PRB 01-33E

REPORT OF THE PREMIER'S ADVISORY COUNCIL ON HEALTH (ALBERTA) – AN OVERVIEW

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21 February 2002

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INTRODUCTION

In August 2000, Alberta Premier Ralph Klein established a 12-member Advisory Council on Health under the chairmanship of the Right Honourable Donald Mazankowski. The Advisory Council was asked to review Alberta's publicly funded health system and develop recommendations to improve the quality of health services and preserve the system's sustainability.

The Advisory Council's report, *A Framework for Reform*,(1) was released on 8 January 2002 to considerable media attention. This was followed, two weeks later, by the Alberta government's response to the Advisory Council's report, indicating that the Government would begin immediately to implement a number of the Council's recommendations.

This paper provides an overview of the Advisory Council's recommendations and the Alberta government's response.

ADVISORY COUNCIL ON HEALTH – REPORT

A. Sustainability

Assessing the sustainability of the health system was a significant aspect of the Advisory Council's work. At the outset, the Council defined a sustainable health system as one with:

- sufficient financial and human resources;
- resources available to respond to forces that drive change and increase costs; and

(1) *A Framework for Reform*, Report of the Premier's Advisory Council on Health, December 2001 (released 8 January 2002). http://www.premiersadvisory.com/reform.html

- plans in place to ensure the availability of adequate resources to support the health system in the longer term.(2)

The Advisory Council's report is framed around the Council's conclusion that Alberta's health system will not be sustainable in the longer term unless fundamental changes are made to both the manner in which the system is funded and the way health services are delivered.(3) This conclusion is based on the Council's conviction that extracting greater system efficiencies and improving administration to realize cost savings, while important to achieve, will not be sufficient to offset increasing costs, rising expectations and greater demand for health services.

To support its conclusion, the Advisory Council presents statistics which provide evidence of increased spending on health and rising health care costs:

- total health spending in Alberta increased from $4.1 billion in 1991-1992 to $7.1 billion in 2001-2002;
- health now comprises about 33% of Alberta's program expenditures compared to 24% a decade ago;
- current trends put spending on health at 50% of provincial program spending by 2008; and
- health care spending is growing faster than the rate of growth of the Alberta economy.

The Advisory Council also points to factors that it believes will drive significant cost increases. These factors are:

- population growth and aging;
- emerging and new technologies;
- rising labour costs;
- new drugs;
- increased incidence of chronic and new diseases; and
- rising expectations and demands.

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(2) *Ibid*., p. 12.

(3) *Ibid*., p. 1.

To achieve a sustainable health system, the Advisory Council recommends a combination of reforms in five broad areas aimed at:

- enabling people and communities to take greater responsibility for their health;
- reorganizing health care delivery;
- finding new sources of revenue to pay for health services;
- ensuring an adequate supply and the best use of health providers; and
- assessing outcomes and improving quality.(4)

B. Staying Healthy

The Advisory Council identifies maintaining good health as the best way to sustain the health system in the longer term.(5) Specific recommendations include:

- establishing clear health objectives and targets for the next decade and measuring progress in meeting those goals;
- providing health education in schools;
- supporting children living in poverty;
- encouraging children and youth to attain high levels of education;
- providing better information about how to stay healthy;
- providing incentives for people to stay healthy; and
- discouraging tobacco use.(6)

These recommendations flow from mounting evidence of the positive impact of a healthy lifestyle, high socio-economic status and high educational level on health. The Advisory Council's goal is to rebalance: (a) health prevention measures; and (b) health services aimed at diagnosing and treating illness and injury.

In response to these recommendations, the Alberta government will be undertaking student health initiatives, working to update the Canada Food Guide, increasing tobacco taxes, and developing a number of health information and promotion initiatives.(7)

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(4) *Ibid*., p. 14.

(5) *Ibid*., p. 41.

(6) *Ibid.,* pp. 42-43.

(7) *Building a better public health care system*: Alberta government response to the Premier's Advisory Council on Health Report, 23 January 2002, p. 4 (referred to as the "Government Response").

C. Reorganize Health Care Delivery

1. Access to Quality Health Services

The report identifies "access to health services" as the most important issue for Alberta residents. The main concern is waiting times for certain medical procedures, diagnostic tests, treatments for certain diseases and conditions, appointments with specialists, and finding a family doctor.

The Advisory Council emphasizes that Alberta residents should be able to expect access to health care services when needed and on equitable terms.(8) Key recommendations relating to access include:

- guaranteed access to selected health services within 90 days of a diagnosis and recommendation by a physician;
- reduced waiting times by introducing a centralized booking system for certain procedures, posting waiting times for selected procedures on the Internet, and allowing people to access services from any physician or hospital;
- the provision of more choice in relation to the health care services received and where the services are received;
- primary health care reform; and
- new approaches to chronic disease management.(9)

The care guarantee proposal would require regional health authorities to provide the relevant health service within 90 days. If unable to do so, they would have to acquire the service elsewhere at the region's expense.

The Alberta government has slated care guarantees to begin in 2003, and centralized booking for certain procedures to commence in 2006.(10)

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(8) *A Framework for Reform* (2002), p. 19.

(9) *Ibid*., pp. 43-44.

(10) Government Response (2002), p. 4.

2. Opening the Health System to More Competition and Choice/ Introducing More Accountability

The Advisory Council describes the current health system as a "command and control system" that provides little choice and hamstrings regional health authorities.

> People have no choice but to get the health services they need from the publicly insured system, and wait their turn in line. The system is organized by government, paid for by government, insured by government, and evaluated by government. Regional health authorities have an important role to play in delivering health services but their budgets are almost completely determined by government, the expectations are set by government, and they are accountable to government. They have too little real authority and they have few, if any, options if they are unable to meet their residents' health needs within existing resources.(11)

Recommendations in this area encompass giving health authorities more flexibility and introducing more choice and competition. Government would no longer act as the insurer, provider and evaluator of health services, but would focus instead on establishing the "overall direction and allocating funding to health authorities."(12) Health authorities, in turn, would concentrate on providing health services directly or through service agreements with other entities.

The Advisory Council advocates "an innovative blend of public and privately delivered health services – delivered under contract with regional health authorities and publicly funded."(13) Clearly, the Council believes that consideration must be given to the role of the private sector in delivering health care services, particularly in relation to improving access and developing centres of specialization.(14)

Some of the specific recommendations in this regard include:

- establishing multi-year contracts between the province and health authorities setting out performance targets and budgets;
- increasing cooperation among regional health authorities;

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(11) *A Framework for Reform* (2002), p. 21.

(12) *Ibid*., p. 24.

(13) *Ibid*., p. 56.

(14) *Ibid*., p. 25.

- establishing service agreements between health authorities and providers such as other regions, clinics, private or not-for-profit providers or facilities, and groups of health providers;
- developing centres of specialization;
- expanding comprehensive primary care models;
- encouraging a range of public, private and not-for-profit organizations and facilities to deliver health care services;
- encouraging groups of health care providers to establish "care groups" and offering a range of services to health authorities and individuals; and
- integrating mental health services with the work of regional health authorities.(15)

The Government has targeted 2004 as the date for having multi-year contracts with regional health authorities in place.

D. Paying for Health Care

Two of the Advisory Council's recommendations have garnered significant public and media attention largely because of their potential implications under the *Canada Health Act* and their financial impact on individuals. These are:

- redefining what health services should be publicly covered; and
- diversifying the revenue stream to pay for health services.

1. What Services should be Publicly Covered

The Advisory Council's proposals regarding publicly funded health services start from the premise that the Medicare system was never designed to cover the full basket of health services, treatments and technologies that the public has come to expect and demand.

In its initial form, publicly funded health care covered only care provided by hospitals and doctors. And the five principles of the *Canada Health Act* (portability, accessibility, comprehensiveness, public administration, and universality) as well as the financial penalties associated with user fees and extra billing continue to apply only to medically necessary hospital and physician services, rather than to the many other services

(15) *Ibid*., p. 7.

(pharmaceuticals, eye examinations, home care, for example) that the provinces and territories cover under their Medicare programs.

The Advisory Council suggests that if public coverage is to exist for treatments for serious illnesses and injuries, as well as for illness management, decisions will have to be made about what services are eligible for public coverage. The Council recommends the creation of a permanent expert panel to review and make such decisions.(16) There would be a two-stage review process. First, the panel would review all existing categories of publicly funded services to determine whether they should continue to be publicly insured. Then, the panel would determine whether new diagnostic treatments, services or drugs should receive public coverage. New items warranting public coverage would be added to the coverage list only if there were sufficient public revenues to cover the cost or if other services were removed from the list. Services ineligible for public funding could be provided by public or private health care providers and paid for through supplementary insurance, out-of-pocket, or through medical savings accounts (MSAs).(17)

The Alberta government has announced the creation of an expert panel. By the end of August 2002, the panel is to recommend what services should be insured; and by the end of October 2002, the panel is to develop criteria for reviewing new services and treatments.(18)

2. Diversifying the Revenue Stream

Having concluded that new funding sources are needed to sustain Alberta's health care system, the Advisory Council presents a number of options for diversifying the revenue stream to pay for health care. Some of the options examined include:

- levying additional taxes;
- making health care services taxable benefits;
- increasing health care premiums;

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(16) Decisions by such an expert panel, particularly those recommending the delisting of certain hospital and physician services and treatments from public coverage, could raise interpretation questions under the "comprehensiveness" criterion of the *Canada Health Act*. Section 9 of the *Canada Health Act* states: "In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners." Insured health services are medically necessary physician and hospital services.

(17) *A Framework for Reform* (2002), pp. 45-46. For a detailed discussion of MSAs, see *Medical Savings Accounts – A Comparative Overview*, PRB 01-20E, by Margaret Smith, Parliamentary Research Branch, Library of Parliament, 30 October 2001.

(18) *Ibid.*, p. 5.

- expanding supplementary or private insurance;
- imposing user fees;
- allowing privately funded/privately delivered health care;
- establishing medical savings accounts (MSAs); and
- allowing variable health premiums in an Alberta Health Care Account.(19)

The Advisory Council found some options more palatable than others. The report notes there is little appetite in Alberta for increasing taxes. It rejects making health care services a taxable benefit for the following reasons: the potential for financial hardship among sectors of the general population, added complexity to the tax system, lack of visibility, and the likelihood that payment in this form would be viewed as a type of double taxation. Concern was expressed about point-of-service user fees because, for people with low incomes, these fees constitute barriers to care; as well, they violate the *Canada Health Act*.

The privately funded/privately delivered health care option would involve creating a parallel private system where one could obtain publicly insured and non-insured services in a private facility and pay for both types of services out-of-pocket or through supplementary insurance. This contrasts with the current system where insured health services are paid for publicly and direct payment for access to insured services is not permitted. The Advisory Council notes that this option may provide more choice, but it is not its preferred option.

As for supplementary insurance, the Advisory Council does not recommend expanding private insurance to cover publicly funded services, but notes that supplementary insurance could be used to cover services that are not publicly insured.(20)

The Advisory Council's preferred approach is to tie health care premiums to health care costs and the scope of insured services (this would involve a premium increase) and to develop a unique funding regime based on MSAs or variable premiums in an Alberta Health Care Account, both of which the Council recommends for further study.(21)

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(19) *Ibid*., pp. 52-61.

(20) *Ibid*.

(21) *Ibid.,* p. 61.

The report provides a basic outline of how the medical savings account option would work. Individuals would have an account into which a set amount of money (adjusted for certain factors such as age and sex) would be allocated each year. This could be equal to their Alberta health care premium or a combination of their premium and other money provided by the province. (The government would pay the premiums for low-income individuals.) The MSA could pay for insured health care services used each year. Initially, this would include all insured services, except hospital services.

Individuals who used all the money in their MSA and had additional health expenses during the year would either have to pay such expenses out-of-pocket up to an annual maximum before public coverage applied or would receive full public coverage for needed health services as soon as their MSA was exhausted. (The Council did not recommend which of these plan designs should be used.)

Any money remaining in an MSA at the end of the year would belong to the individual and could be used to pay for other health services or saved for future requirements.(22)

Another financing option explored in the report is the variable premium in an Alberta Health Care Account. This proposal has some of the characteristics of an MSA but involves using Alberta health care premiums as a co-payment (20% of the cost was suggested) for certain publicly insured health services with provision for charging a premium supplement based on taxable income to individuals who had exhausted their annual premium account and needed additional health services. Children and low-income individuals would be exempt.(23)

The MSA proposal could raise concerns under the *Canada Health Act,* particularly if individuals have to pay for insured health services when their MSA is exhausted.

The Alberta government has made two important announcements in this regard: increases in health care premiums; and the creation of an MLA task force (to report by September 2002) to recommend alternative revenue sources for regional health authorities as well as a provincial funding framework.(24)

Finally, the Advisory Council recommends that regional health authorities be permitted to raise additional money to pay for the services they provide.(25)

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(22) *Ibid*., p. 57.

(23) *Ibid*., pp. 58-59.

(24) Government Response (2002), p. 5.

(25) *A Framework for Reform* (2002), p. 62.

E. Incentives to Attract, Retain and Make the Best Use of Health Providers

The Advisory Council report acknowledges Alberta's acute shortage of physicians, nurses and other health providers as well as ongoing problems with low morale among health personnel. The report also notes that the province has had little success in providing integrated patient care or putting the right incentives in place to foster integrated care models.

To address these concerns, the Council has proposed a number of recommendations, including:

- developing comprehensive workforce plans;
- implementing alternative approaches to paying for physicians; and
- expanding opportunities for physicians and other health providers to deliver a broader range of services.(26)

The Government Response notes that a comprehensive workforce plan is underway as well as efforts to make more effective use of health care providers' skills. The Government has targeted 2005 as the year in which it hopes to have 50% of physicians on alternative payment plans.(27)

F. Evaluating Outcomes/Assessing Quality

The Advisory Council makes a number of recommendations aimed at improving the quality of Alberta's health system, including:

- supporting health research;
- increasing investment in information technology;
- instituting integrated electronic patient records;
- promoting Alberta's health sector as an economic driver; and
- establishing a permanent, independent Outcomes Commission to access outcomes and quality, establish performance measures, and report to the public.(28) (An Outcomes Commission will be established in 2002.)

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(26) *Ibid*., p. 10.

(27) Government Response (2002), p. 4.

(28) *Ibid*., pp. 68-69.

The Advisory Council notes that the absence of good information is a serious impediment to the development of an efficient outcome-oriented health system. The report describes the current Alberta system as being plagued with incompatible information systems that impede information-sharing and make it difficult if not impossible to track outcomes and improve quality. The Advisory Council calls for: investments in information technology; the creation of an electronic health record, including a debit-style electronic health card that would track use of health services and related costs; and the establishment of health information technology standards.(29)

The Government Response supports the creation of an electronic health information system, including electronic health records and province-wide information technology standards.(30)

COMMENTARY

A Framework for Reform is one of a number of provincial health reports – including the Clair Report from Quebec (2000), the Fyke Report from Saskatchewan (2001), and the Leger Report from New Brunswick (2002) – that outline approaches and plans for health system renewal.

The Alberta Report's principal conclusion is that Alberta's health system will not be sustainable in the longer term unless fundamental changes are made to both the manner in which the system is funded and the way health services are delivered. This sets the tone for reform proposals that include a greater emphasis on health promotion and disease prevention, improved access and quality, better assessment of outcomes, primary care reform, a greater role for the private sector in delivering health services, and new sources of revenue to pay for health care.

A number of the Advisory Council's recommendations – particularly those relating to providing care guarantees, improving access to health services, assessing outcomes, integrating health services, and promoting health research and healthy lifestyles – appear to have been generally well received. However, concerns have been expressed in some quarters about approaches that could result in services and treatments being delisted from public coverage,

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(29) *A Framework for Reform* (2002), p. 6.

(30) Government Response (2002), p. 6.

involve greater private-sector participation in the delivery of publicly funded services, and diversify the health care revenue stream by requiring individuals to contribute more money toward the cost of health care.

The work of translating a number of the Advisory Council's recommendations into an operational framework is underway. The expert panel charged with determining what services and treatments will continue to receive public coverage; as well, an MLA task force studying revenue sources for regional health authorities and a provincial funding framework will report later in 2002. The efforts of these bodies are likely to set the stage for the development of concrete proposals for determining the types of services covered by Alberta's health care system and how additional funds are to be raised and applied toward health care costs.