Richard Plain

RP: My name's Richard Plain. I was the first professor hired in the Alberta university systems to teach health economics. That was done back in 1964 by Dean Walter Mackenzie. I had a joint appointment in the Faculty of Medicine and the Faculty of Arts, which simply reflected I was associated with the Masters program in Health Services Administration and in the general Department of Economics with the Faculty of Arts. I started as part of my responsibility is to do teaching and research focused upon the Alberta healthcare system and in training generations of administrators so they had broader backgrounds and were able to do a better job than simply individuals brought in off the street when they were required to try and deal with the administration of a very complex social program. So that is where I came from. The other part of it, the other dimension to it is that I always had a strong interest in the consumer movements. I was extensively involved in the Consumers Association of Canada. I've been the vice president from the policy side, from the national CAC, and also for the provincial CAC. I've been on the health committee there for I don't know, about 32 years or something like that or more. So I had a basis then in professionally as a health economist dealing with a system at that time where the province of Alberta had just come into Medicare in terms of 1969 in July, that actually Alberta came into the medical services delivery system, under what we now know as the Alberta Healthcare Insurance Plan, after staying out for a year on the basis of certain ideological concerns, etc. But when 50-50 cost-sharing came in and a realization became all too clear that what Albertans were doing was underwriting healthcare expenditures by the rest of Canada, they soon joined. So from that day on basically, Alberta matching or tying into my career, we had the hospital insurance, the Diagnostic Services Act, which was passed in the middle '50s now being brought into coordination with the medical services insurance plan. So we then actually had the very nucleus of what eventually came to be the Canada Health Act, which did incorporate those plus some extensions into it. I've been at Medicare from its beginning in this province, from involvement on a personal from the consumer and from the public sector side, and responsible for the training and administration, training of administrators from within those areas. So that then, whether I kind of liked it or not, of course I was interested in the public delivery of a comprehensive health insurance that covered hospital and medical services, also that it was portable, that it was publicly administered, that it lowered the costs, and it was universal. And that it was accessible to all, regardless of their ability to pay. When a medical emergency arose, it was not a financial emergency. It was a case where the needs were met and the care was delivered, medically required care. So those were, when you start from that set of principles, which are enshrined in '84 legislation and the Canada Act today, but came in kind of piecemeal, but all that originating with Emmett Hall, the Hall Commission.

Q: Say something about that.

RP: I had a very interesting conference one time at McGill. I was delivering at that time a paper on the incidents of extra billing in government, in Alberta. I had a number of

statistics and other things backward and forward, and talking about how that was affecting access to the Alberta system and how and what was going on. I delivered that at McGill, and present were Tommy Douglas, Justice Emmett Hall, and the other founders basically of what we know today as the Medicare system. I had opportunity in other settings to actually have a debate with the Canadian Medical Association representative on the Hall Commission at the time, Dr. Mark … mmm. So we got into the pros and cons on the CMA side, but basically he was part of the group, which was appointed by Diefenbaker and the Hall Commission. He was accused of being a blue ribbon Conservative group that would completely destroy any opportunity of Canada ever having a national Medicare plan. But when the smoke cleared off everything, this group came out and clearly spelled out why you needed a universal, comprehensive, publicly administered, fully accessible, portable plan. So that came from a mix and that included, as I say, from justice for eminent lawyer in both the labour and other sides, respected jurists appointed by a Conservative government, a number of other individuals that were certainly not part of any left wing so-called orientation or viewpoints, who looked at the merits of the case. Their decisions then came out in the 1964 Hall Commission reports, which I now have an electronic copy of, because that saved a lot of reading of the documents of that, and which principles need to be reread today.

Q: How did the Act come in?

RP: I'll just finish off that little excursion off to McGill there. So after the conference then, and also the secretary to the Hall Commission, his book is up on the sociologists, a very fine man and a scholar… So that opportunity to actually meet, talk, interface, and have a few drinks or so in an informal setting with the actual people that put this system together certainly added the colour, the flavour and dimension to what otherwise were relative dusty but important pages. As you read through them side by side you began to understand what had been done, what had been looked at, and how extensive the investigations had been and thorough the debates had been that actually led to the creation of the Hall Report. So as I say, the charter we're talking in Alberta about, the Alberta Charter, well the charter for Canadians was laid out in Chapter 1 or 2 on the overview of the Hall Commission. The broad chapter in terms of a charter for Canadians set out in that side, much more extensive of course than the existing Medicare system evolved that we've been talking about here or anywhere else. But even that original concept came from that framework. So anyway, getting a little bit better organized in the chronology of events, in '69 in July when medical services was actually implemented here, in which we had a medical services commission headed by Jim Faulkner and a board, three or four or five people to administer the medical insurance plan. Now that replaced the Medical Services Incorporated Plan, the MSI plan. Prior to that time, in the evolution of events, after universal hospital insurance and diagnostic services coverage came in in the mid '50s and money was provided by the federal government for new equipment, new hospitals and other things, then a great push came to be able to access the physicians. The fundamental fact of the matter is hospitals have doctors and doctors have patients. It gets forgotten and I'm not so sure it's not forgotten today, because people talk and say, well we could do things to change the use of hospitals, we could control things. My friends, the person the people that make the decisions about who should be admitted

to a hospital are your physicians, based upon their medical assessment. They prescribe the treatment regimes and decide when you should be discharged. It is not hospital administrators, it is not any in between – it's that group that are paid and are a focus outside of the hospital per se but of course an integral part of the overall system. So anyway, with that in mind, in '69 the Alberta government had said, okay we've got the 50-50 cost share program, we like MSI, because in that system Alberta had pretty well developed a model in which individual subscriptions paid by corporations, businesses and individuals provided coverage for a wide number of the population. The government had stepped in and also provided coverage for a number of people with limited means. They were building then a relatively comprehensive system, at least compared to what the Americans have today. Alberta was well on the way in their own way to build this mix of a system that was beginning to look like a universal system, beginning to provide the range of services and things. The physicians at the time, they ran MSI. So they eliminated the private insurance competitors, because a physician-run plan, well it set the budget. They said, well guys, I guess we're going to be over the budget. ?? They stayed within the budget, stayed within the plan. We ran it, we delivered it, we do it. This is our plan. And it was not for profit. So the for-profit private insurance plans were eliminated by your friendly neighborhood physician group. They ran the plan in the context. So with that MSI plan that Alberta was rather proud of at that time, that evolution coming on side, then the national plan came and said, wait a minute, this is fully covered. But Alberta, yes you've come a lot further than most of the other Canadian provinces were able to accommodate. Most of them have no hope of ever doing what you're doing in Alberta. Some other provinces, yes they had similar types of plans in place. This will be for all Canadians. Everyone, regardless of where you are, where you're located, all the sick and the ill that medically required services for the physician and for the hospital diagnostic services should be provided. So after that hiatus of a year, then Alberta joined and we then started the process in the first round for the first six or seven years in which medical practitioners had never had it so good. Once they, with their own plans, things were really improving, because they were paid then. If there was a downturn, if there was a recession, if there was anything back and forth, they were getting their bills paid. So bad debts were no longer part of the phenomenon of physician. Basically you came in, there's your plan, you hand it in, you got your money. What could be better? So that group of generation of physicians and everything else, they had a 10% increase just if the fee schedule remained frozen, because they had no bad debt allowance, which was somewhere from 5 to 10 per cent of their business. So I'd say the first six or seven years or so this was thought to be a very nice situation for organized medicine. Then came the problems of, gee the rate of increase in our fees and our payments and everything, we're not keeping up with what we think we should be getting. At the time, the commission employed some previous physicians to work with them and there was pretty hardnosed cost-control bargaining going on – a variation only in the public arena of what went on with the MSI tradition when the physicians ran the plan. So in about the '70s or so then with fairly tight control over physician spending, then physician positions began to look for other ways of increasing their income. That began the process that led to the second Hall review, I believe commissioned by Joe Clark in his small period in office. Kind of an amazing event that he had two Conservative prime ministers I think that did that commissioning. In any event, it was the Liberals that dealt with their implementation

afterwards. But in any event, then the hearings were carried on throughout the country. That's during that time more and more of course outcries were evidencing itself. The information and documentation I was gathering on the extra-billing, who was doing it, the price discrimination. Doctors saying, gee, ministers don't get billed, or if we did it's really an accident. Or other medical practitioners, oh it's not good to do that. Widows, are they widows, what are they? Well then a number of the physicians saying, well no we're not going to do this. And a number saying, oh ya we are big time. All sorts of this was going on and of course was destroying the access issue, which was to say, wait a minute, if we're going to have to resolve the issue about what is fair and reasonable to pay physicians, deal with that thank you. But don't turn that into saying, well you can stay on a public insurance plan, and then decide when they come through the door how much extra you'll charge. So they thought, well gee if you came in well dressed in a nice suit and everything else, oh hi, how are you doing, what can I do for you today? Where are you from? Oh I'm from Calgary. I'm in the oil industry. Oh, oil industry from Calgary, nice suit. Or back at the desk, Mildred was sizing up the patients as they went through, as to who get the extra tariff laid on them. But in that process, you've got people like, I remember cases here in St. Alberta, a lady that didn't have the money to take her $5 to one of the local clinics here, extra-billed just for a visit. It was either buy Hamburger Helper or go to the doctor for her kid. She bought the Hamburger Helper and her kid had quite a bad incident with respect to ear infections and everything that resulted from it. So you just get into that. There's no good way out of that, there's no good way for the physicians to run a perfect price discrimination scheme. Then secondly, it allows them to maximize their income, but why do the rest of us want to get into that system? If you set it up then you'd have the minister ??, what are we doing here? So that eventually, as things mounted, we got into the activities that led to the formulation after the Hall second report, which was part of the public continuing outcry, then the hearings then into Ottawa. Then Monique Bégin and the 1984 Canada Health Act and Pierre Elliot Trudeau and that Liberal regime at that time that did pass that act.

Q: That, I'm told, is why Friends of Medicare began in 1979.

RP: Ya, so go back to Friends of Medicare. In this whole problem issue with the first round of issues, coming in with the extra-billing happening to patients and people of all descriptions and everything backward and forward, it seemed to much of the population a betrayal of what had been promised, and governments' not acting to correct. Also some of the hospitals were doing hospital user fees of $10 charge, that type of thing creeping in. How far would this go? If governments held down their spending and allowed user fees you'd just undermine the system that we all agreed should work and was in Alberta by '69 and across all of Canada by '71. All the provinces were in because New Brunswick I think was the last one to finally get in. So coming then from, here's the health economists documenting these types of things and here's what's happening. This is impacting access and doing other things in that line, also being part of consumer groups, but it had a much wider range of interest. To say, okay there's a very large consumer group that are concerned just about the health issues. So but as an information working group that came out of a mix of people, a mix of people from consumer, a mix of people general public, some of the union, some of the other side. A whole range in an ad hoc way were meeting,

talking, commenting, lobbying. Then the idea of an organization actually called Friends of Medicare came up. Now in many other provinces this is called Alberta Healthcare Coalition. But the Friends of Medicare, I cannot remember, but I think that is an Alberta-created name. Who created it or how we created it or whether it's lost of times of history as far as I know. But I think when the decision, I distinctly remember the decision to say, well let's create some special organization. By that time I was back out of mayor's chair, because I served one term there, back at the university again. So I think that timing is about correct there. So the special group. Well it had no money and it had whatever we could do, whatever we could research as volunteers and grassroots. It was the grassroots trying to fight for what they believed were their social rights to healthcare. I ended up in the middle of all that. So then we ended up, in terms of both consumer when groups or media were coming in then, I found myself and many other people here, but from time to time as reporter to say, oh it's a consumer association, thank you. Oh what would your Friends of Medicare …? After a while you just shake your head. So that took us into things leading up to the Canada Health Act in '84. I remember groups of people, I think by that time certainly Heather Smith, UNA, Wendy Armstrong, Consumers Association. A number of us went down to Ottawa, scraped some money together somehow and went down and lobbied all the ministers that we could get a hold of at that time in terms of and, or sorry, MPs, and stated our case. Just said that, and I think that was, no that was Bégin, no I'm sorry that was Marleau. That is the next fight. 1984 was Begin and the Canada Health Act. But Marleau came after. Marleau was the facility fee fight, so my apology. We all went down to Ottawa, but that was Marleau. Ya, we're still with Begin, I'm sorry. Okay so then that fight, so the briefs were put in and all the rest of the things went on. Then back came the report and the new Canada Health Act was put in. People said, well okay if you're going to hand over the money to the federal government, you've got to enforce these conditions. So what came was said, all right, if you take the money yes, you say you're going to work in the program, yes. For every dollar you take out we'll take it out of your provincial treasury. You take it out of the patients' hide, we'll take it out of yours. Well that was not welcome very much. Mind you, on our side we were looking for a lot stiffer penalty than just a dollar for dollar side. But anyway that was the compromise, and it worked quite successfully. I guess for a number of reasons, provincial governments did not want to be seen, first of all you're breaking the law, you're an outlaw, and it ends up to millions of dollars. Now in today's $17 billion Alberta budget, you'd think, well okay so you lost $10 million or you lost a million here, this is really not a good thing to be focused. You're a lawbreaker, you don't ??, and you're costing millions of dollars of tax money in terms of transfers from Ottawa. What are you doing? So a classic illustration of maladministration. So the Ottawa draftsmen and policymakers were quite shrewd as to how effective that dollar-for-dollar penalty for the extra billing actually would be. Now there's still provinces that there is some extra billing going on, but it just doesn't seem to be in the grassroots in their provincial sides, from what I can see. Mind you, it's a big country; so you don't exactly know what's happening in other parts of it.

Q: This was put to the test in Alberta right then, wasn't it?

RP: Alberta, every dollar and every cent was spelled out. The quarterly reports came through and all set out as to who did what. Because of the Alberta premium system, Alberta was one of the two premium provinces, well there may have been three at the time – BC., Ontario, and Alberta. So you did have classifications to say, well who was fully subsidized, who was partially subsidized, and then who had to pay the whole group. So enter then the partially subsidized group, then they had an income range for individuals or families. If you were from 0 to 15,000 or 0 to 20,000, whatever, then they say okay, then the extra billing from the records came back. Well here's the percentage being extra-billed. Then it was, well the poorest of the poor were being in the big system that was going into extra-billing were getting extra-billed as well, or as much or more than those in the so-called wealthy or high-income group. Well then that really finished off Monique Bégin, who was a social worker in terms of her background, or sociologist, sorry, not social worker, sociologist. That really got her, plus a number of the others once that came through and there was no more obfuscation back and forth. In went that first teeth into the Canada Health Act on the extra-billing penalties on Medicare and any user fees on the hospital on the other side. That was sort of out of the group, the grassroots group. To Friends of Medicare, consumers' association, people of academia, teachers, you name it, and businesspeople, a few, this was good. We finally thought we'd restored equilibrium. Well that was one battle. The next…

Q: Did Alberta attempt to challenge that?

RP: I was trying to remember whether it was, I think David Russell was the minister of health at the time on the Monique Bégin side. Was Gordon Miniely … ? I think it was David Russell, an architect out of Calgary.

Q: I think Miniely was the guy that got into trouble.

RP: For making a deal with a medical practitioner who didn't have the qualifications to do cardiac assessments. He was an accountant. So I think David Russell was the provincial minister at the time. Alberta was of course anything that would deal with this. Also there were changes with respect to the 50-50 arrangement. When it came through with 50-50 cost sharing, they said here's the average cost. So that meant that Alberta had a richer plan or when it came in its doctors were paid a little bit more than somebody else or its hospitals charged, so they wouldn't actually get 50% of their cost covered. But they'd get maybe 46 or something of that sort. But it's fairly close. Then we had the change into established program funding to say, well okay, and it was partly linked to the Quebec issues that were boiling on the side and saying, healthcare is a totally provincial responsibility with exception of those things dealing with things like the military, sailors, RCMP, and individuals on reserves. But other than that, this is, sorry federal government, this is not your area constitutionally, period. It was a quintessential Canadian arrangement here for a national Medicare plan anyway to say, well federal government has absolutely no business to be able to establish a national plan, except one thing. What's that? Money. Hmm. That's always good to raise the curiosity and outright interest of the provinces. So out of that came the 50-50. Well we'll pick up 50-50, when they were experiencing as part of the postwar period this continual rise in demand from the population for hospital and

medical services coverage, on one hand promoted by the doctor-based group on the medical side, and on the hospital side from the Blue Cross. Because the Blue Cross had been right after the Second World War plans, and the Alberta Blue Cross plan then had started to offer and provide hospital insurance so people could get to the hospital and use the services on the other sides. That was growing and those were quite large enrollments in those plans. That's happening across the provinces, but it was a patchwork, depending on the ability of individuals to pay, depending on the organization. These voluntary insurance groups had different degrees of coverage and success. But it was all moving to try to get some type of a comprehensive plan to try to get universal coverage to be able to ensure access for all the population. Also they had portability. You're going to have a nation, you say I've got a good plan here. If I'm going to go to Ontario and I'm going to lose 20% of my benefits or I've got to go to Alberta and I'm in Ontario and I'm going to lose it or BC or Saskatchewan, what have we got here? We've got a significant barrier to the free movement of labour across the country and also to businesses. Depending what happened, the phenomenon with respect to a publicly funded plan is this. If you have, as we have today, a universal, comprehensive, publicly administered, full accessible, portable plan, last-dollar finance in one area. If you had that in one province and you had only 80% in the other, then you've got a significant difference to businesses, if they're competing in the market. Because these costs for your hospital and insurance, medical service thing, these are nocturnal, these are significant input costs, significant part of your overhead cost. So it would create a basis for cost differentials between provinces in competition in Canada based solely upon the degree to which I guess the Canadian Taxpayers Association would say that the state was subsidizing the costs of the social service called Medicare in one province compared to another. So in all that discussion, so there were a lot of reasons why both the business as well as the consumer and other groups and labour groups of course and everything else, because I mean you know you lose your job you lost your different coverages, or you get different coverages, different benefits package, you're all over the place. Particularly those that had national unions, well now what have we got in here trying to negotiate 15 different plans. It's going to be a fascinating exercise. So all these things came to the fore in that…

Q: In the changes to the Established Program Funding.

RP: Ya, that's right. So the block said, okay you're mature provinces, you know best. Cuz the other one, the old 50-50, they said, oh so hospital service and diagnostic services, ya. The books. What do you mean? The books, we want to see what that hospital spent on those services. If you did not spend it according to this side, you the provincial government owe us the money. So you got the whole business of cost-control folks in Ottawa then demanding the books related to what was going on down into the hospitals from the provincial level government and leading to that issue. Now that happened in varying degrees, mind you, so it wasn't, why were those bananas bought in High Ridge or somewhere? But it was in the process of getting into a very invasive procedure as far as the provinces were concerned. As far as the federal government was concerned, it's hundreds of millions of dollars. We, the provincial general auditor, is responsible for ensuring that dollars voted by parliament are spent as parliament directed. No friends, anything else. Has it been done? We're going to answer that and if we can't answer that

we're going to explain, you know. So okay, let's save ourselves a lot of administration, a lot of grief. The provinces are mature; it was a good time. Respect Quebec autonomy, other sides, direction, Alberta being one of the leaders too. Okay, we'll give you a block of funds and that's yours. So many points income tax, corporate tax equivalent. I think there were a few dollars for certain programs. But generally, transferred tax points or other equivalents back to the provinces to do what they may with.

Q: What year did this happen?

RP: Well that was program funding, that's Pierre Trudeau. Was that before?

Q: I thought that was before.

RP: It could well…

Q: I thought that was one of the reasons extra-billing began to be allowed.

RP: Well, no it was just a matter that physicians then could extra-bill. There was nothing to prevent it. Then the province, I think, amended the Alberta Healthcare Insurance Act and said, we're not getting extra-billed. If you want to stay in the plan you, whatever is agreed with respect to the tariff of fees, that's it. So I could find out but I don't remember exactly. But the fact is that in the Trudeau era is when the status program funding came in. So they said, okay we got the money, hmm. Well I wonder. Then came the discussions. Well gee were health services really getting the support they should've been getting, or was that going into a highway? Did it go into holding down taxes in general? Did it go into anything? Then the cry is, okay where did you spend the money? Well gee we the provincial government, this is just the general revenue of the province. It's another tax point, it's in the general revenue fund, we don't track where your dollars go. You pay your personal income tax, we don't break it down to see where your personal tax dollars go. We've got these, these are our tax, this is our tax money. We're not doing that. Well that then led to all sorts of issues about who was doing what, whether they're living up to it, and a tightening of, in the '80s of course in this province, we had some very severe times again with that recession. The $9 barrel of oil era, all those things all hit. So came the concern, but not just Alberta, across Canada, what was being done with the money that was allocated? Then new areas of demands arising and needs, whether those should be included or expanded. We'd like to expand the basis of Medicare but we'd like to know that things were being done. So all that went on and on. Then we got, and in that process now between the 1984 side and then, now we're getting into the '90s. We're moving into the era now between '84 and Marleau's letter. Diane Marleau wrote a letter.

Q: Talk about the buildup to that.

RP: And said, as a result of this growth in the facility fees, coming out of Calgary. Gimbel and Associates then in the cataract clinic business had said, well we're not getting enough surgical time; given the market we think we've got out there to do cataracts. Technology has changed and cataracts no longer was a sandbag like this and holding like

that. We'll just open up a clinic and do it outside and the people will pay for the service and everything's all well. The Medicare side, well you get the service. So that then led to very rapid growth in cataracts, because you could get a quick service if you parted with the money to Mr. Gimbel. And other groups began to get into this whole business as well, so the complaints. So said all right, this is a medically insured service. Well how are they? Well oh no this is just a facility fee. Marleau's letter saying, uh-uh, if you open a private clinic, fair enough, we are not there to tell the provinces how to manage, how to operate its healthcare system. But let us say to you that if this is something that you're providing in the hospital with other services, and you elect to move it out and do it over in another area with another group, public or private or something else, this is a hospital service. So your clinics are hospitals for the Act purposes, and there is no out-of-pocket charge or else it's dollar-for-dollar. So then Alberta went through a painful process of getting itself fined dollar-for-dollar on the facility fee side. In other provinces it was starting to happen too, but Alberta had more active core between its Friends of Medicare, consumer groups, and other groups around. We did a number of consumer groups and a number of studies and surveys on cataracts and people across the area saying how much they had to pay and what they were. Then information came out, the extent of it. So then came the Marleau letter. But to lead up to the Marleau letter, then that's where I think really in the Friends of Medicare component came a fairly, we also created a Friday group, which just was a Friday meeting group over in UNA.

Q: Friends of Medicare had gone into a coma-like state.

RP: Ya. So there were quotes coming back and forth from Friends of Medicare. But basically, depending on who was there, anyway so there was a more active group emerging from the, I think, Friday group, Friends of Medicare, consumers' association, seniors' associations, a number of groups around those tables. I think probably nurses' assistants at large, from whatever. So that culminated in a group going down to Ottawa and meeting with various ministers, or Marleau I think, and then with the various members. I remember because we actually got lunch behind the curtains while meeting with some of the Liberal sides I think. We think that contributed at the time to that letter. I think we met, Marleau had written that letter something about-- maybe this was another time. I know Marleau fell out of favour with Chrétien, I believe, for whatever reason and ended up removed from health portfolio. She had a background I think in accounting or something of that sort or in the medical business, and knew it very well. So she really knew what was happening in those areas. So that takes us also, okay so that's the federal government. Using the federal means under the quintessential Canadian idea that you can run a national Medicare plan and, depending on the cost-sharing arrangements between the provincial and federal governments with teeth, on the conditional grants that are allocated.

Q: The first manifestation of facility fees was the Gimbel clinics.

RP: Ya. Then we got into I think we're getting into again another period in the commodity market into the '90s. Coming out of the '80s, the ? oil and accumulation of significant debts has Dick Johnson, who was then the minister in the treasury, and the

Getty government had used Keynesian methods to try to ameliorate the worst of the recessions that hit the province. So they engaged in some fairly significant capital expenditures in hospitals and other related care across the province and added quite a bit more to the debt for capital purposes. Somebody could argue a portion of that is really the good debt in the sense it is long-run payoffs; another group argued that debt is debt and you were in the process, if you were accumulating more debt just from operating purposes anyway. So any of that. By that time it got into the Ralph Klein era. As Getty stepped down under an unhappy decade and Klein then showed up on the scheme of things. Now the Liberals under Lawrence Decore of course in the provincial area had said this for PC government is the worst wastrel group we've ever had, we need good solid fiscal management, and waved his wallet and everything, and just about cleaned out the Conservatives in that election. … Ya, Mike Percy from business school and whole other groups. So all of that was linked to those reforms and what you've got to do is balance the provincial books. Both the Liberals were on that for the political side, because they saw they could get a large part of the right-wing vote with that. So it was really a right-wing Liberal group that were probably, well no they might've been, they were actually more right-wing than the Tories that were in power through the Getty Keynesians and other sides. Then came Klein. Now we had no doubt about what indeed was the key priority, and that was to eliminate the debt. That was fairly straightforward; the message was kept there. So what you had to do was start cutting programs. The problem was that there wasn't too much spending. It wasn't on the revenue side; there was just too much spending. The thoughts that Alberta still had one of the lowest tax regimes than anything else around and most things might be looked at were thought to be only dreamt up on occasion by people of leftist and academic and other suspicious types, and not to be really be uttered by society. Particularly if you were in Calgary. Though it could be raised in Northern Alberta and still survive, when you got to Calgary well nobody would even think of that. Anyway, so the popular ex-mayor of Calgary then rode that theme and we had the massive cuts then. Now the cuts were centred around, and that really had considerable impact on healthcare. Because this then led to the first systematic attack on the comprehensiveness principle in Medicare which is, well what services are covered, and the whole discussion about the core services. Well we'll à la Oregon, Oregon is a state in the United States that went along and said, let's define certain key or core services. All right, here they are. And let's take a look at how much money we've got. Okay, we'll cover heart attacks, we'll cover strokes, we'll cover babies, simple fractures. What's the bill? Everything from fractures on is out. Here's the core services. So that whole discussion, what could be the core services. Parts of the Calgary group and the other sides then were involved in this whole matter, proposing it to the Medical Association. Things were really looking dim in terms of them coming and saying, well we should have a nice increase. Well the government was in the tank, the debt was in there. They were cutting services, academic positions were down, school positions were down, hospitals were being closed, thousands of nurses going here. And the medical profession are going to get a fee increase? Not on your nelly. So a core in that group, then the medical profession started to get more active now in say, well okay, what happens if we de-insure? So in effect if we de-insure, reduce it, but we still have the core of services there, so like if we've got 75 or 80 or 85% covered, then we can price and sell the rest of those services, we probably can do as well or maybe even better than a system in which

we're faced with a set amount of money and we've got to split this pie among all the different disciplines. Because I don't know whether you know it or not, but under a fee-for-services in Alberta there's no relationship between really the time, skill and everything involved with respect to the fee. What happens is in all 35 or 45 specialties, then it's a question of how the relative earnings in the specialty compare to the others that are thought to be similar. If you look at it, then you adjust the fees. They've got all the information there and you adjust the fees back on the AMA committees and you see if they got 10% there on a fee, whether it was for surgeries or if offices it's in general practices, that went up by $2 here, then what would that generate? Okay, let's see, we've got three quarters of a billion in that package, we think we can get maybe, maybe we'll get $800 million out of them or maybe they're going to cut it back to $700 million. Well here's what the fee sides would be. So the answer, sort of say, okay we're capped as far as the AMA was concerned and capped as far as of course the hospitals were concerned, because they were cut. Now what? Then came a lot of the pressure on the core services, the comprehensiveness of the plan and all that. Out of that then came the whole fight again. Friends of Medicare, consumer groups, consumer association, and I think the Friday group, which was sort of a more quiet back, the Friday group was more of a strategy group. Then there were the individual groups all went back and did whatever their own thing. It wasn't that there was some master plan necessarily, but it was an exchange of views on this. So the Friday group, so out of this then came the fight about the services.

Q: Did they de-insure a significant number of services?

RP: No. Actually I think, if I remember correctly, Marv Moore was in there. The minister, I think he got vasectomies out, I think he got eye examinations for people over 65 and over and under, or no, between 16 and 50, 64, and those under were covered and those over were covered. Then I think eventually that got reinstated. But there was a small amount was tried in the public were not going to buy into de-insurance as a way of balancing the comprehensiveness with respect to access to services. Then so all that discussion, which there was a considerable amount, and then Bill 11 now, which was again really, that was the one that backed Klein right off I think in terms of what he had been hoping for the restructuring of the system.

Q: It was actually the second generation of legislation. The first was Bill 37, which essentially proposed the same thing, public payment for private services.

RP: Ya. So then came, I think I did a study then on impacts of privatization, private delivery under certain circumstances, on Alberta. I got set out, then a number of others got into the act. People said, and the physicians that were arguing that they should be able to carry onto the next step and have a two parallel system. In effect, doctors could be in and doctors could be out, back into that theme. You were in or you were out. Well it wasn't extra billing, no. Well what was it? Well if you came in and you were oil and you came in and you were a farmer, well you got Medicare and you didn't. So that scheme, well let's put them in a different setting. We had MRI. With the MRI debates, we had a whole set of activities as physicians were trying to find ways, certain physicians. Mind

you, we need to be very careful, because there have been many physicians that were very committed all the way through to the Canada Health Act type of healthcare delivery system. But they were quieter in Alberta.

Q: I remember two or three CMA presidents in a row appearing to present a case for two-tier medicine when they were elected.

RP: Ya it's, well in recent times we've had the worst cases with respect to the National Medical Association, which is the CMA. With the advent of Dr. Day from the Cambie Clinic in Vancouver, then CMA takes turns across the company as to which group will be able to pick the president. So out of British Columbia came Day and that group. Of course he's a very strong advocate for pulling much of the public sector coverage provision of services into the private clinics, and of an activity-based funding model and other things along those lines. So the whole issue about what happens when the private clinics are established and you start to have the governments or the health authorities then funding more of the Medicare services through the private clinics, what happens to healthcare under that setting? So one of the, and of course Calgary was a strong proponent in that, one of the reasons it was a strong proponent of that of course is that they had effectively, Calgary Regional Health Authority sold off the Holy Cross. Sold off the Holy Cross, blew up the Calgary General, and told the Salvation Army, which was the women's hospital in Calgary, 150 beds, hey we don't need you. So they took out about in the neighbourhood of 1100 beds out of inner-core Calgary, I think on the thought that somehow somebody was going to give them a number of beds out in the suburbs, particularly in the southern part of Calgary. Well whatever the reasons, they took out large amounts of beds as part of the cuts. Fire them, blow up the hospital, take it out. The Calgary General, that's not coming back. It'll salt the earth and nothing will ever grow again for that one. But when it came to the Holy Cross and the Salvation Army, they came back.

Q: Was that the Grace Hospital?

FR: Salvation Army, Grace ya. Because that one was picked up by HRG Health Resources Group; I think they call themselves HRC now, whatever. That was headed up I think by the head of orthopedic surgery out of the Foothills and that group. They started with a floor or two of the Salvation Army Grace that had been sold to investors. I don't know their, I forget, well there's a group that are a part of that ownership group down there. Anyway, they viewed that as an opportunity for the private sector to get into ownership of the hospitals. They then proceeded to, and through the clinic, say, well it isn't just the cataract clinic, that's kind of a small thing. We now want to do some major surgeries. We want to do hips now and overnight. So this is major surgery and it's overnight stays and everything else. Then came the whole discussion about, well what's going on, because now what you've got is the private sector building hospitals. They said, no we don't need to build a hospital, we've already got an existing hospital that the Calgary Health Authority gave us for a few cents on the dollar. So a hospital is a hospital. Are the doctors good? Well ya, they're the same ones that are operating over in the Foothills and other areas. So then the whole debate started. The first side from the

consumer movement, the health movements, Friends of Medicare combinations, I don't remember. Wendy was in it right from the beginning to the end, and Verna and a few others. It was the College of Physicians and Surgeons. Look, when is a clinic a clinic and when is a hospital a hospital? These people are doing some major surgeries. So the College of Physicians and Surgeons got into a major debate and discussion on it and finally said, after they reviewed everything, well okay, these people can do hips, then can do overnight stays and other things there. So they said, technically it's possible to do this; this can be done in a safe and responsible manner, so we have no reason to forbid it on grounds that it's going to be a practice of medicine that's unsafe and therefore we could simply rule it out. We can't rule that out, so this can proceed and we're reasonably confident that the people know what they're talking about and it'll work. So then the question was, well in terms of the funding. Well we had the Marleau letter so you can't charge more than what you'd get for a similar procedure for the Medicare patients. But for anyone else that wasn't a resident of Alberta, that opened the door. Then if you happened to be in a different group, whether you came for procedures (there wasn't just hips but a number of other things could be done – arms, knees, joints and things of that sort), if you're a Workers Compensation Board… Oh well, you don't have to wait or get on the waiting list. My goodness, we can whip this thing right through. Well we'll put them through. The private clinic worker that is some waiting and is repaired is a happy worker. So happy employer, this is a wonderful thing. They said, and it is really wonderful because here's what you're going to pay. That's going to be very different from the Medicare and other coverage. Otherwise the worker went into the public sector and didn't pay anything for the hospital or the physician fee, but it was a longer wait. So we really have within Medicare, which is within the public sector's funding, you really have then this other group called Workman's Compensation Board, that seemed to fall within the public sector, that was really not much consequences when the public sector seemed at capacity, all of a sudden jumped ship and say, well our job is take care of our workers. Here's a quicker way of doing it and getting a good service, and we'll pay for it. RCMP, well if you get hurt or something of that sort, hmm, why not. Some of the armed forces. So all these groups then started to be candidates for that type of clinic operation. But again, that still isn't big, I don't think. Now the question about out-of-province then, how much would come into that? After all, Gimbel at one time used to have buses go up to Saskatchewan. Load them up, and all the people that needed cataracts from Saskatchewan would come down and pay $1500 or three times the fee or whatever it was, in Calgary. Saskatchewan was just going nuts.

Q: So Marleau's letter didn't exclude people who would otherwise be covered by Medicare, because they lived in Saskatchewan?

FR: That's right. Across borders we have, even to this day, a very significant issue now arising. But I'll just try and finish that comment with respect to the Calgary thing. So Calgary then, markets were found other than just the Medicare market, sorry, and the Medicare market was one in which the Calgary Regional Health Authority said, okay we destroyed all these hospitals and everything else. All right, we need 500 hips, we can't pay any more than the other side, but here's the amount – 500 hips go to you, are you interested? That's the payment. Yes, thank you. So then the contracting out. Sorry, back in

the earlier response I should've said one of the things was, in terms of contracting out in terms of the cataract private clinics, that also occurs extensively in Calgary. And a number of ear, nose and throat. So there's a number that went into some of the, I believe the Holy Cross in Calgary. There's a whole range of contracted-out services that in the Capital Region were relatively nominal, in the Calgary Region were greater occurring. But the issue when it finally got into the Bill 11 side was to say, well wait a minute, this is not just something, well can you do it, which is the college side, so you know it's safe to do. This has got a lot more implications. Well what is it? Well if we've got the physicians busy over working in the private clinics doing these things and they're not doing the contracted Medicare stuff but they're doing other services, what you've done is set up a platform to take a large number of the skilled medical manpower or person power out of Medicare. So you can significantly hurt the Medicare system by allowing and licensing these private clinics and allowing them to expand. What you'll do is take medical hours, manpower, away from the delivery of Medicare services. Since the pay is usually higher because they no longer have the single-payer control over fees, then what you will also tend to do is take some of the more skilled of the practitioners over where the rewards are the highest. Under Medicare, it tends to be the case that the people that are better at doing one type of surgery or the other will do it, simply because they're better able to handle that service than maybe someone else, for whatever reasons. Now they'll be over doing anything that any surgeon can do simply because there's a lot more bucks in it. So the whole argument was, you're going to significantly hurt Medicare if this just is opened up and you let these guys go. So then that ended up eventually in the Bill 11 fight. People looked up and people were hanging over the galleries of Legislature. They're at the doors and people were marching, and all hell broke loose throughout the province. They said, Ralph Klein is about to destroy Medicare and the population is saying, we can hardly wait until we get a hold of Ralph. So when the smoke cleared off, out came Bill 11. Okay, if you're going to be contracted out, then the minister has got to, for these private clinics, the minister has got to sign off on it. He's got to say, in my opinion this will not harm and hurt the Medicare system. I've looked at this case and this situation and have signed off on that. There's other aspects, but I think that's generally the essence of what's in the Bill 11 legislation – the harm-to-Medicare component. So contracting out, and the next thing we know or hear of is investors in Calgary then building a new facility, in effect really a quasi-hospital, because if I understood the College right, the only difference between the HRC operation and a hospital is there was no emergency. They were overnight, they were doing hips, they were doing major surgeries, this and that. And of course they don't want emergencies because what you're going to do is get the general public in there, blocking up and all these other things. What we want to do is generally cherry pick the system. Things that would really require complicated cases, very complex cases that say needed a hip or some other operation, would not be done in those clinics. They would go to the public sector side. So then generally speaking for medical reasons, then the public sector starts to get the much more complicated, complex cases. Then over in AMA land, they don't get paid any better than they do for the guy who does the straightforward cases. Alberta, I think, failed to get the relative value unit systems in that varied the rates or compensation across that side. So now we're into this modern issue led by the Cambie Clinic, led by the CMA. The Canadian Medical Association, now in recent times, like the difference between the

former pediatric cardiac surgeon, Colin McKay[ALHI: his name was actually Colin McMillan], who was a Medicare-supporting CMA president. Then came Dr. Day out of British Columbia. Then came another guy after him, two or three in a row. They also got rid of a bunch of people in the CMA office, editorial boards and other things along the line. So the CMA has been advocating very strongly for relieving the pressure on Medicare, giving patients more choice. People should be able to just go to the clinics of their choice – if they want to pay the full fee, they pay the full fee. Of course Dr. Day's fee is a very nice fee, way higher than the Medicare fee. Day has refused to turn his books over to the British Columbia minister of health. I don't know whether he's in lawsuits involved there or not, the Cambie Clinic. Then they gotta find out what's going on in there.

So anyway, so there's a whole group growing there. Then in British Columbia, sorry in Quebec, there's the Chaouilli case. When the smoke cleared off that, the Supreme Court said, well this, in four to three or whatever decision, hmm, this does violate the Quebec charter, but not the Canada Charter of Rights. Therefore, there is a case for saying that Mr. Chaoulli or, I don't know, he was a medical practitioner there or a patient or whatever, should be able to access private insurance to be able to pay for the service and a private service. I've been told, although I haven't checked that out, that that's led to quite a growth in private clinics within Quebec and Montreal, changes, for certain ranges of services that were around, I think hips and things of that sort. I don't think the Quebec government of course was very interested in opening the door to widespread parallel systems starting up, because they have some desire to maintain their tenure in office. But they have got this charter side. So then this has been used by a number of parallel medical groups here saying, well now wait a minute, here's all this Chaoulli thing, and they've got the choice; we wouldn't have to wait, and look at these waiting lists. So the Fraser Institute has been leading the waiting list charge for a number of years. The relief supposedly is to drop the patients paying full tariffs outside of Medicare into private surgical clinics. So to run a parallel system, variation on the NHS stuff, reference after reference to say how well this works in Britain or how well it works in Europe, and this is the answer. Now taking that up to the present in Alberta, now that was underway and activities seem to be pointing in that direction fairly clearly when Ron Liepert was in. I'm not so sure that the Calgary investor group that started the hospital or whatever they're building down there…

Q: By Foothills..

FR: By Foothills, ya. Well that was started in Liepert's time or before, whatever. But the net result is then that the government of Alberta looking at the growing waiting list, because once they decided under Liepert the answer was to one, create a more efficient system, a more efficient system, okay. And also we won't give them the money that they think they need to operate the systems – health, hospitals and other related systems. So that then backed up the waiting lists considerably. The Alberta Health Services Board, which was to… fired all the RHA boards on May 15th, 2008 was that, probably, didn't have any way to take that over until March of about 2009. That's when our friend Duckett showed up on the scene. So Duckett presided over a system that didn't have its key administrator, so it had run major deficits. Then he faced a budget crunch that restricted

the amount going into health, so he had two problems to face. One, he couldn't meet basically his basic requirements for sustaining the existing system. And by June of 2009 he and a super board made up of business people, other than for one doctor out of Toronto, had got to the point that they got permission to go and borrow money from the bank so they could continue to operate. The waiting lists had mounted very considerably for the items that were on the provincial-federal surgical waiting list study or waiting list group, which the federal government met with the provinces. The federal government put quite a bit of cash into it to deal with what, nationwide, provinces had believed were certain lists of services where the waiting lists were not reasonable, in terms of access to services that's reasonable access to services. So the waiting list study out of that then, the money to go in that to do the job and the federal government, the Harper government, saying, okay we want action and we put the money in there and okay we're all working around to do that. Alberta hits a commodity downturn, goes into the super board, cuts the head off all its management, gets a new guy in who's still trying to figure out what to do, and things deteriorate in a major way. Pressures are really mounting, particularly in Calgary. It's got more beds but the new board really crunched for cash and told not to start going out and firing people wholesale or anything like that, then said, well we're not going to open facilities. So what we'll do is we'll get the bed blockers out, which are people in acute hospitals that have nowhere else to go. So we'll take those out but you can't then use those beds for operating purposes. We've got empty beds but you can't use them? Well you didn't have them for acute beds in the first place, did you? Well no, they were blocked because people were waiting to go into long-term care. Well ya, if we take them out, you haven't lost a bed, have you, for active acute services? Well no, but my God, we're in the business of trying to do something about waiting lists. Yes but if you do that, you'll increase costs. We can't have a cost increase. The last thing we can afford to do is to have you use the hospital capacity. We can't afford to run our healthcare or else we'll hurt our budget. So new developments in Calgary at the Foothills and other places, and I think the new heart institute and Mazankowski and a number of other things couldn't get opened or were delayed. People as they were retired weren't replaced unless they were deemed to be absolutely essential. A lot of the administration were turfed out the door, but in terms of mainline nurses and stuff, they weren't pruning the UNA lists or anything of that sort. Then we got into the Alberta Hospital. Another money saver would be, let's take …

Q: 246 beds.

FR: Ya, out. We'll take 100 or so and put them in the long-term care facility near the Misericordia, or sorry, the new lodge. We'll take out that many beds, leave a small forensic unit. Then a whole rebellion went on. Then the union movement, AUPE plus all the rest and the psychiatrists and everything else, then it became clear after a while that this was a no-win situation. That was near the end of, well that was getting near the end of Liepert, who was presiding over all this. So the solution was a variation to say, well if they don't have the money to operate the system, we can't operate the system. If they can't operate the system, the waiting lists are going to get worse. The situation is worse, they can't provide the services. Well why can't you do that? Well one of the other things is, we haven't any labour agreements. What's that? Well see we said there was a shortage of

nurses and a shortage of doctors and all that. Well we put some pretty generous by today's terms agreements or escalators into the agreements. So I mean if we've got a 6% escalator coming in and we've in effect got 2% to deal with that, we're done. We're smoked. We've gotta take out existing capacity, however you want to do that. So it became very clear, well by June 2009, well we'll short term, can we go and borrow? Wait a minute, we told you that's all the money you had, and now you're going to go out and borrow money. Wait a minute, like over here in the provincial treasury if we do that… Then all of a sudden the government got into it saying, oh no that's all right. You can use the line of credit, dah dah dah. When Capital Health, when it was formed and facing the same crisis it said, oh you know, if we went down and borrowed the money we'd just have to pay back the interest and we could smooth out some of these things over time. So some of them went down to investigate the possibility of borrowing. The provincial treasurer explained to them in such clear terms what would happen to anyone who thought what they would do is to totally disregard the budget that was sent and start borrowing money and just paying the interest. They said, well I'm short $100 million. Well I wouldn't have to pay $100 million in interest. No, I can just pay $10 million and I would get additional money. Then you'll add to the… So anyway, in desperation that went on in June 2009. So then came the realization that, or indication from the government saying, uh-uh, this is a Medicare province. Okay, we're not going down that end, what's it mean? It means a lot more money. Okay, here's the cash come in place to take care of the deficit that HS has presided over, and here's additional cash to get you up to a base-year reading. Then here's the rest of the next four years that allow you; you'll have a controlled budget but you'll be able to sort this out. It means that they're going to have to of course do some very interesting, have some interesting discussions with their labour groups, because over 70% of the operating costs of a hospital involve labour costs basically, somewhere in there. So that's one of the big issues. Then you've got all the rest of your purchasing arrangements and all that that goes on backward and forward. But somewhere the labour cost component will have to be addressed of course in terms of the reality of shortages. Well you've got to meet the market. If you don't pay, you may not get them. If you're already, mind you, the highest in the country, then it may be possible to aware smaller or get agreement, however reluctant, by leaders, to have smaller increases in other areas, because you're still ahead of the game where you're not going to lose. That's all negotiations and that's all UNA and the other stuff that'll be going on. All that's to come. But the story is, I believe the thing is to say, okay, government of Alberta said, we looked at this and we are going to stick with the Canada Act. Now okay, we're going to put money into the existing system. Then we've got, under the Liepert side, we hired a specialist in activity based funding, which is volume based funding, to do Duckett. He wants to implement that. Now he's doing it. The first round is long-term care. That's to begin in April, to my understanding. Well no one knows what that will be about, but the focus has been in the acute care side as to what this, and I think that's 2011, to try to put that into the acute-care side. In the meantime, the minister replacement from Mr. Liepert, has said, what is going on over here? Oh well, we incentivized doctors and hospitals. Oh ya, we're going to pay them on what they do. If you doctors do more than the other doctors, you'll get more. If a hospital does better than another hospital… We're going to have competition and that's going to solve things. Well wait a minute, I'd like to hear all about this. This is news to me. And also we need to establish some lines here between

what AHS is doing and what the government health is doing with respect to policy issues. And ground ambulances, well we did the urban side and as we got into rural Alberta there's integration between the ambulances and emergency services, and it becomes less clear and all problems there. I've just stopped all integration of the services in rural Alberta. So there's a whole re-think going on right now on policy and initiatives as to how they will work? Medicare direction. But you've got AHS and it's board direction very much on the Liepert or that direction, reduce the cost. The activity-based model is a real major issue. There's pros and cons on it, but certainly one of the cons would be if you haven't got your costs correct, which is little likelihood that you would, but if you're doing an appendectomy and you're only paying so much for an appendectomy across the province, and somebody is going to, if the distribution was normal, 50% would get overpaid and 50% would be underpaid. And how's the little hospital out in rural Alberta, the little 25-bedder, how's it's going to do against the surgical volumes that go to Royal Alec? If you actually get all the overhead and teaching and stuff out of the Royal Alec stuff, then those guys who do four of those a year compared to guys who do 1,100, I wonder if there's going to be a difference here. I wonder what the price. I wonder what are we doing here. So the needs-based funding, which was population-based funding that said, here's the IRW so the complexity weights and cost differentials said that the Edmonton area, because they were older and sicker, had far greater needs than the Calgary area. Therefore, in RHA transfers, larger funds were needed where they were sicker and older. Well if you just do it on here's so much, an appendectomy is an appendectomy, now what happened to the needs-based differences in various regions of the province with respect to it? So there's all sorts of interesting issues are going to crop up again, this time on the region and meeting the needs for a comprehensive fully accessible system in terms of delivery and meeting the principles within the province. Because the old system was needs-based block funding for the RHA and said the RHAs had the responsibility of sorting it out within the areas. Then encompassed with the idea that we'll create an Alberta Health Act, a new one, and we'll put in an Alberta Health Charter. The original charter of course came from Hall. Canada won the general framework. The Alberta one has some number of aspects to it plus other issues. Hall actually spent a fair amount talking about individual responsibilities as well as collective responsibilities on all the sides. Too it's some of the background that came out of the Horne, the paper here. But Bill 11, the Hospital Act, Medical Professions Act, the Alberta Healthcare Insurance Act – all of this legislation that was built over all these decades that protected other things then was to be replaced by this act that will be enabling but not. It'll be in the regulations that the specifications or the controls will be in the regulations by simply order-in-council versus amendments to the act, which then gets you back to Bill 11 and the discussions or whatever else may come in. So there's those hearings that have been held. So very much the future of the Medicare system or variations on it will be debated again. We'll be back to Hall visitation from '64 onward, this time with a charger in the middle of it plus the rest.

Q: Alberta based though.

TW: The Alberta base, supposedly. Now we'll see what the population or what their actions are. With a lot more money into the system, right now what they're trying to do is

alleviate and bring those waiting lists that were created for hips and knees and all that stuff down to the benchmarks, the provincial or national benchmarks that have been agreed on, that those are the maximums. So they've gone over them in the clampdown, try to get them down, and they've got the money and resources to do it. The first round though, Alberta Health Services, then using just a contracting-out or kind of a variation on the activity-based funding model, gave the major awards to the private clinics in Calgary. So the thing then is, well where's the need? If the needs are higher as we said with respect to greater in the Capital Region because you've older, sicker population and you're pouring more money into private clinics in Calgary and this is a province-wide system, are you telling us we're driving to Calgary? I think we have problems commuting from the airport now, but continuing on down…Interesting enough, the Wild Rose Alliance, somebody told me, had actually passed a resolution and it said, well they believe all public healthcare should be fully funded by the ??s. So again, in the interesting issues of where and crossing all political borders, which Medicare does, where seemingly the right and the middle and the muddle where we're at, we're trying to re-converge onto the central framework in the act. Which way it goes, there's lots of opportunity for diversions. In the middle of it is, well we're building a new hospital down here and we want more private and other things. So the price of maintenance of full Canadian and Alberta Medicare system is eternal vigilance to just sort of take a phrase off of Thomas Paine – the price of democracy is eternal vigilance. Well the price of retaining your Medicare system as set out is just about like that. But a lot of the pressure where significant numbers, to my knowledge, of Calgarians particularly were going to other provinces. I even have some acquaintances here for example that have said, I needed a hip, they told me such and such. Hey, I paid for my MRI, they told me I had to wait for that. I paid the $750 and got my MRI. I went down and it cost me $12,000 or whatever at Cambie Clinic. They did it there, my hip's fine, and I'm taken care of. Well that was fine for them, but it's not very fine for the person of modest means or ordinary means as to what or how they would do it or access it. So all of this is happening that the province's current minister of British Columbia is saying, well there's no reason that British Columbia can't be a centre of excellence, point of tourist destination, now that the leverage is over for healthcare. Well why is that? Because you see they can come, these clinics, surgical clinics. The British Columbia Medical Plan—no, we're not extra billing, we're not doing the facility fee. No no, they're from another province, another province let me tell you. So then the whole discussion, I think we're at the point again where we need to say on the Canada act or another visitation down to Ottawa and say, wait a minute, we're supposed to have a Canada Health Act, right guys? You're given the money for? Ya. And you're saying, well okay, what's happening within the province, each of the provinces and territories? Well what's happening in between? If you happen to be a Canadian and from Alberta moving to BC, what is going on here? It's one nation. Now the federal government of course are not happy position. Well this is a provincial area but they still control the money. If they say, well when is this coming due for the next look? Well maybe it's three years from now or two years or whatever. Provinces, guess what, how would you like another addition? Or which is the carrot approach, well we'll give some money for you that can't provide the needs to meet that requirement, and you won't have to see your people going across the provincial borders. But then wait a minute, we're supposed to have, in terms of the Canadian Health Transfer Act, so much money and

everything sent across, and we're not, we don't want to do all that and then open up. You know we'll start to fund every set of services. We've done it sort of on this special waiting list grouping but we're not going to ? a wide map. So there'll be a lot of discussion of those things for sure. But again, it's all centered around the new polar issues that there has not been sufficient resources, however measured, been allocated to meet a number of the needs. Alberta having one of the highest income of all the provinces in the country, and Calgary being the highest of all of them in terms of being a major corporate centre, and being a major corporate centre for international oil and petroleum corporations. As I understand it, whether you're in Dubai or whether you're in Houston or whether you're in Calgary, no matter where you're at you're covered by your Exxon card. Your Exxon card provides you with a very nice package. If you need your care, go and get your care. You could have it in the public sector and Exxon doesn't get billed. Or you could have it in another sector and Exxon does get billed. But whatever it is, you're covered by the package and you get it. All you have to do is take your card.

Q: When they do go to the HRG hospital, that is covered by the Canada Health Act, they do bill Medicare.

TW: Ya, Medicare…

Q: Then they're allowed to do extra billing, because the people aren't covered strictly by that Marleau letter.

TW: Ya, because if the Workman's Compensation Board isn't in there, the RCMP…

Q: But does Medicare still pay for that RCMP procedure?

TW: No, as far as I know, there's all these people that are outside it, and they charge whatever is agreed on for the rate.

Q: Are there cases of individuals whose treatment is covered in part by the Medicare payment and then in part by …

TW: Not supposed to be.

Q: So these people are completely outside.

TW: Ya, that's from what I understand on it.

Q: With the Canada Health Act, when I attended the Fred Horne press conference where he released his little paper, it seemed to me that he was suggesting that we're going to look very closely at what strictly speaking has to fall under the Canada Health Act – how far the province could go in shedding responsibilities without running afoul of the Canada Health Act. Is that possible?

TW: No, indeed that's what's going on in a number of the provinces rather than just Alberta. So if you say your senior needing care goes into an auxiliary hospital, if you say the senior is into now another facility, another setting. So in the comprehensive care package that was in the RHAs then the RHA would say, okay, we've got a block of funds but we try to find the least-cost location providing quality care for our patients. If that means that we have to spend a lot of money on homecare but the patient could still reside at home, okay we'll do that rather than to try to have them accommodated in an institution. Then we've got people in assisted living. Well that's people where they would pay whatever is required to be in that accommodation, but they would maybe need a pharmacist to help them or a home-care worker or a nurse. So those would be coming in. The province has put a lot of money into various assisted living complexes, in terms of subsidies to entrepreneurs or developers, so that when they build these facilities, then there was a limit on what they could charge in those facilities for the rent of the apartments or the living accommodation. A good place to check that would be the…

Q: Some of them are out of reach for those of modest means.

TW: No, there's no question. What it is is the set of as many circumstances in which it was possible for people with means to stay not involved in the public-sector setting. They wanted to minimize the number of people that had means from being involved in the public-sector setting, and to accommodate as many outside as possible. There's a whole range of things that are involved in that. So the question though is that in some of the cases, like my wife, she has a 95-year-old aunt living in Ironwood Estates over here. That's a place where she goes down and gets her meals. So Margaret goes over from time to time. We watch and go with her and she goes over to the doctor and she needs some other things, or homecare comes by. But she's 95 and still able to live in that setting. But she pays the full rate that's involved in that setting. If you didn't have the money, then I don't exactly know what does happen.

Q: Some of these seniors were bed-seekers, and as long as they were they were covered by Medicare.

TW: Ya, if you get them out, then comes the issue. So that's why a number of seniors lie for days in the emergency ward. If you ever admit them, then you can't get them out. So if you can possibly treat them without admitting them, then they were left. Like my dad spent five days in an emergency ward and I had to go down there. So there's that whole pressure not to admit because if you get them in and you don't have anyplace to go. In my dad's case, he came out of an auxiliary hospital and then in there. But a lot of them have no other place to go. If they're at that level, their health has deteriorated to that point. Then the hospital has to face what they're going to do. If they admit them, they got them, if they haven't got an auxiliary hospital or nursing home that they can discharge them to. Now the nursing home sides are getting more complicated.

Q: At least they have a Nursing Home Act, whereas the other facilities may not.

TW: Ya, the continuing-care issue is where comprehensiveness is a major, major matter.

Q: Once they're out of the hospital and in care, they have to bear the costs.

TW: Ya. They can move them from a hospital into things like a sub-acute setting. Generally speaking, if they can move them out of the hospital setting where the hospital services delivered within hospital services, if it's not a hospital then what is it? But then that's where I think you get into the Marleau letter on the clinic. You said, okay you took the clinic and said to surgery, well gee we're doing the cataract surgery there but not in a public hospital, therefore you can charge. No, no, no, this says that is a hospital. Well if that's defined for that purpose, now what happens over here on the continuing-care issues? So that would be quite a whole fascinating dimension of the-- I haven't heard anybody or seen any exploration yet of this. Because in part it's a physician saying they're discharging them. Well we will discharge them to an auxiliary hospital, we'll discharge them to a nursing home but we can't discharge them to assisted living. We can discharge them to their home. They're not fit to do that. But in ? the position, Marleau, which ? said, what? Is to pay the doctors special bonus to move them out. One of the things that's implicit in this Medicare system is that we pay the doctors independently of the hospitals. We pay the doctor to use professional judgment for his or her patient. The doctor has the right to then recommend admission to that hospital, the responsibility with respect to the care, and when to discharge. In terms of, that'll be determined in consultation. But that is the idea that the doctor is paid by the patient. Though it is paid on behalf of the patient that is under the public insurance plan, it is no different than if I, you're the doctor and I hand you the money. It has been paid on my behalf because I'm a member of a plan, but you're being paid for caring for me. What Duckett isn't telling about is saying, no we'll change this term. Now rather than just the doctor being paid for taking care of me and my best interests, now I will give the doctor something to do something different than he would've otherwise or she would've otherwise have done. There's a very fundamental difference here between who is the doctor working for. It gets into a whole ethical and it gets into a whole major debate here. In our cultural tradition, if I can use that term, it's an economist using that term, maybe it's pretty alien, but in the British and other systems where the doctor specialists, the hospital specialists are part of a funded system, they're an employee of the hospital. Okay well it's the hospital pays and how much money you got, and I guess they do whatever. But this one said, no no no, we're not turning the doctors into, as they would've said in Tommy Douglas's Saskatchewan, an employee of the state. They will be independent and for very good reasons. Not just because doctors want to be independent, and we have to pay all this money for all these little shops and little practices all over the place, which are very inefficient. You could put them all into a big… But one of the big payoffs to patients supposedly is that we have that physician paid by us or on our behalf to give the professional opinion free of any other economic or other forces that would interfere with their judgment. So this is not a small thing and that's why I want to get that through to Gene [ALHI: Gene Zwozdesky was Minister of Health at the time of this interview], who I think is kind of looking. But a lot of them don't understand the systems or think about them in that way.

Q: Are you going to have a chance to explain this to Gene?

TW: Not in the short term here, but I hope to send something to them. To get it through and say the incentivization so-called is… The administrators of the hospital, it's not only Dr. Duckett that's got a set of claws in there. That's very interesting by the way, if you look at what he gets paid for. But also his executive teams. I don't know how far this goes down now, but there are wide… I picked up one one time through the Internet and talked about what the amount that would be paid to the vice-president of finance for his incentives for the performance of the system. Here were the things that he was going to get paid a bonus for in addition to his base salary. Then to me, the objection here was, look, to pay the doctor to do something different to the patient, to try to take and say to any of the people that are running the entire system, here's what we identified. You'll get bonus for, okay shortening the waiting list. Oh ya, okay shortening the waiting list, therefore you get another $50,000. Gee, I thought that was your work. Well ya, but also Duckett gets bonus for people getting flu shots. Duckett gets a bonus… So you create all these myriad of things and say, wait a minute, what is this? It's all the utilization, it's the whole performance of the system. There's all these things, they're measurable, you can quantify them. But that isn't the outcome of the health system, it's the improvement of my individual health status. Well then they got that. So you had two measures in there. They do have a survey on what was patient health status. They had that-- do you think it improved or deteriorated? That was self-assessment. Do you think… so there's a couple there. When you've got this comes from the private sector remuneration of executives and employees. In the private-sector side things are way, way easier. They have one metric that's very important, and that is the so-called bottom line. If it is profitable, and profits are there and profits have increased, we reward you. If profits have fallen, we might admonish you. If you create losses, we're going to fire your butt. A combination of that takes all of the hundreds of things that a corporation might be doing or anything there, and boils it right down there. Starbucks guy, GM guy, mining guy, and everything else, what happened to the province, what happened to me in terms of my shareholders. I've got a common, simple, measurable metric. I have not got that nor will I ever have in the health system. Now you're trying to create that. I can find 10,000 different things that are done in the public health system. How do you pick which is important? This is not good news, in my view. In my opinion, if we let them be paid on these bases for whatever they're putting in there, it's saying, well if you went to a kingdom and all of the patients had one leg on a health ? and say, I think your doctors are only paid for cutting off legs. So this is why it matters what they're trying to do with this system. Just waiting list, yes there's a reason and everything for waiting list. But just waiting lists are not a thing by itself to run through to assess a healthcare system. Cambie Clinic and the Fraser Institute might have that type of thing in mind, because you can run big volumes through. But doctors that over-service, doctors that over-utilize, if after a while then we're back to the one-legged people, then how many people are getting hips they don't need? We've got these whole types of issues. So it's a whole matter that needs to be, that's going to be opened up. Those decisions were made internally and looked at in terms of RHAs, in terms of volumes, what's done and other things and stuff. But this is trying to incentivize it, incentivize them at other levels.

[END]