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Mazankowski Report at 20

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

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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 spend 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 Mazankowski report began with a list of policy objectives in choosing among revenue options.*

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 gen-

eral 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.

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).

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.

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: 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).

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 analysis 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.

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 popu-

lation 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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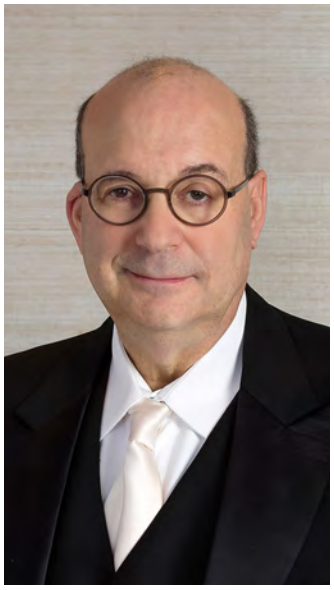

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Endnotes

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" (p. 30).

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