

This paper is intended to launch a discussion.

With it, the Alberta Liberal Caucus begins to publicly formulate its health care policy. It's only a first step, but we're confident it's a step in the right direction. We've sought the advice and insight of health care experts from across the province, and reviewed stacks of literature, research and data.

Now that we've put these ideas on the table, we're ready to talk further. In the months ahead, we will actively seek the input of other Albertans. With your help, we can further refine and expand our vision.

That vision is built around a vibrant, effective, sustainable public health care system.

Are these the right recommendations? If not, how should they be changed? What needs to be added? Are these positions supported by good evidence, as well as appealing theory?

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Summary

Section 1—Moral Issues

Canadians believe that health care should be provided on the basis of need, not on the basis of ability to pay—a principle eloquently outlined in the Canada Health Act. Alberta should rededicate itself to this goal. Our government has a moral duty to support and protect our health care system.

The government also has a duty to ensure that we have the most affordable and effective system possible. We deserve to get the best overall value for our health dollars, whether those dollars come from our tax bills or directly out of our pockets. Before undertaking any major changes to our health care system, the province must examine, with an open mind, the probable outcomes. For example, the vast weight of evidence shows that health care becomes less efficient and more expensive when left vulnerable to market forces.

Section 2—Economic Issues

Some people argue that market forces should be put to work to help create a more efficient, inexpensive and convenient health care system. Unfortunately, health care isn't simply a commodity, like fast food. In study after study, private, for-profit health care has been proven to be a poor idea. It increases costs, drives up administrative inefficiencies, creates barriers to equal access, and can threaten quality of care.

A well-managed, properly funded public health care system is clearly the best option for Alberta, now and for the future.

Section 3—Fiscal Issues

Recently, the Premier claimed that Alberta's health care spending has doubled in the past five years, and that it could soon consume half of our province's total budget. However, the latest figures from the Canadian Institute for Health Information (CIHI) don't justify those assertions. In fact, Alberta's per capita health spending is not much different from the levels of ten or fifteen years ago.

That's not to say that funding has been stable throughout that time. Since the current government came to power in 1993, health spending was slashed, then

drastically increased, and now appears to be headed for another round of cuts. Spending has been determined by the political climate, and by the whims of the global energy market, rather than by any kind of practical long-term vision. Instead of subjecting the system to unpredictable budgetary gyrations, the government should commit itself to stable, per-capita health spending, adjusted annually for inflation.

Section 4—Demographic Issues

The baby boom will not bankrupt medicare. Although it is true that health care demands will rise as our population ages, the rise will be predictable, gradual, and manageable.

If we begin to plan now, we can minimize and accommodate the health care needs of an older population. By promoting healthy aging, and exploring different ways to treat aging patients, the province can reduce the proportion of elderly people in institutions.

Section 5—Service Delivery Issues

In order to sustain and improve our health care system, we must take a comprehensive look at the way health care is delivered.

Some of that work has been done for us. For example, Alberta's Auditor General extensively criticized the Department of Health and Wellness in his 2000-2001 Annual Report, and made over 20 recommendations for improvement. In reforming our health care system, the government should begin by implementing those recommendations.

This report looks at other service delivery issues, including:

- **Regionalization**

Alberta's 17 Regional Health Authorities have helped consolidate and coordinate our health care system. However, as the regions have grown in strength, the Department of Health and Wellness has weakened. Rather than overseeing and steering the regions, the Department often ends up following their lead. Alberta needs a rejuvenated Department of Health and Wellness—one that can hold the regions to account, and provide strong, stable leadership for Alberta's health care system.

- **Continuum of care**
By putting more effort into public health and home care, we can save money overall. Public health should consistently influence the government in virtually every area of policy. Factors such as income, employment, education, environments and social services all have huge impacts on public health.
- **Workforce planning**
For years, the Alberta government hasn't adequately tracked its health care workforce. We have no way of knowing how health care workers are being utilized in the system, and no way of predicting (and preparing for) our workforce needs in the future. Better data would allow us to assess our province's long-term needs, analyze trends, and make long-term plans.
- **Scope of practice**
In Alberta, we're not making the best possible use of our medical professionals. Nurses, pharmacists, technicians, therapists and others don't have the opportunity to put all of their knowledge and abilities to work. We can reduce the burden on our doctors (and our system) by giving people more direct access to other professionals.
- **Conflicts of interest**
Our government needs to define strict, province-wide conflict of interest regulations for Regional Health Authority board members, staff, and physicians. In cases of ongoing conflict of interest, a province-wide law should require these officials to make a choice: either terminate their positions with the RHA or end their connections with the private health care company.
- **Alternative methods of payment**
Where appropriate, the province should aggressively explore alternatives to paying doctors by fee-for-service. In doing so, we shouldn't focus merely on saving money. We need to look at the best way to care for patients, and to create an atmosphere where doctors can collaborate and cooperate with other health care providers.
- **Innovative service delivery**
By examining successful models and pilot projects in Alberta and across Canada, the province can design more innovative and efficient strategies for delivering health care. For instance:
 - Alberta should open more Community Health Centres, and closely monitor and evaluate their performance.
 - Palliative care should be available throughout Alberta, without charge.
 - People should have 24-hour access to health care advice and services, to reduce overcrowding on emergency wards.

- We should develop specialized “boutique” surgical centres in hospitals, to decrease surgical waiting lists and improve efficiency and quality.
- **Pharmacare**
Prescription drug costs are among the fastest rising health expenses for provincial governments. These rising costs can represent a serious burden on people with lower incomes—who are less likely to have private insurance and more likely to get sick. Alberta should institute a more extensive pharmacare program, based on models in other Canadian provinces. By doing so, we can help curb pharmaceutical costs and ensure proper access to medications.
- **Health technology assessment**
In deciding on the best treatments for their patients, doctors must sort through a continuous barrage of new—and increasingly costly—drugs and technologies. The government, the medical profession, universities and others must develop a strategy to test and evaluate them—to determine whether new treatments are actually more effective, or merely more expensive.

SECTION 1:

Moral Issues

- **RECOMMENDATION #1:**

Alberta’s government must rededicate itself to the fundamental moral principle underlying the Canada Health Act: everyone deserves equal access to the health care they need, regardless of ability to pay.

Medicare is one of Canada’s defining achievements.

Canadians consistently point to universal health care as one of our country’s defining achievements. In Canada, we believe that health care should be provided on the basis of need, not on the basis of ability to pay.

Up until now, Alberta’s health care system has done a good job of living up to that principle. If your daughter wakes up with a high fever that won’t come down, you can take her to the doctor without worrying about the unexpected expense. If your spouse requires complex medical treatment and an extended stay in the hospital, you don’t need to re-mortgage the house. If you have a pacemaker, you don’t have to pay exorbitant insurance premiums because of your “pre-existing condition”.

“Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed.”

Justice Emmett Hall¹

In the US, the best health care goes to those who can pay.

In the United States, the best health care typically goes to the people who can afford to pay for it. Those with inadequate private health insurance—not to mention the estimated 40 million Americans with no health insurance at all—have a much harder time getting the care they need for themselves and their families.

Shortly after the Second World War, Canada took a different path. In 1947, Saskatchewan introduced our country's first universal, public hospital insurance plan. A decade later, the federal government passed the Hospital Insurance and Diagnostic Services Act, essentially giving all Canadians similar protection.

In 1968, (again following Saskatchewan's lead), the federal government passed the Medical Care Act, to cover doctors' services outside of hospitals.

The Canada Health Act, passed in 1984, replaced the two earlier pieces of legislation. It also included provisions to prevent extra-billing and user fees, in order to promote "continued access to quality health care without financial or other barriers."

Canadians value their health care system, and trust their governments to support and protect it. Alberta's Department of Health and Wellness should recognize this, and act accordingly.

- **RECOMMENDATION #2:**
Alberta's government must acknowledge its moral duty to provide effective health care in the most efficient manner possible, taking into consideration all spending on health care, both public and private.

Health care, whether publicly or privately funded, costs a lot of money. Governments have a moral duty to ensure that citizens have the most efficient, affordable and effective system possible. We deserve to get the best overall value for our health dollars, whether those dollars come from our tax bills or directly out of our pockets.

Before undertaking any major changes to our health care system, the province must examine, with an open mind, the probable outcomes.

For example, the vast weight of evidence shows that health care becomes less efficient and more expensive when left vulnerable to market forces. Therefore, it would be irresponsible to encourage more market forces and profit motives in Alberta's health care system.

Health care becomes less efficient and more expensive when left to market forces

US public sector health care spending is higher than in Canada.

Government should pursue strategies that have proven effective.

A glance south of the border confirms this:

Americans...pay more in taxes for health care [than Canadians or almost all other people in the developed world] in addition to (or despite) their massive contributions through the private sector.²

In the United States, where market influences are stronger than anywhere else, *public sector spending alone* on health care was US\$1599 per capita in 1994—\$150 more than in Canada. Meanwhile, corporations and individuals were forced to spend additional billions on doctor and hospital bills, and on private insurance. Between 37 and 41 million Americans had no health care insurance at all in 1994. Most other people (or their employers) faced substantial insurance deductibles, fees, and premiums.³ The situation is no better today.

In contrast, Canada spends fewer tax dollars on health care, and at the same time provides universal access to its citizens. Compared with the US, our system of publicly funded health care is clearly a bargain.

To preserve and improve health care in Alberta, the provincial government has an obligation to spend our tax dollars wisely. At the same time, it must avoid shifting the financial burden directly onto the shoulders of Alberta patients. It should pursue strategies that have proven effective, and reject strategies that have been shown to lead to higher costs, reduced efficiency, and reduced accessibility.

Economic Issues

- **RECOMMENDATION #3:**

Alberta's government should acknowledge that health care is not well-suited to market forces, and that factors of competition, pricing, and profit can lead to a system that is both less efficient and less fair.

The free market works well for many things. For example, let's say you're looking for a fast food meal. You can choose from a vast variety of meals—everything from hamburgers to tacos, to Szechwan beef. You're sure to find a restaurant nearby, even in the middle of the night. Service is speedy and prices are low.

Would the same principles work for our health care system? Could we put market forces to work to create a more efficient, inexpensive and convenient health system?

Those who see health care as a commodity believe so. They feel that health care belongs in the private sector, in the hands of for-profit companies competing with each other to deliver services. The market, they argue, will create an efficient, innovative, and responsive system. It will provide the greatest benefits to the most patients at the lowest cost, while simultaneously putting profits into the pockets of shareholders.

Their arguments seem persuasive, at least on the surface. However, a valid argument needs to be supported by facts.

The facts in this case point elsewhere. Private, for-profit health care has been proven to be a poor idea. The evidence is abundant, clear, and overwhelming.

Health care does not benefit from market-based reforms. Instead, for-profit competition increases costs, drives up administrative inefficiencies, creates barriers to equal access, and can threaten quality of care.

Health care does not benefit from market reforms.

Arnold Relman, a senior statesman of medicine in the US, eloquently points out the contrast between the goals of business, and the goals of health care: “In business, success is measured in terms of increasing sales volume and revenues—the last thing we want to see in the health-care system.”⁴

Reasons why private health care costs more.

Why does private health care cost more?

- Private businesses, by their very nature, work hard to maximize growth and profitability. Neither goal is compatible with reducing the demands on our health care system, or with keeping costs down.
- It takes more time and money for administrators to deal with a multitude of private insurance schemes than with a universal public plan.
- Executives, in addition to running health care facilities, must look after investor relations, marketing, corporate filings and securities requirements, and many other activities. This takes extra time and often demands specialized skills, greatly adding to administrative costs.
- Stock options and other incentives offered to executives and clinicians add expense. They also fuel a powerful vested interest, encouraging doctors and administrators to drive up the service demands in their facilities.
- Marketing—completely unnecessary in a public system—is an expensive necessity in private health care.
- Private businesses must pay income and property taxes. As well, political contributions become strategically useful.

No study has found that for-profit hospitals are less expensive.

An article in the *New England Journal of Medicine* (5 August, 1999) points out that “no peer-reviewed study has found that for-profit hospitals are less expensive.” In regions of the US where investor-owned hospitals dominate, US Medicare (the government program that provides health services to people over 65) pays more—

not only for hospital care but also for home care and care in other facilities. The article described examples of huge marketing budgets, big executive bonuses, and questionable billing practices at for-profit hospitals. It also cited several studies that found a lower standard of care at for-profit hospitals.⁵

Another study, published in the *Journal of the American Medical Association*, raised serious concerns about the quality of care in investor-owned for-profit Health Maintenance Organizations (HMOs). They concluded, “[T]he decade old experiment with market medicine is a failure. The drive for profit is compromising the quality of care, the number of uninsured persons is increasing, those with insurance are increasingly dissatisfied, bureaucracy is proliferating, and costs are again rapidly escalating.”⁶

Do these studies have any real-life relevance here in Alberta? Our experience so far shows that privatization has hurt, rather than helped the system.

The Consumers’ Association of Canada conducted a study comparing waiting lists and costs for cataract surgery in different regions of Alberta. They found that costs were highest and waiting lists longest in regions dominated by private health clinics.

Competition drove costs up, not down.

In Calgary, where all cataract surgery was done in private clinics, waiting lists averaged 16-24 weeks—even though Calgary had the most eye surgeons in the province. The most common extra charge to patients was \$400 for upgraded lenses.

In Edmonton, public hospitals performed 80 percent of cataract surgery. Waiting lists averaged five to seven weeks, and patients choosing upgraded lenses were charged \$250. In Lethbridge, where all cataract surgery was done in public hospitals, waiting lists averaged four to seven weeks, and patients received upgraded lenses for free (the regional health authority purchased them for well under \$100).⁷

Privatization has hurt Alberta’s health care system.

Why market forces don't work for health care.

Whether we look at studies in prestigious medical and economics journals, or at real-life examples here in Alberta, the conclusion is the same. Health care is not a commodity like any other.

Why don't market forces work for health care?

A theoretically perfect free market is driven by relentless self-interest. Buyers exercise their power to decide when, where, and how they spend their money. Sellers compete with each other for customers.

When the market works efficiently it benefits everyone. Buyers get low prices and quality service, and sellers make a healthy profit.

In private health care, however, the balance of knowledge and power lies in the hands of the sellers—the practitioners, administrators and investors.

When doctors talk, we listen. We're not in a position to make our own diagnoses, interpret test results, or give ourselves clinical treatment.

We need doctors to wield their knowledge and power in a way that's best for our health care needs, not only what is best for their businesses. Relentless self-interest is the last thing we want from health care providers.

Doctors also control our access to drugs, tests, specialists, and hospitals. They determine what treatments to give us, and tell us whether or not we require follow-up appointments.

Patients can't choose when and how they'll spend their health care dollars.

Competition fails in health care because it's almost impossible for patients to choose when and how they'll spend their health care dollars. You can test drive cars, try on clothes, and comparison shop for groceries. But you can't "test drive" a cancer therapy or "try on" an eye operation. If your toddler has a high fever, you don't have time to shop around for a doctor. If you have chest pains, you won't look for a hospital offering a triple coronary bypass for the price of a double.

Despite the superficial appeal of applying free market strategies to bring down health care spending, it simply doesn't work.

A well-managed, properly funded public health care system is clearly the best option for Alberta, now and for the future.

Well-managed public health care system is the best option

SECTION 3

Fiscal Issues

- **RECOMMENDATION #4:**
Alberta's government should acknowledge that health care spending in Alberta is not 'out of control'; that by reliable measures it is at about the same level as through most of the 1980s; and that Alberta's spending on health care is reasonable compared to other provinces.

Alberta's health spending is about the same as it was 15 years ago.

Let's take a big breath, and say it all together: "Health care spending in Alberta is NOT out of control." Feel better? If not, say it again.

In October 2001, the Canadian Institute for Health Information (CIHI) released its latest statistics on government health care spending in Canada.⁸ Although CIHI found that costs were indeed rising, nothing in their statistics justifies the alarmist language routinely used by Alberta's government.

By reliable measures, our province's health spending is about the same today as it was 10 or even 15 years ago. We could be doing a lot more to ensure that our health dollars are wisely spent, but there's no reason to panic.

Nevertheless, in the Legislature a few weeks following the release of the CIHI report, the Premier offered his own interpretations of the findings:

THE REPORT ACCORDING TO THE PREMIER

In constant 1992 dollars health spending in Canada has grown from about \$1,700 per person in 1992 to about \$2,200 per person today, and that's roughly a 30 percent increase in constant dollars.⁹

WHAT THE REPORT ACTUALLY SAYS

In constant 1992 dollars, per capita health care spending in Canada has grown from \$1721.58 in 1991/92 to \$1988.91 (forecast) for 2001/2002—a 15.5% increase, or about 1.5% per year.¹⁰

THE REPORT ACCORDING TO THE PREMIER

[I]f you do the math and you see the way that health care costs have gone up over the past five years, one could logically come to the conclusion that indeed it will consume up to 50 percent of the budget if we don't get things under control.¹¹

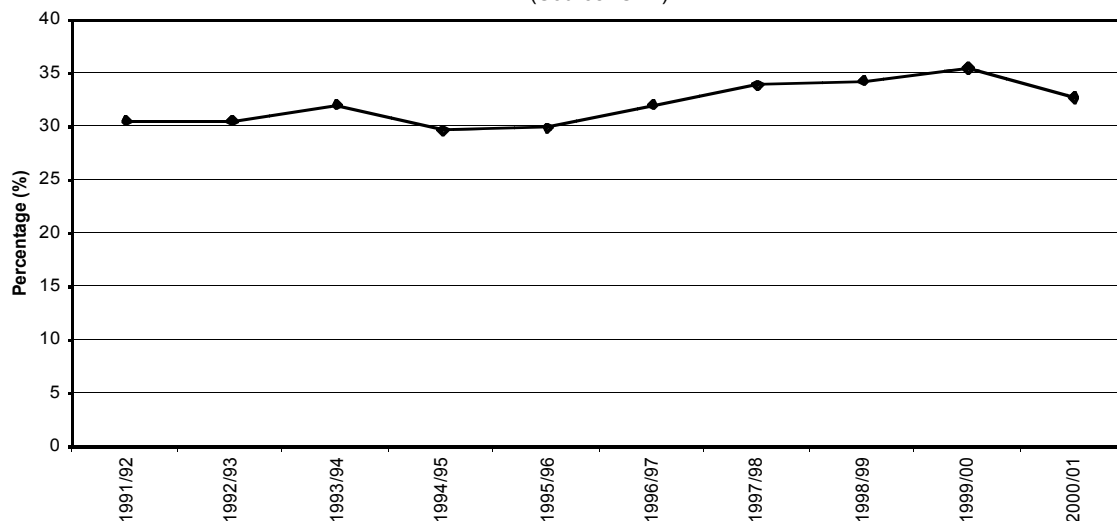
WHAT THE REPORT ACTUALLY SAYS

Five years ago, in 1995/96, health care accounted for 29.9% of Alberta's budget. Over the next four years the figures are 32.0%, 33.8%, 34.2% and 35.5%. For 2001/2002, CIHI forecasts that Alberta will spend 32.7% of its budget on health care.¹² It's hard to see how a prediction of 50% could conceivably be "logical".

Health care will not consume 50% of provincial budget.

Alberta government health spending, as a percentage of the total budget, has changed little in the past decade

(Source: CIHI)



In fact, in October 2001 the Toronto Dominion bank released its own report on provincial finances, and predicted that Alberta will spend no more than 35% of its total budget on health in the next five years.

Health care costs have not “doubled” in past five years.

In the Legislature, the Premier also insisted repeatedly (and emphatically) that Alberta’s health costs had “doubled” in the past five years.¹³ The CIHI report doesn’t come close to supporting this.

Without adjusting for inflation or population growth, Alberta’s health care spending has risen from \$3.86 billion in 1995/96 to \$6.29 billion in 2000/01—approximately a 63% increase.¹⁴

Now, let’s factor in inflation and population growth. Per capita spending, in constant dollars, has risen 35.7%, or just over one third.¹⁵ Finally, keep in mind that the 1995/96 spending figures came from the darkest depths of the health care cuts. In that year, Alberta’s per capita spending plunged lower than it had at any time since 1980/81.

Since 1992/93, per capita spending has risen about 5.5%.

Let’s go back just three more years, to 1992/93 (the year before Ralph Klein became premier). In the eight years from 1992/93 to 2000/01, per capita spending rose about 5.5% in constant dollars. That’s right: 5.5%.¹⁶

A different way to measure health care spending is to look at it as a percentage of Alberta’s total economic activity, or Gross Domestic Product. CIHI predicts that Alberta will spend 4.7% of its 2000/2001 Gross Domestic Product on health care. 15 years ago, in 1985/86, Alberta spent 4.8% of its GDP on health care. In the intervening years, the figure has been as low as 4.1% and as high as 6.0%. The average for the 15 years is 5.1%.¹⁷

In other words, the amount of the GDP that we're paying for health care has changed very little in the past 15 years.

Spending, as a percentage of Alberta's GDP, has changed very little in the past 15 years

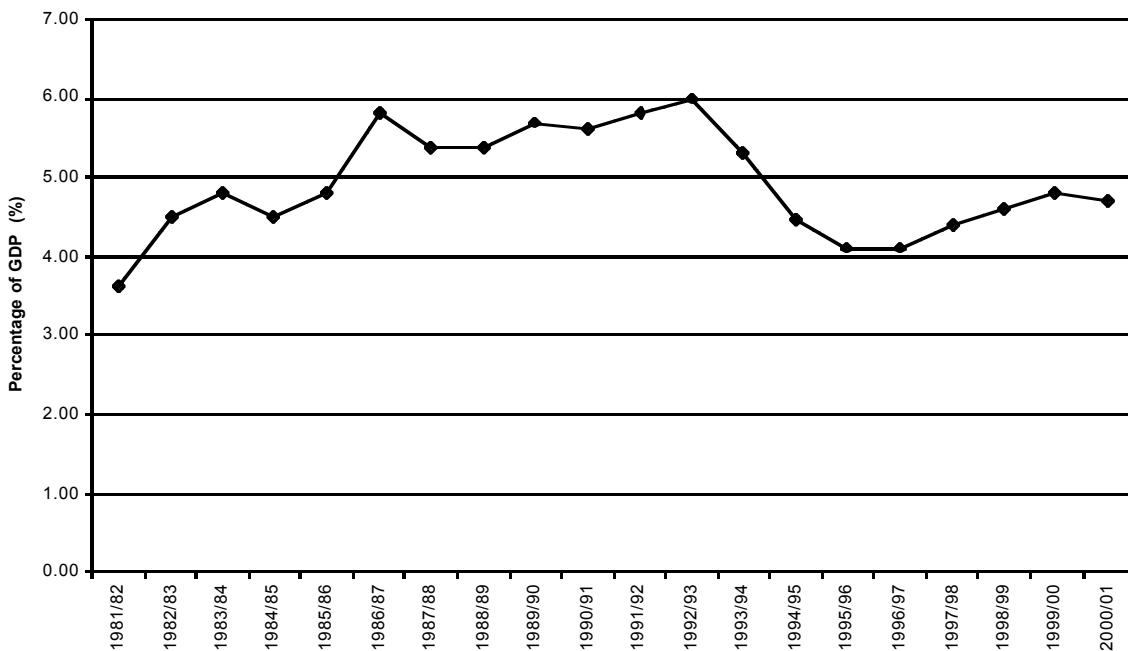
For a full decade before the current government came to power, health care spending had been carefully controlled, and remained remarkably stable. In fact, from 1983/84 until now (a period of 18 years) Alberta's health care spending (measured per capita, in constant dollars) has risen just 9.1%—about one half of one per cent annually.¹⁸

And how does Alberta's health care spending compare with that of other provinces? In 2000/01, according to CIHI, Alberta's government spent \$2081.83 per capita on health care—slightly below the national average of \$2089.42.¹⁹ As a percentage of GDP, Alberta's spending sits at 4.7—well below the national average of 6.3.²⁰

Alberta's health spending is below national average

By any reasonable, reliable measure, Alberta's health care spending is NOT out of control. The government should stop telling us otherwise.

Alberta government health spending, as a percentage of GDP, has changed little in past 20 years
(Source: CIHI)



RECOMMENDATION #5:

The government should commit to long-term stability in health care funding, adjusting for population growth, inflation, and aging.

Health care spending has fluctuated wildly since Ralph Klein became premier.

Health care spending was stable before 1993, but since then it has been anything but.

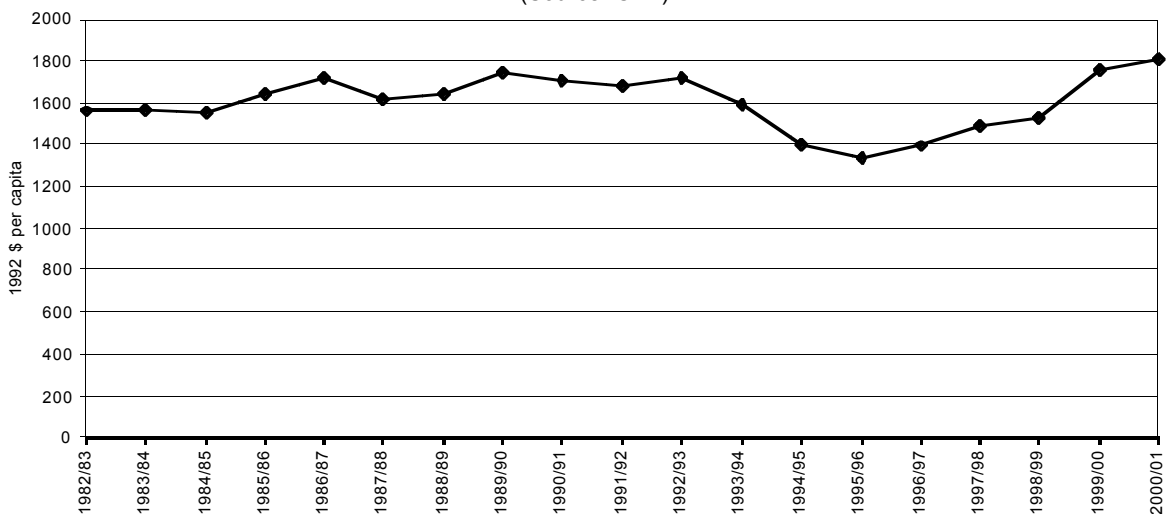
First, the Klein government slashed spending drastically—22% over the first three years (per capita spending, in constant dollars). Then, as the political backlash grew and provincial surpluses ballooned, it poured money back into the system. After an eight-year roller coaster ride, funding returned to where it started, leaving many people wondering why the cuts had been made in the first place.

These budgetary gyrations were wasteful and pointless. Massive layoffs in the mid-90s created staff shortages today. Cutbacks led to a shortage of beds and equipment, and to the deterioration of facilities.

Now, with the energy sector facing hard times, the government seems poised to take us for another plunge. Under questioning from the Opposition Health Critic

Alberta government health spending (per capita, in constant dollars) has changed little since 1982/83

(Source: CIHI)



about a tightening of the health budget announced in October, 2001, the Premier replied:

Mr. Speaker, I don't know if the hon. member is so consumed by reading his own press releases and his own musings and his own writings that he doesn't read the newspapers. I would ask him to read the newspaper today and check the price of oil. It's below \$20. The revenue situation today, as opposed to what it was even six months ago, is vastly different, and we have to make the appropriate adjustments.²¹

In other words, energy prices—not patient needs, not thought-out planning—dictate health spending policies in Alberta.

A well-planned, well-managed public health care system demands stable, long-term funding. The government must establish predictable funding levels, adjusted annually for population growth, inflation, and aging. As it is, Alberta's patients are being held hostage to the whims of the global energy market.

Energy prices dictate health spending policies.

SECTION 4

Demographic Issues

- **RECOMMENDATION #6:**

Alberta’s government should acknowledge that the aging population need not threaten Alberta’s public health care system.

The baby boom will not bankrupt medicare

Rising costs will not be unmanageable.

For years, we’ve heard variations on a worrisome theme:

The baby boomers will bankrupt medicare. When that apocalyptic population bulge reaches retirement age, they’ll need more visits to the doctor, more lengthy and costly hospital stays, and more disability assistance. The public system will not be able to stand the strain.

Again, it’s an argument that makes sense on the surface—but only on the surface. Like the other myths we’ve looked at—private hospitals are more efficient than public hospitals; greater competition will help reduce health care costs; health care spending is out of control—it doesn’t hold up to scrutiny.

Apocalyptic demography, or more generally the claim that attempting to meet the health care needs of an aging population will bankrupt modern societies, or make universal health care systems unsustainable, is a “zombie”, an idea or allegation that is intellectually dead but can never be permanently put to rest. However many times it is refuted by fact and argument, it always pops back up again to walk about, sowing confusion and making mischief.²²

It’s true that health care demands will rise as our population ages. However, there’s absolutely no reason to assume that the change will be unmanageable.

The report *Revitalizing Medicare*, prepared for the Tommy Douglas Research Institute, estimates that the

rising age of the population will only contribute about 1% per capita per year to total health spending, if age-specific use rates don't change. Most of that increase, they say, is due to the fact that seniors receive increasingly intense medical treatment: "[T]he problem is that more is being done to and for each senior, not that there are more seniors.

Some of this increase in services has been beneficial. Many older Canadians lead more independent lives because of joint replacements and eye surgery. However, many studies have documented serious problems with inappropriate servicing of the elderly.²³

The report cites studies in Saskatchewan and Manitoba, showing that many hospitalized seniors could be more appropriately cared for at home, or in long-term facilities. Other studies show that 5-10% of hospital admissions for seniors are caused by drug-related illnesses.

The report's estimate—a 1% per year increase in age-related spending—may even turn out to be too high. It's impossible to accurately forecast health care needs 20 or 30 years in the future. A recent UBC study looked at hospital bed usage in 1969, and asked an intriguing question: if health economists back then had been asked to predict the system's needs up to the year 2000, how accurate would their predictions have been?

What did they find? "A projection of use made in 1969 based on assumed constant age-specific use rates would have been not merely erroneous, but wildly so—triple the actual value...at the end of the century."²⁴

An economist in 1969 couldn't have known that hospital bed use would actually decline steadily over the next 30 years. With advances in medical technology, fewer operations require overnight stays. Patients spend less time in hospital, they recover more quickly, and they don't cost the system as much.

Based on the trends since 1969, the study's authors see no reason to expect a massive increase in health care demands as the baby boom ages. "Changes in the age

It's almost impossible to forecast health care needs 20 or 30 years in the future.

Study suggests population aging is not a major factor in rising health care costs.

structure of the overall population have not in the past been major contributors to trends in the per capita utilization of health care services, and they will not be in the future.”²⁵

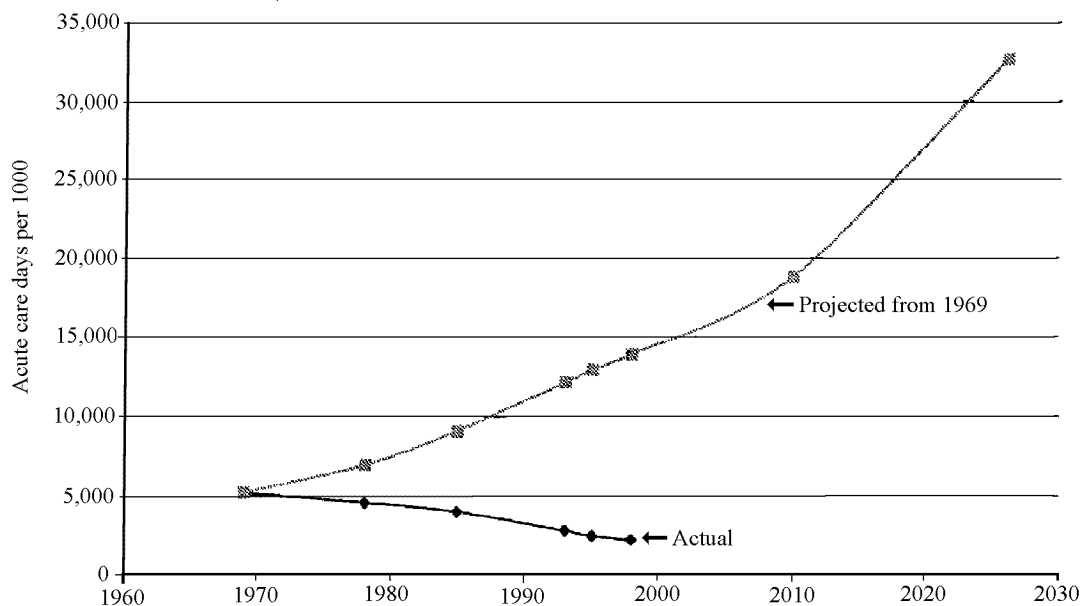
An Alberta study found much the same thing. Nursing professor Donna Wilson decided to test the theory that population aging is a major factor in rising health care costs. She examined the records of 40,000 Albertans who died in hospital between 1992 and 1997, to see how much care they required during the five years before death. She discovered that patients who were 65 years or older when they died received fewer high-cost medical procedures than those in any other age group.

Patients aged one to 19, for example, received an average of 3.5 expensive hospital treatments in the five years before they died. Patients aged 20 to 64 received an average of 2.0 expensive treatments before they died. Patients aged 65 to 89 received only 1.6, while those over 90 received 0.9.²⁶

The baby boom won't break medicare. In fact, with proper management, public health care will only improve with age

BC: Acute care hospital days, actual and projected from 1969, for ages 65+

Source: "Apocalypse No"



- **RECOMMENDATION #7:**
Alberta’s government should begin planning now to minimize and accommodate the health care needs of an older population.

We’ve established that an aging population will not have an apocalyptic effect on our health care system. The system will face some extra costs, but with proper planning these can be kept to a minimum.

Fortunately, we have plenty of time to prepare. The oldest baby boomers turn 65 in 2010, and those born in 1959 (the peak of the baby boom) won’t retire until 2024.

In their report, “Understanding Canada’s Health Care Costs” (Aug. 2000), the Provincial and Territorial Ministers of Health estimated that population aging would account for a 0.8 per cent rise in Canadian health care spending in 2000/01. Over the next 25 years, they predicted that figure to rise only to about 1.3 per cent.²⁷

In other words, the baby boom is a glacier, not an avalanche.

By promoting healthier aging, the government can slow that glacier to a virtual standstill. As the UBC study shows, we’re already seeing a drop in hospital bed use, as the elderly live longer, healthier lives. “Acute care rates among the population over 65 have been cut roughly in half since 1969....”²⁸ Fewer people suffer from chronic illness and disability reducing the demand for long-term care.

At the same time, the government can explore different ways to treat elderly patients. By properly supporting and promoting home care, for instance, the province can reduce the number of elderly people in institutions.

We can already see examples of this principle in action. In Edmonton, the Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) has helped hundreds of seniors stay out of hospital. In addition to

We have plenty of time to prepare.

Government should promote healthier aging.

monitoring patients' health, CHOICE promotes proper nutrition and exercise, and also gives seniors a place to socialize.

- **RECOMMENDATION #8:**
Alberta's government should promote awareness of personal directives in the same manner they do for organ donations.

Personal directives can remove a burden from our families.

In addition to providing new programs and facilities, as a society we must become more comfortable with the topic of death. When aggressive medical treatment is no longer helpful, or even kind, people should be given the opportunity to die with comfort, compassion and dignity.

Alberta's Personal Directives Act gives us the right to leave instructions to our family and our health providers in case we lose the ability to make decisions for ourselves. Among other things, a personal directive can specify what medical treatments we wish to receive and where we want to live. It can also assign an agent, or agents, to make personal decisions on our behalf.

If we make our wishes known, we avoid forcing others to make choices—possibly the wrong choices—for us.

As our population ages, the importance of this issue grows steadily. Although the Act has been law for over four years, many Albertans still don't know about personal directives. Governments need to do more to promote them.

SECTION 5

Service Delivery Issues

- **RECOMMENDATION #9:**
The Minister of Health and Wellness should implement the recommendations of the Auditor General's 2000-2001 report.

Is the provincial government doing all it can to ensure that our health care dollars are being spent wisely?

According to Auditor General Peter Valentine, the answer is a clear “No.” In his 2000-2001 Annual Report, Valentine reserves special criticism for the Department of Health and Wellness:

[T]he Department continually spends more money on our health care system without knowing the value of that extra spending. The primary risk for the Department, regional health authorities, and physicians is that costs will escalate but results won't improve.²⁹

The Report makes over 20 clearly defined recommendations for improving the way Alberta manages and tracks its health care spending. Valentine points out that he has been reporting many of the same problems for years now, without an adequate response.

These findings and my recommendations are not new. ...I do not believe that management ignores my audits and recommendations. Management agrees with recommendations and tries to implement them. However, progress is unsatisfactory.³⁰

Instead of seeking “solutions” outside of our public health care system, the Minister of Health and Wellness should implement the strategies that are already on the table. A special task force should be struck in the Department, to deal specifically with the Auditor General's recommendations.

Auditor General critical of Department of Health and Wellness.

So far, the Auditor General's advice has not been followed.

- **RECOMMENDATION #10:**

Alberta’s government should review and evaluate regionalization, with particular focus on the relationship between the regions and the Department of Health and Wellness, and the capacity of the Department to hold the regions to account.

Department of Health and Wellness has lost much of its capacity.

In many ways, Alberta’s 17 Regional Health Authorities have helped to consolidate and coordinate our health care system. However, regionalization has also brought new problems.

As the strength of the regions has grown in the past eight years, the capacity of the Department of Health and Wellness has shrunk. The Department’s workforce was cut by more than half in the 1990s. No fewer than seven Deputy Ministers took turns running the Department between 1993 and 2001. The same period saw widespread turnover of senior and middle management. As a result, the Department has struggled with weak leadership, and a loss of corporate memory.

There is a widespread perception that the Department operates as an ‘ad hoc’ system, responding to external pressures more than setting directions of its own. For instance, the Department often has no choice but to bend to the will of the regional authorities. If Calgary’s health authority runs a large deficit, the province consistently tops up the funding to compensate. “[S]upplementary funding is commonly used and one-time funding is now chronic,” says the Auditor General. He continues:

The principle that we follow as individuals, of managing within the resources we have, does not seem to apply. Health authorities spend money before their business plans are approved and the Department is not doing enough to measure and report the quality and cost of health services.³¹

The Department is no longer able to hold the regions to account.

The Department must be able to hold the regions to account. Before regionalization, the Department monitored and rated all hospitals through the Hospital

Performance Index (HPI). Although the Index had problems of its own, at least it represented a level of accountability.

Without adequate data, there's no way to evaluate and compare the performance of the regional health authorities, or to help them plan for the future. The province needs to create a system to continually gather and analyze data from the regions.

Accountability is of central importance to the health care system of Alberta. Accountability is about the setting of expectations, measuring results and costs, and taking action to improve results. It is key to achieving cost-effective use of resources and dealing with increasing demands for service.³²

The Department may no longer have the organizational resources—technical and management staff, information, experience, attitude—to steer Alberta's health care system. This is potentially a profound problem, given the scale of spending on health care by the provincial government and the impact of the system on people's lives. It cuts to the heart of the concerns of the Auditor-General.

Alberta needs a renewed Department of Health and Wellness—one that can hold the regions to account, and provide strong, stable leadership for Alberta's health care system.

The Department may no longer be able to steer Alberta's health care system.

- **RECOMMENDATION #11:**
Alberta's government should explore ways to balance the continuum of care in our province, by placing a greater emphasis on home care and public health.

What's the most direct way to decrease spending on hospitals? Reduce the number of hospital patients. By putting more effort into public health and home care, we can save a lot of money overall.

Public health should consistently influence government agenda.

We need to do more to keep our population healthy. Public health should consistently influence the government in virtually every area of policy. Factors such as income, employment, education, environments and social services all have huge impacts on public health.

In December, 1996, Health Canada presented a groundbreaking document on precisely this topic. “Population Health Promotion” combines two ideas—health promotion (“a process for enabling people to take control over and improve their health”) and population health (“an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population”). The authors, Nancy Hamilton and Tariq Bhatti, have built a model for generating specific strategies for improving health.³³

By working with the Health Promotion Development Division, and putting the Population Health Promotion model to work, the province could explore ways to keep us healthy—and out of hospitals.

Alberta should also keep a close eye on public health initiatives in other provinces, such as Ontario’s recent decision to provide free flu shots to all its citizens.

When people do become sick, injured or frail, we must give them the support they need to stay out of hospital, unless hospitalization is the only appropriate course of treatment. We don’t want people to remain in acute care simply because they can’t afford to look after themselves at home.

Clearly, a public health care system can’t thrive without well-financed, well-managed hospitals. As a society, however, we should see active treatment as a last resort.

- **RECOMMENDATION #12:**
Alberta’s government should do a better job of planning to ensure an adequate health care workforce.

For years, the Alberta government hasn’t adequately tracked its health care workforce. If we don’t know how

many doctors, nurses, and other workers are being used in the system, there's no way to plan for the future.

For example, there is a common concern over a growing shortage of physicians. If we're short on physicians, is it because we have overloaded them with responsibilities that could be better handled by others? Is it because too few are being trained? Is it because of the larger proportion of women physicians, who are more likely to take time away from medicine for personal and family reasons? With the proper data, we could answer these questions.

In addition, as the average age of the health care workforce rises, we face a surge in retirements in the next decade. While there have been recent increases in positions for students of nursing, medicine, and other health professions, it isn't clear that these increases properly anticipate future demands.

At the same time, not enough information is being gathered on the province-wide health of our population. Better data would allow us to assess our province's long-term needs, analyze trends, and make long-term plans to accommodate them.

Better data would help us plan for the future.

- **RECOMMENDATION #13:**
Alberta's government should act quickly to ensure that all health care professionals can fully utilize their training and expertise.

In Alberta, we're not making the best possible use of our medical professionals. Nurses, pharmacists, technicians, therapists and others don't have the opportunity to put all of their knowledge and abilities to work. We can reduce the burden on our doctors (and our system) by giving people more direct access to other professionals.

Under the current system, virtually every facet of acute care has to go through a physician. This includes such things as regular blood work for chronic illness, physiotherapy for clients with disabilities or handicaps that require a life adjustment, diabetic teaching and

Albertans should have more direct access to health professionals.

Doctors should only be consulted when medically necessary.

follow-up, even century tub baths for the elderly or infirm.

It makes no sense to insert a physician into the process unless it's medically necessary. It creates an extra trip for the patient, an extra task for the doctor, and an extra bill for our health care system. At the same time, it robs other medical professionals of the trust, responsibility and appreciation they've earned through years of training.

We need to understand the full potential of all professional staff, and then adjust our system in order to capitalize on that potential. At the same time, we should reduce our reliance on physicians as gatekeepers. By doing so, we can make our health care system more efficient, and more affordable.

- **RECOMMENDATION #14:**
Alberta's government should define strict, province-wide conflict of interest regulations for Regional Health Authority board members, medical staff, and physicians.

Concerns expressed about conflicts of interest in regional health authorities.

It's a basic premise of good government: people entrusted with spending public funds must not benefit directly from how those funds are spent. The private interest of a public official should never interfere—or be perceived to interfere—with the public interest he or she is hired to serve.

When that happens, it's called a conflict of interest.

It's a serious concern, and one that's been repeatedly expressed about Alberta's regional health authorities, especially the Calgary Health Region. The Calgary Health Region awards surgical contracts to corporations closely tied to regional department heads or, in one case, a Senior Vice President of the Region. Many people feel that these contracts represent apparent or potential conflicts of interest, and that the Calgary Health Region's integrity could be compromised.

Alberta's Auditor General and the Calgary Health Region itself acknowledge that these conflicts exist. However,

they merely require the officials in question to declare their conflict, and to avoid a direct role in making decisions on those matters.

That's not good enough. In cases of ongoing conflict of interest, a province-wide law should require these officials to make a choice: either terminate their positions with the RHA or end their connections with the private health care company.

This is a common approach in most public and private sector organizations. There's no reason not to expect our RHAs to live up to the same standards.

- **RECOMMENDATION #15:**
Alberta's government should aggressively explore alternative methods of payment for Alberta's doctors, and reduce our reliance on fee-for-service billing.

Most doctors are paid by fee-for-service—that is, they bill a specific amount for each procedure they do, regardless of how long it takes. In some health care fields, fee-for-service may well be the most sensible and efficient system. For many doctors, however, there may be better alternatives.

Should we consider paying salaries to some doctors? Should we use a “capitation” formula, where doctors are paid a set amount of funding for each patient they care for?

It's time for the government to closely examine its options in this area. It should look at models that are already up and running here and elsewhere in Canada, and actively encourage similar experiments throughout Alberta.

Whatever method of payment we choose, we shouldn't focus merely on saving money. We need to look at the best way to care for patients, and to create an atmosphere where doctors can collaborate and cooperate with other health care providers. We must also ensure that doctors

There are alternatives to fee-for-service.

Cost should not be our only concern.

are compensated fairly (and competitively) for the services they provide.

Our country needs more success stories like the one in Marathon, Ontario (population 5000):

The town ... formed the Marathon Physician Crisis Coalition and asked the provincial government to establish a group practice and fund the doctors on a non-fee-for-service basis that would provide a lifestyle and practice patterns less likely to cause burn-out. Within a year, Marathon had recruited six full-time physicians and was able to resume obstetrics and emergency coverage.³⁴

When the right balance is struck, everyone comes out a winner. Patients gain better access to medical care, doctors reduce their stress levels and increase their job satisfaction, and the system saves money.

- **RECOMMENDATION #16:**
Alberta's government should actively support more innovative, efficient and effective ways of delivering health care—based on successful models and pilot projects already operating in Alberta and Canada.

Community Health Centres

Primary health care—a patient's first level of contact with the system—plays a fundamental role in maintaining a healthy population. Unless patients have easy, reliable access to health services in their communities, small problems can quickly become big ones. Unfortunately, access is not always easy.

Many family doctors don't accept new patients.

For example, a recent survey of family doctors in Edmonton's Capital Health Region found that only 31% routinely accept new patients, and another 38% only accept them under certain circumstances. The remaining 31% don't accept new patients at all. Patients who do have family doctors face longer waits when they book basic appointments.³⁵

Since the early 1970s, governments and provincial medical associations have been evaluating new ways of delivering primary health care.

In Quebec, 146 *centres locaux de services communautaires* (CLSCs) serve specific geographic populations. CLSCs are open nights and weekends. Along with family health services, the centres also integrate mental health, home care, public health, and a provincial telephone health advice line. Some centres, especially in rural areas, work closely with hospital and long-term care facilities. They also cooperate with police and municipal governments to address social issues that affect health.^{36 37}

Ontario currently has 66 community health centres (CHCs), similar to Quebec's CLSCs, and is considering expanding the network further. Ontario's Minister of Health recently called the CHCs an integral part of health reform in that province.^{38 39}

Alberta has three CHCs of its own—the Boyle McCauley Health Centre in Edmonton, the Alexandra Health Centre in Calgary, and the Calgary Urban Project Society. Manitoba and Saskatchewan also have several CHCs.

Early studies suggest that CHCs may cost less than fee-for-service, and in some cases provide better care.^{40 41 42}

⁴³Alberta should open more Community Health Centres, and closely monitor and evaluate their performance.

Palliative Care

[A]llowing people to die outside an acute care facility can provide more dignity for the patient, as well as better symptom control. It also spares the acute care system the temptation, some might say obligation, of providing high-technology, high cost acute care to people who need only effective symptom control, comfort and compassion.⁴⁴

Palliative care programs have been gradually developing in Alberta for many years. They provide care to terminally ill patients and their families, including pain control and

Community Health Centres work well in Quebec and Ontario.

Palliative care is proving valuable in Alberta.

Palliative care patients should not be charged.

social and pastoral support. Palliative care can be provided in specialized facilities or at home, depending on circumstances. Unfortunately palliative care is not available across Alberta, and is not regarded as a core service of regional health authorities.

These services are remarkably valuable in responding to the needs and fears of patients and their loved ones when facing the prospect of death. By improving availability and public awareness of palliative care, we can help individuals—and our society as a whole—to accept death as a natural part of life.

In addition, palliative care patients must pay money for services that are provided free to acute care patients. This may stem from the historical view that palliative care is a form of long-term care. However, most patients today spend only a few weeks, or even a few days, in palliative care.

On grounds of compassion, palliative care should be provided without patient charges. It should also be deemed a core health care service, available in every region of Alberta.

Emergency Wards

People need convenient alternatives to emergency wards.

Long delays in emergency wards are frustrating for the public, and an irritant to the health care system. They stem from at least two underlying problems: unnecessary visits to emergency wards, and slow transfers of patients out of emergency wards.

It is common to hear concerns that people ‘abuse’ emergency wards by visiting them with minor ailments. Certainly a large portion of emergency patients do not have life-threatening problems. However, very few people visit emergency wards without any cause. People often go there when there is no reasonable alternative, especially after hours.

Many patients ... come to ER because there is nowhere else to go. These patients do not need

hospitalization or most of the sophisticated services available in ER. Rather, they may only need a telephone call, or other services that could be provided in a clinic setting. However, there is often no choice. The only service available, particularly after regular hours, is too often the local hospital emergency department.⁴⁵

Innovations like the Capital Health Link in Edmonton help reduce unnecessary emergency visits, by giving people information and alternatives. Fortunately, this kind of service is gradually being extended across the province.

Providing 24-hour community health centres could also stream people away from emergency wards and into more appropriate services. By giving people simple, convenient and less costly options, we can substantially reduce overcrowded emergency wards.

We should also continue to look closely at very focussed preventive programs. For example, aggressive flu vaccination campaigns appear to have reduced emergency room demands in Calgary and Edmonton.

With the very tight supply of acute care beds in Alberta it is now normal for many emergency wards to house patients for 24 to 72 hours while they wait for a space in the hospital. This is not the purpose of emergency wards and is not good patient treatment. In part it reflects the exceedingly low ratio of active treatment beds to the population of Alberta, a problem made worse by the number of long-term patients occupying these beds while awaiting transfer to long-term care centres. We must take aggressive action to reduce this problem.

Surgical waiting lists

Although we often read about them in the media, reports of long waiting lists are notoriously unreliable and easy to manipulate. For instance, a patient might decide to book knee surgery for the summer, when it's more convenient.

Innovations can ease burden on emergency wards.

For-profit clinics will likely increase waiting lists for many patients.

The clinic, in turn, could say, “We’ve got patients waiting until July.”

That said, waiting lists are certainly a problem in some areas. We must find ways to bring them under control.

It’s unlikely that the solution lies in encouraging regional health authorities to contract services to for-profit providers. In fact, the decision in the fall of 2001 to allow for-profit clinics to conduct major procedures such as total hip and knee replacements will probably *increase* waiting lists for many patients.

Why? For-profit providers will attract surgeons, anesthetists, nurses and other staff (already in short supply) away from the public system. However, the for-profit providers will only be licensed for uncomplicated cases; the complicated cases will remain in the public system. With fewer staff in the public system, the waiting lists for complicated cases will grow.

This should be a particular concern for seniors. Many of the complications (e.g. diabetes, heart conditions, previous surgery for the same condition) are more likely among older patients. Waiting lists for young, healthy patients—such as recreational athletes with injured knees—might get shorter. But waiting lists for those who need care the most will get longer, and the most expensive and difficult cases will be concentrated in the public system.

“Boutique” surgical centres represent a better solution.

A better response to surgical waiting lists is to create highly specialized surgical centres *within* the public system. These ‘boutique’ centres could treat all cases, and would have the full support of the public hospital immediately at hand, including blood services, ICUs, diagnostics, lab, inventory, and so on. Orthopedic centres of this type are already well-established in some major public hospitals and function extremely efficiently.

- **RECOMMENDATION #17:**
Alberta should institute a more extensive public pharmacare program, based on models in other Canadian provinces, to help curb rapidly rising pharmaceutical costs and to ensure proper access to medications.

Prescription drug costs are among the fastest rising health expenses for provincial governments. In Alberta, costs have more than doubled in the past ten years—from about \$74 per Albertan in 1991/92 to about \$158 today.⁴⁶

These rising costs can represent a serious burden on people with lower incomes—who are less likely to have private insurance and more likely to get sick.

In 1997, the National Forum on Health Care—an expert panel of health care researchers and professionals—recommended a national pharmacare program. They argued that prescription drugs are just as medically necessary as doctor and hospital services, and should be treated as such. For instance, they saw no logical reason why drugs that are covered in hospitals are not covered when the patients go home.

The Forum recommended universal “first dollar coverage”—with no deductibles (where coverage only kicks in after patients have paid some initial costs) or co-payments (where patients pay for a percentage of each prescription). To pay for the program, they suggested expanding doctor payments to include prescription drugs.

^{47 48 49}

Alberta’s public drug plan currently covers only a portion of the population, such as seniors or people on social assistance.⁵⁰

Five provinces—B.C., Saskatchewan, Manitoba, Ontario and Quebec—already have universal prescription drug plans that cover the general population under age 65.⁵¹ However, all of these have deductibles and co-payments. Some (like Quebec) involve both public and private insurers, which increases administrative costs and diminishes the buying power that could be achieved with a single payer system (the government).⁵²

Prescription drug costs can be a serious burden.

B.C. has lowest combined public/private drug cost in Canada.

B.C. has Canada's most comprehensive universal pharmacare system, and also has the lowest combined public/private cost in Canada (\$285 per person in 2000).^{53 54}

How does B.C. keep costs down? The province's "reference drug" program allows the government to comparison shop for the most effective drug at the lowest price. If several drugs work equally well, only the least expensive one is covered (unless there's a medical reason why a patient needs a more expensive drug).⁵⁵ This program has saved B.C. \$44 million a year since 1995.⁵⁶ B.C. also has a central, secure computer database through which all pharmacies and emergency departments can check a person's prescription history—so pharmacists can avoid duplication and assess possible interactions with other drugs.

Even under B.C.'s public plan, however, drug costs continue to rise. A national purchasing plan—or at least more co-operation among the provinces in purchasing drugs—would allow bulk buying of drugs and more consistent coverage across provinces. As a province with a reputation for concerns about cost controls, Alberta could take the lead on this issue.

We can reduce our reliance on prescription drugs.

We can also keep pharmacare costs down simply by reducing our reliance on prescription drugs. We should put more emphasis on disease prevention and health promotion. We should do a better job of discouraging inappropriate, ineffective (and potentially harmful) drug use, such as prescribing antibiotics to treat viral infections. At the same time, we should address other issues—such as poverty, low education, unhealthy environment—that can create health problems.^{57 58}

After evaluating models in other provinces, and taking steps to keep costs to a minimum, Alberta should look for ways to extend prescription drug coverage to all its citizens.

- **RECOMMENDATION #18:**
Alberta should work more actively, in cooperation with Ottawa and the other provinces, to test and evaluate new drugs and medical technologies.

In deciding on the best treatments for their patients, doctors must sort through a continuous barrage of new—and increasingly costly—drugs and technologies.

The government, the medical profession, universities and others must explore ways to help doctors decide whether new treatments are actually more effective, or merely more expensive. Where cheaper, older methods work equally well, we need to steer doctors in that direction.

One option, among many, is to give Alberta's Health Technology Assessment Unit the resources it needs to do this job, and encourage it to work more closely with Ottawa and the other provinces.

Conclusion

Now that we've put these ideas on the table, we're ready to talk further. In the months ahead, we will actively seek the input of other Albertans. With your help, we can further refine and expand our vision.

That vision is built around a vibrant, effective, sustainable public health care system.

Are these the right recommendations? If not, how should they be changed? What needs to be added? Are these positions supported by good evidence, as well as appealing theory?

Contact us with your thoughts and questions:

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Reading List

Care to explore these issues further? Here are a few places to begin. Some of these articles and studies may be downloaded for free from the Internet.

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By R.G. Evans et al.
Centre for Health Services and Policy Research, University of British Columbia, 2001.
May be ordered (\$2) at www.chspr.ubc.ca/hpru
- **“Revitalizing medicare: Shared problems, public solutions.”**
By Michael Rachlis et al..
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By Kevin Taft and Gillian Steward
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By Nancy Hamilton and Tariq Bhatti
Health Canada, 1996.
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- **Preliminary Provincial and Territorial Government Health Expenditure Estimates 1974/75 to 2001/2002.**
Canadian Institute for Health Information, 2001.
Available for free download at ecomm.cihi.ca
- **Public Bodies, Private Interests: Surgical Contracts and Conflict of Interest at the Calgary Regional Health Authority**
By Gillian Steward
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