2). The *Act* then permits the Minister to make regulations which will determine all of the details of the plan, including:

- who is eligible for coverage;
- which drugs are covered;
- the amount of co-pays, premiums, subsidies and deductibles;
- benefits to be paid; and,
- the bulk purchase of drugs.

The key difference between a statute and a regulation is that a statute is approved by the Legislative Assembly following debate before it becomes law, whereas a regulation is not.

With respect to statutes, government introduces a bill in the Legislature, which is then given first reading and passed without debate. When the bill is reintroduced for a second reading, it is subject to debate in the Legislature where Members of the Legislative

Assembly are able to directly question the premier and cabinet. If the bill passes the second reading, it may be forwarded to the appropriate standing committee of the Legislature for any hearings and/or further consideration. The bill is then reintroduced and any amendments arising out of the committee process are debated. The bill is then usually passed into law, subject to formal approval by the Lieutenant Governor. The new law will generally contain a provision providing when or how it will come into force.

Most statutes provide that a particular individual or body can create subordinate legislation on topics specified in the statute. The individual or body enacting the subordinate legislation does so in accordance with the authority granted under the enabling legislation. Such provisions ensure that the government or an administrative body can adapt certain standards relatively quickly to respond to a change in circumstances. For instance, the *Employment Standards Code*, R.S.A. 2000, c. E-9, provides that the Lieutenant Governor in Council (i.e. Cabinet) may make regulations regarding, among other things, minimum wage.

Regulations are a form of subordinate legislation. Like other subordinate legislation, they have the force of law, but come into being very differently than statutes. While the individual or body making the regulations may seek public input in advance, there is no requirement that regulations be the subject of debate or even that they be disclosed to the public in advance. In essence, the only obligation on the entity with the regulation-making power is that it acts in accordance with the power granted to it under the applicable statute.

Generally, regulations must be filed with the Registrar of Regulations and be published in the Alberta Gazette, part II. In Alberta, a few regulations are exempt from publication.

Budgeted health care spending for the fiscal year 2010-11 is \$15 billion dollars which represents 39% of provincial budgeted expenses for the fiscal year. If Government adopts the *Drug Program Act* model of legislation for the new *AHA*, it is possible that none of the substantive provisions will be subject to legislative debate and approval. Changes can then be made to the health care system simply by issuing new regulations, without any notice and without debate.

## **VI. Patient Rights**

The Supreme Court of Canada in *Chaouli v. Quebec*, [2005] 1 S.C.R. 791, held that the prohibition on private health insurance provided for in the *Health Insurance Act* and the *Hospital Insurance Act* of Quebec were unconstitutional under s. 1 of the *Quebec Charter of Human Rights and Freedoms*. As a result, according to the Supreme Court, where access to medically necessary insured health services were not provided in a timely fashion, Quebec could not prohibit a resident from purchasing private insurance in order to obtain services from an opted-out medical doctor, i.e. a doctor who elected not to participate in the public system. No challenge has been made to similar provisions in the *AHCIA* or the *Hospitals Act* likely due to the fact that there are no “opted out” doctors in Alberta.

The *AHCA* and the *Hospitals Act* contain important provisions restricting the issuing of private insurance for insured services and preventing any public subsidization of the private for-profit system by the public system. An inroad, however, has been allowed in the *HCPA* which establishes a private for-profit system of delivery for some surgical procedures. This model has resulted in a decline in the ability of the publicly funded, approved hospitals to provide a full range of insured hospital services. It also results in systemic insecurity in the delivery of certain surgical services, higher surgical costs, and less public accountability in standards of surgical care.

Rather than resort to a private insurance system, patient rights in the health care system are best guaranteed by ensuring there is a sound regulatory system setting health care standards and watching over the delivery of all health care services. Patient rights are also well-served in the long run by ensuring that the publicly-funded approved hospital system is not eroded by the diversion of public funds to more expensive for-profit surgical facilities.

### **Conclusions:**

Our review of the legislation demonstrates that Government performs four key functions in the provision of health care in Alberta through its Core Health Care Framework, namely:

- Establishing, administering and funding health care insurance plans;
- Organizing the delivery of publicly-funded health care services;
- Establishing and enforcing standards for health and all health care services; and,

- Restricting the growth of a parallel for-profit health care system.

Each function plays a key role in the provision of health services to Albertans. There is no obvious need to consolidate all of the core health care framework legislation into one *Act*. The legislative framework could be improved by: (a) increasing the coverage provided under the health care plans; (b) increasing Government's role in the setting and enforcing of standards; (c) ensuring the on-going viability of publicly-funded hospitals and service providers; and, (d) limiting the growth of the private for-profit system.

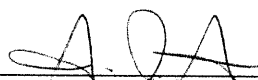
An "enabling" statute is not a preferred method for implementing health care plans, the delivery of health services or the regulation of the standards for health care institutions. However attractive such legislation may be, it offers no assurances that the regulations promulgated by Ministerial or Cabinet regulations will ensure:

- a health care insurance plan which complies with and improves on the requirements of the *CHA*;
- the delivery of insured services using public funding will be organized in a manner that preserves delivery of health care on a non-profit model;
- the establishment and enforcement of appropriate standards for health and health services in Alberta; or
- that the growth of the private for-profit system will be restricted.

It will not be possible to comment on the usefulness of the proposed *AHA* until a draft bill is available to the public. If, as proposed, it is drafted as an enabling statute, it will not be possible to comment on its effectiveness or its impact until the regulations are drafted and

published. It will be important to insist on further consultation with Government once the key elements of its new reforms are apparent.

CHIVERS CARPENTER

Per:  \_\_\_\_\_

GWEN J. GRAY, Q.C.



