Health Financing

Financing of the health care system was a frequent topic for discussion during the Conversation on Health. A variety of sources of funding, funding models, and tax incentives and disincentives were highlighted in discussions and submissions. Here is a selection of what British Columbians had to say on the subject of financing health care.

Sources of Funding

Many participants emphasize that they are open to exploring a variety of sources for funding health care. Many consider taxation to be the most equitable means of funding. Taxation options include increases in income tax rates or dedicated health care taxes. Some participants suggest using Registered Retirement Savings accounts to help people save for their future health care needs. Some propose user fees as a solution to addressing funding issues and to reduce misuse of the health care system. However, some participants are not persuaded that over-utilization is truly a major cost factor or that user fees would generate much revenue, and others oppose the introduction of user fees due to concerns related to equity of access.

Many participants cite the federal cut backs in the early 1990s as the point where health care in British Columbia began to decline in quality. They recommend that the federal health care transfers to the provinces return to historic levels. Others emphasize that British Columbia has not effectively used the recent increases in federal transfer payments and that shifting the blame between the federal and provincial governments will not solve the issues facing health care.
Funding Models

Many British Columbians see the global budget funding model as inefficient and a deterrent to solving access issues. Participants are looking for a mechanism to encourage the health care system to utilize its resources to their fullest potential in an environment of accountability where progress can be measured. Activity based funding, as practiced in the United Kingdom, is suggested by some participants as a means of achieving accountability and creating incentives for improving the efficiency of service delivery. Some participants look to funding based on patient outcomes or other objective measures of performance to achieve the same goals. Regardless of the approach, there is general agreement that funding models should encourage longer term planning. Short budget cycles are seen as a source of inefficiency and poor spending decisions.

*We talk about things being under funded but, really, we’ve never examined what that funding was intended for and whether the original scope of that funding was realistic or not and the accountability around it. So at the end of the day, you can’t throw money at a problem and say, ‘Fix this.’ Well, what am I fixing exactly and with what outcome?*

– Focused Workshop on Delivery Models, Vancouver

Tax Incentives and Disincentives

Tax policy is described as a means to encourage changes in behaviour. Increased taxes on items deemed to be unhealthy, such as junk food, cigarettes and alcohol are suggested to reduce their use and generate revenues that could fund health care. Many British Columbians are also concerned that their efforts to live healthy lives are not rewarded. Participants suggested that health and fitness products and services should be tax free or tax deductible. Many British Columbians support making fees for complementary and alternative medicine tax deductible to encourage their use. Some participants caution that tax incentives reward those who already have the ability to afford health care and request that the socio-economic disparity in health outcomes not be increased by benefits that exclude those with low incomes.

*Hey, I drink a [tonne] of beer, but I understand that could come back to haunt me and the health-care system down the road. I would pay extra tax for the privilege of drinking beer - and I think people who sit … eating chips and watching TV all night should pay more for their junk food.*

– Web Dialogue, Vancouver
Conclusion

Many participants see adjusting the source, amount and mechanisms, of health care funding as a means to achieving sustainability in the health care system. There are numerous solutions proposed and references made to international examples. The common features of many of these recommendations are improved accountability, efficiency and outcomes. Many British Columbians are willing to accept increased personal and collective financial responsibility in return for a health care system they can rely on. While increased funding is often seen as a requirement for positive change, there is an understanding that money alone will not solve the issues facing health care in British Columbia.

One of the things we learned at the Romanow dialogues… was that [citizens] would accept higher taxes if you could demonstrate that there was going to be a different healthcare system…

– International Symposium, Vancouver
Health Financing

This chapter contains the following topics:

**Funding Models**

**Hospital Funding Models**

**Federal/Provincial Financing**

**User Fees**

**Tax Policy**

**Tax Incentives and Disincentives**

<table>
<thead>
<tr>
<th>Related Electronic Written Submissions</th>
</tr>
</thead>
</table>
| Submission to the BC Conversation on Health  
Submitted by the Society of Specialist Physicians and Surgeons |
| Smoke Free BC - Healthy People, Healthy Place  
Submitted by Dr. Roland Guasparini |
| A Summary of the Public Forum on Health Care Organized by the Kamloops Citizens Concerned About Public Health Care  
Submitted by the Kamloops Citizens |
| Submission to the Conversation on Health  
Submitted by the BC Cancer Agency |
| Advancing Leadership and Innovation In Specialized Health Care in BC  
Submitted by the VGH and UBC Hospital Foundation |
| Why Wait? Public Solutions to Cure Surgical Waitlists  
Submitted by the Canadian Centre for Policy Alternatives |
| Submission to the British Columbia Conversation on Health  
Submitted by the Life Sciences British Columbia |
| A Vision for Better Health  
Submitted by British Columbia Dental Association |
| Submission to the Conversation on Health  
Submitted by the BC Nurses' Union |
Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Innovation and Efficiency; Health Care Models; Health Care Spending; Food Quality and the Environment as Determinants of Health; Health Financing; Lifestyle and Health and Public Private Debate.

Funding Models

Comments and Concerns

International Funding Models
Funding Linked to Improved Efficiency
Funding Challenges

• Comments on international funding models:

  • When they implemented the physician funding system in England there were all kinds of problems. Basically, doctors got up to 1000 points. They got points for reaching designated targets and they got a certain amount of money per point. Doctors could get 25,000 pounds if they hit 900 out of 1000 points. All kinds of things happened because of that, for example, doctors stopped working after hours because they were already making more money. Doctors were spending a lot more time on diabetes and did not spend time on things that did not have points. The nurses thought they were doing all the work and did not get any more of the money. One of the things I heard decision makers say there is that it is no longer a topic that you have to measure your outcomes, and that value for outcomes has become part of the system. No doctors are saying, I am not going to tell you how I am doing or I do not want you to know what the quality of care is, that debate is over.

  • The United Kingdom made fundamental changes to their funding model, so that the cash follows the patients. Instead of facilities receiving money and doing what they can, which is what we do now and what they used to do, providers are paid for the services they provide. Patients can receive services at either private or public facilities, with no cost to themselves. The result was competition among providers to put patients first and to earn their patronage. Apparently patient satisfaction went up, waitlists went down and costs did not go up; the money was simply spent differently. I think it is a concept worth considering because the model already exists and from everything I have heard it works.
The system in the United Kingdom is entirely tax funded. Over the last few years private insurance has slightly declined in the United Kingdom. Ninety per cent of the people in the United Kingdom just use the National Health Service.

The United Kingdom uses a population-based funding model. These funds are used to hire doctors, nurses, managers and other professionals. They also looked at improving quality in a variety of areas by providing bonus points for reaching specific targets. Some of them are process targets rather than outcome targets at least to start with because they have a much better information system.

One of the ways the European countries have re-structured health is by having the health care dollars that are now spent on me actually follow me, almost like a voucher system. This way you take the dollars away from the huge bureaucracies that build up around hospitals and health regions and use them to cover individual medical costs that the patient purchases. This way it allows the individual to select the most efficient, effective and wait-time efficient hospital or doctor within the region and province.

A 2005 study published in the British Medical Journal on, the implications of the payment by results financing system, warned of the potential danger of over servicing. In a comparison of short-stay emergency admissions between hospitals, that had introduced the new funding arrangement and those that had not, researchers found more admission in hospitals with results-based funding. This is because short stay admissions attract higher payments under the new system than outpatient emergency care, so hospitals have an incentive to increase admissions.

I am going to sound the alarm that the road that our Government is heading down with respect to pay for results funding, a failed competitive model imported from Britain, is likely only to make things worse. The chair of the British Medical Association Consultants Committee said that political modeling has brought the National Health Service (NHS) to its knees. The Government diverted billions of pounds from improving efficiency to create an internal market in which hospitals compete for patients. The excessive use of private firms to provide NHS services has been costly, disruptive and has fragmented care. The independent sector should be used only where the NHS needs it, not thrust into its midst like a carelessly placed hand grenade.

The money the United Kingdom is spent, and gets into the system, through primary care trusts. The health authorities and health boards are responsible for public health/population health and are responsible for spending the money on individual health care and for providing primary care. They bring together
primary care, public health and all the money that flows into the acute sector. It is about putting the incentive and the power into primary care.

• Canada publicly finances 70 per cent of health care. European countries average about 76 and some countries are well into the 80’s. Europe funds a high percentage of health care and a wider range of services than Canada but rarely 100 per cent of any service. Canada funds almost 100 per cent of hospital and physician services but less than 50 per cent and sometimes zero of other services. Europeans also have some supplementary insurance to make up the gap between the direct charge and the total cost, so out of pocket expenses may be lower. Canada has decided to put all of its social capital into the hospital medical basket and not fund a whole lot of anything else.

• In the developed East Asian systems there are much lower levels of public expenditure, with the exception of Japan, and very low levels of Gross Domestic Product expenditure. The funding levels appear low but this is something of an artifact of the developmental state of the health care systems. The universal health systems of both Taiwan and Korea are much newer than western counterparts or Japan. Both Taiwan and Korea have experienced considerable cost growth in recent years. Korea’s year on year growth rate has been over eight per cent since around 2000 when they put their national social insurer in place. All three countries face an uncertain future due to the demographic changes that they are going through.

• None of the systems in Japan, Korea and Taiwan have waiting lists due to the unrestricted access policies. None of the systems have a wide emphasis on quality assurance or improvement, nor are they underpinned by population health ideals or goals. Although it does need to be recognized that these western ideas of population health are in some ways counter to the strong belief within many Asian societies that health is actually a family and an individual responsibility, not that of the state.

• In all three countries, Japan, Korea and Taiwan, co-payments provide a core funding mechanism and patients will pay about 30 per cent of the costs whether in hospital or primary care in Japan. In Korea co-payments are about 40 per cent of costs; hence quite large sums of money are going into patient co-payments. In none of the three is there a tradition of private insurance so patients will in some cases personally pay quite large sums of money. That said, all three do have safety nets and there are limits on catastrophic payments. In Taiwan, for instance, a patient will pay no more than ten per cent of their annual income in health care payments. Despite the co-payments and the relatively low present costs of these systems, all three systems face cost growth pressures.
Japan has kept costs at around the average for the Organization for Economic Co-operation and Development (OECD) largely been through active fee schedule management. However, it faces problems of population aging and does not necessarily have a solution to stem cost growth. It also has a significant problem, in terms of funding long term care, because of population aging. Taiwan and Korea face quite serious problems because insurance premiums have simply not kept pace with service demand and their fee schedules have also led to quite distorted service delivery patterns.

Diagnosis related grouping (DRG) payments, case payments and global budgets have been the key means for cost control in the health care systems of Korea, Taiwan and Japan. Each country has experimented variously with them. In Korea a DRG pilot has been found to control costs with marginal impact on service quality while in Taiwan case payments have been linked to the off-loading of high cost patients.

In Taiwan, there has been an incentive to over provide high tech hospital services which has led to the growth in very large high tech hospitals over the last ten to fifteen years and to under provide ambulatory and basic hospital services. This was because of the structure of their social insurance fee schedule. In Korea certain services are over provided, for example, the caesarean rate in Korea is 43 per cent and specialties such as ophthalmology and dermatology attract much higher levels of funding than do many others. And so, among medical graduates, this has skewed the demand for training places in certain specialties.

The Japanese system has a few thousand social insurance organizations. This might appear to, and does to some degree, offer considerable choice to the population but the system is otherwise quite strictly structured around three tiers of insurance that cover different groups within the population which the government pays different subsidy levels to. Often referred to as the valve that regulates the Japanese system is the fee schedule that insurers pay to service providers. This fee schedule serves to unify the Japanese health system because it mandates a common pay rate for listed services on that schedule. That pay rate is the same regardless of which tier or insurer a person is covered by. In this way it insures equitable and universal service access. The fee schedule is revised every two years by the Health Ministry and the main player in that process outside of the ministry is the Japan Medical Association. Every item on the fee schedule is scrutinized in the process and costs are controlled by reducing the fee for services that are over utilized and raising the fee for services that have been under utilized. This fee schedule serves as the only rationing mechanism within the Japanese health care system.
The American medical system, designed in the late 40s, depends to a large extent on employer contributions as a way of avoiding a national health care system similar to our own. This system of employer contributions to employee health costs adds an average of 1,400 dollars to the cost of an American made automobile but is not recognized in any tax-based measure of medical costs. This major source of money spent on medicine but not counted in any measure of government expense will obviously skew any comparisons made between our health system and those in the United States.

The Puget Sound Medical services encourage wellness and pays according to wellness. They pay their providers a flat rate per year per patient and cover a broader range of services.

In theory the Oregon Plan and Medical Savings Accounts are good ideas. In practice, neither of these concepts has been shown to improve service or reduce costs. The Oregon Plan is the most direct method because each year a decision is made about the total amount of public spending on health care. Based on available funding, services are offered down to a defined cut-off beyond which there will be inadequate funds. A panel of experts assisted by members of the public determines what constitutes the bundle of available services. Each year, the fund pays for a defined volume of work and services, such as, all emergency treatment to save life and limb, and a defined number of joint replacements, cataract operations, diagnostic tests and pharmaceuticals. Very expensive treatments with limited evidence of benefit are at the lower end of the list of priorities and might not be funded. The plan thus advocates explicit rationing by de-listing services. In Oregon, the Oregon Plan generated considerable controversy and has not achieved a reduction in public health spending. No other jurisdiction has been able to successfully implement a similar plan. Medical Savings Accounts shift the locus of control for spending to patients instead of third parties like administrators to improve efficiency and reduce costs. Again, the plan sounds sensible but an analysis of its implementation in Canada suggests it might actually raise costs by increasing spending on the relatively well (80 per cent of patients consume less than 600 dollars a year in health care) and might only produce modest savings by severely rationing care for the sickest patients (the one per cent who account for more than 25 per cent of annual health care costs).

Comments and concerns about funding being linked to improved efficiency:

I do not agree that funding from the provincial government to health authorities should be based, at least in part, on their level of operating efficiency and patient outcomes because ultimately patients would be the ones that pay the price in the
end when funding is cut. Cutbacks in funding are not the answer! Correcting the problem is.

- This measure, of funding based on operating efficiency and patient outcomes, would be very difficult to determine and could be very subjective leaving some health authorities unable to deal with the health needs of their region. There is no way to determine the health needs of a given population vis-à-vis another under differing circumstances.

- I absolutely disagree with this idea that funding from the provincial government to health authorities should be based on their level of operating efficiency and patient outcomes. There are many reasons that this would create a disparity in the delivery of health care. The fundamental basis of this idea is that all areas and people delivering health care services are equal and this simply is not true.

- I believe we have to be careful to not confuse operating efficiency with best practices, which have to be based on evidence or patient outcomes.

- Payments by results schemes are not appropriate for improving Medicare. They would make current problems much worse and would destabilize the acute care sector by eliminating any certainty for budgeting or long term planning.

- Let us work at making the existing system work more efficiently. Pilot projects could be used to try out new ways of doing things.

- Pilot projects are disruptive and lack multi-year commitments, so they are difficult to measure.

- **Comments on funding challenges:**

  - If we make the political decision that there is probably already enough money in the system, the challenge in achieving better performance must lie in improving leadership, priority-setting, decision-making and management at all levels. We must do better on health promotion, public health and preventive medicine. On the other hand, there are many in society and among the ranks of the health professions who believe that the system we have is already doing very well and while its underlying principles seem secure we would adjust its design and the way it is working at our peril.

  - The existing budget is by definition aligned with the status quo, which is mostly a legacy of thinking of the early 1970s. Does it necessarily follow that this is the only model or formulation we are capable of or has the time come, especially in light of yet another massive budget surplus, to consider whether to expand the scope of health services to more within currently under-financed sub-sectors such as PharmaCare and dentistry.
• The choosing and the paying are always separated by great distances and time. The chooser often is not the payer. The equation is results over cost equals value. We do not know what the results are. We do not know what the cost is. So how do we get to value?

• The biggest challenge in health care is that if you conceive it as a public good and a public service, it is built on a huge juggernaut of entrepreneurial activity that increasingly views it as a commodity. Keeping public costs reasonable and keeping utilization to the effective end of it actually conflicts with an entrepreneurial marketing agenda, which is why this tension exists in perpetuity.

• Our public system is based on a 1960s model when it was possible to pay for an entirely publicly funded system. It is not possible to do this any more. There are simply too many demands on the system.

• The current lump sum funding environment of the health authorities is not conducive to a fully public/private operation system.

• A mix of direct taxation (including income taxes and premiums), indirect taxation (federal and provincial sales taxes), private insurance and out-of-pocket payments finance the health care system in British Columbia. Physician and hospital services are covered almost entirely by the first two sources, which in British Columbia turn out to be more or less proportionate to incomes. Pharmaceutical sector financing is quite regressive, as one would expect, since about half of British Columbia’s drug bill is financed by out-of-pocket payments or private insurance. The relatively high proportion of private payment for home and nursing home sectors would suggest that financing for these sectors is also regressive.

• Our system has a similar per capita cost to France, the number one rated system, while ours is ranked 30th- there must be a large productivity gap.

• Health care systems that rely more heavily on direct taxes as a source of finance tend to be more progressive because income and other direct taxes are usually designed to be progressive, with tax rates being a direct function of income levels. Indirect taxes, such as consumption taxes, tend to be regressive, with a greater proportionate burden of payment falling on lower income individuals. Indirect taxes tend to consume a greater portion of income at the lower end of the income scale; a direct result of the fact that these taxes are often levied on non-discretionary goods. These goods are purchased out of necessity by poor and rich alike but obviously account for a greater share of the disposable income of those less well off. Out-of-pocket payments tend to be the most regressive form of health care financing because they represent a much larger proportion of the income of lower-income individuals. In addition, a higher proportion of lower-
income individuals have poorer health, making the impact even more pronounced.

- Canadians have consistently stated that they want a predominantly public, single-payer health care system. They are prepared to, and do, pay for some health care services entirely out-of-pocket or partially through user-pay charges. Canada remains the only industrialized nation to permit user charges for some health care services yet precludes them for almost all medical and hospital care. The questions of why some services are subjected to co-payment while others are not, and why the proportions of co-payment vary significantly from service to service needs to be addressed.

- There are three opportunities to substantially shift the culture of health care delivery in British Columbia: the primary care partnership with the British Columbia Medical Association (BCMA), the health innovation fund and the primary care charter. This is an opportunity to challenge thinking. But the primary care charter is physician focused whereas primary care is not solely physician based; it is multi-disciplinary, inter-disciplinary care. However, the politics and the power in the province have created a document around primary health care that is physician centric. Almost everyone who is not a physician is actually quite disappointed in the direction we are heading.

- There is no recognition that the services non-profits provide are cost efficient.

- I feel that allowing donations to fund operating costs as well as equipment could lead to private individuals to seek treatment at a public hospital, contrary to the Canada Health Act.

- While health care costs continue to go up so does the value of the St. Paul's Hospital asset. This is an asset we have no control or say over right now but an asset that could help pay for our health care.

- The north has experience a culture of innovation that must be preserved and encouraged.

- The St. Paul's and St Joseph affair is an excellent example of poor administration because they did not even know that this misuse of public resources was happening when a private contractor was renting out time on their diagnostic equipment.

- The private surgical clinic has been given access to public resources ostensibly since December 2006. That access, whether intended or not, has included use of publicly-funded labour (the Sterile Processing Technicians, of which I am one) and on-site resources (the autoclaves in the Sterile Processing Department) in
processing the equipment of a private surgical clinic. Such work has been conducted fully and completely on the public purse.

- We need to have government move away from direct delivery of health care and instead focus on providing funding. This would streamline the delivery of health care. Government does not farm or build homes and these services are delivered to everybody regardless of the ability to pay. Government does a good job of ensuring that the poor are taken care of in these fields without the intervention seen in health care.

**Ideas and Suggestions**

**Alternate Funding Models**

**Funding Health Authorities**

**Activity Based Funding**

**Revenue Sources and Generation**

**Funding Challenges**

**Improving Efficiency through Funding**

- Ideas about alternative funding models:
  - Each resident should have an annual health care account, modelled after the Employment Insurance program. Unused funds in these accounts could be carried forward into subsequent years to fund future health care needs.
  - British Columbians should be allowed to spend money they have saved in Registered Retirement Savings Plans on health care needs and have these payments be tax deductible. Many seniors have a great deal of money in Registered Retirement Savings Plans and would want to pay for services if it got them faster service that was tax deductible.
  - A system should be established similar to Registered Retirement Savings Accounts to allow British Columbians to save for future health care expenses. These funds could be withdrawn tax free after the age of 65 to be used to pay for services not covered by the Medical Services Plan. Anyone can contribute this health care plan, including employers.
  - Medical Savings Accounts where everyone is given a certain amount of funds to spend on health care combined with insurance with a deductible equal to the balance of the Medical Services Plan would provide people with full coverage and incentive to use the funds judiciously because unused balances are carried forward.
• An annual health budget for each resident could be created with unused dollars saved by the individual for future use. The exhaustion of the budget would be a problem solved by that individual.

• We should pay for all our health services through one insurance plan, funded through our income taxes and based on our ability to pay.

• Our system should be organized like an insurance company, with compulsory participation and everyone paying premiums based on actual cost to deliver the service.

• We should create a three-tiered system. Tier three will be for welfare recipients and people in need but not the handicapped. There will be minimal emergency services with a yearly limit of money for each patient. Tier two will be similar to the existing health care system with increased insurance premiums and should be consistent in all provinces and territories. User fees for all services must be paid to 20 per cent of the yearly earning of each patient. There should be a life-time limit or maximum for each patient’s spending on his insurance. Tier one will be an extended version of Tier two coupled with additional private insurance. The life-time limit of money will depend on the type of private insurance. There will be the possibility to get a voucher for the cost of services in government hospitals, which can be used everywhere in the world for treatment.

• The provincial government should create an open-ended account specifically for health care, guaranteed by the Government and separated from general revenues. All of British Columbians’ medical expenses would be paid from this account. As the funds in the account are depleted the tax payers would replenish the account to sustain the health system through fees or a dedicated tax.

• I like the idea of changing the model so that the patient is viewed as a revenue source as opposed to a cost line item. A caution to that is the general move towards a density driven decision making model as our province and country become more urbanized.

• Restructure funding to involve all four levels of Government in health initiatives that are cost-shared, such as affordable housing, low barrier housing, harm reduction, safe clinics, community-based clinics, protective services, safe cities, mental health and addictions.

• There is a lot of funding available in the form of gifts, donations and contributions but we need improved mechanisms to allow the giving of gifts to the health care system.

• Grants and donations must be energetically sought from those in this aging population who have no-one to leave their estate to.
• Government has capital sitting unused, such as closed post offices and schools. Sell these assets and put money into health care.

• Maintain a government system and use strategies similar to rewards for careful drivers. Substantially increase annual health care premiums to reflect true costs but offer significant discounts to people who work actively to achieve and maintain positive health. The more people stay healthy the more resources become available to treat those people who are really sick.

• Link funding to income. In other words, those that can more than afford top quality medical care might possibly pay a little more for their procedures, whereas those with meagre incomes would pay considerably less.

• The next three decades of cost increases can be supported by health bonds. These are issued like the war bonds and are only intended to help pay for the cost of care of the baby boomers for the short term, until attrition reduces their numbers.

• Define health care core services for the public system and non-core at 80 per cent of the capacity of the existing system. The private system would then provide publicly funded services over top of the core services.

• We should negotiate with large suppliers of goods or services for higher discounts or partial/fully donated goods and services. In return, a large and tasteful form of sponsor advertising could be displayed on the building with the highest value sponsor in the top position. A large electronic display (pixel board or Jumbo-Tron television) mounted on the most visible area that includes a thank you, the sponsor’s log and company names informing the passers-by of who sponsors the hospital. This type of board would be easily updated from a user inside the hospital and will constantly keep regular passers-by interested as the sponsors may change. Short television or radio ads can also be considered a method of thanking sponsors. These ads could be purchased at a small percentage taken from the savings.

• Consider pay for performance through the use of a funding secretariat with some dedicated resources and some commitment over a few years to manage it.

• A national spending account for each individual would result in more individual control and incentives for not abusing the system.

• For all our working lives we have taken care of our health and our finances in the expectation that when we became older, and increasingly need health care, we would be able to receive and pay for timely and effective care. Now we find that there are a substantial number of people who are determined to have a system
which penalizes those who have been responsible in favour of those who have chosen to depend on others for their health care.

- What about giving patients money that they can use to shop around internationally.
- Making sure that money follows the patients and rewarding the best gives others the incentive to improve.
- We should use a medical credit system like they have in Singapore and South Africa.

- **Ideas about funding health authorities:**
  - Funding to health authorities should be based on the population they serve and the particular services and expertise they provide. Vancouver hospitals provide specialized medical services to the whole province not just to Vancouver residents and their funding should reflect that.
  - Let hospitals and their boards handle the money and get rid of Health Authorities.
  - We need to put in place processes to tie funding directly to productivity. These are automatically built into successful private business models as they go out of business if they are not productive.
  - The funding for health authorities needs to be based in part on outcomes and patient satisfaction surveys. This information should be based on services provided at hospitals and clinics; staff attitudes, including clerical staff, towards patients; response times from health authority officials to public inquires and how closely the health authority follows guidelines, mandates and direction from the Ministry of Health.

- **Ideas about activity based funding:**
  - The reality in countries like Britain that use activity based funding or payment by results is that there are no waits. We need to learn from this.
  - In a system such as ours, geographically organized, activity-based funding makes little sense.
  - Activity based funding is a basic economic principle. It is an internal market. It is where the patient going to the hospital is a source of delight to the finance department of the hospital instead of a cost.
  - Activity based funding is something that could take place within the public system. Even if you wanted to have a pure public monopoly, you can still do that with activity based funding. It is simply a way of paying the hospitals.
• **Ideas about sources of revenue and revenue generation:**
  
  - There should be a single source of revenue for all health care. Multiple sources increase administration and lead to the break down of the system.
  
  - We have to recognize that the North generates lots of provincial wealth. We should spend more on health care in the North to recognize this fact.
  
  - We need an economic development strategy that will primarily deal with development in remote areas of the province. It may be natural resources but we have got to start to look at where these populations are and how we can affect them positively through better living circumstances that are funded through economic development.
  
  - A huge increase in energy production would mean a huge boost to our economy. If we could create a surplus like Alberta has, our health care system would be in much better shape than it is.
  
  - I believe the excess billions of dollars from the Insurance Corporation of British Columbia (ICBC) should be diverted to health care to fund the hospitals properly.
  
  - Revenue for core services should remain a blend of premiums, general revenue and co-payment.
  
  - Loosening the *Canada Health Act* to get more private funding is not a real answer. That is basically not looking at finding out why costs are rising but simply trying to push costs elsewhere.
  
  - We could create a co-insurance program which is tax-payer based.
  
  - A solution to the funding problem may come from public-private partnership projects.
  
  - Government has a better credit rating and can secure cheaper loans than private enterprise. For this reason alone, government should continue to build infrastructure.

• **Ideas about funding challenges:**
  
  - The current problems in the health care system cannot be solved with better management and efficiencies when our ability to provide care is being cut. It will take a different attitude in Government and a willingness to raise taxes to correct this.
  
  - The Ministry of Health needs to get out of paying doctors and into funding the health authorities to provide all medical services. In this way health authorities could ensure that all residents in their area have access to care by funding clinics per patient served. Each clinic would have a registry, with a minimum number
and possibly a maximum, of patients to be registered for the clinic to receive funding.

- One of the reasons why British Columbia is so much better off than some of the other provinces is because we believe in boutiques. Children’s Hospital and the Cancer Agency are boutiques. They are provincial resources. They are in different locations but our rates are better because they are centrally controlled. You have the expertise, the efficiency and the effectiveness. We are not duplicating services.

- There is a need for some other kind of funding because of the stranglehold that physicians have over the Medical Services Plan. It could be called the allied health services plan. It would allow health professionals other than physicians to tap into a fee-for-service type structure. As an organization delivering sexual health services, we subsidize the system to the tune of thousands of dollars a year doing pap tests for which we cannot get reimbursement because they are not being done by a physician. This new fund could fund services such as this.

- Allow people to buy better care. Set a minimum standard that is universal and allow those that can to buy more.

- I hope that our Government will find ways to continue a system that provides all essential medical services, financed by our taxes.

- **Ideas about improving efficiency through funding:**
  - Use report cards to link funding to efficiencies by increasing funding for successful programs and decreasing funding for poor programs.
  - Once procedures and methodologies have been put in place to assess operating efficiency and health outcomes, much of the resources for health will be spent demonstrating value for money. The cure may be worse than the disease.
  - Start mirroring other industries that have taken a lean production approach to costly production processes within their industries.
  - Increase competition on the employer and labour side of the model.
  - We should shift ambulatory care delivery from hospitals to efficient facilities such as home care and other home based programs.
  - Study alternative delivery models to improve efficiency.
  - We need to look at the most efficient and effective service delivery model that focuses on broader criteria, rather than just costs.
• Budget for need after a thorough assessment. We need to know how many x-ray machines, hip surgeries, cancer radiation treatments we need based on demographics and experience.

• Introduce patient-based performance metrics for hospital services.

• Patient health outcomes are based mostly on the level of funding and the availability of doctors and nurses. A lack of doctors and nurses and lower levels of funding contribute to decreased health outcomes. Health care is not a business and can not be treated as such. It makes absolutely no sense to reduce funding to a health authority that has bad patient health outcomes. Penalizing a health authority is a false economy and will only make a bad situation worse.

**Outstanding Questions**

- Are our funding mechanisms and incentives matched to what we want to achieve?

- Would it be feasible if an escalator increase was adopted for health funding based on the Cost of Living (COLA) index?

- With activity-based funding how will rural hospitals compete?

**Hospital Funding Models**

**Comments and Concerns**

- **Shortages of Hospital Resources**
- **Hospital Budgeting**
- **Funding Hospital Infrastructure**

- **Comments on efficiency of hospitals:**

  • Have a separate hospital or clinic for cosmetic surgery.

  • There should be a standardization of equipment between hospitals to ensure equipment can be used everywhere and that staff anywhere know how to use the equipment properly.

  • Hospitals need a clear mandate to have fewer administrative staff. Enforced budgeting clearly does not work.

  • We should support the expansion of surgical centres that specialize in high volume procedures.
Cardiovascular disease is the leading cause of death in British Columbia. Other provinces have realized this fact and have established Heart Institutes.

We should have more facilities distributed throughout the province to reduce travel for patients.

We need more resources for triage and fast tracking.

The contracting out of services is definitely not working, and is not as financially lucrative as was envisioned. We have to accept that this experiment failed.

Fund and resource community care to reduce the pressures on ambulance care, emergency care and even police response to elderly calls.

We should support infrastructure improvements for hospitals.

It would be a good use of resources to convert closed schools into community health clinics and seniors facilities.

Small facilities embedded in communities and neighbourhoods should be funded to reduce pressures on central hospitals.

Do not compare hospitals to hotels.

Hospitals suffer from operating inefficiencies. Most departments work in silos and yet very much depend on other departments or external resources to make things work. It is a complex environment that has loose standards, methods and procedures.

The cluster model of hospice care is less expensive than hospital care and provides opportunities to partner with non-profit organizations.

All renovations and new hospital construction should be power smart to save money.

One focus of cost cutting could be energy consumption of hospitals. Conservation could save 10 per cent of the monthly bill or higher depending on the solution used.

There is no incentive for hospitals to act like a business.

Too much is being wasted in hospitals. We need to increase accountability and transparency.

The way that hospitals are funded encourages inefficiency. Block funding means that the managers are scared of both overspending and under spending their monies. Both sins are penalized, so limits are placed on services until they realize that a surplus will be created, resulting in a reduced allowance for the next year and what follows is frivolous and urgent expenditures.
• Smaller hospitals may only be able to support part-time health care staff. This makes attracting and retaining staff difficult.

• Hospital policies that discontinued the option for a patient to request and pay for a semi-private or private room have resulted in less income for the hospital.

• Hospitals in other countries keep track of their expenditures and control inventory. Our hospitals do not. Equipment and supplies are handed out without being purchased by the patient. When supplies come in they are not being matched to the packing slips and they are stored in places that anyone could access. These practices would cause most business to run in the red pretty quickly.

• The efficiency of a hospital should not be used to affect eligibility for patient care. It could and should be used to monitor and modify performance of health care providers.

• There is a surprising lack of accountability in the operations of the health authorities and hospitals. Nobody knows what it costs to do a procedure in one hospital compared to the next. Endless meetings with highly paid participants occur without measurable results. Consultants galore are writing thick reports that simply gather dust. The administrators have no incentive to improve on that because they can spend the money as they see fit.

• Comments on shortages of hospital resources:
  • There is a lack of operating room capacity and surgeons.
  • Equipment such as echocardiography and carotid duplex ultrasound machines are relatively inexpensive and in wide use across the country in other facilities but are in short supply in British Columbia.
  • There is a lack of equipment and lack of storage in hospital.
  • The supplies used in the hospitals are not accounted for, leading to potential for theft and misuse.
  • We need more high tech equipment.
  • Multi-million dollar machines stay idle because the hospitals are not receiving funding to keep them staffed.
  • Do not buy more expensive new and improved diagnostic equipment. What we have now should do. Get more of the current models in all areas, rather than some improved version in just a few centers. Bigger and better is not always smarter.
  • Geriatric activation units are needed to meet the needs of weak, debilitated elderly whose acute medical needs have been stabilized.
• Lab services are inefficient.
• There was no oxygen at the hospital when I was having trouble breathing.
• Power drills are a pivotal piece of equipment for surgeons, especially neurosurgeons. Vancouver Hospital has recently decided to buy new drills for the operating room but instead of purchasing the drills, unanimously supported by the surgeons, they have opted to buy a cheaper, less functional device. It is clearly another example that the current health care system prioritizes money savings over patient care.
• Emergency rooms are a major problem and need more resources. There are no magic bullets in utilization management.

• **Comments on hospital budgeting:**
  • Global budgeting creates a spend it or lose it mentality. Hospitals budget their funding ineffectively as they lack incentive to serve patients efficiently and in fact have incentive to misuse funds.
  • There is a misuse of resources because of the way hospitals must budget with overly high estimates to ensure funding is not cut.
  • The global budget system for funding hospitals results in limiting and rationing health care, closing beds and operating rooms, reducing surgery and simply not treating patients.
  • Hospitals are funded globally, with all the money going into one big hole.
  • I have some real concerns about how hospitals are funded and how that money is handed out. The hospitals do not seem to be fiscally responsible with their money, nor do they have to get the best price for equipment or other products.
  • Global funding encourages people not to do things and instead to keep the money for end of year. Other jurisdictions have funding based on use which encourages hospitals to be competitive and meet a quality standard.
  • During a two-year period the hospital in question came in under budget and found that their efficiency meant nothing because their budget was cut, as obviously they did not need the funding. Later, under new management, pressure was applied to all departments at year end to spend no matter what to come in a little above budget. This caused departments to take the hint and come in much over budget. After squabbling with the health authority over the need for more funding, they eventually got it. They should have been penalized through direct cuts to executive level remuneration at all levels and kept the operating budget the same. The ones coming in under budget should get more
funding consideration to carry on their efficient work and management should get a bonus.

- It seems that in the hospital system you are rewarded when you have spent your entire budget for that year with a bigger budget the next year.
- It seems clear that the problem is that the hospital is not appropriately funded in terms of beds to care for the number of patients that need to be admitted at any one time.

**Comments on funding hospital infrastructure:**

- Women’s Hospital should not ask its employees for money to build a new facility. The funding should come from public money.
- The hospitals are over crowded. We are ten years behind in building new hospitals, as Government does not spend money in the right places.
- Health care professionals are available to work but the health care facilities for them to work in have been closed.
- It is not right that the Government can close down a hospital and remove the equipment. Much of this equipment was purchased through local community fund raisers and should stay in the community.
- We need a commitment to public funding of hospitals. Hospital closures just lead to line-ups elsewhere.
- Many hospitals have empty wards that are unopened due to the costs incurred to staff, power, clean, heat and maintain them.
- We need more funding for beds.
- With the over crowding of the hospitals we need to fund more buildings, equipment and staff.
- The voice of the Northwest Regional Hospital district is not being heard during pre-budget meetings.
- I want to see not only adequate facilities but ample facilities within the public system. When I get inside a hospital I do not want to see the dirty floors I see now.
- Large hospitals take up very valuable, downtown real estate and must provide large areas for parking and servicing. The larger hospitals also tend to be overly utilized and therefore very expensive to maintain and operate.
- Patients have to travel to access needed health services due to inconsistent funding from community to community.
The current funding allocation is imbalanced and inconsistent with the needs of patients and communities.

**Ideas and Suggestions**

- **Revenue Opportunities for Hospitals**
- **Improving the Efficiency of Hospitals**
- **Hospital Funding Models**
- **Hospital Budgeting and Accounting**

- **Ideas about revenue opportunities for hospitals:**
  - We have hospitals where people spend a lot of time waiting, visiting, recovering and working. The hospital provides very limited services to these people. I think there could be huge potential for revenue if we tapped into this market. In Victoria we allow junk food vending machines, Starbucks and Tim Horton’s to sell to the public. The hours of the cafeteria, especially on the weekend, are not satisfactory. A privately owned 24-hour restaurant or coffee shop could lease space and generate income for the hospital.
  - Hospitals should encourage American citizens to come to Canada for operations. We can use the profits to open up operating rooms 24-hours per day and seven days a week.
  - I would like to see the hospitals run a lottery like the Lotto 6/49. I would like to see this administered by the hospitals with all the proceeds going to building new hospitals and purchasing new technologies.
  - Have you thought about corporate sponsorship for items like diagnostic machines? Companies like Telus could sponsor a Magnetic Resonance Imaging machine (MRI) for example. In New Zealand the Children’s Hospital has advertising signs up on the roof, which generates needed income.
  - The rules governing charitable fund raising for hospitals are too restrictive.
  - Many patients who leave the hospital require a prescription, quite often these people are elderly, and are discharged after hours. A public pharmacy at the hospital would generate income for the hospital and be a welcome relief to these patients.
  - We could increase the health care budget by allowing more retail and commercial services in hospitals.
• A fee for service gym could be set up at the hospital. It would promote good health in the hospital and generate revenue.

• The hospitals could lease out space for daycare. This would help to reduce staffing issues and help patients out who are having day procedures or diagnostic testing.

• Hospital waiting rooms could be set up with pay televisions similar to those in patient rooms.

• In the past five years, British Columbian biotech companies Angiotech and QLT have returned over 60 million dollars to University of British Columbia (UBC) Hospital as a return on investment. Boston is an example of where complex patient care combined with medical research brings new economic opportunities to hospitals.

• Hospitals in Winnipeg have more services, such as hair salons, to help pay for health services.

• Ideas about improving hospital efficiency:

  • One method to increase operating efficiencies in hospitals and improve patient service is to increase the percentage of service-based funding (SBF) to health authorities, as an incentive to reduce wait lists. Under a service-based funding model the Government pays a fee for each individual cared for based on the expected costs of treating the patient, as diagnosed at the time of admission. Service-based funding creates incentives for hospitals to treat more patients, thus, reducing waiting lists.

  • Patients should be able to choose which hospital they go to. This would create healthy competition and improve service.

  • The answer is to allow the doctors and nurses to use the medical facilities efficiently. Allow the municipalities, churches, universities, service clubs such as the Shriners and private companies to supply and operate hospitals and then have a government-controlled insurance system pay for it.

  • I believe there is a way to offer financial incentives to hospitals. There are a number of performance measurements which are objectively based on actual data not patient survey results. These include Length of Stay and re-admission rates. The key is not to compare one hospital to the next but to establish a baseline for each hospital. Each hospital’s baseline should be established from their historical data and then monitored for improvements. Financial rewards should be based on their own delta change.
• It just does not make sense to increase funding to an area that is already efficient; the funding needs to go into the areas that are lacking.

• We should run hospitals like hotels with standard room rates and fees.

• Hospital bureaucracy must be more responsive to change and improve their utilization of current resources.

• More items in hospitals should be re-usable.

• Staff and fund the hospitals properly with full time doctors, nurses, surgeons, specialists and psychiatrists. These professionals must be given the resources required to do the job properly and efficiently.

• It is less expensive to renovate an existing hospital than to build a new one.

• **Ideas about hospital funding models:**

  • In a patient-based funding model the patient becomes an asset to the budget and not a liability. One concern would be that rural areas would have less access to service because they do not have enough patients.

  • Privatizing hospital operations could offer substantial savings. Government would still own and build hospitals but existing hospital staff would be terminated and operating contracts tendered to the private sector. This concept has already worked well for highway maintenance in the province.

  • Hospital funding should be based in part on patient satisfaction.

  • Hospitals should be block funded for the hotel bed costs at a fixed amount. The rest of their funding should be per patient according to disease group and procedures preformed.

  • My understanding is that currently hospitals are funded by receiving a fixed fee which is intended to cover operating costs. This method of funding may generate the motivation to perform less services and procedures in order to save money and to not consider the number of staff required for each procedure. Has it been considered whether introducing a variable component to the funding equation, so that hospitals are paid a fixed amount for each procedure they perform, would create efficiencies in the system? I feel that this would create the motivation for hospitals to perform as many procedures as they can in the most efficient manner possible.

  • Hospitals should be rewarded for keeping their operating rooms busy. Funding should be based in part on treating more patients as a goal, rather then the current system where rooms are closed to meet budget needs.
There is a built in overhead cost associated with hospitals having the capacity to deal with emergencies. Health authorities try to limit this cost by ensuring facilities remain at maximum capacity, with the result that predictable conflicts coupled with unpredictable ones creates bed shortages and delays. We need to recognize the need for this capacity and fund it accordingly like we do with fire service and civil disaster preparations.

To reduce wait-times and increase productivity the funding of hospitals should be kept under public control and paid by production and not in a per annum lump sum that has no accountability attached to it.

We must not adopt the European method of health care funding where the hospitals are paid by the patient levels. This method results in patients being kept in the hospital until another patient can fill that space.

Patient outcomes are the most important factor. Funding based on patient outcomes for hospitals would encourage more comprehensive and holistic practices.

Philanthropy is a major source of funding for the Children's Hospital. It is clear that this funding is for value added services and the pursuit of excellence. It is not in place of sufficient funding from the Province. Government must be responsible for the bulk of the funding.

Hospitals should be bidding against one another for the right to do certain procedures.

In China, hospital organizations receive funding for the provision of health care from revenues derived from taxis and buses servicing the region within a given radius of the hospital.

- **Ideas about hospital budgeting and accounting:**

  - I suggest that all medical departments, including mental health, be audited at the end of a budgetary year to see if there is a sudden surge in expenditures in order not to lose funding in the following budget year. There should be a reward system for coming under budget and not a penalty.

  - If we knew exactly how much certain operations and procedures cost there could be more accountability at the hospital level for the services provided. There is always an incentive to do things better if rewards are given for outstanding performance and organization. Conversely, penalties ought to be levied against hospital staff that cannot or will not achieve minimum service standards.

  - The capital budget must be kept separate from the operational budget or else necessary improvements to the physical side will not occur.
• Hospital statistics must be made public to increase the responsibility and accountability of managers.

• It intrigues me that people are now suggesting that hospitals should receive their funding based on patients. In a previous time, hospitals and health care facilities received a per diem rate on the occupied beds. Administrators worked hard to ensure 100 per cent occupancy. In long term care facilities an empty bed was filled as soon as possible to ensure maximum occupancy and maximum income.

• I would like to see hospitals get only half their budgets at one time and then have them work for the remainder of the budget. This would make them less inclined to shut down operating rooms when budgets get to tight.

• I think hospitals should not be allowed to run in the red and should have a balanced budget. All money spent on capital projects and leasing should be fully audited. There is a real atmosphere of a never-ending supply of cash in the health care system.

• Allow departments to carry over any budgetary surpluses to the next fiscal year to help prevent the use it or lose it attitude when it comes to year end spending.

• We must expand medical facilities to accommodate the growth in population before it reaches a critical point.

• We should increase community resources instead of increasing hospital resources.

• May I suggest you get the administrator at the Kamloops hospital in to assess other hospitals and improve their efficiency? I suspect inefficiency rather than lack of money is at the root of many problems at other hospitals.

• Local citizens should be asked to sit on hospital boards.

• Investing in publicly funded and publicly built facilities will result in long-term sustainability.

• Regional centres should receive additional funding.

• Acknowledge the enormous job done by volunteers in raising capital for regional hospitals. These volunteers reduce the load on government dollars and should be acknowledged for their achievement.

• I think we should buy all the hospitals owned by Providence Health Care or stop funding them. The private, non-profit society of Providence Health Care should be transformed into a public health care co-operative.

• British Columbians should buy St. Paul's Hospital and the St. Paul's Hospital Foundation.
• We need to increase the revenue sources for hospitals.

**Outstanding Questions**

• How do hospital authorities allocate resources?
• How are decisions about locations for facilities made?
• Why not only pay hospitals for the work they provide?
• How are hospitals funded?

• Are hospitals paid a lump sum or is the financing based on the number of beds, staff, population growth and other factors? How is it accounted for?

• Why will we not allow organizations like the Shriners' to build children's hospitals?

• Why would you reduce funds for services to patients because the people in charge are not delivering the expected operating efficiency and patient outcomes?

• Why is our system not like Great Britain, where a hospital does not get funds unless they have patients and the hospital that works the hardest to get patients gets the most money?

**Federal/Provincial Financing**

**Comments and Concerns**

• The downloading of health care costs onto the Canadian public is due to budget cuts by the Federal Government.

• The massive federal health transfer payment cuts led to less provincial spending on health beginning in 1993. Health care was in fine shape before the cuts.

• In the 1970s, the Federal Government contributed on average 42 per cent of public health care costs. By 1999, the percentage was down to 10.2. As a result, health care is now a smaller percentage of our Gross Domestic Product. The provincial governments were forced to made cuts in response to the reduced federal funding. Residential beds were reduced in the interior region by 29 per cent. Home support spending fell by 13 per cent from 2001-03. Underlying this is the idea that each government should try to achieve a surplus each year, just as every corporation aims to make a profit.
• Since the early 1990’s, the federal government in successive budgets made massive cuts to social transfers to the provinces. The provincial governments in turn passed these cuts on to various social programs, notably health care. So with billions of dollars in cuts to the public health care system, it was no wonder that the system steadily declined and wait times increased significantly.

• Previous cuts to federal transfer payments brought them to 14 per cent. This is the reason we are in the mess we are in.

• Shifting the blame between federal and provincial governments does not solve our health care problems.

• British Columbia is not spending all of its federal transfer payments on health care.

• Canadians pay enough taxes already. If the British Columbian Government used its transfer payments properly there would be enough money to fund public health for all.

• The British Columbian Government has not pushed the issue of federal transfer payments sufficiently with Ottawa.

• Federal/provincial funding agreements can create disparity.

• Since 2000 health care has not improved but transfers from the federal government have increased. I think the Province has a lot of money but just do not know how to spend it well.

• When we were trying to get funding for pregnancy outreach programs Health Canada would give money directly to these tiny little agencies but they had to make these quarterly reports. You may only have one person working at these agencies and these reports were a huge administrative burden. We were trying to have Health Canada give their money directly to us but they cannot do that because they cannot fund health authorities directly.

• The shift from direct federal cash transfers to the provinces to the federal government offering tax points has resulted in a reduction in the federal portion of health care funding. The federal government had historically contributed up to half of the funds for health care. This shift has also allowed the Provinces to use these tax points for other services and tax cuts. This move has hurt health care in Canada.

• Current census figures suggest that British Columbia is not receiving its share of transfer payments from the federal government to fund the health care system.

• The billions of dollars in new federal funding will not be sufficient to save our abused, overused and out-dated health care system.
Ideas and Suggestions

• Federal government should restore transfer payments to their historic levels.

• The provinces need to work to get the federal government back to funding 50 per cent of health care and education.

• Reinstate federal health care funding to the 50/50 formula.

• We should make the federal government more accountable by demanding more direction from them on how the provinces should spend health care funds.

• We need more federal and provincial funding for First Nations health programs.

• Create an Aboriginal financial funding matrix that includes base funding plus a blended formula jointly funded, federally and provincially. Form a framework that eliminates federal and provincial bureaucratic systems, effectively redistributes funds in a way that gets money directly to communities and supports equitable partnerships.

• Transfer funds from Ottawa should not be put into general revenue but kept separate to show that the money is spent on health care.

• With the influx of seniors coming from other provinces there should be a federal grant given to British Columbia to assist with this growing cost.

• Taxation levels must keep pace with need. Health care funding must be a priority for the federal and provincial governments.

• We should end the Federal transfer program and instead give that tax room to the provinces to use for health care.

Outstanding Questions

• Do the federal health transfer payments that British Columbia receives from Ottawa take the person’s age and/or health condition into account?

• Has the federal government has ever restored or given back to the provinces the transfer payments that were previously cut?

• Of the taxes that British Columbians pay to Ottawa, how much is coming back in federal transfer payments?
User Fees

Comments and Concerns

Socio-Economic Impacts
Legal Implications
The Effect of Implementing a User Fee
Applying User Fees

• Comments on socio-economic impacts:
  • User fees could lead to increased severity of illnesses and higher over all costs if people delay seeing the doctor for financial reasons.
  • Access to services will be limited if user fees are introduced.
  • Human rights will suffer if a pay for service structure is allowed.
  • Health care is a fundamental right and should not be based on the ability to pay.
  • User fees have no impact on people with higher levels of income and they discourage people with lower incomes from using the service.
  • When implementing a user fee either you have a system that exempts so many people that it looks a lot like progressive taxation system or you do not, in which case the burden falls disproportionately on the poor. In Sweden analysts have found that there is a slight decrease in equity of access when you impose additional user fees, even in such an egalitarian society.
  • The working poor are always in the most difficult situation. They are the ones that have to buy their own glasses and prescriptions and they would have to pay this user fee. They would almost be better off on welfare where most of these costs are taken care of.

• Comments on legal implications:
  • It is unconstitutional to charge fees for medical services in Canada.
  • The federal government forbids the charging of user fees.

• Comments on the effects of implementing a user fee:
  • I am against the introduction of user fees for any aspect of care within the health system. I have taken personal responsibility for my health and should not be punished when I need to access the health care system.
  • The elderly, people with chronic health problems and the disabled would be the groups most affected by the introduction of user fees.
It is human nature to exploit goods and services when they appear to be free. If there was a small fee charged to see a doctor, visits will be drastically reduced and the savings will be substantial.

It is human nature to abuse what is free. We can no longer afford this luxury.

A user fees cannot punish the sick or this issue will end up in the courts.

I do not agree with a means test for user fees.

There used to be a small fee to visit the doctor or go to emergency. This fee stopped a lot of extra visits.

It would not be my first choice to introduce an emergency room fee but we do need to find a way to divert the non-emergency cases to other health care providers.

I in no way support the idea of user fees. We should instead encourage people to make donations to support local health care.

Too many people use emergency services unnecessarily. A user fee would reduce unnecessary use.

If there was no charge to get your car fixed, can you imagine the line up at the local auto dealerships? Everyone would be there to get every squeak checked, every engine noise investigated and the oil changed every 500 miles. User fees are necessary.

Family physicians would bear the brunt of having to collect user fees because the majority of patient’s visits are to family physician’s offices. What it would mean for us is that we would have to have two accounting systems, one for the user fees and one for Medical Service Plan billing. If you are a busy family doctor seeing anywhere from 30 to 45 patients in a day, collecting that many user fees is a nightmare logistically. Patient user fees would have to be somewhat discretionary because we know that some of our patients could not afford to pay it. Family physicians are not going to deny patients access to care because of that. I know this has been floated as a means of increasing revenue for health care but I do not think it is a good idea.

We need to change the public’s perception that health care is free. User fees would probably not produce very much revenue but will make people aware of how much health care costs.

People do not appreciate anything that is free. If people paid they would think more about why they are using a service.
• **Comments on applying a user fee:**

  - Examine the possibility of user fees being charged to people who can afford them.
  
  - If user fees are going to be considered they must be based on income. To be fair, user fees would have to be accessed progressively like the taxation system.
  
  - Government should balance free access with a small financial disincentive for inappropriate use.
  
  - Countries with co-payments either exempt many groups, which make it look a lot more like a regressive taxation system, or they reduce equity. That is the reality of how far co-payments can go in solving usage problems.
  
  - User fees will not generate very much revenue due to the expense of added administration.
  
  - The assumption is that people go to the doctor because it is fun or that it is a choice to go. You are dealing with a very small percentage that might be going to the doctor more frequently than is actually needed. In order to address a minority’s action, we are overcompensating by suggesting everybody pay a user fee. We are sending the signal that you should be deterred from going to the doctor when, in fact, it might be appropriate.
  
  - Canada is only one of six Organization for Economic Co-operation and Development (OECD) countries that do not use client cost-sharing of some sort.
  
  - It was standard practice at one time to pay two dollars when attending an emergency room. All citizens can afford to pay a few dollars for such a benefit.
  
  - Looking for new sources of revenue though the collection of user fees offers some potential to limit growth in spending but user fees are not a miracle cure for rising health care costs.
  
  - User fees in Denmark resulted in so many fewer visits to the doctor that the physicians demanded they be removed.
  
  - There was a discretionary user fee for emergency services in the 1980s. The admitting clerk determined whether or not the patient was a genuine medical emergency or if it was something that should have gone elsewhere. It was too difficult to make those kinds of decisions. Take the example of a young mother with a sick child who has a viral illness. As a physician, I could look at that child in 20 seconds and decide the child does not need to be here. However, if you put yourself in the position of the young mother who does not have the skills, the training, or the support it might not be so clear.
If we are going to maintain a reliable public health care system in British Columbia the patient is going to have to begin to pay some portion of the price.

User fees are already applied to glasses, teeth, prosthetics, acupuncture and other services. User fees were charged in the 1970s and our health care system then had very few of the problems we face today.

We have to limit health care spending to a fixed percentage of our budget, even if it means the introduction of user fees or restricting access to some services.

**Ideas and Suggestions**

**Models for User Fees**

**Where and When a User Fee Would Be Appropriate**

- **Ideas about models for user fees:**
  - Allow a defined number of visits to the doctor before charging a fee.
  - Determine the average number of doctor’s visits per year per person and then give everyone that many visits free. After you used up your allotted visits you would be charged on a sliding scale. Couples and families could be allowed to pool their visits.
  - I would like to see a system where every Canadian except seniors, children, pregnant women and postnatal for one year and people with a chronic illness or disability, is allowed 12 visits to the doctor per year. If they need to go more they just have to pay for them. If they do not use their visits they can be rolled over into the next year.
  - Doctors’ offices, hospitals and other health care providers could have a small machine that would allow them to swipe your CareCard. The fee for the visit would then be added to the monthly bill from the Medical Service Plan. User fee payments would be remitted along with your monthly insurance premium directly to the Ministry of Health.
  - Establish a once-a-year user fee that would be paid in advance. If that amount is not used, the credit would be put forward to cover the next year’s fee.
  - Charge a small user fee with half of the cost being refunded if the visit was deemed by the doctor to have been necessary.
  - User fees could be refunded through income tax deductions. Deductions can be calculated on a sliding scale, so that those with a lower income will have a greater percentage refunded than those with a higher income.
Anyone who owns property over a certain value should be required to pay a portion of their medical costs.

Everyone who earns over a reasonable income level should pay a user fee for every doctor’s visit. The user fee should be a nominal amount, such as two to five dollars per visit.

Everyone filing a tax return will be given an evaluation number based on their income. Hospitalization, out-patient treatment or a visit to the family physician would be billed based on the taxpayer’s evaluation number. The higher the taxpayer’s income the higher the payment.

User fees must be bench-marked to the minimum wage.

To make health care professionals accountable to their patients everyone should pay a user fee directly to the doctor. If the patient feels that they did not receive proper care they will go to a different doctor the next time rather than paying to see a doctor they were not satisfied with.

If user fees are accessed for physician services there should be a second tier of health professionals, such as registered nurses or nurse practitioners, whom people could visit free of charge. These health professionals could refer the patient to a physician if it was required and no user fee would be charged for these referred services. This would encourage people to use lower cost health care providers first.

Since allopathic medicine is the only mode supported financially by our government people tend to go that route even when it is not the best option. A solution would be a partial user fee for all health service providers including medical doctors, doctors of Chinese medicine and naturopathic doctors. This would level the playing field and allow people to choose what type of care is best for them.

I think that those who use the medical services above a certain limit through their lifetimes should pay a portion of their costs in user fees.

Low income earners and people in special circumstances could apply for an exclusion from user fees.

User fees could be either a set fee or a percentage of the cost of the procedure.

**Ideas about where and when a user fee would be appropriate:**

- Charge a larger user fee for patients using the ambulance because so many ambulance calls are not emergencies.
- Consider an emergency room user fee but walk -n clinics must be free.
• We should institute a fee for abortion. It is a moral issue.

• Why not have patients pay for meals in hospitals? This could potentially raise the quality of meals and reduce health costs.

• Charge a small user fee for phoning test results to patients.

• Doctors should charge a fee for phone calls to avoid office visits.

• Increase fees for doctor administered tests for driving licenses.

• User fees could be assigned for prescriptions of new drugs.

• All British Columbians should pay the same user fees for a visit at emergency.

• Apply a user fee to reduce unnecessary testing.

• There should be a universal user fee for all health disciplines to limit abuse of the system.

• Visits to the doctor for colds, sore throats and other ailments that simply require time to heal should be charged a user fee.

• British Columbians are willing to pay a fee for better care and timely access.

• We need to charge user fees for access to the system. Too many people are shopping around for health care professionals who will agree to the care that they want, rather than the care they need.

• User fees could be applied for those who go to emergency when they should have gone to their doctor or a clinic.

• Any visitors to the emergency room that are related to drugs, alcohol or tobacco should have to pay 50 per cent of the total cost of the procedure they require.

• Anyone who has enough money for drugs, alcohol and cigarettes should be able to pay a small fee for medical services.

• A user fee should be levied to elderly immigrants or their sponsoring family.

• There should be user fees for any self-inflicted or sports-related sickness or injury.

• User fees should be introduced for people who abuse their health, such as smokers.

• Patients who do not care for themselves should pay for their care and not burden public system.

• A small user fee could be assessed along with a corresponding reduction to Medical Service Plan payments.
• There should be no pay-as-you-go provisions in health care. This includes no
reservation fees, no user fees for emergency services and no queue-jumping fees
for diagnostic services.

• It is expensive for the Medical Services Plan to bill everyone a token amount each
month and then collect on the delinquent token amounts. A token amount
would actually serve a purpose and be far cheaper to collect than would a token
user fee.

• I do not think people would be opposed to a reasonable fee for emergency and
walk-in clinics if it would solve the access problems.

• If public health care is truly in jeopardy, then a user fees for people that come to
Canada or transfer between provinces would be appropriate.

• Universal health care was never intended for the rich, they should have to pay a
user fee.

• No user fees for seniors.

• User fees are fine as long as they are not required to be paid at the doctor’s office
before being seen by doctor.

• Limiting demand through user fees or co-insurance should only be entertained if
attempts to achieve value for money and sustainability on the supply side do not
work.

**Outstanding Questions**

• Would user fees work?

• Can you increase user charges without decreasing equity of access?

• What would the administrative costs be for implementing user fees?
Tax Policy

Comments and Concerns

Taxes to Change Behaviour
Levels of Taxation

- Comments on taxes to change behaviour:
  - The Government has legalized and collects huge revenues from taxes on vices such as alcohol and tobacco. Alcohol and tobacco use cause a huge drain on the health care system.
  - There is no link between the revenue generated from tobacco and the scale of prevention that is being undertaken. It is clear what must be done to have to fewer people smoking in society but we are not achieving that outcome.
  - It is ironic that governments who make a great deal of money on the taxes collected from alcohol, cigarettes and junk food would consider a surcharge on health care for people who suffer as a result of their use.
  - Increasing taxes on junk food will not stop British Columbians from consuming it anymore than the high taxes on cigarettes, drugs and alcohol have limited their use.
  - I drink a ton of beer but I understand that could come back to haunt me and the health care system down the road. I would pay extra tax for the privilege of drinking beer. I think people who sit on around eating chips and watching television all night should pay more for their junk food as well.

- Comments on the level of taxation:
  - The recent reductions in tax rates have caused some of the pressures on the health care system.
  - Corporate taxes are too low to support the health care system.
  - There is a social purpose for taxation that seems largely to have been lost in most of the discussions around sustainability and tax cuts.
  - Governments are giving tax breaks to the top ten per cent of income earners in society. The top ten per cent can go buy their health care anywhere in the world they want to.
  - British Columbia is currently enjoying an economic boom and the provincial government is benefiting from extra tax dollars as a result. This money should be
directed to health care. It is obscene that people sleep in hospital corridors and wait weeks for treatment while the Province has a surplus.

- I am amazed that the only recommendations on funding the health care system all involve people paying more through private insurance, user fees or higher premiums for people with unhealthy lifestyles. How about progressive taxation?

- I am deeply troubled by the emergence of a two-tier system of health care. The second tier, where people pay for health care, indicates to me that those people are capable of paying higher taxes for improved health care for all. I think we should examine our health care taxation capacity because I believe that we can contribute more.

- Current projections of increased spending would be sustainable if we increase taxes. This is a choice open to us as society. We can choose what we value.

- Health care costs are growing faster than the Government’s ability to pay but we can afford tax cuts?

- There is a need for a public system that provides adequate care for all citizens that citizens have to pay for through their income taxes. If there are insufficient tax revenues to pay for such services, why is the Government cutting taxes? It is fine to boast about our low level of taxation but not if it is preventing the provision of adequate health care services.

- The tax cuts have resulted in longer wait-lists.

- British Columbians do not pay enough taxes to properly fund a good health care system.

- I would be happy to spend my own money on health care but I do not want to have it taxed and then have my deductibles increased.

- If you ask British Columbians if they want to pay more taxes they would say no. This is because all they see is a health care system in crisis. Why would we give any more money to a system that is in crisis?

- Health care funding comes from the tax base. There are not enough people being born for the tax base to continue to support health care into the future.

- Health care costs double for individuals once they pass the age of 65 and as we are experiencing an ever shrinking tax base there will be fewer taxpayers to pay for higher health care costs. There will be nowhere to squeeze the needed money from unless you want income taxes to double over the next 30 years.

- There are too few people paying into the system through taxes. For example, people earn tips and do not report them while others report low incomes. Both live wealthy lifestyles while also receiving subsidized medical coverage.
• Taxing pensions takes money away from health services such as fitness classes, prescriptions, quality food and glasses.

• In the 1960s there was a social services tax that was used only to fund hospitals but the government of the day changed that to a sales tax that went into general revenue.

• It is puzzling why health delivery through taxation is such a problem but taxation for roads and highways is not a problem.

• Why not just increase taxes? There are limits to how high taxes can be raised. Beyond a certain point, and we need look no further than the 1990s to see that point, increased taxes affect economic incentives so seriously that the golden goose ceases to lay. This means that the health budget simply cannot grow exponentially at the expense of everything else and must be brought under control.

• British Columbians are being taxed too much already.

• The public must accept the limitations that the public purse has in regards to publicly funded health care. There has to be a limit to the level of taxation that citizens should bear.

• For those who say the public is willing to pay more taxes, who do you think will be paying for most of those? The working class which is getting smaller and smaller. I am not interested in seeing 60 per cent of my income lost due to taxes.

• Public relations initiatives are needed to clearly show what taxation levels would look like if taxes were increased to fund health care.

• There is an underground economy of unscrupulous contractors in the Okanagan Valley who are now handling over 50 per cent of the building industry in the region. As a result, the Government is losing hundreds of thousands of tax dollars that should be going towards health care and drug rehabilitation.

• It is unrealistic of government to expect people over the age of 75 to pay taxes.

• More and more of our budget will go to health care, meaning roads, education and all other budgets will have to be cut. It will be hard to feed our families if our taxes double.

• Medical Services Plan premiums are a flat tax.

• British Columbians do not want taxes over 50 per cent.

• Do not increase taxes because the health system has adequate funds already.
Ideas and Suggestions

Taxes to Change Behaviour
Taxation Levels
Tax Policy

• Ideas about Taxes changing behaviour:
  • Sin taxes on gambling, alcohol, cigarettes and junk foods can be used to support health care.
  • Bad behaviour and habits should be taxed. Poor health and poor lifestyle choices need to have financial consequences.
  • All tax revenue collected from alcohol and tobacco sales should go to the Ministry of Health and not to general revenue.
  • Revenue from tobacco taxes should be used to fund prevention programs.
  • A medical surcharge needs to be added to the price of cigarettes to more accurately reflect their true cost to the health system.
  • The taxes on alcohol and tobacco can be increased to offset increased MediCare costs.
  • New taxes on tobacco should be directed at cigarette manufacturers. This will result in new revenue to help fund health care and an increase in the cost of the cigarettes for the consumer.
  • Tax televisions, video games and other technologies that encourage sedentary behaviour.
  • Junk food should be taxed to discourage people from eating it.
  • Companies that sell fatty foods and junk foods should be penalized through increased taxes.
  • Taxes on unhealthy foods can be used to subsidize healthy alternatives.
  • Increase taxes on high risk activities to offset their costs to the health care system. For example, those who downhill ski should have tax added to equipment and lift tickets to cover the costs of downhill ski accidents.
  • There should be a tax benefit to those who limit the amount of services they use. If someone underutilizes the system, based on an average, per-unit consumption figure, then they would receive a tax break. If they utilized the system more than the average they would receive no benefit.
• **Ideas about levels of taxation:**

  - Increase taxes to provide a good health care system to all British Columbians.
  - I would be willing to pay more taxes, if I knew they were going to health care.
  - British Columbians are willing and able to pay for a caring public health care system.
  - The Government should implement more stringent enforcement and collection of taxes before increasing taxes.
  - We are all willing to pay more taxes to ensure the system remains public.
  - My husband and I pay 50 per cent of our pay cheques to the government. We do this willingly because we believe strongly in health care, education, highways, transportation and the other important work Government performs.
  - Close loop holes that allow big business to escape taxation. This alone would fund hospitals.
  - Re-instate corporate taxes to pre-1990 levels
  - It can be demonstrated that tax rates in Canada are relatively low compared to other industrialized countries and that those countries with higher tax rates, especially for the business sector, have better health outcomes, higher gross domestic products, economic surpluses and a host of other positive social outcomes.
  - One of the things we learned at the Romanow dialogues was that Canadians would accept higher taxes if you could demonstrate that there was going to be an improved health care system but not for simply maintaining the status quo.
  - Stop cutting taxes.
  - The funding challenges that the public health care system faces, as Canada’s population ages, can easily be met if Canada’s most favoured citizens are asked to contribute a little more. All too often, it is Canada’s wealthiest individuals and corporations, enjoying their tax breaks and tax havens, who seek to undermine public confidence in our system while paying less than their fair share.
  - If the Government stopped cutting taxes for the rich we would have more money to spend on health care.
  - Create a health care surcharge tax.
  - I am willing to pay more taxes for better access and more services.
  - A proportional tax increase would be better than privatization.
• Raise taxes if that is necessary to ensure equal access to quality health care for all.

• **Ideas about tax policy:**
  
  • We need to tax the rich and not the poor.
  
  • We should eliminate premium payments and pay for health care from more equitable taxation.
  
  • I strongly believe that a health tax should be developed and kept separate from the general revenues and it should be used exclusively for health care.
  
  • Collect an Employee Health Tax (EHT) to support health care of about two per cent of the payroll.
  
  • Establish a payroll tax instead of Medical Services premiums.
  
  • The benefit of a designated tax for health is that it lets the individual know how much of their tax dollar is going to health, prevents governments from allocating the monies to other uses and provides a degree of accountability related to taxation and service provided.
  
  • A large tax should be assessed to industrial polluters.
  
  • Seniors over 90 should have the right to stop paying income taxes.
  
  • We should allow premiums to be deducted from income taxes.
  
  • Tax non-resident citizens.
  
  • The cost of privately paid operations should be tax deductible.
  
  • Those who have paid for private care should not be able to get a refund back through their taxes.
  
  • Exempt the public health care sector from paying the Goods and Services Tax (GST) and the Provincial Sales Tax (PST).
  
  • Registered Retirement Savings Plan (RRSP) withdrawals for medical purposes should be tax exempt.
  
  • Find a new model for raising health care funds for our aging population and do not use general revenues.
  
  • Lottery funds could be used to fund health care.
  
  • People who do not pay taxes should not be eligible for health care. Many people do not pay taxes as a result of fraud. Limiting their access to health care could be one way to get rid of the underground economy.
  
  • Institute a small health care tax on all users of the health care system that would go into the annual health care budget to fund specific health care goals.
• A referendum should be called to determine the direction people would like to see the taxes being spent.

• Property taxes are used to fund the education system and could be adjusted to fund the health care sector as well.

• British Columbians should be asked to pay for all medical expenses upfront and then be refunded through the income tax system on sliding scale dependent on income. Residents whose income is below a certain threshold would be able to claim the full amount of their medical expenses on their annual income tax and receive a refund. Those above the threshold would receive a progressively decreasing portion of their paid amount back on their tax. Residents whose income was below the threshold would receive a card with their income tax return valid for the tax year. With the card they could take their doctor's receipt to an outlet, such as a bank or lotto store, for a full refund on the same day they received the service. Those less fortunate financially would only be out of pocket a few hours, if need be, but a payment would still be made to remind those of the cost of their treatment.

• I would like a flat tax just for the health care component of our income taxes. Government would determine the tax rate necessary to cover all current health care costs and assess all residents on that basis. The rate would change annually to reflect the increasing or decreasing costs of health care. There should also be a credit system devised to reward those individuals who do not use the system. The credit would be applied against their annual flat tax assessment.

• I propose a negative tax health care system where residents would be refunded for health expenses based on their income; a lower income would get a higher refund and a higher income might not get any refund.

• There should be a 0.5 to one per cent income tax surcharge added on to corporate and personal income tax. These funds would be used to fund incentives for people to change their life styles and live healthier. Tax payers who participated in these programs would get their contributions back and those who do not participate would be penalized by having paid the extra tax.

• Capital equipment purchased by community fund raising should be tax free.

• Lab testing costs should be 100 per cent tax deductible, including testing requested by alternative medical practitioners.

• A portion of the gas tax can be put towards those injured in automobile accidents.

• A sizable levy on gas would be positive as it would cover some of the cost to health care and encourage people to drive less.
• The gun industry should be taxed heavily due to the increased cost to the medical system resulting from gun crime.

• Impose a tax on all cosmetic surgery to fund training positions for plastic surgeons and dermatologists who want to see patients for medically required treatments.

• Provincial sales tax should be charged on all revenue from British Columbia incorporated and licensed medical cannabis suppliers.

**Outstanding Questions**

- Do the countries with the lowest tax rates have the best standards of living and health care outcomes?

- Why are the increased tax revenues from all the new property developments not being used to pay for increased medical services?

- If the health care funding situation is so dire, why does the Government have a surplus and why do they keep talking about cutting taxes?

- Why are Medical Service Plan premiums not integrated into the regular tax system?

- Why is the Government insisting that Provincial Sales Taxes be paid on capital equipment being purchased with donated dollars?

- How much revenue is generated through tobacco taxes?

**Tax Incentives and Disincentives**

**Comments and Concerns**

- Health status stratifies according to socio-economic conditions. Using tax incentives to promote health will benefit people at the higher end of the socio-economic scale who already have good health. The issue should be redistribution of income so that socio-economic disparities in health status are not widened further.

- Naturopathic doctors are not covered by our medical plan and the fees for their services are not tax-deductible as other health care expenses are. This discourages people from using their services.

- If the provincial government would like to improve the physical fitness of all British Columbians by 20 per cent by 2010, why would they tax exercise equipment which is the aid to improving the situation? We do not pay tax on bicycles and it would be prudent to extend the sales tax relief to exercise equipment as well.
• Alternative health care, vitamins and minerals and natural health products should not be taxed. Natural health products are better and safer for people's bodies than chemical-laden prescriptions.

• Healthy foods should not be taxed.

• It is not right to write off drugs but not vitamins. The use of vitamins could save the medical system millions of dollars.

Ideas and Suggestions

Healthy Eating

Healthy Living

• Ideas about tax incentives for eating well:
  • Tax incentives could be used to encourage restaurants to advertise and offer healthier meals to their customers.
  • Food producers and processors can be encouraged to use healthier ingredients through tax incentives.
  • Vitamins and herbal remedies should not be taxed and their costs should be tax deductible.
  • Remove provincial taxes on health foods.
  • Whole foods need to be subsidized so that they are less expensive than unhealthy foods.
  • British Columbians should be encouraged to eat more vegetables, fruits and whole grains by subsidizing their costs.
  • We should not tax fruits and vegetables at all.
  • Salads should be tax free in restaurants.
  • People who suffer from diseases and conditions that require specific diets should be given tax relief. Many of these foods are more expensive than regular foods.

• Ideas about tax incentives for healthy living:
  • Tax incentives should be available for all individuals and corporations to encourage healthy living.
  • Government should offer incentives to corporations that provide gyms and fitness classes for their employees.
· Families enrolling kids in physical activities and sports should receive a tax deduction.
· The 500 dollar tax credit for children’s activities needs to be available to everyone.
· Tax credits to encourage children’s physical and mental health are a good first step.
· All costs related to improving health, including yoga, meditation, and gym memberships should be tax deductible.
· Any fees paid by British Columbians to participate in recreational programs should be tax deductible.
· Re-introduce tax incentives for individuals that invest in their health by purchasing approved programs for weight-loss, smoking cessation and other lifestyle-related disease prevention.
· A tax break should be offered to everyone who can prove on a yearly basis that their heart rate and blood pressure are at healthy levels. This would encourage exercise and healthy living.
· British Columbians who take personal responsibility for living healthy lives and minimizing their use of the health care system should be given a tax break as a positive incentive to continue and to set an example for others.
· It is important that incentives for healthy living are available for all levels of income, not just for the rich. Offering community centres tax credits to pass on to lower income populations have been shown to work by the World Health Organization.
· Lower taxes on physical activity equipment.
· All taxes on health related items should be eliminated.
· Parents who enrol in approved nutrition and health education courses should receive a tax credit.
· More tax incentives need to be available for stay-at-home mothers.
· Government should encourage people to have mammograms, check-ups, immunizations and other preventative procedures through tax deductions and tax credits.
· A system of tax incentives is needed to encourage British Columbians to use the health system appropriately and wisely.
· Tax incentives should be put in place for those families that assist in a home care role for an elderly family member.
• The child tax benefit could be a model for a system to encourage families to stay home to care for a relative.

• Renovations should be tax deductible if they enable an elderly person to continue to live at home.

• Volunteers should be offered tax incentives, such as a reduction in the tax on Registered Retirement Saving Plan withdrawals.

• The costs of accommodations after a surgery should be tax deductible.

• Tax incentives should be available for users of alternative health care as they save the health care system money.

• Norway gives a tax credit back to people who do not use the medical system for a complete year but pay into it. This would be a great incentive to stop people from going in every month just because they sneezed or because the doctor is cute.

• Government should offer a tax credit for bus riders.

• Encourage citizens to leave part of or all of their estate to the medical plan through a tax incentive.

**Outstanding Questions**

• I pay tax for health care I do not use. I pay after-tax dollars to see a registered massage therapist or naturopathic doctor with no compensation. Why can the Government not compensate me in some way for taking care of my overall health and not being a burden on the health care system?

• Why is the Goods and Services tax (GST) charged on alternative medical services such as naturopathic doctors, massage therapy and chiropractic care?

• Why are all natural supplements such as herbs, vitamins, minerals, homeopathic and food supplements charged the Goods and Services Tax (GST) when pharmaceutical drugs are not taxed?