



# Privatization Pressures in Alberta Health Care

Laboratory Services, Home Care,  
and Telehealth Under Austerity



| Alison H. McIntosh



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Alison H. McIntosh

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## About the Author

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## Executive Summary

This report explores contemporary pressures to expand private participation in three areas of Alberta's public health care system: diagnostic laboratory services, home care, and telehealth. I focus on these topics because they are highly contested areas of the health care system. As I outline in this report, they are also parts of the health care system where patient and worker experience could significantly change due to proposed and enacted policies from the current provincial government.

After winning the 2019 provincial election, the newly elected United Conservative Party (UCP) government moved quickly to implement sweeping reforms in the province, and based on the direction signaled in its election platform and the policies enacted in its first year of government, the UCP government is on a path to dramatically transform the health care system in the province.

I begin by describing the UCP's approach to health policy through the lens of key documents, including annual provincial budgets, the MacKinnon/Blue Ribbon Panel report, and the AHS review prepared by Ernst & Young LLP. There is, perhaps unsurprisingly, close alignment between the UCP's 2019 policy platform and the findings of these reports. In the "health care privatization" section of this report, I outline how these government documents set the stage for further privatization in Alberta's health care system. These tendencies align well with long-term neoliberal health care policymaking that increases space for private participation in public services in order to reduce the size and scale of the public sector. As described by Graff-McRae (2017) and even the Ernst & Young AHS review (2020), Alberta already has diverse private health care services, including private membership clinics and non-hospital surgical centres that provide publicly funded surgeries. Within health care, privatization has negative impacts for both patient outcomes and working conditions for staff.

### Diagnostic laboratory services

Decades of dramatic public policy changes for diagnostic laboratories serve as an example of the ways in which political changes have real-world impacts on the health system. I outline how the Alberta government's experimentation with cuts to diagnostic laboratory spending in the 1990s led to laboratory restructuring, job losses, deskilling, and an exodus of pathologists. Between 1994 and 1998, private and public sector diagnostic laboratories responded to funding cuts by consolidating and centralizing their operations. Microbiology labs that restructured during this period to perform more complicated testing without hiring specialists had an increase or lower decrease in error rates compared to those that did not (Church, Don-Joe, & Unger, 2000).

Lessons from laboratory restructuring in the 1990s have ongoing relevance today. In 2020, the Ernst & Young AHS review recommends increasing the proportion of laboratory technicians in diagnostic laboratories, and doctors threaten to leave the province due to funding cuts, much like the situation leading up to the widespread loss of laboratory pathologists beginning in 1994. Cost savings associated with increasing public or private participation in diagnostic laboratory services are difficult to calculate due to differences in the kinds of work done by each type of lab, and assumptions about how savings would be spent (e.g., on shareholder dividends and equipment upgrades for private labs, or on increased volume for public ones). In the 2020 Alberta budget and the Ernst & Young AHS review, the provincial government demonstrates an intention to decrease the role of the public sector in diagnostic laboratories, a change that will have long-term implications for the universal health care system.

## Home care

Like diagnostic laboratory services, home care is a dynamic landscape for public and private service providers. With improved health interventions leading to longer life with more comorbidities, more Canadians, particularly older ones, require home care services. Most home care is provided informally by friends and family, but this responsibility has profound personal and economic consequences. Professional, formalized home care can alleviate burdens on loved ones, and improve patient outcomes at a lower cost than residential care.

Long-term home care is not an insured service under the Canada Health Act (CHA), so eligibility for publicly provided home care services depends on what each province is willing to provide. Private home care providers, particularly for personal care services (in contrast with professional services like registered nurses and physiotherapists), fill the gaps in public provisioning both by accepting private pay clients, and as contract providers for publicly funded services.

The low cost of home care rests on several inequities within the health care system, namely reliance on informal care providers; rationing of care by health authorities that leaves people who cannot pay privately with unmet care needs; and low pay and poor working conditions for home care workers. The benefits of formal home care services, along with documented gaps in care, show that Albertans would benefit from expanding home care programming. However, the UCP government's projected increases to the home care budget do not account for inflation and population growth, likely meaning that more Albertans will have fewer of their home care needs met, and a disproportionate burden of care will continue to fall on friends and family.

## Telehealth

Although forms of distance care using telecommunications technology go back decades, and most provinces have phone advice helplines and remote care from clinical settings, modern incarnations of telehealth through apps are a relatively recent arrival in Canada. A handful of private companies provide access to physicians and other health care professionals through virtual platforms in some Canadian jurisdictions. In some cases, patients pay directly, and in others, the businesses that own the apps have agreements with governments, health authorities, or insurance companies to provide a suite of services to eligible individuals. Recently, the UCP government received negative attention for promoting Babylon, a TELUS Health product. Babylon entered into an Alternative Relationship Plan with the Government of Alberta to provide physician services outside of the standard fee-for-service model. The Alberta Privacy Commissioner is currently investigating Babylon due to privacy concerns with the app. Telehealth app usage is likely to grow in the future because the apps are fast, convenient, and avoid contagion risks present in in-person clinical settings—an advantage that has become particularly important during the COVID-19 pandemic. Although rural and remote patients stand to save significant travel time, evidence from Sweden shows that urban, relatively young patients are the most likely to use telehealth apps (Blix & Jeansson, 2018). To realize the most benefits from expanding telehealth prevalence, Albertans and Canadians more broadly need to ensure that telehealth services uphold the values enshrined in the CHA, and that they reduce, not exacerbate, health inequities.

I conclude the report by describing the challenges patients and workers face in turning the tide on health care privatization. The current pandemic shows the value of a high-quality public health care system that is resilient, modern, and grounded in the values of the CHA. Alberta Precision Laboratories, a publicly owned and operated lab, does public health testing, including for COVID-19. Home care for acute, post-hospital and palliative patients is a universal insured service under the CHA. Services like 811 and virtual care within the public health system lower barriers to accessing care. Underfunding and privatizing put such initiatives at risk by removing capacity and infrastructure from the public system. Patients and workers should work together to enshrine these services and improve equitable access to high quality care. With these considerations in mind, I end the report with 20 recommendations that foster a strong vision for universal health care that leaves no one behind.

# 1. Introduction

Health care is fertile terrain for neoliberal innovation. Decades of declining public investment in health care reinforce and entrench political attitudes that prioritize cutting costs at the expense of working conditions and quality of care. In jurisdictions with universal health care, health budgets represent some of the largest outlays of public sector spending, rendering them a popular target for austerity.

This report explores contemporary pressures to expand private participation in three areas of Alberta's public health care system: diagnostic laboratory services, home care, and telehealth. I focus on these topics because they are dynamic and contested areas of the health care system. As I outline in this report, they are also parts of the health care system where patient and worker experience could see significant change due to proposed and enacted policies from the current provincial government.

After winning the 2019 provincial election, the newly elected United Conservative Party (UCP) government moved quickly to implement sweeping reforms in the province, including announcing an administrative review of Alberta Health Services (AHS) a month after taking office. Based on the direction signaled in its election platform and the policies enacted in its first year of government, it is clear that the UCP government is on a path to dramatically transform the health system in Alberta. This report builds on previous Parkland Institute work about the impacts of privatization on universal public health care in Alberta (e.g. Graff-McRae, 2017; Campanella, 2016).

Alberta's health care landscape has experienced dramatic change before. In the 1990s, the Ralph Klein government made sweeping health care cuts in the name of containing allegedly soaring health care costs. Beginning in 1994, the Klein government cut \$287 million (18%) from the health budget (Fagg, Gordon, Reib, McGann, Higa, Kinniburgh, & Cembrowski, 1999). The cuts had widespread impacts, including eliminating nearly half of the acute care beds in the province (from 4.3 to 2.4 per 1,000 Albertans) (Fagg et al., 1999). Other changes stemming from the Klein government's health care cuts included contracting out procedures to private surgical facilities, making non-hospital overnight surgeries possible, and privatizing laundry services, lab services, and residential care for seniors. Over the next 25 years, subsequent provincial governments continued to enact austerity budgets that left very little room for further cuts or efficiencies in the health care system. Even the recent Alberta New Democratic Party (NDP) government preached fiscal restraint and bargained for no wage increases with public sector unions. Plans to increase privatization of the health care system based on contested arguments that it will reduce costs risks profound and wide-ranging damage to one of our most important social institutions.

This report seeks to assess the impact of increased private delivery on Alberta's public health system, with particular attention to potential impacts in terms of cost, effectiveness, and transparency and accountability. I begin with brief overviews of the UCP and health care privatization in general. I then review privatization trends in diagnostic laboratory services, home care, and telehealth, noting the ways in which these issues impact Albertan patients and workers. In these sections, I assess Alberta's direction in these areas of the health care system as expressed in the UCP's platform, budget, and commissioned reports (specifically, the Blue Ribbon Panel report, and the Ernst & Young AHS review). I then discuss the challenges posed to Alberta's universal health care system by UCP policies, and what Albertans and labour organizations can do to support high-quality conditions of care and work. The report concludes with 20 recommendations to expand and strengthen universal health care in Alberta.

## 2. The UCP Government

Since its election in April 2019, Jason Kenney's United Conservative Party (UCP) has signaled a strong interest in doubling down on Klein-style privatization ideology. The party, which captured 55% of the popular vote in the 2019 provincial election, included in its platform a series of policies to expand private delivery of publicly insured surgeries; privatize hospital laundry services<sup>1</sup>; conduct a review of Alberta Health Services' (AHS) administrative processes; conduct an "impact assessment" of supervised consumption sites; and expand Nurse Practitioners' scope of practice.<sup>2</sup> Since coming to power, the Kenney government has implemented many elements of its policy agenda, with varying levels of controversy. Like many governments, the UCP government also strategically uses reports and commissions to reinforce its worldview, and to validate its planned course of action.

There are three key documents that the UCP has used to advance its political agendas. As with all governments, annual budgets serve as signposts about political directions for ministries. At the time of writing, the UCP had introduced two annual budgets: the 2019 budget, released in October 2019, and the 2020 budget, released in late February 2020. This report focuses on the more recent 2020 budget to assess the government's health spending priorities. An early priority for the UCP was a "Blue Ribbon" panel to examine Alberta's finances. The newly elected UCP government appointed Janice MacKinnon, a former Saskatchewan finance minister, to head up the panel in charge of the Blue Ribbon report. The panel released its report in late August 2019, charting a path forward for public services that included

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1 A real throwback to the Klein years, where an attempt to contract out laundry services resulted in Calgary laundry workers going on a wildcat strike that pushed the Klein government to halt the planned privatization (Chambers, 2012).

2 Nurse Practitioners are highly trained medical professionals, and their expanding scope of practice reflects that. However, as their scope of practice grows to include more autonomous diagnosis and treatment similar to a physician, their compensation does not.

*“The UCP government also strategically uses reports and commissions to reinforce its worldview, and to validate its planned course of action.”*

substantive changes for Albertans, including increasing private delivery of medical procedures. Finally, the UCP government commissioned Ernst & Young LLP to review Alberta Health Services' (AHS) performance and spending. Released to the public in February 2020, the report recommends cutting costs in AHS through outsourcing ancillary hospital services and increasing accommodation fees for long-term care and designated supportive living.

Jason Kenney and UCP ministers frequently refer to the Blue Ribbon Panel report and the AHS review to justify policies and legislation that have will have sweeping effects on Albertans. For example, a core argument in the Blue Ribbon Panel report is that public sector workers are overpaid. Although a peer-reviewed Parkland Institute report challenged that assertion (Ascah, Harrison & Mueller, 2019), the UCP government used the findings of the Blue Ribbon Panel report to back up a public-facing discourse demanding public sector pay cuts that resulted in another round of zero wage increases for major public sector unions. Similarly, Premier Jason Kenney and Health Minister Tyler Shandro used the findings of the AHS review to terminate the agreement with the Alberta Medical Association and attempt to cut physician pay at the outset of the COVID-19 pandemic. Needless to say, that move was poorly received by doctors and much of the general public. Consequently, the provincial government walked back some of the more contentious aspects of the contract dispute, like differences in virtual billing codes between Babylon physicians and other physicians (further described in the telehealth section of this report).

### 3. Health Care Privatization

The above examples illustrate a tendency of the UCP government to commission ideologically favourable reports that it then uses to support some of the more drastic aspects of its policy proposals. As demonstrated by the party's platform and the recommendations of the government's commissioned reports and reviews, the UCP generally favours increased private participation in public sites and services, including within the public health care system. Privatization presents a challenge to the Canada Health Act (1984), which sets out the conditions for the provinces to receive Canada Health Transfers from the federal government. In order to receive the funds, provincial health care insurance plans must ensure that they meet five criteria: public administration, comprehensiveness, universality, portability, and accessibility (c. 6, s. 7). The UCP's support for privatization has potential impacts for all five criteria, but most threatens universality, or the requirement that all Canadians are entitled to medically necessary care without having to pay for coverage through provincial health insurance

*“An influential 2002 systematic review and meta-analysis of patient outcomes in for-profit and non-profit hospitals found that private, for-profit hospitals were associated with an increased risk of death.”*

(Canadian Nurses Association, 2000). The UCP’s proclivity for privatization fits well into the neoliberal project that has grown since the 1970s to become the dominant political discourse in Canada and around much of the world. Yakerson notes that “[i]n the context of health care policy, neoliberalism justifies the trend toward privatization and limited government intervention in the market forces driving health and social welfare” (Yakerson, 2019, p. 265). These trends have real world impacts on quality of care and patient outcomes.

The Ernst & Young AHS review points to several areas of health care delivery in which the UCP government could expand private delivery of publicly insured medical services. For example, the review recommends that AHS sell its wholly owned long-term care subsidiaries: CareWest and Capital Care (Ernst & Young, 2020). The review also recommends expanding the number and type of publicly insured surgeries provided in “non-hospital surgical facilities,” or private surgery clinics (2020). The UCP government followed through on this recommendation by passing Bill 30, the Health Statutes Amendment Act, which streamlines the process of contracting out to for-profit non-hospital surgical clinics. It is important to note that privatized health care already exists in Alberta, with 15% of publicly insured surgeries in Alberta taking place in private non-hospital surgical facilities (Ernst & Young, 2020).

Of concern for potential patients of non-hospital surgical facilities, an influential 2002 systematic review and meta-analysis of patient outcomes in for-profit and non-profit hospitals found that private, for-profit hospitals were associated with an increased risk of death (Devereaux, et al., 2002). Adjusting mortality rates for patient severity showed that private, non-profit hospitals—the kind of hospital most familiar to Canadians—accepted patients with greater disease severity.<sup>3</sup> The authors attribute this phenomenon to the profit motive in for-profit health care that prioritizes administrator compensation over staffing levels and compensation (Devereaux et al., 2002). In the study, for-profit hospitals had fewer highly skilled professionals per risk-adjusted beds (Devereaux et al., 2002). The profit motive exists for all private, for-profit companies, including those in diagnostic laboratory services, home care, and telehealth.

Alberta already has private membership clinics, sites that provide (ostensibly free) primary care and auxiliary services for a fee. A previous Parkland Institute report, *Blurred Lines: Private Membership Clinics and Public Health Care* (Graff-McRae, 2017) examined how private membership clinics skirt around the Alberta Health Care Insurance Plan to provide members-only primary and auxiliary health care. In theory, primary care is generally open to the public and free. However, in practice, barriers to access prevail for members of the general public (Graff-McRae, 2017). That report drew the resounding conclusion that private membership clinics, despite advocate

3 In Canada, most health services are publicly funded but privately delivered. For example, most physicians operate their own practices and are not public employees, and hospitals are owned and operated as non-profit organizations (Lanoix, 2017).

claims to the contrary, do not reduce costs for the public system (Graff-McRae, 2017). They also pose a challenge to equitable access to diagnostic imaging and other parts of the health care system, as patients that can pay for private Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI) scans get faster access than those who cannot. The 2012 Health Services Preferential Access Inquiry found evidence of queue jumping for patient-clients of private membership health services in Alberta (Vertes). The patient, province, and federal government, and sometimes third-party insurers all end up covering overlapping costs of private membership clinics, leaving public health care in Alberta worse off (Graff-McRae, 2017).

Health care privatization also has labour impacts. Chun chronicles how Hospital Employees Union (HEU) members in Vancouver combined struggles for economic redistribution and recognition in a living wage campaign. The campaign focused on HEU's private-sector workers, a minority within the union. Compared to many other union members, this group earned lower wages, and were disproportionately women of colour (Chun, 2016). Union leaders and rank-and-file members described how the multinational for-profit, private employers like food service and laundry corporations showed disregard for the welfare and livelihoods of their employees during bargaining (Chun, 2016). Reiter explains that neoliberal pressures on health care harms conditions for women health care workers, writing that "the implementation of neo liberal politics of structural adjustment globally indicates that it is women, in their capacity as both paid health care workers and unpaid health care providers, who shoulder a disproportionate share of the costs of deteriorating public support for health" (1997, p. 81). The living wage campaign served a dual role of improving pay for low-wage workers, and engaging HEU's higher-wage workers in a solidarity movement with their fellow union members (Chun, 2016). The campaign is ongoing, and it highlights how workers in privatized areas of the health care sector suffer inferior working conditions.

## 4. Diagnostic Laboratory Services

The composition of diagnostic laboratory services frequently changes in Alberta. The degree to which Alberta's labs should be privately owned and operated has been a contentious topic since at least the 1990s. Proponents of privatized labs cite lower costs as a reason to expand private, for-profit participation in diagnostic lab services (e.g. Ernst & Young, 2020, p. 117). Those who support maintaining or expanding public or non-profit owned and delivered lab services argue that private, for-profit companies have less transparency and accountability, worse turnaround times, less public input and oversight, and a profit motive that puts shareholder returns above investments in improving the universal health care system (Friends of Medicare, n.d.).

*“In 1994, the Klein government demanded a 47% decrease in private lab expenditures and a 25% decrease in public sector lab expenditures.”*

Laboratory medicine data likely influences a majority of clinical decisions, although the exact percentage of diagnoses and care decisions reliant on lab results is unclear (Hallworth, 2011). Despite only accounting for about 3.5% of health budgets, increasing demand for laboratory testing due to population growth, aging, and new tests make diagnostic lab services a ripe area for policy innovation (Health Quality Council of Alberta [HQCA], 2017). Within the context of neoliberal policymaking, experiments with cuts to diagnostic laboratory spending and with publicly delivered lab services go back to the 1990s.

In 1994, the Klein government demanded a 47% decrease in private lab expenditures and a 25% decrease in public sector lab expenditures (Fagg et al., 1999). Those cuts led to Alberta Health developing a restructuring plan, also in 1994, that included maintaining a “significant role for private laboratories” while also “maintain[ing] hospital [laboratory] services,” all the while ensuring that “service delivery [was] not micro-managed by Alberta Health” (Fagg et al., 1999, p. 80). The reduced funding for public sector labs resulted in regional health authorities having lower funding levels to provide health care, including diagnostic lab services, in their regions (Fagg et al., 1999).

In response to the cuts, Capital Health Authority's Laboratory Administration integrated the Edmonton-area labs in order to better withstand three years of cuts (Fagg et al., 1999). While the University of Alberta Hospital continued to maintain a publicly owned and operated full-service laboratory that could perform specialty testing for the health authority, other Edmonton-area hospitals converted to rapid-response labs that were privately operated. Following the 1994 cuts, private labs in Edmonton also restructured and merged into Dynacare Kasper Medical Laboratories, which was then awarded a contract by the Capital Health Authority to do most community testing (Fagg et al., 1999; Wright Jr, 2015).

All of these changes occurred over a year and a half, from December 1994 to mid-1996 (Fagg et al., 1999). A limited survey of 28 physicians, management, and staff after the restructuring showed that most felt that overall service, quality, and efficiency of lab services had remained the same or improved. However, laboratory staff perceived their situation as worse off than prior to 1994 (Fagg et al., 1999). Researchers also noted that the laboratories underestimated the need for retraining staff during and after restructuring. The restructuring also resulted in around 600 workers being laid off (Fagg et al., 1999). The researchers did not survey these workers, but presumably they did not have a positive experience of losing their job.

Church et al. outline how withdrawing funding from independent and hospital laboratories in the mid-1990s resulted in fewer Alberta labs providing microbiology services (2000). Post-restructuring, rural labs transferred microbiology analyses to Edmonton and Calgary, while hospital labs merged with private labs in the community to create high-volume, centralized, regional labs (Church et al., 2000). Restructuring resulted in a dramatic reduction in Class A labs that have dedicated technical and medical staff in microbiology testing. This is mostly because Class B and C labs (which conduct less specialized tests) that re-classified to A did not hire staff with expertise in microbiology, despite expanding their test menus to provide those complex services (Church et al., 2000). B and C labs that re-classified to A without dedicated microbiology staff had the highest error rates for organism identification and antibiotic susceptibility. After restructuring, reclassified laboratories had a similar number of errors compared to pre-restructuring, however, the overall error rate more than doubled, from around 11% to 23.5% (Church et al., 2000). Labs that maintained the same classification during restructuring decreased identification error rates from around 6% to 4%. Similarly, while antibiotic susceptibility challenge error rates decreased for all types of labs, labs that changed classification during restructuring decreased this kind of error from around 9.75% in 1993–95 to around 7% in 1996–98, and labs that did not reclassify showed error rate decreases from around 4.5% to 0.2% for the same time periods (Church et al., 2000). These findings also speak to more recent concerns from rural laboratory staff that their concerns and realities do not get represented in provincial-level decisions, and that roles and responsibilities between regional centres and big city hubs are unclear for workers (HQCA, 2017). Restructuring resulted in more resources available for routine use in larger labs, but negatively affected the performance of microbiology labs, particularly in rural services areas (Church et al., 2000).

The Ernst & Young AHS review recommends reducing staffing costs by having higher proportions of laboratory assistants relative to laboratory technicians—a higher-paid position with a larger scope of practice (2020). The review notes that AHS laboratories have varying levels of laboratory

*“There are compelling reasons to consider shifting laboratory services to public ownership and delivery.”*

assistants relative to laboratory technicians, and that standardizing the staffing mix could result in cost savings (Ernst & Young, 2020). As explored by Church et al., however, lack of staff with specialized training, like in microbiology, can compromise quality and reliability of testing due to an increase in diagnostic errors (2000).

Reminiscent of current events in 2020, when doctors are threatening to leave Alberta amidst cuts to their pay, in the mid-1990s 40% of laboratory pathologists left Alberta following cuts to their discipline (Wright Jr, 2015). These government-dictated cuts precipitated a crisis in laboratory staffing until pathologists negotiated a new compensation framework in 1998. In order to bring pathologists back to Alberta after the brain drain and to overcome the province's poor reputation, the new compensation framework made pathologists in Alberta the highest paid in Canada (Wright Jr, 2015). As doctors, including rural physicians, indicate that they cannot afford to keep their practices open in 2020, the experience of Albertan lab pathologists in the 1990s is a cautionary tale of what may be required in the future if physicians leave the province in great numbers.

## Comparing public and private labs

As an example of shifting laboratory ownership and operating models over time, Calgary Lab Services (CLS), the main laboratory for Calgary and surrounding communities, was initially majority (50.1%) private-industry owned and minority (49.9%) owned by the Calgary Regional Health Authority (Wright Jr, 2018). In 2006, the Calgary Regional Health Authority bought out the private side, and CLS became a wholly owned subsidiary of the health authority. When the regional health authorities in Alberta amalgamated to become Alberta Health Services (AHS) in 2008, CLS remained publicly owned, now as a wholly owned subsidiary of AHS (Wright Jr, 2018). Meanwhile, a private company, DynaLife, handles the majority of Edmonton and North zone diagnostic laboratory services (HQCA, 2017).

There are compelling reasons to consider shifting laboratory services to public ownership and delivery. A study in Hamilton, Ontario, indicated that if public hospitals were responsible for analyzing laboratory work collected in their communities, they could complete all daily lab work in less than four hours per day (Sutherland, 2012). These labs achieved economies of scale due to automation and had operational slack that was capable of handling community tests. Reinforcing the importance of public diagnostic laboratories, British Columbia is re-centralizing delivery of lab services to its Provincial Health Services Authority, (Ernst & Young, 2020). These models show potential benefits to increasing public and non-profit delivery of laboratory services. Relevant to all proposals, however, restructuring laboratory service delivery without mandating adequate specialist staffing increases risks of misdiagnosis. Further, retraining staff during and after

restructuring can be an unexpected source of additional costs for the organizations concerned (Church et al., 2000).

There is considerable disagreement about whether transferring ownership and delivery of diagnostic labs from the private to public sector could lead to cost savings and/or increased testing scope and capacity. While the private sector uses savings from improving efficiency and testing capacity to reward executives and shareholders, the public sector could use savings to grow the scope of tests offered (HQCA, 2017). Based on experiences in Hamilton, ON, Sutherland estimates that the Canadian health system could save at least \$250 million per year by moving publicly funded lab work from private ownership and delivery to an integrated public non-profit system (2012). Savings and efficiencies were anticipated with this change due to integrated medical records, staff, and administration (Sutherland, 2012). In August 2015, then-minister of health Sarah Hoffman announced the Government of Alberta would not move forward with further privatization of lab services, stating, “I’m of the opinion that this would have been an experiment. And I’m not prepared to experiment with people’s health and well-being” (Hussey, 2017, para. 24). Instead, the Alberta NDP government planned to phase out DynaLife’s sole contract for laboratory services in northern Alberta, with the aim of achieving provincial ownership of all labs by 2022 (Graff-McRae, 2017). A key step in meeting this goal was the so-called “SuperLab,” a multimillion-dollar laboratory facility intended to improve Alberta’s capacity to provide diagnostic laboratory services within the public system, and create jobs in the Edmonton region (HQCA, 2017).

Conversely, the Ernst & Young AHS review asserts that Alberta Precision Laboratories’ (APL, previously Alberta Public Labs, a wholly owned subsidiary of AHS) in-house testing cost more per test than those they outsourced (2020).<sup>4</sup> The Ernst & Young review recommends outsourcing APL’s testing to the private sector, for projected savings of \$102 million (2020, p 124). However, the review provided no additional information or analysis to interpret how those findings relate to Health Quality Council of Alberta’s (HQCA) determination that public diagnostic testing in Alberta is more cost-effective than private, for-profit testing. For-profit lab services also do not have the same transparency and reporting requirements that public non-profit labs do. For example, Ontario does not report on total errors or significant errors made by private labs, which are protected from having to disclose those errors since they constitute business information (Sutherland, 2012).

It is difficult to compare costs between public and private diagnostic laboratory services because their scopes and settings can be different. For instance, public hospitals do more complex and specialized tests that can require more labour. They also measure their workload differently (Sutherland, 2012). However, non-profit, publicly owned diagnostic

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<sup>4</sup> This calculation does not include APL’s specialized services, including genomics and public health testing (e.g., COVID-19 and HIV). APL currently outsources 23% of its tests to private providers (Ernst & Young, 2020).

laboratory services show some evidence that they are more cost-efficient than private, for-profit operators. Some comparisons are possible in Alberta since CLS is a wholly owned subsidiary of AHS that serves the Calgary and South zones, while DynaLife is a for-profit private company serving Edmonton and the North zone. In 2015-16, a standardized analysis showed that CLS operations were more cost effective than DynaLife's (HQCA, 2017).

Privatization and trends in other aspects of health care can also negatively impact diagnostic laboratories. For instance, the unnecessary and excessive testing that is commonplace in private clinics is still publicly insured (Graff-McRae, 2017). Outside of private membership clinics, around 16% of six common diagnostic tests in Alberta were inappropriately ordered, adding to costs associated with laboratory testing (Chami & Sweetman, 2019). An Ontario-based study by Chami & Sweetman showed that physician compensation schemes impact the number of unnecessary tests ordered (2019). Switching from a fee-for-service model (the most common physician compensation model in Alberta) to some form of a capitation model<sup>5</sup> with continuously rostered patients results in a 3–4% reduction in testing for all patients, in lab requisitions, tests, and the value of the tests ordered. A patient-centric medical practice demonstrates how improvements in continuity of care can reduce burden on the laboratory testing system (Chami & Sweetman, 2019).

## Labs and the UCP

Despite research findings that seem to show at least a cautious indication that public diagnostic laboratories produce cost savings and efficiencies, Alberta's provincial government is pursuing a pro-privatization agenda for labs. Upon its election, the UCP government promptly cancelled the planned SuperLab. In addition to building sufficient capacity to phase out DynaLife's contract for northern Alberta's laboratory services, the SuperLab would also have begun to address the infrastructure gap in Alberta's public labs. By 2017, a majority of public sector laboratory equipment was past its useful life (76% of AHS, and 59% of CLS equipment; HQCA, 2017). The SuperLab represented a significant investment in new facilities and laboratory equipment that would have played a significant part in filling that gap.

Cancelling the SuperLab and planned phaseout of DynaLife's lab contract was a plank in the UCP's platform that the new government followed through on within two months of being sworn in. Budget 2020 provides some indication of the UCP government's priorities for laboratory services in Alberta. Budget 2020 dedicates \$9 million in 2020-21 and \$6 million in 2021-22 for the Northern Laboratory Equipment Upgrade Program. The budget does not specify what facilities will benefit from this funding or explain if \$15 million over two years adequately addresses Alberta's

5 Where physicians receive a regular payment per patient enrolled in their practice, rather than per service. In reality, most capitation models have some additional forms of incentives or bonuses, including based on services ordered/provided in order to incentivize best outcomes and patient access.

laboratory infrastructure gap. Budget 2020 also asserts that some of the \$7 million in 2020-21, \$52 million in 2021-22, and \$77 million in 2022-23 allocated for upgrades and expansions at the Peter Lougheed Hospital in Calgary will go toward laboratory equipment. Budget 2020 indicates that cancelling the SuperLab cost the provincial government \$14 million in 2019-20. The Ernst & Young AHS review estimates that maximizing outsourcing of testing from APL to private labs will save a total of \$102 million (2020). Under health expenditures in Budget 2020, “Diagnostic, Therapeutic and Other Patient Services” shows anticipated overruns of \$47 million from the budgeted amount (budget: \$2,340 million; forecast: \$2,387 million), but expects that 2020-21 and 2021-22 will have lower expenditures at \$2,341 million and \$2,342 million, respectively. These funding levels are lower than the \$2,378 million spent in 2018-19. Budget 2020 does not specify how much funding laboratory services will receive. Taken together, Budget 2020 and the Ernst & Young AHS review show a desire on the part of the UCP government to divest from public laboratory infrastructure. Despite some spending on laboratory equipment at Peter Lougheed Hospital and in the Northern Laboratory Equipment Upgrade Program, cutting spending in the budget and scrapping the SuperLab represent an overall reduction in public spending on diagnostic laboratories in Alberta.

The 2017 *Provincial Plan for Integrated Laboratory Services in Alberta* report by the HQCA shows capital spending per test from AHS/Covenant Health, CLS, and DynaLife. From the 2012-13 to 2015-16 fiscal years, AHS/Covenant Health spent an average of \$0.07 per test, CLS spent an average of \$0.03 per test, and DynaLife spent an average of \$0.27 per test on capital spending on diagnostic equipment for laboratories (HQCA, 2017, p 46).<sup>6</sup> The evident disparity between publicly and privately owned laboratory spending on laboratory infrastructure reflects the aging equipment (including the percentage of equipment past useful life), and infrastructure gaps noted in the report (2017). The Ernst & Young review cites the difference between private and public laboratory infrastructure spending and concludes that outsourcing more laboratory work to the private sector, beginning with community labs, is beneficial because it avoids capital costs of upgrading (2020). The COVID-19 pandemic calls into question the wisdom of outsourcing laboratory testing and neglecting to upgrade laboratory equipment. As the public health laboratory for the province, APL handles the majority of COVID-19 tests for Alberta, a key component in managing public and individual responses to the virus. Outsourcing and selling off public lab services puts these services at risk instead of reversing the long-term impacts of austerity and budgetary restraint that led to the current state of public laboratory infrastructure.

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6 The 2017 HQCA report shows that in 2015-16, AHS and Covenant Health processed 27.7 million tests, CLS processed 28.8 million tests, and DynaLife processed 17.8 million tests (p. 27).

## 5. Home Care

Home care refers to services that are “provided in the home and community setting, that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the informal (family) caregiver” (Canadian Home Care Association, 2004, as cited in Yakerson, 2019, p. 262). The goal of home care is to keep people safe and independent in their homes to prevent health crises and transitions to more cost- and labour-intensive care settings. Home care serves three key functions: acute care substitution, long-term care substitution, and maintenance/prevention (Canadian Healthcare Association, 2009). The “home” in home care can refer to a patient’s private residence in community, or in supportive living levels 1 and 2 (residential care and lodge living) (HQCA, 2014). Some “home care” services are also delivered in community, for example in community clinics that are not acute care settings (Canadian Healthcare Association, 2009).

*“Most home care patients are older people whose conditions are stable, but who require health and personal care support in order to prevent a health decline and to stay at home.”*

Home care recipients are typically referred to as “clients” in government and research documents, a decision that is semantically problematic for expressing how home care fits into essential primary care. This report instead uses “patients,” or “people who need home care” to emphasize that home care is a health service. Alberta Health Services evaluates people who need home care services, and designates them as one of six categories: acute, rehabilitation, long-term supportive, end of life, maintenance, and wellness. In 2018-19, around 80% of home care clients were seniors, and around 72% were designated as long-term supportive or maintenance (HQCA, 2019). In other words, most home care patients are older people whose conditions are stable, but who require health and personal care support in order to prevent a health decline and to stay at home.

This has not always been the case. In 2014, most home care patients were designated as acute, meaning that they are receiving home care for a short period of time, often following surgery or an accident (the second most common category was “maintenance” patients) (HQCA, 2014). Although there is an enduring perception that home care patients are typically elderly, home care is also a cost-effective approach to short-term acute care that reduces long hospital stays. Starting in the 1990s, health authorities increased home care provisioning for short-term acute patients that resulted in a multilateral agreement in 2004 that the funding delivered through the CHA would cover two weeks of publicly funded acute home care after discharge from hospital; two weeks of short-term acute community mental health home care; and short-term end-of-life care (Canadian Healthcare Association, 2009). In other situations, home care is not an insured service under the CHA, meaning that it is at the provinces’ discretion to provide home care or not (Canadian Healthcare Association, 2009). In Alberta, home care covers palliative services, professional services (including

*“A one-day stay in the hospital can cost up to \$1,000, while a day in a long-term care facility costs around \$130, and home care costs about \$55.”*

intake, assessment, treatment, and prevention services in various forms), medication support, rehabilitation services, patient and caregiver education, personal care services, acute/short-term services post-hospitalization, and some respite care (AHS, 2017). These services are provided by AHS or contracted providers. Eligibility depends on need, as assessed by the home care caseworker in conversation with the patient and their caregivers (AHS, 2017).

Home care was a prominent topic in health policy research in the early 2000s. In 2002, the Romanow Commission recommended bringing home care under the insured services that receive health transfer funding from the federal government. The 2002 Kirby Report also had recommendations for expanding and formalizing the role home care plays in the public health system. Also in 2002, provincial, territorial, and federal governments attempted to define a standardized “basket” of home care services but were unable to reach an agreement (Canadian Healthcare Association, 2009). In the early 2000s, the number of people receiving home care services in Canada had increased from earlier decades, but a decreasing percentage of people needing home care services received them (Canadian Healthcare Association, 2009).

## Home care is health care

Many Canadians will need home care at some point in their life, for example following hospital discharge, to remain independent despite chronic disease or disability, as older adults experiencing functional decline, or for end-of-life care. The largest group of people receiving home care are older adults. In 2009, an estimated one million Canadians aged 65 or older received either formal (i.e., paid) or informal (i.e., family or friends) care (Lee, Barken, & Gonzales, 2020). The majority of caregivers are informal ones—in 2012, an estimated 5.4 million Canadians provided informal care, and 78% of them provided care for someone living at home (Lee et al., 2020). Home care is vital care—people who need home care and receive it see multiple benefits, including improved physical and psychological wellbeing, lower rates of hospitalization, and lower risk of death (Lee et al., 2020).

Home care is far less expensive for the health care system than residential care. In an op-ed for the *Canadian Medical Association Journal*, Sibbald argues for a federal elder care strategy that improves quality and cost of care partially by reducing alternative levels of care (2014). Across the continuum of care in Canada, a one-day stay in the hospital can cost up to \$1,000, while a day in a long-term care facility costs around \$130, and home care costs about \$55 (Sibbald, 2014, citing the Canadian Medical Association). When clinically appropriate, home care is cheaper to deliver, and allows people with chronic but stable conditions to stay in their homes and communities. A study of older adults in Ontario who received informal (e.g., friend or family)

*“Evidence that formal, paid care has mental and physical health benefits is an important finding given that informal caregivers provide the majority of home care in Canada.”*

home care, formal home care, and a mix of both found that those receiving formal care had higher life satisfaction, and lower levels of loneliness than those who received partially or fully informal care (Lee et al., 2020). People whose amount of care matched their needs had lower levels of perceived life stress and loneliness, and higher levels of life satisfaction (Lee et al., 2020). However, even minimal home care (less than one hour per week) led to improvements in quality of life for the study participants (Lee et al., 2020). As might be anticipated, the oldest participants (those over 75 years old) received the most care, particularly a combination of formal and informal care (Lee et al., 2020).

Interestingly, people who received only formal home care had lower levels of loneliness than other groups (Lee et al., 2020). The authors of the Ontario-based study hypothesize that in addition to forming relationships with their professional care workers, receiving formal instead of informal care meant that the patients could stay at home without feeling like they were a burden on their family (Lee et al., 2020). In this way, receiving only formal home care reinforced patients' sense of independence. Conversely, people who only received informal caregiving from friends and family may not feel like they can share their social and emotional needs with their caregivers since they are already providing (often intimate) physical help (Lee et al., 2020).

Evidence that formal, paid care has mental and physical health benefits is an important finding given that informal caregivers provide the majority of home care in Canada (Lee et al., 2020). The way that home care is currently configured assumes that informal caregivers, like family members, have the primary responsibility for elder care, and that home care merely supplements the care of informal caregivers. In other words, rather than being treated purely like a health need, home care is treated as a sort of social service that provides relief for caregivers rather than an entitlement to care (Lanoix, 2017). As I will detail in subsequent sections, this configuration is intentional, and along with low wages and attempts to keep unionization low, functions to keep home care costs down (Canadian Healthcare Association, 2009).

Like other forms of continuing care in Canada, home care services can be owned and delivered through public, non-profit, and private agencies. Depending on the province, medically necessary home care may be contracted out to non-profit or private agencies by the public health authority. Some provinces apply means testing for personal support services delivered through the home care system (Canadian Healthcare Association, 2009). In other circumstances, even when some care is publicly owned and delivered, those who can afford it hire private providers to cover services not met by the public system. Six provinces and territories have almost entirely publicly administered and delivered home care services: Saskatchewan, Manitoba, Nunavut, Northwest Territories, Quebec, and Prince Edward

Island. In Alberta, home care is typically publicly administered, and professional (e.g., nursing) services are usually publicly delivered (HQCA, 2019). Personal services like bathing and grooming assistance are typically contracted out to private providers (Canadian Healthcare Association, 2009). Canada has an example of publicly insured home care through the Veterans Independence Program. Qualifying veterans receive the basket of home care services appropriate for their needs (Lanoix, 2017).

The CHA does not define the package of programs and procedures that are “medically necessary” (Lanoix, 2017). As the experience of aging changes in Canada, there is a powerful argument for expanding insured home care services under the CHA (Lanoix, 2017). One reason to include home care as an insured service is that access to publicly funded home care is unequally distributed across Canada. Manitoba, for example, had a universal home care program until the provincial government signed two contracts with private providers for a specialized home care program in 2019 (NUPGE, 2019). Other provinces fund substantially lower levels of home and community-based care (Lanoix, 2017). Since home care enables many patients to maintain their health and is necessary for preventing decline, differential access based on where a patient lives rather than what they need is in contradiction to the principle of universality in the CHA (Lanoix, 2017).

A shift towards home- and community-based care means changing the premise underlying the Canadian health care system. Canada’s health system was primarily designed for acute care, however, a longer-living population that develops more chronic conditions over the life course means that Canadians need more access to assistance with activities of daily living to support long-term health (Lanoix, 2017). Lanoix argues that the demographic transition demands collective action, like fully insuring home care under the CHA (2017). This change would base access to home care on patient need rather than province of residence, and support a social consensus that people deserve care appropriate to their needs even as their needs increase over the course of their life, or as a chronic condition progresses (Lanoix, 2017).

## **Equity issues in home care**

The calculations for the lower cost of home care rest on some assumptions that reflect inequalities in the health system. Home care can be rationed or limited by administrators more effectively than residential care and depends on help from informal caregivers who are not actively billing the health care system. Informal caregivers can face substantial costs in the form of lost pay and lower pension contributions for their own later life (Canadian Healthcare Association, 2009). Although these costs are not reflected in the direct cost of providing home care, they affect the Canadian economy through lost productivity, job vacancies, and in costs to employers

to hire and train new workers to cover care-related vacancies (Canadian Healthcare Association, 2009). Providing partial pay to informal caregivers through programs like the Compassionate Care Benefit and employer-based caregiving benefits helps to alleviate this burden but are another form of privatization in the home care system. In these cases, essential care is contracted out or downloaded to loved ones instead of being directly provided through the health system. Secondly, home-based workers, particularly those employed by contracted private providers, make less money than their publicly employed counterparts, and therefore cost less to hire/contract. Finally, fees can be assessed in home care for things that would be free at point of service in a hospital setting (Canadian Healthcare Association, 2009).

Health expenditures are not evenly distributed across age groups. Although people aged 65 and older make up about 17% of the Canadian population, they account for about 47% of health care spending (Gibbard, 2018, p. 3). An aging population moderately increases acute care spending, and greatly increases continuing care expenses (Lanoix, 2017). While average public spending on health care for Canadians aged 64 and under is \$2,700 per year, average spending for those over 65 is \$12,000 (Gibbard, 2018, p3). Jurisdictions that rely on private providers to deliver numerous home care services through government contracts, like Alberta, introduce a profit motive into an essential health service. For private organizations, few options exist for making a profit in home care. They gain profits by serving clients with less complex and therefore cheaper needs; avoiding communities that have low volumes and high service costs (e.g., remote, rural, and Indigenous communities); paying lower wages to workers; discouraging unionization; and not providing ongoing training to workers (Canadian Healthcare Association, 2009). Home care is less expensive than acute care, and as Canada's population ages, not providing it as part of the basket of insured services can be seen as ageist (Lanoix, 2017). And, since most of the costs in home care are labour costs, saving money usually comes at the expense of working conditions that have knock-on effects for clients like late or skipped appointments and rushed care (Canadian Healthcare Association, 2009).

Another reason to include home care as an insured service is that everyone—barring fatal accident or illness—will grow old. Having home care as part of publicly insured health services supports fair access to health care since many people in later life stages require that care to thrive and survive (Lanoix, 2017). To fill the gaps between needed home care services and provided home care services, many Canadians purchase home care services from private companies. Sometimes, these services are in addition to those provided by health authorities or their contracted providers. In other cases, those who need home care but cannot get it publicly provided are left needing to purchase services out of pocket (Canadian Healthcare

*“Home care is doubly vulnerable because both the people receiving care and those delivering it are often from marginalized communities.”*

Association, 2009). Lee et al. note that patients’ use of formal home care depends not just on eligibility for publicly funded services, but also on their ability to pay for private care, and on knowledge of what resources are available to them (2020). In Canada, private spending on home care outstrips public spending on home care (Canadian Healthcare Association, 2009), however, only 17% of the participants in Lee et al.’s study relied only on formal home care, demonstrating the limited services available to many who need them (2020). The gap between publicly provided home care and required care also shows itself in the high rates of informal caregiving.

As evidenced by the wide range of home care delivery models across Canada, and the services that home care patients say they need but do not receive, home care is susceptible to the whims of policymakers and changes in government. Access to formal care is not equitably distributed (Cranford, Hick & Birdsell, 2018). For example, a lack of Indigenous home care staff, low access to home care in rural and remote communities, and low awareness of available services mean that Indigenous older adults struggle to access appropriate home care services in their communities (HQCA, 2019). To address inadequate access to culturally appropriate care, building supportive housing options in Indigenous communities could fill gaps between home care and long-term care for people who need low levels of care (Canadian Healthcare Association, 2009).

People with mental illnesses also struggle to access appropriate home care support in Canada. For people with mental illnesses, home care can reduce hospitalizations and readmissions (Canadian Healthcare Association, 2009). However, home care for people with mental illnesses can be expensive and may not produce savings for the health system. Many Canadians currently must pay out-of-pocket or through extended health insurance for most mental health services like counselling. One can assume that if more essential primary mental health care were part of universal public services, this situation would change. Until then, however, home care for mental illnesses challenges the assumption that the primary aim of public home care is saving money (Canadian Healthcare Association, 2009). This assumption persists even though home care results in improved outcomes that likely reflect a better quality of life for those whose mental illnesses have previously resulted in hospitalization.

## Home care and care work

For workers, privatized home care—whether through contracting out of publicly-insured services or through private purchase of services—has important implications for labour and for care. As noted by the Canadian Healthcare Association, home care is doubly vulnerable because both the people receiving care and those delivering it are often from marginalized communities (2009). The complex landscape of contracted-out home care

*“Privatization threatens continuity of care due to a large casual workforce, and staff changes if companies win or lose government contracts.”*

means that governments set budgets, health authorities assess patients and oversee contracts, and private providers hire workers. Since unions only represent workers in relation to management but have no direct negotiating power with governments or health authorities, fights to improve worker pay and conditions in home care can hit structural roadblocks (Cranford et al., 2018). Contracting out home care services can also have negative impacts on job satisfaction, resulting in high levels of attrition for care workers (Canadian Healthcare Association, 2009). In order to address these conditions, Cranford and colleagues argue that unions also need to push for funding increases from governments (2018).

In a 2019 survey of cognitively well seniors receiving supportive or maintenance home care, the five most important drivers of patient experience in home care were: relational care; meeting/managing client needs and expectations; scheduling; and information sharing and communication processes (HQCA). Albertan seniors receiving home care services noted that continuity of care is a driving factor in satisfaction with their home care services. Continuity of care means that providers are familiar with the care needs of patients and can help to set patients at ease during care interactions (HQCA, 2019). Due to the nature of home care (workers going to patients' homes), relationships between workers and patients can be stronger than the relationships between fellow workers or the managing agency (Cranford et al., 2018). This situation becomes further complicated by both patients and workers preferring friendly or familial-type relationships between caregivers and patients rather than professional ones. Indeed, in a study of small-town Ontario home care patients, 39% saw their home care worker as a “friend,” and 27% saw their home care worker as both a “friend” and “employee” (Cranford et al., 2018, citing Martin-Matthews, 2007). Privatization threatens continuity of care due to a large casual workforce, and staff changes if companies win or lose government contracts.

Although some patient-worker relationships can be friendly or familial, workers, many of whom are immigrants and women of colour, report frequently experiencing implicit and explicit racism at work. Black workers experienced more frequent pressure to do extra duties than white workers and felt like they were being treated like servants (Cranford et al., 2018). Workers recognized these situations as problematic, but even unionized workers did not often go to their union to report incidences of racism.

Another challenge to growing valuable and close relationships with patients is that workers found the allotted time per task designated by the health authority insufficient for safely providing quality care (Cranford et al., 2018). Despite these challenges, Cranford et al. describe how the Service Employees International Union (SEIU) mobilized their Toronto-area home care members around goals for equal compensation across home care employers,

equal pay between home care and institutional care workers, travel pay, and benefits (Cranford et al., 2018). To raise awareness and worker support, the union emphasized that they were the only entity acting specifically in the workers' interests. In the campaign, the union also explicitly linked quality care to quality work to show that these benefits for workers would have benefits for citizens. Another useful discursive tactic for addressing income security involved public campaigns highlighting the connection between wage levels at private agencies to government decisions. The union argued that since the government holds responsibility for distributing funding for home care, they should also be responsible for ensuring that workers received fair and livable wages (Cranford et al., 2018).

### **Building a better home care system**

Attaining high standards for work and care have tangible impacts on the health care system, and on those who receive care. Most home care recipients in Alberta said that home care helped them stay in their homes longer (HQCA, 2019), representing substantial savings on long-term or hospital care. Home care patients in Alberta rated their care an average of 8.3/10, indicating that these are high quality services for those who need them (HQCA, 2019). However, Albertan home care patients also expressed that they had needs unmet by their current care plan. The five most common unmet service needs were for housekeeping, grounds keeping and yard work, grocery assistance, bathing, and therapies (physio, massage, exercise, etc.) (HQCA, 2019). In particular, the patients surveyed expressed that they need bathing assistance more than one time per week (HQCA, 2019). These unmet needs show that people with chronic conditions who require support to remain at home need more than just health supports. Even with these gaps in care, support/personal care workers provide between 70% and 80% of home and community care in Canada (Canadian Healthcare Association, 2009). Help with many of the activities of daily living (like bathing and eating), and instrumental activities of daily living (like banking, and food shopping and preparation) do not require specialized health knowledge, however, the line between services considered “medically necessary” or not is blurry. Having high-quality food on hand and ready to eat, for example, enables good health, but help with grocery shopping is not a typical home care service (Lanoix, 2017). Since these services are also essential for people to live well while receiving care, Alberta Health and AHS should consider treating them as a social service and expanding access to these supports within the public system.

One challenge facing campaigns to improve working conditions in home care is haphazard alliances with patients. Unions representing home care workers recognized that racism and bad client-worker relationships presented problems for their members but had no strategy to address

them (Cranford et al., 2018). At the same time, the Ontario Caregivers' Association, an alliance of unions, service providers, and some client organizations, proved to be a useful alliance for advocating expanded access to formal home care (Cranford et al., 2018). Strengthening solidarity between patients, workers, family caregivers, and the general public to oppose exploitative care and working conditions stands as an important challenge for unions and organizers.

### Competitive bidding in home care

*“The largest challenge for conditions of care and work in home care comes from competitive bidding for home care contracts.”*

The largest challenge for conditions of care and work in home care comes from competitive bidding for home care contracts. Ontario attempted to adopt a competitive bidding process for home care service delivery contracts starting in 2001. A side effect of this process was that larger, for-profit home care service providers priced out smaller and local non-profit service providers (Yakerson, 2019; NUPGE, 2019). Large for-profit companies can afford to take a temporary loss on the expensive bidding process in order to secure lucrative long-term contracts (NUPGE, 2019). Then, similar to the pattern seen in for-profit assisted living facilities in British Columbia (Longhurst, 2020), the smaller number of remaining large home care service providers can set the cost of services, driving prices up (Yakerson, 2019).

In response to higher prices, health authorities in Ontario cut nursing hours for home care patients by 22%, and the number of homemaking hours by 30% from 2001–2003 (Yakerson, 2019). These cuts meant that fewer people received care from fewer workers, and people receiving home care experienced a reduced quality of care. For patients, the reduced quality and unreliability of the public home care system pushed patients with the financial means to buy private care, resulting in better outcomes for those who could pay than for those who could not (Yakerson, 2019). For workers, use of the competitive bidding model meant that if an agency underbid a competitor, that competitor's staff lost their job, seniority, pension, and benefits (Cranford et al., 2018). These deleterious impacts on Ontario's home care system led to a suspension of competitive bidding in 2008, and formal closure of that model in 2013 (Yakerson, 2019). While the competitive bidding model is no longer in place, employees' experiences were coloured by working through that era of home care in Ontario (Cranford et al., 2018). To remedy some of these problems, the union won a workers' registry for home care support workers that helps maintain workers' seniority and improves employment security (Cranford et al., 2018).

## Home care in Alberta

Alberta's first home care programs began in 1978 and were only for people over age 65. In 1984, home care services in Alberta expanded to include support services and palliative care (Canadian Healthcare Association, 2009). Currently, AHS contracts out about one third of home care services to private providers (Ernst & Young, 2020). More Albertans access private home care services beyond the level of care assessed by AHS.

Although all sources agree that an increasing number of Albertans access home care services, there are significant discrepancies in the reported number of home care patients. The Health Quality Council of Alberta reports that in 2018-19, around 83,000 Albertans received home care (HQCA, 2019). This population increased substantially from 2014-15, when around 73,000 Albertans received home care (HQCA, 2019). These figures show an increase of 13.6% in the number of individual Albertans receiving home care services (p. 1). The Ernst & Young AHS review lists dramatically different home care patient numbers. The report indicates that in 2016-17 there were 119,749 individual home care patients, and by 2018-19 that number increased to 127,214 patients, representing a 6.23% increase (2020, p. 64). Both sources obtained data from AHS, and neither provide enough contextual information to determine why there is a difference of over 44,000 in individual home care recipient numbers, however, Ernst & Young's numbers align with those in the AHS 2018-19 annual report (AHS, 2019, p. 10). Adding further complication to estimating the number of home care recipients and growth in demand for home care, AHS's own performance report on alternate levels of care from the third quarter of 2019 indicate a total of 117,315 unique home care patients, and a 5% increase from the third quarter of 2018 (2020, p. 9).

Like lab services, home care in Alberta saw budget cuts in the 1990s during the Klein government. Following the 2015 election, the Alberta NDP received targeted funding for home care from the federal government to the tune of \$703.2 million over 10 years. The NDP's 2017 provincial budget included a \$200 million increase to home and community care in an attempt to address increasing demand for home care over the past several years (Hussey, 2017). Health ministries and health authorities need to balance cost-effectiveness and care-effectiveness when determining what home care services to provide and to whom. It is difficult to reconcile costs, individual autonomy, quality of care, and patient safety when determining how to deliver home care services (Canadian Healthcare Association, 2009). The UCP's election platform, budgets, the Blue Ribbon Panel report, and the Ernst & Young AHS review offer some indication of how the UCP government views home care within the continuum of care in Alberta.

While the UCP platform pledged to reduce wait times for home care for Albertans with disabilities, it also indicates the UCP will expand access to self-managed care and increase funding for the Residential Access Modification Program (2019). Self-managed care is one way of privatizing home care delivery (NUPGE, 2019). Under this increasingly common model, people who need home care are given a pot of money that they can use to hire their own staff. The relatively low funding amounts available to patients mean that they must pay low wages to their care workers (NUPGE, 2019).

The Blue Ribbon Panel report also mentions home care as an area for improvement in Alberta's health care system (2019). The report notes that average Alternative Levels of Care (ALC)—meaning the number of days a patient stays at a higher level of care (typically in a hospital) than their condition requires—are higher in Alberta than in the report's comparator provinces (British Columbia, Ontario, and Quebec) (2019). Another issue identified in the report is that Alberta has higher hospitalization rates for ambulatory care sensitive conditions than the comparator provinces. The report implies that these issues indicate a failure of the health system, rather than a deficit of adequate staffing for affordable long-term care beds and home care.

Alberta Budget 2020 does not include very many clues about potential changes to home care. The budget notes that an ongoing Home Care and Mental Health Agreement with the federal government, first established in 2017-18 and continuing until 2026-27 will add \$148 million in 2020-21, \$178 million in 2021-22, and then an average of \$144 million each year from 2022-23 through 2026-27 for home care, community care, mental health and addictions infrastructure and programming (2020, p. 111). In 2018-19, home care expenditures were \$682 million. The budget for 2019-2020 was the same, but the forecasted actual was \$709 million, representing a 4% increase. Going forward, the Kenney government is budgeting \$711 million in 2020-21, \$716 million in 2021-22, and \$720 million in 2022-23 (2020, p.126). These increases amount to less than 1% per year, a rate that does not match inflation, much less the year-over-year increases in demand for home care that has outstripped year-over-year population growth since 2014-15.

The AHS review by Ernst & Young provides more guidance on potential directions the UCP government could take in home care delivery. The review notes a lack of consistent availability and delivery of home care services (2020). In particular, rural and remote Albertans may struggle to access appropriate and comprehensive home care supports. Currently, private delivery is more common in urban areas than rural and remote ones (Ernst & Young, 2020). AHS provides oversight and case management for contracted-out home care services. Professional services like nurses are also typically provided by AHS employees. Of the 48 home care contracts with private companies, about two thirds (67%) have Master Service Agreements

*“Continuity is difficult to achieve with contracting out services, where low pay and poor working conditions leads to high staff turnover.”*

(MSAs) that make them more standardized (Ernst & Young, 2020). Despite the MSAs, however, 16.5% of private providers contracted by AHS do not provide required performance data that enables effective oversight (Ernst & Young, 2020). Amongst private home care service providers contracted by AHS, 77% are accredited, and only 55% have quality improvement initiatives (Ernst & Young, 2020). Another problem noted by the Ernst & Young AHS review is that the benchmarks for home care services providers are financial in nature, and do not necessarily reflect quality patient care (2020).

The AHS review recommends addressing oversight problems by switching from financial to patient outcome and safety benchmarks when AHS assesses private home care service providers (2020). These benchmarks could relate to patient-reported outcomes, and functional measures of patient health that reflect quality of care and patient experience. The review also recommends adding these quality and safety benchmarks into accountability agreements with providers (Ernst & Young, 2020). The call to assess home care contracts by patient experience and outcomes could promote higher quality home care. However, an important indicator of quality is continuity of care (HQCA, 2019). Continuity is difficult to achieve with contracting out services, where low pay and poor working conditions leads to high staff turnover, and care contracts ending can mean that staff change frequently (Cranford et al., 2018). Although a core goal of the AHS review is finding potential cost savings for AHS and the health care system, Ernst & Young’s recommendation to optimize home care contracts is “unvalued” (2020). The review does not have estimated savings or costs for undertaking the recommended changes to home care contracts.

Ultimately, the AHS review prioritizes cheaper care. For example, recommendation 15 in the review states that “AHS should continue to strengthen its integration with primary care through the expansion of community based and home care programs to care for patients in the most appropriate setting” (Ernst & Young, 2020, p. 213). Expanding home and community care could help divert costs away from more expensive residential and acute care. While it is clear that a growing number of Albertans require high quality home care, prioritizing home care to save money could harm the ability of Albertans to access consistent, high quality, formal home care in the long term.

## 6. Telehealth

Telehealth may feel like cutting-edge technology to some, however, it has been around in various forms since the 1890s, when an American Civil War surgeon, Major Albert Myer, used telegrams to coordinate patient transportation (Henderson, 2016). In 1905, Dutch physiologist Willem Einthoven successfully transmitted electrocardiogram information over telephone wires (Henderson, 2016). Early remote health care involved telegrams, telephones, radio, and eventually closed-circuit television, but did not gain widespread use.

Telehealth refers to:

The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities (WHO, 2010, p. 9).

Across academic and popular literature, different authors use terms like “telehealth,” “telemedicine,” and “ehealth” to refer to similar technologies and programs (Ditchburn & Marshall, 2016). This report uses “telehealth” because that is the term most used by Alberta Health Services to refer to remote health care delivery involving information and communications technology. While most telehealth programs are government or hospital initiatives to address the health needs of remote patients, a more recent proliferation of telehealth apps promises to connect patients to faster and easier primary care. This report explores research on both varieties of telehealth, and their application to the Alberta context.

Telecommunications technology evolves rapidly and now permeates most aspects of daily life. However, telehealth programs have historically not scaled up or expanded in proportion to the expansion of telecommunications infrastructure (Henderson, 2016). Over the past decade, that situation began to change. Telehealth use is growing rapidly in North America. By 2016, over half of all consultations in Kaiser Permanente, the largest integrated health network in the United States, were virtual (Owens, 2018).

There are some clear benefits to telehealth: rapid access to health care professionals and reduced need to travel for care. Telehealth can be particularly useful for triaging new patients, rural and remote patients, routine prescriptions, diagnosing minor illnesses, and referrals (Ditchburn & Marshall, 2016; Blix & Jeansson, 2018). People with chronic conditions could also benefit from telehealth if it enables ongoing communication with the same care team (Ditchburn & Marshall, 2016), and telehealth for

mental health patients shows promising results from early studies (Blix & Jeansson, 2018). For patients who live far from primary or specialist care, telehealth can ensure access to high quality care without having to leave their home community (Choi et al., 2019). Of particular importance in the current context of the COVID-19 pandemic, accessing medical professionals through telehealth apps minimizes the risks of communicable disease transmission inherent to in-person care settings (Blix & Jeansson, 2018; Choi et al., 2019).

At the same time, telehealth presents similar risks as other virtual services: privacy concerns, absence of body language and other nonverbal cues in communicating, and, unique to the clinical context, inability to do some kinds of tests and diagnoses. These challenges are cause for concern because miscommunication is a leading cause of preventable clinical error, and the most preventable cause of death and disability in health settings (Krell, 2018). Some physicians express concerns that increased use of telehealth apps could result in misdiagnoses, overprescribing, and excessive use of health services (Blix & Jeansson, 2018). Physician acceptance is necessary in order to have successful implementation of telehealth (Choi et al., 2019).

Although communication and privacy concerns persist, current telehealth initiatives demonstrate that they are working well for physicians and patients. In the US, telehealth consultations show no increase in misdiagnoses, increased patient satisfaction, and longer-term outcomes that are no different from in-person health care (Owens, 2018). For physicians in the United States, telehealth interventions have a decreased risk of malpractice claims (Owens, 2018). At a more theoretical level, an expansion of telehealth globally could put pressure on health care systems to improve volume and quality of care as patients gain access to more information about symptoms and treatments (Blix & Jeansson, 2018).

## Telehealth in Alberta

In Canada, there are numerous telehealth programs that serve remote and rural communities. Every province and territory except PEI<sup>7</sup> have telehealth services that connect patients at a site in their community to specialized virtual care in larger centres. Additionally, every province and territory except Nunavut<sup>8</sup> has some form of 811 or health link service where patients can call a hotline staffed by a medical professional (often Registered Nurses) for medical advice and referral. These services are publicly provided through provincial and territorial health authorities. As an example, the Ontario Telehealth Network facilitated 390,000 consultations and avoided 260 million kilometers of travel for patients in 2014 (Webster, 2016). This program requires patients to visit a local clinic to access the telehealth services.

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7 PEI has pilot partnerships with telehealth companies Maple and Telemerge to provide limited and site-specific virtual care.

8 Although Nunavut does not have a general health advice hotline, there is a mental health hotline.

In Alberta, 37 clinical programs use telehealth (Alberta Health Services, n.d. a). Medical professionals including physicians, specialists, and registered nurses can provide telehealth. Uses for telehealth in Alberta include: new consults and assessments; discharge and transition planning; follow-up appointments; family visits; case reviews; group patient education; and peer monitoring (Alberta Health Services, n.d. b). Medical professionals can also use telemedicine to consult each other about managing a patient's care (College of Physicians & Surgeons of Alberta, 2019). Health care professionals in Alberta typically deliver telehealth via videoconference from their office or workplace—often in a large centre—with patients at an AHS site in their local community. In other words, patients receive care at a site near, but not generally in, their home. There are over 1,600 telehealth sites across Alberta, meaning that telehealth can be more accessible than some kinds of specialist care (Alberta Health Services, n.d. b).

The College of Physicians and Surgeons of Alberta (CPSA) specifies that telehealth is an appropriate choice when it is likely to facilitate a “good outcome” (CPSA, 2019). A patient outcome is “good” if it is safe, timely, effective, efficient, equitable, and patient-centred (CPSA, 2019). By these standards, telehealth can be appropriate in some interactions, and inappropriate in others, even with the same practitioner. Additionally, telehealth can be appropriate at some times, but become inappropriate if a patient does not see good outcomes from that form of care delivery. Telehealth should be only one part of a continuity of care, and the CPSA specifies some inappropriate uses of telehealth, including issuing prescriptions from online questionnaires (2019).

As noted above, real-world application of telehealth typically takes one of two forms: institutional program-based virtual care, or app-based, customer-oriented services for primary and allied care. Scholars research both, although rarely with an explicit examination of how telehealth encourages or discourages private health care delivery. I explore these tendencies over the next two sections.

## **Telehealth as an institutional program**

One case study that illuminates some opportunities for telehealth in Alberta comes from the Extension for Community Healthcare Outcomes (ECHO) project from New Mexico. The ECHO project began in 2003 to expand community-based treatment for Hepatitis-C (HCV). ECHO's model involves primary care providers facilitating specialist care to address the complex symptoms and side effects of HCV treatment through consultations with care teams at a “hub” hospital. The “hub and spoke” model expands the reach of medical knowledge and complex care management through professional development for primary care providers. Primary care physicians can prescribe and have an ongoing relationship with the patients over the course

of their treatment, however, the specialist medical expertise and complex treatment management decisions are done by remote specialists at the hub hospital (Henderson, 2016).

Unlike many other telehealth initiatives, ECHO does not do direct service delivery. Instead, the hub ECHO physicians advise the hands-on primary care doctors. ECHO provides insight on one way to handle the privacy concerns for telehealth. In consultations between hub and spoke medical professionals, and for data management purposes, the primary care “spoke” strips patient records of personal information and replaces them with a unique identifier. This model presents a challenge for billing, since specialists do not get access to patients’ personal information. To address this problem, the ECHO coordinating office can make exceptions to the privacy procedures where insurance demands proof of specialist endorsement for expensive or non-standard treatments (Henderson, 2016).

It is fairly affordable to expand the ECHO network for primary care providers. Establishing a hub cost around \$10,000 USD for technology, plus the cost of part-time dedicated IT and administrative staff. For physicians, the cost of technology to become a “spoke” was around \$6,500 USD. Although start-up costs are low, funding for ECHO and related initiatives can be ad hoc, and it is difficult to secure ongoing dedicated funding for the model (Henderson, 2016).

ECHO produces some clear benefits for doctors and patients. The ECHO initiative increased total treatment capacity and number of patients treated for HCV in New Mexico. By 2016, ECHO-style networks treated 41 conditions in six countries. There are ongoing initiatives to have an ECHO-style program for complex chronic conditions that shows improvements in patient satisfaction and reduced health care costs due to fewer expensive hospitalizations and treatments. One incentive for primary care physicians to become ECHO “spokes” is that they receive professional development credits for the specialist expertise they gain through close interactions and consultations with “hub” doctors (Henderson, 2016).

Closer to home, Bele et al. describe a pediatric telehealth initiative between the Alberta Children’s Hospital in Calgary (ACH) and the Medicine Hat Regional Hospital (Bele, Cassidy, Curran, Johnson, Saunders, Blix & Bailey, 2019). This program coordinates pediatric care between the two hospitals for Medicine Hat patients who may require tertiary care at ACH, and patients from the Medicine Hat area who are returning to their community for local care after time in hospital at ACH. This program addresses several challenges faced by both hospitals: ensuring good outcomes for patients from the Medicine Hat area at an appropriate level of care; providing continuity of care and follow-ups for pediatric patients; helping to reduce overcapacity at ACH; and maintaining pediatric expertise in Medicine Hat. The model involves

daily rounds during the week with virtual consultations between medical professionals at both hospitals, and ongoing collaboration between the two hospitals (Bele et al., 2019).

### **For-profit telehealth companies**

One study based in Sweden provides an interesting example of the challenges posed by widespread use of private telehealth apps. There are some notable similarities between the Swedish and Albertan contexts in terms of primary care provisioning. Although renowned as a social democracy with a strong safety net, Sweden has had “right to choose” legislation for over a decade, entrenching a large role for private operators within Swedish health care. In 2015, for example, 36% of net primary care costs in Sweden were for private providers (Blix & Jeansson, 2018). In Alberta, most primary care providers are private operators who bill the government for providing services that are part of the Alberta Health Care Insurance Plan. In Sweden, most primary care visits are low-cost to patients and heavily subsidized by the state. An increase in the ease and availability of primary care via telehealth presents a potential financial problem for health budgets as patients may seek care more frequently. As of 2018, only 2% of primary care visits in Sweden were through telehealth services (Blix & Jeansson, 2018). Some Swedish county health authorities reduce their remuneration to in-person care centres when patients use telemedicine. However, since Sweden has poor scores for patient experience and wait times, more Swedes may see telehealth as an easier way to get timely primary care. Even though Sweden has high rates of internet access, elderly and rural patients form a minority of telehealth users. Instead, urban parents of young children are the largest group of users (around 20% of telehealth patients are 0–6 years old) (Blix & Jeansson, 2018).

Blix and Jeansson argue that coordination and continuity are essential for improving the quality and cost-effectiveness of Swedish primary care via telehealth (2018). Relevant to the Canadian context, a lack of continuity between health jurisdictions creates artificial barriers to digital care that are incongruous with the ways people use apps. The services available to residents of different provinces, including private, for-profit services, varies greatly. Blix and Jeansson assert that digital access to medical professionals can alleviate some of the burdens on physical primary care and hospital settings (2018). Telehealth apps are a convenient and low-risk way to do simple diagnoses, prescriptions, and referrals for non-complex patients. Swedish telehealth user information shows that for populations like young children who have frequent but typically minor illnesses, access to telehealth can help ease parent concerns in a convenient and timely way. However, if digital providers cannot list their own in-person patients as telemedicine patients (as is the case in Sweden), a shift to telehealth could disrupt continuity of care, particularly for long-term patients with complex or chronic conditions (Blix & Jeansson, 2018). Although privacy concerns

*“Telehealth does not automatically reduce disparities in care between urban and rural populations.”*

are paramount, telehealth could also improve coordination of patient information, and help providers improve diagnoses.

Notably from the Swedish experience, without specific and dedicated efforts, telehealth does not automatically reduce disparities in care between urban and rural populations (Blix & Jeansson, 2018). Blix and Jeansson ultimately conclude that telehealth policymaking needs to provide incentives for medical professionals to provide good care but discourage overuse (2018). Achieving this equilibrium could involve reassessing fee structures and the legal framework for telehealth to enable continuity of care and sustainable primary care costs (Blix & Jeansson, 2018).

In Canada, many people, including some physicians, have concerns that private, for-profit telehealth apps like Akira, Dialogue/Lumino, Babylon, Maple, Livecare, GOeVisit, OnCall, MediSeen, Medeo and others violate the universality principle of the CHA (Owens, 2018), which asserts that access to health care should be based on need rather than ability to pay. Another concern is that health care professionals on apps who are not patients' regular care providers do not have access to patients' medical records, and therefore telehealth providers may not have enough information to make accurate diagnoses and prescriptions (Owens, 2018). Science journalist Paul Webster argues that if most Canadians are unwilling to pay for app-based health care because they can access free primary care in a clinic, these start-ups will not succeed, at least not without government intervention (2016). However, this calculus may be changing. Where previously, governments were unwilling to invest in expanding use of telehealth apps because they were new sources of expenses (Webster, 2016), business-friendly conservative provincial governments, extended health insurance companies, big employers, and COVID-19 may converge to grow telehealth app usage in Canada.

While some telehealth companies like Maple allow for individuals to pay per visit or get a monthly or annual subscription, equally common are companies like Akira and Dialogue that primarily cater to employers and insurance companies to be part of extended health benefits plans. These apps promise to increase employee productivity and decrease time away from work by connecting workers directly to health providers without having to leave work for appointments. The COVID-19 pandemic adds motivation for patients and providers to go online in order to avoid risking transmission. The extended health insurance provider for the University of Alberta's academic staff—including Parkland Institute—expanded Lumino, initially a health provider search tool, into a “virtual care service” powered by Dialogue Health, a private telehealth company. COVID-19 concerns feature prominently on the company's website and in the communications staff received about the new service in our extended health benefits. In these ways, telehealth apps bear some resemblance to the private membership

clinics that received considerable attention in the mid-2010s. Paid access (including from employers) to convenient care, in addition to evidence from Sweden that telehealth apps are most popular with urban patients who have more in-person primary care options, raise significant concerns about the role of telehealth apps in making primary care more accessible and equitable.

*“Paid access to convenient care, in addition to evidence from Sweden that telehealth apps are most popular with urban patients who have more in-person primary care options, raise significant concerns about the role of telehealth apps in making primary care more accessible and equitable.”*

## Telehealth and the UCP

In March 2020, a Government of Alberta press release advertised that the Babylon health app, a TELUS Health product, could “serve as a new tool for Albertans to access health-care information and support in response to COVID-19” (Government of Alberta, 19 March 2020). By the end of April 2020, Albertans found out that the provincial privacy commissioner was investigating Babylon based on two separate privacy impact assessments alleging that the app does not adequately protect Albertans’ private information.

As noted above, there are several telehealth apps that work in Alberta, both as direct-to-patient and through employer extended health benefits, and it is unclear why the UCP government decided to promote Babylon specifically. Distinct from apps like Maple, Babylon is free for patients in Alberta because TELUS has an Alternative Relationship Plan (an alternative to the fee-for-service model used for most health care services) with the provincial government. However, PurposeMed, an Albertan telehealth company, is also free for both patients and physicians and did not receive a similar boost from the government. Initial outcry about Babylon stemmed from the revelation that its physicians would receive \$38 per visit (the rate for a basic in-person appointment with a family physician) through the ARP while physicians using the normal fee-for-service billing who consulted with patients virtually could only bill \$20 per visit (e.g., CBC News, 20 March 2020). By March 25, the Government of Alberta updated virtual billing codes to align with rates for in-person visits (Canadian Healthcare Technology, 25 March 2020). In June 2020, the provincial government announced that the virtual billing codes would remain in place indefinitely (Government of Alberta, 8 June 2020).

Although recently in the news for promoting Babylon, the UCP does not prominently feature telehealth in the core documents that signal their priorities. Budget 2020, for example, does not specifically mention telehealth. However, it does note that through Alberta Innovates, the provincial government is investing in “digital health” to control health care costs, improve health outcomes, and attract investments. Telehealth is also not a core topic in the Ernst & Young AHS review, but it does identify that AHS’s 51 telehealth initiatives are “innovative” and “potentially leading” compared to peer provinces in their scope (2020, p. 100). A barrier to growing telehealth noted in the review is that information technology (IT) infrastructure

requires expanding and upgrading to reach the full potential of these programs (Ernst & Young, 2020). The report recommends reviewing and evaluating AHS's telehealth initiatives to find opportunities for consolidation, and balance rolling out initiatives with required investments (e.g., in IT infrastructure). The review also recommends making plans to scale up and mainstream telehealth projects that enable clinical improvements. Ernst & Young recommends considering changes to physician remuneration for telehealth since consultations currently need to take place in AHS facilities for physician compensation (2020). The review uses the Virtual Hospital Project in Edmonton as an example of how receiving specialized and integrated telehealth care at home or in the community shows potential for patients with chronic and complex conditions. The report also recommends using digital tools to improve access to care, and information sharing across providers (Ernst & Young, 2020). At its best, telehealth services can improve access to healthcare, particularly for rural, remote, and otherwise hard to access patients. Realizing the full benefits of these low-barrier health services, however, requires careful planning to ensure that they uphold the values of the CHA, and improve equitable access to care.

## 7. Conclusion and Recommendations

The degree to which private, for-profit entities should participate in Canada's universal health care system is an enduring subject of debate. In Alberta, Klein-era cuts in the 1990s set a stage for neoliberal cost cutting that lasted long after the Klein Progressive Conservatives. These pressures to implement cost-cutting innovations within the health care sector continue under the UCP government, and its platform, legislative activities, budgets, and commissioned reports demonstrate a consistent intention to extend and increase private participation in diagnostic laboratory services, home care, and virtual care. Privatization poses threats to ensuring equitable, accessible, universal health care. Through contracting out, individualized funding, and allowing for-profit providers into diverse areas of health care, governments set the stage for eroded pay and working conditions, infrastructure gaps, and inequitable access to health care.

Although there are mixed findings about whether publicly owned, non-profit or privately owned, for-profit diagnostic laboratories have lower costs, situations like the COVID-19 pandemic emphasize the importance of public health laboratories in health policy and emergency management. Investing in equipment upgrades and appropriate staffing mixes are essential for maintaining and expanding public health testing capacity. After a 40% funding cut over three years beginning in 1994 resulted in 40% of laboratory pathologists leaving Alberta, it took restructuring, pay increases, and years of lost physician expertise to bring these specialists back to the province (Wright Jr., 2015). As doctors threaten to close their practices and leave Alberta amid pay cuts from the UCP government, and public laboratories endure long-term infrastructure gaps, privatizing instead of investing in public delivery threatens to jeopardize the quality of Albertan health care.

In home care, the UCP government is not meeting growing demand for personal and professional services with increased funding. As Alberta's population ages, a comprehensive formal home care sector will allow more Albertans to age at home if clinically appropriate. Currently, most home care is provided informally by friends and family of those who need care, however, emerging evidence that people who receive formal home care experience better physical and psychological health outcomes emphasizes the need to increase capacity in this area (Lee et al., 2020). Informal caregiving places a great financial and emotional toll on those providing care and can also make patients feel like a burden on their loved ones (Lee et al., 2020). Contracting out home care services poses problems for administrative inefficiencies, continuity of care, late or missed appointments, and working conditions. For care workers, contracting out entrenches low pay and casual contracts instead of acknowledging the vital care provided by home care

workers with financial and job security. In order to support care workers and Albertans who require home care to manage their health conditions, Alberta's government must invest in comprehensive, publicly owned and delivered home care supports.

Addressing another facet of at-home and community-based patient care, telehealth apps and programs are likely to continue to grow in use and popularity. Within Alberta's health care system, telehealth that connects patients to care teams at a distance (but usually in AHS facilities) supports continuity of care for patients in their home communities. Telehealth apps hold appeal for employers and some patients because they enable rapid, convenient consultations that reduce time off work and exposure to communicable diseases. That being said, all virtual technologies pose privacy risks, and telehealth apps can negatively impact continuity of care, and there are associated risks of overprescribing and excessive testing (Blix & Jeansson, 2018). Early evidence about telehealth app use indicate that they do not enhance equitable access to primary care, as those who have the most access to in-person care—urban young people—also use telehealth apps the most (Blix & Jeansson, 2018). Concerns with telehealth apps closely align with the problems posed by private membership clinics and require careful consideration. In order to ensure that growing use of telehealth apps and remote care complies with the principles of the CHA, policymakers need to consider whether for-profit companies should broker virtual care, and how to support appropriate use of digital health technologies for rural and remote communities and older adults.

Workers and unions have a large role to play in combatting the negative effects of privatization and contracting-out in health care. Social union movements like those in Vancouver's living wage campaign and in the campaign to improve work conditions for private home care workers in Toronto demonstrate how building solidarity between workers can improve living and working conditions for the most vulnerable workers (Chun, 2016; Cranford et al., 2018). The fight against privatization is also a fight against eroding wages, weakened labour laws, and declining working conditions. Social union campaigns succeed when they connect all workers, including public sector, well-paid, and white workers to the challenges faced by private sector, low-wage, workers of colour (Chun, 2016; Cranford et al., 2018). Although challenging, unions stand to succeed if they find partners in patient groups and community members to support workers' campaigns for better pay and labour conditions (Cranford et al., 2018). Similarly, health care workers, should organize in solidarity with patients and families whose quality of care is threatened by fragmentation and cost-cutting.

In order to respond to the COVID-19 pandemic and future public health emergencies, Albertans need a resilient and comprehensive public health care system. While changes, like aging populations, new laboratory tests,

digital technologies, and virtual access to care pose challenges for health care funding, contracting these areas of health care out to the private sector leaves Albertans behind. For decades, successive provincial governments underfunded the health care system and the workers that make it function. Privatization exacerbates these trends by divesting from public health care infrastructure, leaving Albertans increasingly reliant on private providers for services like laboratory services, home care, and primary care delivered through apps. The legislation that the UCP government has passed to this point in its mandate leaves no room for doubt that it intends to follow through on its plans for increasing privatization of health care in Alberta. In order to support fair and equitable access to health care for everyone, the public health care system needs to be at the forefront of developments in high-quality care instead of an afterthought for policymakers.

With these considerations in mind, here are 20 recommendations to strengthen Alberta's universal health care system:

*“Privatization exacerbates these trends by divesting from public health care infrastructure, leaving Albertans increasingly reliant on private providers for services like laboratory services, home care, and primary care delivered through apps.”*

1. Improve collection of data and establish mandatory reporting for private clinics, private, for-profit diagnostic laboratory companies, home care service providers, and telehealth companies operating in Alberta.
2. Invest in improving equipment and testing capacity for Alberta Precision Laboratories in order to expand public health and specialty testing capacity. The COVID-19 pandemic highlights the critical importance of high-quality public health laboratory testing.
3. Require all diagnostic laboratory services, both public and private, to submit consistent and comparable data in order to accurately determine and compare costs. Use this data to set future policy for community laboratories.
4. Set minimum staffing levels for laboratory assistants and laboratory technicians based on industry-wide best practices that support reliable and accurate diagnoses.
5. Expand the Canada Health Act to include comprehensive home care as a publicly insured service for all Canadians. Comprehensive, publicly funded home care should also include social supports, personal care, and respite services (Canadian Health Care Association, 2009).
6. Expand public delivery of home care and long-term care. Given evidence that contracting out home care results in administrative inefficiencies, and publicly owned and operated long-term care and home care provide more and better service, the role of the private sector in this kind of care should be minimized.

7. Expand eligibility and availability of public home care services. Most home care is provided informally, by friends and families of those who need care. Since receiving formal home care supports decrease loneliness and stress for older adults (Lee et al., 2020), expanding access to these services will improve quality of life for many Albertans.
8. Expand the amount and types of care offered to eligible patients. Unmet needs and insufficient amounts of care, like assistance with errands and more frequent help bathing, indicate that expanding the kinds of care required will improve quality of life for people requiring home care (HQCA, 2019).
9. Increased home care patient complexity and needs (Yakerson, 2019) also show that improved access to publicly funded and delivered residential care options may alleviate caregiver strain and ensure that those who need care receive it in an appropriate setting.
10. As another measure to address patients' complex conditions and the health care burdens stemming from non-adherence to prescription medications, expand pharmacare to people who receive home care (similar to how long-term care residents do not have to co-pay for prescription medications) (Canadian Health care Association, 2009).
11. Proactively assess older adults for unmet care needs. In Denmark, adults aged 75 and older receive twice-yearly home visits by health care workers to note safety concerns and refer to appropriate care and supports as needed (Canadian Health Care Association, 2009). Early interventions could help older adults maintain their health for longer.
12. Expand the financial and leave supports available to informal caregivers to address longer-term needs (Canadian Health care Association, 2009).
13. Given the vital care they provide, all home care workers should receive a living wage, comprehensive benefits, and effective channels to report and address common workplace issues like racism (Lee et al., 2020; Cranford et al., 2018).
14. At the federal level, clarify interpretation of the Canada Health Act as related to private membership clinics (Graff-McRae, 2017) and telehealth.
15. At the provincial level, develop strong regulatory and oversight processes for private membership clinics (Graff-McRae, 2017) and telehealth services or apps.

16. Recognizing that as telehealth technologies will likely grow in use and popularity (both through direct-to-patient apps and as institutional programs in the public health care system), Albertans require strong assurances that their personal data is protected.
17. Policymakers must ensure that telehealth initiatives adhere to the Canada Health Act principles, and that they equitably benefit all Albertans, including rural, remote, and older people.
18. In order to support continuity of care, all Alberta physicians should be able to add and maintain their own patients on virtual care platforms in a way that complements in-person care.
19. Invest in expanding home care and telehealth options to provide care for people with mental illnesses (Canadian Health care Association, 2009; Blix & Jeansson, 2018).
20. Consider shifting physicians from a fee-for-service to some form of blended capitation compensation model. This change could reduce unnecessary lab testing, overprescribing (of particular concern for telehealth providers), and may help support patient-centred care in-person and virtually (Chami & Sweetman, 2019).

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