



United Nurses of Alberta

Submission on the
Minister's Advisory Committee on Health Report
A Foundation for Alberta's Health System

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Introduction

The United Nurses of Alberta (UNA) is the union representing approximately 24,000 of Alberta's Registered Nurses, Registered Psychiatric Nurses, student nurses, mental health and other health workers. UNA members provide care in a wide range of settings including acute care hospitals, rehabilitation centres, long-term care facilities, urgent care centres, home care and community programs and public and mental health programs.

Nurses' top concern is always the safety and good care of our patients, clients or residents. Appropriate resources and conditions of work are necessary to ensure this quality care and UNA has a long history of advocacy aimed at improving nursing workplaces and Alberta's health care delivery. We welcome the opportunity to bring our front line perspective to the discussion of proposed changes to health care legislation and, more broadly, the future of health care in Alberta.

Overview

In the document *A Foundation for Alberta's Health System*, the Minister's Advisory Committee on Health (MACH) argues that "Alberta needs clarity of purpose and direction for the health system."¹ The solution proposed in this document is the development of a legislative framework that would not have an immediate impact on health care delivery in the province but rather "set the tone and direction of regulations, policies and best practices" in the future.² In fact the document specifically advises the reader not to focus on policy and practice but on the overarching "principles and intent" of the proposed legislation.³

¹ Report of the Minister's Advisory Committee on Health. *A Foundation for Alberta's Health System — A New Legislative Framework for Health*, January 20, 2010, p. 6

² Ibid, p. 6

³ Ibid, p. 5

The document then goes on to describe a number of concrete goals for the proposed legislative framework. These include establishing an independent entity charged both with “informing”⁴ decisions about what services would be adopted as part of health care delivery in Alberta and “assessing” whether these services would or would not be publicly funded⁵; defining consistent terminology across future legislation (an example offered in the document of a term needing definition is “publicly funded services”) and consolidating much of Alberta’s health legislation into the new proposed *Alberta Health Act*.⁶ The MACH report argues that the five acts which address publicly funded health services are priorities for consolidation: *Health Care Insurance Act*; *Hospitals Act*; *Nursing Homes Act*; *Health Care Protection Act*; and *Health Insurance Premium Act*.

Based on past and current trends in the organization, management and funding of health care in the province, UNA is concerned about the direction of the government’s plan for health care delivery and payment in Alberta. In regard to the foundational principles referred to in the document, our foremost concern is that the principles and intent articulated do not fully represent the values Albertans hold on health care. Core beliefs about the importance of “public service” oriented care organizations and values in the delivery of health care are missing from the document and the conversations that have emerged since its release.

Furthermore UNA holds that a focus on principles and intent without adequate discussion of the policies and practices that could follow from these principles significantly hinders the opportunity for Albertans to engage in open and democratic debate on the future of health care in our province.

What is missing from the proposed legislation?

Surveys conducted over the past decade have consistently shown that Canadians across the country see publicly funded universal health care as one of the distinguishing features of life in

⁴ Ibid, p. 21

⁵ Ibid, p. 23

⁶ Ibid, p. 18

Canada.⁷ They support the concept of a nationally and publicly-funded system that provides universal coverage and medical care on the basis of need and identify health care as their most valued social program.^{8 9}

However not all Albertans may be aware that Canada's health care system is profoundly decentralized. Due to the division of powers in the Canadian Constitution, Canada's national health insurance program is in reality, a collection of multiple programs administered by each province or territory and bound together through their obligations to provide programs that meet a certain minimal criteria in order to obtain contributions from the federal treasury. The role the federal government plays is to enshrine in federal law the five core principles of the *Canada Health Act*: administration of health care insurance plans by a public authority; comprehensiveness of coverage for all insured health services; universality — uniform terms and conditions for entitlement to health services; portability of coverage across jurisdictions; and the assurance that access to insured services will not be directly or indirectly impeded by extra billing charges.

We are dependent on our provincial government to enact the policies that ensure that our system of universal health coverage continues. Using a narrow interpretation of the *Canada Health Act*, it can be argued that Alberta's existing health legislation currently exceeds the basic requirements. Therefore the promise in the MACH report that the *minimum* requirements of the *Canada Health Act* would be met in a new health act does not necessarily ensure that the *current* level of universal health care in the province will be continued. Without embedding the principles underlying the *Canada Health Act* in the proposed act, Albertans cannot be assured of ongoing universal and accessible publicly managed health care.

⁷ Matthew Mendalohn, *Canadians' Thoughts on their Health Care System: Preserving the Model Through Innovations*, (Saskatoon, Commission on the Future of Health Care in Canada, 2002), p. vii

⁸ Stuart N. Soroka, *Canadian Perceptions of the Health Care System*, (Toronto: Health Council of Canada 2007) p.5.

⁹ Armine Yalnizyan, *Getting Better Health Care; Lessons from (and for) Canada*, (Ottawa: Canadian Centre for Policy Alternatives 2004) p.1.

What are the risks associated with consolidating current legislation?

The MACH report characterizes components of current legislation as “complex and cumbersome”¹⁰ arguing they “inhibit the system’s ability to work out effective ways to access care from the right provider, in the right place, at the right time and at the right cost.”¹¹

However it is the current *Alberta Health Care Insurance Plan Act* that limits the evolution of a private pay system in Alberta by banning private insurance payment for publicly insured medical services and disallowing extra billing to patients over and above the amount paid by Medicare. Similarly, the *Alberta Hospitals Act* bans private insurance and user fees for publicly insured hospital services and the *Health Care Protection Act* limits the scope of services available at privately run non-hospital surgical facilities as well as their ability to sell extra services. Finally it is the regulations associated with *Nursing Homes Act* that include ratios for nursing staff and protect quality of care.

In short, Albertans depend on the protections and regulations associated with these particular acts to shape our public health system. It is unclear what the intent of the MACH report is when it recommends consolidation of the current legislation. Are these acts to be subsumed by the proposed new framework legislation and addressed only in regulations? Or are they to be replaced by other acts at some point in the future? Most importantly, what would future legislation look like and how can the public be expected to provide meaningful feedback on consolidation of existing legislation without access to drafts of legislation?

While UNA recognizes that rationalization of legislation could in principle have positive outcomes, the following two questions need to be addressed: 1) would future legislation ensure that the universality, quality and comprehensiveness of our present system of publicly insured health care organization and delivery continue; and 2) what would replace these pieces of legislation?

¹⁰ Report of the Minister’s Advisory Committee on Health. *A Foundation for Alberta’s Health System — A New Legislative Framework for Health*, January 20, 2010, p. 6

¹¹ Ibid, p. 18

Finally, in regard to the MACH report's stated rationale for consolidation — the difficulty accessing appropriate care — an important question must be raised. Is it the current legislation that hinders access to care, or is it lack of funding to health services and infrastructure that inhibits access to effective care?

Do the proposed foundational principles provide adequate direction for future policy making?

Given the lack of specific detail currently available in the MACH report, a reader naturally turns for direction to the proposed foundational principles for legislation. The MACH report proposes that five principles be included in framework legislation that would provide the direction necessary to guide future health care system decision-making: put people and their families at the centre of their health care; be committed to quality and safety; ensure equitable access to timely care; make use of the best available evidence in decision-making; be focused on health and wellness and public health and; foster a culture of trust and respect.

Some, like the commitment to quality and safety, are principles that most Albertans already assume to be core values of their health care system and of the professionals who deliver that care. Others, although they may initially strike the reader as straightforward, are contentious issues with which health systems and judicial systems nation-wide, have been struggling over the past decade.

What would be the implications of a commitment to the principle of “equitable access to timely care” particularly in the absence of an explicit commitment to the principles of universality and accessibility? In Alberta alone, proposed definitions of “equitable access” have varied considerably over the past decade. These proposed definitions have ranged from: — suggesting that individuals should not be denied basic service if unable to pay, but that those who can pay should; — to suggesting that those who assume greater health risks should contribute more to the costs of the health care system; — and finally to holding to what many would argue was the original intent of the *Canada Health Act*, namely that all Albertans should be assured of all appropriate health services regardless of individual characteristics, and without payment.

The question of timely care has also arisen repeatedly over the past decade. Driven by judicial decisions as well as funding from the *2004 Federal Provincial Accord*, benchmarks have been developed, indicators for public reporting arrived at and reductions in wait times achieved for certain priority areas. Nonetheless, in light of the proposed legislation, what would be the implications of including the principle of “equitable access to timely care” in a legislative framework? If wait times for a publicly funded procedure were to be deemed too lengthy, would that mean the province would then be “obligated” to ensure that parallel privately funded services are available? How would “timely” be defined? And who or what body would be making the decision about appropriate wait times.

Although the MACH report begins with a call to “clarity of purpose and direction” one is left with more questions than answers about the direction the government intends to take.

How will decisions about publicly insured services be made in future and who will make them?

The MACH report recommends that an arms-length entity be established which would inform decisions about services, practices and policies in Alberta’s health system. Governed by an independent board, this entity would be charged with ensuring that “key healthcare decisions are based upon best evidence”.¹² Additionally, the report proposes that this entity would make use of the expertise and resources already existing within the health system and Alberta universities and institutions and would base its recommendations on “evidence-based decision-making.”

However, MACH does not elaborate further on the nature of this decision-making process. Medical effectiveness is not necessarily synonymous with the effectiveness of solutions or processes that can be successfully applied in particular contexts. Nor are either of these definitions of effectiveness synonymous with the views, expertise or realities of stakeholders.¹³ Furthermore the deliberative processes necessary to combine these types of evidence and arrive at policy decisions are anything but straightforward or self-explanatory.

¹² Ibid, p. 22

¹³ Jonathan Lomas et al., *Conceptualizing and Combining Evidence for Health System Guidance* (Ottawa: Canadian Health Services Research Foundation, 2005) p.5

The question of “who” would play significant roles in this new entity is particularly relevant. The health care decisions this new arms-length entity would be asked to address under the current proposal are far-reaching in scope ranging from assessing and analyzing research on pharmaceuticals, new health technologies, and clinical procedures to examining findings on optimal funding models, and decisions around the health system workforce structures and processes.¹⁴ Not only would this arms-length entity be responsible for “informing” health care decision-making it would also be charged with assessing whether the examined “technologies, clinical services, practices and processes are ... to be publicly funded.”¹⁵

Public health care is generally defined as “all medically necessary services” and Albertans fully expect the public system to provide just that, a full spectrum of health services. Would this “arms-length” entity be used to reduce services provided in the public system? Would the public system be reduced to “basic services” a term mentioned in the report?¹⁶ Would this process leave newer technologies or processes, or the latest most effective treatments to be provided by private health care that some Albertans could afford but others not?

The MACH report speaks of plans to engage the public in discussion and debate, seek public input, and make use of existing institutional expertise and resources and all these goals are to be applauded. However UNA holds that policy development and analysis is central to effective government and should not be left to an “arms-length” entity. Governments should be answerable directly to the public for their policy and decisions; any other process compromises transparency and accountability.

What might Alberta’s health care system look like in the future?

What might health care in Alberta look like in the absence of an explicit commitment to the foundational principles of universal health care and without the specific protections afforded publicly insured services through current legislative statutes? What might it look like in the

¹⁴ Report of the Minister’s Advisory Committee on Health. *A Foundation for Alberta’s Health System — A New Legislative Framework for Health*, January 20, 2010, p. 22

¹⁵ Ibid, p. 23

¹⁶ Ibid, p. 1

absence of a single government entity directly accountable to its citizens for its decision? What might it look like in the absence of clearly articulated policy directions that have been subjected to public scrutiny and debate?

Unfortunately, the argument can be made that in many regards such a system might bear some resemblance to the current state of continuing care in Alberta. The costs of continuing care are, by and large, borne by individuals or their families. There is some support available for individuals who are unable to pay and whose income is low enough to allow them to qualify for general income support programs, but this approach would not satisfy the criteria of universality or accessibility. Responsibility for the fastest growing sector of continuing care services in Alberta, the supportive living sector, is shared among more than one ministry, making it more challenging to achieve transparency and accountability. Alberta Health and Wellness assumes responsibility for the delivery of what is deemed medically required “personal care” services (e.g. a weekly bath, delivery of medication, meal assistance, dressing changes) and the Ministry of Seniors and Community Support is responsible for legislation and regulations around what are termed “hospitality and accommodation services” (accommodation, meals, fire regulations etc.). Finally, many of the costs associated with continuing care are unregulated making it a fast growing market for private providers and private insurers.

This was not always the case. When the components of what is now the *Canada Health Act* were first introduced, the vast majority of medically required services were in fact, provided within hospital premises or by physicians in the community. However during the late 1980s and 1990s, drastic cuts in hospital capacity led to patients being discharged sicker and quicker or not admitted at all. Once out of the realm of “hospital care,” universal public coverage of services formerly provided in hospitals, such as nursing care and physiotherapy to support recuperation and rehabilitation, were lost. Health care services were deemed to be publicly insurable as much by virtue of the setting in which they were delivered as due to the fact that they were medically required — ironically, a situation now lamented in the MACH report.

Over the past two decades we have seen a marked shift: many patients who were once cared for in hospital settings are now being cared for in long term care facilities and individuals who once may have qualified for long term care have been shifted to supportive living spaces.

What's in a name? The charge of \$54.25 per day for a private room in a long-term care facility covers the cost of medical supplies and equipment as well as prescription and non-prescription medications and medically required transportation. By way of contrast, costs for "hospitality and accommodation" services in supportive living spaces vary widely as do the costs associated with any "personal care" above what is assessed as medically required. Additionally, the costs of medical supplies and equipment, as well as prescription and non-prescription medications and medically required transportation devolve directly to the resident.

Expenses associated with supportive living are far less predictable and controllable than those associated with long term care facilities. Furthermore arranging for access to services, medication and supplies, and dealing with a number of providers and private insurers requires a significant degree of effort, coordination and planning on the part of those who are already facing chronic and often debilitating illnesses.

Finally, access to nursing services is also a key difference between long-term care beds and supportive living spaces. A resident of the highest level of supportive living (Designated Assisted Living) is eligible for no more hours of registered nursing care than an individual living at home who qualifies for community nursing support from the community care nurse.

Despite the fact that Alberta's population grew by 22% between 1996 and 2006, the actual numbers of long-term beds in nursing homes and auxiliary hospitals did not increase in the first decade of the twenty-first century.¹⁷ ¹⁸ Today only the most seriously disabled and high needs adults (old and young) are admitted to a limited number of traditional long-term care facilities (nursing homes and auxiliary hospitals) and individuals and their families are increasingly directed to supported living spaces.

The MACH report has suggested that in order to have the "right provider providing the right care in the right time",¹⁹ "cumbersome and complex" legislation and regulations must be

¹⁷Stats Canada <<http://www12.statcan.ca/english/census96/data/popdwell/Table.cfm?T=101>>, <<http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/hlt/97550/Index.cfm?TPL=P1C&Page=RETR&LANG=Eng&T=101>>

¹⁸ Health Care '99: A Guide to Health Care in Alberta (Edmonton: Alberta Health and Wellness) p.22

¹⁹ Report of the Minister's Advisory Committee on Health. *A Foundation for Alberta's Health System — A New Legislative Framework for Health*, January 20, 2010, p. 19

removed and/or consolidated.²⁰ The continuing care system in Alberta provides a sobering scenario of the changes to health care that can evolve in the absence of these “obstacles” to health care delivery. What has emerged is an increasingly fragmented and privatized system, characterized by the questionable separation of residence requirements from care requirements, reduced affordability and ever increasing demands on those in need of care to coordinate access to their own services and care.

Conclusion

The choices we make today about our health care system will impact each and every one of us. Any decisions we make should occur only after extensive and thorough democratic discussion.

The MACH report suggests that embedding principles in a broad legislative framework will provide the necessary direction to policy makers, health governing bodies and regulators as well as provide adequate protection for the citizens of Alberta.²¹ UNA holds that there is a need for far more clarity in how the province intends to interpret and apply the proposed principles before Albertans can seriously consider the recommendations of the MACH Report.

A focus on principles and intent without adequate discussion of the policies and practices that could follow from these principles significantly hinders the opportunity for Albertans to engage in open and democratic debate on the future of health care in our province. Albertans should be informed of the specific policies and practices that would follow from the proposed principles and must understand what this could mean for the care of their families.

The MACH report speaks of ongoing citizen engagement in the development of legislation, regulation and policy.²² Yet the workshops conducted to seek input on the MACH report were not initially open to the public. Open and democratic debate has further been hindered by the fact that to date no draft of legislation has been made available. UNA suggests that citizens cannot be

²⁰ Ibid, p. 6

²¹ Ibid, p. 10

²² Ibid, p. 36

expected to provide meaningful feedback without open consultation and access to drafts of legislation.

The MACH report proposes a new “arms-length” entity be established to inform decisions about services, practices and policies in Alberta’s health system and assess whether these technologies and services should be publicly insured. UNA holds that policy development and analysis is central to effective government and should not be left to an “arms-length” entity. Governments should be answerable directly to the public for their policy and decisions; any other process compromises transparency and accountability.

UNA agrees that Albertans deserve a more flexible and responsive health care system, one in which access to health care services would not be limited by setting or provider. However UNA advocates for expanding and enhancing public services to include, for example, care for the frail and chronically ill and comprehensive pharmaceutical coverage.

Governments often question the sustainability of our health care system. UNA suggests that this is a short-sighted perspective: health care costs are not usually optional. They will be paid, either as public services funded by our taxes through our government or directly by citizens from their pockets or from expensive private insurance. With the exception of the United States, Canada already has one of the highest rates of private expenditures on health care among OECD countries;²³ do we want to further increase our private expenditures when research has consistently shown that privately funded health care incurs greater administrative and managerial costs and provides poorer safety outcomes?²⁴ Collective public payment for services has proven to be better at controlling costs, fairer for citizens and far better at ensuring universal access. The question is not whether we can afford such a system. If we are concerned about the overall health and well-being of Albertans, we simply cannot afford *not* to expand our public health care services.

²³ *OECD Health Data 2010: How Does Canada Compare* <<http://www.oecd.org/dataoecd/46/33/38979719.pdf>>

²⁴ Steffie Woolhandler & David U. Himmelstein, *The High Costs of for Profit Care*, Canadian Medical Association Journal, June 8, 2004; 170 (12)



Recommendations to the Minister's Advisory Committee on Health

1. Explicitly articulate the principles of public administration, universality, comprehensiveness, portability and accessibility as foundational principles of a new Alberta Health Act.
2. Ensure that a draft of proposed legislation is made available for public consultation prior to consolidation of any existing legislation.
3. Inform Albertans of the specific policies and practices that would follow from the principles in the Alberta Health Act. Engage Albertans in discussion of the actual services, and conditions for services that will be provided by the health system that would result from a new Alberta Health Act.
4. Articulate in legislation the composition, processes and powers associated with the proposed new arms-length entity and ensure that it is the government that remains directly accountable to Albertans for decisions surrounding health care policy, structures and process.
5. Enhance the sustainability of our health system. Public services are best at controlling health care costs and maintaining sustainability. Government should be expanding public services to control costs, heighten safety and quality and to ensure equality. We must address the issues in the funding, capacity, and stability of our health system. Albertans need - and expect - our public system to grow and improve to meet our health care needs.