



BLURRED LINES:

Private Membership Clinics
and Public Health Care



PARKLAND
INSTITUTE

Rebecca Graff-McRae

CONTENTS

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Executive Summary

Canadians value highly their universal, single-payer public health care system, distinguishing it from two-tier health care in the United States. But we often forget that a line exists between free, universally accessible, medically necessary care and complementary, alternative, cosmetic, or preventative care—a line predicated not on the basis of need, but on the ability to pay. Moreover, this line is frequently, often deliberately, blurred by various private, for-profit health care services. Across Canada some health care providers have found ways to commercialize medicine while professing to remain within the bounds of the Canada Health Act. Accessory fees, block fees, private surgical fees, and membership fees are all attempts to profit from the ill, the injured, and the “worried well.”

This report looks specifically at the phenomenon of private membership clinics in Alberta, which charge annual membership fees for combined physician and complementary practitioner care. The report initially set out to provide an adequate map of these clinics operating within the province. Unfortunately, whether for reasons of ideological, party-political, corporate, or personal interest (or perhaps simply bureaucratic ineptitude), no systematic inventory of membership-based medical clinics has been kept at either the provincial or national level. Despite the data’s severe limitations, this report nonetheless reveals a system of size, scope, and scale of influence about which few Albertans—and perhaps not even the government—are fully aware.

Because the most complete investigations of these clinics to date have come about through audits conducted by Alberta Health, this report subsequently turns to what the audits revealed about the clinics. Between 2011 and 2014, three such clinics underwent audits by Alberta Health to determine if their billing practices and access policies violated the Canada Health Act. Another such audit—of the Copeman Healthcare Centre—was announced in the legislature in May 2016.

Based on documents obtained by Parkland Institute under freedom of information requests, our research finds that while all of the clinics under scrutiny were found to be within the law, the audits overlooked or omitted important avenues of inquiry around access. It also determines that membership clinics can closely skirt the boundaries of provincial and federal legislation in order to maximize profits, maintain exclusivity, and promote their business model to Albertans, corporations, and the provincial government.

Finally, this report also examines the audit process itself that looked into membership clinics, and asks whether there are sufficient measures in Alberta to ensure that the spirit of the Canada Health Act, as much as the letter of the law, is being upheld. The evidence suggests that the audit process is flawed, in that its methodology privileges the protection of business interests, focuses on an extremely narrow scope of investigation, enshrines lack of transparency, and offers little tangible redress for those wronged; that the data collected or released regarding private clinics and how they work is inadequate; that the audits fail to examine potential conflicts of interest; and that the audits have allowed Alberta Health to pass responsibility on to the College of Physicians and Surgeons of Alberta, on the premise that the issue is merely an ethical one, not a political or legal concern, thereby contributing to a troubling lack of enforcement.

This report concludes with a series of recommendations crucial to closing off perceived loopholes and clarifying grey areas—ultimately, ensuring that the blurred line between “public” and “private” health care is held up to the light.

Recommendations:

1. Close legislative loopholes. At the federal level, Health Canada should decisively clarify their interpretation of the Canada Health Act and seek to close legal loopholes currently being exploited by private membership clinics and private surgeries.
2. Exercise greater provincial oversight and regulation of membership- and fee-based clinics. This includes greater enforcement of existing stipulations regarding medical billing and access, as well as increasing the scope of powers of the Canada Health Act and its provincial counterparts to enforce these provisions.
3. Establish an independent ombuds office to ensure that complaints and spurious practices are reviewed objectively and accountably, and with greater enforceability.
4. Implement a more comprehensive and transparent audit process that fully examines the practices of such clinics, not merely their written policies.
5. Improve data collection and mandatory reporting surrounding private membership clinics. Current and accurate information about the number and practices of private clinics allows for more appropriate policy decisions to be made and enables prospective patients to make informed choices about who delivers their health care and at what cost.

- 6.** Alberta Health should provide explicit support for the public health system while exploring options to increase the efficiency of delivering high-demand services. This might include:
 - a.** Exploring evidence-based alternative models of providing primary and preventative health care, but in a setting that does not charge block membership fees.
 - b.** Further exploring proposals to replace the fee-for-service model in ways that implicitly encourage collaborative care without categorizing it as a luxury service.
 - c.** Bringing diagnostic imaging fully under the Alberta Health Care Insurance Plan to reduce the financial incentive for upselling services and providing unnecessary tests. The recent move towards returning all laboratory services to provincial control may help to reduce the commodification of these services and their role in jumping the queue.

Introduction

Canadians value highly their universal, single-payer public health care system, distinguishing it from “two-tier” health care in the United States. But we often forget that a line exists between free, universally accessible, medically necessary care and complementary, alternative, cosmetic, or preventative care—a line predicated not on the basis of need, but on the ability to pay. Moreover, this line is frequently, often deliberately, blurred by various private, for-profit health care services. Some health care providers across Canada have found ways to commercialize medicine while professing to remain within the bounds of the Canada Health Act. Accessory fees, block fees, private surgical fees, and membership fees are all attempts to profit from the ill, the injured, and the “worried well”¹—the otherwise healthy who nonetheless fear they may be unwell, and seek out medical advice for reassurance.

Few Albertans—and perhaps not even the current government—have an adequate map of this system; its size, scope, and scale of influence are still unclear.

Private membership clinics² are a high-profile example of a practice that exploits gaps in the public system and therefore pose particular risks to that system. Much like loss-leaders at retail stores that lure in customers to make more lucrative sales, private membership clinics offer services typical of any family doctor, plus a suite of extras—but at an extra cost.

These clinics first emerged in Alberta as an ostensible solution to long wait times and general physician (GP) shortages as a way to bypass the public system. Later, at the height of the oil boom, they were promoted as a luxury benefit for corporations to attract in-demand executives.³

Private membership clinics are not harmless appendages to the health system. Investigations by the *Globe and Mail* (in collaboration with the Ontario Health Coalition) and the CBC have uncovered serious allegations of systemic wrongdoing at private clinics across the country. In Alberta, the unexpected closure of the membership-fee-based Landmark Collaborative health clinic in September 2017 left patients, physicians, and employees with unanswered questions and no recourse, while the Pure North clinic provoked a scandal that implicated Alberta’s deputy minister of health at the time. Now, more than ever, the government of Alberta needs to address the issue of private clinics.

This report will show that Alberta has an extensive number and system of private health care clinics. Yet, few Albertans—and perhaps not even the current government—have an adequate map of this system; its size, scope, and scale of influence are still unclear. Initially, this report set out to provide such a map, within the constraints of the data available—which turned out to be very little and heavily redacted. Whether for reasons of ideological, party-

political, corporate, or personal interest (or perhaps simply bureaucratic ineptitude), no systematic inventory of membership-based medical clinics has been kept at either the provincial or national level. Instead, the most detailed information regarding these clinics—how they operate, and the legal, regulatory, and ethical complexities surrounding them—comes from a series of audits conducted by Alberta Health between 2011 and 2014. While a limited bureaucratic exercise, the audit process nevertheless provides an unparalleled insight into these clinics and how they were regarded by former Progressive Conservative governments.

Parkland Institute and the Alberta Federation of Labour also obtained documents relating to the audits of three private clinics in Edmonton and Calgary through freedom of information requests. Taken together, the documents catalogue the legalities and technicalities by which these clinics are permitted—or enabled—to operate in Alberta. Most tellingly, what the audit files omit, either through indifference, intent or poor processes, is perhaps more significant than what they include. These documents, and the gaps within them, form the substantive basis for this report, and raise critical questions for the current government to consider.

Section 1 defines the term “private membership clinics” as used in this report. It also critically examines the most frequently cited ideological arguments underpinning the private sector’s increased role in health care provision—despite the lack of evidence in support of these arguments—and traces the political dynamics that have led to increased health care privatization in Alberta.

Section 2 outlines the legislative framework that governs the provision of public health care services in Alberta and the professional bodies that regulate practitioners. As these pieces of legislation are the only benchmark used in Alberta Health’s audits of private clinics, they play a primary role in determining the legality of medical billing and accessibility policies. Section 2 also briefly examines two challenges under the Charter of Rights and Freedoms—the 2005 Chaoulli case and the ongoing Day case—whose rulings may have significant consequences for public health generally in Alberta, and for private membership clinics in particular. These cases suggest that significant gaps exist within the legislative framework and its enforcement, which can be exploited.

Section 3 explores the broad landscape of private membership clinics in Alberta, and how they are positioned between the privatized and public health spheres. The business model and rationale for membership clinics is outlined, illustrating the ways in which persistent myths about the public health system are exploited to promote this private model.

Section 4 delves into the audits of three prominent private membership clinics in Alberta: Preventous Collaborative Health, Provital Health and Wellness, and Copeman Healthcare. These audits were undertaken between 2011 and 2013 (with some aspects of the final reports completed in 2014). This report's analysis of the audits seeks to ascertain the effectiveness of the auditing process itself, and to shed light on the internal political decision-making surrounding their findings. This section also attempts to understand the various strategies by which the clinics under scrutiny seek to navigate the grey areas of federal and provincial legislation in order to remain outside of regulations surrounding billing and public access.

Section 4 also highlights significant concerns that the audits process failed to uncover due to their narrow scope. Because the audits did not interview former or current clients of the clinics, or their former employees, they missed evidence of practices, such as unnecessary testing, purging of patients, and potential double-billing, which represent serious ethical and legislative violations. Because the audits treated each clinic as an individual case, they were unable to make recommendations regarding the wider phenomenon of out-of-pocket membership fees. Because of the flawed nature of the process, it fell to investigative journalists, disgruntled ex-employees, and whistleblowing former patients to expose these concerns. This section concludes with a summary of the common themes among the various audits, their portrayal within government and in the media, and the significant systemic flaws that were exposed.

The report concludes in Section 5 with a series of recommendations regarding these clinics—centred on increased regulation, enforcement, and transparency—intended to ensure that the tenuous line between public and private health care is no longer blurred for corporate advantage.

Section 1: Defining Public and Private Health Care

“Public health care” in Canada is surprisingly difficult to define. Canadians are seemingly well-versed in the basics of our single-payer system—that is, that medically necessary care is free at the point of use and is funded by taxpayer dollars and federal grants to the provinces. By this definition, hospital and physician care are public, while most dental, vision care, prescription drugs, and cosmetic procedures are private—that is, paid for out-of-pocket or via extended health insurance or benefits.

What this definition misses, however, is the distinction between public *funding* and public *delivery*.⁴ The majority of hospitals in Canada are privately owned not-for-profit organizations that receive government funding for specified medical services and infrastructure, while also relying on private donations and investment in specialized equipment or amenities. Physicians’ practices are also private contractors, responsible for their operating and administrative costs but publicly reimbursed for the care they provide on a fee-for-service basis. Private delivery is further divided into different categories based on the presence or absence of a profit motive.⁵

Table 1 details the variations of health care in Canada.

Table 1: Variations on Public and Private Financing and Delivery in Canada’s Health Care System

<p>Privately Funded – Privately Delivered</p> <p>Routine dental Home care Prescription drugs Midwifery care (in some provinces)</p>	<p>Publicly Funded – Privately Delivered</p> <p>Physicians’ practice Hospital care Midwifery care (in some provinces) Some residential elder care Hospital cleaning, laundry, food services</p>
<p>Privately Funded – Publicly Delivered</p> <p>Private or semi-private hospital rooms</p>	<p>Publicly Funded – Publicly Delivered</p> <p>Public health campaigns Vaccination programs Some health research</p>

Source: Adapted by the author from Raisa B. Deber (2002). “Delivering Health Care Services: Public, Not-For-Profit, or Private?” Discussion Paper No. 17, Commission on the Future of Health Care in Canada, August, pp. 2-3; Odette Madore and Marlisa Tiedemann (2005). “Private Health Care Funding and Delivery Under the Canada Health Act.” Library of Parliament, Parliamentary Research and Information Services.

This report focuses specifically on the phenomenon of private membership clinics, defined below as those that provide primary medical care through a general practitioner alongside non-medical health services provided by dietitians, massage therapists, chiropractors, physiotherapists, nurse practitioners, and psychologists, among others for an inclusive membership fee. In this model, each doctor bills Alberta Health for services covered under the Alberta Health Care Insurance Plan (medicare), while the extras are covered through an annual fee that can often be thousands of dollars, paid out of pocket by the patient. While the clinics operating under this model attempt to present a clear distinction between insured and non-insured services—what otherwise might be termed “fee-based” services—the very nature of their practices serve to blur this line, and the more essential delineation between public versus private health care.

WHAT DEFINES PRIVATE MEMBERSHIP CLINICS?

- A hybrid clinic that straddles the line between public and private health care.
- Also known as executive, concierge, or boutique clinics.
- A collaborative clinic model that blends primary medical care with complementary care under the premise of a preventative approach.
- Medical services cover primary physician care and extensive diagnostic assessments (publicly insured), while complementary (uninsured) services often include physiotherapy, consultation with a psychologist or nutritionist, massage, chiropractic, and/or naturopathic treatments.
- All deploy a similar business model based on exclusive membership, with expedited access and convenience, and the promise of improved quality of services or care.
- Medical services covered by the Alberta Health Care Insurance Plan are billed to Alberta Health on a fee-for-service basis, with faster access for private members implied.
- Uninsured medical services and complementary therapies are paid for out of pocket by the patient via membership, block fees, or a la carte. Portions of these fees may be charged to third-party insurance plans.

It must be noted that there are many benefits to this kind of integrated care. The collaborative model, in which physician-led medical care is complemented by services from nurses, dietitians, physiotherapists, other health practitioners, is at the heart of Alberta’s Primary Care Network. It becomes problematic, however, when access to those services is predicated on an upfront fee, or when the extra services being sold have questionable medical value.

The Political Evolution of Private Health Care Clinics in Alberta

In a 2005 *Edmonton Journal* interview, Dr. Brian Day (in his role as Cambie Clinics director and president of the Canadian Independent Medical Clinics Association) remarked, “Alberta of all the provinces in Canada, is the most hostile towards private clinics. We [his Cambie-style facilities] couldn’t function in Alberta.”⁶ Day’s complaints were clearly overstated, as a Health Canada report at that time showed there were 58 “non-hospital” private surgical facilities in Alberta, most of which are related to cosmetic, ophthalmological, or dental surgery.⁷ In fact, the private clinics market in Alberta was already gaining traction via contract surgical facilities, and the phenomenon of membership clinics would come to even greater prominence in the following decade. This part of the report looks at what changed in Alberta’s political and economic landscape to shift public perception.

The very deliberate blurring of the public-private line can be traced back to the politics of the Ralph Klein years (1992–2006), during which ideologically motivated decisions around health funding and delivery were frequently enacted in a manner critics described as “privatization by stealth.”⁸ Beginning with catastrophic cuts to the health budget under Klein’s Progressive Conservative (PC) government, the process of narrowing the range of health services covered by the province opened the door to private health providers to fill the gaps.⁹

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This Trojan Horse strategy created lasting impacts on the public-private dynamic in Alberta: opening up cataract surgeries to out-of-pocket payment (through the Gimbel and other clinics), allowing for-profit MRI and CT diagnostic imaging to charge patients out of pocket for non-urgent scans¹⁰ since 1993, and privatizing medical laboratory services to DynaLife (and its predecessor corporations) from 1995 in a contract worth upwards of \$120 million annually. In 2000, Klein’s proposals for the somewhat-deceptively titled Health Care Protection Act¹¹ provoked a heated dispute with the federal health minister over issues of Alberta’s compliance with the Canada Health Act (CHA). By 2005–2006, the PC strategy of incremental privatization culminated in Klein’s Third Way plan—essentially a two-tiered medical system—and yet another showdown with the federal government. Tellingly, both the Liberal prime minister at the time, Paul Martin, and his Conservative successor Stephen Harper expressed concerns over key aspects of the plan, which proposed to allow physicians to work within both the public and private systems, and implied expedited access based on private payments.¹² As prime minister, Harper warned Klein that the plan risked promoting queue-jumping and would lead to a mass migration of rural doctors to the more profitable urban areas.¹³

Klein's government also initiated the delisting of some health services, a process that continued under the subsequent Ed Stelmach government (2006–2011). The removal of podiatry, home care, pharmaceutical coverage for seniors, and air ambulance services from provincial coverage was proffered as a money-saving exercise, though in reality the economy was minimal. Physiotherapy was delisted for all but trauma and post-operative patients in 2004, and chiropractic was delisted completely in 2009.¹⁴ Many of the delisted services—physiotherapy, chiropractic, massage therapy—are the very ones private membership clinics have honed in on as anchors for their block fees. Other services arguably ought to be publicly covered, with psychology as a powerful example due to the interrelation of mental and physical health.¹⁵

With Klein having driven in the thin end of the privatization wedge, Stelmach continued to push. Stelmach also removed health care premiums, ostensibly widening access by eliminating a regressive fee, but leaving the health care system open to claims that reining in the cost curve left no choice but to delist or contract out some services.

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In the most dramatic example of this approach, made possible by the provisions of the Health Care Protection Act regarding “non-hospital surgical facilities,”¹⁶ Alberta Health engaged in multiple contracts with the private Health Resources Centre (HRC) to conduct orthopedic surgeries. HRC was awarded a two-year contract in 2004 for \$20 million, or 2,500 knee- and hip-replacement surgeries in the Calgary Health Region. A 2012 report for Parkland Institute found that the procedures at HRC cost significantly more than those delivered publicly.¹⁷ These contracts were renewed under the Stelmach government until HRC declared bankruptcy in 2010, leaving the province responsible for outstanding costs.¹⁸ The HRC case not only disproved the prevalent myths of for-profit health care (money saving and efficiency), but also illustrated the Progressive Conservatives' ideological attachment to promoting private industry over public services that could have been provided at the same quality and more economically.

Further to this, consider the investments pursued by former PC cabinet minister¹⁹ Lyle Oberg. Oberg's health consultancy firm Ad Vitam was heavily invested in a proposal to build a fully private, for-profit hospital on lands owned by the Westbank First Nation. The spa-like centre, located near Kelowna, BC, with 10 operating suites and a diagnostic facility, was explicitly targeted to medical tourists and Canadians willing to pay for expedited care. However, the project faced multiple delays and appears to have been shelved indefinitely amid lawsuits against the band and Oberg's company. Oberg also opened a private DNA testing lab in 2010 and sits on the board of directors for the Canadian-owned corporation at the helm of an ongoing project to construct a for-profit public-private partnership (P3) hospital

in Vietnam. Tellingly, Oberg “thinks the export of private health care is a growth industry.”²⁰ According to Oberg, “What you have to remember is that health care is politics. And politics is health care. [...] health care has huge paybacks. It’s a much safer investment than going through the vagaries of the market. Why should you invest in something where a war in Libya or Saudi Arabia, which you have no control over, can determine the price of your commodity? Health care is going to be there. People are going to get ill.”²¹ Oberg’s attitude towards profiteering from those who are ill notwithstanding, the entanglements of his various private health ventures have raised questions over conflicts of interest within political parties: how can politicians work to uphold the principles of our public health system when they are deeply invested—financially as well as ideologically—in private, for-profit competitors?

How can politicians work to uphold the principles of our public health system when they are deeply invested—financially as well as ideologically—in private, for-profit competitors?

This question also underpinned concerns over preferential access in private facilities as a gateway to expedited treatment in the public system. Under former Alberta premier Alison Redford, the Alberta government had continued to contract out surgical and diagnostic procedures to private, for-profit entities. Following claims from multiple sources that patients of the private Helios Clinic in Calgary were able to “jump the queue”—that they were placed higher up on the waiting lists than patients from other (public) clinics for colon screening at the Calgary Colon Cancer Screening Centre—the government launched the Health Services Preferential Access Inquiry (also known as the Queue-Jumping or Vertes Inquiry) in February 2012.²² The inquiry’s final report was delivered to the Speaker of the Alberta Legislature in August 2013. The report found that incidents of queue jumping had occurred, both between Helios and the Colon Cancer Screening Centre, and among members of the Calgary Flames hockey team, who were given expedited access to the H1N1 vaccine at the height of the swine flu epidemic. The inquiry made 12 recommendations, among which the establishment of comprehensive, centralized wait-time management and referral systems have yet to be implemented.

The short-lived Prentice government vowed to address private health clinics.²³ However, neither the premier himself nor his (externally appointed) health minister, Stephen Mandel, ever came out clearly against privatization. The issue became even more prominent in the 2014 by-election for Edmonton-Whitemud, in which Mandel sought to secure a seat in the legislature, and when Prentice’s own connections to a for-profit membership clinic raised significant questions about his commitment to the public health system and his stance on health care privatization.²⁴

These examples—only a handful of many—serve to indicate the deeply entrenched ideology within the Progressive Conservative party from 1992 to 2015; an ideology that equates fiscal responsibility with front-line cuts to health services, then advocates for private enterprise to fill the void—frequently allowing high-profile members to profit financially and politically from these investments. In an astonishing feat of mental gymnastics, during Klein’s showdown with Ottawa over his Third Way proposals, the right-wing Fraser Institute suggested that completely violating the Canada Health Act by instituting user fees for physician and hospital services would actually save the province money.²⁵

A brief overview of some of Alberta’s more prominent private medical facilities reveals a complex web of political, corporate, and academic relationships, many of which are tangential to the oil and gas industry.

A brief overview of some of Alberta’s more prominent private medical facilities reveals a complex web of political, corporate, and academic relationships, many of which are tangential to the oil and gas industry. Calgary-based clinics InLiv, Preventous, and Copeman all specifically mention large oil and gas companies on their corporate client rosters, and private memberships are advertised as an essential executive employment benefit (justified as a cost- and time-saving measure to prevent sick-time losses), but the popularity of these clinics seems to hinge on the state of the economy, especially in Calgary over the last decade.

The infamous (now bankrupt) Health Resources Centre described above had numerous political and academic connections—including former PC cabinet minister and leadership candidate Jim Dinning and links to the Faculty of Medicine at the University of Calgary—and was the principal lobbyist behind the Health Care Protection Act. The HRC’s former director, Dr. Stephen Miller, is now employed with Canadian Surgical Solutions (the private surgery arm of Centric Health), and holds a position on the board of the Alberta Medical Association.

The Alberta NDP and the Public-Private Debate

Based on its first two years in office, the government's record has been at times promising, but at other times hesitant and inconsistent.

As Alberta settles into its first non-PC government in over 40 years, the issue of public versus private health care has been a litmus test for Premier Rachel Notley's NDP government. The Alberta NDP's 2015 election campaign promised much in terms of "protecting and improving public health care," vowing to "end the PCs' costly experiments in privatization, and redirect the funds to publicly delivered services."²⁶ Yet, based on its first two years in office, the government's record has been at times promising, but at other times hesitant and inconsistent. There have been a few decisive examples in favour of bolstering the public system and restricting or rolling back privatization.

Health Minister Sarah Hoffman's controversial decision on northern Alberta laboratory services has been arguably the government's most promising and impactful act. After two years of uncertainty generated by the cancellation of Australian corporation Sonic's nascent contract,²⁷ Hoffman announced in August 2015 a process to gradually phase out DynaLife's longstanding sole contract and return all labs to provincial ownership by 2022.

In 2016, Hoffman also halted a process to contract out hospital laundry services, a move which necessitated the province to shoulder the costs for upgraded facilities. Under Hoffman, publicly funded midwifery services have been expanded, despite lengthy and at times tense negotiations, and the minister has expressed support for exploring nurse practitioner-led models of primary care, although funding for this initiative has not been allocated.

Amidst these positive indications of support for public financing and public delivery of health care services, the NDP's continued ambivalence regarding private membership clinics stands out as irregular. While in opposition, NDP leader Rachel Notley expressed concern over the prevalence of private clinics (in the context of the Preferential Access Inquiry): "I think what this issue actually tips off is a much larger issue of queue jumping that exists with the integration of privately funding health care with publicly funded health care."²⁸ Similarly, current Education Minister David Eggen, formerly the executive director of Friends of Medicare, had also previously spoken out against "elite" clinics like Copeman, calling for a full and comprehensive audit of its billing practices and model.²⁹

In May 2016, Health Minister Hoffman stated that such an audit is underway.³⁰ According to her statement, the new audit was being undertaken by Alberta Health to investigate Copeman Health's compliance with the Canada Health Act. A subsequent CBC report stated there would be two audit processes: the compliance review carried out by Alberta Health and a "more rigorous" investigation conducted by the special investigations unit of Service Alberta, which implies a financial audit of the company's billing practices.³¹ According to correspondence between Friends of Medicare and the Ministry of Health, this audit includes both of Copeman's Alberta locations; however, the official position of the ministry is that the scope of the audit cannot be confirmed while the investigation is ongoing.

While these statements indicate an awareness of the problems raised by private clinics, efforts to address the issue appear piecemeal rather than part of a more coherent policy position. The government also faced embarrassment over an investigation begun in May 2017 into Hoffman's former deputy minister,³² Carl Amrhein, by the provincial ethics commissioner concerning lobbying efforts on behalf of a private health organisation, Pure North S'Energy [sic], a company owned by Canadian Natural Resources Ltd. co-founder and Calgary Flames co-owner Allan Markin. The conflict of interest stems from Amrhein actively supporting Pure North—of which he was a client—while the organisation was under consideration for provincial funding. In 2013, under the Redford government, Pure North had been allocated approximately \$10 million to establish an experimental program of high-dose vitamin supplementation involving seniors. Documents show that then-health minister Fred Horne approved the funding against ministerial advice because the program posed potential health risks, had not been ethically vetted considering the vulnerable nature of the patients, and there was insufficient evidence that the supplements produced positive results.

An internal AHS memo from the provincial medical advisor, commenting on a similar Pure North program involving drop-in centres for the homeless and addicted, highlights the quandary faced by Alberta Health: "it raises a public health concern ..." but "we might be perceived as the big bad AHS if we remove 'free samples' of multivitamins from a drop-in centre that supports the socially disenfranchised."³³

This frank statement might also be applicable to Alberta Health's position vis-à-vis private health care clinics in general: such clinics may pose risks, or they may be engaging in unnecessary testing or pandering to the "worried well,"³⁴ but unless they commit an egregious violation, it may be politically damaging—and in the NDP's case be seen as ideologically driven—to shut them down.

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Privatization and Profit as Ideology

The fiscal right has long justified privatization as opening up the market to competition and allowing consumers more choice.

The fiscal right has long justified privatization as opening up the market to competition and allowing consumers more choice. This narrative is often couched in the language of the left, based on two strands of argument. One argument contends that timely access to health care is a right of all Canadians, and therefore anyone should be free to pay for faster or superior care. This is the justification put forward by the coalition of private surgical facilities supporting Dr. Brian Day in his Charter challenge of BC's Medicare Protection Act. A second argument implies that wealthier Canadians should not be granted free essential services while poorer citizens struggle to obtain dental care, eye care, and drug coverage; that is, free health services should be means-tested.³⁵

Both proposals purport to be concerned with equality: equality of access without waiting, and equality of distribution (paying for health services is not a burden on the rich; it should not be a burden on the poor). Yet both openly and unapologetically advocate for the very thing many Canadians are most averse to: a two-tier health system. One offers private, out-of-pocket payment as a right; the other purports to represent a kind of noble obligation bestowed by the wealthy to the less well-off. Both offer arguments about reduced wait times, more efficiently run services relieving pressures on the public system, and higher-quality care for all.

An extensive body of literature shows these claims to be false:

- **Wait times:** Parallel public-private streams actually put increasing pressure on publicly delivered services, as private facilities drain the public system of human resources (doctors who close their practices to join membership-only clinics, nurses and anaesthetists who are offered higher wages or stock options in private surgical companies). Additionally, those private-pay patients who receive fast-tracked diagnostics are then able to jump the queue back into the public system for treatment.³⁶
- **Cost efficiency:** Market solutions do not always mean lower costs. In fact, the extra costs of private care soon add up: facility fees, extra billing for upgraded services, and additional layers of bureaucracy and administration associated with contracted procedures.³⁷ There are also costs to the public system to rectify botched or inadequate private procedures,³⁸ and to accommodate the delivery of private services in the event of closure or bankruptcy.³⁹ For the taxpayer, there are the hidden costs of using publicly funded infrastructure (for example, the use of converted public hospitals or public operating rooms) to subsidise private enterprise.⁴⁰

- **Organizational efficiency:** Creating a parallel private system does not increase efficiency. Faster care through queue management and streamlined referrals can all be achieved successfully within the public system without cutting corners on care.⁴¹
- **Increased (equitable) access:** Private clinics and surgical facilities have frequently been shown to “cream skim”—meaning they siphon off the easiest, most lucrative procedures and cases, while the more complex are left to the public system.⁴² This not only increases the costs (and often adds to wait times) in the public system, it also means that private-paying patients must return to the public system if complications arise from their private care. Care is no longer prioritised based on need, but on the ability to navigate both systems at once.
- **Freedom of choice:** Only those with the ability to pay are offered multiple health care options, while those without sufficient financial resources are left with one choice: reduced public services or financial hardship. “Private finance strategies (from user fees through private insurance to medical savings accounts) all tend to benefit the wealthy, the healthy, and those who want to sell services.”⁴³

Critics of public health care in Canada have long argued that privatization is the solution to the perceived shortcomings of our universal, single-payer system.

Every single-payer health system has had to engage with the debate over privatization: the United Kingdom projects anxiety over the status of its National Health Service, concern is growing in the Republic of Ireland that its public health system may go the way of Australia’s two-tier approach, and Sweden has seen increasing decentralization and corporatization of its once-renowned health system.⁴⁴ In Canada, the debate has re-emerged in multiple guises for decades—arguably, since the 1966 Medical Care Act was introduced under Lester B. Pearson’s Liberal government. Evidence from research undertaken by the Ontario Health Coalition into private, for-profit clinics in that province found that “these clinics undermine single-tier health care, increase costs for patients, sell unnecessary procedures to increase profits at the expense of patients, and violate patient trust.”⁴⁵

Critics of public health care in Canada have long argued that privatization is the solution to the perceived shortcomings of our universal, single-payer system. In Alberta, the debate has often carried a sharper edge, amidst an often-tumultuous relationship between the province and the federal Health Ministry. Despite a large body of evidence dispelling these myths, the “zombie”⁴⁶ of private health care services continually returns as a purported solution to problems in the health care system. These myths have continued to be especially resilient in Alberta. The “threat” or “opportunity” of private or two-tier health care has frequently been perceived as just around the corner, emerging and re-emerging but never quite reaching resolution: moves to de-list previously insured medical services; the establishment of

private eye surgery clinics; deep cuts to public health budgets and resources; contracting out of surgical procedures; rewriting legislation to allow “non-hospital” private hospitals; and more recently, the rise of private, for-profit medical clinics based on membership fees.

Of these, private membership clinics come closest to two-tier health care: medical services advertised as exclusive, luxurious, expedited, and superior to that which is publicly available. The next section looks at the legislative and regulatory framework that enables these clinics to operate.

Section 2: Legal Frameworks for Health Care: The Albertan and Canadian Contexts

The complexity of private membership clinics, as detailed in the audit case studies later in this report, is rooted in the ability of these clinics to blur the line between public and private health care. The grey areas are many, and these are further magnified by the multiple overlapping layers of federal and provincial legislation, court challenges, and regulatory norms (or standards of practice) upheld by the College of Physicians and Surgeons of Alberta. In this section, these layers are examined and taken apart to identify and explain the loopholes currently being exploited by private health care clinics.

The Canada Health Act

The Canada Health Act (CHA) provides the legislative foundation for the Canadian health care system. Enacted in 1984, the CHA established what we colloquially term medicare: a universal, single-payer approach to funding public health care.

What is required by the CHA?

As health care is a responsibility devolved to the provinces, the CHA functions as a kind of umbrella, setting out the essential elements to which each provincial health insurance plan must adhere in order to receive full transfer payments from Ottawa. The act is centered on five criteria definitive of Canadian health care, often referred to as the “five principles”:

- **Public Administration:** the administration of a provincial health insurance plan must be by a non-profit body.
- **Comprehensiveness:** the plan must insure all medically necessary services, including physician, hospital, and some dental surgeries.
- **Universality:** all insured residents of each province have the right to receive care.
- **Accessibility:** all insured persons should have reasonable access to services, and that health care providers should receive reasonable compensation.
- **Portability:** all those covered by the health insurance plan in their province of residence are entitled to a minimum period of the same coverage should they move provinces or leave the country.

While the CHA is federal legislation, each province has the flexibility to meet the requirements of the act in a variety of ways; only if there is a violation of these criteria will the federal government intervene, and, in such cases, the only recourse is a financial penalty. In fact, the onus is on each province to report any violations, such as extra-billing, as the federal Health Ministry has no jurisdiction to investigate these claims.

Yet, despite its crucial role in setting out the framework for provincial health care coverage across the country, the act itself is often vague, subject to multiple interpretations,⁴⁷ and is difficult to enforce. According to health politics scholar Gerard Boychuk, “enforcement of the CHA is primarily a political rather than legal issue.”⁴⁸ Moreover, despite some attempts at clarification over the past 30 years,⁴⁹ successive federal governments have traditionally supported a very narrow reading of the act—any practice not explicitly proscribed in the legislation is often considered valid by default. For example, in Boychuk’s interpretation, “The CHA does not speak, whatsoever, to the delivery of services and thus draws no distinction between funding and delivery.”⁵⁰

Despite its crucial role in setting out the framework for provincial health care coverage across the country, the act itself is often vague, subject to multiple interpretations, and is difficult to enforce.

What is prohibited by the CHA?

Extra-billing is one of the few stipulations explicitly prohibited by the CHA.⁵¹ Extra-billing is most commonly understood as a charge incurred by a patient for a medical service already covered under a provincial health insurance program over and above the amount compensated by the province—sometimes on the premise of “upgraded” services. The penalty for extra-billing is equivalent to the amount overcharged, with additional deductions to the provincial block grant possible at the discretion of the federal health minister. William Lahey, a professor of health law, wrote in his submission to the Vertes Report (the report of the Health Services Preferential Access Inquiry) that the act “leaves the critical phrases ‘medically necessary’ and ‘medically required’ ill-defined, however, giving each province and territory significant latitude to determine the services that it will fund as medically necessary or required.”⁵²

The key implication of extra-billing is that out-of-pocket charges effectively restrict accessibility. Often interpreted as access to medical treatment based on need, not ability to pay, this principle actually only requires *reasonable* access. In his submission to the Vertes Report, Lahey asserted that accessibility may, in fact, be much more central to the CHA than any of the other criteria:

It should also be recognized that the accessibility criterion is not the only part of the Canada Health Act that addresses accessibility. The Act as a whole is about accessibility to medically necessary (or required) medical and hospital services. In many ways, the most rigorous “accessibility” feature of the Canada Health Act is not the criterion itself but the requirement under section 18 that provinces and territories not allow extra-billing and under section 19 that they not allow user charges.⁵³

The second prohibition under the CHA concerns user charges. Premiums are permissible (as existed in Alberta until 2008) provided those who are unable to pay are still provided access to care.⁵⁴ Block fees for uninsured services are permitted, but not if non-payment of the fee constitutes an obstacle to access. Auxiliary (or accessory) fees—supplemental charges tacked on to services that are already covered by a provincial health plan—are not permitted. The legality of these fees are outlined in Table 2.

Table 2: Permissibility of Block Fees, Auxiliary Fees, and Extra-Billing

Fees	Permissible	Explicitly prohibited	Grey area	Example of charges
Extra-billing		X		Billing both the public system and patient (or third-party insurer) for the same service
Block fees	X		Must clearly outline the uninsured services covered by the fee; must be entirely voluntary and not impede access	An annual fee for sick notes or insurance forms, unnecessary minor procedures, transferring files
Auxiliary fees		X	Quebec legislation had attempted to regulate these fees, but they have been banned as of January 2017	Charges for necessary aspects of an insured service, such as eye drops for cataract surgery, instrument fee for colonoscopy, insertion of IUD

Source: Author

The Alberta Health Care Insurance Act

The Alberta Health Care Insurance Act (AHCIA) is the provincial manifestation of the Canada Health Act in Alberta. Its purpose is to frame and enact the Alberta Health Care Insurance Plan (AHCIP). Because the responsibility for health care is in the provincial domain, each province must establish its own health insurance program and health care system via legislation that meets the criteria established in the CHA. As mentioned above, this is merely the minimum level of coverage that must be provided to avoid transfer payment penalties; a province may choose to provide coverage for medical and health care services over and above the tenets of the CHA.

The AHCIP delineates what services are to be covered by the provincial plan, and what are excluded—insured versus uninsured services. The list of covered services can, and does, change according to the whim of politics and the pressures of finance, as well as the evolving nature of medical procedures. Other pieces of legislation, namely the Hospitals Act and Health Professions Act, set out other aspects of health care funding and delivery.

Coverage under the Alberta Health Care Insurance Plan

What's covered:

- Alberta residents are provided with full coverage for medically necessary physician and some specific dental and oral surgical health services. The professional judgment of a physician is used to determine what insured services are deemed medically necessary.
- Some immunizations
- Some cosmetic procedures are covered where they are deemed medically necessary
- Visits to a psychiatrist are usually covered because a psychiatrist is a medical doctor (mental health services are included in the CHA)

What's not covered:

- Counselling services provided by psychologists or non-physician mental health therapists are not covered regardless of whether or not a referral is made by a patient's physician.
- Cosmetic surgery, such as panniculectomy (tummy tuck), bariatric (lap-band) surgery, and breast reduction (mammoplasty), unless deemed medically necessary.
- Prescription drugs
- Ambulance services
- Routine eye exams for Alberta residents 19–64 years of age
- Eyeglasses and contact lenses
- Routine dental care and dentures
- Some immunizations
- Mental health services received out-of-province or in private facilities

- Vasectomy reversal
- Physiotherapy
- Anaesthetic charges for services not covered by the AHCIP
- Third-party medical services, such as medicals for employment, insurance, or sports
- Hearing aids, medical and surgical appliances, prosthetics, supplies, mobility devices, etc.
- Medical advice with a patient by telephone, unless otherwise stated in the Schedule of Medical Benefits or Schedule of Oral and Maxillofacial Surgery Benefits
- Experimental or research program procedures
- Medical-legal services
- Podiatry and optometry services obtained outside Alberta
- Dentistry services obtained outside Alberta, except for medically required oral surgery

Source: Adapted by the author from Alberta Health: <http://www.health.alberta.ca/AHCIP/what-is-covered.html>; and <http://www.health.alberta.ca/AHCIP/what-is-not-covered.html>

The de-listing of particular services, namely physiotherapy, chiropractic, and massage therapy, as well as the discrepancy between mental health care provided by a psychiatrist as opposed to a psychologist, are actions that directly opened space for private, for-profit provision of those services. In the members-only private clinic model, these services are offered as part of the annual fee as a supposed cost-saving measure to patients.

As with the CHA, the AHCIP:

Expressly prohibits extra-billing and the charging of other fees in respect of insured services by physicians and dentists who are “opted-in” to the Alberta Health Care Insurance Plan; and [d]eems physicians and dentists to be opted-in to the Alberta Health Care Insurance Plan and discourages “opting out” by: requiring physicians to publicly do so for all purposes; prohibiting payments to physicians and reimbursement of patients for services received from opted-out providers in most circumstances; and prohibiting private insurance for services covered by the Plan.⁵⁵

Opting out

In Alberta, physicians who wish to charge private payment for publicly insured services must formally opt out of the AHCIP completely (i.e., not claim any fees under the plan). Private insurance plans to cover publicly insured services are also banned (see the Day case below). Technically, there is no halfway point: a physician either tacitly remains in the public system or explicitly chooses to opt out. However, under the AHCI A there is no restriction on physicians charging for uninsured services while also providing insured services in Alberta.

A 2001 survey of Canada's 10 provinces conducted by health researchers Colleen Flood and Tom Archibald clarified the differences in the regulation of private billing by physicians. Flood and Archibald “found multiple layers of different kinds of regulation that seem to have as their primary objective not to make private practice illegal but rather to prevent the development of a private sector that depends on subsidy from the public sector.”⁵⁶

As Flood and Archibald explain, even among the varying options for “remaining in” or “opting out,” there are limitations on the extent of private billing permitted:

[E]very provincial plan permits physicians to opt out. In Manitoba, Nova Scotia and Ontario the financial incentive to do so is significantly dulled because opted-out physicians cannot bill more than they would receive if they were working within the public plan. In every other province, opted-out physicians can set their fees at any level. However, [...] all of the remaining 7 provinces except Newfoundland and Prince Edward Island have in place measures that prohibit the public purse from subsidizing the private sector. In other words, patients of opted-out physicians are not entitled to any public funds to subsidize the cost of buying their services privately.⁵⁷

Table 3: Opting-Out Stipulations Across Canada

Regulation of private billing	BC	AB	SK	MN	ON	QC	NB	NS	PEI	NL
Are physicians permitted to opt out?	Yes									
Can opted-out physicians bill directly?	No	Yes	Yes	No	No	No	Yes	No	Yes	No
Is there an explicit ban on extra billing by opted-in doctors?	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes (with exceptions)
Can opted-out physicians bill any amount?	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes
Is public sector coverage denied to patients receiving insured services from opted-out doctors?	Yes	Yes	Yes	No	No	Yes	Yes	No	No	No

Source: Adapted by the author from Colleen Flood & Tom Archibald (2001). “The Illegality of Private Health Care in Canada,” *Canadian Medical Association Journal* 164: 6, p. 825.

Note: There are many caveats, exceptions, and complicating factors in how each province addresses the issues of opting-out and billing; this chart is necessarily a simplification of the original cited above.

While the ins and outs of opting in and opting out are complex given the many different ways the provinces have attempted to address this issue, perhaps the most important point regarding private membership clinics is that their physicians remain opted-in; in Alberta this means that they are prohibited from charging additional out-of-pocket fees to patients for any service covered by the provincial health insurance plan. Fees can only be charged for uninsured services. Hence, the hybrid public-private business model adopted by membership clinics is an attempt to skirt around these stipulations while remaining narrowly within them.

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The Health Care Protection Act

Alberta's Health Care Protection Act (HCPA) "creates a regulatory framework for the operation of private surgical clinics that stresses consistency with the Canada Health Act." Designated clinics can provide insured surgical services under a minister-approved agreement with Alberta Health Services (or a predecessor regional health board) with the cost of the service paid for by the public system. Such clinics can also provide uninsured surgical services and enhanced medical goods and services paid for by the patient or a third-party payer.⁵⁹ The act also contains a specific prohibition on queue-jumping. While many Canadian jurisdictions have moved towards more day surgeries in order to reduce hospital stays, the definitions of hospital and non-hospital facilities enshrined in the Health Care Protection Act have proved politically convenient for those wishing to contract out specific surgical procedures as "day surgeries," and thus not requiring a hospital stay.

The Health Care Protection Act, like many similar attempts to innovate around the tenets of the CHA, brought federal-provincial tensions to the fore. The most high-profile opponent of Alberta's proposals, former federal health minister Allan Rock, worried that the HCPA could potentially enable barriers to access: "To permit for-profit facilities to sell enhanced services would create a circumstance that represents a serious concern in relation to the principle of accessibility."⁶⁰ While this "serious concern" was later realized in the form of the Preferential Access Inquiry, the wording used by Rock is crucial to the outcome in both that situation and the current question of private membership clinics: a serious concern is not an explicit violation. It appears that under Alberta's legislative and regulatory framework, explicit violations are difficult to commit, monitor, or penalize.

The College of Physicians and Surgeons of Alberta

In addition to the legislation that governs the administration of health care, professional organizations also play a central role in the regulation of medical practices and standards. While the College of Physicians and Surgeons of Alberta (CPSA) acts primarily as a regulatory body—issuing and enforcing standards of ethical practice—it does so in a political context. Responding to the Preferential Access Inquiry, the College drafted new guidelines on billing for uninsured services. However, these merely reiterated the status quo based on the prevailing interpretation of the CHA: that only uninsured persons or uninsured services can be billed, and fees cannot be a barrier to treatment for insured services.

The CPSA set out to delineate guidelines for its members surrounding:

- charging for uninsured medical services,
- relocating a medical practice,
- terminating the physician/patient relationship, and
- closing or leaving a medical practice.

The new CPSA standards emphasized the wording of policies to ensure they conveyed the letter of the CHA, such that charges for uninsured services were not presented as a barrier to accessing essential medical care—a stipulation that is clearly laid out in the CHA.

According to CPSA registrar Trevor Theman, “Patients can still buy private services, they can buy uninsured services—that’s not an issue. ... What we are saying through this draft standard is that you can’t make that a barrier to accessing the necessary medical services.”⁶² Yet, in another source Theman was quoted as confirming that the new standard would prohibit private clinics from charging membership fees that implied access to essential medical services.⁶³ This is not how the standard has been interpreted by private clinics, as they continue to charge membership fees and continue to see few non-member patients. While their official policies may attest to unrestricted access, in practice the clinics audited saw very few non-paying patients, the majority of whom were adult children of paying members. In effect, the new standards merely required membership clinics to change their wording, not their actual practices.

The latter three CPSA standards prioritized maintaining reasonable access to medical services for patients regardless of where their preferred physician located their practice, but did not explicitly address measures to be taken when a physician chooses to leave or close an inclusive practice to establish or join an exclusive (private) one. Rather, the guidelines suggest that the relocating physician should seek to offer their former patients a list of other available doctors in the area.

The freedom of information documents obtained for this report also highlight a common tendency within Alberta Health during the audits—namely, placing the onus on professional bodies to self-regulate their members regarding equal access and fair billing practices. Given the lack of other avenues of enforcement, this is unsurprising. However, this approach to regulation leaves significant loopholes for private clinics. For example, the CPSA has emphasized that while it “has authority over doctors, it has no jurisdiction over management personnel at clinics who are not physicians.”⁶⁴ That is a fair point, as the CPSA’s formal role is centered on doctors, but it is a moot point if there are no corresponding standards for clinic management. The absence of broader regulations effectively implies that, while physicians are obliged to adhere to CPSA standards, whatever policies or practices are put in place by private clinics’ management are governed solely by the limited scope of the CHA and the Criminal Code.

In some ways, the regulatory role of the CPSA is a necessary result of the narrow interpretation of the CHA and provincial legislation, which gives very little authority to provinces regarding enforcement. On the other hand, relying on the CPSA, for instance, provided a politically expedient route for the then-PC government to appear to address the private health conundrum without actually taking any legislative or regulatory action themselves.

As the case studies below show, violations of the CPSA’s edict are incredibly difficult to prove through current procedures, making these standards tough to enforce in practice.

Legal Challenges: The Possible Implications of Chaoulli and Day

Chaoulli v. Canada (2005) was a case brought before the Supreme Court of Canada that essentially overruled Quebec's ban on the sale of private insurance for publicly covered services. The decision is only applicable in Quebec, as the majority of judges found that the Canadian Charter of Rights and Freedoms was not violated, largely due to different wording of provisions between the Charter and its provincial counterpart. However, the 2005 ruling opened the door to similar challenges across Canada, encouraged the increased proliferation of private-pay clinics and surgical facilities,⁶⁵ and instigated the ongoing controversy over auxiliary fees and user fees in Quebec.⁶⁶

The Day case was brought in response to attempts by the BC Ministry of Health to conduct an audit of Dr. Brian Day's clinics after a preliminary investigation found significant evidence of extra-billing (charging patients out of pocket above and beyond the amount covered by medicare) and double-billing (charging both the public medicare plan and the patient or the patient's private insurance for the same service). Both practices are proscribed under all provincial health plans, including the BC Medicare Protection Act, Alberta's legislation, and the Canada Health Act. As part of the lawsuit, the audit was stayed, and Day was able to claim that it was the ministry's actions that were unconstitutional, not his own billing practices. Day and the affiliated clinics are supported in their challenge by the Canadian Constitution Foundation, a quasi-libertarian think tank which, despite its explicitly pro-privatization stance, was found to have "no political activities" in a Canada Revenue Agency audit initiated under the Harper government.⁶⁷

The costs of private health care services are increasing exponentially faster than those publicly covered.

While ostensibly building on the Chaoulli ruling, the challenge of the Day case aims to go much further; a decision in favour of Day and the private clinics group would not only allow for private-pay options for surgeries, it would open the door to permit all physicians to bill for any medical service at a rate of their choosing while continuing to bill the public plan under fee-for-service reimbursement.⁶⁸ As we have seen with dental care (which in Alberta is among the most expensive in Canada, though it varies widely among practices), the existence of market competition in health care does not create price fairness in and of itself. In fact, the costs of private health care services are increasing exponentially faster than those publicly covered, according to statistics compiled by the Canadian Institute for Health Information.⁶⁹ A favourable ruling will encourage private clinics—from surgeries to GP offices—to literally profit from de-investment in public health care. A report commissioned by the federal government in its role as

intervenor in the case finds that the detrimental effects of permitting private care on this basis would include “greater income inequality, more people in dire financial straits [to pay for care], and even doctors encouraging longer wait times in the public system to nudge patients into the private system.”⁷⁰

The Day case, while specifically focused on “non-hospital” surgical facilities, has the potential to thoroughly undermine the CHA’s prohibition on extra-billing. A favourable ruling would open the door to uncapped, unregulated fees for medical services and de facto permit private membership clinics to institute these charges at will. The carefully blurred line between charging for uninsured rather than insured services would be erased completely.

Section 3: The Private Health Care Landscape in Alberta

Some of the primary objectives for this report were to ascertain just how many executive membership clinics exist in Alberta, how many patients they serve, how much is spent on private medical fees in the province, and what associated costs are passed on to the public system. This basic information has proven exceedingly difficult to obtain, as it is not centrally collected at either the provincial or federal level. While medical clinics must obtain accreditation through the College of Physicians and Surgeons of Alberta, the College does not differentiate its registry based on fee status or types of medical services provided. Facilities that are contracted through Alberta Health to provide provincially covered services are tracked, but while the contracts themselves must be publicly available, they contain very little information about the nature of the clinic, the services they are contracted to provide, or the breakdown of public funds they are granted. At the boundary of public health and private enterprise, business interests clearly trump the public interest. Due to this significant data gap, it was necessary to use a variety of resources to obtain anything like a complete picture of the private clinics network in Alberta.

At the boundary of public health and private enterprise, business interests clearly trump the public interest.

In the *Canada Health Act Annual Report 2005–2006*, there were 58 “non-hospital” private surgical facilities in Alberta, most of which are related to cosmetic, ophthalmological, or dental surgery. According to Health Canada, “of these, 26 facilities have contracts with regional health authorities to provide insured services.”⁷¹ In the 2005–2006 report, Alberta claimed that figures accounting for private (for-profit, non-insured) facilities were “unavailable” in every category; and again in the 2009–2010 report no data was available for any of the intervening years.⁷² There were likewise no figures available in any of the reports from 2014–2015. One can reasonably conclude that either this data is notoriously difficult for the province to obtain, or that the province had no interest in obtaining it.

The CHA annual reports indicated that British Columbia reported 19 private facilities in 2005–2006 and 22 in 2006–2007, but provided no further figures. Likewise, no figures were available to account for “payments to private for-profit facilities for insured health services” in any year up to and including 2014–2015. Additionally, neither Quebec nor Ontario provided figures for these categories, despite both provinces having numerous registered accredited private facilities at this time.

Many of the private, for-profit facilities that operate in Alberta are enabled by either the non-hospital provision in the HCPA or by the grey zone surrounding diagnostic imaging. For instance, only medically necessary scans are covered by the provincial insurance plan, creating a loophole that allows for out-of-pocket payment for privately obtained—and potentially medically unnecessary—scans.

Private Medical Clinics

While there is no central database or even comprehensive collection of information regarding private membership clinics in Alberta, as part of its preliminary investigation of Copeman Clinics in 2013, the Audit and Risk Assessment Unit of Alberta Health enumerated that there were 10 private clinics in the membership or executive model operating in Alberta. However, this information did not include the names, locations, or other details of those facilities.

Research carried out by the Ontario Health Coalition, in tandem with an investigation series by the *Globe and Mail*,⁷³ attempted to catalogue fee-charging medical facilities across Canada, including private surgeries, block fees, auxiliary fees, diagnostic fees for MRIs, and membership fees. Their study identified five boutique (fee-based executive, concierge, or membership clinics) in Alberta, and a total of 21 such facilities across Canada. Of these, 15 were deemed to have charged direct user fees to patients.⁷⁴ However, while the study names two of the clinics scrutinized in this report—Preventous and Provital—it does not mention several others, including the prominent Copeman clinic, which has received extensive media attention for its practices. The other facilities listed for Alberta are not strictly boutique clinics; instead, they are primarily walk-in general practice clinics that also offer out-of-pocket “advanced” medical assessments. Different methodologies and definitions can result in different categorizations, and the various terms used to describe private membership clinics can serve to further confuse attempts to catalogue them.

Types of Fee-charging Clinics in Alberta

Table 4 provides a current listing of three forms of private medical clinics in Alberta:

1. those that operate primarily under the membership model;
2. those which charge out-of-pocket fees for one-time services, such as extended health assessments; and
3. those that adhere to a collaborative model, offering (uninsured) complementary or alternative services but on a pay-per-service basis rather than an annual membership fee.⁷⁵

Table 4: Fee-based Private Health Care Clinics in Alberta

Clinic Name	Alberta Locations	Business Model	Notes
Advanced Primary Care	Calgary	Membership	The physicians who own APC are former employees of Copeman Healthcare Centre.
Centric Health	Calgary	Vary	A subsidiary of Canadian Surgical Solutions, also associated with Lifemark Physiotherapy clinics, which primarily serve WCB and occupational health clients.
Copeman Healthcare	Edmonton, Calgary	Membership	Bought out by Medisys but continues to operate under the Copeman brand as Copeman Healthcare Inc.
Dominion Medical Centres	Edmonton (3)	Out-of-pocket assessment	
Femme Concierge* (now re-branded as Femme & Homme)	Edmonton	Membership	A subsidiary of Imagine Health Group, which also owns several walk-in clinics in Edmonton and Calgary, as well as a chain of pharmacies.
Helios Wellness	Calgary		At the centre of the Preferential Access Inquiry, Helios closed in 2012.
Imagine Health Centres	Edmonton (3), Calgary (2)	Collaborative	Owned by Imagine Health Group, which also owns Femme & Homme Concierge clinic.
InLiv	Calgary	Membership	
Landmark Collaborative Health	Calgary	Membership	Unexpectedly closed as of September 2017.
Lifemark Health	Edmonton, Calgary	Collaborative	A subsidiary of Centric Health. Also operate 16 physiotherapy, massage, and sports medicine clinics in Calgary, six in the Edmonton area, and four in the rest of Alberta under the Lifemark brand
Medisys	Calgary	Vary	Parent company of Copeman and Horizon Occupational Health, which serves mainly WCB and corporate clients.
North Town Medical Centre	Edmonton	Out-of-pocket assessment	
Preventous Collaborative Health	Calgary	Membership	
Prius Medical Clinic	Sherwood Park	Collaborative	Closed in July 2016, reopening under the name Urban Oak (see below).
Provital Health & Wellness	Calgary	Membership	
Urban Oak Clinic	Sherwood Park	Collaborative	Formerly Prius Medical Clinic. A nurse practitioner-led team. Fees charged on a per-service basis.
Wellpoint Workplace Health	Edmonton, Calgary	Collaborative	Occupational health and WCB-related services integrated with family practice. Third-party billing; no out-of-pocket fees.
TOTALS	ALBERTA: 33	MEMBERSHIP FEES: 8	

Source: Adapted by the author from Colleen Flood & Tom Archibald (2001). "The Illegality of Private Health Care in Canada," *Canadian Medical Association Journal* 164: 6, p. 825.

Note: There are many caveats, exceptions, and complicating factors in how each province addresses the issues of opting-out and billing; this chart is necessarily a simplification of the original cited above.

Background: The Key Players

Of the facilities identified in the table above, only three have been subjected to audits by Alberta Health: Provital Health & Wellness, Preventous Collaborative Health, and Copeman Healthcare (both Edmonton and Calgary locations). The specific reasons why these clinics were selected have not been made available to the researcher or to the clinics themselves. However, these were among the most high-profile of the membership clinics operating in Alberta at the time of the audits, and at least one (Copeman) had been the subject of complaints by former patients. The current audit of the Copeman clinics was sparked by details uncovered by CBC reporter Kate McNamara, as well as details divulged in a lawsuit involving ex-employees of the Copeman Clinic in Calgary.⁷⁶ (See further discussion in Section 4.)

Provital Health & Wellness was founded by doctors Donovan Kreutzer and Sarit Sengar in 2009. Provital professes “to be thoroughly focused on preventative screening and to always be proactive, rather than reactive, in our approach to your health.”⁷⁷

Preventous Collaborative Health, headed by Dr. Rohan Bissoondath, operates only one location in Calgary, citing a desire to remain “local” and “personal.” Dr. Bissoondath has appeared regularly on local TV morning shows and in Postmedia-owned periodicals to tout the benefits of “preventative medicine” along his clinic’s model.

Copeman Health Centres are perhaps the most recognizable—some might go so far as to say notorious—of the clinics. Owner Don Copeman founded the Vancouver clinic branch in 2005 to provide “personalized, unhurried care” with the aim to achieve “our primary objective of making people’s lives better” (as stated on the company’s website). The company boldly claims that, “We also reduce the demand for more costly medical interventions by preventing serious illness.”⁷⁸ By 2006, Copeman planned to expand rapidly across Canada, with a view to opening up to 37 locations, starting with expansion to Toronto, London, Ottawa, Calgary, and Halifax. Instead, the company faced opposition from the health ministers in both Ontario and British Columbia after an independent legal team flagged Copeman’s upfront enrollment fee as a method of queue-jumping. It took three years to open a location in Calgary, with a second site in Vancouver and one in Edmonton opening their doors in 2012. In 2014, Medisys bought a controlling stake in the company, adding Copeman to its inventory of private medical facilities across Canada but retaining a separate brand identity.

The Private Clinics Narrative

Each clinic or franchise relies on a similar business model, advanced through adherence to a common narrative and arguments, deployed to justify the private membership model:

- Playing on nostalgia by claiming to practice a bygone style of family medicine that has been squeezed out by pressures on physicians' time and resources. For example, the Preventous Collaborative Health website states, "Remember the traditional family doctor—the one who knew the entire family and was there for you day or night? The doctor who celebrated new babies, watched kids grow up, and told you straight up what you needed to do so you didn't get sick?"⁷⁹
- The claim that fewer patients means more time with each patient, which results in a higher quality of care. For example, Dr. Colleen Friesen (of Copeman Clinic Edmonton) says she sees about 10 patients a day compared to the 30 she used to see when she worked in a public clinic, making a huge difference in how she works and how she's able to help clients, which she says "allows me more time to be able to spend with the patient."⁸⁰
- 24/7 availability and quicker access to physicians and other practitioners.
- The claim that the focus on a collaborative model or complementary care team brings a unique, integrated, and holistic perspective to patients' health. Some facilities, such as the women-only clinic Femme, put a unique spin on this claim by appealing to a niche demographic: "There's just no comparing Femme to any other medical facility. In fact, Femme is the first concierge medical practice in Western Canada dedicated to women's health. Studies have shown that patients in a private concierge medical practice experience dramatically better outcomes than those in the public system, so becoming a Femme member is truly an investment in your health."⁸¹
- The appearance of greater choice, often framed as the "freedom to choose."
- The design and wording of websites use disclaimers, fine print, and caveats to distinguish insured services from those included in the fee package. For example, from the Preventous website: "The annual Twenty-Four Seven Club™ fee is for uninsured medical services only."⁸²
- The claim that preventative health is more effective and saves employers money. In the words of Copeman executive director⁸³ Rick Tiedemann, "Our goal here is really not to have people deal with acute health episodes but really to prevent them in the first place."⁸⁴

- The claim that Albertans already use private health care. Take, for example, this *CTV News* interview with Tiedemann regarding Copeman's business model:

“What we've essentially done is blend private and public health care.”

Tiedemann points out many people using the public health care system also end up paying extra for certain health services including physiotherapy or going to a chiropractor.

“That's private health care,” he said. “There are a lot of people who are probably unknowingly participating in private health care.”⁸⁵

As with most advertising, the claims embedded within these narratives are based on myths, misconceptions, and misinformation. Advertorials, a mainstay of Postmedia publications, are also a crucial link in the narrative. For example, the article “Patient Profile: Athlete offers high praise,” framed as men's health news, appears to be a typical human-interest story.⁸⁶ It relates the experiences of a former soccer player and how a private medical clinic (Copeman) saved his life and got his health back on track. It is only upon reading to the very bottom of the article that the disclaimer appears: “This story was produced by the Calgary Herald Special Projects department in collaboration with advertisers to promote awareness of private health care for commercial purposes. The Calgary Herald's editorial department had no involvement in the creation of this content.”

As with most advertising, the claims embedded within these narratives are based on myths, misconceptions, and misinformation.

In a PowerPoint presentation to Alberta Health executives, Copeman cited the “preventive care delivery gap” as its prime motivator to improve the health care system, and links chronic underfunding of primary and preventive care to its own innovative solution: private-pay health care, and ultimately, contracted health services.⁸⁷

Key phrases such as “We are Friends of Medicare Too!” paint the Copeman corporation as an ally for public health care, undermining the opposition of advocacy groups (namely, Friends of Medicare) which argue that the membership model erodes the foundations of the public system. In Copeman's business case (included in its 2013 Alberta audit file),⁸⁸ the corporation goes to lengths to assert its support for public health care, and its adherence to the Canada Health Act:

CHC (Copeman Health Centre) is a strong proponent of universal public healthcare [...] To that end, CHC is deeply committed to working with government to ensure that it is synchronized with its objectives—and that it is seen to be a responsible and trustworthy partner.⁸⁹

At the same time, however, this statement seeks to position the corporation as a “trustworthy partner” in order to further its long-term goal of selling provincial governments its business model as a supposedly cost-saving innovation in health care delivery:

The CHC team model is scalable, replicable, and highly leverageable [sic]. This means that Governments [sic] could use it to roll out low cost, high value prevention services throughout the province under a standardized clinical and administrative model.

Under an expanded partnership with Government [sic], CHC can provide many additional scalable, reproducible programs including advanced, on-site urgent care. CHC would also be prepared to work with government to leverage its expert physician teams in each location to help reduce the demand for specialist and hospital care.⁹⁰

This pitch reveals the grand aspirations of the company: to become a contract provider of various health care services—including ones currently categorized as insured services, such as urgent care—to shift the traditional delivery of health care towards a preventive, albeit private, model. Such a model would, one assumes, involve similar fees to those currently paid by Copeman clients, even if those might be paid via the provincial health insurance plan. What’s interesting is that such a model already exists in Alberta: Imagine Health Centres, which operate five clinics in Edmonton and Calgary, work under a preventative philosophy. The company offers patients a “multidisciplinary” health team that includes physicians, nurses, physiotherapists, and nutritionists, but without charging block fees or annual fees. The company is so keen to distinguish themselves from exclusive clinics like Copeman, Preventous, and Provital that their website proclaims in all caps: “OPEN TO THE PUBLIC! NO MEMBERSHIP FEES!”⁹¹ This is interesting, given that the parent company also owns the membership-based Femme Concierge (in fact, one of their collaborative walk-in clinics is literally in the same parking lot as the Femme clinic).

The Fees

As private membership clinics have come under increased media and government scrutiny, most have added careful disclaimers to their websites and promotional materials to distinguish between insured and uninsured services.

The tone varies from clinics to clinic: Copeman Healthcare's appears deliberately crafted to echo the language of relevant legislation, while others, such as Femme and Advanced Primary Care, imply that these uninsured services are enhanced extras or luxuries.

Advanced Primary Care:

APC employs an innovative hybrid funding model allowing us to deliver a comprehensive care model. This means that “essential medical services” (as defined provincially) is covered or insured by your provincial health insurance card. In addition to insured or publically [sic] funded medical services, APC offers a wide range of additional supportive and preventative health care services for a specific fee (“uninsured services”), creating a comprehensive care package beyond what is normally provided at a traditional family medicine clinic. [...] We sincerely believe this enhanced scope of primary care services can help our patients live longer and more productive lives in the long term.⁹²

Copeman:

Note: All medically necessary diagnostic and treatment services that may be provided by the physicians practicing from the Copeman Healthcare Centre—or from your family doctor—are paid for by the government under your provincial health insurance plan. The fees charged by Copeman Healthcare are strictly for non-insured health services; payment of the non-insured health services fee is not a condition of access to insured services and does not guarantee access to insured physician services.

Copeman Healthcare's fee for your comprehensive health assessment, whether as a standalone service or as part of a larger program, is strictly for the uninsured components. In Alberta and some other provinces, Copeman Healthcare or physicians working at the Centre may also bill the provincial health insurance plan for a comprehensive physician visit, general visits, as well as certain tests such as ECGs, stress ECGs, audiometry, tonometry and spirometry.⁹³

InLiv:

Services provided by INLIV's physicians that are medically required or indicated, and that would be covered by Alberta Health Care Insurance Plan or other provincial health care plans, will be billed to AHCIP or the appropriate provincial plan. This includes but is not restricted to regular or urgent medical examination, follow up visits, specialists' fees and emergency or hospital care. INLIV's physicians do not provide on-site emergency room or hospital care but will maintain contact with hospital physicians if a client is hospitalized.

The annual fees for the Total Health Management program are for coverage of uninsured medical services only. These services include contact with the physician and health team that does not occur "in person" as well as in-depth counseling about diet, lifestyle and complementary and alternative medicine treatment options, as well as consultations with our integrative and allied medical and health professionals that are not covered by AHCIP.⁹⁴

With each of the clinics, there is a careful, deliberate attempt to differentiate insured and uninsured services, and to stress that fees are *only* for those not covered by AHCIP. Yet, as part of the hybrid clinic model, each clinic also emphasizes the supposedly enhanced medical care on offer: unhurried appointments, no waiting, 24/7 access, and anti-microbial coated walls. The epitome of this sales pitch can be seen on the website for Femme's VIP health experience:

Be treated as our VIP with this exceptional preventive care program. FEMME Supreme is designed for women who want to cover all their bases, have a personal or family history of chronic disease or cancer; require hormone balancing support; or have a health condition that needs more attentive care. This full-feature bundle includes customized health screening, preventive health care, genomic and hormonal assessment, and beauty gifts valued at over \$2,000.⁹⁵

As outlined in Table 5, the various fees charged by these clinics can be quite lucrative for the operator.

Table 5: Fees Charged by Clinic*

Clinic Name	Annual Membership Fee	Renewal Fee	Platinum or Other Packages	Executive Health Assessment Fee
Preventous Collaborative Health ⁹⁶	\$4,895	\$3,300		\$1,595
Provitall Health & Wellness ⁹⁷	\$4,200	\$3,360	\$6,300	\$1,375
Advanced Primary Care ⁹⁸	\$3,025	\$2,775		n/a
InLiv ⁹⁹	\$4,495	\$3,200 (excludes executive health assessment)		\$1,495
Copeman ¹⁰⁰	\$4,495	\$3,495		\$1,850
Femme & Homme Concierge Clinic ¹⁰¹	\$3,800		\$8,500 and up	\$1,900
North Town Medical Clinic ¹⁰²			Not available	Not available
Dominion Health ¹⁰³				\$1,775

*Fees current as of September 2017.

Source: Compiled by author

Section 4: Case Studies

Between 2011 and 2013, Alberta Health conducted audits on three private health clinics: Provital, Preventous, and Copeman. This section attempts to outline what can be learned through information available on the clinic audits. Before doing so, however, it is necessary to describe the audit process and—as will become obvious—its shortcomings.

The audit process undertaken by Alberta Health is at times convoluted, ambiguous, and obscure.

The audit process undertaken by Alberta Health is at times convoluted, ambiguous, and obscure. The regulations surrounding freedom of information (FOI) requests are doubly so, making it difficult to piece together a holistic and accurate picture of the clinics under scrutiny. The most significant barrier to transparency lies with the stipulation that any information which may impact the business interests of a third party is considered exempt from such requests, and is routinely redacted, or worse, the request for information is denied in full. When attempting to shed light on the intersection of corporate business practices and government operations, this effectively privileges corporate rights over accountability and transparency in the public interest.

In short, the full details of what an audit entails are difficult to ascertain; ministry staff in Alberta and BC sidestepped this author's several direct requests for this information. From the FOI files, however, we learn that the audits of the three clinics in question were carried out by the Monitoring and Investigations Branch of Alberta Health, and the team that appears to have performed all of the audits was led by Richard Taylor, then head of the branch. The audits themselves, despite the name, were not primarily financial in nature: while a sample of each clinic's billings to the AHCIIP were examined against Alberta Health records, full forensic accounting was either not undertaken, or was not disclosed in any of the FOIP files obtained for this report. Instead, the audits were mainly based on a "compliance review"—that is, an examination of each clinic's policies to determine whether or not they were in compliance with the Canada Health Act and the Alberta Health Care Insurance Act. This was determined through interviews with the head physician (or physicians) at each clinic, using a predetermined question set, along with requests for documentation of billing codes, fee schedules, and physician remuneration packages. It is also implied that the audit team looked at the clinics' websites to ensure that the wording was consistent with the CHA, though on what basis this evaluation was made is unclear. The scores and comments given to each clinic on these criteria were all redacted.

What provoked the audits is also open to interpretation. In the aftermath of the 2012 Health Services Preferential Access Inquiry described earlier, there was increased scrutiny of private medical clinics from public health advocates within Alberta and from the federal government. In the same year, the director of the Canada Health Act Division of Health Canada instigated an email conversation with members of Alberta Health—specifically within the monitoring and investigations branch—to raise concerns about clinics that charged membership fees. In an email dated July 19, 2012 between senior policy analyst Chrissy Searle and audit team member Terry Mark, Searle indicates that “Health Canada has inquired several times about these types of clinics (Copeman, Provital, and Preventous),” as Health Canada was not permitted to contact the clinics directly about their concerns. She implies that this communication had become increasingly insistent, and suggests an audit may resolve the problem:

I would assume that this will continue until we are able to provide them with some definitive/confident answers to confirm compliance and I believe the only way that we can do this is through a compliance review.¹⁰⁴

It is not clear whether the audits were solely triggered by pressure from Ottawa, from a need to address the bad optics associated with private clinics, or a combination of factors. What is clear, however, is that the audits were undertaken as a primarily internal exercise to dampen external criticisms rather than to address the roots of those concerns.

The files obtained by Parkland Institute via FOI do not indicate why particular clinics were selected for audit. In July 2013 Copeman CEO Chris Nedelmann bluntly posed this question in an email to the head of the audit team, yet there is no reason stated.¹⁰⁵ An Alberta Health memo from January 10, 2013 (by senior policy analyst Chrissy Searle) points to comments made by Copeman’s executive director, Rick Tiedemann, in a 2012 *Metro* news article “that have caused concerns for Alberta Health [...] and will require further clarification.” The three Copeman Healthcare clinics were, at the time of the audits, among the most prominent in Alberta, and Copeman Healthcare was especially infamous given numerous allegations and investigations undertaken in other provinces.¹⁰⁶

The audits of Provital, Preventous, and Copeman centered around the same—or very similar—objectives, as outlined in the terms of reference of the three audit reports:¹⁰⁷

1. “To identify if there is non-compliance with access provisions of federal or provincial legislation caused by private clinics that charge a membership fee.”¹⁰⁸ This clause is in reference to Sections 3 and 12 of the Canada Health Act and the corresponding sections of the Alberta Health Act (2014).

The auditors’ report goes on to clarify that “For these audits we have defined access as access to any physician that is claiming fee-for-service from Alberta Health without having to pay any fee. This will include access to specialists.”¹⁰⁹ This is to differentiate between physicians who are formally “opted out” of the Alberta Health Care Insurance Plan, as any doctors who submit charges for fee-for-service are, by default, opted in. The emphasis on access to specialists reflects the particular concerns raised by the 2012–13 Preferential Access Inquiry.

2. “To identify if there could be extra billing or prohibited fees” under the CHA Section 2 or the AHCIA Section 9.¹¹⁰

The criteria for determining extra billing was whether “the policy or written procedures or agreements on billings clearly prevent extra billing,” including “any service where the patient has been charged a fee and the physician has also charged the Alberta Health Care Insurance Plan.”¹¹¹

There was no allowance made to investigate differences between written policies and unwritten practices or implied expectations. The clinics’ stated policies are deliberately worded to belie this, emphasizing, for instance, that their fees are charged only for uninsured services.

3. “To identify if there were any improper medical expenses billed” to the AHCIP under the AHCIA Section 18.¹¹²

What the Audits Reveal

How did each clinic stack up in relation to these objectives?

a) Preventous Collaborative Health

The auditors noted:

The Preventous website states that the annual membership fee includes timely access to health care, prompt appointments, unrushed consultations, specialist referral service, quality client care services, a total health assessment in your first year, nutritional counselling, fitness counselling, travel clinic services, educational seminars, and online access to nutrition records. This list includes services that are both insured and uninsured, which has prompted Alberta Health to investigate.¹¹³

Proof that only uninsured services are covered by the out-of-pocket fee was determined solely by what the clinic says about its policies.

In this instance, as with the other clinics, proof that only uninsured services are covered by the out-of-pocket fee was determined solely by what the clinic says about its policies. If Preventous was charging a fee-for-service to the AHCIP for insured services, then the annual fee must therefore only cover uninsured extras. Yet, in the above statement from their own website, Preventous explicitly includes insured services—“timely access to health care, prompt appointments, unrushed consultations, [and] specialist referral[s]”—under the umbrella of its membership benefits. This would appear to be a clear violation of the second objective regarding extra billing, and, more insidiously, implies that any patients who did not subscribe to the membership fee would not receive this quality of care, a violation of the access objective.

Despite this, the auditors’ report merely highlights this as an ambiguity, and seems satisfied by the statements of the clinics’ physicians and management that this is not the case. According to Preventous staff, the line between insured and uninsured services is clearly delineated to prospective members, who are assured that the fee is only for the additional services not covered by the AHCIP. It appears sufficient redress, as far as Alberta Health and the audit team are concerned, that the clinic should adapt the wording of their website to provide clarity—that is, to ensure that the phrasing of the benefits they offer is strictly in line with the letter of the CHA, regardless of the implications this may have in practice. The criteria, as outlined in the audit report referred to above, rely on an inherent contradiction and thus can never be satisfactorily met.

b) Provital Health & Wellness

In its statements to the audit team, Provital seemed more open to disclosing the number of “non-member” patients on its books—estimated at 213 in 2012—and its policy of spending 25 hours per week seeing non-paying patients “in the community.” Further requests for clarification of this breakdown revealed that, while one physician felt that this 25 hours was to enable former patients (from his non-member clinic) to access medical services, in practice the majority of that time was spent “doing rounds” at a privately owned long-term care facility. The percentage of practitioners’ time spent delivering insured medical services (as opposed to cosmetic, accessory, occupational health, or other uninsured services) was provided but redacted in the FOI documents.

The question of physicians’ compensation was raised in the audit, and while two of Provital’s doctors are paid through fee-for-service only (only charging the AHCIP for medical services), a third doctor was paid a stipend in addition to fee-for-service (the clinic justified this as she was part-time and mainly performed cosmetic procedures). The other practitioners—massage therapists, nutritionists, chiropractors, and naturopaths—are paid a salary. In short, none of the annual membership fee (up to \$6,900 for one package) went directly towards practitioner compensation. In addition, the three physicians paid overhead costs to the company and were expected to provide telephone and email consultations and house calls for no additional compensation. This led the auditors to question how the clinic’s model could be profitable or advantageous for the individual practitioners. The staff cited the work environment and work-life balance as the major attractions, but added that they spend a lot of time on third-party billing, occupational health, and cosmetic procedures to make up the numbers. As will be further outlined below, these are practices encouraged by the CMA to help physicians to maximize their profits.

c) Copeman

Copeman clinics have been audited twice in Alberta: its Calgary clinic was investigated by Alberta Health and Wellness in 2008–2009, and both the Edmonton and Calgary locations were investigated in 2013. These audits in Alberta followed a widely criticized audit of Copeman’s Vancouver facility, conducted by the BC Ministry of Health in 2007. In May 2016, the Alberta government announced that it would be conducting yet another compliance review and audit of Copeman’s clinics, provoked in large part by a CBC investigative report and anonymous complaints from former patients. Correspondence between Friends of Medicare and staff in the health minister’s office confirms that this current audit includes both the Edmonton and Calgary locations.¹¹⁵

Copeman's multiple audits across various jurisdictions may actually have given it an advantage: its policies and messaging seem deliberately crafted to remain precisely within the narrow lines mandated by the CHA. In his July 2013 letter to Richard Taylor (the head of the Alberta audit team), Copeman CEO Chris Nedelmann took pains to explain the clinics' official policy on access:

Although the centre's primary business is to provide comprehensive prevention programs, and it is not a "walk-in" medical clinic, it is imperative that any person requesting insured medical services of a physician be serviced by notifying an available physician of that request. If the physician determines that they can be accommodated within their schedule and obligations to [the Copeman Health Clinic], then that patient will be invited to receive care at the centre with the physician's approval.¹¹⁶

While this policy manages to technically offer access to potential patients without paying a user or membership fee, it also contains highly ambiguous qualifiers. Statements such as "if they can be accommodated within their schedule and obligations" and "at the physician's discretion" mean that, in practice, "Although they may provide primary care for self-referred patients who do not have a family doctor, they are under no obligation to do so. [...] CHC can provide no guarantee of access for insured care if a client does not have a family doctor."¹¹⁷

While this policy manages to technically offer access to potential patients without paying a user or membership fee, it also contains highly ambiguous qualifiers.

The audit report found that no non-member patients were seen in Copeman's Calgary clinic—a fact admitted to by Don Copeman himself, who said, "We don't advertise that way." The BC audit likewise found that no patients who were not paying clients or their dependents received primary medical care at the Vancouver clinic. Despite this, the BC audit team emphasized that, according to Copeman policy, "CHC physicians were not prevented from providing primary care to non-enrolled patients."¹¹⁸

In February 2014, Postmedia journalist Miriam Ibrahim submitted questions to Alberta Health's Monitoring and Investigations Branch (the unit tasked with the audit). In a written response to the request, a member of the branch acknowledges that, "Our review [the compliance review portion of the audit] indicates there is not a clear distinction between insured and uninsured services" at Copeman; furthermore, "Preliminary indications are there are concerns with access to insured services, extra-billing, and some documentation issues." Each of these concerns would seem to correspond to the three objectives that form the mandate of the audit.¹¹⁹ Yet, as with the BC audit, the final report found that the corporation's practices were in compliance. Partly, this is due to the Copeman team's deliberate navigation of the line between insured and uninsured services.

Again, in the July 2013 letter to the Alberta audit team, Nedelmann managed to clarify and obfuscate at the same time, writing:

Copeman does not provide provincially insured services, and with the exception of fees billed for certain tests provided at our centre, Copeman receives no revenue under the provincial health insurance plan. However, physicians who are independently contracted to Copeman who have chosen to integrate their services with those of our non-physician health teams may provide insured services to Copeman clients at their discretion.¹²⁰

This highly technical distinction between Copeman as a corporate entity and the physicians in its employ (categorized here as independent contractors) meant that the audit in BC had to be conducted as two separate investigations: the first a financial audit of the company and the second a review of the billing practices of a sample of the individual doctors at the clinic. In essence, this amounts to the BC Ministry of Health accepting Copeman's argument that they are essentially two distinct entities separately offering insured and uninsured services to clients, not simply a medical clinic providing a range of medical care to patients. This distinction is crucial in maintaining the rationale of membership clinics and ensuring their technical compliance with the legislation.

However, it belies the fact that these services are very much blurred together from the perspective of patients/clients and, crucially, begs the question as to why a membership is necessary at all when non-physician practitioners could simply charge their own fees and avoid any suggestion of crossover between insured and uninsured care.

The compliance review report from the audit team also exposes a rather cavalier attitude towards the value, both medical and financial, of the services provided at Copeman clinics:

As an example, the records at the clinic do not disclose time spent by a physician on insured vs. uninsured services. Even if they did differentiate on time and the physician spent 10 minutes on uninsured and 80 minutes on insured, this would just mean the patient was getting poor value for their uninsured services. In effect they can charge what they like for uninsured services and the normal guidelines for buyers of any service apply i.e. buyer beware.¹²¹

In taking this stance, the report advocates a government position that would place the onus on the patient to navigate the ins and outs of insured versus uninsured services and their costs. The lack of a regulated fee schedule for uninsured services—notwithstanding Alberta's new, yet unenforceable,

dental fees guide¹²²—has already been a focal point of concern among patient and consumer advocacy groups, and yet, it appears that the response under the Redford government was akin to “shop around.” This potential risk to patients has been recognized at a policy level for years: in their 2000 report on health care privatization, a group of health care experts warned that “the patient is typically at a substantial informational disadvantage” regarding these purportedly optional uninsured services, and often have “no way of evaluating the real value, let alone the true cost, of the extras.”¹²³

Intergovernmental tensions

The three audits reveal fault lines between the provincial and federal levels of government, as well as between governments and professional regulatory bodies such as the College of Physicians and Surgeons of Alberta (CPSA) and the Alberta Medical Association (AMA). There is a considerable degree of buck-passing between them, with no one office prepared to address the issues raised by private membership clinics. This is particularly evident with regard to Copeman Healthcare, but pertains to the other clinics as well.

At the height of the Preferential Access Inquiry, then-health minister Fred Horne put out an open call to Albertans who had experienced extra-billing or been denied access to a physician.¹²⁴ While Horne claimed to be personally “offended”¹²⁵ by the evidence presented at the inquiry, the complaints sent to him by patients and former patients of private membership clinics appeared to be met with form letters and a promise to forward these concerns to the CPSA.¹²⁶ The reply letters also suggested that patients initiate a formal complaint through CPSA procedures. There is no documented evidence to show that Horne addressed these complaints any further.¹²⁷

Despite this inaction, Horne’s call to aggrieved former patients also elicited a direct, defensive intervention from Copeman founder Don Copeman himself.¹²⁸ In response to a complaint regarding one of the physicians at Copeman’s Edmonton clinic, Mr. Copeman felt it necessary to set out his own interpretation of events in a tone that attempts to cast doubt on the veracity of the complaint:

I will say that Ms. Falsetti [the complainant] brought up many important questions, but she assumed they applied to us, which they do not. I am a person who likes to think the most of people, so although Ms. Falsetti’s points seem to follow a well-worn path by special interest groups, I will choose to think it was a genuine personal effort.¹²⁹

Copeman implies that the complaint was fabricated by “special interest groups” to highlight questions that “do not apply” to Copeman’s organization. He then requests an in-person meeting with the minister to discuss the ways in which Copeman Healthcare could be a helpful partner in innovating change in the province’s delivery of public health care. While Horne rejects such a meeting, he refers Mr. Copeman back to the CPSA: “I encourage you to continue working with the College should you have further questions or concerns on this matter.”¹³⁰

On a superficial level, Horne’s reply is a polite exercise in buck-passing (and perhaps a tacit acknowledgement of the conflict of interest represented by such attempts at lobbying); however, given the self-policing nature of the CPSA, the ambiguity of its revised standards, and the fact that it is composed of doctors who may also have a wider personal financial stake in such decisions, its potential to pursue a politically motivated agenda makes this deferral of responsibility seem ill-advised on Horne’s part.

All three of the audit files also contain lengthy email chains between Gigi Mandy, director of the Canada Health Act Division of Health Canada, and staff in the Monitoring and Investigations Branch of Alberta Health. Mandy repeatedly requests details about the audits, and is repeatedly reassured that they are underway— yet little detail is provided to her until the final reports are sent. Though such emails provide an incomplete account of the motivations behind such requests, it is interesting to note that even the federal official tasked with ensuring compliance with the CHA had to apply polite pressure to be kept informed.

What the Audits Did Not Reveal

Across the Copeman, Preventous, and Provital cases, the audit files—what is contained in them as well as what they omit—shed light on the flaws inherent in the audit process in both Alberta and BC. Furthermore, CBC investigations revealed other troubling practices, as described in this section.

Public health care advocates and the opposition NDP heavily criticized BC's 2007 audit of Copeman Healthcare as ineffective and superficial.¹³¹ Yet, when the province of Alberta undertook its audits of the three private clinics beginning in 2011, these criticisms remained unaddressed in both jurisdictions. Instead, despite the considerable amount of time and public resources invested, significant concerns remained that the audits process failed to uncover due to their narrow scope. Given that the Alberta audits followed a very similar process it is unsurprising that they arrived at similar conclusions. Especially unsurprising, given that in preparation for a January 2013 meeting with staff at Preventous, a member of the audit team included the following note:

Ron Liepert approved clinics and he indicated that Ron say's [sic] Copeman went through the ringer in BC and they didn't find anything and therefore we are ok. Ron Liepert is a former MLA, Health Minister and former campaign manager for Alison Redford.¹³²

By casually referencing the former health minister, the note-writer appears to be relying on the weight of political influence to justify the audits process, and hints at pre-formed conclusions. The explicit links drawn between the BC audit of Copeman and subsequent audits of it and other clinics in Alberta, indicates a degree of confidence at the political level that the audits would find no violations. Thus, the Copeman case, in particular, allows for an in-depth comparison of the audits process in the two jurisdictions. The Copeman files also contain more information, in the form of correspondence from founder Don Copeman and CEO Chris Nedelmann to the Ministry of Health and the audit team.

Despite the considerable amount of time and public resources invested, significant concerns remained that the audits process failed to uncover due to their narrow scope.

In his July 5, 2013 letter, Nedelmann sought to clarify the scope of the audit process:

[We] would appreciate you providing us with more detailed information as to why the audit is being conducted. This does not appear to be a random audit of billing practices [...]. Was it triggered by a complaint about the business, clinical, or billing practices at our Edmonton centre? Have the 40 records you would like to review already been identified, are they from random physicians, or will they be randomly elected on the day of the audit? Is the scope of the audit to assess compliance with the Alberta Health Care Insurance Act only, or is it going beyond that?¹³³

While Nedelmann's questions raise legitimate concerns about the transparency and framing of the compliance audit process, they also appear to subtly probe to uncover the trigger behind the review, as though the process would only be justified in light of a specific complaint. Moreover, the tone of the letter implies a slight defensive stance on the part of Copeman Inc.: because this review “does not appear to be a random audit of billing practices,” there is a polite implication that the company feels unfairly singled-out for scrutiny. Again, given Copeman's extensive experience with various audits this seems disingenuous.

Alternative models already exist

The audits, and the provincial government, failed to adequately challenge the clinics' justification of their fee-based business model. Why couldn't a collaborative model be adapted without membership fees? Examples already exist in Alberta—for instance, via Primary Care Networks, or collaborative clinics which feature a variety of non-physician health care professionals in-house, but merely charge patients “per use” of these non-insured services. As discussed in Section 3 of this report, Imagine Health Centres Windermere (Edmonton) includes physiotherapists and other practitioners in its facility, while Wellpoint Workplace Health (Edmonton and Calgary) offers family health, corporate, WCB, and disability services with no out-of-pocket membership fees.

Profit-making as encouraged by CMA

Provital's defense of its business model relies in large part on its assertion that the membership fees themselves do not generate a substantial profit for the company, and that its physicians must engage in third-party billing, cosmetic, and elective procedures to supplement their income. The Canadian Medical Association (CMA) in fact explicitly encourages physicians to engage in such practices in order to maximize their incomes. In its 2015 guide for physicians opening or operating a private practice, the CMA states:

Many physicians feel uncomfortable billing for uninsured or delisted services. After all, what's one doctor's note here or one phone prescription renewal there? ... Uninsured services may add up to a significant amount of the services you provide. Not charging for them could have a negative impact on your bottom line.¹³⁴

While the CMA's primary role is to advocate for doctors' interests, its promotion of financial strategies as crucial to the success of medical practices may contribute to a broader acceptance of the profit motive in health care delivery.

The CBC investigations: double-billing and unnecessary testing

The most troubling allegations of CHA violations were revealed not by the repeated audits of Copeman's policies, but by investigations carried out by the CBC in 2016.¹³⁵ Documents leaked to a journalist by a former patient ("client"), as well as those released in support of a lawsuit against Copeman, claim that internal policies set by the Copeman head office in Vancouver dictated the number and nature of diagnostic tests to be ordered for members—not their medical history or presenting symptoms. Two physicians formerly employed by Copeman's Calgary clinic alleged that unnecessary testing was commonplace and encouraged.¹³⁶ CBC also found in interviews with current and former clinic employees that "doctor approval for such tests was routinely circumvented by the clinic's administrative processes."¹³⁷ The myriad tests were processed through the publicly funded Calgary Lab Services even as patients/clients paid for the privilege of this more "comprehensive" approach. According to the CBC, "Of the 19 tests and assessments Copeman set out in its 2012 schedule for standard patient testing, 16 are covered by Alberta Health. On an initial visit for men over aged 50, for example, the cost absorbed by the province for lab analysis alone reached \$347 per patient."¹³⁸

Further, the CBC investigation revealed other significant grey areas in Copeman's billing practices. While the tests are covered by the AHCIP, and therefore must be covered by the province even if they are deemed unnecessary, the billing practices at Copeman appear to invoice these

The CBC investigation revealed other significant grey areas in Copeman's billing practices.

diagnostic services to patients to allow them to be claimed through third-party insurance or as income tax deductions.¹³⁹ Again, Copeman's practices are in an unsettling grey zone: under CRA regulations, membership fees paid to private clinics are ineligible for tax deductions—but fees for reasonable, medically necessary services are permissible. So even though the diagnostic tests are included as part of a patient/client's annual membership or health assessment package, by disaggregating the costs on an invoice, it can be made to appear as a separate charge for tax purposes. While not technically a violation of the CHA, such practices—if proven—would be at best a manipulation of the intentions of provincial and federal legislation, and at worst, fraudulent. The audits missed these concerns entirely precisely because they were not designed to look for them.

The greatest myth of private health care—that it reduces costs on the public system—is thoroughly debunked by these practices, as each questionable test ordered is paid for by three and possibly four players. In the first (three-player) instance: the patient, the province, and the federal government; in the second (four-player) instance, the patient for out-of-pocket membership fees, the province through AHCIP, the federal government via tax deductions, and third-party insurers through health spending accounts or similar benefits. But in any given scenario, only three players would cover the costs: the patient pays the fees, and if tests are covered by AHCIP the province remits payment to the ordering physician, if the charges are line-itemized, then they qualify for a medical expense deduction. If the tests are not covered under the provincial plan, then these costs may be eligible for coverage under a third-party insurance plan, in which case only the premiums would be tax deductible, rather than the full cost of the membership and/or tests.

The testing protocols at Copeman underscore many of the problems inherent in the for-profit membership model: the profit motive encourages service providers to administer unnecessary tests; these tests cost the public system in time, money, and equipment use; the tests are, for the most part, already covered by the provincial health insurance plan and as such, provide no value for the thousands of dollars patients put out on the membership fee. As per the auditors, “buyer beware,” indeed.¹⁴⁰

Moreover, in attempting to investigate these claims, journalists and researchers alike are challenged by a lack of data pertaining to private clinics and their practices. A spokesperson for Calgary Lab Services said that it was not possible to confirm how much such tests were costing the province, as “generating the information would be too time-consuming.”¹⁴¹ Another FOI request for this data submitted by Parkland Institute was similarly deemed too difficult to fulfill by Alberta Health. Such responses raise the question of whether Alberta Health has been unable or unwilling to track these costs.

The “purging” or prioritizing of patients

In a further investigation by CBC of the Copeman clinic’s Calgary location, former and current Copeman staff revealed the company’s response to the recent economic downturn in the city. Where previously private membership clinics had sold their services to corporate executives and the well-heeled in Calgary’s oil and gas industry offices, the recession and related rounds of layoffs meant many corporate clients were no longer including membership fees as part of their employee benefits. In an internal memo to administrative staff, Copeman’s executive director Rick Tiedemann, instructed staff to persuade patients to pay the fees from their own pockets, or else seek another family doctor for medical visits: they were not to discuss patients’ legal right to continue to see their doctor without paying for the supposedly optional uninsured services.¹⁴²

The allegations, alongside evidence such as the memo obtained by CBC¹⁴³ which appears to substantiate them, expose the fundamental flaw in the audits process: while successive audits found that Copeman (and the other private membership clinics) upheld the CHA on paper, the experiences of patients and staff suggest that violations were not only common, but routine practice. That the tenets of equal access on the basis of medical necessity may have been systematically undermined by Copeman’s business model renders the findings of the previous audits suspect. The failure to undertake a comprehensive financial audit also means potentially fraudulent billing practices were missed. Based on these allegations, Alberta Health has launched a new audit, but if it follows the same format as its predecessors, it may well miss vital evidence of exploitative practices. Health Minister Sarah Hoffman appeared to recognize this when she announced the new audit in the Legislature:

The allegations being made are very serious, and the business is currently being audited by Alberta Health. If there are any findings that show that the company breached the Canada Health Act, we will act. In light of any of these new allegations of fraud, I’ve directed my ministry to take a more rigorous approach, and there is going to be an investigation. I want to be clear that we will not allow excessive billing practices that undermine Albertans’ access to universal public health care.¹⁴⁴

Unanswered questions

These examples from the Copeman case points to a common flaw across the audits of all three clinics: the audit teams only found answers to a very narrow range of questions. Because they were focused on what the clinics said they did rather than what they did in practice, each of the audits was able to conclude that they clinics were in compliance because their policies said they were. This contradictory conclusion in no way encouraged the auditors, or the government, to look beyond the surface. The evidence pointing to questionable practices has been uncovered not by successive audits, but by investigative journalists receiving information directly from former patients and employees.

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Critical Lessons From the Audits Process

Several common threads emerge from an analysis of the audits conducted in the three case studies above, including flaws, inconsistencies, and/or inadequacies.

First, the evidence suggests that the **audit process itself is flawed**, in that its methodology privileges the protection of business interests, focuses on an extremely narrow scope, enshrines lack of transparency, and offers little tangible redress for those wronged. Moreover, what the audits *don't* look for is highly problematic—as the Copeman cases in particular attest, spurious practices were potentially missed in multiple reviews because of the narrow focus on technical compliance with the CHA.

Second, the **data collected or released regarding private clinics and how they work is inadequate**.¹⁴⁵ There is currently no central collection of even basic data on these clinics, including how many exist, where they are, or their financial implications for the public health care system. Despite the forthcoming changes to laboratory ownership, currently DynaLife and Calgary Lab Services maintain proprietary control over all the lab data they collect, including costs associated with private clinics. That Alberta Health has no access to information about aspects of its own service is particularly concerning, and indicates that business interests have been given priority over the public interest.

Third, despite the entanglement of former members of cabinet, heads of professional bodies, academics, and physicians in several prominent for-profit private clinics, the audits fail to examine **potential conflicts of interest**. Rather, the audits reflected a philosophy within the Progressive Conservative government that actively encouraged privatization. Even amidst the high-profile cases of the Helios Clinic and Health Resources

Centre and the fallout from the Preferential Access Inquiry, the government expressed little concern over the political and financial influence being exchanged to promote the private health agenda.

Fourth, the case studies also suggest the audit process has contributed to a troubling **lack of enforcement**. The audits' narrow focus allowed Alberta Health to pass responsibility on to the CPSA, on the premise that the issue is merely an ethical one, not a political or legal concern. The result was that clinics were simply encouraged to change their wording, not their practices or business model. Leaving oversight to medical professional bodies as self-regulation is ineffective and creates the potential for conflicts of interest—essentially tasking these bodies with a watchdog function even as they are engaged in promoting practices that potentially violate the spirit of the Canada Health Act. Even if violations are confirmed, the only penalty at present is a reduction of federal health transfer to the province; there is no financial penalty faced by the clinics themselves and therefore no incentive to change their practices.¹⁴⁶

The audits' focus on the narrow stipulations of the Canada Health Act takes a very restricted view of the principles of accessibility and universality, rather than acknowledging that membership fees are by their nature exclusive, as they put in place a de facto financial barrier and promote a philosophy based on two-tier health care.

The narrow definition of extra-billing used in the audits means that billing practices which are currently legal, but exploitative, are overlooked. As seen in the recent allegations of double-billing and targeting tax loopholes arising from the Copeman lawsuit and CBC investigations discussed above, the legal framework of the CHA offers no penalty for these practices.

While the status quo regarding private membership clinics was cemented in place by successive Progressive Conservative governments, the current NDP government now has the opportunity to address the flaws, loopholes, and grey areas that enable this emerging industry. While the party's approach to prioritizing public health care has thus far been piecemeal, recent decisions to retain or return public control of northern laboratory services and hospital laundry services suggest that this government is inclined to preserve and promote the public system and minimize private sector exploitation of that system. The final section of this report sets out recommendations for ways in which this could be accomplished.

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Section 5: Conclusion and Recommendations

This report has attempted to provide a map of private health clinics in Alberta. As recent stories from elsewhere show, private health clinics pose a serious threat to the sustainability of universal public health care throughout Canada.

Where previous Progressive Conservative governments in Alberta have used health care cuts to undermine the public system and open the door to greater private sector involvement in multiple aspects of health care delivery, private membership clinics represent a unique manifestation of for-profit health care. Aimed at the upper-middle and executive classes, and those who view health as a lifestyle rather than a necessity, such clinics seek to commodify medical care as a luxury benefit for those who can afford it. Even as they claim to relieve the pressure on the public system, these clinics illustrate the risks inherent in believing that privatization is the solution to our health care challenges.

While the NDP government has indicated its support for comprehensive and efficient public health care through pivotal decisions (in particular, on laboratory services), the legacy of the PC laissez-faire ideology still prevails in much of Alberta's political and economic discourse. Given these challenges, does the political will exist to protect and strengthen Alberta's public health care services and resist privatization by stealth? Increased transparency regarding the operation of private clinics, alongside improved oversight and regulation, would offer a clear signal to Albertans that equal access to high quality, efficient health care is truly a right and not a privilege.

To that end, this report posits the following recommendations:

1. Close legislative loopholes. At the federal level, Health Canada should decisively clarify their interpretation of the Canada Health Act and seek to close legal loopholes currently being exploited by private membership clinics and private surgeries.
2. Exercise greater provincial oversight and regulation of membership- and fee-based clinics. This includes greater enforcement of existing stipulations regarding medical billing and access, as well as increasing the scope of powers of the Canada Health Act and its provincial counterparts to enforce these provisions.
3. Establish an independent ombuds office to ensure that complaints and spurious practices are reviewed objectively and accountably, and with greater enforceability.

4. Implement a more comprehensive and transparent audit process that fully examines the practices of such clinics, not merely their written policies.
5. Improve data collection and mandatory reporting surrounding private membership clinics. Current and accurate information about the number and practices of private clinics allows for more appropriate policy decisions to be made and enables prospective patients to make informed choices about who delivers their health care and at what cost.
6. Alberta Health should provide explicit support for the public health system while exploring options to increase the efficiency of delivering high-demand services. This might include:
 - a. Exploring evidence-based alternative models of providing primary and preventative health care, but in a setting that does not charge block membership fees.
 - b. Further exploring proposals to replace the fee-for-service model in ways that implicitly encourage collaborative care without categorizing it as a luxury service.
 - c. Bringing diagnostic imaging fully under the Alberta Health Care Insurance Plan to reduce the financial incentive for upselling services and providing unnecessary tests. The recent move towards returning all laboratory services to provincial control may help to reduce the commodification of these services and their role in jumping the queue.

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Endnotes

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- 5 Health care services can be delivered by for-profit, not-for-profit, or not-only-for-profit agents. For-profit usually refers to corporate entities who have financial obligations to their shareholders—their business model requires them to make a profit in order to pass that on as dividends. Not-for-profit means voluntary or charitable organizations, such as the majority of Canadian hospitals, which are owned by foundations and receive funds from donations in addition to public funding. Not-only-for-profit is a more complex term, sometimes referring to businesses that set aside a percentage of profits for charitable donations, but in the Canadian health care context is often applied to small businesses such as physicians’ offices. Health researcher Raisa Deber distinguishes between “for-profit corporations” and “for-profit” small business, as similar categories, and concludes that smaller enterprises are not as prone to profit-motivated practices as their corporate counterparts. See Deber (2002). “Delivering Health Care Services: Public, Not-For-Profit, or Private?” Commission on the Future of Health Care in Canada, Discussion paper no. 17, pp. 6-7.
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- 9 This is epitomized by the demolition of the Calgary General Hospital in 1998—quite literally blowing up public health infrastructure to make way for privately contracted services.
- 10 The facility fees charged by the private Gimbel clinics were deemed violations of the CHA, for which federal health transfer penalties were applied in 1995-1996—a deduction of \$3.585 million. In 2003, Anne McLellan, the federal health minister at the time, wrote to four provinces, including Alberta, to express formal concerns over the privatization of diagnostic imaging, but penalties were not applied. See Odette Madore (2005). *The Canada Health Act: Overview and Options*. Parliament of Canada. Retrieved from: <http://www.lop.parl.gc.ca/content/lop/researchpublications/944-e.htm#epenaltiestxt>
- 11 The title of the act is deceptive, in that the Health Care Protection Act has been seen as potentially undermining the public health system, having established the conditions under which private surgical facilities could operate and opening the door to the contracting out of insured surgical procedures to for-profit companies. See Caulfield, Flood, and von Tigerstrom (2000), p. 26.
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Volume 1: https://d10k7k7mywg42z.cloudfront.net/assets/534ec3d54f720a70bb000153/HSPAI_Final_Report_Volume_1_Complete.pdf
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- 35 See Sean Speer and Ian Lee (2016). *Toward a More Fair Medicare: Why Canadian health care isn't equitable and how it can be*. Ottawa: MacDonald-Laurier Institute.
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- 39 Again, the most telling example is, the Health Resources Centre in Calgary. See Gibson and Clements (2012), *Delivery Matters*.
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- 52 Ibid.
- 53 Ibid. p. 30.
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- 138 Ibid.
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