# Effective, Efficient and Responsible: The CCF Vision and the Future of Health Care in Canada

## by David Baxter and Andrew Ramlo

"As patients, we are perfectly willing to place matters involving medical judgments entirely in the hands of a highly-skilled group such as you are. In enacting the Medical Care Insurance Act, however, we have said that we, as consumers of medical services, and as taxpayers, have a right to a say in how we pay our medical bills. We have the right to construct an administrative agency, responsible to us, to arrange such payment.

Medical care is not an optional commodity – it is a necessity. When medical services are needed, they should not, in the interests of each of us, be denied to any of us. When a commodity or service is essential our society has long since accepted that consumers have a legitimate right to a voice in making the essential governing decisions in such matters. That voice has been, for medical care, embodied in the Saskatchewan Medical Care Insurance Act, an Act passed by the properly elected legislature of the province of Saskatchewan."

Premier W.S. Lloyd of the Province of Saskatchewan,
addressing a convocation of Saskatchewan doctors, May 3, 1962

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# Effective, Efficient and Responsible:
## The CCF Vision and the Future of Health Care in Canada

**By David Baxter, Executive Director, The Urban Futures Institute, and Andrew Ramlo, Director, Urban Futures Incorporated**

# Preface

One of the authors of this report is approaching 60 years of age, the other has just turned 30. Both have a personal interest in the future of the Canadian health care system, as both (to a lesser or greater extent) will consume and pay for health care in the future. Given this personal involvement in health care, both of us have a deep concern about the direction of current discussions about health care and health care funding reform are taking. This report documents both our concerns about the sustainability of the financing and management of the current health care system in Canada and our proposals for its reform.

There are two themes to the report. The first presents a consumer focused, common sense concept, for financing public health care insurance in Canada that will *a)* prepare health care insurance for the realities of the 21st century and *b)* reduce, to the greatest extent reasonably possible, the inter-generational shifting of the burden of payment for health care during an era where aging will cause the older population to grow at a much greater rate than the population as a whole. The model proposed here to do so is a health care Lifecycle Insurance Fund and Endowment (LIFE) trust.

The second is to demonstrate that the renewal of public health care insurance in Canada could be done in a fashion that is not only in keeping with the system of health care that most Canadians are familiar with, but that is also in keeping with the original vision of provincial government public health care insurance in Canada, introduced by the Canada Commonwealth Federation (CCF) governments of the Province of Saskatchewan.

There will be those who question the appropriateness of two authors who are not part of the health care industry preparing a report proposing changes to the health care system: we refer them to the quotation on the cover. The public, of which we are part, are the customers of health care, in the full meaning of the word customer, which includes both the use of the service and payment for it. This means that the public, not the providers of health care or governments, must be the frame of reference for reform.

Of the public, while the baby boomer generation will be disproportionately the future users of the system and who currently has the loudest voice in the debate, are most concerned about the level and quality of future service, a younger than

boomer perspective is essential, as the burden of payment for the health care of boomers will, given the current annual cash flow payment system, fall disproportionately on today's under 35 population. It is entirely reasonable that this younger generation would argue that today's "pay as you go" system shifts an inequitable share of the burden of future health care costs onto their shoulders. With respect to this demographic aspect of health care funding, it has been suggested that the report be subtitled "Boomers - pay for your own health care".

Conversely, the baby boomers can argue that they have being paying for health care for three or more decades, and hence have a right to the benefits of these contributions: this point is moot, as their money has already been spent on the current older population. The fatal flaw in Canada's current health plan is that it is not a plan: it is simply a system of spending annual revenue on annual expenditures with no thought to the future. The health care (LIFE) trust proposed here eliminates the inter-generation shifting of health care expenditures.

While there has been much discussion of the impact of aging on health care expenditures, and rightly so, the consequences of an aging population pale when compared to the consequences of the recent trend of age standardized per capita health care costs increasing faster than both inflation and economic growth. The challenge in adapting the financing of medicare to the 21st century and to the legitimate expectations of society will be to ensure that consumers of medical services, contributors to medical plans, and taxpayers in the future can afford to pay for health care. This means devising a financing arrangement that ensures that health care services are delivered and used in an "effective, efficient and responsible" manner to keep age specific per capita spending at its current level.

It is has become commonplace to talk about whether the federal or provincial governments should contribute more money to health care. Neither the federal nor the provincial governments pays for health care – taxpayers and plan subscribers do. Establishing direct links between those who pay for health care and those who use and provide its services will be fundamental to any revitalization of the health care system in Canada. Forging these links will be as difficult as it will be essential, for neither governments nor health care providers appreciate being directly accountable for health spending: before any talk is given to more money for the health care system, it will be essential that both opportunities and incentives are in place to ensure that public health care dollars are spent effectively, efficiently, and responsibly. These three criteria, while deemed to be essential in the CCF vision of public health care insurance, have all but disappeared from the health care reform debate, which is increasingly dominated by discussion of how to get, and spend, more money.

In the preparation of this report and in the development of health care LIFE trust concept presented in it, we have relied heavily on the definitions, discussions, and debates that accompanied the articulation of the first provincial health care plan in Canada, that introduced in Saskatchewan in legislation passed in 1961. Two

books have proved most useful in this context, not only in terms of their analysis and narrative, but also in their inclusion of the text of correspondence, reportage, agreements, and legislation, which are frequently cited in this report.

The first of these books is E.A. Tollefson's Bitter Medicine: The Saskatchewan Medicare Feud (Modern Press, Saskatoon, 1963), which provides a mainly legal analysis of the turbulence that accompanied the passing of this legislation: reference to Mr. Tollefson's book are here noted by the letters BM followed by the page number of the citation. The second reference book is Robin F. Badgley and Samuel Wolfe's Doctors Strike: Medical Care and Conflict in Saskatchewan (Macmillan, Toronto, 1967), which focuses more on the political context, and with developments that followed the introduction of the legislation, including the Hall Commission: references to this work are indicated by the letters DS followed by the page number for the citation.

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### I. Introduction.

The spirit of Saskatchewan's CCF governments is often invoked in the discussion of health care reform in Canada. The principles on which these governments established the first provincial public health care insurance plan (as legislated in the 1961 Saskatchewan Medical Care Insurance Act) were the foundation of the subsequent federal and provincial legislation that brought universal public health care insurance to all of Canada by 1971. They have also become a frame of reference for evaluation of this health care system and for proposals to reform it.

In 1962, Saskatchewan Premier Lloyd said that the reasons for the radical health care reform represented by his government's legislation was to "seek to find ways and means to adapt the financing of medicare to the 20th century and the legitimate expectations of society" [DS49]. This is exactly the goal sought today for Canada in the 21st century. In this search, it is important to consult the discussion that occurred in Saskatchewan four decades ago, acknowledging the fundamental role that the vision of a public health care insurance plan articulated by the CCF governments of Tommy Douglas from 1944 to 1961 and the practicality of implementation of such a plan carried out by the CCF government of Woodrow Lloyd from 1961 to 1964, play in the current reality of health care in Canada.

Saskatchewan's health care plan was founded on eight principals. Five of these are well known today as they are similar to those articulated for the Canada health care plan: pre-payment, universal coverage, high quality service, public administration, and acceptability to both those providing and those receiving the services [BM45]. These, however, were not the only principals Premier Douglas deemed essential: he stated that the plan "must also be in a form which will operate effectively, efficiently and responsibly" [BM152]. The reason why these three latter principals are not well known as the other five is, perhaps, found in the words of Walter Erb, the Minister of Public Health in Mr. Douglas's government: "we feel that it is taken for granted that whatever form of administration is finally chosen, it should be effective and efficient … the government has not gone beyond setting down these general principles, which it feels are essential." [BM155].

It is unfortunate that what was taken for granted, that publicly administered health care insurance function "effectively, efficiently and responsibly", was not expressed in the Saskatchewan Legislation, and is not in its offspring in the form

of the Canada Health Act and supporting provincial legislation, nor in much of the debate on health care that has followed. For example, in the current discussion of health care reform, reference is so frequently made to the five pillars of the Canada Health Act, that health care in Canada is to be portable, universal, comprehensive, accessible, and publicly administered, that Ministers of the Federal Government have been criticized for not being able to recite them upon demand: yet there is no criticism if someone forgets to mention efficient, effective and responsible.

The result has been that those who are concerned with attainment of Mr. Douglas's goals of a health care plan that operates in an effective, efficient and responsible manner are all too often painted as being in opposition to his other five principals, when in reality a health care plan must be effective, efficient and responsible if it is to survive to be universal, accessible, portable, and comprehensive. Needless to say, it can be publicly administered and pre-paid without being effective, efficient, or responsible, but it cannot be sustained.

***…a health care plan must be effective, efficient and responsible if it is to survive to be universal, accessible, portable, and comprehensive.***

This report presents a model of a publicly administered health care insurance plan that considers the Saskatchewan CCF governments' eight principals as well as the five of the Canada Health Act. In doing so, this proposal acknowledges the reality that sustainability of a health care insurance plan that meets the five well known criteria will only come if it respects the ability of current, and more particularly, future generations to pay for it, which in turn can only occur if it is effective, efficient, and is treated responsibly by both its users and it providers.

To understand both this proposal and the roots, if not the contemporary reality of Canada's health care system, it is essential to outline the fundamental elements of Saskatchewan's CCF governments' vision for public health insurance plans:

1. Under both Premiers Douglas and Lloyd, the Saskatchewan government was consistent in its requirement that a public health care plan involve universal compulsory insurance coverage that was supported mainly by pre-paid individual premiums paid into a medical insurance fund, was publicly administered by an independent commission and included all non-cosmetic medical services.

2. In the debate about the specific nature of the plan, the CCF governments were emphatic that public administration was a requirement only of the insurance program, not the provision of the services, which was to involve public and private health service providers, to the extent that the legislation explicitly provided the option for health care services to be supplied outside of the plan. There was neither a requirement nor a suggestion that health care be delivered exclusively by public sector employees, with the legislation providing for a wide range of parties to be contractor suppliers of health care services.

3. The plan was to be generally self-supporting through premiums, but with additional financial support from a relatively "low" general tax to subsidize low income households.

4. It was made abundantly clear by the CCF government during the 23 day doctors' strike that followed the implementation of the legislation in 1962 that health care was an essential service. Accessibility of health care services was of such fundamental importance to the CCF government that when a withdrawal of services occurred, it acted to ensure that replacement services were provided. In the case of the doctors' strike, this meant bringing in replacement doctors from outside of Saskatchewan through active recruitment of replacement workers from the rest of Canada, the United States and England.

The remainder of this report outlines the structure of the health care Lifecycle Insurance Fund and Endowment (LIFE) trust concept that can adapt the financing of medicare to the 21st century and to the legitimate expectations of society. To ensure the sustainable existence of a health care plan that is universal, accessible, publicly administered, comprehensive, portable, responsible, effective and efficient, the Trust must have four fundamental characteristics (which are examined in detail in the following sections):

**1. Individual Pre-paid Insurance.** A LIFE Trust involves individual pre-payment for current and future health care expenditures on the basis of a life cycle adjusted insurance premium. The annual individual premium would be equal to the per capita share of current health care expenditures plus an additional amount to be invested to cumulate over time to cover future health care expenditures. The current system is an annual cash flow system, with annual health care expenditures paid for by the current annual tax and contribution cash flow. As with the grasshopper of the Grasshopper and Ant Parable, there is no thought to the future in the current system funding of health care expenditures. As health care expenditures are greatest in older stages of the life cycle, such "pay as you go" systems put a disproportionate burden on the working aged contributory/tax payer population in situations where the highest growth rates are in the older age groups (e.g., the reality of Canada's future demography). By requiring individual pre-payment over the life cycle, rather than just over one year, an insurance trust will (over time) ensure generational equity in payment for health care and for health care insurance.

Individual and direct payment for health care insurance is an essential component to sustainable health care. It is essential that premium payment is made by individual plan members, as it is the only way they can know the reality of health care costs, the first step to ensuring responsible use. This means eliminating the use of general revenue to pay for health care, replacing taxation with premium payment as was the case in the CCF legislation. To ensure universality, in cases where a person does not have the income to make full premium payments,

government redistribution of income outside of the insurance plan would be required.

**2. A Publicly Administered LIFE Trust Commission.** The CCF vision required that the administration of health care insurance be removed from the political sphere, and be made the responsibility of an independent health care commission which reported to the Legislature. In the context of LIFE Trusts, the commission would be both the plan administrator and fiduciary agent for the trusted funds. It must therefore be independent of (but responsible to) the government and of the contracted providers of health care services (be they employers or employees). As with the CCF model, the Commission would only administer the plan and would not be the employer, contracting with "authorized agencies", be they public, private or third sector (not for profit), for the efficient, effective and responsible delivery of health care services.

**3. A Single, Comprehensive, Universal and Compulsory Health Care LIFE Trust.** All public sector expenditures relating to the health care of individuals would be included in the mandate and the budget of the Commission. Thus it would include not only the doctors, hospitals, and laboratory tests covered under prevailing heath care legislation, but also aspects of health care covered under other legislation, such as prescriptions, home care, nursing home, and workers compensation. By encompassing all health spending within a single budget, isolated spending silos would be eliminated, thereby providing the opportunity to realize system wide efficiency and responsibility.

While it would have an interest in the wider issues of community health, environmental standards, and the like, the Commission would be required to focus directly on the pre-paid health care insurance for individuals. Clearly, there is a wide range of interpretation of what these comprehensives services might be, but as a starting point they would be what they are now.

The compulsory aspect of the plan is necessitated by its universality. Public health care insurance involves a social contract, involving obligations and rights on the part of all parties to the contract: to use the system, people must be part of it. As with the CCF vision, services offered under the plan would be essential services, for if they were not essential, there would be no need for them to be provided in a publicly administered, universal and compulsory plan.

**4. A Responsible and Affordable Health Care LIFE Trust.** While the goals of health care are not about money, paying for health care services certainly is. In order to bring responsibility to both the use and the provision of health care, the total annual spending on health care must be controlled – over the past five years, age standardized health expenditures have grown at more than twice the rate of inflation. Setting global limits on health spending will provide the currently missing incentives required to foster efficiency, effectiveness and responsibility on the part of both users and providers of health care services. Note that this does

not imply "caps" on the incomes of health care providers and suppliers or on the use of services by plan members: increasing efficiency and responsibility must provide the options for both of these.

## II. Demographics, the Life Cycle of Health Spending, and Health Care Insurance

### A. Insurance

The arguments for a comprehensive, compulsory, universal, and accessible health insurance plan, and for its public administration, have not changed since the original vision articulated by Tommy Douglas almost half a century ago:

> … there are many people who cannot avail themselves of the voluntary plans, either because they cannot afford the premiums or because they have congenital conditions which are not covered by them. It is for these reasons that the government has come to the conclusion it should embark upon a comprehensive medical care program that will cover all our people. [DS22].

He was also emphatic that the plan involve pre-payment and include all people, not merely out of love of humanity, but also because "the only way we can have a real insurance scheme is to cover the good risks as well as the bad, thus spreading the costs over the entire population" [DS22]. Further, the insurance scheme was to involve direct and individual payment of insurance premiums by way of "a personal tax plus contributions from the general revenue of the Province … the Government will set the personal tax at a level which is within the capacity to pay of all self-supporting persons" [BM154].

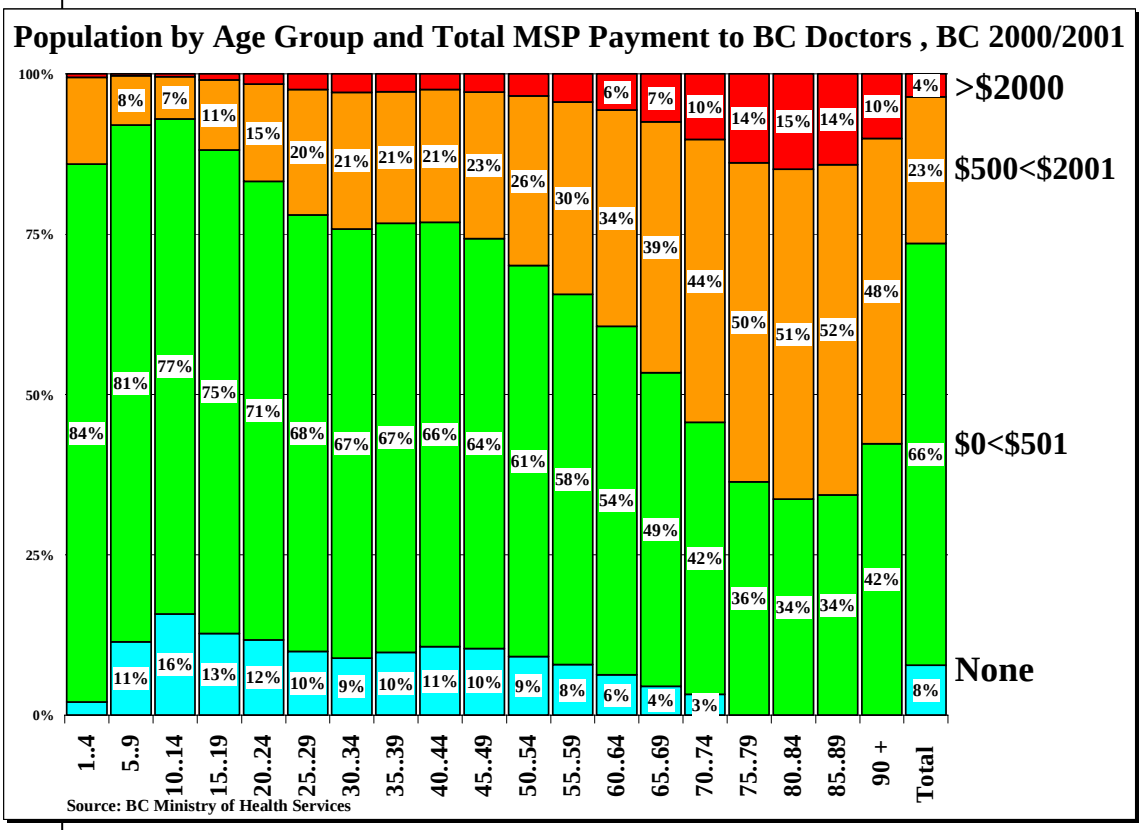
***…health care is being used for purposes other than those that insurance is predicated upon: use of the heath care system is much more wide spread than for the catastrophic events that insurance provides for.***

While it is often forgotten in the heat of the current discussions of reform, it must be remembered that the fundamental issue in adapting the financing of medicare to the 21st century and to the legitimate expectations of society is not merely health care, but health care insurance. Pre-paid insurance is something we purchase with the hope that it is never used, buying it only in case the very small probability that an unpredictable and unlikely catastrophe does occur. If disaster does strike, its costs are usually very large with respect to individual income, and often with respect to individual wealth as well: by spreading risks, and contributions, widely, insurance provides each of us with the resources in the unlikely case that we will need them.

All spending on health care is not insurance related (i.e., to deal with the potential consequences of an unlikely and unpredictable catastrophe): there is a component that is the result of regular health maintenance. For example, 92% of the population of British Columbia in 2001 were patients for which the BC Medical Services Plan made a payment to a registered practitioner, with utilization ranging

from a low of 84% of the people aged 10 to 14 to a high of 100% of the people aged 75 and older (Figure One). On the surface, this indicates that health care is being used for purposes other than those that insurance is predicated upon: use of the heath care system is much more wide spread than for the catastrophic events that insurance provides for. In this context, use of the health care system is both common place and predictable, and hence would dictate an annual membership fee to use the systems services (much like a health club membership) rather than an insurance premium.

**Figure 1 (Source: BC Ministry of Health Services)**



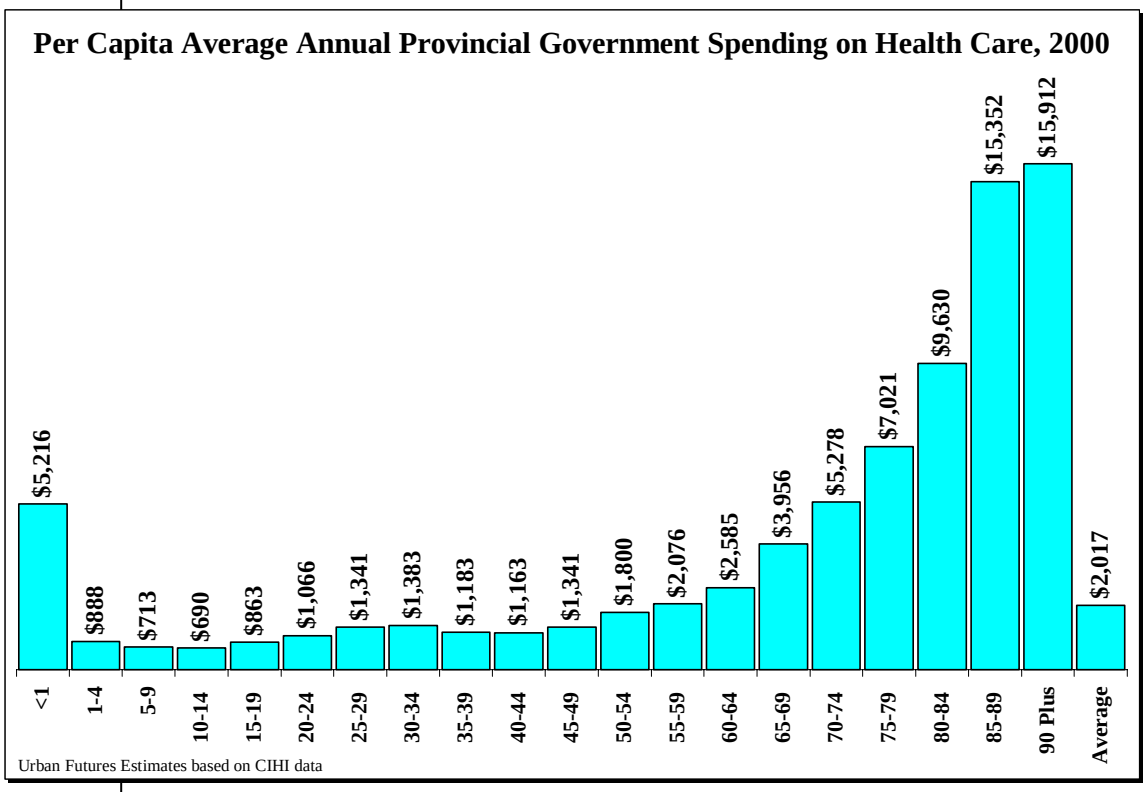

Having said this, the separation of annual maintenance use from disaster insurance is not as simple as saying it. To the extent that annual use leads to measures that are preventative of catastrophic events, or to their early identification and perhaps lower treatment costs, annual use is linked to insurance. This is shown in the BC MSP data which show that while there is a very high annual subscriber utilization, for the majority of the users, it involves relatively low payments to medical service providers (8% of the population did not use the system and 66% did but incurred practitioner costs of $500 or less during the year). However, for a few – 1 out of 2,000 people – annual payments to practitioners exceeded $10,000 in 2000/2001. This is the context wherein the insurance aspect become dominant, where the exceedingly high costs of a medical emergency, a serious medical condition or disease, or a chronic condition create a significant and unpredictable burden on a few of us each year, and where we must

spread risks across a large number of people. It is here assumed that payment for both annual use and pre-payment for insurance purposes will continue to be included in a single transaction.

**B. The Life Cycle of Spending**

The use of the health care system involves both annual use and insurance: it also involves a pattern of increasing per capita annual costs with increasing age. Regardless of the health care system, after the first year of life, as we age we are more likely to need to use the system more often and for care that involves larger costs. Figure Two shows Canadian average annual provincial government spending on health care per person by age group for the year 2000 (as estimated by the authors using CIHI data). It shows the life cycle pattern of health care spending around the average of $2,017 per person per year.

**Figure 2**




*The use of the health care system involves both annual use and insurance: it also involves a pattern of increasing per capita annual costs with increasing age.*

In the first year of life, per capita average health care costs of $5,216 are almost twice the overall average of $2,017 per year. Other than this first year, the first twenty years of life are the lowest cost stage, with average annual cost ranging between $690 to $888 per person per year. The per capita annual costs during the next thirty-five years of life, from age 20 to 54, are also below the overall average of $2,017, ranging from $1,163 to $1,800 per person in the age group per year. From age 55 on, however, not only are per capita costs above the average, they

increase exponentially, from $2,076 per person per year in the 55 to 59 age group to $9,630 in the 80 to 84 age group and $15,912 in the 90 plus age group. With the front edge of the baby boom bulge sitting at age 55, the next two decades will be characterized by an ever increasing percentage of the population aging into increasingly expensive health expenditure age groups.

It is in this context that today's pay as you go, financing health care expenditures out of current revenues, will not serve us well. The current annual cash flow (taxes and premiums for revenue that is spent on annual expenditures) approach may spread current risks across the current population: it does not, however, put anything aside to pay for the inevitable increase in health spending that aging will bring years in the future. Looking at the per capita average health care expenditure by age group chart should lead any prudent insurer to require that, on average, contributors pre-pay for some of their expected high average cost health care later in their lives earlier in their life cycle. In this sense, insurance should not only underwrite for maintenance use and risk in the current year, but also for the long term life cycle pattern that clearly shows that utilization costs and risks are greatest in the later years of life. It is also obvious that the current cash flow, pay as you go health care plan will generate dramatic increases in total and average annual costs if the 55 plus age groups increase more rapidly than the 1 to 54 age groups (i.e., if the population ages).

***It is in this context of increasing spending on healthcare with age that today's pay as you go financing health care will not serve us well.***

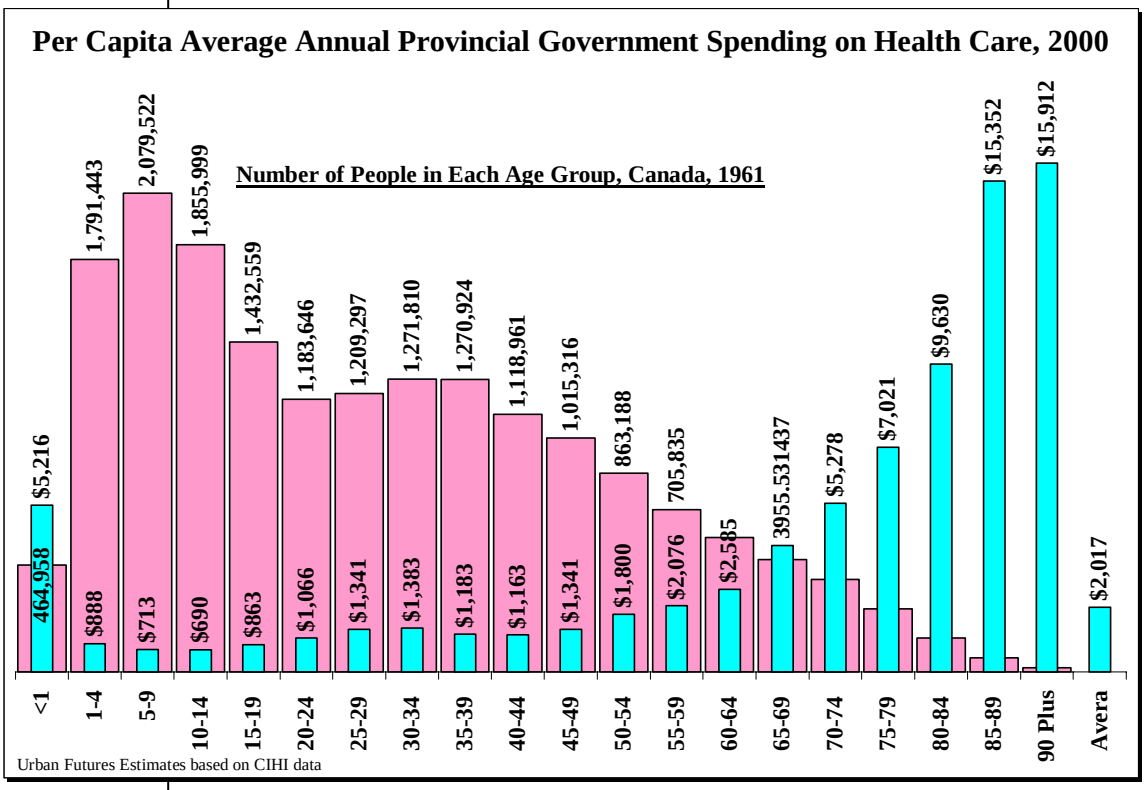
In the past, health plans in Canada had the luxury of having a small portion of the population in the high average cost, older age groups relative to the number of people in the below average cost working age groups. In 1961, the year of the passage of the Saskatchewan legislation, the demography of Canada was perfect for the introduction of a health care plan based on universal, compulsory coverage (Figure Three). There were 7.2 million people in the lowest per capita health care 1 to 19 age group, accounting for 39% of the population; 7.9 million (43%) in the below average cost 20 to 54 age group, and only 2.7 million people (15%) in the high cost 55 plus age groups. In total, there were only 208 people in the high average annual expenditure age group for every 1000 in the low per capita average expenditure 1 to 54 age groups.

This situation had hardly changed by 1971 when all of the provinces in Canada had introduced Saskatchewan derived and federally supported health care plans: 2% of the population was under the age of 1, 38% was aged 1 to 19, 44% was aged 20 to 54, and 16% was aged 55 plus, for a ratio of 216 people in the above average annual per capita expenditure age groups per 1000 in the below average age groups.

The 1960s and early 1970s were the perfect time to introduce compulsory universal health care plans funded, either directly or indirectly, by transfers between a large group of low cost contributors and a relatively small number of high cost beneficiaries. The upturn in birth rates that started in 1937 and prevailed until 1996 created a 30 year demographic wedge in Canada's population

that has been essentially contained in the low cost stage of the health care expenditure life cycle since the introduction of the Canadian health care system – there has been an abundance of contributors relative to the beneficiaries. It is for this reason very little of the increase in health care costs over the past thirty years can be attributed to demographics.

**Figure 3**

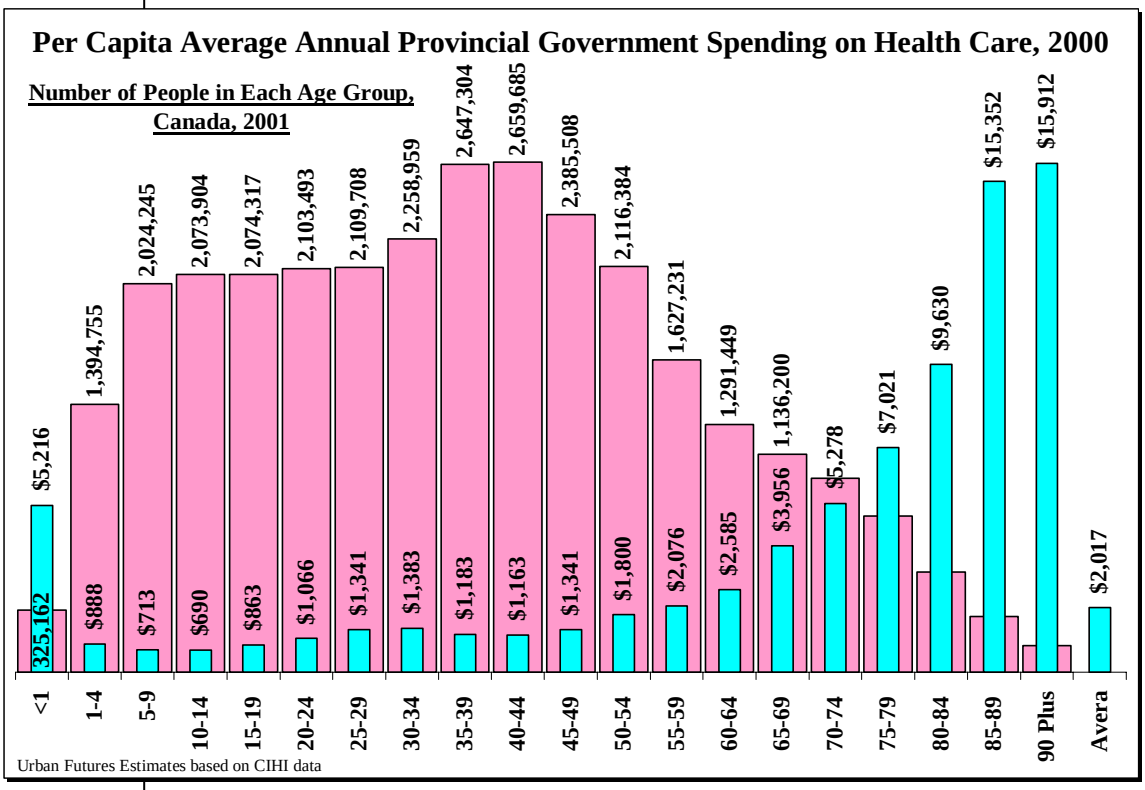



***The 1960s and early 1970s were the perfect time to introduce universal health care plans funded by transfers between a large group of low cost contributors and a relatively small number of high cost beneficiaries.***

Having said this, the bulge has not been standing still within this age group: each year since 1960 Canada's population has aged, with the bulge shifting to the right into successively older, higher per capita average health spending age groups. By 2001, the front edge of the bulge, the people who were in the 15-19 age group in 1961, had reached the 55 to 59 age group, aging into, for the first time since the year of their birth, an above average annual per capita health care expenditure age group (Figure Four).

*Effective, Efficient and Responsible: Canadian Healthcare in the 21st Century*

**Figure 4**




*However, since its introduction Canada's population has aged significantly. The Baby Boom bulge will continue to shift into higher and higher average annual per capita health spending age groups.*

With the share of the population (and since 1991, the number of people) in the under 35 age groups shrinking (the result of the declining birth rates Canada experienced in the post-1960 period), the size of the below average per capita expenditure age group has declined relative to the size of the above average per capita expenditure group. In 2001, there were 300 people in the above average per capita expenditure age groups for every 1000 people in the below average expenditure 1 to 54 years of age group, 50% higher than in 1961. In 2001, only 24% (7.7 million) of the population was in the lowest per capita expenditure 1 to 19 age group, with another 53% (16.3 million) in the other below average expenditure age group, the 20 to 54 age group: 22% (6.8 million) were in the above average expenditure 55 plus age group and 1% were under the age of 1.

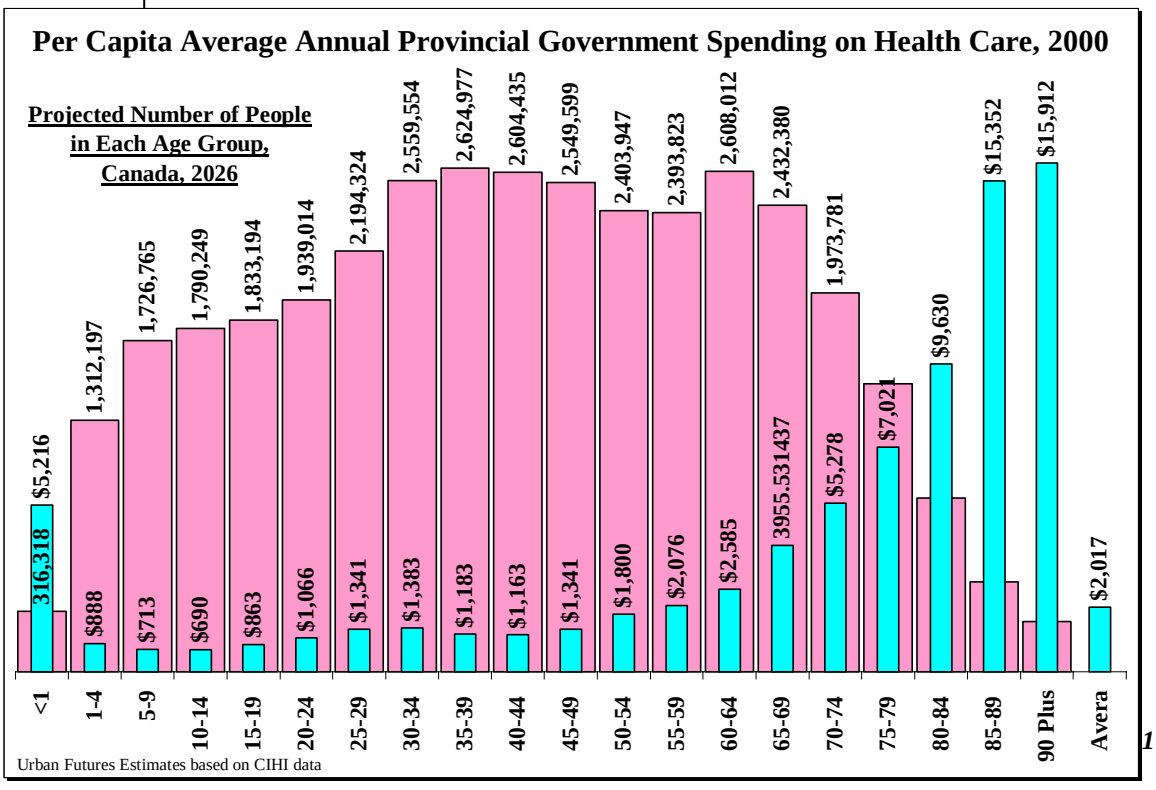
With Canada's long life expectancies and low birth rates, the bulge will continue to shift into higher and higher average annual per capita health spending age groups. Today's 55 year olds will be around for another quarter century, and will increasingly need more frequent and more costly access to health care. Given it's below the replacement level birth rates, the younger population can only increase through net immigration of young people to Canada.

***In 1961, there were five people in the below average per capita expenditure category for every one in the above average age groups. By 2026 there will be fewer than 2 people in the below average age groups for each person in the above average age groups.***

A trend projection of Canada's population, including immigration and emigration at their recent average annual rates (0.75% and 0.16% of the population, respectively), births and deaths at their current age specific rates, and aging, shows that aging will provide significant pressure for demand driven increases in expenditure on health care. This will occur even if age specific health care expenditures are held constant at their current level as shown on Figure Two. As is shown below, and is discussed in detail in the next section, it is essential that age specific health care spending be held constant in real terms at their current level (i.e., the only increases would be at the rate of inflation, and hence, projections will be in constant dollars) if the current health system is to be sustained.

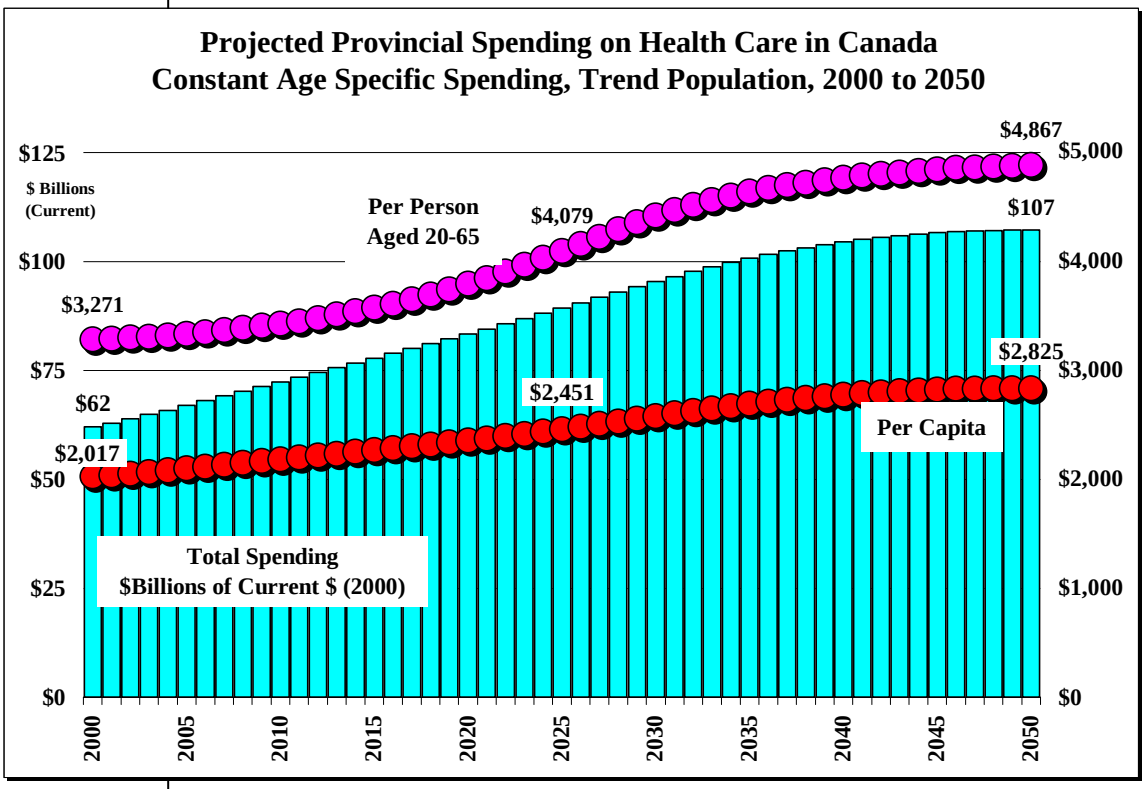
Following current demographic trends, between 2000 and 2026, the population of Canada would increase by 5,859,000 people (19%). In 2026 (Figure 5) 34% of the population (12.5 million) would be in the high per capita expenditure 55 plus age groups (more than twice 1961's 15%) and 1% in the under age of 1 group: the proportion in the below average expenditure age groups will have declined by a proportionate amount, with only 18% in the 1 to 19 age group (less than half of 1961's 39%), and 46% in the 20 to 54 age group (compared to 1961's 43%). This will result in there being 547 people in the above average per capita spending age groups per 1000 people in the below average expenditure age groups, a more than two and one half times increase in the ratio from 1961. In 1961, there were five people in the below average per capita expenditure category for every one in the above average age groups. By 2026 there will be fewer than 2 people in the below average age groups for each person in the above average age groups.

**Figure 5**



The use of the population projection, along with the requirement that the age specific pattern of health care spending remains, in constant dollars, at its current level, permits measurement of the magnitude of the increase in health spending that will be driven by the aging of Canada's population (Figure 6). This projection shows that even with constant age specific health care spending, the aging of Canada's population will increase inflation adjusted (constant dollar) per capita spending on health care continuously over the coming decades, with 2025's per person expenditures of $2,451 being 21% higher than today's $2,017, and the 2050 expenditures of $2,825 per person being 40% greater. With the majority of the tax burden falling on the working aged 20 to 64 age groups, total provincial health care spending per person aged 20 to 64 would increase by 25% over the next quarter century, from 2000's $3,271 per person to $4,079 in 2025, and by 49% to $4,867 in 2050.

**Figure 6**

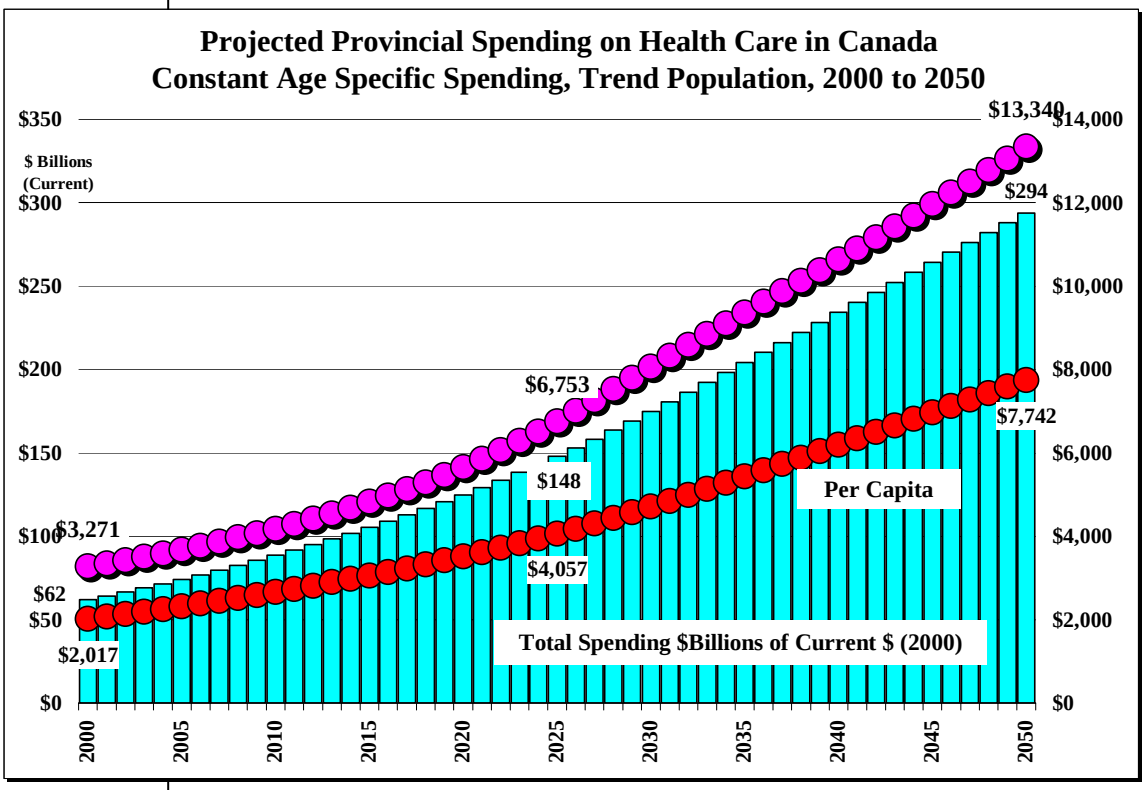



The reason for the requirement that age specific health care spending per capita be held constant is shown in the consequences of not doing so. The most recent continuous data series of per capita age specific health care costs are from CIHI for the 1996 to 1999 period. These data show that per capita provincial government health expenditures increased by 12% over the period, for an average of 4% per year. During the same period, general inflation (as measured by the consumer price index) averaged 1.5% year: in constant dollars, per capita

provincial government health expenditures increased by an annual average of 2.5% over this period. As the composition of the population also changed over this period, it is necessary to age standardize this rate using a constant age profile: the age standardized constant dollar increase in per capita provincial government health expenditure was 2% per year over the period. There were three sources of this increase (inflation in the costs of health care, increases in health care services, and increased utilization of health care services): unfortunately, these three cannot be separated from the total increase with currently available data.

If the 1996 to 1999 average of 2% annual increase in the age standardized constant dollar per capita expenditure is permitted to continue, total health care expenditures in constant dollars would skyrocket (Figure 7). Total provincial health expenditures in constant dollars would double, from 2000's $62 billion to $148 by 2025, and would increase almost five fold to $295 billion by 2050. Per capita constant dollar health expenditures would double by 2025, increasing to $4,092, and increase fourfold to $7,930 by 2050, as would expenditures per person aged 20 to 64, which would increase to $6,761 by 2025, and to $13,677 by 2050.

**Figure 7**




While there has been much discussion of the impact of aging on health care expenditures, and rightly so, the consequences of an aging population pale when compared to the consequences of the recent trend of age standardized per capita

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health care costs increasing faster than both inflation and economic growth. The challenge in adapting the financing of medicare to the 21st century and to the legitimate expectations of society will be to ensure that consumers of medical services, contributors to medical plans, and taxpayers in the future can afford to pay for health care. This means devising a financing arrangement that does not shift the burden of the aging of the population onto the next generation and ensuring that health care services are delivered and used in an "effective, efficient and responsible" manner to keep age specific per capita spending at its current level.

## IV. Life Cycle Insurance Fund and Endowment (LIFE) Trusts

The current "pay as you go" system of health care financing will place a much greater relative burden on the contributory population of future generations than it has in the past, as the size of the above average per capita health care cost age group relative to the size of the below average cost age groups will be much greater in the future than it ever has been in the past. The current generation of people in these older (55 plus) age groups has been fortunate to have the large 1938 to 1967 population cohort (in the 35 to 64 age group today) in the working age groups since the introduction of health care plans in Canada. In contrast, the current generation of young people (under the age of 35) in Canada will have to deal with the health care costs of having this same large cohort in the above average cost, older age groups over the next thirty years.

*The current "pay as you go" system of financing will place a much greater relative burden on the contributory population of future generations than it has in the past*

It is entirely reasonable that this younger generation would argue that a pay as you go system shifts an inequitable share of the burden of future health care costs onto their shoulders. Conversely, the people in the bulge cohort can argue that they have being paying for health care for three or more decades, and hence have a right to the benefits of these contributions: this point is moot, as their money has already been spent on the current older population. The fatal flaw in Canada's health plan is that it is not a plan: it a collect today what you spend today system that gives no thought to the future.

At the very least, a sustainable health care plan has to anticipate future demands brought about by shifts in the age composition of the population. The way to do this is to move the health care plan from an annual cash flow system to a health care Lifecycle Insurance Fund and Endowment trust.

The first element of health care LIFE trust is that it would pay, out of premiums, the full amount of annual health care expenditures, in a fashion that makes a direct connection between use of the health care system, the subscribers and plan members, and the payment for services and insurance. This differs greatly from the current system, which has no mechanisms or incentives to ensure that the use and the provision of health care is done in an efficient, effective and responsible fashion. As discussed in greater detail in the next section, it is essential that

health care be paid for from premiums, with income redistribution occurring outside of the plan, so that those paying for and using the system are aware of the costs. Note that this approach involves no new cost, as this amount is already being spent: the only change is the mechanism for how it travels from taxpayers to the health commission to the health care service providers.

Using the 2000 data shown on Figure Two, this means a base of $2,107 per year per person to pay for current health care expenditure, including both the regular use and insurance against risks during the current year. In addition, annual premiums must include a pre-payment towards insurance for future health care services and risks based on the life cycle of health spending. This incremental life cycle premium would be invested by the Health Commission in a trust fund which would earn interest to provide it with the revenue to meet demographically driven growth in expenditures in the future.

Before detailing the calculation of this life cycle insurance premium, it is important to note that all of the money would be deposited into a single account – individual medical savings accounts are not proposed, as they do not provide the mechanism of spreading the risks across the entire population. The life cycle premiums are to be invested, exactly as occurs in other forms of long term insurance, to offset future health care expenditures. The Commission would have a trust responsibility for these funds, to make certain that governments do not get their short term hands on them.

Total provincial spending per person during a person's lifetime can be calculated using the age specific spending profile shown on Figure Two. In its simplest form, this calculation involves multiplying the per capita annual spending by 5 (as a person spends five years in each five year age group) and summing the results. On this basis, the total amount spent on the average person during a 95 year lifetime would be $375,528, or an average of $3,953 per year.

Unfortunately, few of us have a 95 year lifetime: life expectancy at birth in Canada is currently only 80 years. If the age specific expenditures are multiplied by the probability of someone reaching each age group (e.g., at current mortality rates, only 90% of people born live to have a 65th birthday), a total life time expenditure adjusted for survivorship of $226,134 is calculated, for an average of $2,380 per year over a 95 year lifetime.

Rather than paying this amount annually over a person's life time, a single amount could be invested at their birth to provide health care insurance over their life: this amount would be the present value of the future stream of payments discounted at the rate of interest paid on the investment.

If no interest was earned, $226,134 per person would be the amount invested at birth for an insurance policy that would pay for health care over the life cycle of the insured population. As the majority of these expenditures fall late in a

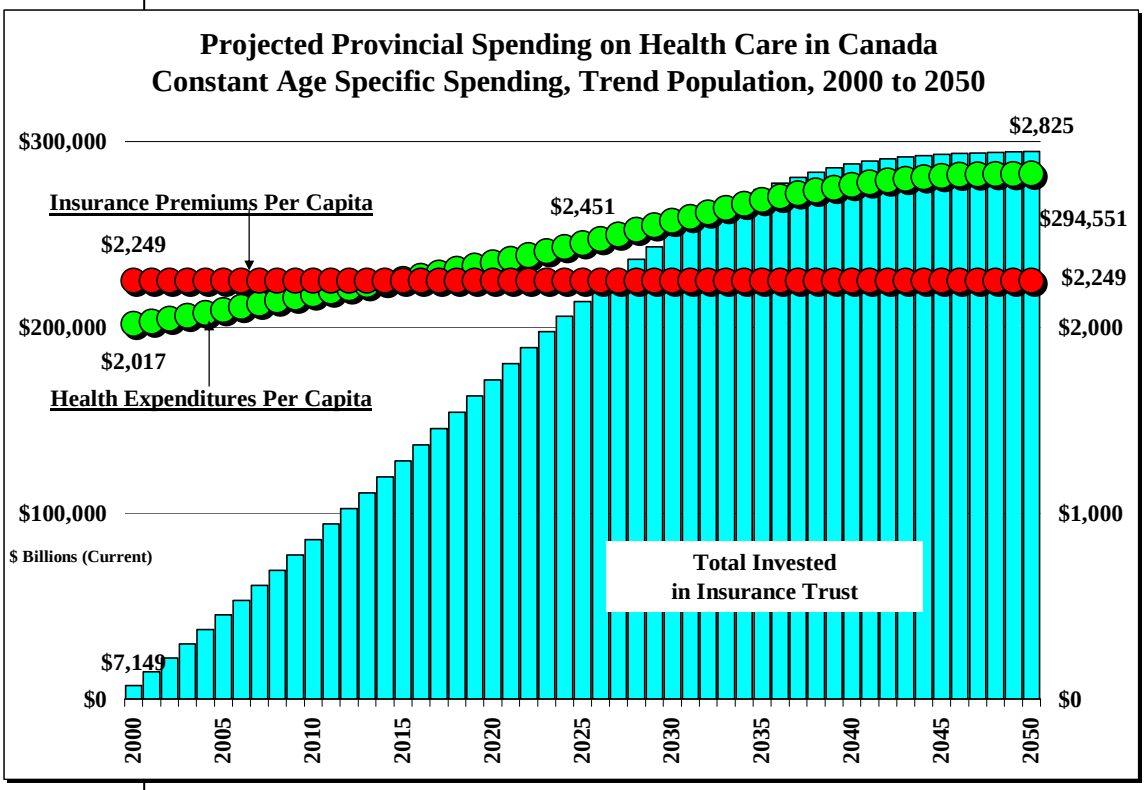
person's life, the higher the interest rate earned on the investment, the lower the amount of the single payment for a lifetime health insurance policy at the time of birth: for example, if 7.5% per annum (after inflation and without tax, as the funds are invested by the Health Care Commission) could be earned on the amount invested, it would be necessary to pay only $16,362 at each child's birth to cover their lifetime health care costs with today's expenditure pattern. This shows the impact of compounding of interest, and of spreading of risk, as the interest earned on a $16,362 investment would pay for a lifetime's health care if the risks are spread over a large enough population and age specific health care costs are held constant.

In the current context, however, the challenge is not merely to set aside funds at birth as an investment to cover health care costs over the subsequent three-quarters of a century or more, but to develop a financing system for a situation where 42% of the population is currently between the ages of 35 and 64, and hence will be reaching the highest costs stage of the health care life cycle within the next 10 to 40 years. If pricing of the insurance premium was based on current age (i.e., within age group funding), then the older population would face extremely high single payments for health care insurance. For example, at 7.5% per annum, while only $16,362 would have to be set aside at a child's birth to provide health insurance for life, a 70 year old would have to cough up $53,740 to insure for the expected average costs of health care in their remaining years.

Following the income and social criteria of the CCF vision, the burden of the pre-payment for health care insurance spending must be spread across all age groups. For clarity and simplicity, the approach considered here is to have a total premium of $2,250 (to be precise $2,249.13) per person per year, with this amount remaining constant in real terms (i.e., increasing only at the rate of inflation) in perpetuity. The base premium is the $2,017 per person currently being spent on health care, with an additional $232 life cycle pre-payment premium to cover the costs of increasing health care spending over a person's life cycle. This means that in the near term subscribers will be paying 11.5% ($232) more per year than the $2,017 per year required to cover the current year's costs, in order to remove the intergenerational shift of health care costs and to endow the health care system.

By 2025, however, the $2,249.13 premium will be $201 (8%) less than the $2,451 that will be required by the pay as you go system, and $575 (20%) less that the $2,825 that the cash flow approach would require in 2050 (Figure 8). Assuming that the invested funds earned 7.5% per annum, this payment scheme would ensure a perpetual endowment (in the range of $294 billion) that would be used to keep annual payments at $2,250, below the lifetime average of $2,380, forever. [Recall that constant dollars are being considered: the current dollar premiums would be this base amount adjusted for inflation.]

**Figure 8**




For the first 14 years, the annual payment of health care and pre-payment for health insurance would be higher than it would with the current annual cash flow approach: in every year thereafter it would be lower. This means that after 2014, there would not be a sufficient inflow of funds from premiums alone to cover the annual costs of health care as the front edge of the aging demographic wedge hits the highest cost stage of the life cycle: this is when the endowment portion of the health care LIFE trust is called upon, with the annual yield of 7.5% providing more revenue than the shortfall until 2046. Given the general stabilization of population (albeit with a slowly increasing proportion of people in the older age groups that a below the replacement level birth rate causes) after 2046, the yield from the trust would equal the shortfall, and the intergenerational shifting of health care costs would be eliminated.

The higher the annual contribution, the lower the yield rate necessary for the plan to be funded in perpetuity. For example, if the premium was $2,830 (the annual average of the lifetime health care cost $226,134 over a 95 year lifetime), with the life cycle premium invested at 4.36% per year, a perpetual endowment fund would also be created.

It may be argued that an 11.5% increase in health care premiums in the first year of the plan is too high. If the increase in payments was phased in over time, clearly the math would require that the long term future payment be higher. Thus if payments were to start at $2,017 (the current average cash flow cost), then by 2014 they would have to be $2,380 and then plateau in order for the insurance to be sustainable in perpetuity. This would mean a real (i.e., excluding inflation) annual premium increase of 1.3% over the next 15 years. This, however, would putting a greater burden on the younger age groups to pay for the health care of an aging population.

So there it is: if health care cost on an age specific basis can be contained at today's level, for an increase of 63 cents per person per day - less than the cost of a cup of coffee, and way below the cost of a double decaf low fat soy latte - the current universally accessible, publicly administered, comprehensive health care system with a greatly reduced intergenerational burden can be sustained in perpetuity. While the specific values will change until the system is introduced, the math will not: a once-only increase in premiums of approximately 11.5% this year will result in constant premiums that will fund an endowment that will maintain the health care system with its current characteristics in perpetuity (assuming investment yield of 7.5%).

The conclusion is that if the current age specific health care spending pattern is maintained, then the CCF vision of health care is sustainable through the use of health care Lifecycle Insurance Fund and Endowment trust and formula determined health care spending limits. The public's part of the social contract concerning health care will involve paying a bit more now and less later, and in using the health care system responsibly. The health care provider's part of the social contract will be to work within a funding formula that provides for aging and inflation, and encourages them to work together and with the public to ensure the sustainability of the health care system by finding ways of providing effective, efficient, and responsible health care.

## V. Controlling Health Expenditures

It is instructive, prior to discussing the mechanisms for controlling of health care costs in the current context, to consider how costs were managed in what was effectively the pilot programme for the 1961 Saskatchewan Legislation, the regional health care plan put in place in the Swift Current Health Region in 1946. Before doing so, however, it is important to acknowledge that it was neither T.C. Douglas nor the CCF who started public health care insurance in Canada. It was a farmer and reeve from the Saskatchewan Rural Municipality of McKillop, Mr. Matt Anderson, who from 1927 on worked diligently to establish a health care plan for the municipality's residents: by 1939 he succeeded in implementing a health care plan, with insurance based on a tax (i.e., premium) of $5 per resident in the municipality to a maximum of $50 per family, that provided medical

services to the residents of the municipality, with doctors working on either a fee for service or monthly stipend basis, with the funds administered by the municipality [DS13-16]. It was the "Matt Anderson Plan" that was the basis for both the Swift Current and Saskatchewan plans, and ultimately, the Canada Health Act.

If McKillop was the image, Swift Current was the proto-type. In 1946, a prepaid, publicly administered health insurance plan (including medical, dental for children up to 16 years of age, and hospital care) for the Swift Current region (one of the poorest in Saskatchewan at that time) was put in place, with services delivered on a fee for service basis by private practitioners, and funding based on a combination of personal tax (i.e., compulsory individual premium) of 75% of the costs plus a land tax of 2 mills on assessed value, and a grant from the province. Private practitioners embraced the program because they were assured payment, something that was not the case prior to the plan. [DS19]

The Swift Current experience holds more than historical relevance to the current discussion, in that it provided a mechanism to adjust expenditures when costs exceeded revenues:

> "Payment was on a fee-for-service basis, with the doctors accepting 75 percent of the College's 1939 schedule of fees as payment in full. One of the financial difficulties experienced by the region as the result of using the fee-for-service method of remuneration was the inability to estimate accurately the amount of money it would require to pay for the services rendered. The unknown quantity was the rate of utilization. To meet this difficulty the regional board (comprised of a medical health officer plus one representative for each municipality in the region) and the Swift Current and District Medical Society agreed that starting with the year 1949 there would be a limited fund available to pay for all physicians' services. Should the total cost of physicians' services rendered, reckoned on the basis of 75 percent of the College's 1945 schedule of fees, exceed that amount, payments for the year to physicians would be prorated accordingly. Continued high utilization resulted in physicians receiving payments at less that 75 percent of the 1939 schedule of fees until 1953 when, at the insistence of the doctors, a small utilization fee was imposed on home and office calls. This had the effect of reducing the rate of utilization while at the same time providing an additional source of income for the doctors." [BM41].

Here was a working mechanism for maintaining health care budgets that considered both the cost and the utilization sides of health care. However, as might have been anticipated "subsequent negotiations … resulted in the

percentage of the schedule paid being increased and the budgetary ceiling being removed." [BM41].

Turning to the current context of controlling health care expenditures in the 21st century, it is important to note that there is a tendency for policy makers to want to micro-manage health spending, with limits and caps, regulations and programs at a very detailed level. Once more, the Saskatchewan experience suggests quite a different approach. On the health care providers side, in 1943 the College of Physicians and Surgeons of Saskatchewan Health Care Committee presented a proposal for a compulsory universal health insurance program in the province. This proposal was silent on how to finance such a plan because "finance is a detail on which we, as medical men, are not experts. We prefer to leave it to the experts." [BM30].

On the government's side, Premier Lloyd's comments were in complete agreement with the College:

> "As patients, we are perfectly willing to place matters involving medical judgments entirely in the hands of a highly-skilled group such as you are. In enacting the Medical Care Insurance Act, however, we have said that we, as consumers of medical services, and as taxpayers, have a right to a say in how we pay our medical bills. We have the right to construct an administrative agency, responsible to us, to arrange such payment. … When a commodity or service is essential our society has long since accepted that consumers have a legitimate right to a voice in making the essential governing decisions in such matters. That voice has been, for medical care, embodied in the Saskatchewan Medical Care Insurance Act, an Act passed by the properly elected legislature of the province of Saskatchewan." [DS49]

To paraphrase the implicit agreement, the budget and the legislation for universal, publicly provided, compulsory health care is the domain of the government, acting on behalf of taxpayers and consumers, while how to deliver health care services within this budget is the domain of the health service providers.

The fundamental issue in development of a financially sustainable health care system is not how to control health care costs, but rather to decide to control them. Only when the decision has been made to control cost do the questions of how to do so become relevant. Thus provincial governments today find themselves in exactly the same position as the CCF government under both Douglas and Lloyd: they must make a political decision that will both achieve the financial objective and provide the opportunities and incentives for both health care consumers and providers to find the most responsible way to deliver services with the funding framework.

It is here proposed that, following the guidance of the Saskatchewan experience, the government sets an annual budget for public sector health care expenditures, the public health care commission sets the standards to be attained, with both of these parties leaving it to health care providers to work together and with the communities they serve to determine how best to deliver health care services. The proposed formula for determining the global health care budget is to take the current age specific spending per capita, increase it by the annual rate of inflation, and multiply the result by the current age profile of the population. This would ensure that health care providers have funding that maintained the status quo with respect to the cost of living and the funds to deal with the current level of services for an aging population. Health care providers would contract with the health care commission to deliver health care services of a specified quality and quantity within a specified budget.

This approach would precisely match expenditures to revenues from the health care LIFE trust described in the preceding section. It is extremely important to note that the global funding limit would in no way limit the increase in compensation to health care providers to inflation. By setting a global budget and a level of service to be provided, this approach would leave it to the health care providers to not only determine how best to do provide the specified health care, but also would provide them with the incentive to do so, as every increased efficiency they discovered would increase their compensation. Clearly, in order for this to be effective, the silos of health care would have to be removed, with a unified approach that engaged all health care providers, from pharmaceutical firms, health care professionals, to maintenance staff, giving them both the freedom and the necessity to work together, and with their communities, to find the most efficient way to deliver the required standard of health care. Consumers, in their turn, knowing what their utilization of the health care system costs, would have the incentives to use the system in an efficient and responsible fashion, and to work with health care providers to ensure that other consumers were also responsible.

The reason for this approach is to build into the Canadian health care system something that is missing - mechanisms to ensure attainment of the three implicit goals of an effective, efficient, and responsible health care system. Currently, the users of health care do not know how much health care costs, let alone how much the services they personally receive cost, and have no direct financial incentive for responsible use. Similarly, the providers of health care have no financial incentive to pursue efficiency or effectiveness. They do not have to present patients with bills, with the only barrier to increasing their revenue being the resistance of governments, who in turn have no real incentive to ensure efficiency, as the costs are buried in taxes and transfer payments. Without such incentives, health care will experience what in environmental literature is know as the tragedy of the commons, the destruction of something that we all collectively benefit from because there are no requirements for individual responsibility in its use.

Clearly, at some point, real per capita age specific health care expenditures will have to be stopped from increasing faster than inflation, from increasing as a share of GDP, and from increasing as a share of provincial budgets, for such unchecked growth is unsustainable. At some point, either by design or default, such limits will be reached: better that it be by design.

Can growth in age specific per capita health care spending be curtailed? Yes, because of the public sector monopoly on spending, and the provisions that would adjust spending for growth in both revenues and expenditures due to both general inflation and aging of the population. Just as the CCF government in Saskatchewan decided how health care should be paid for, contemporary governments must define the parameters for public spending on health care, and do so in a manner that is both logical and predictable.

What is important is that it does so in a way that provides incentive for responsible, efficient, and effective provision and use of health services. Controls on wages and prices will not do this, as they strip away incentives: setting a global budget and letting providers and users change how things are done in order to improve both their position and the system will provide such incentives. With such incentives, it is hard to argue that the dedicated, bright and innovative people who provide and use health care cannot come up with better ways to do things than today's system. What can be argued is that if they don't find a way to limit the growth of expenditures to that determined by aging and inflation, then the five pillar model of health care in Canada will be a thing of the past.

The first step will be, at the same time, the easiest and the most difficult: this will be making the decision that the total expenditures for health care will be determined, now and in the future, as the product of the current (i.e., at the time that the program is put in place) average per person age specific annual expenditure times the number of people in each age group in the population. This will allow the current and future universal spending for health care to be set. The revenue side will be determined by multiplying the per capita average annual expenditure plus the life cycle insurance premium by the total population, with the amount of the age pre-payment premium being set aside in the LIFE trust account. Annually in the future both the amount of the contributors' payments and the total budget will be increased by the rate of inflation.

This will mean that everyone will know what the limits are. Contributors and users will know how much health care is going to cost them in the future and providers will know how much money there is pay for everything, including their incomes. This is the base that must be established before any other changes can be made, as without this global cap on spending, there will be no incentive to ensure that either users or providers will act in an efficient, effective, and responsible fashion: so long as there is the belief that there will always be more

money for health care, the pressure will be to get more of it. The deterioration of health care in Canada that has paralleled increasing cost is evidence enough that sustaining Canada's health care system requires something other than simply throwing more money at it.

The global budget cap will provide for the status quo, in terms of current prices, services and costs. It means that providers will know that they can earn what they are earning now plus inflation: more importantly, it will also mean that if they want increases greater than that caused by the aging of the population and inflation, they can have it by finding better – more effective, efficient, and responsible – ways of delivering the same services. By having the Public Health Commission administer the fund in trust on behalf of the contributors, the providers of services cannot achieve increases in incomes by erosion of the services provided. Rather, the contractors, be they public, private or not for profit, will be able to increase their revenue through true increases in efficiency.

It may be argued that there are no ways to increase the efficiency, effectiveness and responsibility of the health care system: this argument is the logical extension of the current situation where there is no incentive to do so. Finding these will be up to the innovation and imagination of the providers and users of health care services. Personal experience, and the on-going debate about health care delivery, suggests that there are many ways in which the bright, creative people who work in delivery of health care services and who make up the communities they serve can find more efficient and effective ways to do so – if they have the incentive.

Note that this in no way requires a change, or the status quo, in the structure of how health care is delivered: it can remain as it is today in terms of the current mix of public employees working with private contractors and not for profit agencies, or not. What it does require is that these groups work together with their communities to deliver the same, and hopefully better, health care services within a fixed and known total cost. Doctors may decide to establish clinics in partnership with nurses, physiotherapists, nutritionists, and fitness trainers, with each focusing on their specialty within an overall care environment. Prescription costs may be balanced with hospital labour costs to find the best balance between pharmaceutical care and in-hospital care. Nurses, social workers and care givers may form partnerships in hospice and day care contexts as an alternative to institutional care. Nurses may work with non-nursing staff to ensure that nurses are able to focus on the specialist tasks they excel at, with non-nurse assistants freeing them from non-specialist activities. Communities may establish, as they did in Saskatchewan, clinics where professionals were on salary, and where volunteers were deeply engaged in clinic activities. To extend an earlier quote, such a structure would give everyone in and using the health care system the incentives and the opportunities to find ways and means to adapt medicare to the 21st century and the legitimate expectations of society.

The reality of the need to control health care costs, and to provide incentives to find more efficient ways of delivering health care, may not be compatible with the objectives of some providers, even with the provision for increased funding to offset the effects of population aging and inflation as they may be by this plan. Such was the case four decades ago in Saskatchewan and, ultimately, it will be necessary to respond to such situations as the Saskatchewan government did then, when, in the face of threats of permanent withdrawal of services, Premier Lloyd stated:

> "I do not question your right to quit the practice of medicine or leave the province of Saskatchewan any time you see fit. I do contend that there is no need to make that decision a cause of anxiety to your patients." [DS48].

The establishment of a functional basis for health care funding would not only provide incentives for change on the supply side: it would also provide them on the demand side, building the basis for more responsible use of the system. Again, while it may be argued that nothing can be done to reduce demand on the health system: again, from both the debate about health care reform and from personal experience, there is a lot of room to change customer behaviour.

The first, and fundamental, step towards making people responsible is making them aware. This is why the premiums must be paid directly by the contributors, even if they are reimbursed for some or all of it: so long as the real costs of health care, both individual and per capita are hidden from the users and contributors, there is no reason to expect responsible use. It is here proposed that the most equitable approach is that every subscriber to the plan must pay their per capita share of the total costs, just as they did in the CCF plan. Old and young; rich and poor; child and parent – all would have to pony up their per capita share of the annual cost of health care. Society, of course, would help some people with their payments, but it would do so outside of the plan, through income re-distribution, just as T.C. Douglas proposed. It is essential, however, that to achieve his "responsible" health care system, that everyone be aware of what the costs of the plan are, and the only way to do so is to separate income redistribution from health care: each year people must pay their health care and insurance premiums and get a tax credit and/or a cheque to make up the difference.

On the basis of the fundamental understanding of the costs of health care would go other incentives to encourage responsible use of the system. Certainly a basic step would be for all system users to receive, as they did in Saskatchewan, a copy of the invoice for the full costs of the services that they used.

Other steps may go beyond the information stage, to involve targeted programs and, in some instances, surcharges on premiums and taxing higher risk behaviour. The use of approaches to manage demand stems from the reality that behaviour can be changed, and over relatively short periods of time, if the proper incentives

are in place: for example, over the past decade in British Columbia, age standardized mortality rates due to motor vehicle accidents have been reduced by 50% - seat belt laws, counter-attack don't drink and drive programs, education and branding of responsible driving behaviour have all worked to reduce road deaths. Similar programs can be introduced with respect to use of the health care system.

Again, the range of opportunities to bring the realities of the 21st century to the demand side of the health care system are limited only by the willingness to pursue them. Some examples include a) using pricing to encourage people to be responsible for their health by tying premiums to life style behaviour (as life insurance premiums do) with respect to issues such as cholesterol or weight targets; b) adding $1 to every ski-lift ticket to go directly to the costs of knee surgery; and c) having sin-tax (e.g., cigarette taxes) revenue paid directly to the health care system. These are but a few suggestions; the reality of a sustainable, portable, universal, comprehensive, accessible and publicly administered health care system will come when there is a logically based and known budget, tied to inflation and demographic change, that provides the necessary incentives for both users and providers of health care services to act in an efficient, effective, and responsible manner.

## VI. Publicly administered but not (solely) publicly delivered.

The principle of public administration of the health insurance plan was one of the CCF's visionary pillars, but this did not mean that such administration was to be as an agent of government. Rather it was to be a Commission reporting to the legislature which was, in Tommy Douglas's words,

> "free from political interference and influence … having sufficient power and jurisdiction to enable it to establish and administer a plan which will provide the best possible health insurance plan for the people of (the) province. … (and) while the government is responsible for placing policy before the Commission and for matters of finance, collections, disbursements, audits and reports, the Commission shall nevertheless be independent in the manner and detail of the mechanics necessary to carry this policy into effect and to obtain the objectives desired by the Act". [BM36]

Publicly administered does not necessarily mean government operated, government staffed, government owned, or even government funded. It means exactly and only that a public agency, one responsible to and empowered by the legislature, administers the provisions of the legislation. In both vision and implementation, the CCF provided for a very wide range of sectoral involvement in the delivery of health care, not only in terms of public, private and third sectors, but also within these: the Saskatchewan legislation provided options for both

health care providers and health care users to contract outside of the legislation, for doctors to be employees of the government, independent contractors, and contractors to approved health care agencies [BM 29, 77, 111-112, 125-126, 187,192, DS59,].

One of the interesting responses to the doctors' strike that accompanied the implementation of the Saskatchewan legislation in 1962 was the shutting of privately owned health clinics as doctors refused to practice under the new legislation, followed immediately by the opening of community and co-operative funded clinics staffed with replacement doctors who would work under the legislation. In some cases, these clinics continued to operate long after the strike was over to bring private clinics prices down to the level provided for in the legislation [DS85].

The reality of health care then and now is that most but not all of health care involves the private sector. Doctors, the heart of health care, are almost entirely private contractors working on a fee for service basis, as individuals, partnerships, and for profit share corporations, just as are most pharmacists, opticians, and dentists. Additionally, the equipment and supplies used by medical providers, the pharmaceuticals prescribed, the test ordered, the beds, buildings and bed-pans, have all been overwhelmingly the products of persons not in the employ of governments but in private, for profit firms. To argue that there cannot be a for-profit component of health care is to ignore the reality that most of the current health care system is. Having said this, there is also significant public sector employment, and there is a case to be made for its continuing role. The purpose of the Saskatchewan legislation was not to increase the number of public sector employees, but rather was to "establish and administer a plan which will provide the best possible health insurance plan for the people of (the) province".

What must be determined, and what will be the core responsibly of public health care commission, is the best possible combination of workers, physical plant and technology to achieve the health care objectives of Canadians in an affordable and responsible fashion.

The CCF's insistence on a health care system that was free from political influence was coupled with an insistence that health care services were essential services: while people had a choice whether they wished to work in Saskatchewan providing health care services, they could not shut the health care system down to pursue their own economic interests. The doctors in Saskatchewan went on strike, and they used the word strike themselves [DS44]. The CCF government knew that the doctors were on strike, and it used the word strike itself [DS63]. The CCF government broke the strike by bringing in workers to replace those who were on strike [DS52]. Thus, while the health care plan is to be administered without political interference or influence, it must deliver health care. This brings up the closing point of the Saskatchewan experience, which is not about the delivery of health care at all, but about conduct by those opposed to changes in

the health care system. The authors of both books referenced here were adamant that the actions of withdrawal of services in health care because of legislation that affected the economic interests of health care providers was not appropriate.

Professor Tollefson:

> …any right a minority might have to exert pressure on the government through the imposition of hardship on the people is surely subject to severe constitutional limitation in a democratic society. The every essence of a democracy is that the people, in return for the right to elect a government sympathetic to their needs, have renounced the right to use force as an instrument of political persuasion, whether that force takes the crude form of assault on one's neighbour or the sophisticated form of preventing him from obtaining goods and services which are essential to a healthy life. It may be suggested that there are certain fundamental rights the infringement of which would justify the use of force even in a democracy; but great care must be taken to avoid confusing fundamental rights with self-interest or the preservation of economic or professional status quo.
>
> To the extent that the medicare controversy in Saskatchewan displayed a public lack of confidence in the democratic system of government, and involved approval of the force as a method of political persuasion, it is indeed a frightening precedent, seemingly beckoning to all pressure groups in our society. [BM149].

Professor Badgley and Samuel Wolfe:

> … government in the pursuit of its responsibilities should be neither directed nor intimidated by those who would threaten it with conflict or violence. In defence of human or civil rights, government should pursue its objectives in spite of organized resistance. … We believe it was an abuse of the democratic process for pressure groups … to attempt to subvert legislation to which a duly elected government had been committed. [DS172].

## VII. Conclusions.

In this report, we have presented a conceptual approach to health care financing in Canada that respects the expertise of those employed in the health care system and the ability of Canadians to pay for health care. This approach, if implemented, would ensure that the five pillars of Canada's current health act - portability, universality, comprehensive coverage, accessibility, and publicly administration – would be maintained. It would also ensure that the pillars of

Canada's founding provincial health insurance, the 1961 Saskatchewan Medical Insurance Act, would be attained, with particular emphasis on its requirement for a public health care system that was efficient, effective, and responsible. Combined the 8 pillars will provide the key to the development of a health care system that can adapt to the fiscal and demographic realities 21st century and the legitimate expectations of society.

Responsibility on both the consumer and producer side of the equation is fostered by establishing the amount available for health spending to the product of current age specific per capita health spending times the age profile of the population adjusted for inflation. This ensures funding for the status quo and aging without limiting the opportunity to improve either health care or the compensation of health care providers. On the producer side, improvement in compensation will go hand in hand with improvement in effectiveness, not merely as a result of changes within one health care "silo" but by bringing about change throughout the system. On the consumer side, improvement in health care will start with consumers recognizing the true cost of health care, and grow by the development of opportunities for more responsible use of the system and by engaging them, as individuals and communities, in changing both behaviour that affects health care and the operation of the health care system.

Responsibility will also be fostered by requiring that, through the health care LIFE trusts, people pre-pay for their health insurance not on a year by year basis, but over their life cycle. This will mean that each generation pays for their own health care over their lives: the baby boomers will pay for their own health care; and so will generations to come.

The health care system in Canada does not belong to either health care providers or governments. It belongs to the people of Canada, and they must be the point of reference in its reform. Its is their legitimate expectation that, in exchange for paying for a health care system that is universal, portable, accessible, comprehensive, and publicly administered, they get one that is effective, efficient, and responsible. The health care LIFE trust will do it.

## OUR PROPOSAL:

A comprehensive, universal, portable, accessible and publicly administered health care system that is effective, efficient, responsible and, most importantly, sustainable, will involve:

1. Premiums paid directly by plan members (everyone) into a health care Lifecycle Insurance Fund and Endowment (LIFE) trust;
2. Premiums that include the full cost of current health care plus a premium to pre-pay for health care later in the life cycle;
3. The health LIFE trust to be administered and invested by a public health care commission that is responsible to the legislatures, but is free from political interference from government, health care providers, and health care users;
4. Health care providers contracting with the public health care commission for the provision of health care services;
5. Total annual health care spending set at the product of the current age specific per capita health care expenditures adjusted for inflation times the current age profile of the population; and,
6. Health care providers having the responsibility for providing contracted services within the global caps based on inflation and aging, but they must also have the freedom to work with communities to find the most efficient, effective and responsible way of doing so,