



Failing to Deliver

The Alberta Surgical Initiative and Declining Surgical Capacity



| Andrew Longhurst

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Executive Summary

Announced in 2019, the Alberta Surgical Initiative (ASI) represents a significant expansion of for-profit, corporate health care. In February 2020, the Alberta government announced it would spend \$400 million outsourcing surgeries to for-profit facilities and committed to doubling the number of outsourced surgeries over three years, from 15 per cent to 30 per cent of total surgeries provincewide. These publicly funded surgeries would be paid for by Alberta Health Services and the Alberta Health Care Insurance Plan, but performed in for-profit facilities. While only three years of data are available so far, the significant costs and risks to Alberta's public health-care system are already apparent.

Through Freedom of Information requests, statistical analysis, and a review of the research literature, this report evaluates claims made by the Alberta government about the effectiveness of the Alberta Surgical Initiative in reducing wait times and the role of for-profit surgical outsourcing. This report finds that Alberta has among the worst performance in reducing surgical wait times in Canada. The province has prioritized for-profit surgical delivery rather than system improvement and fully utilizing the nearly 30 per cent of unused public operating room capacity.

Contrary to government claims that outsourcing to for-profit facilities increases provincial surgical capacity, data suggest that the expansion of chartered surgical facilities (CSFs) has diverted resources away from public hospitals and, in turn, reduced provincial surgical volumes.

Under the Alberta Surgical Initiative, provincial surgical activity has failed to increase from pre-pandemic levels, and public hospitals face reduced capacity and operating room funding. And yet, investor-owned surgical facilities are expanding through substantial contracts with the government. Between 2018-2019 and 2021-2022, surgical volumes in chartered surgical facilities increased by 48 per cent while surgical activity in public hospitals declined by 12 per cent.

Surgical outsourcing comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long term, especially for patients requiring complex surgeries only performed in the public system. The expansion of this for-profit sector invites a greater risk of two-tier health care through unlawful patient fees contrary to provincial and federal legislation.

A New Legal Framework for Chartered Surgical Facilities

In 2020, the Alberta government passed Bill 30, which established the new Health Facilities Act, and amended the Alberta Health Care Insurance Act. The legislation itself does not increase surgical outsourcing, but the creation of “chartered surgical facilities” streamlines the process of approving facilities, creates greater certainty for investors looking to open CSFs, and establishes a more expansive form of for-profit surgical facility that paves the way for a for-profit hospital sector. Under the legislation, CSFs can upsell patients medical goods and services, as well as perform private-pay procedures. Public funds will subsidize the expansion of this for-profit sector by allowing these corporations to maximize public and private revenue streams.

Changes to the Alberta Health Care Insurance Act also allow legal entities other than physicians and physician professional corporations to bill the government for the provision of insured services. This fundamentally restructures how public funds may flow by allowing corporate (non-physician) entities to have a direct payment relationship with the government.

With this new framework in place, the for-profit sector is expanding with significant new public subsidy under the Alberta Surgical Initiative. In 2009-2010, AHS held contracts with 36 CSFs; by 2021-2022, 51 CSFs were under contract. Since the introduction of the ASI (2018-2019 – 2021-2022), the number of contracted surgical procedures performed by CSFs has increased from 29,052 to 43,078 — an increase of 48 per cent. Payments to contracted CSFs increased from \$17.2 million in 2018-2019 to \$27.7 million in 2021-2022 — or by 61 per cent. The largest annual increase in AHS payments to CSFs was between 2020-2021 and 2021-2022 (27 per cent) — the third year of the ASI. This reflects new and expanded CSF contracts taking effect.

The continued growth of the for-profit surgical sector will likely continue based on analysis of signed contracts between AHS and for-profit providers. In 2022-2023, the maximum value of all surgical contracts was \$79.7 million — a significant increase in the actual AHS payments to CSFs from \$27.7 million in 2021-2022.

Evaluating the Performance of the Alberta Surgical Initiative

Like all provinces, Alberta is struggling to work down the pandemic surgical backlog. However, wait times for three of four priority procedures were already increasing prior to the pandemic.

In 2022, Alberta had among the worst wait-time performance for priority procedures in the country. Furthermore, the trend from 2019 (the start of the ASI) to 2022 indicates that wait times for hip and knee replacements have worsened significantly, and more precipitously than the Canadian average:

- In 2022, 65 per cent of Alberta cataract patients received surgery within the benchmark, and just below the Canadian average of 66 per cent. Since the start of the ASI (from 2019 to 2022), the share of patients meeting the benchmark has increased from 44 to 65 per cent — the largest increase among the provinces.
- In 2022, 38 per cent of Alberta hip replacement patients received their surgery within the benchmark compared to the Canadian average of 57 per cent. Since the start of the ASI, the share of patients meeting the benchmark declined from 64 to 38 per cent — the second-largest decline among the provinces.
- In 2022, 27 per cent of Alberta knee replacement patients received their surgery within the benchmark compared to the Canadian average of 50 per cent. Since the start of the ASI, the share of patients meeting the benchmark has declined from 62 to 27 per cent — the third-largest decline among the provinces.

Some provinces increased surgical activity in 2021 over pre-pandemic levels (B.C., N.B., N.S., and P.E.I.); Alberta never achieved this, raising questions about the prioritization of funding and staffing for CSFs and its effect on public hospitals.

Increasing total surgical capacity in the province has been the primary argument for greater outsourcing through the ASI. However, surgical volumes data obtained through Freedom of Information requests reveal that the ASI is failing to meet its stated objectives. Of most concern is the fact that the province's total surgical activity declined in the first three years of the ASI.

Specifically, analysis of data obtained from AHS shows that:

- Total provincial surgical volumes have declined since the beginning of the ASI, to levels below those of the 2014-2015 volumes. Fewer total surgeries were performed in 2021-2022 (268,335) than in 2018-2019, that is, pre-pandemic and before the ASI (285,945).
- Total provincial surgical volumes declined by 6 per cent between 2018-2019 and 2021-2022 (the most recent data available).
- The expansion of for-profit surgical delivery appears to be undermining the ability of AHS facilities to increase or even maintain their surgical volumes. The number of surgeries performed in CSFs increased from 29,052 in 2018-2019 to 43,078 in 2021-2022 (or 48 per cent), while public hospital volumes declined from 256,893 to 225,257 (or 12 per cent).

- The share of total provincial surgeries outsourced to CSFs increased from 10 per cent in 2018-2019 to 16 per cent in 2021-2022. During the same years, the share of total surgeries performed in public hospitals declined from 90 per cent to 84 per cent.
- Since 2010-2011, the greatest reduction in public hospital surgical volumes occurred during each of the first three years of the ASI (2019-2020, 2020-2021, 2021-2022), suggesting that funding and staffing resources have shifted from the public to the for-profit sector — or at least constrained public hospitals from increasing surgical activity.

This reduction in AHS surgical volumes cannot be explained by the pandemic alone, since surgical activity in CSFs increased between 2018-2019 and 2021-2022. Declining funding for public operating rooms (ORs), as well as a reduction in staffed hospital medical and surgical beds per capita, suggest that the government's focus on increasing CSF surgical activity has constrained hospital staffing and surgical activity. Between 2018-2019 and 2020-2021, public operating room expenditures decreased from \$576 million to \$561 million. In 2018-2019, Alberta had 139 hospital medical and surgical beds per 100k population, which declined to 130 beds per 100k in 2020-2021. Declining public operating room funding limits surgical activity, and hospital capacity constraints limit the number of surgeries that may be completed; this can lead to surgery cancellations and longer wait times.

Provincial surgical volumes were lower in 2021-2022 than in 2018-2019, despite claims that the ASI would increase provincial surgical capacity. Reduced public sector surgical volumes — and reduced public operating room funding and staffed hospital beds — at a time when CSFs have *increased* surgical activity suggest that public funding and staffing resources have been redirected to for-profit facilities.

The growth of this for-profit sector appears to be exacerbating AHS staffing shortages and constraining surgical activity in public hospitals.

Problems With For-Profit Surgical Delivery

Increased public-sector staffing shortages and destabilized public hospitals

Outsourcing surgeries leads to competition between public and for-profit sectors for a limited pool of specialized healthcare professionals. The private sector offers incentives such as reduced workloads, less complex patients, and higher pay to attract workers from the public system. As a result, surgical activity in public hospitals has declined while for-profit facilities focus on lower-complexity procedures, destabilizing the public hospital system. Over time, entrenching for-profit providers also reduces the public system's ability to negotiate prices with private providers.

Unlawful extra-billing and two-tier health care

Arguments in favour of for-profit delivery are often based on the claim that contracted facilities will not engage in unlawful extra-billing (also called two-tier health care), which is the practice of private billing for medically necessary procedures that are covered by public healthcare. However, evidence shows that for-profit clinics and surgical chains are entrenching two-tier health care in Canada through unlawful extra-billing practices.

Higher cost of for-profit surgical delivery

The Alberta government claims that surgical outsourcing will reduce costs because the per-procedure costs are lower in CSFs. While it is not possible to evaluate this specific claim because the data have not been made public, evidence from Alberta, other provinces, and internationally do not support this claim and point to a higher cost of for-profit surgical delivery.

Conflict of interest and medical decision-making

When surgical care is provided by a for-profit facility, medical decision-making is much more susceptible to conflict of interest leading to inappropriate surgeries and diagnostic testing. When outsourcing surgical services, governments may face increased costs because for-profit providers have a financial incentive to selectively offer and perform more profitable procedures even if they are clinically inappropriate.

Patient safety and care quality concerns

Evidence shows that for-profit health-care delivery is generally less safe and provides lower-quality care. When health-care facilities are profit-motivated, they must find ways to reduce costs and return profits to investors. The primary strategy among for-profit hospitals, ambulatory care facilities, and long-term care homes in Canada and the U.S. is to maintain lower staffing levels and fewer highly-skilled personnel per patient.

Conclusion

The Alberta Surgical Initiative, with its focus on for-profit surgical delivery, has failed to increase total provincial surgical activity to pre-pandemic levels.

Alberta's wait times for priority procedures are among the longest in Canada. Despite claims that the Alberta Surgical Initiative would increase the surgical activity in the province, an evaluation of the first three years of the initiative suggest that funding and staffing have been diverted to chartered surgical facilities at the expense of public hospitals.

This evaluation provides new evidence indicating that health-care personnel are a fixed resource, and that expansion of a parallel, for-profit surgical delivery sector is constraining surgical activity in public hospitals. Between 2018-2019 and 2021-2022, contracted surgical volumes in chartered surgical facilities increased 48 per cent, and public payments to for-profit facilities climbed 61 per cent. At the same time, public hospital surgical activity declined 12 per cent as the public sector faces reduced capacity and operating room funding.

For-profit surgical delivery has become a big business. Public contracts for surgical outsourcing could reach \$78 million in 2022-2023. At the same time, staffing and funding levels in public AHS facilities have declined. A new contract with a national for-profit surgical chain shows that AHS will be subsidizing this corporation by up to \$105 million through 2029.

Evidence shows that the for-profit surgical sector is a gateway to two-tier health care, as for-profit facilities and corporate chains have been found to provide preferential access and charge patients unlawfully.

Surgical privatization comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long term. However, by focusing on public-sector policy strategies based on research evidence, the Alberta government can reduce surgical wait times. This will require a move away from privatization and for the government to commit to public investment and improvement.

Recommendations

Based on the research evidence, this report recommends that the provincial government shift away from private surgical delivery and fully commit to public system improvement. The Alberta government should implement policy strategies that can reduce wait times over the long term:

- **Adopt single-entry models, teamwork, and improved waitlist management:** Primary care providers often refer patients to specific surgeons who each keep their own waitlists for consultations and surgeries. There is often no centralized management or oversight of these waitlists by hospitals or health authorities. Single-entry models, on the other hand, include the central intake of referrals from primary care providers (or self-referrals, if appropriate), pooled referrals and a waitlist shared by a team of surgeons and other providers, and triage for urgency and appropriateness.

- **Maximize and extend hospital operating room capacity:**

Maximizing and extending hospital operating room hours as well as improving performance can also reduce wait times and costs. Specific strategies include optimizing scheduling and reducing downtime. The 2019 Ernst & Young AHS review found that physical public operating room (OR) capacity was used at 71 per cent in 2018-2019 and that an additional 18,713 operating room slates could be added, particularly during underutilized evenings and weekends, to make more effective use of existing public capacity. International evidence shows that increasing public sector capacity, rather than outsourcing, has the greatest potential to reduce waits in the long run.

- **Increase access to seniors' home and community care:**

Increasing access to these services, especially for seniors, reduces hospital bed shortages, cancellations of scheduled surgeries and, ultimately, surgical wait times for all patients. Many patients occupying inpatient hospital beds cannot be discharged due to the lack of community-based alternatives. They are referred to as “alternate level of care” (ALC) patients, and the majority are seniors. The lack of available publicly funded seniors' home and community care in Alberta has been documented by the Parkland Institute; recent data show it to be an ongoing barrier to improving patient flow and reducing surgical wait times.

- **Reduce the overuse of medical imaging and surgeries:**

Reducing surgical wait times also requires a focus on addressing the overuse of medical imaging and surgeries when they provide little or no diagnostic or treatment benefit or may cause harm. In Canada, up to 30 per cent of medical and surgical interventions are potentially unnecessary. Alberta is making improvements across most areas with common overuse of tests and treatments of low clinical value. However, expanded outsourcing of low-complexity surgical procedures to profit-motivated facilities (and surgeons) is likely to undermine efforts to reduce and eliminate clinically inappropriate surgeries and diagnostic tests that provide little or no value to patients.

- **Adopt a “vaccines-plus” public health strategy to reduce health system strain and delayed surgical care:** The ongoing burden of unmitigated SARS-CoV-2 transmission — along with other viruses disproportionately affecting children, seniors, frontline workers, and vulnerable people — is contributing to severe health system strain. In order to manage inpatient volumes that remain much higher than pre-pandemic, hospitals have been forced to

continue postponing scheduled surgeries in order to free up staffing resources, especially nurses, and inpatient beds. As a result, AHS faces challenges in increasing surgical volumes above pre-pandemic levels as this report shows. Alberta will have greater success at preventing delayed surgical care and working down backlogs if it adopts a “vaccines-plus” public health strategy. This requires the provincial government and public health officials to manage the ongoing pandemic and severe pressures on the health system in a manner consistent with scientific evidence and the goal of reducing transmission and infection, including public indoor air-quality standards, universal mask use in high-risk settings and when viral transmission is high, access to testing, employer-paid sick leave legislation, and encouraging vaccination.

1. Introduction

The Alberta Surgical Initiative (ASI) represents a significant expansion of for-profit, corporate health care.

In February 2020, the Alberta government announced it would spend \$400 million outsourcing surgeries to for-profit facilities (CTV Calgary, 2020). The government also announced plans to double the share of publicly funded surgeries performed in for-profit facilities to 30 per cent of all surgeries in the province, claiming that this policy direction would reduce wait times. The Alberta Surgical Initiative takes inspiration from Saskatchewan, with a focus on the private delivery of publicly funded surgeries in for-profit facilities.

While only three years of data are available, the significant costs and risks to Alberta's public health-care system are already apparent. Through Freedom of Information requests, statistical analysis, and a review of the research literature (see Appendix A: Research Methods and Data Sources), this report evaluates claims made by the Alberta government about the effectiveness of the Alberta Surgical Initiative in reducing wait times and the role of for-profit surgical outsourcing.

This report finds that Alberta has among the worst performance in reducing surgical wait times in Canada. The province has prioritized for-profit surgical delivery rather than system improvement and fully utilizing the nearly 30 per cent of unused public operating room capacity.

Contrary to government claims that outsourcing to for-profit facilities increases provincial surgical capacity, data suggest that the expansion of chartered surgical facilities has diverted resources away from public hospitals and, in turn, reduced provincial surgical volumes.

Under the ASI, provincial surgical activity has failed to increase from pre-pandemic levels, and public hospitals face reduced capacity and operating room funding. And yet, investor-owned surgical facilities are expanding through substantial contracts with the government. Between 2018-2019 and 2021-2022, surgical volumes in chartered surgical facilities increased by 48 per cent, while surgical activity in public hospitals declined by 12 per cent.

Surgical outsourcing comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long term, especially for patients requiring complex surgeries only performed in the public system. The expansion of this for-profit sector invites a greater risk of two-tier health care through unlawful patient fees contrary to provincial and federal legislation.

“Alberta has among the worst performance in reducing surgical wait times in Canada.”

2. The Alberta Surgical Initiative and For-Profit Surgical Delivery

The Government's Case for Surgical Outsourcing and the "Saskatchewan Model"

“The government’s policy focus has been on outsourcing to chartered surgical facilities, without a commitment to utilize public capacity first.”

Upon forming government in April 2019, the Alberta UCP quickly began making the case for fiscal austerity across public services, including health care. It commissioned a number of private-sector consultants that recommended health-care reform, the sale of public assets, and greater private sector involvement. In May 2019, the government commissioned the “Blue Ribbon Panel on Alberta’s Finances,” comprised of conservative individuals and chaired by former Saskatchewan finance minister and health-care privatization proponent, Janice MacKinnon. The panel’s remit was to recommend how to reduce the provincial deficit and debt, but without raising taxes. Among many recommendations, the panel recommended “greater use of alternative service delivery for day procedures and other services that [...] could be delivered in private or not-for-profit facilities” (Blue Ribbon Panel on Alberta’s Finances, 2019, 6). In 2016, Mackinnon had authored a Fraser Institute report arguing that the Saskatchewan Surgical Initiative was successful largely due to increased private surgical delivery (Mackinnon, 2016).

In December 2019, the Alberta government announced initial plans for the “Alberta Surgical Initiative” (ASI) with a focus on outsourcing publicly funded surgeries.¹ The ASI includes efforts to improve waitlist management, implementation of centralized referral pathways, rapid access clinics for orthopedics, optimized surgical activity at rural hospitals, and capital investments in AHS facilities (AHS, n.d.-a; Ernst & Young, 2019, 66). However, the government’s policy focus has been on outsourcing to chartered surgical facilities, without a commitment to utilize public capacity first.

Then, in February 2020, the Alberta government stated that the ASI would deliver an *additional* 80,000 surgeries provincially by 2022-2023 (Alberta Treasury Board and Finance, 2020, 126). By spring 2022, the government claimed that “record volumes of surgeries were completed in Chartered Surgical Facilities (CSFs) in 2021-2022 and will further increase in 2022-2023” (Alberta Treasury Board and Finance, 2022, 127). The government added: “CSFs free up capacity in hospitals and reduce wait times.” This report critically evaluates these claims.

¹ Outsourcing is also referred to as “contracting out,” “private delivery,” and “for-profit delivery.”

Policies on the Move: Understanding the Saskatchewan Surgical Initiative

Since the Alberta Surgical Initiative takes inspiration from elsewhere, it is important to understand the Saskatchewan experience and the role of surgical outsourcing in relation to public sector investment.

The four-year Saskatchewan Surgical Initiative ran from 2010 to 2014, and involved \$176 million of new funding for surgical services, with an additional \$60.5 million in 2014-2015 (Government of Saskatchewan, 2014, 6). The initiative included the following elements:

- creation of an online specialist directory;
- pooling referrals to enable patients to option to see the first available specialist in some specialties;
- increased funding for additional operating room nurses;
- a falls prevention initiative;
- a focus on reducing clinical variation and streamlining referrals through the introduction of single-entry referral pathways for hip and knee replacements, lower back pain, bariatric surgery, prostate assessment, and pelvic floor conditions; and
- outsourcing surgeries and diagnostic imaging to for-profit clinics.

When the Saskatchewan Surgical Initiative was introduced in 2010, the ministry not only took steps to increase surgical capacity in the public system, it also contracted for-profit clinics to perform publicly funded day surgeries. However, the Alberta government is attributing the short-term success of the Saskatchewan Surgical Initiative to surgical privatization, and not the public system improvement and efficiency strategies.

Since the end of the Initiative in 2014, the province has prioritized private financing and private delivery instead of increasing public sector capacity and scaling up system improvements (Piller, 2020; Vescera, 2020; White-Crummey, 2020). In June 2022, the province announced plans to outsource hip and knee procedures to a private clinic, in addition to an existing contract with Calgary-based Surgical Centres Inc. (acquired by Clearpoint Health Network in January 2023), which received more than \$10 million in 2021 (Vescera, 2022a). In July 2022, plans were finalized to issue a request for proposal for a company to build a new private surgical centre (Vescera, 2022b). With the focus on privatization, surgical and diagnostic wait times in Saskatchewan were among some of the longest in Canada in 2022 (see Table 1).

Table 1. Percentage of Patients Receiving Surgery Within Benchmark, 2022

	Hip replacement (26 weeks)	Knee replacement (26 weeks)	Hip fracture repair (48 hours)	Cataract surgery (16 weeks)
Alberta	38%	27%	89%	65%
British Columbia	62%	56%	77%	81%
Manitoba	43%	26%	88%	43%
New Brunswick	38%	28%	82%	62%
Nfld. and Labrador	45%	36%	88%	39%
Nova Scotia	49%	39%	85%	59%
Ontario	72%	68%	81%	59%
Prince Edward Island	53%	36%	91%	40%
Quebec	45%	32%	-	68%
Saskatchewan	34%	23%	81%	63%
Canada	57%	50%	82%	66%

Source: CIHI, 2023b.

Note: Quebec hip fracture repair data for 2022 are unavailable.

“The large injection of funding during the SSI to increase public sector capacity was likely the most significant factor reducing waits.”

Saskatchewan’s public system redesign initiatives helped reduce wait times for priority procedures between 2010 and 2015. As well, a review of public expenditures shows that the large injection of funding during the SSI to increase public sector capacity was likely the most significant factor reducing waits.

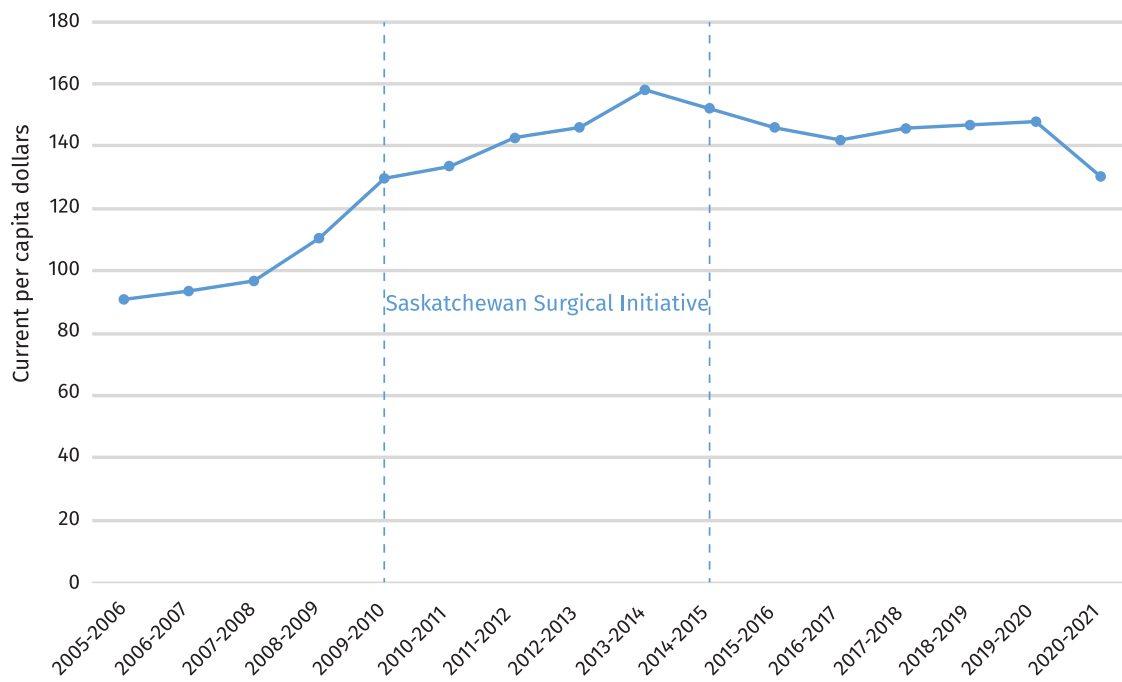
Saskatchewan Surgical Initiative Wait-Time Reductions Due to Expanded Public Sector Capacity

Wait-time reductions during the Saskatchewan Surgical Initiative relied on a significant short-term injection of funding to expand public sector surgical capacity. Public hospital operating room funding steadily climbed from \$129 per capita in 2009-2010 to \$158 per capita in 2013-2014 (Figure 1). The increased public sector capacity is also reflected in the increase in staffed medical and surgical beds during the SSI, which is another indicator of the increased capacity that sustained greater surgical volumes. The number of funded and staffed medical and surgical recovery beds went up from 136 per 100k population in 2009-2010 to 218 per 100k in 2012-2013, and declined to 173 per 100k in 2020-2021 (Table 2).

As Figure 2 shows, Saskatchewan achieved considerable wait-time improvements resulting from the significant funding to expand public-sector capacity. However, proponents of privatization suggest that Saskatchewan’s success was the result of for-profit surgical delivery when, in fact, wait-time improvements arose from investment in public-sector capacity and efficiency improvements. Once the time-limited funding for increased public-sector capacity ended, wait times quickly deteriorated. International evidence

shows that short-term funding for temporary additional capacity is unlikely to reduce wait times over the long term (Kreinder, 2010, 11). By 2022, Saskatchewan had the worst wait-time performance in the country for hip and knee replacements (Table 1).

Figure 1. Per-Capita Hospital Operating Room Expenditure in Current Dollars in Saskatchewan, 2005-2006 to 2020-2021

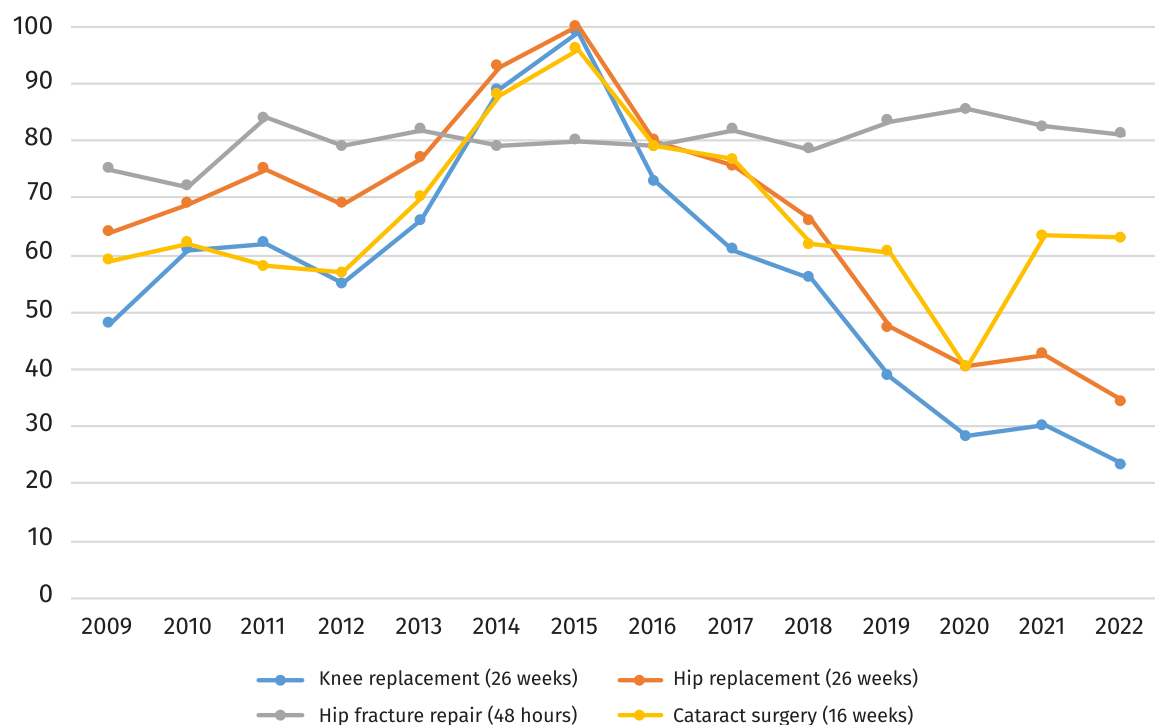


Source: Author's calculations from CIHI (2022b); population estimates retrieved from CIHI (2022a), Appendix A.

Table 2: Hospital Medical and Surgical Beds Staffed and in Operation per 100k in Saskatchewan, 2009-2010 to 2020-2021

	Beds per 100k
2009-2010	135.9
2010-2011	142.7
2011-2012	217.5
2012-2013	217.8
2013-2014	199.0
2014-2015	197.4
2015-2016	192.8
2016-2017	194.8
2017-2018	191.7
2018-2019	192.2
2019-2020	178.9
2020-2021	173.3

Source: CIHI (2022b), Table D.10.2.

Figure 2. Percentage of Patients Meeting Wait-Time Benchmark in Saskatchewan, 2009-2022

Source: CIHI Wait Times for Priority Procedures, 2023b.

Laying the Foundation for Surgical and Hospital Privatization in Alberta

Short-term wait-time improvements in Saskatchewan resulted from a significant expansion of public-sector capacity and efficiency improvements. Despite this, the Saskatchewan experience has been held up by proponents of surgical privatization — including private sector consultants commissioned by the Alberta government — because for-profit surgical provision was the centrepiece of the SSI. In market-oriented policy experimentation, governments like to draw on policy models that support their pre-existing ideological beliefs (Peck and Theodore, 2015). In this case, the Saskatchewan Surgical Initiative has been trumpeted as a success of privatization — a narrative that aligns with the Alberta government’s ideological preference for greater for-profit involvement in health care.

In recent years, the preference for market-based policies has influenced health-care policy-making in Alberta. In May 2019, the newly elected Alberta government commissioned Ernst & Young to review Alberta Health Services (AHS) for cost savings and improved performance (see McIntosh, 2020).

Consistent with the Blue Ribbon Panel on Alberta's Finances, the consultants recommended outsourcing more surgeries, including those that require an overnight stay or longer: "Alberta Health could consider reviewing the criteria for delivery of procedures in non-hospital surgical facilities to identify opportunities to deliver additional services, including potential (sic) those that require overnight stays" (Ernst & Young, 2019, 108).

Despite the implication that CSFs would need to essentially become acute care hospitals, the review did not discuss the requisite increase in skilled staffing that would be required to safely offer overnight stays and complex surgical care, and the potential to exacerbate hospital staffing shortages and wait times (see Longhurst, Cohen & McGregor, 2016, 15).

The Ernst & Young review did, however, note that public hospital operating room capacity was utilized at only 71 per cent of the time across AHS in 2018-2019, indicating an unused capacity for 18,713 additional operating room slates (Ernst & Young, 2019, 81). The Alberta government accepted most recommendations, signalling its intent to encourage an expanded for-profit surgical sector (Parsons, 2020), but made no commitment to prioritize the full utilization of surgical capacity in public ORs.

Following the Ernst & Young review, the government announced in the February 2020 provincial budget that it would spend \$400 million outsourcing surgeries to private surgical facilities, and invest \$100 million in public sector operating rooms (CTV Calgary, 2020). The government also committed to doubling the number of outsourced surgeries over three years — from 15 per cent to 30 per cent of total surgeries province-wide — representing a significant shift of surgical delivery from the public to private sector. Then-health minister Tyler Shandro stated:

We promised we would reduce surgical wait times, and we're delivering on that promise. This ambitious plan will mean Alberta will have the best wait-time performance in Canada. (Government of Alberta, 2019)

Bill 30 and the Health Facilities Act

At the same time that the Government of Alberta was committing to expand for-profit surgical delivery, legislative changes were also underway to help create a larger for-profit surgical sector and regulatory certainty for investors. When the government came to power in 2019, there was already an expansive legislative framework to support surgical and hospital privatization.

Alberta's policy experimentation with expanding for-profit surgical delivery goes back over two decades. In 2000, the Health Care Protection Act,

“Alberta’s policy experimentation with expanding for-profit surgical delivery goes back over two decades.”

enacted by the Klein government, introduced the most expansive legislative framework in Canada to legitimize, regulate, and encourage for-profit surgical delivery (Prémont, 2002, 12-14).

The Health Care Protection Act explicitly blurred the distinction between *funding* and *delivery* of health-care services by creating private surgical facilities whereby private-pay (“uninsured”) services may be performed in the same facilities that have contracts with the government to provide publicly funded (“insured”) services at no cost to patients. As health law professor Marie-Claude Prémont noted in her 2002 paper for the Romanow Commission, “what the Alberta statute creates, then, is a plan for subsidizing the for-profit surgical facility with public health-care funds” through “the co-existence of insured and uninsured services in the same [private facility]” (ibid., 13).

The Health Care Protection Act also introduced “enhanced goods and services” whereby facilities can charge patients for premium versions of fully publicly insured goods and services, such as upgraded cataract lens replacements. At the time, Prémont described that the object of the Act “is to ensure the profitability of the for-profit surgical facility with the assistance of a constant flow of public health dollars” (ibid.).

The Alberta government moved quickly to build from the existing Health Care Protection Act. On July 6, 2020, Bill 30 (Health Statutes Amendment Act) was introduced in the Alberta Legislature. Bill 30 amended seven acts and repealed two acts (Government of Alberta, 2020b). The most important amendments relevant to surgical privatization were to the Health Care Protection Act, renamed the Health Facilities Act, and the Alberta Health Care Insurance Act. According to Premier Jason Kenney, Bill 30 was necessary to help encourage the creation of a larger market for private surgical providers:

[Bill 30 will] make it easier for chartered surgical facilities to work with us and AHS to provide publicly funded surgeries to people who need them. [...] The proposed amendments here in Bill 30 would reduce barriers and administrative burdens so that new chartered surgical facilities can more easily open, reducing surgical wait times for cataracts among other surgeries. [...] The current process for chartered surgical facilities to open and contract with AHS can take as much as two years. (Alberta, 2020)

The new Health Facilities Act came into force on July 29, 2020. On its own, the legislation does not increase contracting out of publicly funded surgeries, but the creation of “chartered surgical facilities” (CSFs) streamlines the process of approving for-profit facilities and creates greater regulatory certainty for investors looking to open them.

Amendments to the Alberta Health Care Insurance Act allow legal entities other than physicians and physician professional corporations to bill the government for the provision of insured services (Longhurst, 2020, 4-6). This fundamentally restructures how public funds may flow for insured physician services by allowing corporate (non-physician) entities to have a direct payment relationship with the government. In turn, this opens the door to corporate, investor-owned chartered surgical facilities that directly employ or contract physicians and other staff, and gives legal authority to these corporate facilities to bill the government directly.

Chartered Surgical Facilities: Opening the Door to For-Profit Hospitals

The new Health Facilities Act establishes chartered surgical facilities separate from the pre-existing definition of a “private hospital,” but opens the door to facilities that resemble private *hospitals* rather than private *clinics* (Health Facilities Act, 2000).

Under the legislation, “private hospitals” are banned (ibid., s. 1). A private hospital is defined as “an acute care facility that provides emergency, diagnostic, surgical *and* medical services, *and* admits patients for medically supervised stays exceeding 12 hours” (ibid., s. 0.1(1), emphasis added).

This definition (and the use of the word “and”) means that these facilities are only defined as “private hospitals” if they meet *all* criteria. CSFs must not fall within the definition of a “private hospital,” since those cannot lawfully operate. As it is unlikely CSFs will provide emergency services, CSFs remain outside of the definition of private hospitals, which allows them to offer the remainder of services: diagnostics, surgical services, medical services, and even surgeries that require more than a 12-hour stay. In other words, CSFs have very few limitations on the services they may offer, and could potentially operate a hospital-like facility as long as they do not fall under the definition of “private hospital.”

Additionally, the new legislation stipulates that CSFs also cannot offer “major surgical services” as defined by the College of Physicians and Surgeons of Alberta (Health Facilities Act, 200, s. 2(2); CPSA, 2022a, s. 45). However, the list of major surgical services is quite limited: procedures involving general anesthetic on patients under 18 months of age; procedures on the contents of the retroperitoneal space; procedures on the contents of the cranium; procedures on the contents of the thorax; and procedures for which the medical facility has not been accredited. Once again, this places relatively minor limits on the procedures that these facilities can perform.

In addition to providing insured services that are covered under the public Alberta Health Care Insurance Plan, the same facilities are able to provide uninsured services. It is common, for example, for the ophthalmologists who bill the provincial plan for insured services to also perform various uninsured services such as laser eye surgery in for-profit facilities.

In addition, CSFs can upsell patients “enhanced medical goods or services.” These 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” (Health Facilities Act, 2000, s. 0.1(e)). Put another way, “enhanced” medical goods and services are a form of two-tier health care. This upselling is common in certain specialties. For example, in the 2019-2020 fiscal year, ophthalmologists sold patients nearly \$1.6 million in enhanced goods or services (AHS, n.d.-c).

In sum, the new Health Facilities Act creates the new designation of “chartered surgical facility” as a more expansive form of for-profit surgical facility and opens the door for the initial stages of a for-profit hospital sector.

“The for-profit surgical sector is expanding through significant new public funding under the Alberta Surgical Initiative.”

Growth of the For-Profit Surgical Sector in Alberta

Since the early 2000s, the for-profit surgical sector has benefited from government outsourcing and revenue from private-pay procedures. This for-profit sector is expanding through significant new public funding under the Alberta Surgical Initiative.

As of November 2022, there were 80 accredited CSFs in Alberta, with 34 per cent providing dental surgeries, followed by multi-surgical (including orthopedics) (25 per cent), dermatology (16 per cent), and ophthalmology (15 per cent) (Table 3). However, not all CSFs have contracts with AHS for publicly funded surgeries, as some facilities may only provide private-pay services. In 2009-2010, AHS held contracts with 36 CSFs, and by 2021-2022, 51 CSFs were under contract (AHS, 2010; 2022a).

Table 3: Chartered Surgical Facilities in Alberta as of November 18, 2022

Procedures offered	Number	Percentage of total CSFs
Dental	27	34%
Multi-surgical	20	25%
Dermatology	13	16%
Ophthalmology	12	15%
Plastic surgery	3	4%
Assisted reproductive technology	2	3%
Gynecology	2	3%
Orthopedic surgery	1	1%
Total	80	100%

Source: CPSA, 2022b.

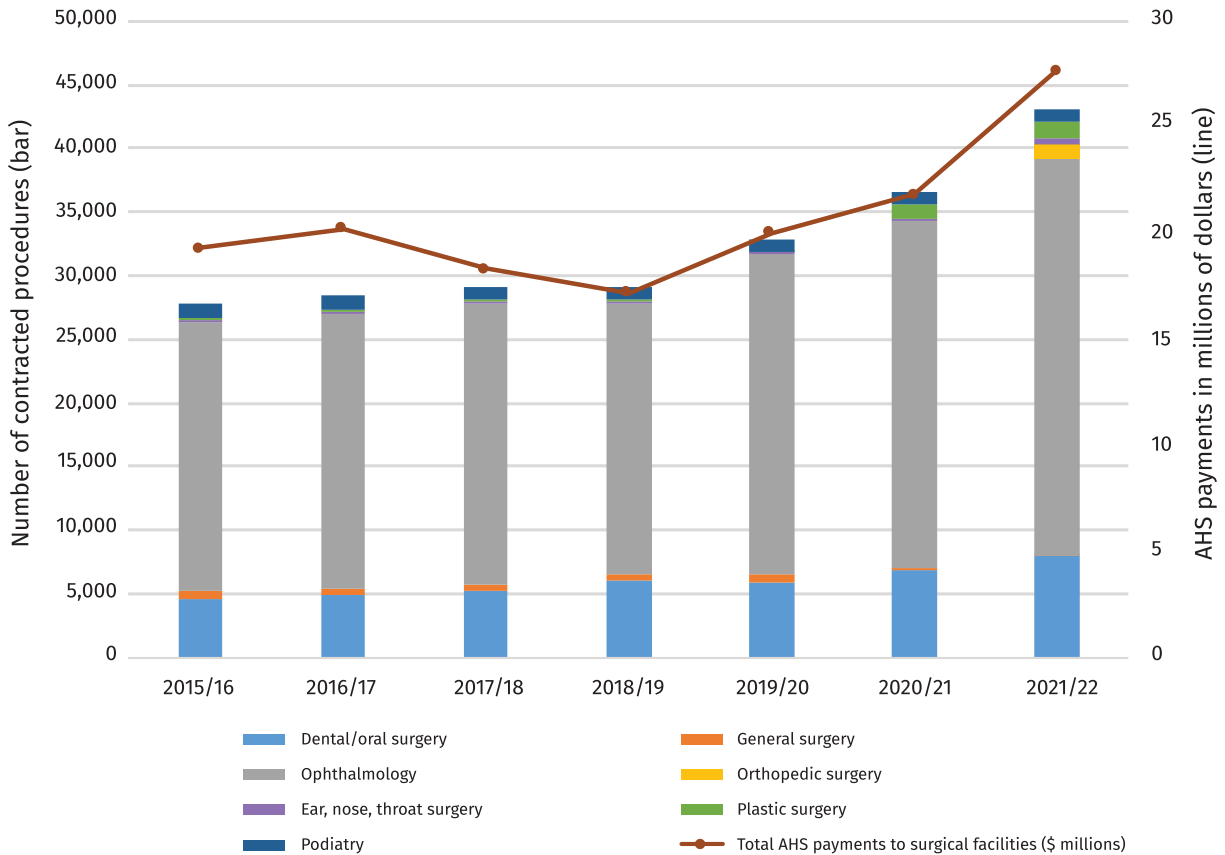
Analysis of data obtained from Freedom of Information, AHS financial documents, and AHS contracts with CSFs shows the following:

- The total number of contracted surgical procedures performed in CSFs has increased from 27,787 in 2015-2016 to 43,078 in 2021-2022 — an increase of 55 per cent (Figure 3 and Appendix B). Since the introduction of the ASI (2018-2019 – 2021-2022), the number of contracted surgical procedures performed by CSFs has increased from 29,052 to 43,078 — an increase of 48 per cent. The growth has been most significant for plastic surgery, orthopedics, and surgeries of the ear, nose, and throat (ENT).
- Ophthalmologic procedures (mainly cataract surgeries) have represented the greatest absolute number of procedures and share of total procedures outsourced to CSFs (Figure 3 and Appendix B). In 2021-2022, 31,252 contracted ophthalmologic procedures were performed, up from 21,311 procedures in 2018-2019.
- Ophthalmologic (73 per cent), dental/oral surgery (19 per cent), plastic surgery (3 per cent), and orthopedic surgery (3 per cent) accounted for the greatest share of total contracted volume in 2021-2022 (Figure 3).
- Payments to contracted CSFs increased from \$17.2 million in 2018-2019 to \$27.7 million in 2021-2022 — or by 61 per cent (Figure 3 and Appendix B). The largest annual increase in AHS payments to CSFs was between 2020-2021 and 2021-2022 (27 per cent) — the third year of the ASI. This reflects new and expanded CSF contracts taking effect. (AHS payments to CSFs do not include physician billings to the Alberta Health Care Insurance Plan. Payments contained in Figure 3 and Appendix B only constitute the “facility fee” paid to the facility.)

“In 2022-2023, the maximum value of all surgical contracts is \$79.7 million.”

- Based on analysis of signed contracts (Appendix C), the growth of the for-profit surgical sector is likely to continue. In 2022-2023, the maximum value of all surgical contracts is \$79.7 million. This represents a significant potential increase in the total AHS payments to CSFs based on the 2021-2022 amount of \$27.7 million. Orthopedic surgeries have the greatest maximum contract value of \$39.8 million, followed by dental/oral surgery (\$22.1 million) and ophthalmology (\$13.5 million) (Figure 4). Many of the new outsourced orthopedic surgeries will be performed in the newly constructed Alberta Surgical Group's Heritage Valley Ltd. facility in Edmonton — a 21,000 square-foot facility that will perform up to 8,000 procedures each year (Archer, 2022), and Clearpoint Health Network/Canadian Surgery Solutions facilities in Calgary (Canadian Press, 2023).
- The top three CSFs by maximum contract value (not actual payment) in 2022-2023 were Alberta Surgical Group — Heritage Valley Ltd. (\$27.3 million), Clearpoint Health Network (\$8.2 million), and a numbered corporation (12846284 Canada Inc., at \$6.2 million) (Appendix C).
- A new contract between AHS and Clearpoint Health Network (operating as “Canadian Surgery Solutions”), effective January 1, 2023, commits AHS to paying the for-profit provider a total of \$104.7 million from 2023 to 2029 for 3,000 hip and knee replacements per year (Figure 5) (Canadian Press, 2023). Unlike other surgical contracts negotiated between AHS and CSFs, AHS has provided Clearpoint Health Network with surgical volume and payment guarantees (AHS, 2023a, 8, 42, 48) — favourable terms for the corporate chain as it provides revenue certainty for investors. The contract between AHS and Clearpoint Health Network includes “volume floors” which are “the minimum number of surgeries to be allocated by AHS to the Service Provider,” and are set out in a section redacted by AHS in the public version of the contract (AHS, 2023a, 42).

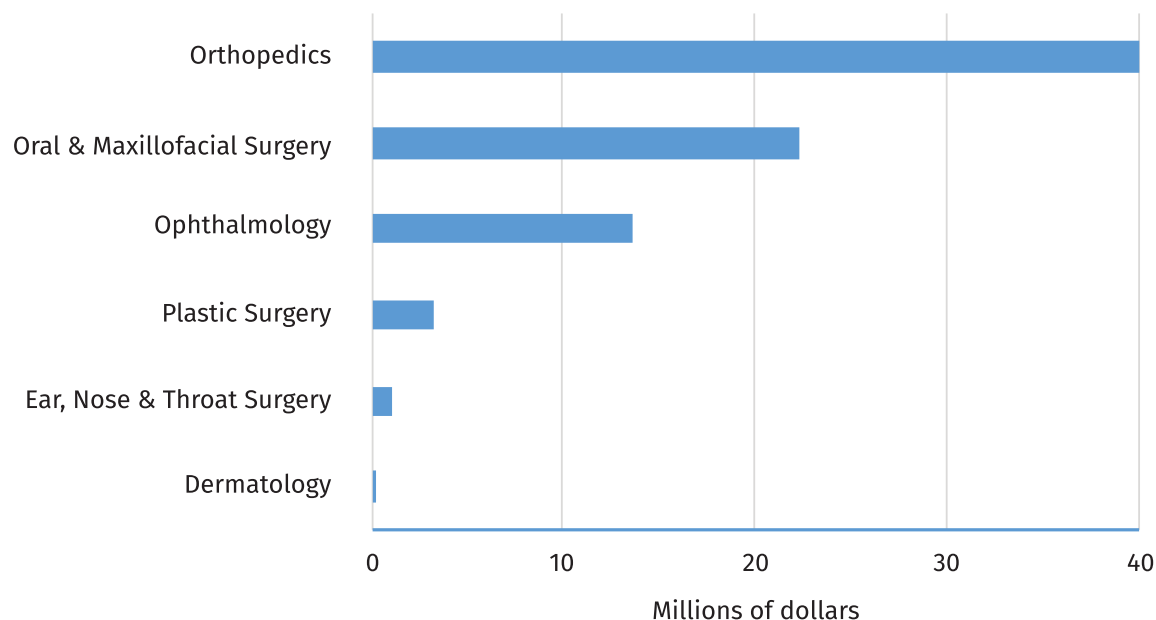
Figure 3: Volume of AHS Contracted Procedures and Total Payments to Chartered Surgical Facilities, 2015-2016 to 2021-2022



Sources: Numbers of contracted procedures are from AHS (2022b). Total AHS payments to surgical facilities were extracted from “Contracts under the Health Facilities Act” (previously called “Contracts under the Health Care Protection Act”) in Consolidated Schedule of Expenses by Object, AHS Annual Reports from 2015-2016 to 2021-2022 (AHS, n.d.-d).

Note: See Appendix B for data table. AHS payments to CSFs do not include physician billings to the Alberta Health Care Insurance Plan. The above payments only constitute the “facility fee” paid by AHS for the private facility.

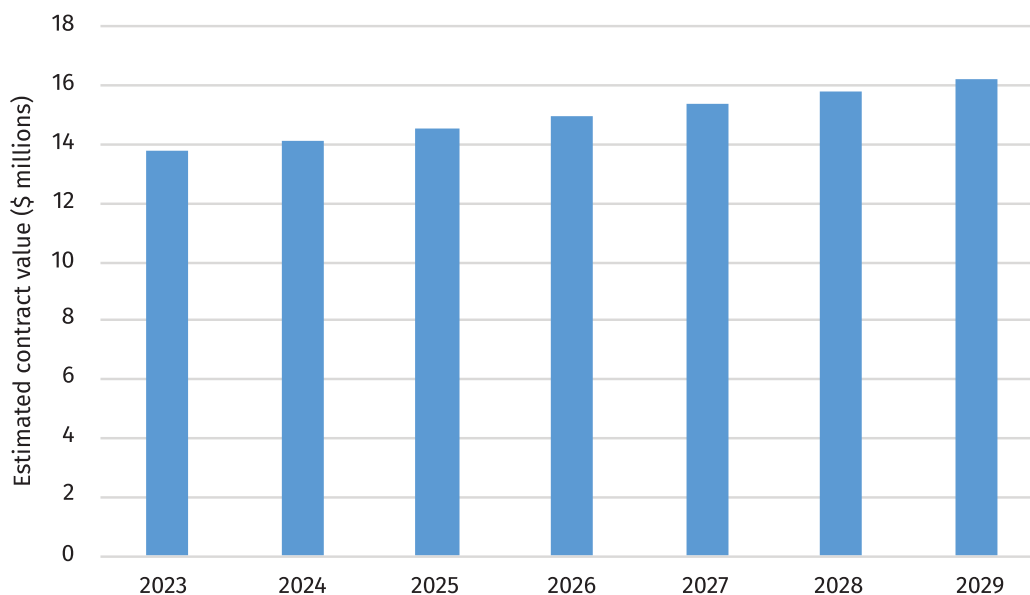
Figure 4: Maximum Contract Values for Contracted Chartered Surgical Facilities by Procedure Type in Alberta, 2022-2023



Source: Author's analysis of point-in-time data extracted from AHS (2022c).

Notes: Pregnancy terminations are excluded. The figures above do not represent actual payments. New contracts and contract extensions with existing providers are signed and posted on the AHS website on a continuous basis. Therefore, amounts are subject to change and should be interpreted with caution.

Figure 5: Clearpoint Health Network (operating as “Canadian Surgery Solutions”) Estimated Contract Values for Orthopedic Procedures in Alberta, 2023-2029



Source: AHS, 2023a, 48.

Note: The amounts are maximum contract values and do not represent actual payments.

“Calgary-based Surgical Centres Inc. engaged in unlawful extra-billing in B.C. during the same time it held outsourcing contracts with AHS and B.C. health authorities.”

For-Profit Surgical Clinics and Unlawful Extra-Billing

Calgary-based Surgical Centres Inc. engaged in unlawful extra-billing in B.C. during the same time it held outsourcing contracts with AHS and B.C. health authorities. In B.C., three Surgical Centres Inc. facilities were audited by the provincial government, with extra-billing estimated at \$2.1 million between 2015-2016 and 2020-2021 (Table 4).

Extra-billing is an unlawful practice whereby clinics bill patients privately for medically necessary procedures that are already covered by the public health-care system (through provincial health insurance plans). Extra-billing allows wealthier patients to jump the queue by paying for medically necessary health-care privately, and is prohibited under provincial legislation and the Canada Health Act.

Between 2015-2016 and 2020-2021, Surgical Centres Inc. received the second-largest amount of public funds for surgical outsourcing in B.C. (Longhurst, 2022, 14). In Alberta, AHS held a contract with Surgical Centres Inc. valued at \$155 million between 2012-2013 to 2021-2022 (Appendix D). The B.C. government purchased Surgical Centres Inc. facilities in Victoria and Nanaimo in 2022, bringing them into the public system, reportedly because their ORs were underutilized (B.C. Ministry of Health, 2022). Then, in January 2023, Clearpoint acquired Calgary-based Surgical Centres Inc., which, at the time, owned one surgical centre in B.C. and two each in Alberta and Saskatchewan (Clearpoint Health Network, 2023b).

Clearpoint Health Network is a new national chain of for-profit surgical facilities owned by Kensington Capital Partners — a Toronto-based private equity firm (Clearpoint Health Network, 2023a; Kensington Capital Partners, 2019). Kensington Capital Partners holds a \$1.7 billion portfolio in information technology, health care, and consumer services. Clearpoint Health Network, operating as Canadian Surgery Solutions in Alberta, is likely be one of the largest contracted for-profit surgical providers in Alberta based on contract value (see Figure 5 and Appendix B).

Clearpoint Health Network also owns False Creek Healthcare Centre in Vancouver, which received \$12.2 million in B.C. health authority contract payments between 2015-2016 and 2020-2021. Under its previous owner, the facility was audited by the B.C. government, found to have engaged in unlawful extra-billing, and had its Vancouver Coastal Health Authority contract terminated (Longhurst, 2022, 4). In 2019, False Creek Healthcare Centre was acquired by Kensington Capital Partners (Fayerman, 2019). The two largest regional health authorities renewed contracts with the False Creek Healthcare Centre after it was acquired by Clearpoint Health Network, which is wholly owned by Kensington Capital Partners.

In February 2023, CBC revealed that Clearpoint Health Network is exploiting an apparent loophole in the Canada Health Act by charging patients up to \$28,000 to have an orthopedic surgery performed in another province (Crawley, 2023).

Table 4: Unlawful Extra-Billing at Surgical Centres Inc. Facilities in B.C. in Dollars, 2009-2022

	Type(s) of extra-billing	Estimated extra-billing amount (in dollars)	Date clinic referred for audit	Audit period	B.C. Medicare Protection Act violation
Audit report 1	Extra-billing by clinic	1,936,834	June 2008	2015-2016 to 2016-2017	s. 17
	Overlapping claims by clinic	989		2015-2016 to 2016-2017	s. 17
Subtotal		1,937,823			
Audit report 2	Extra-billing by clinic	87,714	April 2008	2015-2016 to 2016-2017	s. 17
	Overlapping claims by clinic	29,616			s. 17
	Extra-billing by medical practitioners	35,768			s. 17
Subtotal		153,098			
Audit report 3	Overlapping claims by clinic	1,114	June 2020	2018-2019 to 2019-2020	s. 17
Total		2,092,035			

Source: B.C. Ministry of Health, 2023.

3. Evaluating the Performance of the Alberta Surgical Initiative

Like all provinces, Alberta is struggling to work down the pandemic surgical backlog. The Canadian Institute for Health Information (CIHI) reports provincial wait times from surgery booking to completion (called Wait 2, see Table 5), but there are also additional wait times (not reported by CIHI) that account for the patient's full surgical journey.

“In 2022, Alberta had among the worst wait-time performance for priority procedures in the country.”

In 2022, Alberta had among the worst wait-time performance for priority procedures in the country, with a minority of hip and knee surgery patients meeting the benchmark. Furthermore, the trend from between 2019 and the start of the ASI (and pandemic) and 2022 indicates that wait times for hip and knee replacements have deteriorated significantly, and more precipitously than the Canadian average (Table 6). Specifically, the data show:

- In 2022, 38 per cent of Alberta hip replacement patients received their surgery within the benchmark compared to the Canadian average of 57 per cent (Table 1). Since the start of the ASI (from 2019 to 2022), the share of patients meeting the benchmark declined from 64 to 38 per cent (Figure 6) — the second-largest decline among the provinces (Table 6).
- In 2022, 27 per cent of Alberta knee replacement patients received their surgery within the benchmark compared to the Canadian average of 50 per cent (Table 1). Since the start of the ASI (from 2019 to 2022), the share of patients meeting the benchmark has declined from 62 to 27 per cent (Figure 6) — the third-largest decline among the provinces (Table 6).
- In 2022, 65 per cent of Alberta cataract patients received surgery within the benchmark, and just below the Canadian average of 66 per cent (Table 1). Since the start of the ASI (from 2019 to 2022), the share of patients meeting the benchmark has increased from 44 to 65 per cent (Figure 6) — the largest increase among the provinces (Table 6).
- In 2022, 89 per cent of Alberta hip fracture repair (an urgent procedure) patients received surgery within the benchmark, and above the Canadian average of 82 per cent (Table 1). Since the start of the ASI (from 2019 to 2022), the share of patients meeting the benchmark has declined from 91 to 89 per cent (Figure 6).

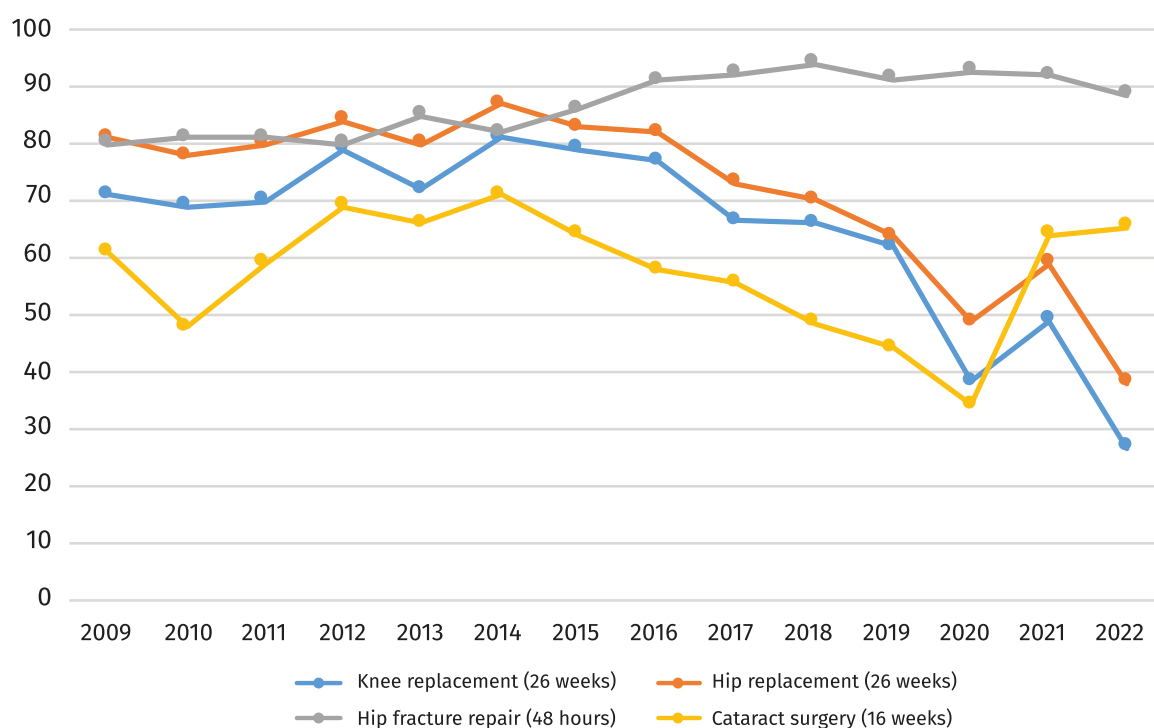
Alberta made progress between 2019 (pre-pandemic baseline) and 2021 to increase the share of patients meeting the hip replacement and knee replacement benchmark, but wait times increased significantly between 2021 and 2022. Cataract surgery wait times significantly improved overall

between 2020 and 2021 but flatlined between 2021 and 2022 (Figure 6). And while Alberta was performing poorly in these areas before the pandemic, the province has had limited success working down the pandemic backlog and sustaining wait-time improvements across priority procedures. As the next section shows, all provinces have been dealing with pandemic backlogs, but not all have seen the significant decline in timely access for joint replacements.

Table 5: Wait Times for Surgical Patients

Wait 1	Referral from primary care to specialist (surgical) consultation
Wait 2	Surgery booking to completion of surgery
Wait 3	Referral to diagnostics to completion of diagnostic testing (e.g., MRI scan) <i>May be concurrent to or following Wait 1 depending on care/referral pathway, urgency, and other factors.</i>
Wait 4	Surgery completion to patient recovery

Figure 6: Percentage of Patients Meeting the Benchmark for Priority Procedures in Alberta, 2009-2022



Source: CIHI, 2023b.

Note: Wait-time benchmarks refer to the period from surgery booking to surgery completion (Wait 2).

Table 6: Percentage Point Change in Patients Receiving Surgery Within Benchmark, 2019-2022

	Hip replacement (26 weeks)	Knee replacement (26 weeks)	Hip fracture repair (acute/day surgery)	Cataract surgery (16 weeks)
Alberta	-26	-35	-3	21
British Columbia	-14	-10	-3	12
Manitoba	-12	-20	-6	10
New Brunswick	-10	-16	-7	-4
Nfld. and Labrador	-31	-36	3	-24
Nova Scotia	-10	-9	-4	-1
Ontario	-13	-12	-5	-14
Prince Edward Island	-13	8	-3	12
Quebec	-31	-41	-	-14
Saskatchewan	-13	-15	-2	3
Canada	-18	-19	-4	-5

Source: CIHI, 2023b.

Note: Quebec hip fracture repair data for 2022 are unavailable.

“Surgical wait times in Alberta for three of four priority areas were already increasing prior to the pandemic.”

Wait Times and the COVID-19 Pandemic

Surgical wait times in Alberta for three of four priority areas were already increasing prior to the pandemic. The percentage of Alberta patients meeting the benchmark for knee and hip replacements and cataract surgeries began falling in 2014, while the share of patients meeting the benchmark for hip fracture repair (an urgent procedure) improved since 2014.

The pandemic has presented unprecedented challenges for surgical delivery. The decrease in surgical activity across provinces ranged from 15 per cent (PEI) to 39 per cent (N.L.) between March-September 2019 and March-September 2020 (Table 7). Surgical activity declined by 23 per cent between those periods in 2019 and 2020. This created a significant backlog on top of the ongoing (and increasing) demand for surgeries each year.

Between the periods of March-September 2019 and March-September 2020, Alberta performed over 40,000 fewer surgeries (Table 7). However, by the period of March-September 2021, Alberta had nearly returned to 2019 pre-pandemic activity. But most worrisome, in 2022, surgical activity was down 6 per cent from pre-pandemic volumes. Some provinces increased surgical activity in 2021 over pre-pandemic levels (B.C., N.B., N.S., and P.E.I.). Alberta, however, never achieved this, raising questions about the prioritization of funding and staffing for CSFs, and its effect on public hospitals.

Table 7: Surgical Volumes by Province (Scheduled and Unplanned), Pre-Pandemic and Pandemic

	Pre-pandemic	Pandemic			% change in surgical volumes		
	Mar-Sep 2019	Mar-Sep 2020	Mar-Sep 2021	Mar-Sep 2022	2019 to 2020	2019 to 2021	2019 to 2022
AB	180,473	138,840	174,315	169,499	-23%	-3%	-6%
BC	249,166	197,924	259,059	217,049	-21%	4%	-13%
MB	58,839	47,916	49,443	49,997	-19%	-16%	-15%
NB	34,592	27,503	34,650	29,362	-20%	0%	-15%
NL	35,768	21,934	32,454	27,541	-39%	-9%	-23%
NS	52,325	36,181	52,964	51,765	-31%	1%	-1%
ON	626,822	399,891	548,499	607,786	-36%	-12%	-3%
PEI	6,490	5,543	6,825	6,630	-15%	5%	2%
SK	61,387	42,530	57,045	58,580	-31%	-7%	-5%

Source: Author's calculations from CIHI (2023a).

Note: Quebec data are unavailable for all comparison periods, and are therefore excluded.

Provincial Surgical Volumes Decreased Under the Alberta Surgical Initiative

Increasing total surgical capacity in the province has been the primary argument for greater outsourcing through the ASI. However, surgical volumes data obtained through Freedom of Information requests reveal that the ASI is failing to meet its stated objectives, and most concerning, the province's total surgical activity has declined.

Specifically, analysis of AHS data shows:

- Total provincial surgical volumes have declined since the beginning of the ASI to levels below of 2014-2015 volumes (Table 8). Fewer total surgeries were performed in 2021-2022 (268,335) than in 2018-2019, that is, pre-pandemic and before the ASI (285,945).
- Total provincial surgical volumes declined by 6 per cent between 2018-2019 and 2021-2022, the most recent data available (Table 9).
- The expansion of for-profit surgical delivery appears to be undermining the ability of AHS facilities to increase or even maintain surgical volumes. The number of surgeries performed in CSFs increased from 29,052 in 2018-2019 to 43,078 in 2021-2022 (or 48 per cent), while public hospital volumes declined from 256,893 to 225,257 (or 12 per cent) (Tables 8 and 9).

- The share of total provincial surgeries outsourced to CSFs increased from 10 per cent in 2018-2019 to 16 per cent in 2021-2022 (Table 8). During the same years, the share of total surgeries performed in public hospitals declined from 90 per cent to 84 per cent.
- Since 2010-2011, the greatest reduction in public hospital surgical volumes occurred during each of the first three years of the ASI (2019-2020, 2020-2021, 2021-2022), suggesting that funding and staffing resources have shifted from the public to the for-profit sector — or at least constrained public hospitals from increasing surgical activity.
- This reduction in AHS surgical volumes cannot be explained by the pandemic alone, since surgical activity in CSFs increased between 2018-2019 and 2021-2022. Declining funding for public operating rooms (ORs) and a reduction in staffed hospital medical and surgical beds per capita suggest that the government's focus on increasing CSF surgical activity has constrained hospital staffing and surgical activity (Tables 10 and 11).

Table 8: Publicly Funded Surgical Procedures Performed in Chartered Surgical Facilities and AHS Hospitals, 2010-2011 to 2022-2023 YTD

	Chartered surgical facilities		AHS		Total surgical procedures in Alberta
	Number	Share of total	Number	Share of total	
2010-2011	22,369	9.1%	223,344	90.9%	245,713
2011-2012	23,647	9.1%	237,017	90.9%	260,664
2012-2013	24,835	9.5%	235,669	90.5%	260,504
2013-2014	25,687	9.6%	240,990	90.4%	266,677
2014-2015	25,390	9.3%	248,570	90.7%	273,960
2015-2016	27,787	10.1%	248,381	89.9%	276,168
2016-2017	28,390	10.1%	253,127	89.9%	281,517
2017-2018	29,116	10.3%	253,523	89.7%	282,639
2018-2019	29,052	10.2%	256,893	89.8%	285,945
2019-2020	32,809	11.6%	251,149	88.4%	283,958
2020-2021	36,553	13.7%	229,566	86.3%	266,119
2021-2022	43,078	16.1%	225,257	83.9%	268,335
2022-2023 YTD (Apr 1, 2022 - Nov 6, 2022)	16,912	-	141,893	-	158,805

Source: AHS (2022), obtained via a Freedom of Information request.

Note: Contracted CSF activity excludes pregnancy terminations.

Table 9: Change in Publicly Funded Surgical Procedures Performed in Chartered Surgical Facilities and AHS During Alberta Surgical Initiative, 2018-2019 to 2021-2022

	Chartered surgical facilities	AHS	Total surgical procedures in Alberta
2018-2019	29,052	256,893	285,945
2021-2022	43,078	225,257	268,335
No. change	14,026	-31,636	-17,610
% change	48.3%	-12.3%	-6.2%

Source: AHS (2022), obtained via a Freedom of Information request.

Public Operating Room Funding Decreased Under Alberta Surgical Initiative

Declining public operating room funding is contributing to reduced surgical volumes in AHS facilities. Between 2018-2019 and 2020-2021, public operating room expenditures decreased from \$576 million to \$561 million (Table 10).

Table 10: Public Operating Room Expenditure in Millions of Current Dollars in Alberta, 2009-2010 to 2020-2021

Public OR Expenditure	
2009-2010	434.6
2010-2011	449.3
2011-2012	469.1
2012-2013	486.5
2013-2014	521.1
2014-2015	549.2
2015-2016	558.0
2016-2017	551.7
2017-2018	560.2
2018-2019	576.0
2019-2020	575.0
2020-2021	561.0

Source: CIHI (2022b), Table B.9.1.

Number of Staffed Medical and Surgical Hospital Beds Declining

In 2018-2019, Alberta had 139 hospital medical and surgical beds per 100k population, which declined to 130 beds per 100k in 2020-2021 (Table 11). The decline of staffed medical and surgical hospital beds is also contributing to declining public sector surgical volumes. While many surgeries no longer require overnight stays, these staffed beds are required for patients to recover from more complex surgeries.

Hospital overcrowding occurs when not enough staffed medical and surgical beds are available to accommodate COVID-19 patients requiring care, patients with other illnesses, and when patients cannot be discharged for lack of community-based alternatives (e.g., long-term care). These capacity constraints limit the number of surgeries that may be completed and can lead to surgery cancellations and longer wait times.

Table 11: Hospital Medical and Surgical Beds Staffed and in Operation per 100k Population in Alberta, 2009-2010 to 2020-2021

Beds per 100k	
2009-2010	143.6
2010-2011	142.2
2011-2012	150.9
2012-2013	150.0
2013-2014	146.0
2014-2015	141.1
2015-2016	140.8
2016-2017	140.0
2017-2018	137.4
2018-2019	139.0
2019-2020	138.0
2020-2021	130.3

Source: CIHI (2022b), Table B.11.2

“The growth of this for-profit sector appears to be exacerbating AHS staffing shortages and constraining surgical activity in public hospitals.”

In conclusion, provincial surgical volumes were lower in 2021-2022 than in 2018-2019 (and even 2014-2015), despite claims that the ASI would increase provincial surgical capacity. Reduced public sector surgical volumes — and reduced public operating room funding and staffed hospital beds — at a time when CSFs have *increased* surgical activity suggest that public funding and staffing resources have been redirected to for-profit facilities. The growth of this for-profit sector appears to be exacerbating AHS staffing shortages and constraining surgical activity in public hospitals.

Claims of Cost-Efficiency and the Problem of Contract Transparency

The Alberta government claims that surgical outsourcing reduces costs because the per-procedure costs are lower in CSFs. In June 2022, when announcing the development of a new CSF in the Edmonton area, the Alberta government stated that “[e]xpected cost savings are in the range of 20 per cent for each [orthopedic] procedure performed in the community facility rather than in a hospital” (Government of Alberta, 2022b). While it is not possible to evaluate this specific claim — since the data have not been made public — available evidence from Alberta (see below) as well other provinces and internationally do not support this claim (see next section).

Cost comparisons obtained from the Alberta Workers’ Compensation Board show that average per-case costs for hernia repair surgeries are more expensive in CSFs than public hospitals. The Alberta Workers’ Compensation Board pays for workers to receive surgeries for workplace injuries and contracts AHS and CSFs to perform these procedures. Unfortunately, incomplete cost reporting from AHS to the Workers’ Compensation Board limits our ability to make accurate cost comparisons between all procedures that are commonly performed in both public and for-profit settings. However, data obtained from the Workers’ Compensation Board show billing data for hernia repairs performed in both settings, thereby making accurate comparison possible. Hernia repair costs (averaged from 2015 to July 31, 2022) are 9 per cent cheaper in public hospitals than those performed in CSFs (Table 12).

This finding is supported by previous Parkland Institute research. A 2012 research report on the costs of surgical outsourcing in Alberta also revealed higher costs in for-profit surgical centres. In this case, the Alberta government ended contracts with the Health Resource Centre in Calgary for publicly funded surgical services in 2010 because their services were more expensive than the public sector (Gibson & Clements, 2012). The higher costs at the for-profit centre ranged from 7 to 32 per cent, and were revealed in an internal government briefing note obtained by a Freedom of Information request (ibid., 12). The Health Resource Centre also went

bankrupt and required public subsidy in order to keep the facility afloat. The bankruptcy and closure came at significant public expense and risk to the public system as hospitals had to quickly provide surgeries for those patients.

The Canadian and international evidence on the higher cost of for-profit surgical delivery, and health-care delivery, generally, is reviewed in the next section.

Table 12: Average Cost per Inguinal or Femoral Hernia Repair Surgery Performed in CSF and Public Hospital for Workers' Compensation Board, 2015-2022 (to July 31)

	Contracted CSF	Public AHS hospital
No. of surgeries	618	32
Avg. cost per surgery (\$)	4,484	4,096
Difference in avg. cost (\$)	387	-387
Difference in avg. cost (%)	9%	-9%

Source: WCB Alberta (2022).

4. Problems With For-Profit Surgical Delivery

“For-profit health-care delivery worsens public-sector staffing shortages and destabilizes public hospitals, is more expensive, lower quality, and less safe.”

The weight of the academic evidence and policy experience in Canada and internationally shows that for-profit health-care delivery worsens public-sector staffing shortages and destabilizes public hospitals, is more expensive, lower quality, and less safe (Canadian Foundation for Healthcare Improvement, 2004; Longhurst, Cohen & McGregor, 2016).

Increased Public-Sector Staffing Shortages and Destabilized Public Hospitals

When surgeries are outsourced, the public and for-profit sectors compete for a limited pool of specialized health-care professionals. The private sector may offer incentives to attract health-care workers from the public system, such as reduced workloads, less complex patients, and higher pay. Prior to the ASI, Alberta was outsourcing a limited range of surgeries, with limited or no anesthesia requirements.

As Alberta moves to outsource more complex procedures (including orthopedic surgeries), anesthetists, respiratory therapists, operating room and recovery nurses, and other professionals in high demand will be pulled into the for-profit sector. A confidential AHS slide deck prepared for its board and released through a Freedom of Information request acknowledged “critical anesthesia gaps” and ongoing surgical workforce shortages (AHS, 2022e, 21). This leads to staffing shortages and longer waits in the public system (Canadian Foundation for Healthcare Improvement, 2005).

Staffing and overall costs may increase as the public sector must compete with the for-profit sector to recruit and retain staff. This makes it difficult for the public sector to contain rising health-care costs, maintain and increase capacity. Section 3 of this report shows that the ASI’s focus on increasing for-profit delivery appears to be at the expense of public operating room funding, staffed hospital beds, and public sector surgical activity. Surgical activity in AHS facilities declined by 12 per cent between 2018-2019 and 2021-2022, while CSF activity increased by 48 per cent (Table 9).

In Alberta and other provinces, private surgical facilities also achieve profits by focusing on lower complexity procedures, and leaving the more complex procedures and patients to public hospitals (Longhurst, Cohen & McGregor, 2016). This allows CSFs to maintain high volumes of relatively simple procedures, allowing for the greatest return on investment. There is only one CSF approved for “extended stay,” and all AHS-contracted CSFs are only “day stay” facilities, with limitations placed on the complexity of procedures that may be performed (CPSA, 2018).

This practice of “cream skimming” healthier patients and less complex procedures while offloading more complex patients, procedures, and complications to public hospitals destabilizes the public hospital system. Over time, by relying on for-profit providers, the public system has less ability to negotiate prices with private providers because it loses the capacity to provide these services. This problem is borne out by the English experience with the for-profit surgical sector.

The British Medical Association found “distorted case-mix, whereby the treatment centre has ‘cherry picked’ cases, [and] the loss of continuity of patient care and control of patient pathways” (BMA Health Policy and Economic Research Unit, 2005, 4). As we know from the B.C. government’s difficulty obtaining basic records from Cambie Surgeries Corporation (B.C. Ministry of Health, 2012), the private sector’s tendency to maintain proprietary control over information makes it very difficult to monitor and publicly report on private surgical facilities’ operations and “cream skimming” practices.

Higher Cost of For-Profit Surgical Delivery

The cost-efficiency of public sector delivery compared to for-profit delivery is supported by the peer-reviewed evidence and the experience in other provinces. In B.C., the workers’ compensation system (WorkSafeBC) often uses private clinics for expedited surgeries. A 2011 study published in *Healthcare Policy* found that WorkSafeBC paid almost four times more (375 per cent) for an expedited knee meniscectomy in a private clinic (\$3,222) than it would have cost for a non-expedited surgery in a public hospital (\$859), despite worse return-to-work outcomes for patients receiving private-sector surgery (Koehoorn et al., 2011, 57). In Quebec in 2014, the provincial government ended contracts with two private surgical centres (Rockland MD and the Eye Institute of the Laurentians) because the per-case costs were lower in the public system (Duchaine and Lacoursiere, 2014; Lacoursiere, 2014). In April 2023, government data obtained under Freedom of Information revealed that Quebec paid up to 2.5 times more for procedures performed in for-profit clinics compared those performed in public hospitals in 2019-2020 (Lindsay, 2023).

The private delivery of publicly funded surgeries is a form of public-private partnership (P3) whereby facility capital costs are negotiated into the per-unit procedure price. This is attractive to provincial governments as costs are only expressed as operating expenditures, rather than capital debt, with the private sector financing the capital asset (at a higher borrowing cost than what is available to government).

“The cost-efficiency of public sector delivery compared to for-profit delivery is supported by the peer-reviewed evidence and the experience in other provinces.”

In their review of the Canadian and international evidence on the cost efficiency of P3s, professors Anthony Boardman (University of British Columbia), Matti Siemiatycki (University of Toronto), and Aidan Vining (Simon Fraser University) identify the following disadvantages of P3s in terms of value for money for taxpayers: P3s have higher financing costs and higher private-sector transaction costs and risks; private-sector profit margins are built into contracts and are a cost to the government; and significant (and often unaccounted for) “transaction costs” are borne by the government to initiate, negotiate, and manage the P3 relationship over the life of the contract (Boardman et al., 2016, 13).

But unlike other P3 arrangements where the government assumes ownership over the capital asset at the end of the contract term, Alberta’s approach to outsourcing surgeries means that the public has helped pay for the CSF and equipment but the private sector owns it. Thus, the benefits of asset ownership are exclusively realized by the private sector. As well, this P3 model means provincial governments have no guarantee that these assets — paid for through funding from the public sector — will remain available to the public system should other revenue streams become more lucrative (e.g., private-pay patients).

Conflict of Interest and Medical Decision-Making

When surgical care is provided by a for-profit facility, medical decision-making — especially for elective surgery — is much more susceptible to conflict of interest leading to inappropriate surgeries and diagnostic testing. Surgeries are inappropriate if they do not provide a health benefit to the patient, are risky, or result in deterioration in a patient’s health status. When contracting out surgical services, governments may face increased costs because for-profit providers have a financial incentive to selectively offer and perform more profitable procedures even if they are clinically inappropriate (Horwitz, 2005).

The question of surgical appropriateness remains a significant issue within the public system as well, especially when physicians are compensated on a “fee-for-service” basis. But the evidence from the U.S. — with its well-established for-profit surgical sector — focuses attention specifically on the financial incentive for private clinics to prefer healthier patients and simpler, lower-cost surgeries in order to increase their profit margin (i.e., cream skimming) (Gonzalez, 2004; Kreinder, 2010, 16).

U.S. studies have found a relationship between physician ownership of surgical centres and increased use of surgeries to treat patients (Hollingsworth et al., 2009; Mitchell, 2010; Yee, 2011). In one U.S. study, physician board directors of surgery centres “steered patients from hospitals to their affiliate [private surgery centres]” (Yee, 2011, p. 904). Physician

“For-profit providers have a financial incentive to selectively offer and perform more profitable procedures even if they are clinically inappropriate.”

board membership, on average, “led to a 27 per cent increase in a physician’s procedure volume and a 16 per cent increase in a physician’s colonoscopy volume” (ibid.).

With Alberta’s plans to outsource 30 per cent of total surgeries, a significant share of routine procedures will move into the for-profit surgical sector. Investor-owned surgical facilities realize economies of scale by focusing on simpler, high-volume procedures in order to achieve higher profit margins relative to more complex patients and unpredictable procedures. This can create perverse incentives whereby the profit motive conflicts with efforts to reduce the overuse of clinically inappropriate surgeries. This is especially the case when surgeons are investors and have a financial stake in driving business to their surgical centres as well as institutional investors, like private equity firms, that have revenue expectations.

One of the significant barriers to addressing potential conflict of interest and its effect on clinical decision-making is that the operations of for-profit clinics are shrouded in secrecy. Contractual details — including staffing arrangements and the negotiated costs per procedure between health authorities and private providers — are kept secret, preventing public scrutiny of the financial arrangements and costs of for-profit delivery.

In Alberta, like other provinces, clinic owners, investors, and the contractual arrangements between for-profit facilities and their physicians are not publicly disclosed. B.C. serves as a cautionary lesson. When the province uncovered evidence of unlawful extra-billing at Brian Day’s clinics, the corporation refused to fully disclose their financial statements, ledgers, and contractual arrangements with physicians (Longhurst, Cohen & McGregor, 2016, 21).

“When health-care facilities are profit-motivated, they must find ways to reduce costs and return profits to investors.”

Patient Safety and Care Quality Concerns With For-Profit Delivery

Evidence from Canada and internationally shows that for-profit health-care delivery is generally less safe and provides lower-quality care (Modi et al., 2018; Rosenau & Linder, 2003). Much of the research comes from the U.S. and England, where for-profit clinics, surgery centres, and hospitals are widespread. There remains a lack of peer-reviewed research in Canada due to the much smaller volume of total procedures outsourced to for-profit facilities. However, as many provinces increase the private delivery of surgical procedures, evidence from other jurisdictions and media reports caution against outsourcing due to lower quality and safety risks.

When health-care facilities are profit-motivated, they must find ways to reduce costs and return profits to investors. The primary strategy among

for-profit hospitals, ambulatory care facilities, and long-term care homes in the Canada and U.S. is to maintain lower staffing levels and fewer highly-skilled personnel per bed (Devereaux et al., 2002a; 2002b; Ronald, 2016; Office of the Seniors Advocate, 2020, 9-10). In turn, hospitals with fewer skilled personnel per hospital bed are associated with higher mortality rates (Devereaux et al., 2002a).

Patient safety may be sacrificed in order to generate profits for investors. Devereaux and colleagues compared mortality rates for 26,000 for-profit and non-profit hospitals, serving 38 million patients in the U.S., and concluded that “private for-profit ownership of hospitals, in comparison with private not-for-profit ownership, results in a higher risk of death for patients” (ibid., 1399). The researchers raise concerns about the negative health outcomes if governments open the door to for-profit hospital care in Canada. Currently, there is no public reporting of complications or serious incidents in CSFs in Alberta or private surgical centres anywhere in Canada.

In England, the British Medical Association has also found significant issues with the quality, safety, and continuity of care in the country’s private surgical sector. Two-thirds of clinical directors surveyed across three specialty areas reported patients who developed complications following treatment in private clinics and who required readmission to public hospitals — which is not only a safety concern but also an additional cost burden to the public system (BMA Health Policy and Economic Research Unit, 2005). Half of the clinical directors surveyed were “concerned about the general quality of care provided [...] particularly by [...] [private surgical centres]. Concerns centre[d] around the quality of specialist care provided by the treatment centres, the loss of continuity in medical provision and the lack of long term patient care” (ibid., 4).

An estimated 82 for-profit hospitals in England offloaded £250 million to the public system over three years, as patients were transferred to public hospitals due to complications in private hospitals (CHPI, 2017, 5). In England, the lack of comparable high-quality clinical outcomes data makes it difficult to comprehensively assess the quality of care provided by the for-profit sector (CHPI, 2017, 6; King’s Fund, 2009).

A growing body of research shows the risks of outsourcing health services to the for-profit sector. In a 2022 study by University of Oxford researchers published in the *Lancet Public Health* journal, researchers concluded that “private sector outsourcing [in England] corresponded with significantly increased rates of treatable mortality, potentially as a result of a decline in the quality of health-care services” (Goodair & Reeves, 2002). England has a well-established for-profit surgical sector where a growing share of surgeries are performed, including 27 per cent of trauma and orthopedics in 2021-2022 (Peytrignet et al., 2022).

“For-profit clinics and surgical chains are entrenching two-tier health care in Canada through unlawful extra-billing practices.”

Risk of Unlawful Extra-Billing and Two-Tier Health Care

Arguments in favour of for-profit delivery are often based on the claim that contracted facilities will not engage in unlawful extra-billing (also called two-tier health care), which is contrary to the Canada Health Act. Extra-billing is an unlawful practice whereby clinics bill patients privately for medically necessary procedures that are already covered by the public health-care system (through provincial health insurance plans). However, the distinction between publicly funded for-profit delivery (at no cost to the patient) and private payment (also called two-tier health care, where the patient pays to “jump the queue”) cannot be easily separated. Evidence shows that for-profit clinics and surgical chains are entrenching two-tier health care in Canada through unlawful extra-billing practices.

The B.C. case is instructive, where a well-established for-profit surgical and diagnostic sector has grown from both government outsourcing (totalling \$393 million between 2015-2016 and 2020-2021) and unlawful extra-billing against the Canada Health Act (Longhurst, 2022).

It has required extensive research and multiple Freedom of Information requests to determine that B.C. health authorities contracted with for-profit surgical providers — False Creek Healthcare Centre, Kamloops Surgical Centre, and Surgical Centres Inc. — that were audited and found to have engaged in unlawful extra-billing contrary to the B.C. Medicare Protection Act and the Canada Health Act (Longhurst, 2022).

This report provides new evidence that Calgary-based Surgical Centres Inc. (acquired by Clearpoint Health Network in January 2023) was engaged in unlawful extra-billing in B.C. during the same time it held outsourcing contracts with AHS and B.C. health authorities.

Three Surgical Centres Inc. facilities in B.C. were audited by the provincial government for unlawful extra-billing between 2015-2016 and 2020-2021 (see section *For-profit surgical clinics and unlawful extra-billing* in this report; B.C. Ministry of Health, 2023, 18). From 2012-2013 to 2021-2022, AHS held a contract with Surgical Centres Inc. valued at \$155 million (Appendix D). In 2022, the B.C. government purchased Surgical Centres Inc. facilities in Victoria and Nanaimo and brought them into the public system, reportedly because their ORs were underutilized (B.C. Ministry of Health, 2022). Then, in January 2023, Surgical Centres Inc.’s facilities in B.C., Alberta, and Saskatchewan were acquired by Clearpoint Health Network, which is one of the major for-profit providers in Alberta. In February 2023, CBC revealed that Clearpoint Health Network is exploiting an apparent loophole in the Canada Health Act by charging patients up to \$28,000 to have an orthopedic surgery performed in another province (Crawley, 2023).

5. Recommendations

Based on the research evidence, this report recommends that the provincial government shift away from for-profit surgical delivery and fully commit to public system improvement. Instead of expanding for-profit surgical outsourcing at the expense of the public system, the Alberta government should implement policy strategies that can reduce wait times over the long term.

Waits for scheduled surgeries exist in all countries. They are influenced by population demographics, health system financing and governance, the health workforce, and how services are organized. Health systems that rely heavily on private finance, such as the U.S., do not provide equitable access based on medical need.

There are numerous policy strategies available to provincial governments to reduce wait times, but governments have tended to focus on short-term increases in surgical activity. International evidence shows that short-term funding for temporary additional capacity is unlikely to reduce wait times over the long term (Kreindler, 2010, 11). Canadian provinces have largely focused on short-term injections of funding — with an increased focus on outsourcing surgeries and diagnostics to for-profit clinics — rather than a sustained focus on improvement and investment in the public system.

Adopt Single-Entry Models, Teamwork, and Improved Waitlist Management

Wait times can be reduced if instead of referring patients to a specific surgeon, they are referred to a *single-entry model*. Single-entry models (SEMs) generally include central intake of referrals from primary care providers (or self-referrals, if appropriate), pooled referrals, a waitlist shared by a team of surgeons and other providers, and triage for urgency and appropriateness.

In a SEM, a patient's primary care provider makes a referral to the SEM (comprised of surgeons and other providers, as appropriate). If the patient is a surgical candidate, the referral is then triaged based on the condition and urgency to the first-available surgeon with the shortest wait and most appropriate expertise. If the patient is not a surgical candidate, they may be referred to specialized supports and non-operative therapies. In orthopedics, for example, a specially trained physiotherapist may initially assess and triage for surgical candidacy or non-operative therapy.

In many parts of the country, primary care providers refer patients to specific surgeons who each keep their own waitlists for consultations and surgeries. There is often no centralized management or oversight of these waitlists

“Team-based care delivered through a single-entry model is more timely, consistent, and appropriate.”

by hospitals or health authorities, with the exception of cancer and cardiac care. This creates inequities in waits as some patients wait much longer than others. In contrast, SEMs minimize the number of waitlists and balance the workload, ensuring that every surgeon has consistent work. This can significantly reduce long waits common among senior surgeons and ensure that equally qualified younger surgeons are able to provide surgeries more quickly.

Timely access to treatment and satisfaction improve when health-care professionals work together in multi-professional teams using a single-entry model. In a *Canadian Medical Association Journal* commentary, Dr. David Urbach and Dr. Danielle Martin state that SEMs are an “efficient, fair, and ethical approach to addressing pent-up demand for surgery in the presence of constrained resources” (Urbach & Martin, 2020, 1).

Team-based care delivered through a single-entry model is more timely, consistent, and appropriate. It also eliminates unnecessary steps and delays, particularly when health-care professionals are supported to work to their full scope of practice. This frees surgeons’ time to perform additional surgeries and consult with patients who are indeed possible surgical candidates. Patient and provider satisfaction is high with SEMs (Milakovic et al., 2021), and evidence shows improved quality indicators for joint replacements (Demani et al., 2019).

The ASI includes initiatives to streamline referral processes and move to SEMs. In summer and fall 2022, a new SEM launched across all AHS zones (AHS, n.d.-b). The Facilitated Access to Specialized Treatment (FAST) initiative is beginning with orthopedics and urology and expanding to other specialties through 2024. Primary care providers will send referrals to a new centralized AHS service, giving patients the option to see the next available specialist with the shortest waitlist, a particular specialist, or an out-of-zone specialist. FAST shows promise to reduce wait times, improve patient experience and care quality. However, like the Saskatchewan experience, there is concern that this improvement initiative is not receiving the policy focus required and is overshadowed by the government’s focus on surgical outsourcing.

Maximize and Extend Hospital Operating Room Capacity

Maximizing and extending hospital operating room capacity as well as improving performance can also reduce wait times and costs. Specific strategies include optimizing scheduling and reducing downtime. For example, if two ORs are used with a staggered schedule, surgical teams can “swing” between rooms as their patients are prepared for surgery by other team members.

“International research shows that increasing public sector acute care capacity, rather than outsourcing, has the greatest potential to reduce waits in the long run.”

Efforts to maximize operating room time may also include moving less-complex procedures out of hospital ORs into specialized outpatient procedure rooms, scheduling more complex cases at the end of the day (which reduces delays and cancellations), and investing in more equipment so surgeons don't lose time waiting for equipment to be cleaned. Standardizing surgical procedures, equipment, and clinical practices can reduce variation and increase productivity with a relatively small investment of money.

Maximizing underused hospital operating room capacity should be prioritized. The 2019 Ernst & Young AHS review found that physical public operating room capacity was used at 71 per cent in 2018-2019 and that an additional 18,713 operating room slates could be added to make more effective use of existing public capacity (Ernst & Young, 2019, 81).

The Ernst & Young review noted that many AHS ORs are not performing surgeries into evenings and weekends, and that this would help maximize the use of existing ORs (*ibid.*, 81-82). Declining AHS surgical volumes (see Table 8) demonstrates that the government has not prioritized this recommendation, and instead, has focused on increasing CSF surgical activity and shifting resources to the private sector. Furthermore, additional capacity can be created by extending operating room hours, but CSFs will now be competing for the same personnel. Neither the Ministry of Health nor AHS has made firm commitments about fully utilizing underused operating room capacity.

Over the longer term, the international research shows that increasing public sector acute care capacity, rather than outsourcing, has the greatest potential to reduce waits in the long run (Kreindler, 2010, 12). An OECD study of 13 high-income countries found that a greater number of acute care beds is associated with shorter wait times (Borowitz et al., 2013, 27), and a review of 103 academic articles and policy papers concluded that “cross-national comparisons suggest a consistent link between greater capacity (e.g., acute care beds, physicians, overall spending) and shorter wait times” and that “[p]roactive, targeted investment in public-sector capacity is an effective long-term strategy to control wait times” (Kreindler, 2010, 14).

Increase Access to Seniors' Home and Community Care

Better access to publicly funded home and community care, especially for seniors, will reduce hospital bed shortages, cancellations of scheduled surgeries and, ultimately, surgical wait times for all patients (Wait Time Alliance, 2015, 2). Home and community care includes home support (e.g., personal care services, and help with housekeeping, cooking, and taking medications), home nursing, rehabilitation therapy, long-term care and palliative care.

Many patients occupying inpatient hospital beds cannot be discharged due to the lack of community-based alternatives. They are referred to as “alternate level of care” (ALC) patients, and the majority are seniors. As our population ages, more people will require home care, long-term care, and palliative care. According to the Wait Time Alliance (an organization representing 18 medical-specialty associations), “the ALC issue represents the single biggest challenge to improving wait times across the health care system” (2015, 2). The Alliance emphasized the urgency of improving access to seniors’ care in order to reduce the high rates of ALC patients: “If we can improve how we care for our seniors, we will go a long way toward creating a high-performing health care system, thereby benefiting all patients” (37). Investing significantly in seniors’ care can reduce hospital overcrowding and wait times for all patients.

The lack of available publicly funded seniors’ home and community care services in Alberta has been documented by the Parkland Institute (Campanella, 2016), and recent data show it to be an ongoing barrier to improving patient flow and reducing surgical wait times. In Alberta in 2020-2021, average patient days in ALC were 19 per cent of total patient days — the second-lowest of the provinces, after Saskatchewan (CIHI, 2022d). However, another measure — hospital stays extended until home care services or supports are ready — suggests that there is inadequate access to publicly funded seniors’ home and community. In 2019-2020, patients in Alberta waited a median of 12 days in hospital because home care or other supports were not ready — a number greater than B.C.’s (seven days), Ontario’s (eight days), and Saskatchewan’s (nine days) (CIHI, 2022e).

Reduce the Overuse of Medical Imaging and Surgeries

Reducing surgical wait times also requires a focus on addressing the overuse of medical imaging and surgeries when they provide little or no diagnostic or treatment benefit. A 2017 report from Choosing Wisely Canada and the Canadian Institute for Health Information concluded that up to 30 per cent of procedures, imaging tests, and pharmaceutical therapies across eight priority areas are potentially unnecessary (CIHI, 2017; Grant, 2017).

Technological advances have contributed to the growth of medical imaging (e.g., x-ray, MRI, CT), which can be necessary for diagnosis. However, growing evidence suggests that many imaging tests are not necessary and may cause avoidable patient harm. Based on a review of eight Canadian studies, the share of inappropriate MRI exams was estimated to range from 2 to 28.5 per cent, in large measure because methodologies in these studies varied (Vanderby et al., 2015). A national approach to appropriateness, supported with better data reporting and quality improvement programs, would likely reduce inappropriate medical imaging and wait times for those with urgent needs.

“Reducing inappropriate surgeries requires a movement towards shared decision-making between patients and health-care providers.”

There is also growing recognition that surgical interventions may not always be appropriate for patients. Surgical care is appropriate when it is based on available evidence and the patient’s health status. Inappropriate surgeries are those that provide no health benefit to the patient, are risky, and may result in deterioration in a patient’s health.

Inappropriate surgeries can be reduced by ensuring physicians are supported to use the best available evidence in assessing whether a surgery is appropriate for their patient, and by involving and fully informing patients of the potential benefits, risks, and outcomes of surgery. In other words, reducing inappropriate surgeries requires a movement towards shared decision-making between patients and health-care providers, with patients actively involved in the decision to undergo surgery or pursue non-operative therapies.

Routine, low complexity surgical procedures, such as cataract surgery and joint replacements, often have high clinical variation. This means patients with similar diagnoses receive different treatments depending on when, where, and by whom they are treated, despite clinical evidence on the optimal treatment. For example, a 2002 study of B.C. cataract surgery patients found that 26 per cent of patients reported either no change or a deterioration to their eyesight after surgery (Wright et al., 2002). The study used patient-reported outcome measures (PROMs) to provide patients’ perspectives on their health and the appropriateness of the interventions.

PROMs are standardized and validated surveys completed independently by patients, typically before and after surgery. This data can be used to identify where there are variations resulting in poor outcomes, to support clinicians to make necessary changes in their clinical practice, and to inform health system planners where quality improvement efforts are needed.

Growing momentum through the Choosing Wisely campaign and PROM collection — beginning with national standards for hip and knee replacements — is encouraging (CIHI, 2019). Ultimately, PROM collection needs to be systematically and routinely used by clinicians and health system administrators to reduce unnecessary clinical variation and to improve the safety and quality of care.

There are encouraging signs that Alberta is reducing clinically inappropriate medical imaging and surgeries. A 2022 report, published by Choosing Wisely Canada and CIHI, shows Alberta making improvements across most areas with common overuse of tests and treatments of low clinical value (Choosing Wisely Canada and CIHI, 2022). Alberta needs to remain focused on its Choosing Wisely efforts, and in many areas can do this by expanding single-entry models with team-based care and a focus on prevention and self-management. For example, the Rapid Access Clinics for Low Back

Pain in Ontario allow patients to see a multidisciplinary team that provides education and supports non-operative self-management (Choosing Wisely Canada and CIHI, 2022, 19). The clinics help reduce the unnecessary referral to a spine surgeon and MRI overuse.

Adopt a “Vaccines-Plus” Public Health Strategy to Reduce Health System Strain and Delayed Surgical Care

Finally, the ongoing burden of unmitigated SARS-CoV-2 transmission — along with other viruses disproportionately affecting children, seniors, and vulnerable people — is contributing to severe health system strain. In order to manage inpatient volumes that remain much higher than pre-pandemic, hospitals have been forced to continue postponing scheduled surgeries in order to free up staffing resources, especially nurses, and inpatient beds. As a result, AHS faces challenges in increasing surgical volumes above pre-pandemic levels as this report has shown.

Alberta will be much more resilient and able to prevent delayed surgical care if it adopts a “vaccines-plus” public health strategy (Greenhalgh et al., 2022). This requires the provincial government and public health officials to manage the ongoing pandemic and the resulting severe pressures on the health system in a manner consistent with scientific evidence and the goal of preventing infection and transmission. A vaccines-plus strategy includes these six elements:

Deliver public education programs that show SARS-CoV-2 is airborne

There is scientific consensus that the *primary* transmission mode of SARS-CoV-2, the virus that causes COVID-19, is through the inhalation of aerosols that float in the air like cigarette smoke (Greenhalgh et al., 2022). These aerosols can reach dangerous concentrations especially in poorly ventilated spaces. Most provincial public health authorities have not clearly communicated and educated the public on the airborne transmission as evident by the focus in many businesses and public settings on handwashing and cleaning surfaces.

Set public indoor air-quality standards

As an airborne virus, improving ventilation in schools, hospitals and long-term care, workplaces, and other congregate settings should be a priority (Greenhalgh et al., 2022). Provinces, including Alberta, have not set indoor air-quality standards in workplaces and higher-risk congregate settings such as schools, child care facilities, and health-care facilities. It is also a matter of occupational health and safety: employers must take reasonable steps to prevent workers from contracting workplace-acquired infections. Alberta can look to jurisdictions like Belgium that have started regulating indoor air quality in public places and requiring public display of CO2 monitoring

(Chini, 2022). In spaces with limited or poor mechanical ventilation, portable HEPA air filtration units should be used to improve filtration. Monitoring indoor air quality with CO2 monitors and keeping levels below 800 parts per million reduces transmission risk.

Mandate universal indoor masking when viral transmission is high

Tight-fitting, high-quality masks and respirator prevent the inhalation of infected aerosols (Greenhalgh et al., 2022). No Canadian province has set mask standards outside of health-care settings, and the Alberta government has even banned school mask mandates (French, 2022), which are an evidence-based tool to help prevent infection and overwhelmed hospitals.

Increase access to (and provide guidance on) testing

Testing can help reduce onward transmission and community and health-care outbreaks that strain health services. Rapid tests are an effective public-health tool and can quickly identify infectious individuals and help prevent onward transmission. Rapid antigen tests are a helpful tool to quickly determine whether a person is infectious. PCR tests, while providing higher sensitivity, are a confirmatory diagnostic tool. Both types of testing are the basis for a comprehensive and publicly funded testing approach that will help us reduce spread and protect our health system's capacity to deliver timely surgical care.

Require 10-day isolation for positive cases and provide at least 10 paid sick days

Evidence shows that most people remain infectious for up to ten days (Adam, 2022). Alberta should provide legislated paid sick leave.

Stay up-to-date with current vaccinations that protect against severe disease and death

As current vaccines offer limited protection against infection and long COVID, vaccines should be used in combination with the above measures intended to prevent transmission in the first place.

6. Conclusion

“The Alberta Surgical Initiative, with its focus on for-profit surgical delivery, has failed to increase total provincial surgical activity to pre-pandemic levels.”

The Alberta Surgical Initiative, with its focus on for-profit surgical delivery, has failed to increase total provincial surgical activity to pre-pandemic levels. Alberta's wait times for priority procedures are among the longest in Canada.

Despite claims that the Alberta Surgical Initiative would increase the surgical activity in the province, an evaluation of the first three years of the initiative suggest that funding and staffing have been diverted to chartered surgical facilities at the expense of public hospitals. This report provides new evidence indicating that health-care personnel are a fixed resource, and that expansion of a parallel, for-profit surgical delivery sector is constraining surgical activity in public hospitals. Between 2018-2019 and 2021-2022, contracted surgical volumes in chartered surgical facilities increased 48 per cent in Alberta, while public payments to for-profit facilities climbed 61 per cent. At the same time, public hospital surgical activity in AHS facilities declined 12 per cent as the public sector faces reduced capacity and operating room funding.

For-profit surgical delivery has become a big business. Public contracts for surgical outsourcing could reach \$78 million in 2022-2023. At the same time, staffing and funding levels in public AHS facilities have declined. A new contract with a national for-profit surgical chain could cost Alberta Health Services nearly \$105 million through 2029.

Evidence shows that the for-profit surgical sector is a gateway to two-tier health care as for-profit facilities and corporate chains have been found to provide preferential access and charge patients unlawfully.

Surgical privatization comes at the expense of public hospitals and undermines efforts to reduce surgical wait times over the long term. However, by focusing on public-sector policy strategies based on the research evidence, the Alberta government can reduce surgical wait times. This will require a move away from surgical privatization and for the government to commit to public system improvement:

- prioritize the use of single-entry and team-based referral models;
- improve and maximize public operating room capacity and expand acute care capacity;
- increase access to seniors' home and community care thereby reducing hospital overcrowding;
- reduce the overuse of clinically inappropriate medical imaging and surgeries; and,
- adopt a “vaccines-plus” public health strategy to reduce health system strain and delayed surgical care.

There is promising public system improvement work underway, but it requires the full commitment from the government.

The expansion of chartered surgical facilities and movement towards a for-profit hospital sector will undermine the evidence-based policy solutions needed to reduce public wait times and protect the integrity of a public health-care system. A significant policy shift is required.

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Appendix A: Research Methods and Data Sources

This research uses Freedom of Information requests, descriptive statistical analysis of publicly available and requested data, and a review of the academic and policy literatures. Specific methods and data sources are described below.

Freedom of Information requests: The author requested statistical data from Alberta Health Services (AHS), Alberta Health (AH), and the Saskatchewan Ministry of Health. Data obtained from AHS includes the number of completed surgical procedures performed in AHS facilities and contracted CSFs (excluding pregnancy terminations) between 2010-2011 and 2022-2023. The author requested actual AHS payments to for-profit surgical facilities by facility name and fiscal year, but AHS denied access to this information citing harm to the economic interests of AHS due to the ongoing surgical outsourcing procurement process. The report also draws on a B.C. FOI request that reveals B.C. government audits for unlawful extra-billing at Calgary-based Surgical Centres Inc. (acquired by Clearpoint Health Network in January 2023) facilities in B.C. (B.C. Ministry of Health, 2023).

Data extraction: The author extracted the list of accredited CSFs from the College of Physicians and Surgeons of Alberta website (CPSA, 2022b), AHS payments to CSFs from AHS financial documents (AHS, n.d.-d), and contract data from the AHS website (AHS, 2022c; 2022d; 2023b). Each contract contains estimated or maximum contract values. AHS contract data were extracted from website updates in November 2022 and January 2023. After extracting contract values from each contract, the author created a dataset to enable analysis.

Descriptive statistical analysis: The above FOI requests and extracted data were analyzed in addition to multiple datasets from the Canadian Institute for Health Information (CIHI). The author made a custom data request to Alberta Workers' Compensation Board (2022) for cost comparisons of hernia repair surgeries performed in contracted CSFs and public hospitals.

Literature review: The author reviewed the peer-reviewed and policy literatures about the problems with for-profit surgical delivery (Section 4) and policy strategies to reduce surgical wait times and improve care quality (Section 5).

Appendix B: Volume of AHS Contracted Procedures and Total Payments to Chartered Surgical Facilities, 2015-2016 to 2021-2022

	2015/16	2016/17	2017/18	2018/19	2019/20*	2020/21	2021/22	Change %, 2018/19 to 2021/22	Change %, 2015/16 to 2021/2022
Dental/oral surgery	4,620	4,870	5,294	6,007	5,805	6,873	7,974	33%	73%
General surgery	643	561	444	534	649	75	3	-99%	-100%
Ophthalmology	21,145	21,572	22,138	21,311	25,263	27,335	31,252	47%	48%
Orthopedic surgery	-	-	-	-	-	-	1,117	-	-
Ear, nose, throat surgery	103	111	98	101	115	237	481	376%	367%
Plastic surgery	185	191	137	107	95	1,090	1,330	1143%	619%
Podiatry	1,091	1,085	1,005	992	882	943	921	-7%	-16%
Total procedures	27,787	28,390	29,116	29,052	32,809	36,553	43,078	48%	55%
% annual change		2.2%	2.6%	-0.2%	12.9%	11.4%	17.9%	-	-
Total AHS payments to surgical facilities (\$ millions)	19.30	20.20	18.34	17.19	20.04	21.83	27.70	61%	43%
% annual change		4.7%	-9.2%	-6.3%	16.6%	8.9%	26.9%	-	-

Sources: Numbers of contracted procedures are from AHS (2022b). Total AHS payments to surgical facilities were extracted from “Contracts under the Health Facilities Act” (previously called “Contracts under the Health Care Protection Act”) in Consolidated Schedule of Expenses by Object, AHS Annual Reports from 2015-2016 to 2021-2022 (AHS, n.d.-d).

Note: Contracted volumes exclude pregnancy terminations. AHS payments to CSFs do not include physician billings to Alberta Health Care Insurance Plan. The above payments only constitute the “facility fee” paid by AHS to the private facility.

* Alberta Surgical Initiative was announced in December 2019.

Appendix C: Contracted Chartered Surgical Facilities By Maximum Contract Value in 2022-2023

	Dermatology	Ear, Nose & Throat	Ophthalmology	Oral & Maxillofacial	Orthopedics	Plastic	Total
Alberta Surgical Group - Heritage Valley Ltd.					27,303,860		27,303,860
Clearpoint Health Network					8,208,563		8,208,563
12846284 Canada Inc.			6,235,256				6,235,256
Holy Cross Surgical Services			5,879,146				5,879,146
Weiss Clinic Inc.					3,422,509	944,920	4,367,429
L. C. McLean Professional Corporation				2,453,709			2,453,709
Darrell Andrew Paul Gotaas Professional Corporation				2,453,709			2,453,709
Saranjeev S. Lalh Professional Corporation				2,453,709			2,453,709
Reena M. Talwar Professional Corporation				2,453,709			2,453,709
Kevin E. Lung Professional Corporation				1,801,969			1,801,969
George Forrest Professional Corporation				1,801,969			1,801,969
Alberta Surgical Centre Inc.					871,661	886,591	1,758,253
Sandeep Dhesi Professional Corporation				1,395,000			1,395,000
Plastic & Cosmetic Laser Surgical Centre Ltd.						1,283,224	1,283,224
Alberta Cornea and Cataract Consultants Ltd. o/a Eye Q Premium Laser			1,125,000				1,125,000
Graham Cobb Professional Corporation				1,116,000			1,116,000
Miller Smith Professional Corporation				1,116,000			1,116,000
Simon Touchan Professional Corporation				1,116,000			1,116,000
Todd P. Fairbanks Professional Corporation				1,116,000			1,116,000
Brett Habijanac Professional Dental Corporation				1,116,000			1,116,000
Steve Bureau Professional Corporation				1,116,000			1,116,000
2354693 Alberta Ltd.		1,023,726					1,023,726
Kevin Robertson Professional Corporation				600,000			600,000
Audrey Chan Professional Corporation			255,742				255,742
Thomas C. Nakatsui Professional Corporation	90,000						90,000
Southgate Surgical Suites Ltd.						77,200	77,200
Southland Surgical Centre Inc.						22,500	22,500
Total	90,000	1,023,726	13,495,145	22,109,775	39,806,593	3,214,436	79,739,675

Sources: Data extracted from current AHS contracts with CSFs as of November 2022 (2022c).

60 Note: The amounts do not represent actual payment. Actual payments may be less than maximum contract values.

Appendix D: Surgical Centres Inc. Maximum Contract Values With AHS, 2012-2013 to 2021-2022

	Contract value (\$)
2012/13	14,765,627
2013/14	14,765,627
2014/15	14,765,627
2015/16	14,765,627
2016/17	14,765,627
2017/18	14,765,627
2018/19	14,765,627
2019/20	14,765,627
2020/21	18,502,802
2021/22	18,813,800
Total	155,441,614

Sources: AHS, 2022c; 2022d.

Note: The amounts do not represent actual payment. Actual payments may be less than maximum contract values.



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