Ralph Klein's "third way" program – an analysis

CUPE National
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Alberta Premier Ralph Klein and Minister of Health and Wellness Iris Evans announced their "third way" changes to health care on July 12, 2005. Titled *Moving Ahead With Better Health Care*, the 11-page package outlined 12 actions.

The "third way" program has some positive elements, but these are overshadowed by its privatization agenda. The most alarming step is the approval of hospital user fees for "enhanced medical goods and services". Key points from the Alberta government's plan are identified in the boxes, followed by a brief analysis.

Action 8: Make changes to legislation and regulations

Step 1: Change regulations

- Changes in regulations recently enacted allow Albertans to use private insurance to pay for podiatry and chiropractic services beyond what is covered by the provincial health plan.
- As of September, health authorities will be able to charge patients for special accommodations (beyond the standard room) and for "enhanced medical good and services beyond what doctors decide is medically necessary – for example, a special kind of hip replacement."

Step 2: Consider a new Health Care Assurance Act for Alberta

- The new Act would consolidate 39 different provincial laws and over 100 regulations that apply to health care. It could:
- Establish "reasonable waiting time" and "care guarantees";
- Include "principles to guide the system";
- Commit to "reasonable access to medically necessary, basic medicare services" that would be covered by the provincial health plan, and define "which services could be covered by private insurance";
- Set standards, guidelines, protocols and best practices.

Comments

The Alberta government has invited regional health authorities to charge user fees for medical services. It is creating a legal framework to define the health care services that will be covered by public insurance, freeing everything else for the insurance industry. Klein and his government characterize publicly insured services as "basic" and the services opened up to private payment as "non-essential", in order to allay fears of two-

tier medicine. They also packaged user fees for medical care such as hip surgery – something groundbreaking - with fees for accommodation upgrades – something that has existed for years. Charging patients for new and improved technology or procedures such as the Birmingham hip resurfacing is clearly a violation of the equality of access principle in the Canada Health Act. Packaging this with user fees for private rooms obscures the magnitude of the change.

The principles for a new Alberta health care act might include "reasonable access". Together with the proposed care guarantee, this could be used to justify overriding the principle of equality of access in the *Canada Health Act*.

"Standards, guidelines and best practices" are a step forward if they are developed and monitored by an independent body of medical providers, health policy analysts, ethicists and public interest groups for the purpose of strengthening the public health care system. On the other hand, Alberta would set Medicare back if it follows the United Kingdom model of performance contracts. In the UK, rigid standards have skewed health care planning priorities, added another layer of administration, and destabilized the public system. They were developed as part of health reforms that favoured the private sector. Given the Alberta government's inclination to two-tier health care, this might well be their chosen model.

British Columbia's model of "performance agreements" is another one to avoid. The agreements tie the compensation of health authority chief executive officers to performance goals. The most specific and concrete target in the B.C. agreements is reduction in spending on support and administrative services. Since those agreements were implemented, health authorities have privatized 8,500 jobs and intensively cut services in many areas. Remaining workers had their wages cut by 15 percent while chief executive officers receive fat bonuses for making cuts beyond the targets. Ontario's Bill 8 contains "accountability and performance agreements" which may follow the same path.

If the Alberta government is genuinely interested in improving accountability and adherence with best practices, it will use democratic processes aimed at strengthening the public health care system. Quality standards and guidelines for health care must be developed by providers, patients and community groups working with government. Administrators and providers must be accountable to the local communities they serve, not to cost-cutting targets set from above. There is no place for private industry involvement or goals and processes aimed at service cuts and privatization.

Action 1: Put an overall health policy in place.

- By January 2006, the provincial government will announce a Health Services Plan developed by health boards. It will "identify what health services Albertans can expect to receive, how quickly, and where.
- Develop a Public Health Strategic Plan.
- Develop and implement a Provincial Research Strategy. Promote Alberta's health sector as a significant provincial economic driver.

Comments

The Health Services Plan seems to complement the regulatory changes in Action 8, most notably the definition of "medically necessary services" and the care guarantee.

The Public Health Strategic Plan could be positive, but it might instead blame individuals for health problems rather than dealing with the systemic causes and proposing community solutions.
The research strategy looks like an economic development rather than a public health strategy, promoting no doubt private over public investment in health research. This usually means more biomedical and pharmaceutical research rather than research on health determinants, public health, and primary care.

Action 2: Improve access and efficiency

Expand the Alberta Waitlist Registry information on waiting times for key treatments and services.

Expand on a recent pilot project to centralize booking for surgeries and diagnostic procedures, to speed up access.

Comments

On the surface, better management of waitlists and health information seems like a positive reform. However, in the context of the government's privatization strategy, the waitlist registry and pilot projects are superficial. To deal with waitlist pressures, the government needs to invest substantially in the public health care system rather than make regional health authorities entrepreneurs competing for private health dollars.

Already, the proliferation of private clinics in Alberta is draining resources from the public system and lengthening waiting lists. Evidence from the United Kingdom, France and within Canada demonstrates that adding more private health care draws doctors, nurses and other medical personnel away from the public system. If Alberta genuinely wants to address wait times, it will stop licensing private clinics and focus on public solutions.

Action 3: Get serious about wellness and injury prevention

- Awards for employers who promote healthy workplaces.
- Healthy U campaign with added focus on healthy eating and physical activity for young children.
- Make booster seats for children mandatory.
- Promote injury prevention at home. Send every household information on health care costs and what people can do to stay healthy.
- Launch new strategy on HIV, Hepatitis and sexually transmitted diseases.
- Study tax and other incentives to promote healthy living.
- New immunization strategy for children.
- Proclaim Smoke Free Places Act by January 2006.

Comments

The government is exclusively focussed on individual solutions and individual responsibility for health problems and health costs. Certainly, government programs should empower individuals to look after their health. Support to individuals must, however, be part of a broader health promotion strategy that deals with root causes and empowers communities to create healthy environments. Without community-wide programs and social policy changes, this wellness campaign looks like a decoy.

Giving households information on health costs and "wellness" ideas is part of the right wing strategy to make Canadians blame themselves and each other for health problems, rather than looking at structural factors like poverty, racism, and inadequate housing. Focussing on individual health conditions also draws attention away from the bigger costs drivers such as pharmaceutical drugs and medical supplies and equipment. Tax breaks for fitness club memberships, private rehab programs and vitamin purchases will only benefit the well-to-do.

Creating tax incentives or waving health premiums for citizens who demonstrate a healthy lifestyle also creates a new layer of administration. The resources it would take to set up the system and carry out the monitoring and accounting could be better used by investing in health promotion, community development, and chronic care programs that will truly help Albertans improve their health.

Awards to employers will likely be limited to fitness and wellness programs. They will not deal with the larger problems of workplace hazards and injuries, which have increased with deregulation and privatization. Alberta recently lowered the age limit for children able to work without guardian consent, which will likely lead to more injuries and deaths of young workers.

Action 9 – Control spiralling drug costs and increase coverage

- Consider consolidating provincial drug subsidy programs and purchasing drugs centrally.
- By October and with other provinces and the federal government, launch a national framework for expensive drugs for rare diseases. Coordinate drug research, reviews and approvals – costs shared with drug companies.
- By Fall 2005, begin to study alternative models for Alberta pharmacare program, including an "insurance approach that would extend coverage to more Albertans and adjust how much people pay depending on their incomes"
- By April 2007, work with neighbouring provinces to establish a western Canadian consortium for bulk purchasing of drugs.

Comments

Bulk purchasing - by government departments and public agencies within Alberta, and potentially by western provinces as a group - is one of the positive elements of this package.

The "national framework for expensive drugs for rare diseases" is not defined. If this applies to drug coverage, it is an even more narrow definition of pharmacare than

catastrophic drug coverage, which has been floated in national discussions. What we in fact need is a national drug plan that is publicly funded and administered and that provides first-dollar coverage for first-line therapeutic treatments.

Costs would be controlled by a national evidence-based formulary and reference-based pricing in addition to bulk purchasing. Reform of patent legislation to end "evergreening" and other patent extensions is also necessary to reign in drug costs.

The proposal to coordinate on drug research and approvals between the federal government, provinces and drug companies is a major step backwards. Allowing corporate-oriented provincial governments a bigger role in national drug reviews and approvals is risky, and certainly formalizing the interests of drug companies by having them outright fund the process would undermine our drug safety system. Already drug approvals and regulation are overly influenced by the industry. This proposal would officially sanction their influence.

Action 10 – Improve quality in long term care

- Average care hours per resident have been increased from 3.1 to 3.4 per day.
- By Fall 2005, announce new standards for accommodation and care in long term care centres, based on the MLA task force currently underway.
- By January 2006, complete an actuarial study on continuing care insurance.

Comments

Increasing the minimum resident care hours is a long-overdue change. Understaffing in long-term care facilities has caused excessive rates of injury and illness for both residents and workers. Other changes are also urgently needed. The Auditor General's May report found substandard care in one third of facilities across Alberta. Half of the facilities did ensure that seniors receive an annual physician exam.

The emphasis on private insurance for continuing care suggests that the government has already decided not to increase funding for long-term care or improve standards and public delivery.

Action 6 – Implement an electronic health record for all Albertans

- electronic access to diagnostic imaging and lab test results
- online information from pharmacies on drugs dispensed
- high speed connection for rural health care providers

Comments

Better information sharing between health providers is positive, but will the information system be kept in the public health care system? The British Columbia Liberal government last year privatized its Medical Services Plan and Pharmacare databases, and it is now accepting bids for its nurse information line. Bidding is down to two American-owned multinational corporations, and concerns about privacy are uppermost. Under the U.S. Patriot Act, agencies like the FBI and CIA have access to confidential

medical records handled by American companies.

Action 7 – Primary Health Care

- Launch nine local primary care networks in Fall 2005, with a bigger emphasis on multidisciplinary teams.
- With the federal government, begin training for the networks on interdisciplinary practice and chronic disease management.

Comments

This direction is one of the positive elements in the 12-point plan. Primary care pilots date back a number of years, to one-time federal primary care funding of the late 1990s. The best model would be community health centres, which offer a wide range of health care and social service, community development and health promotion programs, with providers working as a team and paid on salary. Community health centres are governed by boards that are accountable to their local community.

Expanding group primary care practices of physicians, nurse practitioners, pharmacists and other medical providers is also a positive change.

Other Actions:

Action 4 – Children's Health (coverage of prescription drugs for Crohn's disease and MS for children under 18, education on crystal meth, ten-year "healthy kids" strategy with focus on diabetes and fetal alcohol spectrum disorder)

Action 5 – Mental Health ($25 million over three years for mental health services, including telehealth, community extension teams, day and community support programs, and better linkages with hospitals)

Action 11 – Supply of health care providers (recruit and train in rural communities, recruit aboriginal students, focus on scope of practice principles to achieve cost effectiveness, bring all regulated health professionals under one act)

Action 12 – Rural Communities (expand access to mental health services, telehealth, home and community care, and primary health care)

Comments

These actions appear to be positive changes. Of particular interest to CUPE is the commitment to increase the participation of aboriginal people in health disciplines, if this extends to our members' occupations. The Saskatchewan CUPE health care council has negotiated "representative workforce" agreements that may be of interest. Also positive is the plan to do away with the separate regulation of different health professions (and the competition and fragmentation this fosters), and the apparent commitment to use providers to full scope of practice.

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