

Health Care Reform Options for Alberta

by Bacchus Barua, Jason Clemens, and Taylor Jackson

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

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

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

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

funding—Alberta, like most provinces in Canada, primarily funds hospitals using prospective global budgets wherein grants are provided to a hospital irrespective of activity in that particular year and the hospital's resources are not directly linked to the services provided. Such a system imbeds incentives for hospitals to provide fewer services, facilitate quicker releases, avoid costly patients, and shift patients to outside providers since they are seen as costs rather than sources of revenues. By contrast, high performing universal health care systems like Australia, France, Germany, the Netherlands, Sweden, Switzerland, and the United Kingdom generally fund hospitals based on some measure of activity. Moving towards activity-based funding has the potential to encourage competition, increase the volume of services provided, improve quality and reduce wait times.

3. Increase efficiency by creating a centralized surgical registry and pooling referrals—Canada requires patients to first visit a primary care physician in order to get a referral to a specialist. The creation of a central, province-wide, standard for assessing and prioritizing patients on wait lists and pooled referrals for specialists was quite successful in Saskatchewan. While Alberta has made some strides in this direction with the Closed Loop Referral Management Program, the Medical

Access to Service program, and the Alberta Netcare eReferral tool, more should be done to replicate the success in Saskatchewan.

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

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

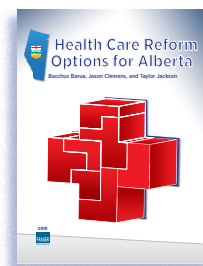
6. Revisit what's covered by the public system—Provinces have considerable latitude in prescribing what is covered by the public system. While the Canada Health Act pertains to medically necessary services, there is currently no clear definition of "medical necessity". As has been recommended in the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

7. Require individuals to share in the costs of treatment (with means-tested protections for vulnerable groups)—Of all the potential reforms, only cost sharing is expressly prohibited by the Canada Health Act. Cost sharing, which comes in a variety of forms and can cover a wide range of services, is a standard feature of most industrialized countries' universal access health care systems. Cost sharing involves having the

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

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

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



*Health Care Reform Options
for Alberta*

by Bacchus Barua, Jason Clemens,
and Taylor Jackson

[Click here to read
the full report](#)

