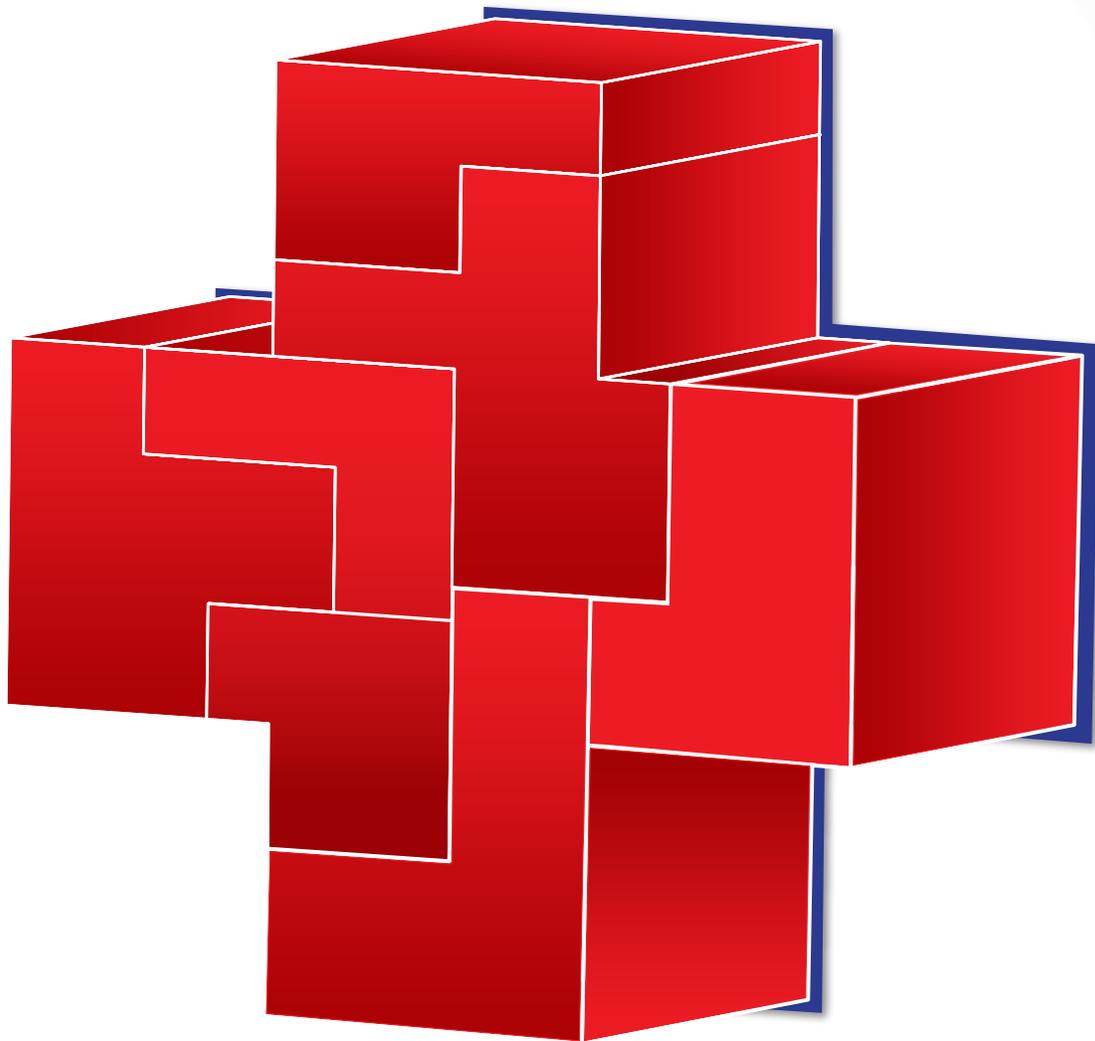




Health Care Reform Options for Alberta

Bacchus Barua, Jason Clemens, and Taylor Jackson



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by Bacchus Barua, Jason Clemens, and Taylor Jackson

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Executive Summary

Canada is widely acknowledged to be a comparatively high spender among countries with universal health care but achieves only a modest to average rating on measures of performance. Within Canada, Alberta is a relatively high spender with modest results. For instance, on a per-capita basis, Alberta's provincial spending ranks second, behind only Newfoundland & Labrador. In performance, however, Alberta ranks 5th for physicians per capita, 7th for nurses, 6th (out of nine) for hospital beds, 5th for MRI units, 8th for CT Scanners, and 6th for wait times for medically necessary care. The combination of high spending, modest results, and the state of finances in the province mean that Alberta must review current spending with a focus on reforms to achieve better results.

Although the Canada Health Act (CHA) has both explicit and implicit limiting effects on a province's ability to reform health care, there are nonetheless a number of potential reforms that should be considered, based on their successful use in other universal health care countries. The following provides a brief summary of the reforms discussed at length in the paper.

1 Expand capacity and incentivize competition via private providers

The use of private firms in the delivery of publicly funded health care services, so long as the firms are not charging additional fees and generally adhere to the principles of the CHA is not, contrary to popular perception, prohibited by the Canada Health Act. In fact, the use of third-party private clinics within the public system was a key ingredient in neighbouring Saskatchewan's successful reduction in wait times. Alberta made some progress on the use of private providers in the early 2000s with the introduction of Bill 11, but there are several limitations in the Bill that should be eliminated or revised. Specifically, the ban on the operation of private hospitals and the requirement that all major surgical services be delivered in a public hospitals should be eliminated.

2 Encourage competition among public and private providers by remunerating hospitals through activity-based funding

Alberta, like most provinces in Canada, primarily funds hospitals using prospective global budgets wherein grants are provided to a hospital irrespective of activity in that particular year and the hospital's resources are not directly linked to the services provided. Such a system imbeds incentives for hospitals to provide fewer services, facilitate quicker releases, avoid costly patients, and shift patients to outside providers since they are seen as costs rather than sources of revenues. By contrast, high performing universal health care systems like Australia, France, Germany, the

Netherlands, Sweden, Switzerland, and the United Kingdom generally fund hospitals based on some measure of activity. Moving towards activity-based funding has the potential to encourage competition, increase the volume of services provided, improve quality and reduce wait times.

3 Increase efficiency by creating a centralized surgical registry and pooling referrals

Canada requires patients to first visit a primary care physician for a referral to a specialist. The creation of a central, province-wide, standard for assessing and prioritizing patients on wait lists and pooled referrals for specialists was quite successful in Saskatchewan. While Alberta has made some strides in this direction with the Closed Loop Referral Management Program, the Medical Access to Service program, and the Alberta Netcare eReferral tool, more should be done to replicate the success in Saskatchewan.

4 Remove provincial restrictions on private parallel financing and delivery of medically necessary services

One area of existing activity that could be extended is the province's private parallel system of health care wherein Albertans pay out of pocket or obtain private insurance for the full cost of services. Such a system is the norm in countries such as Australia, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Sweden, Switzerland, and the United Kingdom. As part of a health care reform, Alberta should consider a fully private parallel sector, where private finances—either private insurance or direct payment—are used to acquire the same medically necessary care from private providers as are funded and provided by the public system.

5 Allow dual-practice for physicians

Dual practice permits physicians and other health professionals to work in both the private and public sectors. While current regulations and, particularly, the CHA does not prohibit dual practice, Canada's use of dual practice is quite constrained compared to practice in other countries—primarily as a result of provincial legislation. Alberta, for instance, only allows fully opted-out physicians to charge fees above the provincial rates. As a result, provincial legislation effectively encourages physicians to choose either the public or the private sector. Allowing physicians to practice in both settings has the potential to use scarce and highly skilled medical resources more effectively, and does not force physicians to leave the public system in order to take up private practice.

6 Revisit what's covered by the public system

Provinces have considerable latitude in prescribing what is covered by the public system. While the Canada Health Act pertains to medically necessary services, there is currently no clear definition of "medical necessity". As has been recommended in the past, narrowing and better focusing on what constitutes medical necessity could be a constructive part of a broader set of reforms.

7 Require individuals to share in the costs of treatment (with means-tested protections for vulnerable groups)

Of all the potential reforms, only cost sharing is expressly prohibited by the Canada Health Act. Cost sharing, which comes in a variety of forms and can cover a wide range of services, is a standard feature of most industrialized countries' universal access health care systems. Cost sharing involves having the patient pay some portion of the costs of their health services out of pocket. This can take the form of a deductible, wherein patients pay out-of-pocket up to some threshold before insurance takes effect, or a co-payment, where patients pay a set percentage of the total cost of a service up to some threshold at which point the insurance covers a larger share of the total cost and in most circumstances covers the entirety of the costs. Cost sharing can also involve premiums on insurance. Most universal access health care systems use some mix of these cost sharing mechanisms across a wide range of services. The inclusion of some form of cost sharing tends to result in a better, more efficient use of existing health resources by helping to prioritize the demands placed on the health care system. At the same time, there are various mechanisms— like annual income-based caps on out-of-pocket spending and exemptions for vulnerable populations—to shield lower-income people from the costs.

How the federal government interprets the contravention of the CHA by the use cost-sharing also matters. For example, under a strict interpretation, the federal government would simply make non-discretionary dollar-for-dollar reductions to the Canada Health Transfer. This is not necessarily problematic, as the collected fees could simply be used to compensate for the lost revenue, while preserving the incentive structure for the demand of medical services.

Canada, and Alberta in particular, are comparatively high spenders on health care but at best modest performers within the group of countries and sub-national jurisdictions that maintain universal access to health care. As the province struggles with the need for broad fiscal reforms and lengthy wait times, there is a critical need to review health care spending as well as the broader structure of health care delivery and regulation.

Introduction

The size of Alberta's current operating budget deficit, the latest estimate of which is \$7.8 billion, and the fact that it has not proportionately improved as commodity prices and to a lesser extent the provincial economy have rebounded means that, absent tax increases, broad spending reductions and reforms will likely have to be enacted if a balanced budget is to be achieved within the next few years. At \$20.6 billion, health care spending in Alberta represents the single largest item in the operating budget, representing 42.1% of all program spending (total spending excluding interest costs) (Alberta, Department of Finance, 2018). Compounding the fiscal pressures for reform of health care is the fact that Canada, and Alberta in particular, are comparatively high spenders on health care but at best modest performers within the group of countries and subnational jurisdictions that maintain universal access to health care. Simply put, Canada and Alberta spend comparatively high levels on health care but achieve only poor-to-moderate results in access to, and the performance of, the health care system.

As the province struggles with the need for broad fiscal reforms, there is an opportunity to review health care spending as well as the broader structure of health care delivery and regulation. This publication first sets Alberta's health care in the context of Canada's broader approach to, and performance in, health care compared to other universal access health care countries. Prior to delving into potential reforms, the publication then examines the actual and perceived limitations for reform placed on the provinces by the federal Canada Health Act (CHA). [1] It then describes a number of areas of potential reform based on differences between Canada and thus Alberta's approach to universal access health care and the approach used by other successful, high-performing universal access health care countries. In addition, this section examines recommendations made in 2001 by the previous Premier's Advisory Council on Health for Alberta, [2] which spent over a year examining and assessing the province's health care system. The study concludes with a series of recommendations.

[1] For information and background on the Canada Health Act, please see Esmail and Barua, 2018; Clemens and Esmail, 2012.

[2] In *A Framework for Reform: Report of the Premier's Advisory Council on Health*, commonly referred to as the "Mazankowski Report". Cited as Mazankowski, 2001.

1. Canadian and Albertan Health Care in a Broader Context

In order to understand Alberta's health care system, it is first important to place the province's health care system in the larger context of how Canada compares to other countries that maintain universal access. More specifically, this section uses a representative selection of indicators from Barua and Jacques (2018a) to provide an overview of the cost, access to, and performance of Canada's health care system in comparison to that of other OECD countries that maintain universal access.

1. Health care spending

There are two principal ways to compare how much countries spend on health care. The first is health care spending as a percentage of gross domestic product (GDP). The second measure is health care spending per person adjusted by purchasing power parity (PPP) to account for currency differences among countries. Each measure has strengths and weaknesses. [3] For instance, health spending as a share of GDP adjusts for income differences among countries but can be affected by short-term economic fluctuations. The publication presents both measures to provide a more comprehensive assessment of the cost of Canada's health care system.

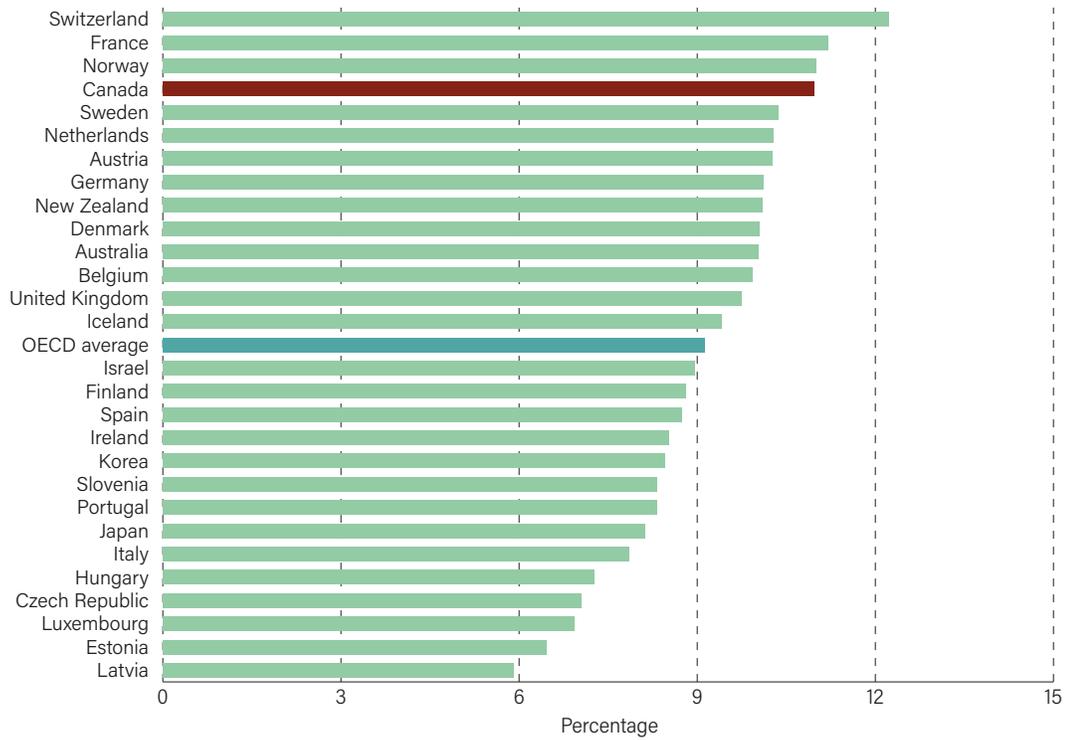
Figure 1 illustrates the share of the economy consumed by health care (total spending) for the 28 OECD countries that maintain universal access to health care and for which comparable data from the OECD is available. Canada ranks fourth with 11.0% of GDP consumed by health care spending (based on 2016 data, the latest available comparable data). [4] Only Switzerland, France, and Norway spend more as a share of their economy than Canada on universal access health care. Figure 2 compares and ranks the same 28 OECD countries based on per-person spending on health care as of 2016. On this measure, Canada ranks 10th, spending \$4,920 per person (US PPP), 16.3% above the OECD average.

By either of these measures, spending as a share of the economy or spending on a per-person basis, Canada is a comparatively high-spending country on health care

[3] For further information on cost comparison methodology and conceptual issues, please see Barua and Jacques, 2018a.

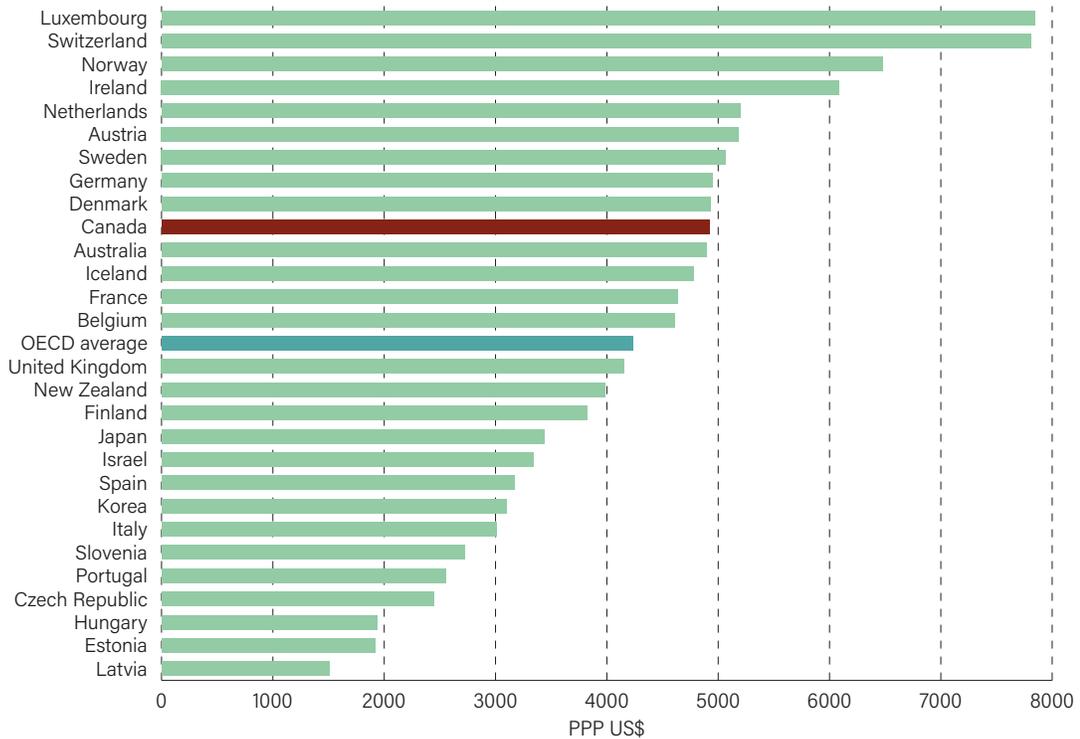
[4] Please note that both health spending as a share of the economy (GDP) and on a per-person basis have been standardized for age differences among countries. This is necessary given that countries with relatively older populations would be expected to spend more on health care and/or have poorer outcomes simply because they have older populations that use a relatively higher level of resources (Barua, Hasan, and Timmermans, 2017).

Figure 1: Health-care spending as a percentage of GDP, age-adjusted, 2016



Source: Barua and Jacques, 2018a: figure 2a, p. 10.

Figure 2: Health-care spending per person (PPP US\$), age-adjusted, 2016



Source: Barua and Jacques, 2018a: figure 2b, p. 10.

within the group of industrialized countries (OECD) that maintains universal access to health care. The next section is critical to gaining a broad understanding of the functionality of Canada's health care system since it provides comparative data on the performance of Canada's health care system. After all, a high-spending country with high performance is a starkly different situation than a high-spending country that performs comparatively poorly.

2. Health care performance

This section explores the comparative performance of Canada with other universal access health care countries within the OECD with measures of (1) availability of resources, (2) use of resources, (3) timely access to health care, and (4) clinical performance and quality.

1. Availability of resources

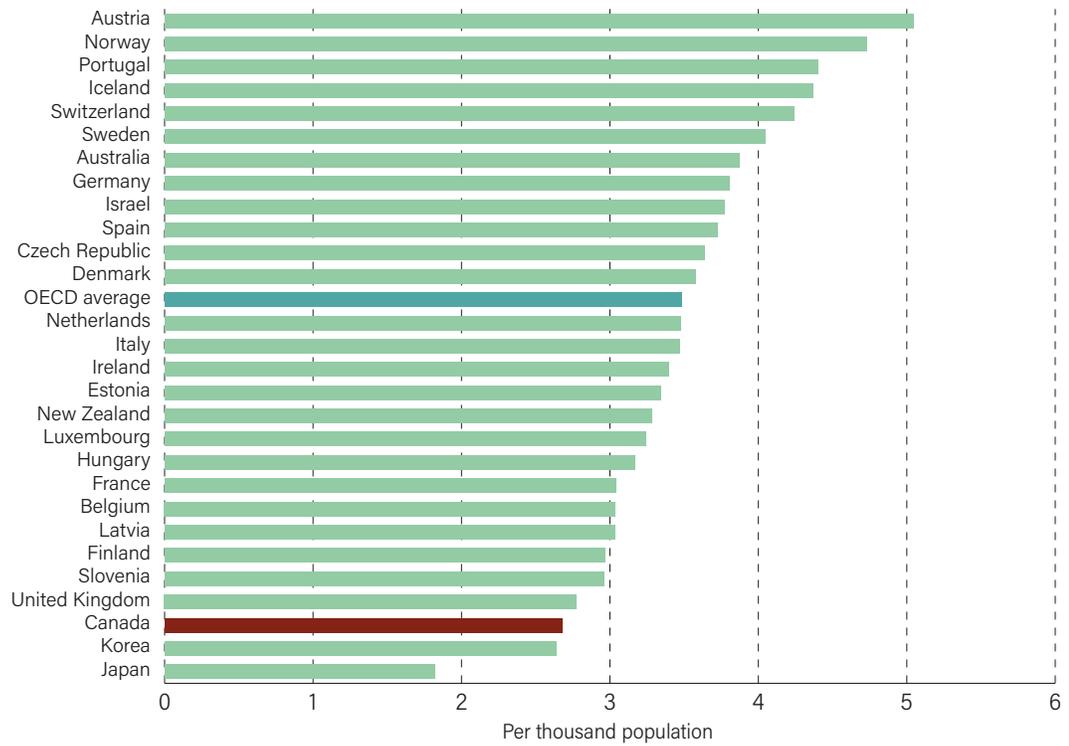
One obvious aspect of any health care system's performance is the availability of key resources to patients. Five measures are used to gauge the comparative availability of resources in Canada's health care system: physicians, nurses, acute beds, MRIs, and CT scanners. All five measures are adjusted for the age and size of population to ensure comparability across countries. Figure 3a and figure 3b illustrate the number of physicians and nurses, the key health-care personnel for the OECD countries with universal access. On physicians (adjusted for population), Canada ranks third last (26th of 28 countries) with 2.7 physicians per 1,000 people. This is almost half the rate of first-ranked Austria, which has 5.0 physicians per 1,000 people. Canada performs less poorly for the availability of nurses. At 10.3 nurses per 1,000 people, Canada ranks 14th of the 28 OECD countries covered in this analysis and basically on par with the OECD average (10.1 nurses per 1,000 people).

The availability of acute care beds is another vital measure of the availability of resources. The ranking and numbers for the OECD countries included in the analysis is depicted in figure 3c. Canada ranks second last (25th of 26 countries) with 2.1 acute care beds per 1,000 people. The OECD average is 3.7 beds per 1,000 people and Korea, which ranks first, maintains 8.2 acute care beds per 1,000 people.

The two final measures used to assess resource availability measure medical technologies, which has been a long-standing concern for Canada. [5] More specifically, the number of MRIs and CT scanners adjusted for population is used to assess the availability of medical technology in Canada compared to other countries with universal access. Figure 3d shows the results for MRIs adjusted by population. Of the 27 OECD countries included in the MRI analysis, Canada ranks 22nd with 9.9 MRI

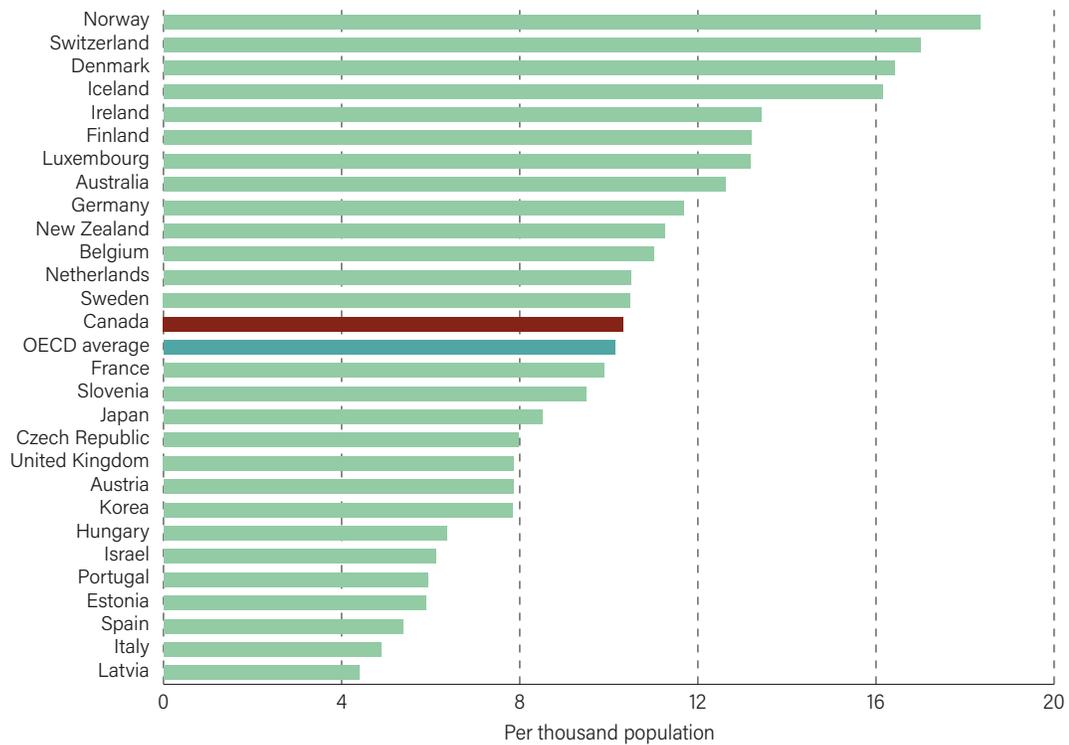
[5] For example, the 2000 federal budget established the Medical Equipment Fund, which was designed to provide \$1 billion in funding for the provinces to improve the availability of medical technologies.

Figure 3a: Physicians per '000 population, age-adjusted, 2016 or most recent



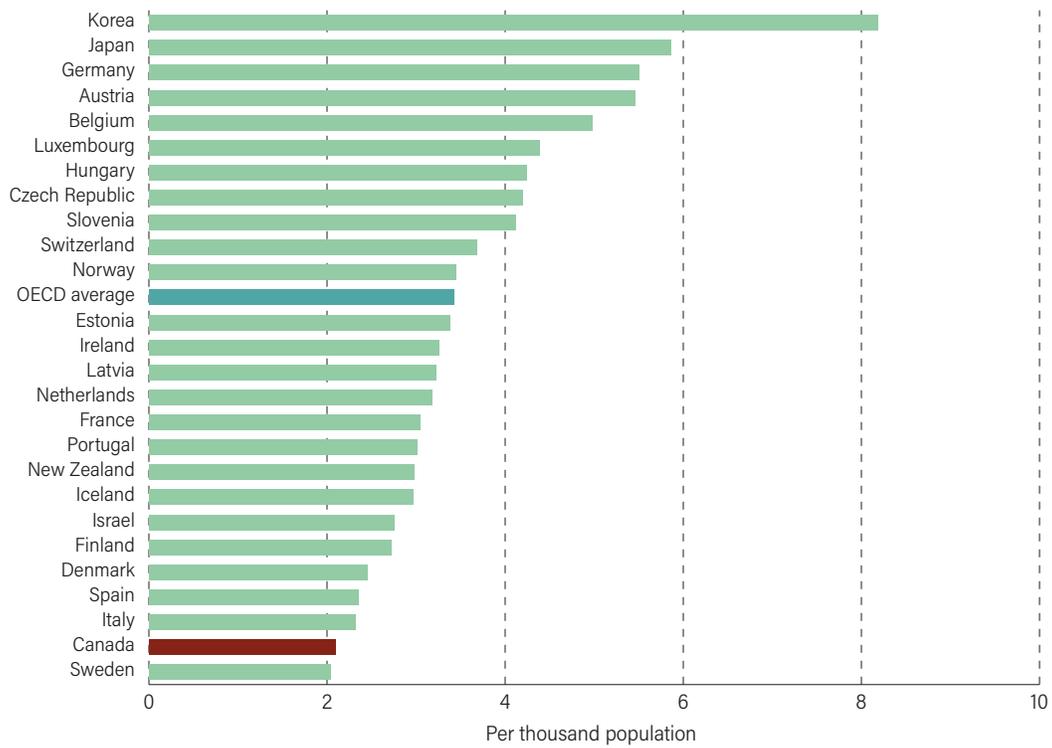
Source: Barua and Jacques, 2018a: figure 3a, p. 13.

Figure 3b: Nurses per '000 population, age-adjusted, 2016 or most recent



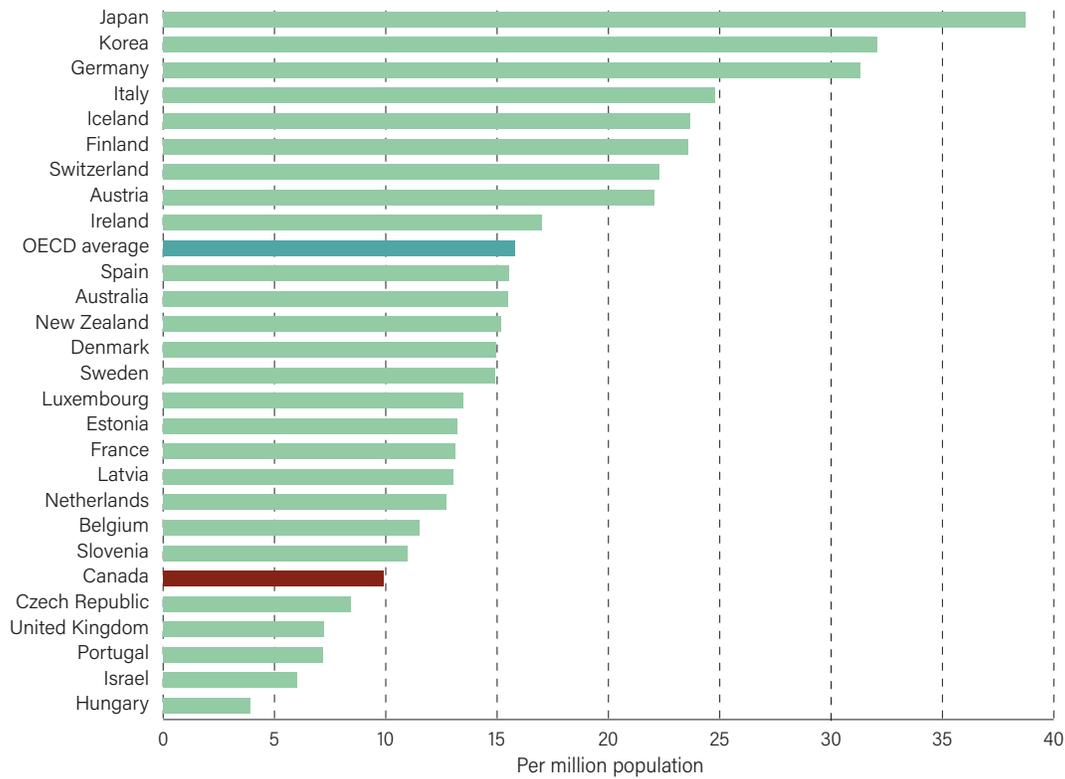
Source: Barua and Jacques, 2018a: figure 3b, p. 14.

Figure 3c: Acute-care beds per '000 population, age-adjusted, 2016 or most recent



Source: Barua and Jacques, 2018a: figure 3c, p. 14.

Figure 3d: MRI units per million population, age-adjusted, 2016 or most recent

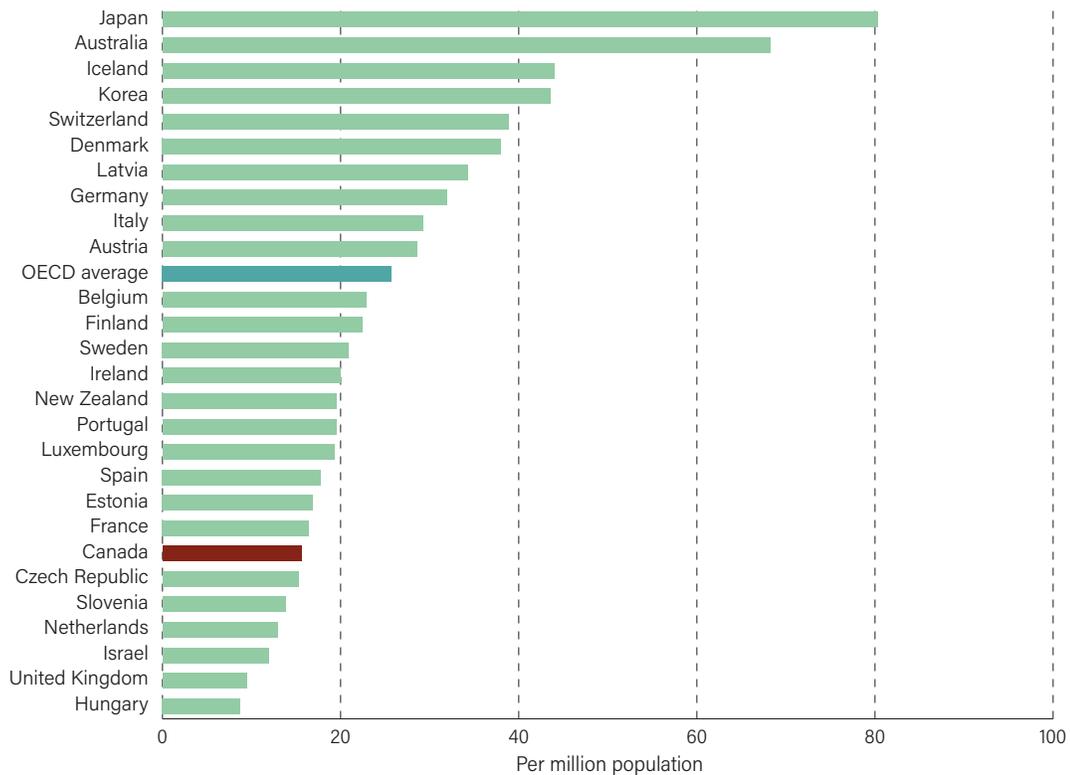


Source: Barua and Jacques, 2018a: figure 4a, p. 17.

units available per 1 million people. The OECD average is 16.4 and the average for the top three countries (Japan, Korea, and Germany) is 34.0 MRI per 1 million people. Figure 3e shows the results and ranking for CT scanners per 1 million people for the 27 countries included in the analysis. Canada’s performance on the availability of CT scanners is not much better than was observed for MRIs. Canada ranked 21st of the 27 countries with 15.6 CT scanners per 1 million people. The OECD average in 2016 was 26.7 CT scanners per 1 million people.

Canada is ranked near the bottom of OECD countries for availability of both human and capital resources—save for nurses. It is worth noting that Canada’s poor performance on resource availability is unique, in that countries like Japan and Korea that have relatively low numbers of physicians have some of the highest levels of physical capital available to those physicians, thereby potentially offsetting some of the performance issues that could stem from a lower level of physicians. In other words, it is unique to observe in the countries analyzed weak performance across all or most measures of resource availability.

Figure 3e: CT scanners per million population, age-adjusted, 2016 or most recent



Source: Barua and Jacques, 2018a: figure 4b, p. 17.

2. Use of resources

While the availability of resources presented above captures the basic inputs available for use in health care in each country, it does not capture the degree to which those resources are being used to deliver health care to patients. In this sense, a system could have many human and capital resources but a low level of use, where patients are not actually receiving care. Table 1 displays Canada's performance and ranking on a host of general and procedure-specific measures of health care use as well as the OECD average. Again, the measures in this section are adjusted for the age and size of population to ensure comparability across countries.

Overall, Canada appears to be an average performer though there are a number of important insights. For instance, while Canada ranks quite poorly for availability of physicians (figure 3a), its ranking for doctor consultations is significantly better: 8th of 28 countries. In other words, Canada's comparatively effective use of doctors mitigates somewhat the comparatively low level of availability. However, Canada's performance on discharge rates [6] and several specific procedures stand out as quite poor. Indeed, for discharge rates—an indicator of the number of services provided by hospitals—Canada ranks last among the 28 countries measured. While an improvement from the results observed regarding availability of resources, Canada's moderate performance on use of resources still lags relative to its comparative level of spending.

Table 1: General health system utilization of resources, age-adjusted, 2016

General Measures	Canada	Rank	OECD Average
Doctor Consultations (per capita)	8.0	8 (of 28)	7.0
Discharge Rates (per 100,000)	8,704.1	28 (of 28)	15,917.8
MRI Exams (per 1,000)	56.8	11 (of 25)	62.4
CT Exams (per 1,000)	153.5	12 (of 25)	137.5
Procedure Utilization	Rate (per 100,000 population)	Rank	Average of Selected Countries
Cataract Surgery	1121.5	9 (of 26)	920.7
Transluminal coronary angioplasty	168.6	18 (of 25)	202.4
Coronary artery bypass graft	60.0	3 (of 25)	38.2
Stem cell transplantation	6.0	16 (of 25)	7.1
Appendectomy	111.9	18 (of 25)	128.8
Cholecystectomy	213.5	7 (of 24)	179.3
Repair of inguinal hernia	191.1	12 (of 24)	181.1
Hip replacement	160.0	17 (of 25)	189.7
Knee replacement	191.8	7 (of 25)	145.4

Source: OECD, 2018a; calculations by authors

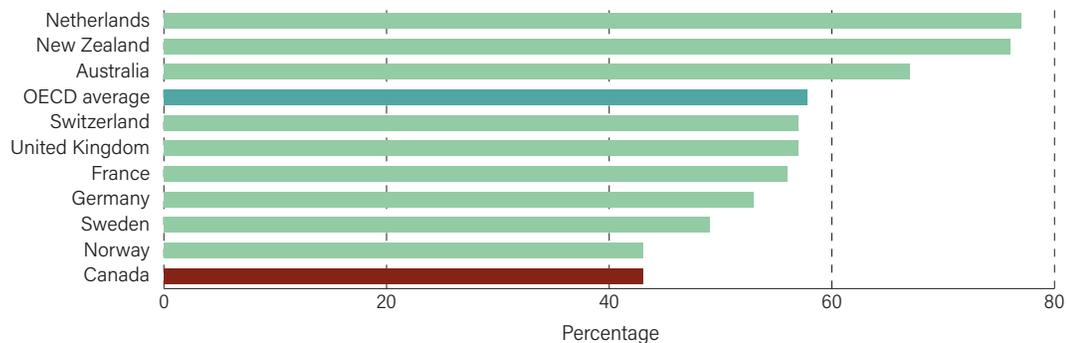
[6] The OECD defines hospital discharge rates as “the number of patients who leave a hospital after staying at least one night” including “deaths in hospital following inpatient care” (2015: 106).

3. Timely access to health care

For universal access health care countries like Canada that share the goal of ensuring access to health services regardless of the ability to pay, measuring actual accessibility is paramount. An important dimension of accessibility is the timeliness of access to medically necessary health care services—that is, wait times for health care. When patients do not receive timely access to care their condition can deteriorate and their suffering worsen (Day, 2013; Esmail, 2009; Barua and Hasan, 2018).

The Commonwealth Fund regularly publishes measures on the timeliness of health care delivery for a select group of countries based on wait times surveys (Commonwealth Fund, 2017). The results of several key measures of wait times for the universal access countries included in the Commonwealth Fund’s analyses are illustrated in figures 4a to 4c. Figure 4a shows the percentage of respondents that were able to get a “same day appointment” when they were ill for the 10 countries included in the analysis. Canada ranks last at 43% of respondents indicating same-day access compared to 58% for the average, and 77% for the Netherlands, which ranked first.

Figure 4a: Percentage of patients able to make a same-day appointment when sick, 2016

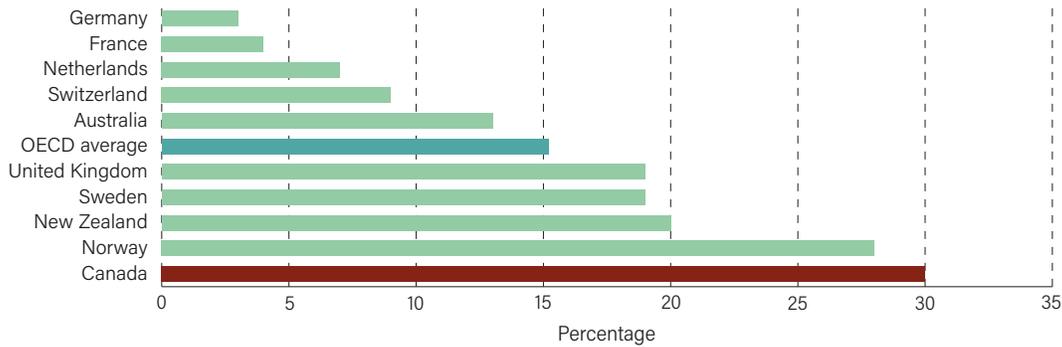


Source: Barua and Jacques, 2018a: figure 6a, p. 25.

Figure 4b and figure 4c show the results for wait times for specialist appointments and elective surgery. More specifically, figure 4b shows the results for patients (surveyed) who waited two months or more for a specialist appointment. At 30%, Canada ranked the worst of the 10 countries. The average was 15%, or half the rate of Canada; and Germany, which ranked first, only recorded 3% of respondents indicating they had to wait two months or more for a specialist appointment. Figure 4c depicts the results for respondents who waited four months or more for elective surgery. Again Canada ranked worst of the 10 countries with 18% of respondents indicating that they waited four months or longer for elective surgery. The average for the 10 countries was 9%, or half the Canadian rate; and Germany, which again ranked first, recorded zero respondents indicating a wait of four months or longer.

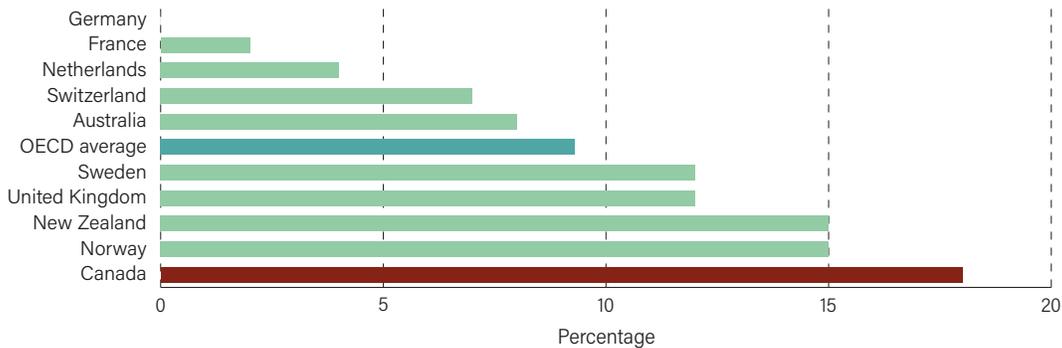
The poor performance of Canada with respect to wait times is not a recent phenomenon. For instance, research published the Fraser Institute dating back more than two decades has shown worsening wait times for medical procedures in Canada (Barua and

Figure 4b: Percentage of patients who waited 2 months or more for an appointment with specialist, 2016



Source: Barua and Jacques, 2018a: figure 6b, p. 26.

Figure 4c: Percentage of patients who waited 4 months or more for elective surgery, 2016



Source: Barua and Jacques, 2018a: figure 6c, p. 26.

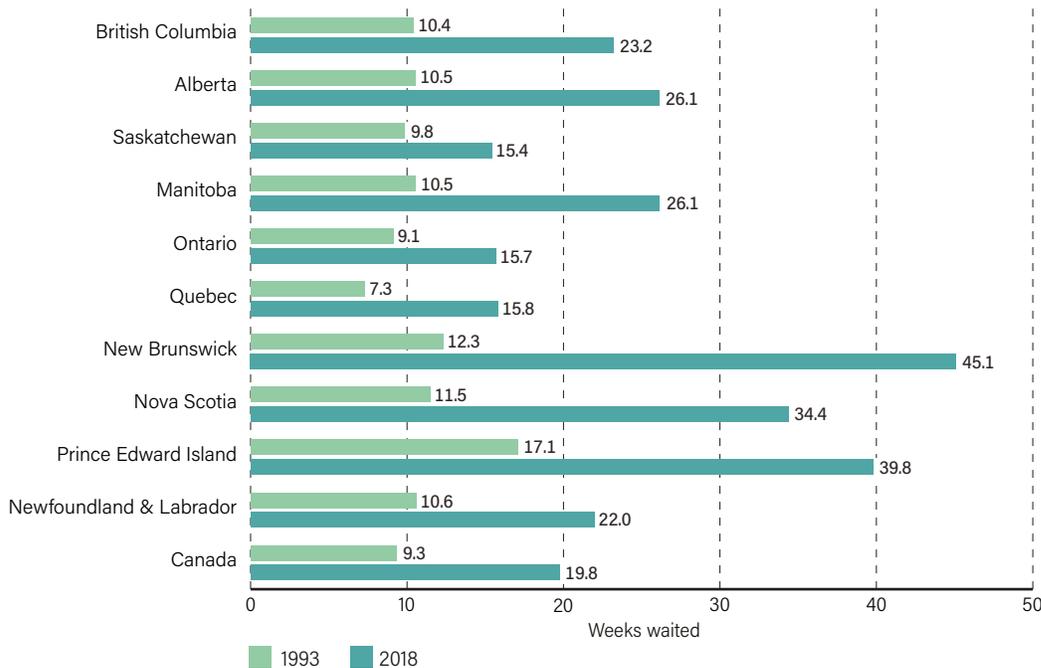
Jacques, 2018b). The 2018 report on wait times stated: “Specialist physicians surveyed report a median waiting time of 19.8 weeks between referral from a general practitioner and receipt of treatment ... This year’s wait time is 113% longer than in 1993, when it was just 9.3 weeks” (Barua and Jacques, 2018b). Figure 5 shows the median wait times from GP referral to the actual medical treatment by province as well as for Canada.

4. Clinical performance and quality

The fourth and final group of measures in the evaluation considers clinical outcomes and the quality of health services. These measures aim to capture performance with respect to actual health care outcomes based on available data from the OECD. Barua and Jacques (2018a) examined data on 11 indicators of clinical performance and quality:

- one indicator of primary care—diabetes-related amputation of a lower extremity;
- four indicators of acute care—hip-fracture surgery initiated within 2 days of admission to the hospital, 30-day mortality after admission to hospital for AMI, hemorrhagic stroke, and ischemic stroke;

Figure 5: Median wait (weeks) between referral by GP and treatment, provinces and Canada, 1993 and 2018



- one indicator of mental health care—in-patient suicide among patients diagnosed with a mental disorder;
- three indicators of cancer care—five-year survival rates for breast, cervical, and colorectal cancer; and
- two indicators of patient safety—obstetric trauma during a vaginal delivery with an instrument, and without.

Tables 2 and 3 summarize the results and ranking for Canada as well as the OECD average. Table 2 specifically shows Canada's performance and ranking on measures of quality and clinical outcomes for primary care, acute care, and mental health care. The results for Canada on these indicators are mixed. On the primary care indicator, Canada ranks in the bottom half of countries. For acute care, Canada ranks in the top quarter of countries on two indicators but in the bottom half for the other two measures (though not statistically different from the OECD average). In terms of mental health clinical performance and quality, Canada ranks around the bottom 25% of countries (again, not statistically different from the OECD average). Table 3 examines clinical performance and quality for cancer care and patient safety based on available OECD data. Canada performs relatively well in cancer care as measured by five-year net survival rates (statistically better than the OECD average on three out of four indicators). On both patient safety indicators, however, Canada exhibits the worst performance of the 19 countries for which data is available.

Table 2: Quality and Clinical Performance, 2015; primary care, acute care, mental health care

Measures		Canada	Rank	OECD Average
Diabetes lower extremity amputation	Age-sex standardized rate per 100,000; 15 years and older	7.4 ^w	17 (of 24)	6.0
Hip-fracture surgery initiated within 48 hours after admission to the hospital	Crude rate per 100 patients; 65 years and older	93.4	4 (of 22)	80.9
Admission-based AMI 30 day in-hospital mortality	Age-sex standardized rate per 100; 45 years and older	5.1 ^b	6 (of 28)	7.0
Admission-based Hemorrhagic stroke 30 day in-hospital mortality	Age-sex standardized rate per 100; 45 years and older	24.2 ^a	18 (of 28)	22.4
Admission-based Ischemic stroke 30 day in-hospital mortality	Age-sex standardized rate per 100; 45 years and older	8.5 ^a	18 (of 28)	7.8
In-patient suicide among patients diagnosed with a mental disorder	Age-sex standardized rate per 100	0.06 ^a	12 (of 16)	0.05

Note: w = statistically worse than average; b = statistically better than average; a = not statistically different from average. Calculations by authors based on the upper and lower confidence intervals of each country in relation to the average upper and lower confidence intervals of all countries in each group.

Source: OECD, 2018a.

Table 3: Quality and Clinical Performance; cancer care and patient safety

Measure		Canada	Rank	OECD Average
Breast Cancer	Five year net survival (2010–2014)	88.2 ^b	6 (of 26)	86.0
Cervical cancer	Five year net survival (2010–2014)	66.6 ^a	12 (of 26)	67.2
Colon Cancer	Five year net survival (2010–2014)	66.9 ^b	6 (of 26)	64.3
Obstetric trauma vaginal delivery with instrument (2015)	Crude rate per 100 vaginal deliveries; 15 years and older; female	16.9	19 (of 19)	5.8
Obstetric trauma vaginal delivery without instrument (2015)	Crude rate per 100 vaginal deliveries; 15 years and older; female	3.1	19 (of 19)	1.6

Note: b = statistically better than average; a = not statistically different from average. Calculations by authors based on the upper and lower confidence intervals of each country in relation to the average upper and lower confidence intervals of all countries in each group.

Source: OECD, 2018a.

Overall, when comparing the cost of Canada's health care system with its performance, it is difficult to conclude that Canada is a high-performing country. The high comparative spending on health care in Canada is not matched by equally strong performance. Specifically, Canada tends to rank in the middle-to-low end of performance across all four areas analyzed: (1) availability of resources, (2) use of resources, (3) timely access to health care, and (4) clinical performance and quality. There is, therefore, a real opportunity for Canada to learn from other jurisdictions that spend similar or perhaps even fewer resources on health care but are currently outperforming Canada.

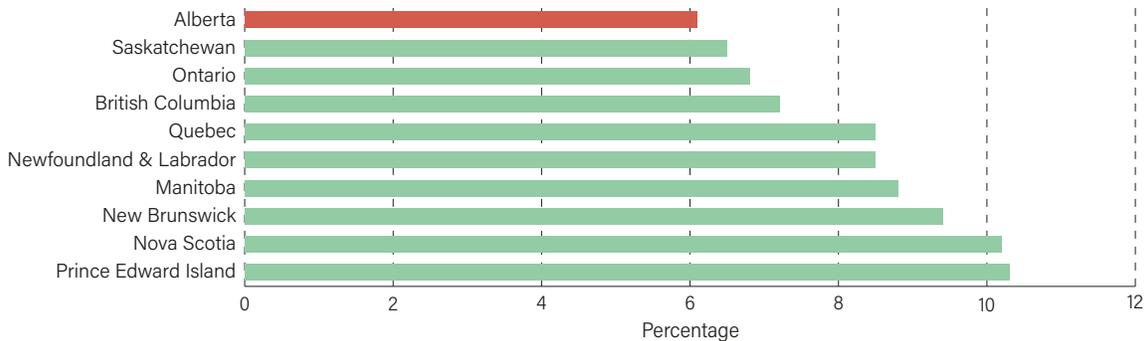
Provincial health care in Canada

The data above provides a fairly clear picture of how poorly Canada’s health care system performs in light of the high level of spending. Given the focus of this paper on Alberta, it is important to place the province in context within Canada. First, consider the differences in spending (costs) on health care among provinces. Similar to discussions of the cost differences among countries, examining the financial resources that provinces have to devote to maintaining their health care systems is critical to understanding the value for money of each province. As with international comparisons, it is useful to examine two measures of health care spending by provincial governments in Canada.

Figure 6a depicts provincial government spending on health care as a percentage of GDP, while figure 6b shows per-person spending on health care by each of the provincial governments in 2018, the latest year of available data. The figures show two very different stories. As a percentage of GDP, Alberta’s provincial government spends the least on health care: 6.1% of provincial GDP. However, as soon as the figures are examined on a per-person basis, Alberta ranks as the second highest spender among the provinces, spending of \$5,097 per person.

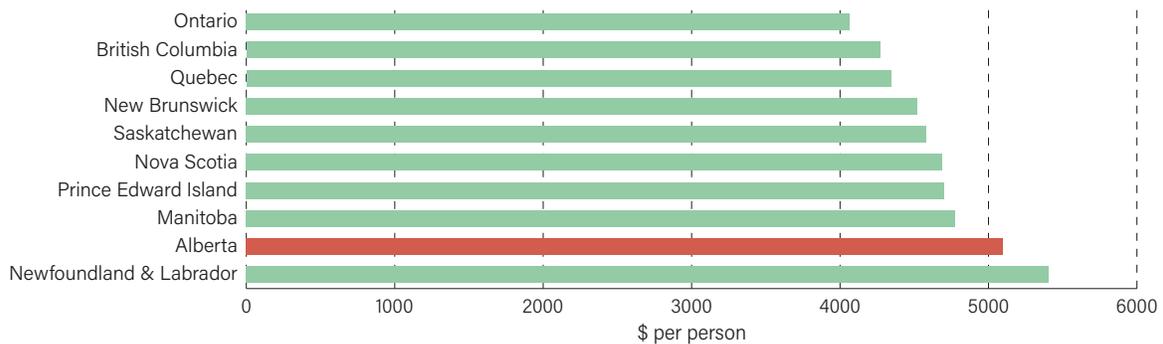
It is, however, important to understand that the per-person numbers presented above are not adjusted for the age of the population. Given that Alberta has one of the

Figure 6a: Provincial government health spending as a percentage of GDP, 2018



Source: CIHI, 2018a (forecast).

Figure 6b: Provincial government health spending per person, 2018



Source: CIHI, 2018a (forecast).

youngest populations in Canada and the clear link between health care spending and the age of the population, [7] Alberta's second-placed ranking in spending should be of even greater concern. For example, the CIHI (2018a) estimated that in 2016, after adjusting for differences in population age and sex, provincial government spending on health care in Alberta was the highest among the provinces. [8]

While Alberta's high level of spending has clear implications for its fiscal sustainability (Barua, Palacios, and Emes, 2017), there is also evidence to suggest that this high level of spending does not translate into commensurate performance. A comprehensive study of provincial health care in Canada completed in 2013 (Barua, 2013) examined both cost and performance across the same four areas outlined above for the international comparisons. Table 4 summarizes the component parts of the analysis as well as the overall score attributed to each of the provinces. Alberta was ranked 7th overall, out-performing only Newfoundland & Labrador, Prince Edward Island, and Saskatchewan [9] when both costs and performance are compared. Like Canada within the group of industrialized countries maintaining universal access health care, Alberta was observed to be a comparatively high spender within Canada but does not enjoy commensurate performance.

While a comprehensive replication of that analysis is beyond the scope of this paper, below a selection of key health care indicators in the four areas previously examined is presented in order to gauge whether there is any evidence of improvement that could result in a different conclusion. The data examined is for the most recent year available, but—unlike the international comparisons—generally not adjusted for provincial age profiles (unless so indicated).

1. *Availability of resources in Alberta*

Figure 7a and figure 7b illustrate the number of physicians and nurses per thousand population across the Canadian provinces. Despite ranking second highest for per-capita spending, Alberta ranks in the middle of the pack for physicians and nurses. Figure 7c examines hospital beds per thousand population across the country (another area where Canada as a whole does poorly): Alberta ranks sixth (amongst the nine provinces for which data were available) for the number of beds per thousand population.

[7] For a discussion of the relationship between the age structure of a population and health care spending, please see Clemens, Stedman, and Emes, 2017.

[8] See table B.4.6 in CIHI, 2018a for provincial/territorial government-sector per-capita health expenditure standardized by age and sex. Other measures from the CIHI provide further insight into the high level of spending in the province. For example, the cost of a standard hospital stay in Alberta was \$8,112 in 2016/17—the highest among provinces (CIHI, 2018b). In addition, the average gross clinical payments per physician in Alberta was \$380,384 in 2015/16 (CIHI, 2017b)—again, highest among provinces in Canada.

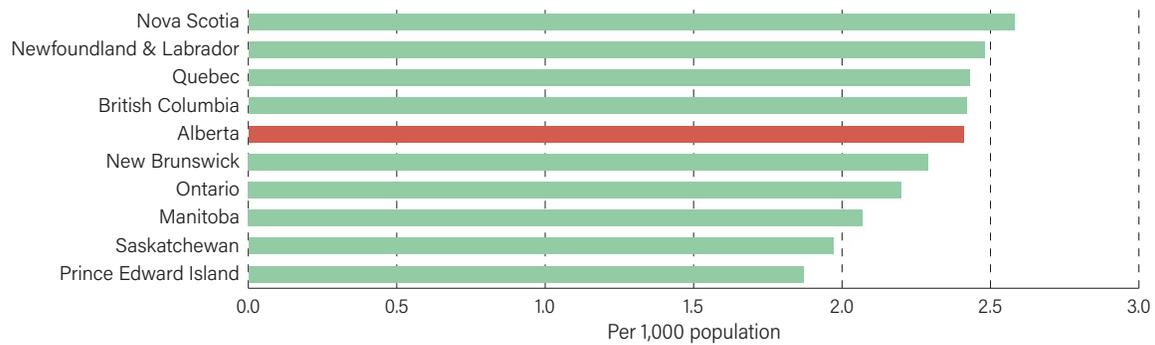
[9] Saskatchewan's performance on this index should be treated with caution as the results were based on data from 2010 (or the most recent year), which precedes the Saskatchewan Surgical Initiative (SSI) (2010–2014). The SSI resulted in considerable improvement in the provinces health care system, notably with regard to wait times for treatment (MacKinnon, 2016).

Table 4: Scores for components, overall value, cost, and value for money

	Components				Overall Value	Cost	Value for Money
	Availablilty of resources	Use of resources	Access to resources	Clinical Performance			
British Columbia	1.75	3.95	3.71	3.53	2.50	8.52	4.12
Alberta	3.06	7.88	7.75	10.00	7.71	2.15	3.35
Saskatchewan	0.55	5.22	5.42	0.00	1.92	4.61	1.17
Manitoba	0.00	7.53	5.13	9.33	5.49	4.83	3.66
Ontario	3.46	10.00	10.00	7.11	8.32	7.75	7.43
Quebec	10.00	7.36	8.95	9.33	10.00	10.00	10.00
New Brunswick	6.81	9.10	5.94	7.21	7.83	5.86	5.87
Nova Scotia	5.96	5.89	4.40	6.46	5.73	6.22	4.73
Prince Edward Island	1.13	0.00	0.00	4.23	0.00	5.47	0.48
Newfoundland & Labrador	6.68	5.70	3.41	3.92	4.74	0.00	0.00

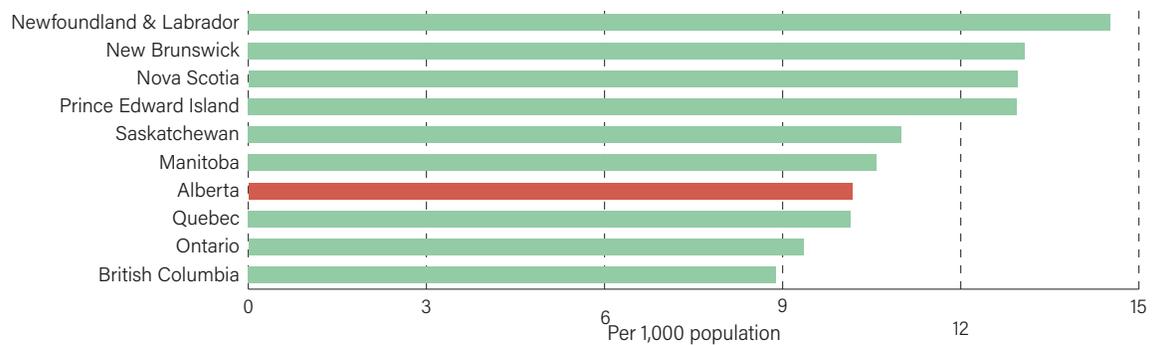
Source: Barua, 2013: table 1, p. vi. Based on publicly available data for the year 2010 (or the most recent year available) from the CIHI and the Fraser Institute

Figure 7a: Physicians per 1,000 population, 2016



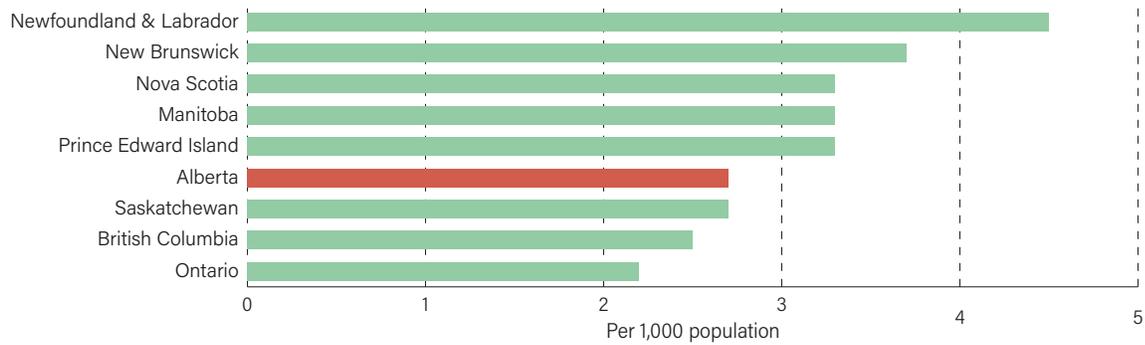
Source: CIHI, 2017b.

Figure 7b: Nurses employed in direct care per 1,000 population, 2017



Note: Includes registered nurses (including nurse practitioners) and licensed practical nurses. Registered psychiatric nurses were excluded because data for several provinces were missing.
Source: CIHI, 2018c: table 5.

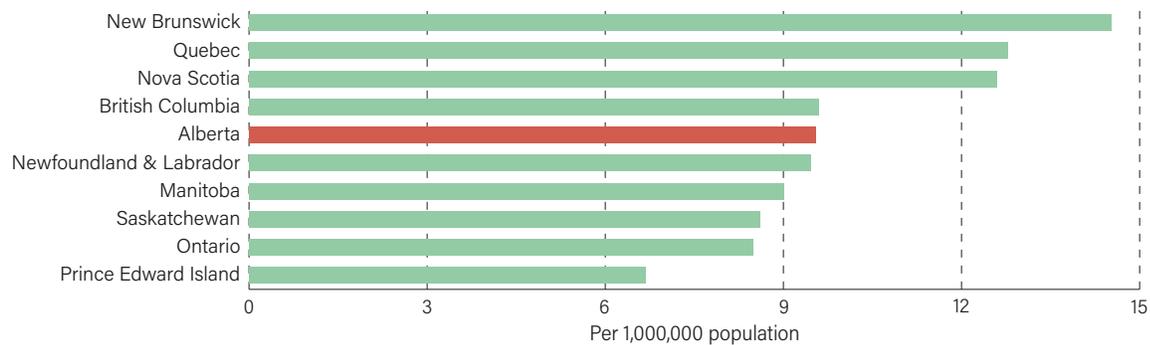
Figure 7c: Beds per 1,000 population, 2016/17



Source: CIHI, 2018a: Appendix D1; CIHI, 2018d. Data for Quebec were unavailable; calculations by authors.

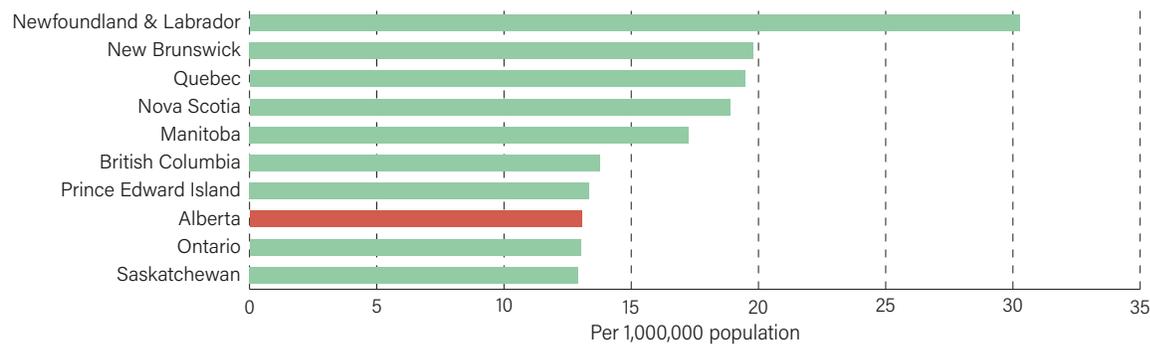
A similar result occurs when we examine the availability of key medical imaging resources. As can be seen in figure 8a, Alberta once again ranks in the middle of the pack for the number of MRI units available per million population. Further, figure 8b shows that Alberta has fewer CT scanners per million population than most provinces, ranking third last. Again, while the availability of resources presented above captures the basic inputs available for use in health care in each province, it does not necessarily capture the degree to which those resources are being used to deliver health care to patients.

Figure 8a: MRI units per 1,000,000 population, 2017



Source: CADTH, 2018: table 10.

Figure 8b: CT units per 1,000,000 population, 2017

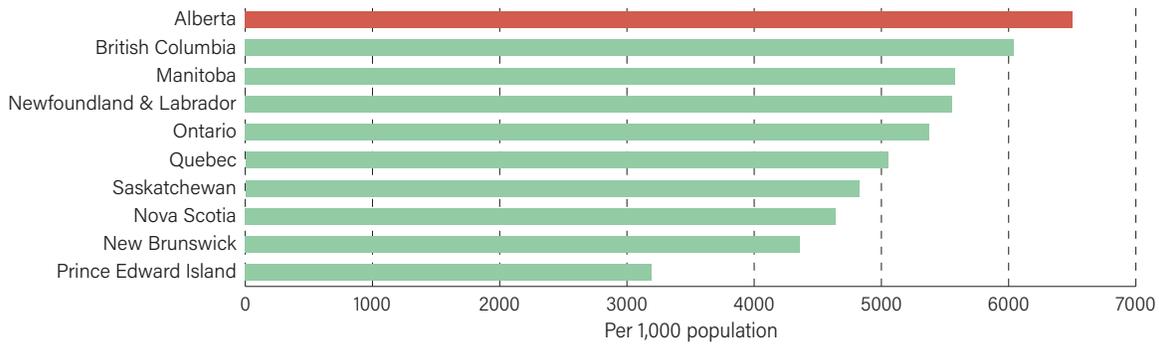


Source: CADTH, 2018: table 7.

2. Use of resources in Alberta

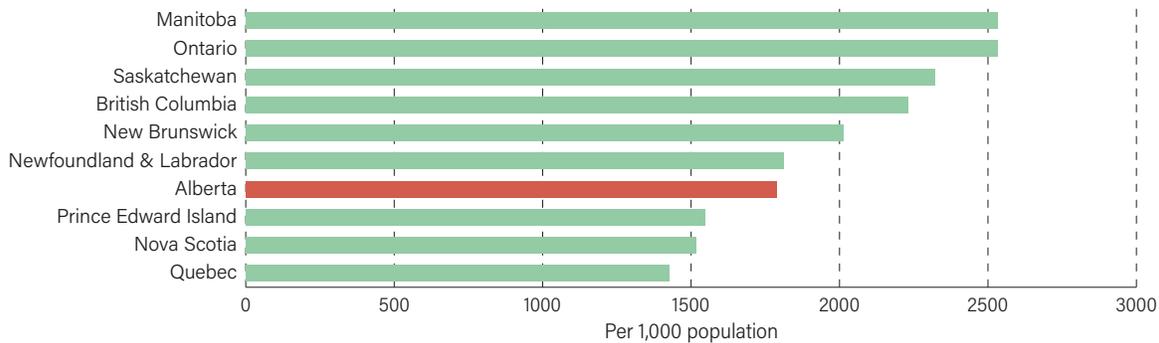
Figure 9a and figure 9b rank the provinces based on two indicators of physician activity. As can be seen in figure 9a, Alberta ranks at the top for the total number of consultations and visits per thousand population for 2015/16. However, as can be seen in figure 9b, physicians provide fewer procedures per person than six other provinces, ranking above only Quebec, Nova Scotia, and Prince Edward Island. Further, figure 9c reveals that Alberta ranked in the middle of the pack on the indicator measuring the rate of hospitalization in the province (adjusted for age and sex by the CIHI), indicating lower hospital activity than one might expect given the high spending in the province. Alberta’s middling performance is again obvious in figure 10a, which reports data capturing the number of MRI exams per thousand population. However, it is particularly notable that Alberta ranks last for the number of CT scans (figure 10b).

Figure 9a: Total consultations and visits per 1,000 population, 2015/16



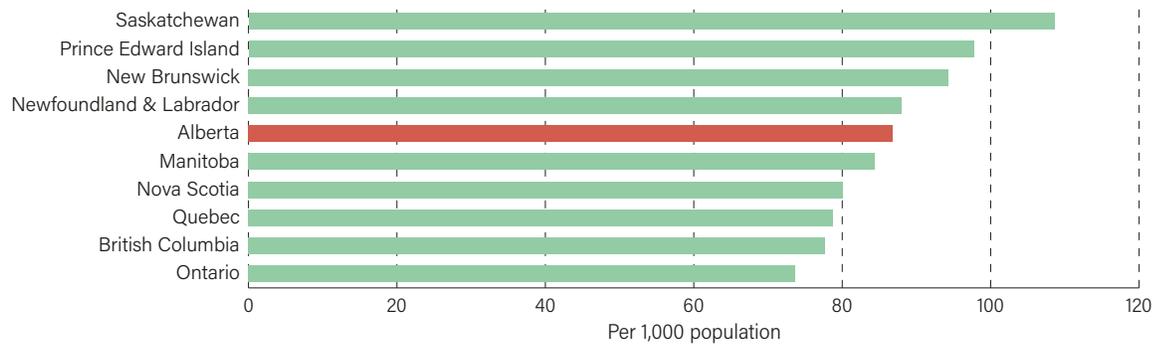
Source: CIHI, 2017b: table B4.

Figure 9b: Total procedures per 1,000 population, 2015/16



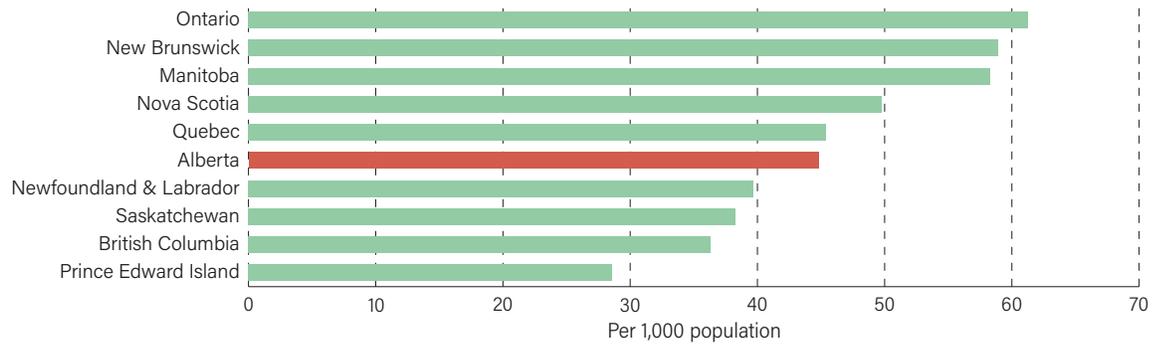
Source: CIHI, 2017b: table B4.

Figure 9c: Age-sex standardized hospitalization rate per 1,000 population, 2016/17



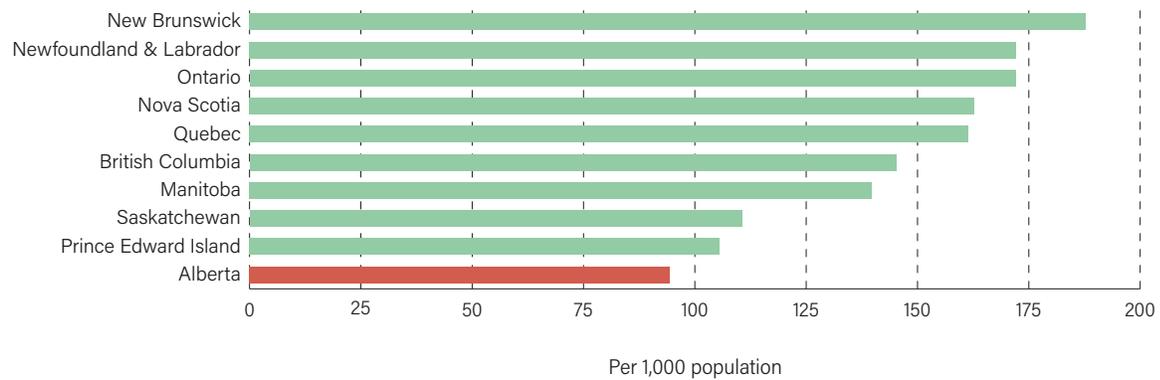
Source: CIHI, 2018e.

Figure 10a: MRI examinations per 1,000 population, 2017



Source: CADTH, 2018: table 11.

Figure 10b: CT examinations per 1,000 population, 2017

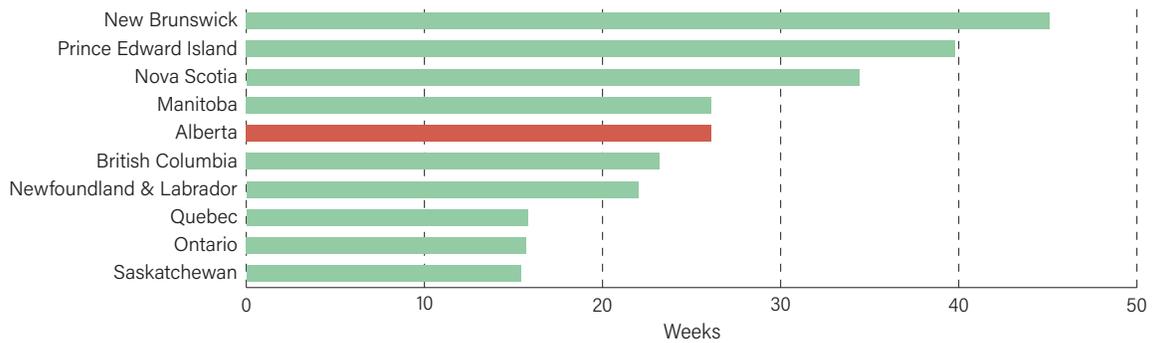


Source: CADTH, 2018: table 8.

3. *Timely access to health care in Alberta*

The most readily available comprehensive information about timely access to care, is available from the Fraser Institute’s annual survey of wait times. Figure 11 shows the median wait times (in weeks) from GP referral to treatment by a specialist for each of the provinces in 2018 reported by the most recent survey. Alberta ranked 6th among the provinces with a median wait time of 26.1 weeks, which is a substantial increase from 1993 when the data was first collected and the wait time was 10.5 weeks (Barua and Jacques, 2018b). Simply put, wait times in Alberta, like the rest of the country, have increased markedly over the past 25 years.

Figure 11: Weeks waited from referral by GP to treatment, 2018



Source: Barua and Jacques, 2018.

4. *Clinical performance and quality in Alberta*

Finally, a sense of the quality of Alberta’s health care system can be gleaned from the CIHI’s collection of indicators measuring the two broad categories of Safety (table 5a) as well as Appropriateness and Effectiveness (table 5b). As indicated in table 5a, Alberta’s performance is mixed on the five indicators of Safety reported by the CIHI: statistically better than the national average on two, worse on one, and the same on one (performance on one indicator is only reported, but not statistically assessed by the CIHI). On the 12 indicators measuring Appropriateness and Effectiveness (table 5b), Alberta’s performance is mediocre to poor: statistically better than the national average only on one indicator, the same on seven indicators, and worse on four indicators.

Table 5a: Category “Safety”, Canadian Institute for Health Information

Indicators	Alberta	Statistical difference from average	Canada
In Hospital Sepsis (per 1,000) 2017–2018	3.8	Same	4.0
Obstetric Trauma (with instrument) 2017–2018	16.3%	Better	18.4%
Potentially Inappropriate Medication Prescribed to Seniors 2016–2017	53.4%	N/A	46.8%
Falls in the Last 30 Days in Long-Term Care 2017–2018	15.8%	Better	16.3%
Worsened Pressure Ulcer in Long-Term Care 2017–2018	3.1%	Worse	2.8%

Source: CIHI, 2018f.

Table 5b: Category "Appropriateness and Effectiveness," Canadian Institute for Health Information

Indicators	Alberta	Statistical difference from average	Canada
30-Day Overall Readmission 2017–2018	9.0%	Same	9.1%
30-Day Medical Readmission 2017–2018	13.5%	Same	13.7%
30-Day Surgical Readmission 2017–2018	6.8%	Same	6.8%
30-Day Obstetric Readmission 2017–2018	2.2%	Same	2.1%
30-Day Readmission: Patients Age 19 and Younger 2017–2018	6.7%	Same	6.8%
Ambulatory Care Sensitive Conditions (per 100,000) 2016–2017	347	Worse	325
High Users of Hospital Beds (per 100) 2016–2017	4.8%	Worse	4.5%
Hospital Standardized Mortality Ratio (HSMR) 2017–2018	93	Worse	89
Hospital Deaths Following Major Surgery 2017–2018	1.5%	Same	1.6%
Low-Risk Caesarean Sections 2016–2017	15.9%	Same	15.6%
Potentially inappropriate use of antipsychotics in long-term care 2017–2018	17.1%	Better	21.2%
Restraint Use in Long-Term Care 2017–2018	6.1%	Worse	5.7%

Source: CIHI, 2018f.

The indicators presented here are in no way meant to provide a comprehensive picture of the performance of Alberta's health care system today, but they corroborate the findings of Barua's 2013 study, which indicated that there was an imbalance between Alberta's high spending and overall performance (Barua, 2013). Put simply, more recent data suggests that this imbalance persists.

Overall, Canada is clearly a comparatively high spender on health care but only a middle-to-low performer. These outcomes should broadly indicate to Canadians that the country's health care system needs genuine reform. Among the provinces, Alberta is a relatively high spender but, at best, an average performer. In other words, Alberta is a high spending province within a high spending country but only a modest performer within a low-to-modest performing country.

2. The Canada Health Act— Understanding What the Provinces Can and Cannot Do

Under section 92 (7), the *Constitution Act of 1867*, provincial Legislatures are assigned the exclusive right to make laws in relation to “[t]he Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals” (Canada, 1982). This is generally interpreted to mean that the provision (but not necessarily payment) for medical treatment in Canada is a provincial responsibility. This being the case, provincial governments have the authority to make “decisions about what services will be provided under a universal scheme, how those services will be funded and remunerated, who will be permitted to deliver services, and whether those services can be partly or fully funded privately is determined exclusively by provincial governments in Canada” (Esmail and Barua, 2018: 16). In other words, the provision, but not payment, for medical treatment in Canada is a provincial responsibility.

The federal government, however, is able to influence certain characteristics of provincial health care systems by exercising its federal spending power through the Canada Health Act (CHA). Revised in 1984 under the Mulroney Tories, the CHA is best thought of as a financial act, in that it defines the terms and conditions under which provincial governments will receive payments from the federal government through the Canada Health Transfer (CHT). [10] Put differently, the CHA governs federal spending and the conditions under which the provinces are eligible for such spending; it does not directly govern the actions of individuals or other health care providers working in the provincial health systems. [11] Thus, the substantial cash transfers tied to compliance with the CHA can and do influence provincial health policy. [12]

In fiscal year 2018/19, the federal government will spend an estimated \$38.6 billion on the Canada Health Transfer, making it by far the single largest transfer to the provinces. [13] Alberta expects to receive \$4.5 billion for its share of the CHT, representing 54.3% of transfers to the province from the federal government and 22.0% of provincial spending on health care (Alberta, Dep’t of Finance, 2018). Put simply,

[10] For information on the federal Canada Health Transfer (CHT), please see Canada, Department of Finance, 2011.

[11] For a broader analysis of the CHA including a legal assessment, see Watts, 2013.

[12] As we discuss later in this report, provinces (including Alberta) regulate well beyond what is required to meet the conditions of the CHA.

[13] Canada, Dep’t of Finance, 2018. See table A2.8, page 324, in Annex 2. Note that the CHT is more than double the cost of the Canada Social Transfer and Equalization payments.

the dollar value of the CHT represents a material source of resources to the province and the restrictions attached to it represent a real constraint on the reform alternatives available to the province.

As mentioned, whether the provinces actually receive these transfers depends on whether they are deemed to adhere to the Canada Health Act, which consists of 23 sections, by the federal government. Of particular note are the sections giving definitions (section 2), the five program criteria (sections 8–12), the potential consequences following violations of the criteria (sections 14–17), and non-discretionary reductions related to user-fees and extra-billing (sections 18–21). Although a detailed analysis of what is clearly permitted, prohibited, and unclear in the CHA is beyond the scope of this paper, a brief summary of research analysing its salient aspects is presented below.

The main components of the CHA that set the framework for Canada’s health care system are in sections 8 to 12. These five components or what are commonly referred to as the principles of the Canada Health Act are: (1) public administration, (2) comprehensiveness, (3) universality, (4) portability, and (5) accessibility. Public administration (section 8) requires that the health care insurance plan of a province must be administered and operated by a non-profit public authority. This aspect of the CHA clearly establishes that the public insurance system for health care cannot be administered by a private for-profit company, and precludes a competitive insurance market with multiple insurers. That being said, as Clemens and Esmail (2012) note, it does not specifically “preclude a social insurance system, where an agency designated by government but functionally independent from government operates the health insurance program on a premium funded basis”, pointing out that the Act places “no restriction on health insurance plans that are not operated by the provincial government” (Clemens and Esmail, 2012: 13).

Comprehensiveness (section 9) mandates that the health care insurance plan of a province must cover all insured health care services provided by hospitals and medical practitioners deemed medically necessary or required, as well as surgical-dental services provided in a hospital setting. The Act does not, however, clearly define or even provide parameters for what are deemed medically necessary/required services. As a result, provinces have considerable discretion and latitude in defining what is a “covered service”. Some analysts have interpreted that discretion as clarifying the roles for the provinces while others have argued that it creates ambiguity or a lack of clarity about what the federal government considers “essential services”. [14] The combination of a lack of clarity coupled with the federal government’s unilateral ability to determine whether a province is adhering to the CHA, as well as the ongoing political sensitivity to the Act, creates a fairly risk-averse environment for those wishing to reform health care at the provincial level.

[14] For an informative discussion of core medical services in Canada, please see Flood, Stabile, and Tuohy, 2008. One of the important insights in this paper is that Canada has a comparatively narrow focus on payments to doctors and hospitals in part because the CHA only applies to payments for services by doctors and hospitals.

Universality (section 10) requires that the health care insurance plan of a province cover 100% of insured persons in a uniform and equal manner. This section is fairly clear in that it precludes “any opportunity for individuals to tailor their universal insurance policy to their unique situation and preferences” (Clemens and Esmail, 2012: 17). Again, it should be noted that this constraint applies only to the insurance plan of the province, and does not pertain to other potential insurance plans, or services not covered by the provincial plan. Portability (section 11) ensures that insured persons in one province have health care coverage while travelling or moving to another province.

Finally, accessibility (section 12) requires that “the health care insurance plan of a province ... must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons” while also ensuring that health care providers are compensated at a reasonable level. [15] However, the term “reasonable access” is not defined by the CHA, allowing the federal government of the day full discretion over its interpretation and the degree to which provinces meet, or fail, this criterion.

While the principles included in the CHA are helpful in understanding the broad intentions of the Canadian health care system, the lack of clarity and specificity about the meaning, definitions, and parameters for the various principles are at the root of the uncertainty surrounding the CHA and what the provinces can and cannot do to reform health care. This uncertainty is compounded by later sections (14–17) in the CHA that explain how violations of the five principles can lead to a reduction (in proportion to the gravity of the default) or possibly even the withholding of the Canada Health Transfer. Just as the criterion for whether a province is deemed to be complying with the CHA is almost entirely at the discretion of the federal government, the penalties for non-compliance are also, for the most part, at the discretion of the federal government.

As the recent analysis of the CHA by Esmail and Barua (2018) confirmed, one area in the CHA that is abundantly clear is its prohibition against extra billing or user fees for covered, that is insured medical services. [16] Sections 18–21 of the Act clearly state that provinces will face a non-discretionary penalty wherein the province’s CHT payment will be reduced by an amount equal to what was charged to the patient(s) for covered services. The effect of this prohibition is that none of the Canadian provinces have pursued cost sharing, which is a typical feature of many universal health care systems around the world. [17]

There are, however, a number of policy options available to provinces that are not specifically prohibited under the CHA, including private parallel insurance, direct

[15] Canada, 2018. Note that this condition only applies to provincial residents. In other words, fees and other charges assessed on an out-of-province resident or non-resident is within the CHA guidelines.

[16] The same conclusion was reached in the analysis of the CHA by Clemens and Esmail (2012).

[17] For information on cost sharing, see Gliberman, 2016; and for a broader discussion of Canada’s health care system compared to other universal health care countries, see Barua and Jacques, 2018a.

payment for medical services, dual practice for doctors, and private delivery of health services. However, the CHA also does not expressly allow these reforms and indeed many advocates for the *status quo* have argued that they would violate either the interpretation or intent of the CHA. [18] It is this lack of clarity in the CHA coupled with the contentiousness of health care reform more broadly that has stifled innovation and genuine health care reform at the provincial level of government.

Reforms of provincial health care not specifically prohibited by the CHA

While the CHA prohibits private companies from operating a province's health insurance plan, as well as private insurance that shares the cost of publicly insured medically necessary services, the Act actually does not specifically preclude parallel or independent private health insurance for medically necessary services. Further, while the CHA prohibits extra billing and user fees within the public health care system, the CHA does not prohibit individuals from directly paying the full cost for such services so long as the activity exists completely outside of the public system. In other words, the CHA does not expressly prevent reforms that would create a parallel private insurance system covering medically necessary health services that Canadians would pay individually and privately rather than through the public system. To be clear, though, such a system would have to operate independently of the public health care system. The CHA clearly prohibits private insurance sharing the cost of medically necessary services with the public insurance system.

Another policy option not expressly prohibited by the CHA is dual practice by physicians, wherein physicians practice medicine in both public and private settings. Such circumstances are not disallowed so long as the practice in the public setting adheres to the five principles of the CHA and does not involve cost sharing or extra billing. This means that under the CHA, Canadian physicians are not clearly prohibited from practicing both in the current public system as well as in a private parallel system (Esmail and Barua, 2018; Clemens and Esmail, 2012). [19]

An area of the CHA that is generally misunderstood is the question of private provision of publicly insured medical services. There is no express provision in the CHA that disallows provinces contracting with private providers to deliver medically necessary services covered by the public health care system. Indeed, a large portion of Canadian health care is already delivered privately since doctors' offices and clinics are private entities and many diagnostic services and treatments are also delivered by private entities. Extending the use of private firms for the delivery of health care

[18] Note that, in the 2005 *Chaoulli* case, the Supreme Court of Canada specifically rejected this argument if the CHA does not specifically state an "interpretation" or "intent"; and yet, more than a decade later, many groups continue to make this argument in their opposition to health care reform. See, as an example, Tomlinson, 2017.

[19] For a broad discussion and analysis of physician supply, including forward estimates, please see Globerman, Barua, and Hasan, 2018.

services within the existing publicly insured system is well within the framework of the CHA. In this sense, it would not be a violation of the CHA framework if provincial health care systems provided services through private, non-profit or for-profit, institutions so long as the overarching public scheme remained accessible to everyone under uniform terms and conditions and without cost-sharing. It is worth noting that many successful universal access health care countries such as Australia, France, Germany, the Netherlands, Sweden, and Switzerland use private and even for-profit entities in their health care systems. [20]

Given the potential of policy options that are not expressly prohibited by the CHA, it may seem surprising that provinces have not chosen to experiment with at least some of these reforms—especially since such policies are the hallmarks of more successful universal health care systems around the world (Esmail and Walker, 2008). One of the reasons this may be the case is the previously mentioned lack of clarity and at times specificity in the CHA, which means that many sections are open to fairly broad interpretations. This uncertainty is further compounded by the discretion afforded the federal government by the CHA to interpret its provisions. Put simply, health reforms deemed acceptable by the federal government at a particular point in time could easily be interpreted as a violation later when a different party holds power in Ottawa. The lack of clarity in the CHA coupled with the interpretative discretion afforded the federal government results in a general risk-aversion on the part of provinces to reform since the determination of whether a province is in violation of the CHA is almost entirely up to the discretion of the federal government of the day. The lack of clarity in the CHA has also afforded many groups [21] opposed to any reform of Canada’s health care system the ability to claim such reforms violate the CHA, one of the country’s most politically sensitive pieces of legislation. [22]

The overall result of the CHA’s vagueness and lack of specificity, the ensuing variations in the interpretation by different groups of what the CHA means, and the sensitivity of Canadians broadly to health care reform has been stifling provincial policy innovation. [23] Indeed, given the large financial penalties that could be imposed,

[20] For more information on the role of private for-profit firms in health care in other successful universal health care countries, see Barua and Esmail, 2015; for a broad comparison of public and private health care in Canada and other universal health care countries, see Blomqvist and Busby, 2015; for a discussion of health care in the Netherlands, see Esmail, 2014b; for a discussion of health care in Germany, see Esmail, 2014a; for an analysis of health care in Australia, see Esmail, 2013a; and for a discussion of health care in Switzerland and Sweden, see Lundback, 2013.

[21] For example, the Friends of Medicare (<http://www.friendsofmedicare.org/>) has argued that privatization would violate the tenets of the CHA even though there is a general consensus that such reforms are (1) in line with most other universal health care countries, and (2) do not violate the conditions of the CHA so long as additional private payments are not required or charged to patients.

[22] For an excellent analysis of the dynamics related to health care reform in Canada, please see Blomqvist, 2010.

[23] For an interesting perspective on health care innovation, please see Canada, Ministry of Health, 2015 (Report of the Advisory Panel on Healthcare Innovation).

provinces appear to have become markedly risk averse when considering health care reform, ignoring potential policy innovations that are successful in other universal health care systems and that would likely not be in violation of the CHA as written.

That being said, the implications for Alberta health care reform are clear: while the CHA expressly prohibits extra billing and user fees, other important reforms are not clearly disallowed. There is, however, ample ambiguity and the discretion afforded the federal government of the day in interpreting the rather opaque details of the CHA. The provinces would be well advised to request clarification, if not outright reform, of the CHA. Alberta is, however, in a position to enact a number of reforms not specifically prohibited by the CHA.

3. Health Care Options for Alberta

Health care systems differ dramatically in the way they are financed, regulated, and delivered. It has, however, been pointed out in numerous studies that Canada's health care system differs from other successful universal health care systems in some very specific ways. For example, a recent study by Esmail and Barua (2018) compared Canada's approach to health care with that of Australia, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, and the United Kingdom. The countries all share with Canada the common goal of ensuring universal access to health care regardless of a patient's ability to pay, but generally perform on par or better than Canada on most indicators of performance (Esmail and Walker, 2008; Barua and Jacques, 2018a). The analysis by Esmail and Barua revealed significant differences between international practice and Canada's approach to private insurance and direct private payment for core medical services, private delivery of core medical services, dual practice by physicians, methods of remuneration for hospitals, and cost sharing for core medical services. Importantly, other studies have repeatedly indicated that many of the ways in which the Canadian model diverges in these areas of health care policy help explain, conceptually and empirically, its relatively mediocre performance—and specifically, its poor record on timely access to care—despite its high spending (Esmail and Walker, 2008; Gliberman, 2013).

The reforms presented in this section are included based on their real-world use and success in other universal access health care countries, as evidenced by the studies noted previously. In addition, this section reviews and includes references to the report by then Premier Klein's Premier's Advisory Council on Health, which spent over a year evaluating and then recommending reforms to the province's health care system. [24] This review of the 2001 report is presented not only to buttress the current recommendations but also to underscore the fact that many of these recommendations have been in the public debate for nearly two decades. For reference, in the spring of 2000, Ralph Klein, then Premier of Alberta, tapped former federal finance minister Don Mazankowski to chair a 12-person advisory council to evaluate the province's health care system and formulate recommendations for wide-ranging and sweeping reform. In late 2001, the Premier's Advisory Council on Health (hereafter referred to as the Premier's Council) submitted its report, which included 44 recommendations, many of which called for a fundamental change in the way health care was financed and delivered in the province.

In retrospect, because the province delayed acting on the report in deference to the federal government's review (Romanow, 2002), which was led by former

[24] *A Framework for Reform: Report of the Premier's Advisory Council on Health*, commonly referred to as the "Mazankowski Report". Cited as Mazankowski, 2001.

Saskatchewan Premier Roy Romanow, there was very little fundamental action or reform. Essentially, the delay in taking action resulted in a loss of momentum towards reform, and the pending and eventual election in 2004 derailed any serious efforts at reforming the province's health care system in 2003 and 2004. [25] Nonetheless, it is useful, and indeed insightful, to review some of the key recommendations made by the Premier's Council back in 2001 since they are as relevant today as they were nearly two decades ago. In addition, they highlight that many of the recommendations contained in this publication have been suggested in the past by a wide range of organizations both inside and outside the government.

1. Expand capacity and incentivize competition via private providers

One of the solutions offered by the Premier's Council to tackle the supply of medical services was to contract publicly funded services to third-party private clinics. While the traditional approach in Alberta, and Canada more generally, has involved simply pouring more money into the public system (Barua and Eisen, 2017), the "extensive literature on competition in health care markets is that a carefully crafted policy that encourages competition among non-profit, for-profit, and public providers can result in a health care system that is fiscally sustainable, ensures access to quality health care, and results in better health outcomes" (Ruseski, 2009: 42).

As Professor Janice MacKinnon, the former NDP Finance Minister for Saskatchewan, noted, while increasing capacity on its own is "not a solution to reducing wait times, successful wait-time reduction involves increasing capacity" (2016: 25). The long wait times in Alberta, and Canada more generally, are clear evidence that not enough services are being supplied in order to meet demand. MacKinnon adds that:

[t]he use of private clinics to deliver health-care services is common in other OECD countries and there are many reasons that procedures like elective day surgeries can be delivered more effectively in clinics ... [which] are located outside the complex and expensive hospital settings and have the advantage of only performing specific procedures that can be delivered more effectively and efficiently. Also, they are less susceptible to hospital-based infections and offer more convenient access. (2016: 25-26)

Critically, the use of private firms in the delivery of public health care, so long as the firms are not charging additional fees and generally adhere to the principles of the CHA is not, contrary to popular perception, prohibited by the Canada Health Act. Despite the absence of a prohibition, the use of private, for-profit firms in Canada's

[25] For an insightful examination of the change in momentum in the early 2000s that ended in very little genuine reform of health care, please see Boothe and Carson, 2003.

health care system is quite inconsistent. For instance, most doctor's offices and clinics are private firms acting within the public health care system. In addition, most independent diagnostic facilities are also privately owned and operated on a for-profit basis. On the other hand, Canada's use of private hospitals is distinctly limited compared to that found in other universal access health care countries (table 5).

Table 6 shows data for Canada and a number of other universal access health care countries on the presence of private non-profit and for-profit hospitals. In 2015, private, for-profit hospitals represented just 1% of the total compared to 64% in the Netherlands, 51% in Switzerland, 43% in Germany, 39% in Australia, and 33% in France (Esmail and Barua, 2018). [26] Recall from section 1 that many of these countries spend the same or less than Canada on universal access health care but achieve better results. Importantly, in Australia and Sweden, governments contract with private for-profit hospitals for the provision of universally accessible services and universally accessible hospital care is delivered by public, private not-for-profit, and private for-profit hospitals in Germany, France and Switzerland. We also have experiments in Canada that demonstrate the benefits of using the private, for-profit sector to a great degree.

Table 6: Hospitals, by ownership, 2015 (or most recent year)

	Total	Public	Private not for profit	Private for profit	Proportion of private, for-profit hospitals
Australia (2014)	1,322	698	107	517	39%
Canada (2015)	719	712	0	7	1%
France (2015)	3,089	1,389	691	1,009	33%
Germany (2015)	3,108	806	979	1,323	43%
Netherlands (2014)	505	0	181	324	64%
New Zealand (2015)	165	85	28	52	32%
Sweden	83	77	3	3	4%
Switzerland (2013)	293	61	82	150	51%

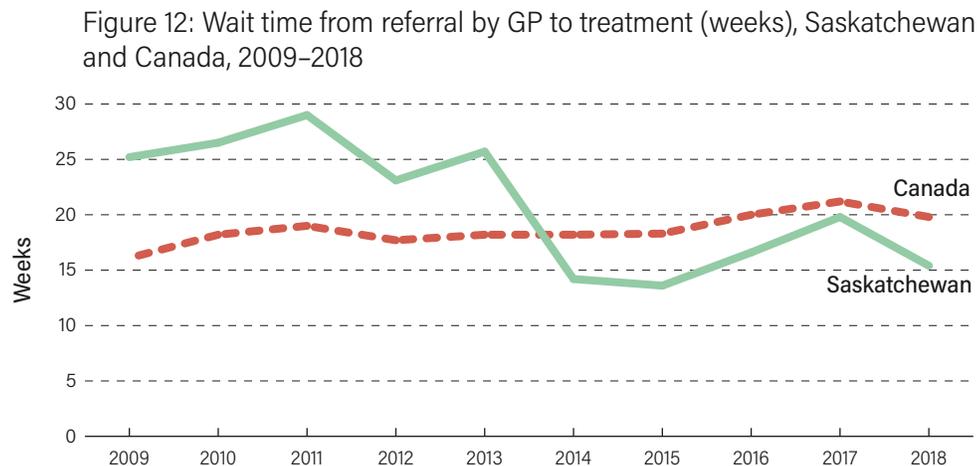
Source: adapted from Esmail and Barua, 2018: table 2, p. 9.

[26] In Canada, most hospitals are technically private, not-for-profit institutions. However, like researchers Esmail and Walker (2008), the OECD categorizes them as public hospitals because they "are controlled by government units" (OECD, 2018b). Data for the Netherlands and Switzerland should be interpreted with caution. For further details, see Barua and Esmail (2015).

Saskatchewan Surgical Initiative

In 2010, Saskatchewan took an innovative step in Canadian health policy with the establishment of the Saskatchewan Surgical Initiative (SSI). [27] The SSI was a health care program designed to lower surgical wait times in the province. Its guiding principle was that by March 2014 no Saskatchewan patient would wait more than three months for surgery. A central feature of the SSI was the use of private, for-profit clinics in the public health care system in order to increase surgical capacity. While controversial, the reform allowed 34 day-surgery procedures to be performed in private clinics (Mackinnon, 2016). Former NDP Saskatchewan Finance Minister Janice MacKinnon concluded that this reform, in conjunction with others, led to a more effective and efficient delivery of services as these procedures no longer had to be performed in complex and expensive hospital settings.

The movement of certain surgical procedures to private clinics produced positive outcomes both in terms of procedural costs and wait times. On cost, a 2012 report from Saskatchewan Health found that the total cost of performing the 34 procedures in private clinics was, on average, 26% less than comparable procedures completed in hospitals (Mackinnon, 2016). Critically, the use of private clinics and the SSI in general produced a marked reduction in the province's surgical wait times. As figure 12 shows, wait times began falling in Saskatchewan after 2011 and by 2014 they were lower than the median wait time across Canada, where they remain as of 2018. More specifically, in 2010 when Saskatchewan introduced the SSI, the median wait time from GP referral to treatment was 26.5 weeks compared to the national average of 18.2 weeks. By 2014, the last year of the SSI, the median wait time in the province had fallen to 14.2 weeks, a decline of 46.5%. In addition, the median wait time in Saskatchewan was now below the national average, something



Source: Various authors, 1993–2018, *Waiting Your Turn*.

[27] This section draws on reports by Janice Mackinnon (2013, 2016).

that had never occurred since the data began being collected in 1993. Wait times have increased since 2014 though they remain below the national average. The SSI experiment in Saskatchewan demonstrates the potential for private health providers to improve the effectiveness of existing resources while expanding the total capacity of health services.

Alberta Health Care Protection Act

Interestingly, Alberta made some strides in this direction in the early 2000s with the introduction of Bill 11. The bill, the Alberta Health Care Protection Act (Alberta, 2000–2016) “expanded the role of for-profit private clinics within the public system by allowing RHAs to contract with private, for-profit surgical facilities. It also expanded the role of private clinics by allowing them to perform more complicated procedures that might require overnight stays” (Ruseski, 2009: 9). Alberta’s health insurance plan also

recognizes non-hospital surgical and diagnostic facilities that offer procedures that do not require an overnight stay in the facility for post-operative recovery, operation, or diagnosis ... [although] no new facilities were accredited until 2005, when there were 58 non-hospital surgical facilities, 26 of which had contracts to provide medically insured services under the Health Care Protection Act. In 2008, there were 63 accredited non-hospital surgical facilities but no change in the number of facilities with contracts under the Health Care Protection Act ... [the growth occurred] at a time of capacity reductions in the non-profit hospital sector and follows implementation of the Regional Health Authorities Act, which specifically allows regions to contract with private providers of services” (Ruseski, 2009: 11).

However, examination of available data in 2008 revealed that “[o]nly a few surgical specialties are contracted out, including dermatology (in Edmonton only), ophthalmology, oral surgery, otolaryngology (in Edmonton only), orthopaedic surgery (in Calgary only), plastic surgery (in Edmonton only), and reproductive health” (Ruseski, 2009: 12).

While Bill 11 clearly established a path for Alberta to contract services to third-party private clinics, it also contained a number of limitations that prevented the evolution of a robust private sector competing for the delivery of publicly insured services. For example, Ramsay and Esmail noted that Bill 11:

prohibits private hospitals; limits the operation of private, non-hospital surgical facilities to those approved by the minister of health; prohibits the charging or paying of a fee to jump the queue for faster access to service; prohibits non-hospital surgical facilities from charging facility fees to patients; prohibits charges for enhanced medical goods and services above the actual cost to provide them; and

requires that no fees be charged for enhanced goods or services unless the nature and cost of these goods and services is explained fully to patients ... Facilities are allowed to provide insured surgeries only when they have a contract with a health authority. (2004: 39)

While these limitations have been examined in detail by Boychuk (2008) and Ruseski (2009), two particular areas for reform are identified below with specific application in improving capacity and competition via third-party providers (contracted to deliver publicly insured services) that could be undertaken within the confines of the Canada Health Act.

1. Remove the provincial ban on the operation of private hospitals. Currently, Bill 11 allows the provision of surgical services only in a public hospital or an approved surgical facility. (Alberta Health, 2000–2016: RSA 2000 c. H-3.3, s. 1)
2. Explicitly allow major surgeries to be delivered in private facilities or hospitals. Currently, Bill 11 requires all major surgical services, including emergency, diagnostic, surgical and medical services and medically supervised stays exceeding 12 hours, to be delivered in a public hospital. (Alberta Health, 2000–2016: RSA 2000 c. H-1, s. 2; 2000 c. H-7, s. 146; 2008 c. 34, s. 18)

The intention of these reforms would be to move towards an environment where the public insurer becomes indifferent to the ownership structure of the delivery of services (as long as the service is publicly funded in full, costs the public insurer the same (or less), and is available to all Albertans). There could, of course, be a number of conflicts with the CHA, depending on the manner in which other non-insured services or facility fees are charged. (These are explored in detail in Boychuk 2008 and 2012, as well as section 2 of this report.)

It is notable that the potential for the private sector to deliver publicly insured services was clearly recognized in Alberta's 2001 report by the Premier's Advisory Council on Health led by former federal finance minister Don Mazankowski (Mazankowski, 2001). Indeed, the Council boldly recommended that the province needed "an innovative blend of public, private, and not-for-profit organizations and facilities to deliver health care services" and that it was time "to consider what role the private sector can play in complementing health services available in the public sector, improving access, and encouraging centres of specialization"; and specifically recommended that the province and its regional health authorities "contract with a wide variety of providers including other regions, clinics, private and not-for-profit providers, and groups of health providers" (Mazankowski, 2001: 7, 25, 40).

The experience in neighbouring Saskatchewan coupled with the wide-spread successful use of private, for-profit firms in the delivery of universal access health care in many countries indicates that such reform should at the very least be considered alongside other potential reforms.

2. Encourage competition between public and private providers by remunerating hospitals through activity-based funding

A number of reports and health care analysts have noted the inefficient nature of current funding for hospitals. As Esmail noted:

[i]t is valuable to reiterate the benefits created by combining activity-based funding and competition with private provision of services. Vitally, when it comes to efficiency, ownership (though an important factor) may be less important than the extent of competition. Both public and private providers are likely to be less efficient in the absence of competition, while both are likely to operate more efficiently when it is present. The key advantage of introducing more private provision in health care is that it would provide greater competition, putting pressure on all providers (whether public or private) to operate more efficiently. (2013a: 27)

A key area for policy reform affecting competition and efficiency is the method by which hospitals are remunerated. Currently Alberta, like most provinces in Canada, primarily funds hospitals using prospective global budgets under which the “funding total and its allocation across hospitals is set at the beginning of the fiscal year. The funding levels and allocations may be adjusted over time—using socio-demographic, political and economic factors to determine future payments—but mainly follow historic patterns” (CIHI, 2010: 3). In other words, global budgeting provides a specific grant to a hospital irrespective of activity in that particular year and the hospital’s resources are, therefore, not directly and specifically linked to the services provided. While this system of funding

provides a straightforward way of creating budgetary predictability, and a simple means of limiting growth in hospital expenditures through the supply side lever of capped budgets ... the response of hospitals has been to restrict admissions in order to stay within budget, resulting in lengthening waiting lists. [They also] do not incent hospitals to incur higher costs to increase quality, nor to decrease waiting lists. Furthermore, global budgets risk perpetuating historical inequities or inefficiencies. (Sutherland, 2011: 4)

An increasingly common way for universal health care countries in the developed world to fund hospitals is to base payment on some measure of activity. Activity-based funding (ABF), according to the strictest definition, provided by the Canadian Institute for Health Information (CIHI):

can be defined by two features: first, a case mix system [28] is used to describe hospital activity and to define its products or outputs; second, a payment price is set for each case mix group in advance of the funding period and payments to the hospital are

[28] For a detailed description of case-mix system and activity-based funding, see CIHI, 2010.

made on a per case basis ... Other funding models that share principles of activity-based funding include case mix funding, diagnosis-related group (DRG)-based funding, patient-focused funding, pay for performance (P4P), payment by results (PbR), prospective payment system (PPS) and service-based funding. (CIHI, 2010: 3)

Esmail and Barua’s examination (2018) of high performing universal health care systems in the OECD revealed that, unlike the practice in Canada, DRG-like [29] (or per procedure/service) payments are the predominant method used to remunerate hospitals in high performing universal health care systems like Australia, France, Germany, the Netherlands, Sweden, Switzerland, and the United Kingdom (table 7). [30] Not only does moving towards activity-based funding for hospitals “simplify the introduction of greater competition and privately owned and operated providers into the hospital sector” (Esmail 2007: 24) but it also has the potential to “lead to a

Table 7: Detailed Acute-Care Hospital Payment

	Public	Private not for profit	Private for profit
Australia	Per case, DRG-like	By procedure, service	By procedure, service
Canada	Prospective global budget	Prospective global budget	Prospective global budget
France	Per case, DRG-like	Per case, DRG-like	Per case, DRG-like
Germany	Per case, DRG-like	Per case, DRG-like	Per case, DRG-like
Netherlands	Per case, DRG-like	Per case, DRG-like	—
New Zealand	Prospective global budget	—	—
Sweden	Prospective global budget, per case, DRG-like*	Prospective global budget, per case, DRG-like*	Per case, DRG-like
Switzerland	Per case, DRG-like	Per case, DRG-like	Per case, DRG-like
United Kingdom	Per case, DRG-like	By procedure, service	Retrospective

Source: Esmail and Barua, 2018: table 5, p. 13.

[29] “Diagnosis Related Groups [DRGs] refers to groups of hospital cases based on diagnoses, procedures performed and patient characteristics (age, gender and co-morbidities)” (OECD, 2016: 3). “Developed in the United States, DRGs were introduced in the hospital management of many European countries over the last twenty years” (HOPE, 2009: 92).

[30] In many countries, this method of payment was combined with a form of global budgeting. Notably, Australia, France, the Netherlands, and the United Kingdom use DRG-like payments for public hospitals but “locate this within an overall global budget”.

greater volume of services being delivered using existing health care infrastructure, reductions in waiting time, reductions in excessive hospital stays, improved quality of care, more rapid diffusion of medical technologies and best practice methods, and the elimination of waste” (Esmail, 2013a: 27).

It is important to note that a shift to activity-based funding, while it may lower the costs per procedure, may also result in higher overall spending as a result of an increased volume of services delivered to patients. As a result, some researchers recommend “blending’ ABF with global budgets, where the rate of ABF funding is set as the proportion of variable cost to total cost, or approximately 40% of total current hospital funding levels” and capping hospital activity so that “[a]dditional volumes under ABF should be remunerated at a marginal cost or linked to achieving policy priorities” (Sutherland, 2011: 16). Broadly speaking, however, “reviews of hospital funding mechanisms have generally found that activity-based funding is markedly superior to budget-based funding in terms of efficiency and output” as well as “a positive benefit to including private providers within an activity-based funding model, particularly if a competitive bidding process is employed to determine compensation rates” (Esmail, 2013a, 26–27).

3. Increase efficiency by creating a centralized surgical registry and pooling referrals

Canada, like many universal health care systems, regulates patient access to specialists by means of a system called “gate-keeping”. Patients are required to first visit a primary care physician for a referral to a specialist. As shown earlier in this paper, Canadians can face considerably long waits in order to receive a consultation, never mind waiting further for diagnostic tests and eventual treatment. Unfortunately, the challenges posed by financial and capacity constraints are compounded by the fact that currently family practitioners refer each patient directly to a particular specialist while possibly unaware of other capable specialists who may have shorter wait times.

Another central feature of the Saskatchewan Surgical Initiative (SSI) that contributed greatly to the initiative’s success was the creation of a centralized surgical registry. This system allowed the establishment of a provincial-wide standard for assessing and prioritizing patients on waiting lists to help ensure that patients were treated according to the severity of their condition (MacKinnon, 2016). As part of the registry, the province also introduced a “pooled referral” system whereby doctors agreed to have referrals to specialists pooled, rather than referring patients to a specific specialist. This allowed patients to search for and choose the specialist they desired, after reviewing the wait times to see the specialist.

Alberta, like many other provinces in Canada, has been closely studying both centralized surgical registries and pooled referrals, and has already made some strides in this direction with programs like the AHS Closed Loop Referral Management Program, the Medical Access to Service (MAS) program (Canadian Medical Association, 2011: 6, 8), and the Alberta Netcare eReferral tool (Alberta Health Services, 2015). It is worth noting that both of these reforms were included in Alberta’s 2001 report by the

Premier’s Advisory Council on Health, which suggested: “providing all Albertans with a 90 day guarantee of access to selected health services”, “reducing waiting times by introducing centralized booking, posting waiting times for selected procedures on a website, and allowing people to access services from any physician or hospital”, “providing Albertans with more choice in the health care services they receive and where they receive them” and “encouraging an innovative blend of public, private and not-for-profit organizations and facilities to deliver health care services (Mazankowski, 2001: 6, 7).

4. Private parallel financing and delivery of medically necessary services

One area of existing activity that could be extended is the province’s private parallel system of health care wherein Albertans pay entirely out of pocket, or obtain private insurance for the full cost of services. Such a reform was again part of the original 2001 Mazankowski report. It is important to note that there are several reasons that the presence of a private parallel system may be desirable. These include enabling patients to receive more timely care, freeing up resources in the public system, providing a pressure-valve when the public system is overwhelmed, and incentivizing improvements in service delivery in the public via competition (Esmail, 2013a).

Such a system—often referred to as “two-tier” health care by Canadians—is actually the norm in other developed countries with universal health care. For example, a private health care system that is complementary or parallel to the public health care system is found in Australia, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Sweden, Switzerland, and the United Kingdom (Ramsay and Esmail, 2004). While the preceding discussion presented a case (and path forward) for the provision of publicly funded services delivered by third-party private providers within the confines of the Canada Health Act, the feasibility of a fully private parallel sector, where private finances—either private insurance or direct payment—are used to acquire the same medically necessary care from private providers as those funded and provided by the public, is more complex. There are three aspects of this reform: (a) private insurance, (b) direct billing, and (c) private provision.

a. Private Insurance for medically necessary services

While many high-performing universal health care countries [31] allow private insurers to cover basic health care, [32] including when these are delivered by providers

[31] For example, in Australia, private insurers can offer coverage for enhanced non-medical accommodation services (for example, private rooms in hospitals), expanded choice of providers, choice of doctor, and quicker access to health care. Further, in countries like Germany, the Netherlands, and Switzerland, multiple insurers (including private insurers) compete in a regulated environment to provide basic benefits (Barua and Esmail, 2013).

[32] As Esmail and Barua note, “[t]he question of who pays for health care services—an individual, a public insurer, or a private insurer—is independent of the question of the profit motive of the institution where the service is delivered” (2018: 8).

whose services are eligible for funding by basic primary health coverage (to varying extents), Canada's current private health care insurance sector is purely focused on the financing of supplementary services, that is, services other than those provided by physicians and hospitals. (table 8).

Table 8: Health care insurance in Canada and eight other OECD countries

	Primary Insurance System	Primary Private Insurance	Secondary Private Insurance				
			Can cover core services	Expanded coverage (non-medical)	Expanded choice of provider	Quicker access	Choice of doctor
Australia	Tax-Funded National Health System	x	✓	✓	✓	✓	✓
Canada	Tax-Funded National Health System	x	x	—	—	—	—
France	Tax-Funded National Health System	x	✓	✓	x	x	✓
Germany	Multiple insurers, with choice of insurer	✓	—	✓	✓	✓	✓
Netherlands	Multiple insurers, with choice of insurer	✓	—	—	—	—	—
New Zealand	Tax-Funded National Health System	x	✓	✓	✓	✓	✓
Sweden	Tax-Funded National Health System	x	✓	—	✓	✓	—
Switzerland	Multiple insurers, with choice of insurer	✓	—	✓	✓	✓	✓
United Kingdom	Tax-Funded National Health System	x	✓	✓	—	✓	—

Source: Esmail and Barua, 2018: table 1, p. 6.

One reason for the relative absence of private insurers for medically necessary services is the Canada Health Act. Specifically, the CHA disallows

private insurance for medically necessary services that share the cost of medically necessary services (as opposed to add-on uninsured or non-medically necessary services like private accommodation or superior implants) with the public insurance scheme ... [however it] does not explicitly disallow parallel or separate private insurance for medically necessary physician and hospital services, or direct full payment for those services. (Esmail and Barua, 2018: 20–21) [33]

[33] As discussed in section 3, various interpretations of the CHA's five criteria, and in particular interpretations of the criterion of Accessibility (section 12), suggest that it could be read to do so.

Despite the possibility of allowing privately funded voluntary insurance for, or direct private purchase of, medically necessary physician and hospital services, most provinces [34] —including Alberta—explicitly prohibit private insurers from funding publicly insured services. Section 26 of the Alberta Health Care Insurance Act, states that: “[a]n insurer shall not enter into, issue, maintain in force or renew a contract or initiate or renew a self-insurance plan under which any resident or group of residents is provided with any prepaid basic health services or extended health services or indemnification for all or part of the cost of any basic health services or extended health services” (Alberta, 2000–2018: RSA 1980 c. A-24, s. 17; 1996 c. 6, s. 13). Further, while the Health Insurance Premiums Act allows individuals to opt out of the province’s health insurance plan, it prohibits them from obtaining third-party insurance (Boychuck, 2008).

b. Direct payment / billing for medically necessary services

While the CHA’s restrictions on partial direct payments in the form of user fees and extra billing clearly require provinces to ensure that medically necessary or required services provided through the public scheme are fully funded (100% or first-dollar coverage), without any allowance for providers or facilities to request privately funded payments above what will be paid under the public scheme for medically necessary services, the CHA does not explicitly [35] prohibit direct private purchase (in full) of medically necessary physician and hospital services from private providers. Nevertheless, the ability of physicians to charge patients directly for the full cost of medically necessary services may be limited by provincial legislation.

Alberta is one of the few provinces that does not prohibit participating (or “opted-in” physicians) from billing patients directly for medical services, so long as the rates are no higher than the public fee schedule (Boychuck, 2008; Flood and Archibald, 2001). Importantly, as is the case in almost every other Canadian province (with the exception of Ontario), physicians are able to “opt-out” of the public insurance plan. Further, there are no limitations on the rates that opted-out physicians may charge. Although the provincial prohibition on the purchase of third-party insurance mentioned previously poses a significant challenge, patients willing to pay directly for the full cost of their medical care out of pocket should be able to do so in Alberta from opted-out physicians.

[34] Flood and Archibald note that “[s]ix of the 10 provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) prohibit contracts of private insurance to cover the kinds of services that are publicly funded” while “patients of opted-out or extra-billing physicians can substitute private for public coverage in New Brunswick, Newfoundland and Labrador, Nova Scotia, and Saskatchewan” (2001: 828). Madore and Tiedmann note that “Newfoundland & Labrador is the only province that both allows private insurance to cover services insured under its provincial insurance plan and does not use other means to discourage physicians from opting out of the public plan” (2005: 7).

[35] Again, various interpretations of the CHA’s five criteria might, however, do so. See Esmail and Barua, 2018 for more on this.

c. *Private delivery of medical services*

Interestingly, while Bill 11 provided increased latitude for contracting private surgical facilities, it also contained a number of restrictions that hampered the introduction of a private parallel system of health care. As mentioned earlier, it stated that “[n]o person shall operate a private hospital in Alberta” and prevented physicians from providing major medical services outside of public hospitals (Alberta, 2000–2016: RSA 2000 c. H-3.3, s. 1; c. H-1, s. 2; c. H-7, s. 146; 2008 c. 34, s. 18). While the distinction between a private hospital and approved surgical facility was unclear, Bill 11 clearly restricted the private sector to providing only a small range of services. Further, it stated that “private surgical facilities are not allowed to bill patients directly for medically necessary services or to engage in activities that result in “queue jumping”. Direct billing is allowed, however, for enhanced non-medical services” (Ruseski, 2009: 9).

In addition to the reforms proposed earlier for the private delivery of services, to encourage the development of a private parallel health care sector Alberta’s government could pursue the following reforms that are within the confines of the Canada Health Act:

1. amend the Alberta Health Care Insurance Act and the Health Insurance Premium Act to allow the purchase of third-party private insurance for medically necessary services;
2. remove restrictions on direct payment for services, paid in full by residents out of pocket.

5. Dual practice

Depending on any reforms related to extending or enhancing the province’s private parallel system of health care, additional reforms permitting what is referred to as “dual practice” would also be recommended. Under dual practice, physicians and other health professionals work in both the private and public sectors. While current regulations and, particularly, the CHA does not prohibit dual practice, Canada’s use of dual practice is quite constrained compared to practice in other countries (table 9).

There are a number of reasons that allowing physicians to practice in both the public and private health care sectors may be desirable. For example, Esmail suggests that allowing dual practice

has the benefit of making more efficient use of highly skilled medical resources. Importantly, under dual practice, any spare time that may be available to physicians because of limitations upon practice under the universal scheme or restricted access to operating theatres can be employed to treat patients in private settings, thus increasing the total volume of services provided. Even in the absence of such “free time”, physicians may be encouraged to take less time as leisure and work additional hours in return for supplementary private compensation. (Esmail, 2013a: 29)

Table 9: Dual practice of physicians

	Outpatient Specialist	Inpatient
Australia	✓ – always	✓ – always
Canada	✗	✗
France	✓ – always	✓ – sometimes
Germany	✓ – always	–
The Netherlands	✓ – always	✓ – always
New Zealand*	✓	✓
Sweden	✓ – sometimes	✓ – sometimes
Switzerland	✓ – always	✓ – always
The United Kingdom	✓ – always	✓ – always

Source: Esmail and Barua, 2018: table 3, p. 10.

Although dual practice is common around the world, many countries with universal health care have taken steps to ensure physicians continue to practice in the public sector. These include imposing restrictions on earnings, requiring physicians who work in the private sector to commit to working a certain number of hours in the public sector, and restrictions on the use of public hospitals for private patients (Esmail, 2013a; Flood and Haugan, 2010). It may, however, be argued that allowing physicians to practice in both settings, instead of having to choose one or the other, may mitigate concern that a private sector might drain resources from the public sector since physicians would not be required to leave the public system in order to practice privately.

As mentioned previously, the Canada Health Act does not explicitly require that provinces disallow dual practice. Provinces are free, according to the explicit requirements under the CHA, [36] to allow physicians to practice in both public and private settings as long as the services they provide in public settings are accessible, comprehensive, universal, portable, and publicly administered, and without cost sharing or extra billing. However, provincial legislation across Canada has resulted in an environment where, except in Newfoundland & Labrador, physicians must opt in or out of the public plan and thus are effectively prevented from working in both the public and private sectors either through direct prohibition, or financial disincentives (Flood and Archibald, 2001). In Alberta, a “status disincentive” is used “to deter physicians from opting out and charging more than what is payable under the public plan” (Flood and Archibald, 2001: 828) as only an opted-out physician can charge fees above the provincial rates. As a result, provincial legislation effectively “requires that physicians operate either completely inside the public system or opt out of public payment completely” (Boychuck, 2008: 12).

[36] Ujjal Dosanjh, a former Federal Minister of Health, has argued that dual practice is not permitted under the CHA’s criterion of Accessibility (Madore, 2006).

6. Revisiting what's covered by the public system

Another area of reform suggested by the Mazankowski report that attracted a great deal of attention at the time was the call to re-evaluate what constituted the core services to be covered by the public system and for non-governmental institutions to be included in the delivery of services. As the Premier's Council noted in its assessment of the problems in the current system: "It operates as an unregulated monopoly where the province acts as insurer, provider and evaluator of health services. There's little choice or competition. The focus is more on hospitals and health providers and less on people who need health services" (Mazankowski, 2001: 4).

The report also recommended reviewing and, indeed, limiting what was included in publicly insured services, which were at the time, and still are highly controversial recommendations. Specifically, the Premier's Council suggested that Alberta should

[l]imit health services that are publicly insured. When the Canada Health Act was introduced, it was never designed to cover the full range of health care services now available. In fact, it only requires public coverage for most physician and hospital services. But all provinces have added to the range of health services that are publicly funded. And many people have come to believe that all health services are or should be publicly insured and universally available at no cost to the individual. (Mazankowski, 2001: 30)

It is notable that provinces may have considerable latitude in this regard. Specifically, while the Canada Health Act pertains to medically necessary services, there is currently no clear definition of "medical necessity" that is consistent across provinces and time. Indeed, Emery and Kneebone conclude that "[t]he federally legislated definitions of medical necessity leave discretion for how provinces define what hospital and physician services are medically necessary or medically required, and what levels of services are medically necessary. Provinces can 'delist' those services provided by physicians that government determines are not 'medically necessary' or are not 'necessary'" (Emery and Kneebone, 2013: 4). [37]

7. Cost sharing

Of all the potential reforms presented in this section, only cost sharing is expressly prohibited by the Canada Health Act (as discussed in section 2). Cost sharing, which comes in a variety of forms and can cover a wide range of services, is a standard feature of most industrialized countries' universal access health care systems. Cost sharing involves having the patient pay some portion of the costs of their health services out

[37] Again, it is important to note that the CHA's lack of clarity means that the federal government of the day may certainly determine that such delisting may contravene one of its five principles.

of pocket. In other words, cost sharing means that patients pay some portion of their health services directly; the current Canadian approach prohibits any cost sharing for health services covered by the public system.

Cost sharing can take the form of a deductible, wherein patients pay out of pocket up to some threshold before insurance takes effect. Cost sharing can also take the form of a co-pay, where patients pay a set percentage of the total cost of a service up to some threshold at which the insurance covers a larger share of the total cost and in most circumstances covers the entirety of the costs. Cost sharing can also involve premiums on insurance.

Most universal access health care systems use some mix of these cost sharing mechanisms across a wide range of services. As a recent analysis of cost sharing in universal access countries noted:

Empirical evidence generally suggests that cost sharing at the point of consumption does lead to a reduced use of health care services at the margin; however, the evidence does not consistently establish that cost sharing results in adverse long-term health outcomes. This latter result might reflect the fact that exemptions and subsidies that are granted for specific services and for low-income and other “vulnerable” patient groups mitigate risks that cost sharing will discourage the consumption of necessary medical treatments and procedures. (Globerman (2016: 1)

Put simply, the inclusion of some form of cost sharing tends to result in a better, more efficient use of existing health resources by helping to prioritize the demands placed on the health care system. However, it is also important to recognize the various mechanisms put in place to shield lower-income people from such costs. [38]

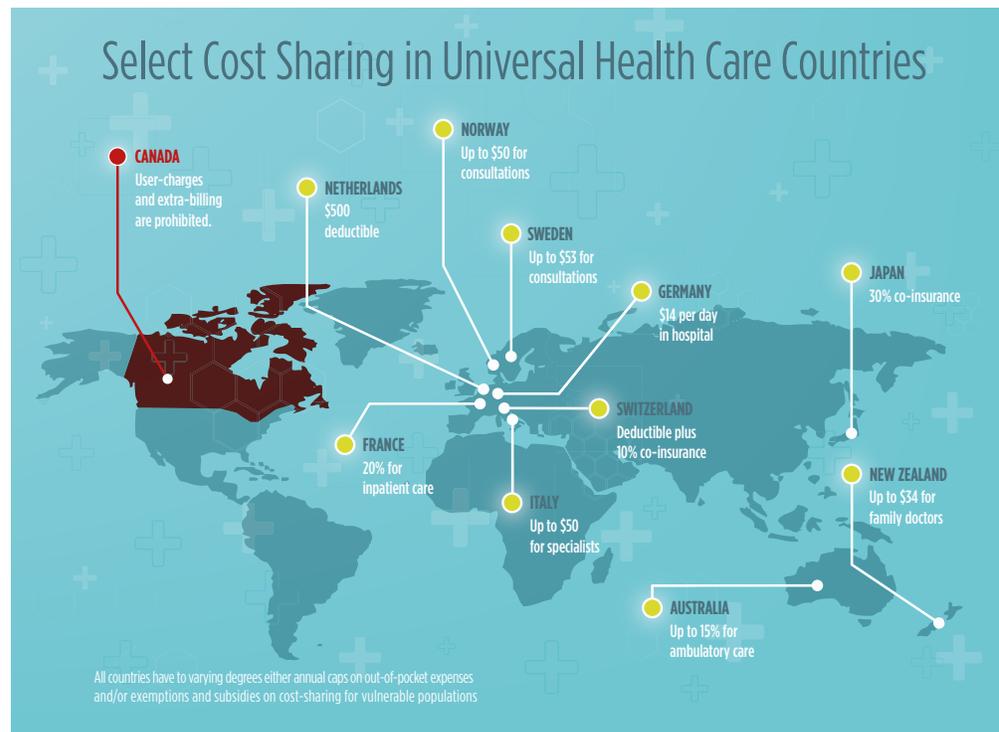
Figure 13 illustrates some of the cost sharing mechanisms used in universal access countries, [39] most of which spend the same or less than Canada on health care (as a share of the economy) but often perform better on access and/or performance. [40] Some of the mechanisms worth noting are Australia’s co-payment for ambulatory services, Germany’s co-payment for hospital and rehabilitation stays, the Netherlands requirement that all residents purchase private health insurance with a deductible plus some cost sharing for certain services such as medical transportation, Sweden’s co-payments for health care and hospital visits and doctor consultations, and Switzerland’s required insurance coverage with a deductible plus co-payments for certain services. As indicated previously, there is a wide range of mechanisms available for cost sharing and they can cover a wide range of services.

[38] The Rand Corporation’s study on cost sharing is one of the central references for the insight about cost sharing, health outcomes, and the importance of exempting lower-income people. Please see Brook *et al.*, 2006 for more information, including the original study.

[39] For a quick reference on different cost sharing schemes for a select group of universal health care countries, see Esmail and Barua, 2018: table 6: Cost Sharing.

[40] For more information on the health care systems in some of the countries included in figure 13, please see Peng and Tiessen, 2015; Esmail, 2013a, 2013b, 2014a, 2014b; Lundback, 2013.

Figure 13: Select Cost Sharing in Universal Health Care Countries



Source: Infographic for Globberman, 2016: <<https://www.fraserinstitute.org/sites/default/files/select-cost-sharing-in-universal-health-care-countries-infographic.jpg>>.

The Mazankowski Report specifically noted the need to include cost sharing in the reform of health care financing in Alberta:

Many have suggested—and the Council agrees—that without fundamental changes in how we pay for health services, the current health system is not sustainable ... If we restrict ourselves to a system where all the funding comes from provincial and federal taxes we have little choice but to ration services—and Albertans deserve better. We can't sustain a system where people are told: these services or treatments are available, they will diagnose health problems, cure illnesses, and make your life better, but they cost too much so you can't have them. (Mazankowski, 2001: 4)

The Council made a number of specific recommendations on potential new sources of funding including “medical savings accounts, increased health care premiums, user fees, co-payments, deductibles, taxable benefits, or supplementary insurance” (Mazankowski, 2001: 30) These reforms would clearly [41] require changes to the

[41] The Castonguay report suggested a tax-based deductible that would not be collected at the point of care, and further that failure of payment would not result in denial of access to care. See Boychuck, 2008 for more information and the context of the recommendations. It is unclear whether such a deductible would provide to the necessary incentives to reduce excess demand for health care services.

Canada Health Act or the province would have to forego portions of its share of the Canada Health Transfer from the federal government.

How the federal government chooses to interpret the contravention of the CHA with respect to cost-sharing also matters. For example, under a strict interpretation, the federal government would simply be required to make non-discretionary dollar-for-dollar reductions to the Canada Health Transfer. This is not necessarily problematic, as the collected fees could simply be used to compensate for the lost revenue, while preserving the incentive structure for the demand of medical services. However, if the federal government determines, in its opinion, that such cost sharing compromises the criterion of reasonable access, it could theoretically withdraw all cash transfers for health care.

4. Key Recommendations for Reform of Alberta's Health Care System

First, it is important to recognize how ambiguous sections of the Canada Health Act, its interpretation by different groups, its political sensitivity, and the discretion afforded the federal government in determining compliance combine to create an environment in which provincial governments considering health care reform are reluctant to take risks. It would be helpful if Alberta and the other provinces were to request that the federal government introduce clarifying language into the Canada Health Act so that it provides greater specificity about what is prohibited and what is allowed, as well as the precise magnitude of financial penalties associated with specific violations of the act (via the withholding of CHT transfers). This would also reduce the discretionary latitude currently afforded the government of the day in Ottawa. At the very least, the additional clarity would allow for a national debate on both the role of the federal government in imposing such restrictions as well as the efficacy of the individual restrictions themselves. [42]

There are also a number of specific reform recommendations that should be considered, each of which is summarily explained below.

1. Expand capacity and incentivize competition via private providers

The recognition that increased capacity is part of the solution in reducing wait times coupled with the widespread use of private providers in other successful universal health care countries leads to the recommendation that Alberta should consider expanding its use of third-party private providers in the delivery of health care. Indeed, the experience of neighbouring Saskatchewan provides a powerful and recent example of the benefits of contracting out public services to private providers. The use of private firms in the delivery of public health care, so long as the firms are not charging additional fees and generally adhering to the principles of the CHA is not, contrary to popular perception, prohibited by the Canada Health Act.

Alberta did make some strides in the direction of using private providers in the early 2000s with the introduction of Bill 11, but several limitations were included in the Bill that should be reviewed. In particular, the ban on the operation of private hospitals and the requirement that all major surgical services, including emergency,

[42] For a discussion of the role of the federal government in health care and a broad discussion of federalism in Canada, please see Eisen, Barua, Clemens, and Lafleur, 2016.

diagnostic, surgical and medical services and medically supervised stays exceeding 12 hours be delivered in a public hospital should be eliminated so as to expand the scope for private delivery in the province.

2. Encourage competition among public and private providers by remunerating hospitals through activity-based funding

Another key area for policy reform that would encourage competition and efficiency is the method by which hospitals are remunerated. Currently Alberta, like most provinces in Canada, primarily funds hospitals using prospective global budgets wherein grants are provided to a hospital irrespective of activity in that particular year, and the hospital's resources are, therefore, not directly and specifically linked to the services provided. While this method of funding can enable governments to control total spending, as noted by Esmail and Barua, "the incentive structure encourages the delivery of few services, quicker discharges, the avoidance of costly patients, and shifting patients to outside institutions as a means of controlling expenditures" (2018: 12).

By contrast, high performing universal health care systems like Australia, France, Germany, the Netherlands, Sweden, Switzerland, and the United Kingdom generally fund hospitals based on some measure of activity. Moving towards activity-based funding has the potential to encourage competition, increase the volume of services provided, improve quality, and reduce wait times. Indeed, "reviews of hospital funding mechanisms have generally found that activity-based funding is markedly superior to budget-based funding in terms of efficiency and output" as well as "a positive benefit to including private providers within an activity-based funding model, particularly if a competitive bidding process is employed to determine compensation rates" (Esmail, 2013a: 26–27). At the very least, beginning experimental reforms with activity-based funding should be pursued.

3. Increase efficiency by creating a centralized surgical registry and pooling referrals

Canada, like many universal health care systems, requires patients to first visit a primary care physician for a referral to a specialist. Another central feature of the Saskatchewan Surgical Initiative (SSI) that can be seen as contributing most to the initiative's success was the creation of a centralized surgical registry. This system established a province-wide standard for assessing and prioritizing patients on waiting lists to help ensure that patients were treated according to the severity of their condition. As part of the registry, the province also introduced a "pooled referral" system whereby doctors agreed to have referrals to specialists pooled, rather than referring patients to a particular specialist. This allowed patients to search for and choose the specialist they desired, after reviewing the wait times to see the specialist.

Alberta, like many other provinces in Canada, has been closely studying both centralized surgical registries and pooled referrals, and has already made some strides in this direction with programs like the Closed Loop Referral Management Program, the Medical Access to Service program, and the Alberta Netcare eReferral tool.

4. Remove provincial restrictions on private parallel financing and delivery of medically necessary services

One area of existing activity that could be extended is the province’s private parallel system of health care in which Albertans pay entirely out of pocket, or obtain private insurance for the full cost of services. Such a system—often referred to as “two-tier” health care by Canadians—is actually the norm in other developed countries with universal health care. For example, a private health care system that is complementary or parallel to the public health care system is found in Australia, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Sweden, Switzerland, and the United Kingdom.

While the preceding discussion clearly presents a case (and path forward) for the provision of publicly funded services delivered by third-party private providers within the confines of the Canada Health Act, the feasibility of a fully private parallel sector, where private finances—either private insurance or direct payment—are used to acquire the same medically necessary care from private providers as are funded and provided by the public, is more complex. Each of three aspects of this reform, namely (a) private insurance, (b) direct billing, and (c) private provision are analyzed in more detail below.

a. Private Insurance for medically necessary services

While many high performing universal health care countries allow private insurers to cover basic health care, including when these are delivered by providers whose services are eligible for funding by basic primary health coverage (to varying extents), Canada’s current private health care insurance sector is purely focused on the financing of supplementary services. While the CHA disallows

private insurance for medically necessary services that share the cost of medically necessary services (as opposed to add-on uninsured or non-medically necessary services like private accommodation or superior implants) with the public insurance scheme ... [it] does not explicitly disallow parallel or separate private insurance for medically necessary physician and hospital services, or direct full payment for those services. (Esmail and Barua, 2018: 20–21)

Despite this possibility of allowing privately funded voluntary insurance for, or direct private purchase of, medically necessary physician and hospital services, most provinces—including Alberta via section 26 of the Alberta Health Care Insurance Act—explicitly

prohibit private insurers from funding publicly insured services. Further, while the Health Insurance Premiums Act allows individuals to opt out of the province’s health insurance plan, it prohibits them from obtaining third-party insurance.

b. Direct payment / billing for medically necessary services

While the CHA’s restrictions on partial direct payments in the form of user fees and extra-billing clearly require provinces to ensure medically necessary or required services provided through the public scheme are fully funded (100% or first-dollar coverage), without any allowance for providers or facilities to request privately funded payments above what will be paid under the public scheme for medically necessary services, the CHA does not explicitly [43] prohibit direct private purchase (in full) of medically necessary physician and hospital services from private providers.

Alberta is also one of the few provinces that does not prohibit participating (or “opted-in” physicians) from billing patients directly for medical services, so long as the rates are no higher than the public fee schedule. Further, like almost every other Canadian province (with the exception of Ontario), physicians are able to “opt out” of the public insurance plan. There are also no limitations on the rates that opted-out physicians may charge. Although the provincial prohibition on the purchase of third-party insurance mentioned previously poses a significant challenge, patients willing to pay directly for the full cost of their medical care out of pocket should be able to do so in Alberta from opted-out physicians.

c. Private delivery of medical services

Interestingly, while Bill 11 provided increased latitude for the contracting of private surgical facilities, it also contained a number of restrictions that hampered the introduction of a private parallel health care system. As mentioned earlier, it stated that “[n]o person shall operate a private hospital in Alberta” and prevented physicians from providing major medical services outside of public hospitals (Alberta, 2000–2016: RSA 2000 c. H-3.3, s. 1; c. H-1, s. 2; c. H-7, s. 146; 2008 c. 34, s. 18). While the distinction between a private hospital and approved surgical facility was unclear, Bill 11 clearly restricted the private sector to providing only a small range of services. Further, it stated that “private surgical facilities are not allowed to bill patients directly for medically necessary services or to engage in activities that result in ‘queue jumping’”. Direct billing is allowed, however, for enhanced non-medical services” (Ruseski, 2009: 9).

In addition to the reforms proposed earlier for the private delivery of services, Alberta’s government could pursue the following reforms to encourage the development of a private parallel health care sector that are within the confines of the CHA:

1. amend the Alberta Health Care Insurance Act and the Health Insurance Premium Act to allow the purchase of third-party private insurance for medically necessary services;
2. remove restrictions on direct payment for services in full, by residents out of pocket.

[43] Again, various interpretations of the CHA’s five criteria might do so (Esmail and Barua, 2018).

5. Allow dual practice for physicians

Depending on any reforms designed to extend or enhance the province’s private parallel system of health care, additional reforms to permit what is referred to as “dual practice”—physicians and other health professionals working in both the private and public sectors—would also be recommended. While current regulations and particularly the CHA does not prohibit dual practice, Canada’s use of dual practice is quite constrained compared to the practice of other countries. In Alberta, a status-disincentive is used “to deter physicians from opting out and charging more than what is payable under the public plan” (Flood and Archibald, 2001: 828) and only an opted-out physician can charge fees above the provincial rates. As a result, provincial legislation effectively “requires that physicians operate either completely inside the public system or opt-out of public payment completely” (Boychuck, 2008: 12).

6. Revisit what’s covered by the public system

Another area of reform suggested by the Mazakowski report that attracted a great deal of attention at the time was the call to re-evaluate what constituted the core services to be covered by the public system and for non-governmental institutions to be included in the delivery of services. The Premier’s Council specifically recommended limiting the health services that are publicly insured.

It is notable that provinces may have considerable latitude in this regard. Specifically, while the Canada Health Act pertains to medically necessary services, there is currently no clear definition of “medical necessity” that is consistent across provinces and time. Indeed, Emery and Kneebone conclude that “[t]he federally legislated definitions of medical necessity leave discretion for how provinces define what hospital and physician services are medically necessary or medically required, and what levels of services are medically necessary. Provinces can ‘delist’ those services provided by physicians that government determines are not ‘medically necessary’ or are not ‘necessary’” (Emery and Kneebone, 2013: 4).

7. Require individuals to share in the costs of treatment (with means-tested protections for vulnerable groups)

Of all the potential reforms, only cost sharing is expressly prohibited by the Canada Health Act. Cost sharing, which comes in a variety of forms and can cover a wide range of services, is a standard feature of most industrialized countries’ universal access health care systems. Cost sharing involves having the patient pay some portion of the costs of their health services out of pocket (that is, directly). The current Canadian approach, however, prohibits any cost sharing for health services covered by the public system.

Cost sharing can take the form of a deductible, wherein patients pay out of pocket up to some threshold before insurance takes effect. Cost sharing can also take the form of a co-pay, where patients pay a set percentage of the total cost of a service up to some threshold at which the insurance covers a larger share of the total cost and in most circumstances covers the entirety of the costs. Cost sharing can also involve premiums on insurance. Most universal access health care systems use some mix of these cost sharing mechanisms across a wide range of services.

Put simply, the inclusion of some form of cost sharing tends to result in a better, more efficient use of existing health resources by helping to prioritize the demands placed on the health care system. However, it is also important to recognize the various mechanisms put into place to shield lower-income people from such costs (for example, annual income-based caps on out-of-pocket spending, and exemptions for vulnerable populations).

The Mazankowski Report specifically noted the need to include cost sharing in the reform of health care financing in Alberta:

Many have suggested—and the Council agrees—that without fundamental changes in how we pay for health services, the current health system is not sustainable ... If we restrict ourselves to a system where all the funding comes from provincial and federal taxes we have little choice but to ration services—and Albertans deserve better. We can't sustain a system where people are told: these services or treatments are available, they will diagnose health problems, cure illnesses, and make your life better, but they cost too much so you can't have them. (Mazankowski, 2001: 4)

The Council made a number of specific recommendations on potential new sources of funding including “medical savings accounts, increased health care premiums, user fees, co-payments, deductibles, taxable benefits, or supplementary insurance” (Mazankowski, 2001: 30) These reforms would clearly require changes to the Canada Health Act or the province would have to forego portions of its share of the Canada Health Transfer from the federal government.

How the federal government chooses to interpret the contravention of the CHA with respect to cost-sharing also matters. For example, under a strict interpretation, the federal government would simply be required to make non-discretionary dollar-for-dollar reductions to the Canada Health Transfer. This is not necessarily problematic, as the collected fees could simply be used to compensate for the lost revenue, while preserving the incentive structure for the demand of medical services. However, if the federal government determines, in its opinion, that such cost sharing compromises the criterion of reasonable access, it could theoretically withdraw all cash transfers for health care.

Canada, and Alberta in particular, are comparatively high spenders on health care but at best modest performers within the group of countries and sub-national jurisdictions that maintain universal access to health care. As the province struggles with the need for broad fiscal reforms and lengthy wait times, there is a critical need to review health care spending as well as the broader structure of health care delivery and regulation. This paper has offered a broad range of possible reforms to Alberta's health care system aimed primarily at achieving improved performance given current resources based on the experiences of other successful universal health care countries.

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