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The Mazankowski Report *at 20*

Reviving Canada's best ever plan for medicare reform

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Foreword

By Brian Lee Crowley

Former Deputy Prime Minister Don Mazankowski's death last year on October 28 reminded me of the extraordinary contribution he made to public life over a career that spanned a number of decades. A tribute seemed in order, but what?

It was natural for me to focus on his leadership role in reimagining the Canadian health care system, a job he took on for then-Alberta premier the late Ralph Klein.

Klein was determined to reform medicare, not least because he saw its voracious appetite for tax dollars as perhaps the biggest threat to his legacy of low taxes and eliminating the net debt of the province.

The premier had already made one stab at reform in 2000 with Bill 11. Not having sufficiently prepared the public for the proposals he tabled, opposition quickly arose, forcing the premier to backtrack rather ignominiously. He and his advisors, still convinced of the need for reform, went back to the drawing board.

They concluded, I think, that they had made a fundamental strategic error in assuming the public understood and agreed that medicare was unsustainable. The issue then was not so much the content of any particular reforms, but rather how to get a real hearing for serious change.

Politicians' credibility was low, even that of "King Ralph," popular as he was. His ham-fisted first attempt at changing medicare had earned him suspicion and distrust in many quarters. So who would have the credibility to lead the reform effort?

In a stroke of political genius, Klein settled on Don Mazankowski. A long-time MP from Vegreville, a very successful and highly competent senior cabinet minister under Brian Mulroney and a sympathetic public personage, now retired from political life, Maz (as he was universally known) had just the kind

of trusted senior statesman persona Klein needed to ensure any eventual reform plans got a respectful hearing.

Maz was not enough, however. Premier Klein also needed to assemble a group of leading thinkers, professionals and community figures from different political backgrounds and regions. The group needed to be solid and credible enough that if they could be brought to agree on a package of changes to medicare, the public would be inclined follow their lead.

Thus was born the Alberta Premier's Advisory Council on Health (invariably referred to by its members as the Mazankowski Committee, a usage followed here). It included doctors and nurses, Liberals and Tories, rural and urban residents, thinkers and practitioners and even three non-Albertans, of whom I was honoured to be one.

We met regularly for over a year under Don's chairmanship. Affable and genial as he was, those adjectives do not begin to convey the skillful way he had of driving our internal debates to a conclusion that would rally support from the various ideas and interests represented on the Committee. He started every meeting by reminding us that the premier had brought us together in the hope that we would rise to the challenge of thinking boldly and innovatively about how to make medicare work better for Albertans and be sustainable for years to come. As one of our collaborators on the final report said to me, Maz may have been a conservative politician, but ideology was never a driving force for him. He was a good thinker and someone who understood that the best politicians are ones who put forward policies that actually are for the public good, even if the public may wish it were otherwise.

Every member of the Committee contributed significantly to the report. Many of the ideas that still resonate in the Mazankowski report, however, are ones that I like to think I helped to introduce and promote within the group, ideas such as: a clear division between the purchaser of health care services (mostly the regional health authorities) and the providers of those services; those providers could come from the public or private sector and would earn their money by competing on the basis of efficiency and effectiveness; and ways needed to be found to make people more aware of and accountable for the public health care spending they triggered. As a result, Maz called me the report's "intellectual architect" which, given the stature and the brains of the other members of the committee, I regarded as high praise indeed.

Every one of us put some water in our wine to get a report we could all sign on to, but we did so and there was a great deal of pride and enthusiasm in the committee for our handiwork when we were done. And whatever any of the individual members contributed, the greatest credit for our willingness to give Premier Klein the bold ideas he sought belongs to our leader, Don Mazankowski.

Twenty years on, many people seem to believe that the Mazankowski report was not acted on because the public support was not there. All I can say is that that is not at all how it appeared to us at the time. On the contrary. Soon after the report's release, we were told that it received the enthusiastic and unanimous endorsement of the Klein government's caucus in the legislature and, more importantly, was viewed favourably by something like 80 percent of public opinion.

I personally lay the responsibility for the report's failure to drive reform at the feet of a timid political class that thought it wanted bold ideas but then quailed at the prospect of actually having to defend them. The premier's office handed over the "selling" of the report to someone who had no involvement in its preparation and who few if any of the Committee's members had ever heard of. This was a job that should have gone to Maz.

Then we were briefed on how the government's spokesman intended to describe the report and its recommendations. We were shocked to discover that none of us recognised in that briefing the report we had laboured so diligently to conceive and then deliver. Given such uninspiring leadership, none of us were surprised, but we all were disappointed, when our report sank from sight.

Twenty years' worth of subsequent events have shown our recommendations to have been prescient, as this collection of essays shows. Those same events have equally shown the emptiness of the findings of the Romanow report (written contemporaneously to the Mazankowski report), whose recommendations I always thought could be summarised as "nothing wrong with medicare that more spending won't fix," despite the fact that few other industrialised countries in the world spend as much on health care as Canada and yet they generally get better results (Commonwealth Fund 2021). I personally am convinced that there are no reforms to medicare that can succeed without relying heavily on Maz's Committee's thinking, although obviously specific details can be different.

When that reform finally happens, as surely it must, Don Mazankowski's courageous leadership and abiding concern for the well-being of his fellow Canadians in the health care field will finally get the recognition they deserve. Canada could use a lot more Don Mazankowskis.

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Ottawa, January 2022

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Mazankowski: The man who had the prescription for medicare 20 years ago

Janice MacKinnon

Introduction

The 20th anniversary of the Mazankowski report, *A Framework for Reform: Report of the Premier's Advisory Council on Health* (2001), is an appropriate time to assess the report's significant role in health care reform. Many of the report's ideas and recommendations were reflected in subsequent reports, health policies, and court judgments, but unfortunately some of the challenges highlighted 20 years ago remain unresolved today. As the country faces enormous pressure on health services caused by the COVID pandemic, it is particularly important today to reflect on Mazankowski's ideas for reform.

The Alberta government commissioned the report at a pivotal time in the 21st century history of Canadian health care. Its mandate, "To provide strategic advice to the Premier on the preservation and future enhancement of quality health services for Albertans and on the continuing sustainability of the publicly funded health system" (2001, 11), reflected growing public concern about the quality of health care that patients were receiving, especially the long wait times for treatment, and the equally important concern of governments about the long-term fiscal sustainability of the medicare system that had been created in the 1960s.

The report was also timely in that it coincided with other federal and provincial reports. Federally, the government commissioned the Romanow report, *Building on Values: The Future of Health Care in Canada* (2002), and the

Senate released the Kirby report, *The Health of Canadians – The Federal Role* (2002). There were also provincial reports, such as Saskatchewan's Fyke report, *Caring for Medicare: Sustaining a Quality System* (2001) and Quebec's Clair Commission report, *Emerging Solutions: Report and Recommendations* (2001).

Interestingly, there were areas of common agreement among the various reports; for example, the general support for prevention, primary health care reform, changing the fee-for-service physician payment model, and improving information and accountability. However, there were major disagreements among the reports about critical issues like the sustainability of the health care system and the scope and nature of change required. Thus, this assessment will first consider the areas of common agreement with an analysis of the results achieved, then consider the more significant areas of difference.

Prevention, primary health care reform, and the role and compensation of physicians

The Mazankowski report, like other federal and provincial reports, argued that prevention was key to improving the health of Albertans and containing health care costs. It stated: "The best long-term strategy for sustaining the health system is to encourage people to stay healthy." The report added: "If we rely on simply treating people when they get sick, the increasing costs of new treatments and technology could bankrupt the system" (2001, 5). The analysis was based on population health: the report argued that the main determinants of health are education, income, employment, and environment. Hence improving people's health required a holistic approach that involved strategies like reducing poverty or curbing tobacco use (2001, 14).

As well as supporting prevention, all the reports endorsed some form of primary health care reform. The Mazankowski report described the benefits for patient care of a primary health care model that involved "multidisciplinary teams of health providers working together – doctors and nurses, nurse practitioners, dieticians, social workers" (2001, 33). However, the report also cited some major obstacles to moving to a primary health care model; for instance, many of the services that are part of a primary health care model are not funded by medicare and moving to such a model would require reforming the way physicians are compensated and their role in the health care system.

Structural problems with medicare

In the 20 years since the reports were released, there has been progress on investing more in prevention, moving to a primary health care model, and reforming the compensation and role of physicians, but the progress has been slow, primarily because of the way medicare was originally structured. In the 1960s when medicare was created, the health care system focused on treatment – doctors and hospitals – not on prevention. Thus, doctor and hospital

services were fully covered by medicare but other services that are critical for primary health care were not. Doctors were paid on a fee-for-service basis and were the gatekeepers for patient access to the health care system, making it difficult to move to a primary health care model in which a variety of health care professionals work as a team.

Also, medicare services are funded from general revenue without any direct contribution by patients, meaning there is no restraint on demand. By fully covering doctor and hospital services, the government was funding the most expensive parts of the health care system. With no restraint on demand and the most expensive services being covered, the cost of medicare escalated well beyond projected costs, leaving limited funds available for preventative programs. Moreover, as the rate of increase in health care spending outpaced the rate of revenue growth, funding for health care crowded out funding for other areas such as social programs, which are fundamental to improving the overall health of the population.

Sustainability of the health care system

Though there was agreement on some issues, on others there were stark differences, notably the sustainability of the health care system, the seriousness of wait times, and the nature and extent of change required. On sustainability, the Romanow report stated that the health care system was as sustainable as Canadians wanted it to be and cited the fact that relative to Gross Domestic Product (GDP), Canada spent much less on health care than did the United States (2002, xxiii and 27). But comparing Canada's health care system to the American one is like a student comparing him or herself to the worst kid in the class.

The Mazankowski report made it clear that "Without changes, spending on health care is not sustainable" (2001, 27) and it provided a better way to measure sustainability. Unlike other reports that considered health care spending relative to GDP, the Mazankowski report focused on the share of provincial program spending that was spent on health care. The report stated that in 1990/1991, Alberta spent 24 percent of its budget on health care and 76 percent on all other government programs. But in 2000/2001 about one-third of the province's spending went on health care, leaving 65 percent for other government programs.

This analysis correctly diagnosed the sustainability problem: because health care spending was increasing at a faster rate than growth in the economy, it was cannibalizing other program spending. With health care taking up an ever-growing percentage of provincial program spending, it was crowding out spending on other important areas like education, infrastructure, social services, and security (2001, 28). And, of course, education and social programs were critical to improving overall population health. Thus, a major achievement of the Mazankowski report was to provide a comprehensive analysis of the reasons why the health care system was not sustainable.

Health care coverage

While many of the ideas in the Mazankowski report influenced subsequent policies, some of its recommendations did not produce significant changes. The most notable is the report's recommendations on health care coverage which are central to addressing the unsustainability of medicare. It argued that there should be a review of "what can and should be covered by Medicare" because, "the system was never designed to cover all aspects of health services, but people have come to expect that it will – and at no cost to individuals" (2001, 5). The idea never gained traction and in fact, rather than discussing ways to curtail coverage, the discussion in Canada has been more about adding programs such as home care, long-term care, or pharmacare to the list of covered services.

Funding the health care system

Another significant point of departure between the Romanow and Mazankowski reports centred on the funding of health care. The Romanow Commission's main recommendation on funding was that the federal government increase its contribution to health care to finance reforms and enhanced services. The Mazankowski report related funding to the sustainability challenge. Health care funding was already taking up a disproportionate share of provincial spending, and with an aging population and new treatments and drugs becoming available, the problem would only worsen. Finding efficiencies and streamlining services were necessary but would not be "sufficient to offset increasing demands and rising costs." The report continued, "If we depend only on provincial and federal general revenues to support health care, we have few options other than rationing" (2001, 7). Hence, the report was adamant that new sources of revenue needed to be found and it established some basic principles for revenue options (2001, 4-7). Finding new sources of revenue for health care would limit the crowding out of funding for other programs that were essential to overall population health and would provide a direct link between patients using the system and its costs. As economist Jack Mintz finds in his contribution to this series, reform of health care funding is still required 20 years after the Mazankowski report.

Wait times for health care

Without new sources of revenue, rationing of services would be necessary, which in turn meant long wait times for care. The Mazankowski report saw wait times for care as a serious problem. The report stated: "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." It continued: "Waiting times are too long for many procedures and this causes Albertans to worry about whether the health system will be there when they need it" (2001, 4). The report also made specific recommendations to tackle wait times: pa-

tients should be given a 90-day guarantee of access to services and wait times should be reduced by introducing centralized booking, posting wait times on a website, and allowing people to access services from any physician or hospital (2001, 6).

Thus, while the Romanow Commission argued that the health care system was sustainable and essentially working well, the Mazankowski report provided a convincing diagnosis of its two main problems: fiscal sustainability and long wait times for care.

Reducing wait times for care

The Mazankowski report had some influence in the area of wait times. Its recommendations for reducing wait times by introducing centralized booking, posting wait times on a website, and allowing people to access services from any physician or hospital formed the core of the 2010 Saskatchewan Surgical Initiative's report, *Sooner, Safer Smarter: A Plan to Transform the Surgical Patient Experience*, which led to a dramatic decline in wait times for elective surgeries.

Ideology, competition and the private sector in health care

Having diagnosed the health care system's two major problems, the Mazankowski report recommended solutions. One necessary change was in ideology. The report stated that Canadians should move beyond the common practice to "just rehash the rhetoric of old arguments." Instead, it argued that all ideas needed to be up for consideration (2001, 30).

In contrast to the Romanow report, the Mazankowski report stated boldly that "More spending is not the answer." It cited studies and international comparisons showing that "above a certain amount of basic funding, there is no direct relationship between spending on health care services and the overall health of the population" (2001, 30). Instead, making the health care system sustainable and addressing long wait times for care required major structural changes.

The most important structural change that the Mazankowski report recommended was to introduce more competition and private service delivery into the health care system. These ideas were fundamentally at odds with the Romanow report, which argued that the single-payer Canadian health care system was less costly than the American private system. The problem with this reasoning is none of the Canadian reports in fact favoured getting rid of the single-payer health care system. Instead, they were supporting private delivery of services; the *Canada Health Act* requires public administration of health care, but not public delivery of services. The Romanow report distinguished between the private delivery of ancillary services, such as laundry services, which it supported, and private delivery of health care services, which

it rejected on the grounds that quality could not be assured and that private companies would cream off the least complicated procedures, leaving the public system burdened with the more complicated and costly ones (2002, 7).

The Mazankowski report made a strong case for introducing more competition and private services in delivering health care. The Canadian health care system was described as an "unregulated monopoly where the province acts as insurer, provider and evaluator of health services" (2001, 4). Rather than the existing highly regulated system, the report declared "It's time to open up the system, take the shackles off, allow health authorities to try new ideas, encourage competition and choice." The province, according to the report, should establish multi-year contracts with health authorities "setting out performance targets… and budgets," and the health districts should contract with public, private, and non-profit service providers with the goal of getting the highest quality services at the best price (2001, 5).

Another of the Mazankowski report's major recommendation was that the health care system needed to become patient focused. It argued, "the focus is more on hospitals and health providers and less on people [who] have little choice but to go where the public health system points us and wait in line if we need to" (2001, 4).

Patients first

The Mazankowski report's ideas were reflected in subsequent reports on health care. The 2009 report on Saskatchewan health care, For Patients' Sake: Patient First Review Commissioner's Report to the Saskatchewan Minister of Health, took up the Mazankowski report's theme of making the health care system more patient focused. The report stated that the interests of stakeholders – doctors and other health care professionals, unions, management, and government departments – dominated the health care system at the expense of patients. Hence, the report called for a fundamental cultural change that would focus the system on patients. The report argued that patients should play a greater role in managing their own health care and have more of a voice in managing the system. It also stated that focusing on patients would help break down the silos in the health care system and result in more integrated, coordinated care.

The *Chaoulli* case

The diagnosis of the problems in the health care system and the recommended solutions in the Mazankowski report influenced court decisions, subsequent health care reports, and government policies.

The similarities between the Mazankowski report and the 2005 Supreme Court decision in the *Chaoulli* case are striking (*Chaoulli* v. Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35). The case involved a challenge to the power of the Quebec government to enforce its monopoly pro-

vision of medicare services by preventing citizens from buying private health insurance for services covered by medicare, while failing to deliver services in a timely way. The majority decision was that "prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with the life and security of the person as protected by s. 7 of the Charter" (*Chaoulli* v. Quebec 2005, par. 124).

Especially interesting were the comments the Justices made about the Canadian health care system. Their consensus was that wait times for treatment were serious and resulted in compromised quality of life and in some cases death. The long wait times were also linked directly to the structure of the health care system and to ideology. One Justice commented that waiting lists were "intentional" in that they resulted from government policy decisions and they represented a "form of rationing." The Chief Justice challenged the idea that the Canadian monopoly for medicare services resulted in a superior system. She wrote, "Many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada" (*Chaoulli* v. Quebec 2005, par. 39, par 142, par 1423, par. 140). The decision also cited the role of ideology. One Justice stated that evidence of the negative effects of wait times had been available for some time but that governments had failed to address the problem; the debates had focused on "a socio-political philosophy" so that governments had "lost sight of the urgency of taking concrete action" (par. 96).

Conclusion

The Mazankowski report had a significant influence on health care reform in Canada. It provided a succinct and insightful analysis of two of the main problems with the Canadian health system: its sustainability and long wait times for care. As well as providing an astute diagnosis of the problems in Canadian health care, the report made a compelling case for structural change. It argued persuasively that more competition and private delivery of health care services would lead to more choice and innovation. Moreover, the report's diagnosis of the problems and recommended solutions had an influence on future court decisions, health care reports, and government policies. In the *Chaoulli* decision, for instance, some of the analyses by the Supreme Court Justices of the structural problems in Canadian health care mirrored ideas in the Mazankowski report. Subsequent reports echoed the idea that patients – not stakeholders – should be the focus of the health care system. The changes recommended in the Mazankowski report to reduce wait times were reflected in subsequent provincial strategies to reduce wait times.

In short, the report was insightful when it was released, and its impact was felt well beyond the first decade of the 21st century.

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How Canadians' deep affection for the status quo blocks health care reform efforts like the Mazankowski report

Jeffrey Simpson

In 2000, the World Health Organization (WHO) dropped a bombshell, figuratively speaking, on the Canadian health care system. By then medicare had already become a Canadian icon, a symbol of policy virtue, a publicly funded system for hospitals and doctors that had begun in Saskatchewan and became national in scope in the late 1960s.

When the WHO assembled data to compare "overall health system performance" in 191 countries, it shocked Canadians that their system ranked a miserable 30th (WHO 2000). Reaction was swift and predictable. Critics of the Canadian system seized upon the WHO report to justify their criticisms; defenders tore into the report's methodology.

Despite methodological controversies, the WHO report provided an indication that all was not entirely well with Canada's cherished medicare system. Part of the issue was funding, which remains a key flashpoint for debates about medicare reform. The Canadian economy was performing strongly when medicare became law in the late 1960s. Creators of the system assumed, as politicians often do in good times, that buoyant revenues would continue to pay *sine die* for this new health program. The 1970s, however, delivered

the Arab-Israel conflict, a resulting oil embargo, and years of stagflation along with slow growth, double-digit inflation, soaring interest rates, high unemployment, and government deficits.

Still, medicare proved fairly impervious to significant reforms. By the time the WHO rankings came out in 2000, there was at least some appetite among officials for ideas to fix the problems. Reports piled up.

The first came in Alberta (*A Framework for Reform*) from an impressive group of experts from within and beyond Alberta under the leadership of former federal deputy prime minister Don Mazankowski (Premier's Advisory Council on Health for Alberta 2001). Others soon followed: the Romanow report commissioned by the federal government from Roy Romanow, a former Saskatchewan NDP premier (Commission on the Future of Health Care in Canada 2002); a multi-volume study under Senator Michael Kirby (Standing Senate Committee on Social Affairs, Science and Technology 2002); an examination of the Quebec system by Claude Castonguay, the health minister who had created the Quebec system (Task Force on the Funding of the Health System 2008); and another review of the national system by Kenneth Fyke, a former deputy minister in Saskatchewan and British Columbia (Commission on Medicare 2001). There were also smaller studies by interest groups, collections of essays by academics, and books.

> *The Canadian economy was performing strongly when medicare became law in the late 1960s.*

Many focused on how medicare should be paid for. Controversies over money between Ottawa and the provinces, and between provincial governments and providers (mostly doctors) had arisen soon after medicare's inception – controversies that continue to this day. Under fiscal pressure, Ottawa cut provincial health care transfers. Provinces in turn restricted their spending, including for health care, cuts that caused doctors to complain about the impact on their remuneration and assert that they intended to bill "extra" for procedures. The practice of "extra billing" threatened to introduce additional private payments into health care.

Thus was created the first confrontation between public-only payment – a principle at the philosophical and practical core of medicare – and the idea of introducing supplementary private financing.

The commissions that followed the 2000 WHO report grappled with that public-private debate. The Mazankowski report (and Claude Castonguay's in Que-

bec) went furthest in leaning towards more private payments. At the opposite end of the public-private spectrum stood the Romanow report that rejected all forms of private payment and argued for more public money to prop up and improve the existing system.

The Mazankowski approach slammed into political walls everywhere. Even Premier Ralph Klein, who had established the Mazankowski Advisory Council on Health, recoiled from the report's most controversial recommendations. Medicare, even in Alberta, was too firmly entrenched in the psyche of Canadians as a symbol of their citizenship. Canadians saw medicare as an example of equality and fairness. Its growing costs and evident weaknesses – the lack of consistently timely care and uneven access except for emergencies and life-threatening problems – could not shake medicare's grip. International comparisons long after the 2000 WHO report consistently showed Canadian medicare to be a poor-to-average system when compared to largely public health care systems in advanced industrial countries. Those comparisons never resonated with Canadians who, if they knew anything about another system, had heard only about the US health care system and wanted nothing like it.

It mattered not to Canadians and their governments that after examining the international evidence, the Canadian Medical Association in 2010 (which at the time was led by Dr. Jeffrey Turnbull, a staunch supporter of public health care) concluded that "a case can certainly be made that Canada's health care system is not delivering value for money spent: Canada is one of the highest spenders of health care when compared to other industrialized countries that offer universal care … [but] Canada's health care system is under-performing on several key measures, such as timely access" (CMA 2010, 2-3). The Canadian Nurses Association, another strong defender of medicare, concluded in the same year that "Canadians are not satisfied with the capacity of the health system to provide them with timely access to care… The inability of Canadians to access appropriate and timely care is evidence of fundamental shortfalls in the health system" (Canadian Nurses Association 2011, 2).

The Mazankowski report, looking only at Alberta's system, had reached similar conclusions nearly a decade before, although the report did acknowledge that "there is much to be proud of in Alberta's health system," adding "people who receive care rate it highly" (Premier's Advisory Council on Health for Alberta 2001, 4). Nonetheless, the report recommended a substantial overhaul of the system, especially considering new methods of financing medicare. Twenty years after the report's publication, a balanced summary of its impact would be that some of the secondary recommendations (of the kind made in almost all the other reports on health care) have been accepted but few of the more controversial ones have been implemented. Put another way, the easy suggestions found favour; the difficult, radical ones did not.

Of the secondary recommendations, electronic health records are now more common, although not of the kind recommended in the report. Alberta

launched a Healthy U campaign and a Tobacco Reduction Strategy to encourage healthier lifestyles (smoking rates have fallen sharply for many reasons across Canada except in Nunavut). The province shrunk the number of regional health authorities from 17 to nine and then to five (every province has re-arranged its regional health authorities in the last 10 to 15 years). The Alberta government promised that health policies would be based on a "patient-first" philosophy (the Mazankowski report called it "customers first"), a phrase every province adopted to the point of cliché. It urged primary-care physicians to group themselves into clinics with nurses, nurse practitioners, dieticians and other health care providers along with a changed model for physician remuneration based less on fee-for-service and more on blended models of pay. This idea, recommended in other reports, did take root although it remains far from a universal way for family doctors to practice and be paid.

> *"The majority of doctors are private entrepreneurs paid on a fee-for-service basis by the public system.*

The Mazankowski report – and here it did plough new ground – encouraged private clinics to provide care under contracts with the provincial government. One example was the Calgary Eye Centre and other similar institutions, owned and operated by ophthalmologists who provide services under contract with the local health authority. These institutions flowed from the Mazakowski report's argument that if health care services are publicly funded and standards are in place, it should make no difference if the facilities that deliver the services are public, private, or non-for-profit. That approach did percolate outside the province, where such arrangements became somewhat more common, but still far from the norm. Today, the idea of private delivery for publicly financed services remains controversial for those who believe in all-circumstances-all-the-time public institutions – the irony being, of course, that the majority of doctors are private entrepreneurs paid on a fee-for-service basis by the public system.

Of the primary and most controversial recommendations, almost none were implemented, starting with the report's suggestions for injecting more private money into basic health care provided by doctors and in hospitals. The report argued against a completely parallel private health care system. It rejected user fees for health services, which are common in some G20 countries, observing "while user fees may reduce demand, they are also a much greater barrier to care for people with low incomes" (Premier's Advisory Council on Health for Alberta 2001, 55). It also rejected making health care services "taxable benefits." It spurned a dedicated health care tax.

The report did urge serious consideration of personal medical savings accounts. But it seemed to favour above all other options the creation of variable premiums as a co-payment for using health care services and a personal health care account in which all except low-income people would "pay a co-payment for a fixed portion of the health care services they use" (2001, 58).

Strangely, having placed these options in the policy window and described them in broad terms, the report did not provide models or offer details about how these significant changes might work. In any event, neither of these ideas ever received serious consideration by Alberta governments, or by governments elsewhere in Canada. The argument for private payment, as opposed to private provision for publicly financed health care, could not overcome in Alberta or anywhere else citizens' deep attachment to the health care status quo or, to put matters differently, fear of change.

The report's arguments for opening the system to forms of private payments rested on philosophical (or ideological) and financial foundations. The report's philosophy was anti-statist, as in this early statement: "There are serious flaws in the way the system is organized. It operates as an unregulated monopoly where the province acts as insurer, provider and evaluator of heath services. There is little choice or competition" (2001, 4). Later, the report contrasted what it called the "command-and-control" health care system with the education system, where "parents can choose which school they want their children to attend" and where "post-secondary institutions compete for students, introduce new programs to attract more students, and publish their results" (2001, 21).

Shopping for better products or services certainly applies in market economics, and it exists in certain European public health systems. Countries such as Germany and the Netherlands use a modern-day model of Bismarkian social policy in which competing health funds offer varieties of choice within a publicly financed framework. Canada, however, never bought into this kind of system, creating instead a variety of the British National Health System (NHS) with a centralized registry of services, doctors working for the NHS, hospitals run by the NHS, and patients provided with heath care cards for NHS billing. Nor for Canada the recent Swedish model where doctors and hospitals can establish their own clinics to compete with public ones, with public money following the patient to wherever she or he feels the best treatment can be found.

The Mazankowski report pilloried the province's NHS-inspired philosophy, complaining that "there's no competition and no incentive to provide the most efficient and effective services available… The system is organized around facilities and providers, not individual Albertans" (2001, 21). If "customers" are not satisfied, "They cannot take their business elsewhere so there is no incentive to keep improving service unless it is to save money" (2001, 21).

The patient-as-customer model has its attractions, and limitations. As in the Bismarkian-inspired systems and the Swedish reforms, competing plans or clinics can improve service as people move from one provider to another. But health care is not like a commercial product because there is usually considerable asymmetry of information between patients and medical practitioners. True, there is a plethora of information about diseases or medical problems online these days, but almost all the websites counsel users to check with their doctors. Therefore, the patient-as-consumer assumes a level of medical information that very few individuals would possess to put against the knowledge of health care providers and institutions.

The imperative of getting more private money into health care also arose from what the Mazankowski council believed to be medicare's fiscal drag on provincial finances. At the beginning of the report, the council rang the alarm bell: "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. Spending on health is crowding out other important areas like education, infrastructure, social services or security. If health spending trends don't change, by 2008 we could be spending half of the province's budget on health" (2001, 4). Later on, the report correctly said that examining money spent versus health care outcomes in other countries demonstrated that "more money, if it not used effectively or in combination with other reforms, will not necessarily result in better health outcomes" (2001, 28).

> *Canada's health care spending was among the highest for countries with largely public systems.*

The Alberta budget of 2003, the year after release of the Mazankowski report, provided for a 7.5 percent increase in the health care budget, followed by increases of 4.3 percent and 5.5 percent in the next two years. In 2003, health care accounted for 30 percent of government spending, but the trend line was clearly up. This was the short-term context for the Mazankowski report's conclusion that "the current health care system is not sustainable if it is solely funded from provincial and federal government budgets" (2001, 53).

In those years the Alberta economy boomed. No balanced consideration of the "sustainability" argument can be made by only looking at the expenditure side of the ledger. On the revenue side of the 2003 budget, the Klein government bragged about Alberta having no sales tax, no payroll tax, no capital gains tax, Canada's lowest fuel tax, the country's lowest corporate tax rate, the lowest personal income tax rates, and a plan to eliminate completely the

province's debt. These low tax rates were a cornerstone of what the government hailed as the "Alberta Advantage."

If Alberta did face a long-term budgetary challenge, it partly flowed from the province being a price-taker for its oil and natural gas or, as the report put it, "annual revenues to the province … can fluctuate significantly as the price of oil and gas swings up or down" (2001, 28). But it also flowed from the Alberta Advantage attitude to taxes, a philosophy the report was unwilling to challenge. It merely said: "Many Albertans would likely object to increasing taxes and there would be strong objections to any form of a sales tax, even if were dedicated to health care" (2001, 55). A realistic assessment perhaps, but certainly not a brave one.

The refusal to contemplate, let alone implement, a provincial sales tax sets Alberta apart from all Canadian provinces, most US states, and all European countries. It defies what almost every economist believes to be sensible tax policy. But in Alberta, the population has come to believe that to live without a sales tax is a kind of preordained right of citizenship. And although various think tanks, editorialists, and economists have argued for a sales tax, politicians of every stripe believe it to be the "third rail" of Alberta politics: touch it and you die.

So the idea of using private money to pay for some health care was driven in part by the report's acceptance of the Alberta Advantage low-tax philosophy. If raising every general tax – personal, corporate, sales – were ruled out, then some other form of revenue might be needed, namely some form of private payment for health care. Or the government could run deficits, which Alberta did when fossil fuel revenues fell.

By 2019-2020, the government was running huge deficits thanks to a combination of slumping oil prices and the early pandemic expenditures – and health care was taking 36 percent of spending ($21 billion), a far cry from the Mazankowski report's prediction that health could consume 50 percent of the budget by 2008. Still, health care had grown in real terms following the report, such that Alberta's spending on health became the second highest per capita in Canada, behind only Newfoundland and Labrador.

The Mazankowski report made only passing references to international comparisons, perhaps because apart from the controversial WHO report, few comparative studies were then available. As some emerged, the weaknesses of the Alberta system (which mirrored those across Canada) were reinforced. Canada's health care spending was among the highest for countries with largely public systems – 11.5 percent of GNP in 2019 – but the results were far from the best.

The Commonwealth Fund's reports based on surveys of patients and practitioners in 11 countries consistently rank Canada's system at or near the bottom (Commonwealth Fund 2021; CIHI 2017). As the Mazankowski report

underscored, an enduring weakness of the Alberta (and Canadian) system was timely access. This flaw was reflected in the Commonwealth surveys. For example, among countries with public systems, Canada ranked second last in the time lag for getting an appointment with a doctor, last in finding medical care in the evenings, weekends, or holidays, second worst for time taken to see a specialist, the highest use of hospital emergency rooms, and the second longest wait times for non-emergency surgery. The Organization for Economic Cooperation and Development (OECD) studies showed a mixed record for Canada, despite per capita spending on health care having risen from $5240 in 2010 to $6666 in 2019.

> *Albertans (like other Canadians) were reasonably satisfied with their health care system overall.*

Mixed record or not, as the Mazankowski report pointed out, Albertans (like other Canadians) were reasonably satisfied with their health care system overall. In the latest Commonwealth survey, 63 percent of Canadians said their system was "very good" or "good." This level of approval, while sounding impressive, was the second-lowest among the 11 countries surveyed, with Norwegians, Swiss and Germans reporting satisfaction levels above 80 percent. Australians and New Zealanders reported levels in the high 70s, an interesting finding for Canadian health care academics who are usually quick to decry the private payment elements in the systems of those countries. Their more mixed systems apparently attract higher levels of satisfaction than does the Canadian. The 2021 Commonwealth Fund report ranked Canada last among countries with public systems on performance compared to spending.

The majority's satisfaction level within Canada for the existing health care system partly explains why recommendations for wholesale changes, as in Mazankowski (and Castonguay), fell flat. As does the good quality of care, once accessed, and the fact that Canadians do not know other, better systems. There is also the fear of the unknown, since this is the only system Canadians have experienced. No political party in Alberta or elsewhere has dared to question the essential structure and method of financing medicare, and importantly there are only a few centres of criticism among think tanks or university professors.

Indeed, it is one of the ironies of health care discussions that the institutions best equipped to provide robust critiques of any status quo – universities – are populated with medicare's most ardent defenders. Many health care professors in these institutions might critically nibble at the margins of medi-

care's structure and financing model but they do not advance anything like the substantial overhaul proposed in the Mazankowski report. If anything, these experts often want the funding and structure of medicare expanded to incorporate all prescription drugs (pharmacare), long-term care, home care, and perhaps even dentistry. Medicare-plus is their preferred model for change. The Canadian health care model that ranks near the bottom of international comparisons is the one they prefer for expanded coverage.

Might it happen, as the Mazankowski report predicted in 2002, that inexorably rising health care costs will "squeeze out" spending on other important government programs? Those costs have certainly been rising. An aging population will cause them to rise faster still because more people, especially women, will be living beyond age 80, and even 90, with the attendant health care costs that aging brings.

The "squeezing" effect has happened, is happening, and will happen, but at what rate and with what results? A decade or so ago, the amount governments spent on health care eclipsed for the first time the amount spent on all levels of education. Since the largest sums for health are spent on the older cohorts of the population, whereas education is mostly for the younger cohorts, an inter-generational transfer of resources is occurring. And since the share of the population in the older cohorts is growing, and since older people tend to vote in higher proportions than younger people, the political imperatives of health care spending are unlikely to be attenuated.

Under Prime Minister Paul Martin, who promised a medicare "fix for a generation," federal transfers rose by $40 billion over 10 years. Martin insisted this money would bring "transformative change." It proved to bring nothing of the kind. Some of the extra money was promised for procedures disproportionately used by older people – radiation, hip fracture surgery, cataracts, and joint replacements. The new money did indeed buy more of these procedures, and wait times went down for a while – except that demand kept rising so that the wait times rose again.

What happened to much of the new federal money is a lesson in public finance. As could have been predicted, the providers (mostly doctors) who are organized and targeted in ambition grabbed a disproportionate share of the money. Patients, by contrast, present to the health system as individuals. They are not organized and face the asymmetrical disadvantage of lacking the knowledge of providers. Hospital administrators did well too, as their salaries rose. Federal transfers, then as now, patch but have not fundamentally altered the system; in part because Ottawa has few if any powers to direct how federal transfers will be spent, health being a provincial jurisdiction.

Alberta will face substantial pressures on its health care system unless it dusts off the Mazankowski report and tries one of the private options for payment, which no political party will apparently do. Alberta has a large deficit arising from a drop in oil and natural gas prices, the province's failure to build a

large rainy-day fund when fossil fuel royalties were abundant, and its refusal to introduce a broad-based sales tax. It now confronts a long-term decline in the demand for oil and natural gas, the revenues from which successive Alberta governments so unwisely and for so long excessively depended.

In retrospect, the Mazankowski report was ahead of its time, but that time never came – at least for its more radical proposals of introducing private payments into the public system. Nor did the time arrive for a 90-day "guarantee of access to selected heath services" (2001, 6), a target neither Alberta nor any province has come close to achieving. The idea did spread for electronic health records, but not ones that would show patients how much their treatment had cost the system each year – an idea tried by the Tony Blair government in Britain that subsequent analysis showed had no effect on patient behaviour. Nor was the report's recommendation taken up for a review of what should be covered by medicare, the report's inference being that it had been extended willy-nilly to services not initially contemplated but now considered essential by citizens.

Some day, maybe, the already stretched Canadian health care system will so alarm enough Canadians who wait too long for access that Mazankowski-type changes in the private/public mix might find some receptivity. Alberta and the rest of Canada are not there yet.

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A bill coming due: Building on Mazankowski's ideas on paying for medicare

Jack M. Mintz

The Report of the Premier's Advisory Council on Health (the Mazankowski report) dealt with the time-honoured issue – how to pay for public health expenditures. By 2001, the costs for health care were growing faster than the economy's growth and gobbling up an increasing portion of the provincial budget. The report concluded with a statement that was familiar to governments at that time and has been ever since:

> The continuing escalation of health care costs without a clear funding plan and the consequent impact on federal and provincial treasuries creates an unstable climate and affects the confidence and performance of the health care system. (2001, 31)

The report made innovative recommendations with respect to "paying for health care" (2001, 29-30):

1. Decide on how much of the provincial budget will be spent on health and stick to it.
2. Work with health authorities to seek efficiencies and reduce costs.
3. Consider new sources of revenues.
4. Limit health services that are publicly insured.

This discussion focuses on the third recommendation: new revenue sources.[1] The Mazankowski report suggested that various options be studied including medical savings accounts, health care premiums, user fees, co-payments, deductibles, taxable benefits under the income tax, and supplementary insurance. The report also recommended examining other options such as cost-recovery payments for non-medically insured services or local health authority plebiscites to approve supplementary revenues such as a flat fee on residents.

Regardless of the split between public and private health provision, public spending must be supported by some combination of government tax and non-tax revenues. The task here is to look at the Mazankowski report's suggestions to determine whether there are options worthy of further consideration besides the current approach of primarily using general revenues to fund health care in Canada.

While there is much to commend in the report's willingness to raise ideas for new approaches to revenue generation, its impact – little different than the many other reports on health care in Canada – unfortunately failed to achieve a shift in funding sources in the past two decades. As shown below, health care is funded in Canada largely by general government revenues, similar to the way it is funded in the United Kingdom. There is no social security fund to support health care like those in the United States or some continental European countries. Premiums, user fees, or co-payments continue to be limited to non-medicare services like drugs, home care, and long-term care in Canada, unlike other countries that are more willing to use incentive-based mechanisms to fund public health care. Taxing benefits through the income tax system has been largely rejected.

The discussion below is divided into three sections. First, what did the Mazankowki report recommend regarding alternative revenue sources? Second, what is the current practice in Canada in funding health care and how does this compare to other countries? Third, what revenue options could be considered in the future to provide more resources or even replace some of the current revenue sources used to fund health care? I will conclude with some speculative comments about options since, as the report made clear, it is better to fund the system rather than ration health care.

What did the Mazankowski report say about new revenue sources?

Like all good panel studies, the Mazankowski report began with a list of policy objectives in choosing among revenue options. It included a better use of economic resources to improve our standard of living, including health (economic efficiency), equity, minimizing compliance and administrative costs, and fiscal sustainability.

Under efficiency, the Mazankowski report included objectives such as "incentives for people to stay healthy," "provide opportunities for individuals to make more choices," improve accountability, and encourage "savings to cover future health care costs." The efficiency issues are not the only ones, however. Levies impose different distortions on the economy besides choosing between health care services versus other consumer goods. A payroll tax used to fund health care, for example, discourages work.

In tax policy parlance, equity objectives can be broken into "horizontal equity" (those with equal resources bear the same tax burden) and "vertical equity" (those with less ability pay less). The Mazankowski report focused on vertical equity issues such as "no Albertans should be denied access to health services because they are unable to pay" and those "with low income… must be protected" (2001, 53). It implicitly argues for horizontal equity in the sense that "all Albertans should be covered for catastrophic illnesses and injuries," for which costs tend to fall on those who become ill versus those who are well.

The report then considered several new revenue sources. Some were discussed and rejected, including a new health tax such as a dedicated sales tax (e.g., Alberta HST) or a supplementary income tax payment.

User fees were rejected as well. Even though such fees would provide efficiency benefits and support sustainability, they would be a barrier to care for low-income households as they are applied at the point of service. The report also rejected proposals to levy a graduated income tax payment on benefits, even though only higher income individuals would pay the benefit tax when they filed their income taxes.

The report proposed increasing the health care premium existing at that time (perhaps indexing it to health care costs), which would be easily administered and therefore acceptable. However, the report seemed to be even more supportive of innovative approaches that would put more emphasis on consumer choice and incentives. These included supplementary insurance plans with co-payments that could cover non-medicare services, some of which are already used for drugs, home care, and long-term care.

The report paid special attention to medical savings accounts whereby individuals or families would be given a set amount of money to spend on health services. The amount set aside would be equal to a health care premium plus any additional provincial funding put into the account. Individuals would pay for certain health care services up to an annual amount with excess spending covered by the government or the household. Households would pay from their own resources only if there was a "corridor of spending" – that would be health care spending covered by the individual or family on amounts between the medical savings account and the point at which full medicare coverage would be applied.

An alternative to medical savings accounts that the Mazankowski report proposed was variable premiums (which vary by ability to pay), whereby a co-payment would be funded by a health care premium paid by the individual. The co-payment could be set as a portion of health care expenditures (e.g. 20 percent) and limited to a portion of taxable income (e.g. 3 percent). This approach, though, is not that much different from the concept of paying income tax on benefits if it is operated through the income tax system.[2]

How does Canada fund public health care spending?

Provincial governments use a variety of revenues to fund health care spending in Canada: general revenues, dedicated revenues, user fees, co-payments, and health transfers from the federal government. Some provinces have labelled certain general revenues as "health care" taxes, even though the revenues are not dedicated to a special health care fund. Given that money is fungible, however, a dedicated revenue source that is smaller than the health spending budget is no different for practical purposes than a non-dedicated one. Nonetheless, with a dedicated tax, the public will view that they have a stake in a good health system that is supported by money coming from their own pockets – in other words, "value for money."

Table 1 compares sources of provincial budgetary health care funding for the four largest Canadian provinces for the 2019/20 fiscal year. It provides the percentage of provincial public health spending funded by different sources: general revenues, employer payroll taxes, health premiums, federal transfers, and compulsory payments (e.g., insurance payments, co-payments, and user fees). One could include insurance premium taxes on health and dental insurance premiums as a source of revenue (these roughly amount to an estimated $1 billion for Canada), even though they are typically ignored.

By far, general revenues are the most important source of revenue for public health care funding, followed by the Canada Health Transfer, which the federal government provides to each province on a per capita basis. The transfer is similar to general revenue in the sense that the funding is included in the general revenue account of the province despite some conditions attached (e.g., penalties if the province assesses user fees to fund medicare services). Provinces assess user charges for some services related to non-medicare health care ranging from hospital parking fees to co-payments for drugs, long-term care, and home care.

What is striking about Table 1 is that Alberta is the only large province that does not levy a health premium or employer health payroll tax. British Columbia's health premium was converted in 2019 to an employer payroll tax assessed at 1.95 percent, joining Quebec (4.26 percent) and Ontario (1.95 percent).[3] Ontario also has an income-tested health premium that exempts incomes below $20,000 and rises in steps to a maximum of $900 when incomes reach $200,600.

Table 1: Funding sources
(in $billions and as a percentage of provincial health care spending)
by the four largest provinces: 2019-20.

	British Columbia	Alberta	Ontario	Québec
Public health spending	**$21.7**	**$22.6**	**$63.3**	**$38.7**
Employer payroll tax	$1.9 (8.6%)		$6.8 (10.8%)	$6.9 (14.4%)
Health premium			$4.1 (6.15)	
Canada health transfer	$5.5 (25.3%)	$4.7 (20.8%)	$15.6 (24.6%)	$9.1 (23.5%)
Payments for health services	$3.1 (14.3%)	$1.0 (4.4%)	$6.0* (9.5%)	$2.5 (6.4%)
General revenues	$11.2 (51.6%)	$16.9 (70.8%)	$30.8 (48.7%)	$20.2 (52.2%)

**Estimated based on out-of-pocket payments by province.*

Sources: Canadian Institute of Health Information (2019 provincial spending on health NHEX tables), 2019-20 provincial budgets (revenues sources) and Finance Canada (2019-20 CHT transfers).

Alberta did have a health premium at the time of the Mazankowski report but it was eliminated in 2009, contrary to the report's view that funding sources such as these should continue and even increase. In its March 2015 budget, the Prentice government introduced an income-related health care premium similar to the one in place in Ontario. However, in May 2015 the Alberta government was defeated by the NDP, which then cancelled the proposed health premium. Outside of user charges for non-medicare expenses, Alberta has made little use of incentive-based payments due to limitations under the *Canada Health Act*. Neither has Alberta introduced a social insurance scheme whereby residents would contribute to a fund dedicated to health care spending.[4]

Compared to other selected countries, Canada and the United Kingdom rely most on general revenues to fund both public and private health spending (Table 2), at roughly 70 percent and 80 percent, respectively. Japan, Germany, and the United States levy payroll taxes to cover health-related social insurance costs. Because of the mandated penalty that is a component of the US's *Affordable Health Care Act* (AHC or Obamacare), the Organization of Economic Cooperation and Development (OECD) treats these payments as compulsory funding, reducing what was previously considered "voluntary" funding. However, in late 2018 Congress withdrew the AHC penalty, although several states assess a penalty on those who are uninsured.

Table 2 also confirms a conclusion in the Mazankowski report and in the later federal government report, *Unleashing Innovation: Excellent Healthcare for Canada* (Advisory Panel on Healthcare Innovation 2015) that spending and health care performance are not strongly correlated. The US spends most but ranks poorly in health care outcomes, according to a comprehensive anal-

ysis undertaken by the Commonwealth Fund (2021). Canada ranks second poorest of 11 countries even though governmental spending on health care is more than in the UK or Australia, which have better performing health care systems.

Table 2: Funding sources for total health spending as share of GDP (in percentages), 2019

	Canada	US	UK	Germany	Australia	Japan
Budgetary revenue	7.5	6.5	8.1	1.5	6.3	3.7
Social insurance	0.2	1.4	–	7.6	–	5.5
Compulsory payment	–	5.3	–	0.8	0.1	–
Voluntary payment	1.4	–	0.3	0.2	–	0.3
Other revenues	1.6	2.9	1.8	1.6	1.9	1.5
Total health spending	10.8	16.8	10.2	11.7	9.4	11.0
2021 ranking*	10	11	4	7	3	–

**Commonwealth Fund ranking of 11 countries (Norway was highest).*

Source: OECD health statistics (2020), Commonwealth Fund (2021).

Overall, Canada tends to rely most on general revenues to fund health care. Little incentive-based payments are used for medicare (i.e., hospital and physician services), although incentive-based payments are used for non-medicare services such as drugs, home care, and long-term care. As discussed earlier, the Mazankowski report suggested that governments look carefully at medical savings accounts or a co-payment system to improve incentives to stay healthy and increase accountability. These recommendations were different from those in the Romanow report, which came out a year later and argued that incentive-based systems discourage people from seeking early prevention and would be a tax on the "sick" (Commission on the Future of Health Care in Canada 2002).[5] The Mazankowski report clearly stayed away from dedicated sales or payroll taxes that are not linked to incentives. Nor did it recommend creating a fund for long-term medical expenses for an aging society. Twenty years later, there has been little change in the sources used to fund health care expenses.

What might a new report consider today?

The Mazankowski report correctly stressed the need for new funding sources. While it was too focused on incentive-based approaches, some other important funding sources should perhaps be considered as well. These include (i) the type of revenue source used to fund health care, (ii) social insurance

funding and (iii) tax-based funding. Below, I shall discuss these in detail.

Best revenue sources

Governments could opt for general revenue sources to fund health care (as they are already doing) or, instead, choose explicitly or implicitly dedicated revenues such as health premiums, payroll taxes, or sales taxes. With each type of tax, efficiency, equity, and administrative or compliance issues are involved and should be compared.

The health care premium is more efficient than other revenue sources, including sales, payroll, and income taxes. It is a "lump sum" tax in the sense it is not related to hours worked, savings, or risk-taking. Payroll taxes discourage employment and work effort. Income taxes discourage both employment and saving. Sales taxes like the HST encourage people to consume untaxed goods and services including leisure (thereby operating like a payroll tax and discouraging work effort).

Furthermore, health care premiums can be viewed as "horizontally" equitable in the sense of being a charge for the benefits received from public health insurance even if they are not directly linked to amounts consumed by a household. However, the flat premium cost falls most heavily on the poor, which is the reason Alberta exempted low-income Albertans from paying it. Ontario addressed this issue with a premium related to income, an approach that would have been adopted in Alberta had the Prentice government not lost the 2015 election.

In terms of equity, payroll taxes can be geared to income levels if paid by employees. However, it is costly for a province to assess employee payroll taxes unless they are administered through the income tax system. Currently, Alberta has a tax collection agreement with the federal government that will not allow the province to choose a tax base different from the federal base. Unless the agreement can be changed to allow for provincial taxes on employment earnings (similar to the Canada Pension Plan payroll taxes on employed and self-employed earnings), a payroll tax would therefore need to rely on employers for implementation, similar to other provinces. Most provinces exempt smaller employers from such taxes, therefore making the payroll tax horizontally inequitable between large and small employers.

Further, employer payroll taxes are regressive, hurting most those who might be laid off. They are also unfair because they exempt contract labour. If, instead, a payroll tax was shifted back to employees in the form of lower wages paid, the employer payroll tax would be proportional to income and would affect all employees. However, payroll taxes fall on the working population only, exempting those who do not work, such as retirees.

A dedicated sales tax to fund health care like an Alberta HST would be more equitable than a payroll tax or health premium. It would affect both working

and retired Albertans and therefore would apply to a larger tax base. With the low-income tax credit and exemptions for necessities, the HST has a somewhat progressive impact. In a transition, however, it would be imposed on retirees who are consuming goods and services from their fixed incomes, which could be partly alleviated by an age-related income tax credit.

The Mazankowski report did not address these issues when it was considering the choice of general revenue sources to fund health care. Given that health care spending is over 40 percent of Alberta's budget, a certain level of general funding will be required even if incentive-based payments were to be adopted. Thus, the efficiency and equity issues raised above are critical in assessing current approaches to funding health care.

A social insurance fund?

The Mazankowski report appropriately mentions the importance of encouraging savings against future health care expenditures such as through medical savings accounts. The same can apply to public savings used to fund health care. Many countries have adopted social insurance funds with precisely this objective, given that health care expenditure is age-related (heaviest at the end of one's life). Thus, as the population ages, a public fund established earlier on could be used to cover health care costs. Contributions made to the fund would cover benefits out of the fund, similar to the Canada Pension Plan.

When the Canada Pension Plan (CPP) was created, the contributions made by employees exceeded the benefits paid to retirees. This allowed the CPP to grow its assets to pay for future benefits. Any new health-related social insurance fund created today would be unlikely to have enough contributions to fund current expenditures without raising new taxes through, for example, a payroll tax, sales tax, or health premium. This interim cost caused by the gap in funding could be partly alleviated by directing transfers from sustainability funds such as Alberta's Heritage Fund towards the health care fund as well. The social insurance approach could focus on younger members of the population who are working and in less need of health care funding. Or alternatively, the social insurance approach could fund non-medicare expenditures such as long-term care, home care, and dental care.

Rearranging tax support

Several existing tax policies aim to provide tax relief to help cover health-related expenses. These include the disability tax credit, the caregiver credit, and the medical expense credit under the income tax; various sales tax exemptions related to medical services, prescription drugs, and other medical products; and the income tax exemption of employer-paid health and dental insurance benefits. Except for provincial tax credits, many are largely federal measures, so a province has little flexibility to change these programs.

Nonetheless, federal and provincial governments have significant shared tax

fields under the income and sales taxes. They also coordinate other tax policies from time to time such as excise taxes. Both levels of government could make some attempt to restructure tax relief programs to support lower income Canadians, particularly to pay for non-medicare expenses. For example, the federal Advisory Panel on Health Care Innovation (2015) recommended eliminating the medical expense credit and the exemption of employer-paid health and dental insurance benefits to cover the cost of a new federal refundable medical expense credit equal to 25 percent to cover qualifying non-medicare expenses. Provinces could piggy-back on the federal credit.

Incentive-based payments (again)

As discussed above, the Mazankowski report preferred the innovative idea of medical savings accounts and variable premiums to encourage consumer choice, accountability, and incentives to stay healthy. The report was right to emphasize these options since they do provide important efficiency benefits. Like user fees, however, these options have been accused of being a "tax on the sick" since some people must pay out of their own pockets to cover some of their own health care costs.

The idea of paying out of pocket turns horizontal equity on its head since medical expenses are a public benefit provided to the broad population, both rich and poor, who could contribute funds for their health care costs through insurance. Including co-payments or other incentives is consistent with social insurance policies aimed at focusing on the most needy by limiting benefits or reducing moral hazard behaviour (e.g., overusing the system). It could be argued that it is fair that those using health services should contribute more.

The medical savings account idea is an intriguing approach even if it is complex to administer. It would require tracking the fund's assets and payments for qualifying medical expenses for each household. While it would engage households to monitor their health spending account, ultimately the government would have to assess the efficiency gains from using this approach.

In my view, the variable premium approach is more practical to consider. If permitted by federal legislation, it would be a good way to fund at least a portion of both medicare expenses and non-medicare expenses such as home care, long-term care, pharmaceutical drugs, and dental care. To save administrative expenses, these payments could be accepted and monitored through the income tax system and be limited to a percentage of income with exemptions to relieve low-income Canadians from paying the tax.

Conclusion

The Mazankowski report developed innovative approaches to raising new revenues to fund health care. While dismissive of user fees, it did support medical savings accounts and a variable premium incentive-based approach.

Unfortunately, and perhaps resulting from the common philosophy of dismissing incentive-based payments that informed the federal Romanow report, the Mazankowski report's ideas did not get more attention.

If it were possible to use incentive-based payments, they would be useful, along with general revenues, as a source of funding for health care in Canada. Canada's federal and provincial governments should therefore pay more attention to two issues: the mix of general and incentive-based levies used to fund health care and the establishment of a fund to cover future health care costs. Like the Mazankowski report, I would argue that a variable health premium should be on the top of the agenda, perhaps operated through the income tax. Further, in the future, we should have a dedicated tax to create a health-related social insurance fund along with incentive-based payments as funding sources, rather than relying solely on general revenues to pay for health care services in Canada.

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Endnotes

1 The report also included a discussion of privately funded and privately delivered health care services as a method to raise additional revenues (2021, 54). While one could shift more services from public to private funding to raise more revenue, this approach would raise structural issues that go beyond simply finding new revenue sources. In this paper, I shall focus on funding public spending for health care that would require current or other revenue sources even if costs were reduced or other structural reforms were introduced.

2 The Mazankowski report seemed to miss this point in their discussion of the variable premium. Administrative costs would be substantially reduced by operating the variable premium collected through the personal income tax rather than setting up a new administrative structure. See Goodman, Mintz, and Aba (2002). More detailed analysis can be found in Mintz and Tarasov (2008, 59-89).

3 The employer payroll taxes in Ontario and Quebec apply to payroll above $1 million. In British Columbia employers with less than $500,000 in payroll expenses pay no employer health tax.

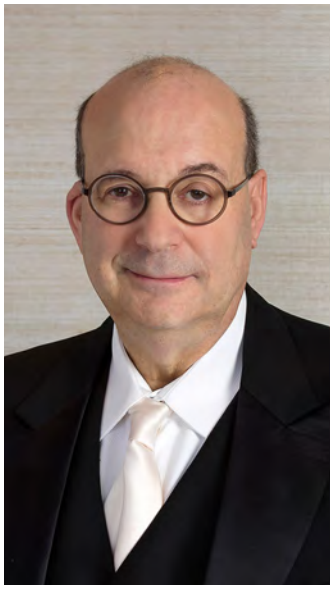
4 Alberta has used its Heritage Fund to fund medical research with dedicated assets equal to $2.1 billion, transferring $500 million to universities to cover medical research in its fiscal year 2020/21.

5 On variable premiums, the Romanow report stated: "Fundamentally, it means that if people are sick or injured, they will be taxed more and pay more for health care. This is counter to the basic premise in Canada's health care system that access should be determined only by need and not by ability to pay. As in the case of MSAs or user fees, it may result in people not using needed health care services, a phenomenon that has been seen in a number of European systems" (30).

About the authors

Janice MacKinnon is a Fellow of the Royal Society of Canada, a member of the Order of Canada, and a former Saskatchewan Finance Minister. She has a PhD and M.A. from Queen's University and an Honours B.A. from the University of Western Ontario She is the author of three books and many articles on public policy issues. She has also served as the Chair of the Board of the Institute for Research on Public Policy, as a board member of the Canada West Foundation and is currently on the advisory board of the Global Affairs Institute. As a cabinet minister in Saskatchewan, she held various portfolios including Minister of Finance, Minister of Social Services, Minister of Economic Development, and Government House leader. From 2010 to 2015 she served as Chair of Canada's Economic Advisory Council. In 2017 she was appointed to the federal advisory panel on NAFTA and the environment. In 2019 she chaired the Blue-Ribbon Panel on Alberta's Finances. She is on the Board of Governors of the University of Alberta, is an Executive Fellow at the University of Calgary School of Public Policy and Professor of fiscal policy at the School of Public Health at the University of Saskatchewan.

Jeffrey Simpson is an Officer of the Order of Canada, was *The Globe and Mail*'s national affairs columnist during which time he wrote about almost all the major Canadian public policy issues, and many international questions. He wrote seven books, one of which won The Governor-General's award; another, titled *Chronic Condition: Why Canada's Health-Care System Needs to be Dragged into the 21st Century*, won the $50,000 Donner Prize for the best book on public policy. He has received eight honorary degrees, lectured at several dozen universities in Canada and abroad, and is a member of the Trilateral Commission. He was on the Board of Governors of the University of Ottawa for nine years and is now an emeritus senior fellow at the Graduate School of Policy and International Affairs at that university.



Jack Mintz is the President's Fellow at the University of Calgary's School of Public Policy and Distinguished Fellow, Macdonald-Laurier Institute. He also serves on the board of Imperial Oil Limited and is the National Policy Advisor for Ernst & Young. Dr. Mintz held the position of Professor of Business Economics at the Rotman School of Business from 1989-2007 and Department of Economics at Queen's University, Kingston, 1978-89. He was a Visiting Professor, New York University Law School, 2007; President and CEO of the C.D. Howe Institute from 1999-2006; Clifford Clark Visiting Economist at the Department of Finance, Ottawa; and Associate Dean (Academic) of the Faculty of Management, University of Toronto, 1993 – 1995. He became a member of the Order of Canada in 2015.

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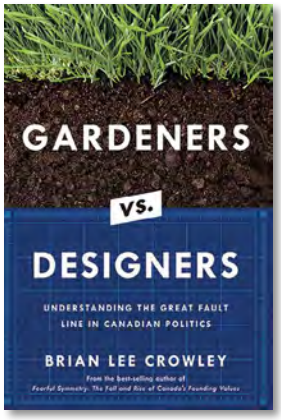

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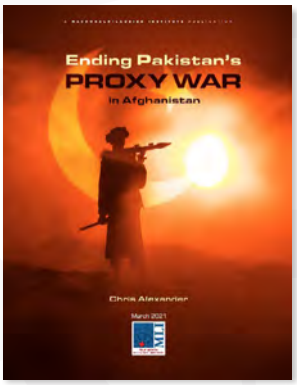

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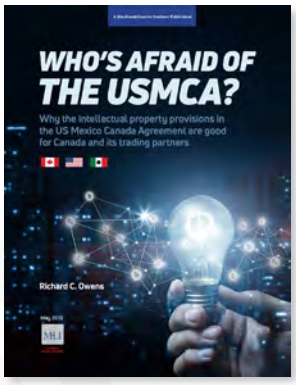

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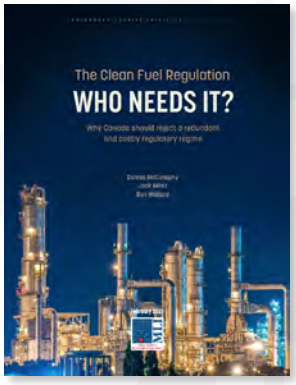

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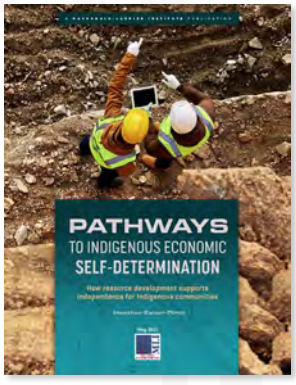

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