A SUSTAINABLE HEALTH SYSTEM FOR Alberta

Report of the M.L.A. Task Force on Health Care Funding and Revenue Generation

October, 2002

For additional copies of this document please contact:

Alberta Health and Wellness
Communications Branch
22nd floor, 10025 Jasper Avenue
Edmonton, Alberta T5J 2N3
Phone: (780) 427-7164
Fax: (780) 427-1171

E-mail: health.ahinform@gov.ab.ca

You can find this document on the Government of Alberta internet Web site – http://www.gov.ab.ca

ISBN 0-7785-2694-1
ISBN 0-7785-2695-X; PDF version

MEMBERS OF THE TASK FORCE

- Gordon Graydon, M.L.A., Grande Prairie-Wapiti, Chair
- Doug Horner, M.L.A., Spruce Grove-Sturgeon-St. Albert, Vice-Chair
- Shiraz Shariff, M.L.A., Calgary McCall
- Lloyd Snelgrove, M.L.A., Vermilion-Lloydminster
- Janis Tarchuk, M.L.A., Banff-Cochrane

- Robert Bhatia, Deputy Minister, Alberta Revenue
- Paul Boothe, Member, Health Reform Implementation Team
- Shelley Ewart-Johnson, Deputy Minister, Alberta Health and Wellness
- Peter Kruselnicki, Deputy Minister, Alberta Finance

LETTER FROM THE CHAIR

The Hon. Gary Mar Q.C.
Minister of Health and Wellness
323 Legislature Building, 10800 - 97 Avenue
Edmonton. AB T5K 2B6

Dear Minister Mar,

I am pleased to submit the report of the M.L.A. Task Force on Health Care Funding and Revenue Generation, assigned to examine and recommend alternatives to ensure sufficient, stable revenue to sustain Alberta's health system now and in the future.

Members of the task force have worked diligently to fulfill our mandate and we would like to thank those groups and individuals who took the time to meet with us or submit information for our consideration. Their input made a significant contribution to our task.

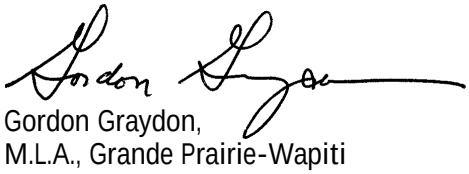
The work of the task force was also supported by the expertise and efforts of the research team who assisted us on this project, and we would like to recognize and thank the following for their first rate work:

- *Professor James Smythe, University of Alberta;*
- *Larry Bailer, Nancy Cuelenaere and staff from Alberta Finance;*
- *Bruce Perry and staff from Alberta Health and Wellness; and,*
- *Bob Howard and Dan Miller from Alberta Revenue.*

We are aware that the recommendations in this report will be controversial and will provoke debate about how best to sustain publicly-funded health care in our province. However, when faced with the reality that our system is under extreme pressures and is not sustainable without a new source of stable, predictable revenue, such debate is needed.

The Premier's Advisory Council on Health Report (the Mazankowski Report)has outlined a comprehensive roadmap for sustaining our health system for the future. This report and its recommendations represent a crossroads on that map.

None of the options to solve this fundamental problem are attractive or easy. But, Alberta has led the way in tackling difficult issues many times before, and we believe our recommendations on revenue generation are responsible *and* essential in order to sustain the future of our health system.



Gordon Graydon,
M.L.A., Grande Prairie-Wapiti
Chair, M.L.A. Task Force on Health Care Funding and Revenue Generation

TABLE OF CONTENTS

MANDATE OF THE TASK FORCE

The mandate and membership of the M.L.A. Task Force on Health Care Funding and Revenue Generation (the task force) was established on February 1, 2002 by Ministerial Order #18/2002. The mandate of the task force included the following five components:

- Ensuring that government funding of health care costs is affordable, the task force will explore options/formulas for establishing ministry funding (e.g. inflation, demographics, fixed percentage of government spending).
- Establishing principles to guide decisions on new sources of revenue to support Alberta's health care system.
- Exploring and doing feasibility studies on options for introducing new revenue sources to support the health care system, the task force will identify revenue generating options that have the most potential, and impacts of implementation.
- Allowing regional health authorities (RHAs), including the Alberta Cancer Board and the Alberta Mental Health Board, to generate additional revenues to pay for services they provide, the task force will identify barriers that exist, that can be removed, and new initiatives that can be implemented.
- Providing financial incentives for people to stay healthy, the task force will consider financial-based incentives and identify impacts of implementation.

INTRODUCTION

The report of the Premier's Advisory Council on Health, chaired by Right Honourable Don Mazankowski, was released in January 2002. By the end of January, the Government of Alberta responded to the report and accepted all 44 recommendations. The government set out a plan and timelines for moving ahead with implementation. To assist in the process, a Health Reform Implementation Team was established along with a series of five task forces and committees to address various aspects of the implementation process.

Following from the Mazankowski Report, four main directions were set for health reform in Alberta:

- *Patient/customer focus* – to help Albertans stay healthy and provide quality service
- *Sustainability* – to address health care funding, expenditures and human resources
- *Accountability* – to encourage better health and management of outcomes and to make the best use of health providers
- *Infrastructure* – to support the health system, with an emphasis on information technology and research.

To examine the issue of sustainable funding, an M.L.A. task force was established, chaired by Gordon Graydon, M.L.A., Grande Prairie-Wapiti. This report highlights the outcomes of the task force's work that took place from February to September 2002. As part of its deliberations, the task force consulted with experts and invited M.L.A.s to contribute their views on this important issue.

Clearly, we have some difficult choices to make. Looking ahead, the cost of health care will undoubtedly increase despite everyone's best efforts to streamline services, implement new approaches, and contain costs. The question for Albertans, then, is how do we want to pay for these increasing costs? Generating new revenues to fund public services is never popular. However, the task force is convinced that the Mazankowski Report's analysis is sound. Part of the solution to the sustainability problem lies in increasing the flow of stable, predictable revenue to the system.

After carefully considering the alternatives, we believe that we have found a solution that will contribute to an accessible, quality, publicly-funded health system – a goal we share with all Albertans.

SUMMARY OF RECOMMENDATIONS

Recommendation 1:

That decisions regarding new health care funding measures be guided by the principles of equity, efficiency and ethics included in this report.

Recommendation 2:

That RHAs be allowed to implement selected measures for generating revenue and that the design of these measures be guided by the principles of equity, efficiency and ethics included in this report. A list of measures considered and recommended by the task force is included in the body of the report.

Recommendation 3:

That the government provide stable, predictable, and sustainable funding for health care through three components:

1) The contribution of general government revenues should grow at a maximum annual rate of four percent from the current base;
2) Health care insurance premiums should be set annually so as to fund 20 percent of the cost of health services insured under the Canada Health Act; and,
3) The remaining funding required be derived from the new, made-in-Alberta approach to health care funding described in this report.

Recommendation 4:

That a new, made-in-Alberta approach to health care funding using a deductible based on ability to pay be developed and administered, together with health care insurance premiums, through the personal income tax system.

Recommendation 5:

That the new, made-in-Alberta approach to health care funding be a vehicle for providing financial incentives for people to stay healthy.

IS ALBERTA'S HEALTH SYSTEM SUSTAINABLE?

The Mazankowski Report addressed this question and concluded that, "Alberta's health system is not sustainable unless we are prepared to make major changes in how we fund and deliver health services." The strategy suggested by the Mazankowski Report to address this problem was two-pronged:

- First, to slow the accelerating rate of growth by implementing important changes in how we deliver health care services; and,
- Second, to increase health care premiums to cover 20 percent of insured health care services and to develop a made-in-Alberta approach for generating additional revenue.

There are a number of different ways of answering the question of sustainability. The question inevitably leads to debates about what figures to use; what trends to consider; how to forecast future costs; how to weigh the options of spending more on health; spending on other areas; or, reducing taxes. Quite often, the answers are very different depending on the views of people who typically look at the issues with very different objectives in mind.

The simple reality, though, is that health care costs are growing faster than government revenue—whether provincial revenue or federal revenue. This reality threatens the future sustainability of the system and leads to the inevitable conclusion that the only way we will be able to sustain the health care system is if we are prepared to pay more.

Think about these facts:

- Currently, 70 percent of overall health spending in Alberta is financed by general provincial revenues, 13 percent by health care premiums, and 17 percent by federal transfer payments.
- Since 1997, health spending has grown at an average of 10.4 percent a year.
- The long-term trend for Alberta's revenue growth has been at about four percent a year. We can never know for sure what future revenues will be, but four percent is a good starting point for these discussions.
- We can't continue to spend 10 percent a year more on health care when we only have four percent more revenue coming in – not unless we are prepared to spend considerably less on important areas like education, the environment, or programs for children in need – or we're prepared to continually increase taxes.

What is Driving the Increases in Health Care Costs?

Health care costs are increasing for a number of reasons.

- The primary reason is that wages and salaries have increased considerably in the last few years. Estimates are that paying the salaries of nurses, doctors, and a range of health care providers makes up almost 80 percent of total spending on health care. The answer is not to pay these people less; their services are essential and the quality of care Albertans receive depends directly on their work. But in the future, salary increases will have to be reasonable or we will not be able to afford the increasing costs.

- New technology and new prescription drugs also add costs. A new MRI machine, for example, can cost well over a million dollars. New prescription drugs come on the market regularly. And while they improve health and cure serious illnesses, they also cost a considerable amount. On top of that, there are increasing costs as a result of expanding the scope of services to Albertans and because of inflation. Albertans want access to the important benefits that new technology and new drugs can bring, but that means we need to find the best ways to pay for it.

- Alberta's population is growing. Because of Alberta's strong economy, more people are coming to Alberta in order to find employment or start businesses. In the next few years, about 19,000 people are expected to move to Alberta from other provinces. And each one of those people, and their families, will require health care services in the future. Looking ahead, we can expect health care costs to increase by about 1.5 percent a year as a result of an increasing population.

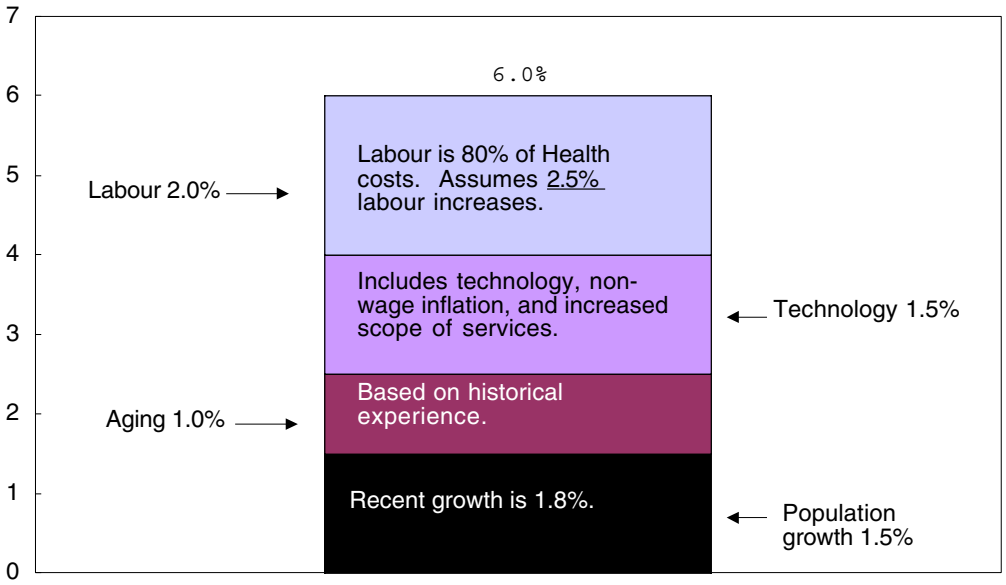
- Alberta's population is also aging. As people age, their health care costs increase, especially during their last years of life. Expectations are that the aging of Alberta's population could add about one percent a year to the health care bill in the future.

We know that, as a result of these and other factors, costs in health care will continue to increase. A number of reforms are currently underway to make the cost increases manageable and bring the rate of growth down from the 10 percent range we've seen in the last few years. These include: primary health care, new ways of delivering services, changes in the scopes of practice of different health providers, and the work of the Expert Advisory Panel reviewing publicly funded services.

However, based on reasonable assumptions about the impact of each of the factors noted above, and the impact of a variety of health reforms, the overall costs of the health system are expected to increase by about six percent a year. This is true in even the best managed health system where steps are taken to change how services are delivered and to contain costs. To avoid costs going over six percent a year, we will need to move ahead aggressively and deliberately on a number of other health care reforms outlined in the Mazankowski Report and addressed in reports from other committees and task forces.

The following table shows how the various factors together result in annual cost increases of about six percent a year in a sustainable health care system.

Chart 1: Components of Health Cost Growth

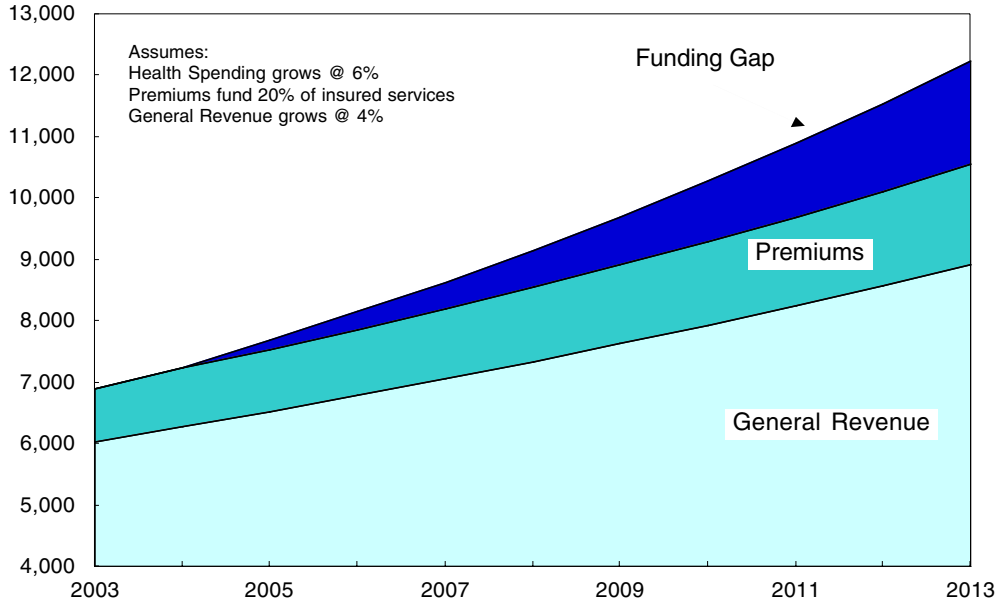


The Funding Gap

We believe, even with all the best efforts in place to manage and contain costs and change the way services are delivered, that costs will continue to increase by about six percent a year. At the same time, the province's revenues are expected to increase by only about four percent a year. That number is based on a careful look at the ups and downs of Alberta's revenues in the past and reasonable assumptions about how our economy should perform in the coming years.

What we have, then, is a two percent gap. It may not sound like much, but, as the following chart shows, it means that by 2008, we will be short over $600 million in funding for the health care system annually. By 2013 (about a year after this year's new crop of Grade 1 students graduates from high school), we'll be facing a gap of $1.7 billion a year. And those projections include an assumption that health care premiums will make up 20 percent of the costs of insured health services.

Chart 2: The Health Funding Gap



In summary, the analysis presented here confirms the conclusions of the Mazankowski Report regarding the unsustainability of the current system. Further, based on some reasonable assumptions regarding future growth and the impact of measures to make the health system more efficient, it establishes a range for the amount of extra funding that will be required in the future. Our next step is to consider solutions to the sustainability problem. We begin by developing a set of principles to guide our work.

Actions to Restore Sustainability

Some General Principles

The discussion around generating additional revenue to sustain the health system should be guided by principles. These are the principles we used to guide our thinking.

Recommendation 1:

That decisions regarding new health care funding measures be guided by the principles of equity, efficiency and ethics described below.

The system for generating revenue should be equitable:

- The system should not impede access to health care.
- The system should not create undue financial hardship for families.
- Those with greater ability to pay should contribute more than those with lesser ability to pay. When people have equivalent health status and ability to pay, those who choose to use the health system more should pay more.
- The system should not create regional disparities in the quality of care.

The system for generating revenue should be efficient:

- The system should create incentives for consumers and providers to use health care responsibly.
- Consumers and providers should see and understand how revenue is generated and the system should aid citizens in holding decision makers accountable for how money is spent and the results that are produced.
- The design of the system should minimize negative impacts on the economy.
- The system should minimize administrative and compliance costs.

The system for generating revenue should be ethical:

- The system should avoid putting providers in positions of conflict of interest.

What RHAs Can Do

The Minister of Health and Wellness asked the task force for policy recommendations on eight options for RHAs to generate additional revenues for the health system. The options and recommendations of the task force are outlined below.

Recommendation 2:

That RHAs be allowed to implement selected measures for generating revenue and that the design of these measures be guided by the principles of equity, efficiency and ethics included in this report. A list of measures considered and recommended by the task force is included below.

Review of RHA Revenue Generation Options

1. Redirect auto insurers' and other third-party liability payments from General Revenue to the health system: Costs of serving patients injured in motor vehicle accidents are recovered by Alberta Health and Wellness through an aggregate assessment charged to automobile insurance companies. Costs are also recovered where third parties are judged liable for health care costs of patients injured in other kinds of accidents. These recoveries are paid into the province's General Revenue Fund and form part of the amount allocated by government to the health system. The budget for health services is not adjusted for variations in the amount collected.

   Recommendation: Continue the current practice of paying amounts recovered from insurers and other third parties for health care costs into General Revenue and showing this amount as a source of revenue for health services. Encourage the collection of information by health authorities to maximize cost recoveries from these third parties.

2. Charges for health services to non-entitled persons: Hospital and physician services provided to out-of-province residents and others who are not entitled to these benefits from Alberta are recovered from the person's home province or the third party responsible for their health care. These include the RCMP, Armed Forces and Workers Compensation Board. For community-based health services, RHAs are authorized or required to recover their costs for some services, but not others. Recoveries are not currently authorized or permitted for public health services, community rehabilitation services and community mental health. In the case of nursing home services, rates for recoveries are set by Alberta Health and Wellness, but do not currently reflect full costs.

   Recommendation: Legislative changes should be made to allow RHAs to recover their costs in providing public health, community rehabilitation and community mental health services to patients who are not entitled to benefits from Alberta. Nursing home rates for those who are not entitled should be adjusted to reflect full costs on a regular basis.

3. Increased rates for preferred accommodation in hospitals (private and semi-private rooms) and clarification of provincial regulations requiring charges for medical goods provided to hospital out-patients: Preferred accommodation rates in acute care hospitals have not been increased in Alberta for many years and tend to be lower than in most other provinces. Current rates for a semi-private room are $18 to $24 a day, and for a private room, $24 to $40 a day. Some provinces do not regulate the rates that can be charged, and these tend to be higher than where rates are regulated.

   Under the *Canada Health Act* and Alberta legislation, insured hospital outpatient services and medically necessary goods used in providing these services must not be subject to charges. However, in some cases, the patient has a choice of goods that may be more convenient, but not related to medical need. In addition, as a service to people treated in hospital outpatient departments, medical goods may be provided for use after discharge, and hospitals are required to recover their costs. Rules regarding when charges are allowed or not allowed, are not always clear.

   Recommendation: Increase preferred accommodation rates in acute care hospitals and clarify the rules governing when charges are allowed and not allowed for medical goods provided to outpatients.

4. Charges for environmental health permits for non-food establishments: There are eight areas of environmental health regulated under the *Public Health Act* including food, barber shops and beauty parlours, housing, institutions, nuisance and general sanitation, recreation areas, swimming pools and work camps. RHAs do not recover the costs of inspecting these areas, and are allowed to charge permit fees only for food establishments. Public and semi-public swimming pools also require permits, but there are no permit fees charged. Other areas are inspected as necessary, sometimes in response to concerns or complaints, but no permits are required.

   Recommendation: Do not institute further fees for permits under the *Public Health Act.*

5. Sale of free-standing continuing care facilities to private operators: Of the 176 long-term care facilities in Alberta, 99 are free-standing and 27 of these are owned by RHAs. Provincial policy requires due diligence of the part of RHAs in disposing of their interests in facilities and the support of the Minister of Infrastructure and the Minister of Health and Wellness. Decisions are made by Cabinet on a case by case basis. Consideration would be given to the projected net proceeds weighed against the costs of leasing and changes in operational responsibility.

   Recommendation: Follow the existing process for consideration of proposed sales of free-standing continuing care facilities to private operators.

6. Clarification of the rules governing the existing relationships between health foundations that generate funds for health facilities and programs and health authorities. Although this is not an option for generating revenue, health foundations raise revenues for use in the health system and therefore have an important role in sustaining the system. The foundations operate under different sets of rules, and expectations about relationships between foundations and RHAs are not always clear.

   Recommendation: Clarify the rules governing existing relationships between health foundations and health authorities.

7. Charges for the use of the proposed province-wide telephone health advice, information and triage contact centre: A $3 per call charge was considered for the province-wide health link currently being developed as an alternative to emergency room use. This new service has the potential for significant cost savings to RHAs. If the $3 per call charge were to deter even five percent of potential callers who then visit an emergency room, the additional cost will exceed the revenue generated by the charge. There are no charges for this service in other jurisdictions.

   Recommendation: Do not institute a charge for use of the proposed province-wide telephone health advice, information and triage contact centre.

8. Recovery of proceeds from Public Health Act prosecutions and penalties: When RHAs go to court to enforce actions under the *Public Health Act*, the courts cannot award costs to the RHA or the proceeds of penalties imposed. Costs of enforcement are borne by the public health system. In contrast, the *Safety Codes Act* allows for fines resulting from offences under that Act to be directed to the municipality that is enforcing the Act.

   Recommendation: Amend the *Public Health Act* to allow courts to direct proceeds to RHAs to recover their costs of prosecution and enforcement under the Act.

In addition to these cost-effectiveness and revenue generation options, the RHAs made presentations to the task force on ways to increase their revenues. Some of their suggestions are already being addressed by government. The RHAs are encouraged to continue their work to identify appropriate revenue sources and to collect the revenues under their jurisdiction. The task force notes that the government has improved the revenue picture for RHAs by:

- Increasing inter-provincial billing rates for acute in-patient services in April 2002, with inflationary adjustment in August 2002. The estimated impact to RHAs is $20 million in additional revenues this fiscal year.
- Allowing charges for permits for food establishments effective October 1, 2002.
- Allowing higher rates to be charged to the Workers' Compensation Board where the minister has approved a proposal.

Sustaining Health Care and Protecting Other Priority Programs

If the cost of an efficient health care system is going to grow faster than government revenues, how can we ensure that health gets the stable, predictable funding it needs *and* that other priority programs like education, the environment and programs for children in need don't get squeezed out? The task force believes that we need clear benchmarks to guide government budgeting in the future.

Recommendation 3:

That the government provide stable, predictable, and sustainable funding for health care through three components:

- *The contribution of general government revenues should grow at a maximum annual rate of four percent from the current base.*
- *Health care insurance premiums should be set annually so as to fund 20 percent of the cost of insured health services.*
- *Remaining funding to be derived from the new, made-in-Alberta approach to health care funding outlined in Recommendation #4.*

Clearly, if other priority programs are going to be maintained, health care spending cannot continue to consume an ever growing share of government spending. To ensure that other priority programs are protected, the contribution of general government revenues to health must be limited to the growth of the revenues themselves. However, if the cost of an efficient health system grows faster than general revenues, then extra funding is needed. To put the health system on a sustainable footing, our recommendation has two additional parts. The first is to agree with the Mazankowski Report's recommendation that health care insurance premiums be set every year to fund 20 percent of the cost of services insured under the Canada Health Act. The second is to recommend a new, made-in-Alberta approach to funding the health care system on a sustainable basis.

Options for Generating Additional Revenue

The task force considered a number of options for generating the additional revenue needed by the health care system. As recommended by the Mazankowski Report, we considered medical savings accounts and variable premiums. We found a number of problems with both of those approaches.

- In both cases, there is no compelling evidence that these approaches would reduce or contain costs. When we look at health care costs, in fact, a small number of people consume a large proportion of these costs. Most people are healthy and have only occasional episodes when they need to use the health care system, while some people are chronically ill or suffer from debilitating illnesses over a lengthy period of time. These people have no choice but to use the health care system, so it is unlikely that the overall bill for the health care system would go down.

- In theory, there are advantages to medical savings accounts because they give people choice and more control over how they use the health care system. But there also are problems with the approach. A number of features would have to be built in to protect low income people and people with chronic health conditions. This could increase complexity and administration. If people were able to keep money that was left in their account at the end of the year, this money would not be available to the health care system. It would have to be made up by spending more money from the province's budget, and that means more taxes would have to come from Albertans.

- In addition, it is difficult to put a system of medical savings accounts in place in a single province when we are part of a national health care system. When people move from Alberta to another province, they would lose the benefits of their medical savings accounts. And for people moving to the province or needing care while they are here, it would be difficult to accommodate this within a medical savings account program.

Recommendation #4:

That a new, made-in-Alberta approach to health care funding using a deductible based on ability to pay be developed and administered, together with health care insurance premiums, through the personal income tax system.

Recommendation #5:

That the new, made-in-Alberta approach to health care funding be a vehicle for providing financial incentives for people to stay healthy.

Rather than pursue medical savings accounts or variable premiums, the task force focused on the following three options:

1. Eliminating health care premiums and generating the additional revenues we need through increases in personal income tax;

2. Raising health care premiums to fill the entire funding gap; and,

3. Introducing a deductible based on ability to pay and administered, together with health care insurance premiums, through the personal tax system.

Option 1: Increasing Income Taxes

Under this option, personal income taxes for Albertans would be increased in order to continue to sustain the health care system. Specifically:

- Health care premiums would be eliminated and all the additional money we need to fill the funding gap would come from increases in personal income taxes.
- The increases in personal income taxes would be dedicated to health care.
- Personal income taxes would increase by an initial two percentage points, bringing Alberta's single rate tax to 12 percent (currently the rate is 10 percent).
- In subsequent years, personal income taxes would increase by one-quarter of a percentage point a year.
- By 2008, Alberta's personal income tax rates would have increased by 30 percent.

What are the pros and cons of this option?

On the positive side:

- People have said that health care premiums aren't fair to Albertans because everyone pays the same amount regardless of their income, aside from people who are eligible for premium subsidies. Under this approach, premiums would be gone and people would pay through personal income tax instead.
- It's easy to administer and requires no major changes in the tax system. But it does mean that taxes would increase every year.
- It shifts the burden of health care costs to people who are more able to pay – that is, from lower income people to higher income people.
- The increased funding coming from increased taxes would be dedicated to health care so Albertans would know that the additional taxes they pay are going directly to support the health care system.

On the negative side:

- Albertans are not very supportive of income tax increases and it runs counter to the government's commitment that the only way taxes are going is down.
- It may affect Alberta's tax competitiveness unless other provinces also move ahead with tax increases as a way of addressing rising health care costs. It also could affect Alberta's ability to compete internationally if our taxes are higher than other major centres.
- There are no incentives for people to moderate their use of the health system, nor for health care providers and managers of the health system to identify and reduce their costs.

Option 2: Increasing Health Care Premiums

Under this option, income taxes would stay the same and the funding gap would be made up by increasing health care premiums. This would mean that:

- Health care premiums would increase by over 15 percent a year.
- By 2008, health care premiums would be double what they are today. Individuals would pay about $88 a month compared to $44 a month today and families would pay about $176 a month compared to $88 a month today.
- Health care premiums would cover 30 percent of the costs of insured health services and 20 percent of total health spending. Currently, premiums cover about 18 percent of the costs of insured health services.

What are the pros and cons of this option?

On the positive side:

- Albertans who pay premiums will be more aware of increasing costs in the health care system as their premiums go up every year to cover the costs.
- It is relatively easy to implement because the system for collecting premiums is in place.

On the negative side:

- An increasing burden for paying for rising health care costs would fall on lower income working people and on middle income groups.
- Subsidies for lower income Albertans would need to increase and there could be an increasing number of people who are unable to pay.
- There are no positive incentives for people to modify their use of the health system or for people who manage the health system to identify and contain their costs.
- The costs to employers who currently cover all or a portion of their employees' health care costs would increase significantly.

Option 3: Introducing a Health Care Deductible

The third option is a new direction for Alberta. It is based on the idea that:

> *People who use the health care system more should pay more if they can afford it, up to some limit.*

This is an important idea for Albertans to consider. Unlike the current system where people tend to think of health care services as "free", the amount people pay for health care under this approach would be tied to how much they use the health care system, provided that they can afford it.

Here is how this option would work:

- People would continue to pay a health care premium to ensure universal access to all insured health services, but now, premiums would be collected through the tax system as part of their source deductions.
- Health care premiums would become more like a "real" insurance premium. They would provide coverage in case people face high costs for health care in a year if they are seriously ill, need surgery, or have an accident. Premiums would increase to cover about 20 percent of the total costs of Alberta's insured health services. This means health premium rates would increase at about 4.5 percent a year. Low income Albertans would continue to have their premiums subsidized.
- In addition, people would also now pay a deductible to cover the annual costs of the health services they use – up to a limit based on their income. After that limit, all further costs would be covered by their premium.
- The maximum deductible a person would have to pay would be capped at, say, 1.5 percent of their taxable income. This means, for example, that the most someone with Alberta's average taxable income of $31,000 would have to pay for their deductible would be $465. In most cases, people would pay less than this because they typically use less than $465 a year in health services. But in this case, even if a person needed a hip replacement at a cost of say $10,000, the most they would pay at tax time would be $465.
- The health care deductible would be paid as part of a person's income taxes and not when he or she receives the service.
- Every Albertan 18 and over would receive an annual statement from the provincial government as part of the tax collection system– let's call it a T4H. It would outline the costs of all the health services they used during the year. Children would be exempt and people with a disability or chronic disease who did not earn an income would not pay a deductible.

What are the pros and cons of this option?

On the positive side:

- It is the only option that links our individual use of the health care system to how much we pay. Each year, we would get a statement of how much we used the system and how much it cost.
- Health care providers and managers would have to identify the costs of all health services and this information would help them better manage costs.
- The burden of paying more for health care falls primarily on those who use the system more and can afford to pay more.
- The current costs of collecting premiums would be eliminated.

On the negative side:

- Although the cost of collecting premiums would be eliminated, there will be other new administrative costs. Albertans would need to have a health care card so that their use of the health care system could be tracked. The health care system would also need to cost out all their services so that each Albertan could receive a statement at the end of the year.
- People with chronic health conditions who earn an income would have to pay for the health care services they use each year, but this would be tied to their income and ability to pay.
- Although the approach does not involve user fees or any payments when people actually receive services, it may be viewed by some as contrary to the Canada Health Act and it may provide a disincentive for some people to get the health care services they need.

Making a Choice

All three of the options we considered are designed to fill the funding gap. In choosing among them, we asked two questions. The first question was: How well did each option do at preserving the equity of the health care system, in particular, ensuring that the access of lower income Albertans was protected?

Lower income Albertans would be protected under all three options.

- In the case of increasing income taxes, the amount they pay is geared to their income and their ability to pay.
- In the case of premiums, subsidies are in place and would continue.
- In the case of deductibles, this option also would be geared to income so lower income people would be protected.

The second question was; how did each funding option contribute to making the health system work more efficiently? Here, Option 3 was a clear winner. Under this option, health care providers will have to know the costs of providing services and show those costs to consumers. By itself, this should contribute to better management in the health care system. In addition, Albertans will get the information they need to be responsible users of the health care system and direct incentives to make healthy lifestyle choices.

Concluding Remarks

Making Alberta's health care system sustainable requires some difficult choices. The task force believes that we need to deal with these choices based on clear principles. Each of the options identified in this report would fill the funding gap and put Alberta's health system on a sustainable course for the future, while protecting the funding for other priority programs. But each of these options also involves Albertans paying more in one way or another. And each of the options involves some disadvantages.

When all factors are considered, we believe that Option 3 – a new, health care deductible based on ability to pay and administered through the personal income tax system – is the best way forward for Alberta.

Appendix A – Oral and Written Submissions to the task force

Members of the Legislative Assembly:

- Mike Cardinal, M.L.A., Athabasca-Wabasca
- Ray Danyluk, M.L.A., Lac La Biche-St. Paul
- Broyce Jacobs, M.L.A., Cardston-Taber-Warner
- Hon. Pat Nelson, M.L.A., Calgary Foothills, Minister, Alberta Finance
- Mary O'Neill, M.L.A., St. Albert
- Kevin Taft, M.L.A., Edmonton-Riverview
- Tony Vandermeer, M.L.A., Edmonton-Manning

Individuals and Organizations:

- Pearl Babiuk, CEO, Lakeland Regional Health Authority
- Nick Chamchuk, private citizen
- Professor Glenn Griener, University of Alberta
- Barb Houston, private citizen
- Brian Lindenberg, Mercer Human Resource Consulting
- Ian Logan, private citizen
- Professor Kenneth McKenzie, University of Calgary
- Allaudin Merali, VP - Finance and Administration, Capital Health Authority
- Monique Mrazek, LSE Health and Social Care, The London School of Economics
- Sheila Weatherill, CEO, Capital Health Authority
- Lorene White, Alberta Home Care Association (Alberta)

- Council of Regional Health Authority CEOs
- Mineral Springs Hospital, Banff
- Provincial Health Authorities of Alberta