

Comment: Bill 11, Health Care Protection Act

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Introduction

Few legislative initiatives have been the subject of more intense public debate than Alberta's Bill 11, the *Health Care Protection Act*.¹ The Bill was introduced on March 2, 2000 and received third and final reading on May 10, 2000. Government amendments were introduced on April 12, 2000 and passed.²

Bill 11 must be considered in the context of the Alberta Government's stated plan to contract out the provision of insured services to for-profit health care facilities. Indeed, it is clear that much of this Bill is specifically designed to both facilitate and regulate that process.

As a result, this Bill raises broad policy concerns about the merits of for-profit versus not-for-profit providers, and questions about the *Canada Health Act*³ and the North American Free Trade Agreement. From the start, these issues received a good deal of attention.

This brief comment will focus on a number of specific legal concerns, including an analysis of the "queue-jumping provisions," potential conflicts of interest and the Bill's privative clause.

There are portions of this Bill that are constructive. For example, Section 12 creates a very helpful requirement for health authorities to disclose and publish their agreements with private surgical facilities. Moreover, there is a clear ban on queue jumping, although the utility of this provision in practice may be questionable as will be discussed below. These provisions can be viewed as useful (indeed, essential) in the face of the government's plan to contract out in a way that would ensure compliance with the *Canada Health Act*.

The challenge of designing appropriate regulations in this context needs to be considered. As health care technology

progresses and as our population ages, the market for "enhanced" health care services seems likely to grow. Indeed, defining and regulating the provision of these services seems likely to be one of the great challenges for future policy makers.⁴ There is clearly a regulatory hole that needs to be filled – although given this, one might ask why the Bill is not more comprehensive in scope rather than focussing on surgical services.

No to "Private Hospitals" but Yes to "Private Facilities"?

Section 1 states that "No person shall operate a private hospital in Alberta." However, this prohibition must be understood by reference to the definitions set out in section 29 of the Bill. A "private hospital" is defined in section 29(m) as an acute care facility other

than a public hospital (as defined in s. 29(n)) that "provides emergency, diagnostic, surgical *and* medical services" (emphasis added) and "admits patients for medically supervised stays exceeding 12 hours." Surgical facilities, which may be permitted to operate under this Bill, are defined in s. 29(q) as facilities "whose primary function is to provide a limited range of surgical services."

This distinction and the prohibition against the operation of private hospitals seem to be an attempt to pacify those concerned about private hospitals. However, the distinction seems an artificial one when one considers the range of "facility services" contemplated as potentially being provided by surgical facilities. The list of possible facility services is contained in the definition at s. 29(g) and includes, for example, diagnostic procedures, physical

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therapy and medical goods and services. A private surgical facility may provide all of these, and in some cases may admit patients for medically supervised stays of more than 12 hours, but still not be prohibited as a “private hospital” as long as it does not fit the definition in s. 29(m). For example, if a facility admitted patients for more than 12 hours and provided diagnostic, surgical and medical services but *not* emergency services, it would not be a “private hospital” for the purposes of the Bill.

Public Hospitals’ Monopoly over “Major Surgical Services”

Section 2(1) states that surgical services may be provided only in a public hospital or an approved surgical facility. A “surgical service” is defined in s. 29(r) as “the alteration of the human anatomy manually or through the use of an instrument or the introduction of any instrument into the human body where such a procedure (i) is carried out with the concurrent use of (A) a drug to induce sedation, or (B) local, regional, or general anaesthesia, to a degree that requires the monitoring of vital signs, or (ii) is normally associated with the kind or degree of risk that is prescribed by the council of the College for the purposes of this clause in by-laws under the *Medical Profession Act*, but does not include a minor surgical procedure that is exempted in the regulations under section 25(1)(a).”

Section 2(2) states that no person shall provide a “major surgical service” except in a public hospital. A “major” surgical service is not defined in the Bill but rather is left to the by-laws of the College of Physicians and Surgeons under the *Medical Profession Act*. In this regard, the Bill gives the College the authority to determine what services can be provided in a “surgical facility.” For better or worse, this gives a great deal of power to the College to determine what must be provided in a public hospital and what can be provided in a private surgical facility. Given the importance and policy nature of these definitions, some may question how appropriate it is for the decision-making authority to be left solely to the College.

Queue-jumping

Sections 3 and 5 deal with queue-jumping and the provision of enhanced services, respectively.

Section 3 is key in terms of preventing a two-tier system and complying with the *Canada Health Act*’s prohibition on

extra-billing and user charges⁵ and criterion of accessibility.⁶ In the first draft of the Bill, section 3 stated that “No person shall give or accept any money or other valuable consideration for the purpose of giving any person priority for the receipt of an insured surgical service.” On the face of it, this wording seems like a clear prohibition against queue-jumping. Unfortunately, when section 3 is read in the context of the entire Bill, particularly section 5 which allows the provision of “enhanced medical services,” the clarity of the prohibition is lost. Indeed, in interpreting sections 3 and 5 several concerns arise that belie the government’s claim that there is no risk of a two-tier system as a result of Bill 11.

The defining of “enhanced medical services” seems likely to remain a key issue in relation to this Bill.

“Enhanced medical services” are defined as “medical goods or services that exceed what would normally be used *in a particular case* in accordance with generally accepted medical practice” (emphasis added). Section 25(1)(g) does provide that regulations may be made “regarding whether a particular medical good or service is or is not an enhanced medical good or service or whether a particular good or service is or is not a medical good or service.” Any such regulations, like all regulations under the Act, would be made following consultation with the College (s. 25(2)).

However, on a case-by-case basis it is the responsibility of a physician to decide whether a particular insured service is medically necessary for any patient. Therefore, the reality is likely to be that a physician working within a private facility or public hospital will determine what medical goods or services “would normally be used.” Physicians have long had a significant amount of discretion in determining a patient’s needs and deciding how to respond to those needs. However, this discretion becomes problematic when combined with financial incentives physicians may have to provide “enhanced medical goods or services.” Physicians may be tempted to characterize a patient’s need for medical good or services as falling beyond that line of “generally accepted medical practice” when this is not really the case.

The defining of “enhanced medical services” seems likely to remain a key issue in relation to this Bill. To cite but one example, enabling the provision of “enhanced medical services” when such services, in other circumstances, would be covered by the public purse has the appearance of a two-tier system. Although a patient’s need for a service may not be such that it would justify the provision of a particular publicly-funded service, e.g. a series of headaches would not

normally justify an MRI, such a patient would now be able to pay for this MRI, both within the public hospital or in a private for-profit hospital. This may well result in a two-tier system whereby the wealthier are able to get certain health needs (albeit needs defined as worthy of “enhanced service”) addressed more quickly in the private sector whereas the poorer may not.

This problem emerges because no bright line can readily be drawn between those services for which private financing is allowed. Simply using “generally accepted practice” as the primary guiding principle creates a situation where clarity will almost never be found. While this large degree of discretion is probably inevitable - indeed, finding a concrete definition of “medical necessity” seems all but impossible - the Bill fails to recognize and address the problems linked to the slipperiness of the “enhanced service” definition. Admittedly this is a daunting regulatory challenge, but it is one that must be embraced if government is going to meaningfully regulate private facilities that provide both insured and un-insured services.

The Bill does seek to provide solutions to some of the “enhanced services” dilemmas. For example, Section 5(5) states: “Where a person is provided (a) with an enhanced medical good or service because the public hospital or designated surgical facility does not have available the medical good or service that would normally be used in accordance with generally accepted medical practice, or (b) with a private or semi-private room because the public hospital or designated surgical facility does not have standard ward accommodation available, the person is not responsible for the extra cost of having the enhanced medical good or service or the private or semi-private room provided.” However, it is quite possible that a physician working either at a public hospital or a private for-profit facility, rather than saying that a service is not available, as envisaged by section 5(5), may instead say to the patient that her need is not sufficient to justify provision of a particular service in the public sector but if she wishes she may purchase the service privately as an “enhanced medical good or service.”

The recent amendment to section 3 is designed to address the controversial issue of “enhanced service queue-jumping.” Unlike the first draft of the Bill, the amended section specifically states that you can’t offer an enhanced service for the purpose of giving an individual priority to receive an insured procedure. As such, a physician would be

prohibited from providing an insured service imbedded within an enhanced one and thereby giving priority to the patient – as was apparently done in the now well known “queue-jumping case” where a man paid \$4,000 for corrective eye surgery when, for all practical purposes, he was receiving medically necessary cataract surgery.⁷ While this is clearly an improvement over the earlier version of

section 3, it will not necessarily resolve the issues raised above. For example, much will turn on the interpretation of the phrase “for the purpose of giving any person priority for the receipt of an insured surgical service.” How will the government monitor,

prove or enforce such a provision? As highlighted by the queue-jumping case, it is easy to justify the provision of enhanced services – particularly when avoiding a waiting list is a by-product of the purchase.

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Enhanced Services, Conflicts of Interest and Informed Consent

As noted above, one of the biggest problems with the Bill is that it helps to create a framework whereby “enhanced services” can be provided more easily. There is, therefore, an economic incentive to expand the definition of “enhanced services” and to narrow or freeze the definition of “generally accepted practice” (see s. 29 (f)). It may thus encourage “diagnostic drift,” the phenomenon where physician diagnosis practices are effected by remuneration strategies. In addition, there is an economic incentive for physicians to recommend enhanced goods and services to their patients. These incentives raise potential conflicts of interest for physicians.

Section 5 is undoubtedly an attempt to deal with these conflict of interest problems that exist whenever a facility is to offer “enhanced services” in addition to “insured services.” The goal of the section is to ensure that a physician clearly discloses relevant information to the patient so that she can make an informed choice. However, other than forcing some of the information to be in writing (s. 5(2)(b)), this section adds little to the content of the existing legal and ethical obligation placed on physicians to disclose relevant information. As is well known, Canadian common law places disclosure duties on health care providers, duties which are particularly onerous in the context of elective procedures.⁸ Moreover, fiduciary law

further heightens the duty to disclose information relevant to potential conflicts of interest.⁹

According to s. 25(1)(c), the regulations under the Act may also include regulations on the statements required under s. 5(2)(b). While it will be necessary to consider the content of any such regulations to properly analyse the implications of these provisions, it seems likely that the regulations will add little of substance to the physicians' already extensive disclosure duties. In fact, there may be some danger that these provisions could actually be read as narrowing or displacing common law disclosure requirements.

Section 5(4) also deserves comment. This section states that a patient may rescind an agreement prior to the goods or services being provided. While this section provides some certainty to patients, it is, once again, merely a weak codification of the right that patients already have under common law to withdraw their consent to a treatment at anytime.¹⁰ The Bill allows, in s. 25(1)(e), for regulations to be made "governing all aspects of how the right to rescind in section 5(4) is to be exercised, and the return of all or part of the money paid under the agreement." Is there a potential for these regulations to restrict or undermine the patient's right to withdraw consent?

In any case, there is the additional question as to whether disclosure requirements are sufficient to deal with conflicts of interest.¹¹ Arguably, if these conflicts are to be addressed meaningfully a more comprehensive provision is required. Several mechanisms have been suggested, such as, a ban on self-referral for enhanced services and a "cooling off" period (i.e., the patient would be required to wait at least a day before been making a final decision about the enhanced service).

The recent amendments do not incorporate these mechanisms but do include additional provisions that attempt to address conflict of interest issues. Subsection (1.1) added to section 5 now states: "No person shall charge or collect a rate for enhanced medical goods or services that is greater than cost plus a reasonable allowance for administration." Presumably by limiting the fees that may be charged for enhanced goods and services, this provision aims to reduce the financial incentives referred to above. Subsection 8(3), which sets out the criteria for approval of

agreements between health authorities and surgical facilities, has also been amended to require that the agreements include "provisions showing how physicians' compliance with the *Medical Profession Act* and by-laws as they relate to conflict of interest and other ethical issues in respect of the operation of the facility will be monitored."

Approval of Agreements

Sections 7 through 12 provide for a health authority, with the consent of the Minister, to enter into an agreement with a private for-profit facility to deliver insured surgical services. There is nothing in the *Canada Health Act* that prevents the delivery of services by private for-profit operators provided the services are paid for in full by the public sector.¹²

As noted above, subsection 8(3) contains a list of criteria that the Minister must consider before an agreement is approved. For example, the Minister must be satisfied that "the provision of insured surgical services as contemplated under the proposed agreement would be consistent with the principles of the *Canada Health Act*" (s. 8(3)(a)), would not have an adverse impact on the publicly funded and administered health system (s. 8(3)(c)) and would entail a public benefit, considering factors such as access to services, cost effectiveness and efficient use of existing capacity (s. 8(3)(d), as amended). However, because there is no monitoring provision, it will be difficult to assess how the government considers and applies these criteria. Indeed, given the equivocal evidence in relation to the value of contracting out for surgical services, it is difficult to see how the government would satisfy section 8(3)(c) or (d). The difficulty of reviewing these decisions (as will be discussed in the next section), further heightens this problem.

Section 12 requires health authorities to make any agreement with a surgical facility available to the public and to publish certain information. This section is significant in that it provides for transparency in the contracts concluded, an important means by which to improve accountability. What is missing from this section, however, is guidance and emphasis on monitoring and enforcement of performance obligations contained in contracts.¹³ Other countries' experiences with contracting out tell us that the process will only be as good as the decision-makers who decide with whom and upon what terms to contract.¹⁴

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Privative Clause

Section 23 provides that “No decision made by the Minister in the exercise or purported exercise of a power or the carrying out or purported carrying out of a duty under this Act may be questioned or reviewed in any court by application for judicial review or otherwise and no order may be made or process entered or proceedings taken in any court, whether by way of injunction, declaratory judgment, prohibition, *quo warranto* or otherwise, to question, review, prohibit or restrain the Minister.” This type of provision is known as a “privative clause” and is designed to shield the Minister’s decisions from judicial review. Such a provision does not make the decisions entirely immune from review. For example, a decision that is beyond the jurisdiction of an administrative body may still be challenged notwithstanding the existence of a privative clause. The amendment to s. 23, which states that a decision of the Minister “may be challenged on judicial review for jurisdictional error or patent unreasonableness” by originating notice, merely confirms this.

A decision which is “patently unreasonable” would fall within the scope of this exception. The failure of the Minister to consider one of the mandated factors under section 8(3), if it could be demonstrated, could also be a basis for saying that the decision was an abuse of discretion and subject to review. However, there is no question that the privative clause will make it more difficult to challenge the Minister’s decision.

Conclusion

This legislation does fill a “gap” in the law and arguably has some value for that reason. In addition, some of the provisions are helpful, e.g. the prohibition on “queue-jumping” and disclosure of contracts. However, a number of concerns with the content of this Bill have been identified, here and elsewhere. It seems likely that the Bill will create more problems than it solves.

Bill 11 ostensibly is about ensuring more efficient delivery of publicly funded services by allowing contracting out to for-profit surgical facilities. However, as this brief comment has pointed out, there are serious concerns that in fact Bill 11, through the definition of “enhanced medical goods and services,” may establish a two-tier system for the kinds of hospital and medical services that are meant to be protected by the *Canada Health Act*. Moreover, the combination of physicians’ discretion with financial incentives to describe

services as “enhanced” rather than medically necessary raises significant conflict of interest issues that should be of concern to us all. Although the government’s amendments at least attempt to address some of the legal issues raised by this Bill, they are not sufficient.

Even setting aside the issue of private financing of surgical and medical services, experience from other jurisdictions that have experimented with contracting out tells us that ensuring accountability, transparency, monitoring and enforcement of contracts is essential. Bill 11 is woefully short on these essential features.

Given the importance of the topic, and the great potential for untenable conflicts to occur when insured and uninsured services are provided together, it is unfortunate that a more thoughtful and comprehensive piece of legislation has not been forthcoming. The implementation of this legislation will no doubt be carefully followed and may either heighten or allay public concerns.

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1. Bill 11, *Health Care Protection Act*, 4th Sess., 24th Leg., 2000.
2. The Bill’s status, text and amendments can be found on the Alberta Legislative Assembly web site, online: <<http://www.assembly.ab.ca>>.
3. R.S.C. 1985, c. C-6.
4. This issue is closely tied to the broader concern of defining “medically necessary” (i.e., those services that are to be covered by the public system). See e.g. T. Caulfield, “Wishful Thinking: Defining ‘Medically Necessary’ in Canada” (1996) 4 *Health L. J.* 63.
5. *Supra* note 3, ss. 18, 19.
6. *Ibid.*, s. 12.
7. L. Johnsrude, “Eye patient paid clinic \$4,000 to jump queue” *Edmonton Journal* (2 March 2000) A1. The patient was told he would have to wait one year for cataract surgery. Instead, he paid \$4,000 to the Gimbel Clinic in Calgary for refractive lens surgery, which was available within a few months and included removing his cataracts.

8. See e.g. B.M. Dickens, "Informed Consent" in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) 117 at 129.
9. See *Henderson v. Johnston* (1956), 5 D.L.R. (2d) 524 (Ont. H.C.), aff'd (1957), 11 D.L.R. (2d) 19 (C.A.), aff'd (1959), 19 D.L.R. (2d) 201 (S.C.C.). In the US case of *Moore v. Regents of the University of California*, 793 P. 2d 479 (Cal. 1990), cert. denied 111 S. Ct. 1388 (1991) it was noted that because doctors are fiduciaries, they are legally required to inform their patients of any conflicts of interest in treating the patient, including disclosure of "personal interests unrelated to the patient's health, whether research or economic, that may affect [the doctor's] medical judgment."
10. *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119
11. See e.g. B.M. Dickens, "Conflicts of Interest in Canadian Health Care Law" (1995) 21 Am. J. L. & Med. 259 at 267.
12. See C.M. Flood, "The Structure and Dynamics of the Canadian Health Care System" in Downie & Caulfield, eds., *supra* note 8 at 5; C.M. Flood, "Contracting Out for Health Services in the Public Sector" (1999) 31 Can. Bus. L. J. 175.
13. See C.M. Flood, "Accountability of Health Service Purchasers" (1998) 20: 2 Dalhousie L. J. 470.
14. See C.M. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000).

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