MACDONALD-LAURIER INSTITUTE

MEDICARE'S MID-LIFE CRISIS

Health Care Reform From the Cradle of Medicare

Janice MacKinnon

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Executive summary

As the oldest of the baby boomers turn 67 this year, the "fiscal squeeze" looms larger and larger. Providing health care for all Canadians while encouraging a robust economy will require a more efficient health care system with better methods of funding.

Changing the health care system to make it more affordable and effective will require addressing the three main structural problems built into the original design of the system: the focus on hospitals and fee for service doctor services; a funding model in which there is no relationship between users of the system and its costs; and the extent to which federal-provincial structures and tensions have made reform more difficult.

A better medicare system requires changing the traditional 1960s hospital model by funding hospitals differently, diverting patients to alternative facilities, and focusing more on a holistic, integrated approach to health. An emphasis on prevention and health promotion would save lives and money in the future. The current full coverage of hospitals and doctors does not leave funding for these areas, and furthermore, it diverts resources from areas like education and income support, which are crucial to supporting a healthy lifestyle and environment.

Most Western European countries have less expensive health care systems with better outcomes. Significant differences include linking patients and taxpayers to the costs of health care through user fees or co-payments; paying doctors a salary; and offering broader coverage for services like home care, physiotherapy, and prescription drugs. Additionally, health care is seen as one of many social services and is subject to reform, like the reforms Canada used in the 1990s to change other social programs.

In Canada, a co-payment could be implemented whereby individuals would pay for services used, up to a ceiling of 3 percent of income. The income tax system would be used to collect the revenue; thus, the administrative costs and complexity would be reduced and the sick should not be deterred from using the system since no fees would be collected when care is accessed.

Health care has been like a car with federal and provincial governments vying for control of the steering wheel. The federal government provides funding and sets standards, and the provinces have the power to design and administer the system and control spending. Controlling costs and making structural changes is complicated by the complexity of federal-provincial relationship. Interprovincial co-operation will also be key to reducing costs.

More use of private clinics, home care, and long-term and chronic care facilities would produce more appropriate and affordable care than hospitals. The health department established the Saskatchewan Surgical Initiative in 2010 to reduce wait times. Comparing the total cost of performing 34 procedures in the clinic versus the health department hospital reveals that it is 26 percent less expensive to use clinics than hospitals, and in all cases the clinics were less expensive.

Preserving the noble ideal of universal health care will require making fundamental changes in Canada's health care system. The changes suggested in this paper will make Canada's health care system more affordable and open the door to investments in other services and programs that are more important in promoting the overall health of the population.

Sommaire

Alors que les premiers baby-boomers atteindront 67 ans cette année, le spectre du « resserrement fiscal » prend de plus en plus d'ampleur. Fournir des soins de santé à tous les Canadiens tout en favorisant une économie vigoureuse nécessitera un système de soins de santé plus efficace tirant parti de meilleures méthodes de financement.

Pour transformer le système de santé en vue de le rendre plus abordable et plus efficace, il faudra régler les trois principaux problèmes structuraux du système depuis sa conception : l'accent mis sur les hôpitaux et la rémunération des médecins à l'acte; le modèle de financement en vertu duquel il n'y a pas de corrélation entre les utilisateurs du système et les coûts rattachés au système; et la mesure dans laquelle les tensions et les structures fédérales-provinciales ont compliqué la réforme.

Pour améliorer le système d'assurance-maladie, il faut modifier le modèle hospitalier traditionnel des années 1960 en finançant les hôpitaux de manière différente, en redirigeant certains patients vers des installations répondant mieux à leurs besoins et en favorisant une approche holistique et systémique à la santé. Si l'on mettait l'accent sur la promotion de la santé et la prévention, cela pourrait sauver des vies et économiser de l'argent. À l'heure actuelle, le financement intégral des hôpitaux et des médecins ne laisse aucune place au financement de ces autres secteurs ; en outre, ce mode de financement accapare des ressources qui autrement seraient attribuées à d'autres secteurs dont l'éducation et le soutien du revenu, essentiels pour assurer un mode de vie sain et un environnement de qualité.

La plupart des pays de l'Europe de l'Ouest sont dotés de systèmes de santé qui sont moins coûteux et génèrent de meilleurs résultats. Parmi les différences notables, mentionnons les suivantes : le recours aux frais d'utilisation ou de participation aux coûts qui établit une corrélation entre les patients et les contribuables et les coûts des soins de santé; le versement d'une rémunération aux médecins basée sur un salaire ; et l'offre d'un large éventail de services comprenant les soins à domicile, la physiothérapie et les médicaments sur ordonnance. En outre, les soins de santé sont considérés au même titre que tous les autres services sociaux et ils peuvent faire donc l'objet d'une réforme, dans l'esprit de celles qui ont été effectuées par le Canada dans les années 1990 à l'égard de différents programmes sociaux.

Au Canada, on pourrait instaurer une formule de participation aux coûts des services en vertu de laquelle les utilisateurs assumeraient une partie de ces coûts jusqu'à concurrence de 3 % de leurs revenus. L'infrastructure mise en place pour l'impôt sur le revenu pourrait servir à recueillir ces frais de participation, ce qui limiterait les coûts administratifs et la complexité du système et éviterait ainsi de dissuader les malades d'utiliser le système de santé, puisqu'aucuns frais ne seraient recueillis au moment de la prestation des services.

Les soins de santé sont comme une voiture dont les gouvernements fédéral et provinciaux se disputent le volant. Le gouvernement fédéral fournit le financement et établit les normes, alors que les provinces exercent le pouvoir de concevoir et d'administrer le système et de contrôler les dépenses. La nature même des relations fédérales-provinciales augmente la complexité du contrôle des coûts et de la mise en œuvre des changements structurels. La coopération interprovinciale sera également la clé pour réduire les coûts.

Il faut que les options comme les soins de longue durée, les cliniques privées, les soins à domicile et les établissements de soins prolongés soient offertes pour garantir des soins de meilleure qualité, plus abordables et plus rapides que ceux offerts par les urgences des hôpitaux. En 2010, le ministère de la santé de la Saskatchewan a mis en œuvre la *Surgical Initiative* (l'Initiative chirurgicale) afin de réduire le temps d'attente. La comparaison du coût total de l'exécution de 34 actes médicaux dans une clinique par rapport au coût total de ces mêmes actes médicaux en milieu hospitalier a révélé qu'il en résultait une économie de 26 pour cent dans les cliniques et soulignons que dans tous les cas, les coûts étaient moins élevés dans les cliniques.

Si l'on veut maintenir le noble idéal des soins de santé universels, il faudra apporter des changements fondamentaux au système de santé du Canada. Les transformations proposées dans le présent document vont rendre le système de santé canadien plus abordable et vont ouvrir la porte aux investissements dans d'autres services et programmes mieux axés sur la promotion de la santé globale de la population.

Introduction

Fundamental changes to Canada's health care system and its funding will be required to help address the looming "fiscal squeeze" caused by the aging of the baby boomers, whose oldest members turned 65 in 2011 (Ragan 2011). Population aging will lead to increased health costs since more than half of one's medical costs occur after 65, and costs will also increase because of technological developments – new treatments, procedures, equipment, and drugs (Robson 2001; CIHI 2001).[1] At the same time, population aging will lead to declining labour force participation, which will slow income and revenue growth. Hence, Canada's health care system will have to both become more efficient and find new and better ways of funding. The purpose of this paper is to recommend changes that can be made by the provinces, which are responsible for designing and administering health care, to achieve these goals while maintaining Canada's single payer publicly funded health care system.

Medicare's design focuses on curative rather than preventative care.

Relative to comparable countries Canada's health care system is expensive, its outcomes average, and its wait times for many procedures long. A Conference Board of Canada study comparing the health care systems in 24 Organization for Economic Co-operation and Development (OECD) countries found that Canada was the third largest spender on health care, but our wait times are among the highest, and in terms of health status – or outcomes – Canada ranked only 13th of 24 countries (2004, 1). Subsequent studies have confirmed similar results.[2]

History of medicare in Canada

The fundamental problems with Canadian health care are especially interesting since the other parts of Canada's social safety net have been reformed to make them more effective and affordable. Programs like the Canada Pension Plan and Canada's welfare and post secondary education systems were changed in the 1990s and made affordable by linking the costs of programs to their benefits, targeting benefits, changing incentives, and introducing competition and other market forces (Federal/Provincial/Territorial CPP Consultations Secretariat 1996).[3] The question, then, is why has there not been a similar restructuring of Canadian health care?

The answer lies in the original structure and financing of the Canadian health care system, which set it apart from those in Western Europe, and created major obstacles to change. Understanding these structural problems is essential to identify what needs to be changed.

The foundations for medicare were laid in the 1950s and 1960s, when the prevailing medical model was curative rather than preventative. For Canadians health care meant hospitals (with their high tech equipment and professional managers) and doctors, whose primary obligation was to cure ill patients (Gagan and Gagan 2002).[4] At that time, there was not the broad range of pharmaceuticals that are available today and it was not possible to treat diseases like cancer in the community. Moreover, the idea that health care involved more than the treatment of illness only began to emerge in the early 1960s when American and British reports first linked smoking to disease. Further research would show how lifestyle and other factors (like income, education, and the environment) affected people's health (Bird and Fraser 1981, 29).

By the time this shift in thinking occurred, decisions had been made about funding health care that set the pattern for the future. In terms of financing, many early reports assumed that some of the costs of medicare would be paid directly by patients or taxpayers. The 1939 Rowell-Sirois Report,

which dealt with federal-provincial fiscal relations, assumed that contributions from employers and employees would raise most of the money (Canada 1954, 42). One of the intellectual architects of Canada's social programs, Leonard Marsh, wrote in his 1943 report that there were "psychological" as well as financial benefits to having taxpayers pay a part of their health care costs. He linked the amount of coverage to the size of contribution made directly by individuals – that is, if more services were to be covered, then individuals would have to pay more directly from their pockets (Bliss 1975, 12-13). Tom Kent, Prime Minister Pearson's key policy adviser when medicare was created in the 1960s, recommended that up to 25 percent of health care costs should come from making health care a taxable benefit. Kent believed that there was a problem with health care being a "free good". If even a small part of what patients and taxpayers paid for health care was related to their use of the system, there would be some restraint on the demand for services. Kent also knew that if medicare were to be funded solely from the general pool of taxes, governments would only be able to cover a narrow range of services (Kent 2005).

Early reports assumed patients would pay for some portion of their health care.

A key decision point came in 1964 when the Hall Commission, established to advise on the structure of medicare, recommended that medicare should cover more than doctors and hospitals and should include other services like home care (Canada 1964, 19). However, the government rejected the idea of having people pay directly for a part of health care costs by making health care services a taxable benefit. Without the extra revenue, the government could not afford broad coverage; thus, coverage was restricted to doctors and hospitals. The government also accepted the Hall Commission's recommendation to fund doctor services on a fee for service basis.

The decision to fund health care solely from general tax revenue, restrict its coverage, and pay doctors on a fee for service basis has had profound implications for Canada's health care system. The pre-medicare link between the costs of medical services and their benefits was broken. With doctors paid according to the number of patients seen, neither doctors nor patients have an incentive to consider what increasing use of the health care system means for its costs. The result, in the words of former Quebec Health Minister Claude Forget, is that the Canadian health care system has "a powerful engine and no brakes". It is a lethal combination of open-ended services for patients with no mechanisms to contain costs (2002, 3).

The health care system has "a powerful engine and no brakes".

Moreover, in fully covering hospitals and doctors, the government funded the expensive services, while other services that are more cost-effective and promote the prevention of illness, were unfunded. This point was made in the 1985 report on government services done by Deputy Prime Minister Erik Nielson, who states that Canada was above average in its spending on health care due to the emphasis on "illness care" in the Canadian system. His report called for more spending on preventative services (Canada Task Force *et al.* 1986, 39, 52). Every major health care report since has recommended more funding for prevention and health promotion and has pointed out that this would save lives and money in the future. However, because hospital and doctor services are fully covered, the incentive for patients is to rely on these expensive acute care services, and this demand is so high that provinces have only limited funds for the health promotion and prevention services that would produce long-term savings. It is a classic Catch 22.

Comparisons between Canadian and Western European health care models

In contrast to Canada, most Western European countries fund health care services in ways that link patients and taxpayers to costs, through user fees or co-payments; doctors are paid by salaries; and there is broader coverage – for instance, there is some funding for services like physiotherapy, home care, and prescription drugs. Thus, there is less incentive to rely on expensive doctor and hospital services and more reason for people to use other services that are more cost-effective and important in preventing illness and future costs to the health care system. Moreover, because of the structural differences in their systems, Western European countries are able to make extensive use of a primary health care model to deliver services. In this model, services are integrated and medical professionals work as part of a team, so rather than seeing a physician a patient might see a dietitian, a physiotherapist, or whatever member of the medical team can best treat the patient's ailment. The result is a more integrated, holistic, and cost-effective model of health care, which helps explain why many European systems are less expensive but have better health care outcomes than Canada's.

Many European health care systems are less expensive but have better outcomes than Canada.

Though virtually every report on health care in Canada has recommended moving to a primary health care model, the obstacles are formidable: many services that are essential to primary health care are not covered by medicare, doctors are paid on a fee for service basis and act as the gatekeepers for access to other services – responsibilities that can be changed by governments only after extensive negotiations – while other health care professionals jealously guard their own scopes of practice (the responsibilities assigned to their profession). There has been progress, particularly in Ontario, in moving family doctors to alternative payment schemes and in using interdisciplinary teams to deliver primary health care, but it has been slow and uneven across the country (Tuohy 2004. 88).[5]

Opposition to reform makes rationing the only way to control costs.

Another difference is that health care in Western European countries is seen as one of many services and is subjected to the kinds of reforms used in Canada in the 1990s to change other Canadian social programs, such as competition, financial incentives, and market forces. In Canada, relative to other areas of social policy, health care has many powerful interest groups – from doctors, nurses, and technicians to public sector unions – and academics who see themselves as the intellectual gatekeepers of the current health care system. When the use of competition or other market mechanisms are advocated (such as in Kirby and Keon 2004; Bliss 2010), public sector unions cry that private sector delivery amounts to privatization of health care, while the intellectual gatekeepers argue that health care is a "public good" as opposed to "a market-driven commodity" (Lewis 2004).[6]

Facing formidable opposition to change, governments have been left with few options to control costs, and they have been forced to rely on restricting the supply of medical services, equipment, and personnel – or rationing – to control costs.[7] But rationing means shortages and Canada has fewer doctors and hospital beds and less equipment than the OECD average. Shortages mean waiting lists and Canada has for some time had longer waiting

lists than countries with comparable health care systems.[8]

Finally, while European countries are unitary states with one level of government funding and administering the health care system, in Canada health care has been like a car with federal and provincial governments vying for control of the steering wheel. The federal government's use of its spending power to fund a national medicare system created a major structural problem and source of tension: while the federal government provided funding and set standards, the provinces had the power to design and administer the system and control spending. Moreover, it is argued that federal transfer payments have induced "a fiscal illusion"; since the money is perceived to come from taxpayers across Canada, taxpayers see such spending as less costly than if the money were raised within their own province (Kneebone 2012, 12).[9] Hence, a dramatic increase in transfers to the provinces, as occurred in 2004 when the federal government committed to increase health transfers by 6 percent per year for 10 years, predictably led to a dramatic increase in provincial spending on health care. From 2004 until 2010 health care spending increased at an annual average of 6.7 percent (Health Council of Canada 2011). Thus, controlling costs and making structural changes have been made more difficult by the complexity and tensions in the federal-provincial relationship.

True change is complicated by the federal-provincial relationship.

What is often overlooked is that since medicare was created in the 1960s, the primary intergovernmental relationship of the provinces has been with the federal government. For example, federal funding for hospital services in the 1950s was an incentive for provinces to go on a spending spree – between 1961 and 1971, the number of hospital beds increased twice as fast as the population (Perry 1989, 650). Similarly, the intergovernmental focus in health care has been on trying to influence the level of and conditions attached to federal transfer payments to the provinces. First Ministers meetings on health care have not been efforts to work together to reform the system; instead they have provided a forum for provincial governments to rally public opinion in support of increased health care transfers. The dominance of the federal-provincial relationship has left little opportunity for the provinces to work together to improve Canadian health care.

Therefore, changing the health care system to make it more affordable and effective will require addressing the three main structural problems built into the original design of the system: the focus on hospitals and fee for service doctor services; a funding model in which there is no relationship between users of the system and its costs; and the extent to which federal-provincial structures and tensions have made reform more difficult.

Changing the medicare model

A more effective and affordable medicare system requires changing the traditional 1960s hospital model by funding hospitals differently, diverting patients to alternative facilities, and focusing more on a holistic, integrated approach to health.

Hospitals are the single biggest cost in Canada's health care system, accounting for more than one third of public spending on health care (CIHI 2011).[10] Hospitals are dominated by health care unions and professional associations that have historically been very adept at using their monopoly control over services in their negotiations with governments, which are fearful of the political implications of a health care strike.[11] Thus, it has been difficult if not impossible to get changes in contract terms that would improve productivity (Kirby and Keon 2004). Just the simple reality of having to juggle the different contract terms of three or four unions in one hospital shows how difficult it is in a hospital setting to allocate resources efficiently.

Competition in the system, which can be achieved by changing the way hospitals are funded and using private health care clinics for specific procedures, can produce more affordable and effective care for patients. Historically, hospitals have been funded globally by health departments or regional health authorities, which means that funding is not directly linked to the level of activity and patients represent a cost. The 2010 OECD report is one of many recommending "hospitals should be funded on an activity and standard cost basis to cut waiting lists" (10).[12] When hospitals are funded according to their activity – the procedures they perform or the patients they treat – there is an incentive for hospitals to perform more efficiently and to put patients first. Also, governments can benchmark the cost and timeliness of performing procedures in various hospitals and reward those with better outcomes.

Private clinics can perform specific surgeries more efficiently than hospitals.

Private clinics can also be used to deliver specific procedures more affordably. Clinics are located outside the complex and expensive hospital setting and have the advantage of only performing specific procedures that can be delivered more efficiently. Also, private clinics are generally not unionized, which allows them more flexibility in organizing staff efficiently, and they do not have the significant administrative costs that hospitals and health regions require to manage union contracts and grievances.

An excellent example of the use of private clinics is the Saskatchewan Surgical Initiative established in 2010 by the health department to reduce wait times (Saskatchewan 2012).[13] The use of private clinics to perform specific surgeries that can be done outside of hospitals was a key part of the strategy. Thus, the Saskatoon and Regina health regions issued requests for proposals for the delivery of specific surgeries based on credentials and experience, service factors, implementation schedule, and pricing (Regina 2011b). In Saskatoon, the winning bidder was Surgical Centres Inc., a Calgary based company with more than 20 years of experience performing day surgeries in non-hospital settings in Alberta and British Columbia (Saskatoon 2011). Surgical Centres Inc. and the other winning bidders then signed contracts with the health regions specifying the number of procedures to be performed, the time frame, and the costs. The facilities were accredited by the Saskatchewan College of Physicians and Surgeons and had to meet the same standards as hospitals.

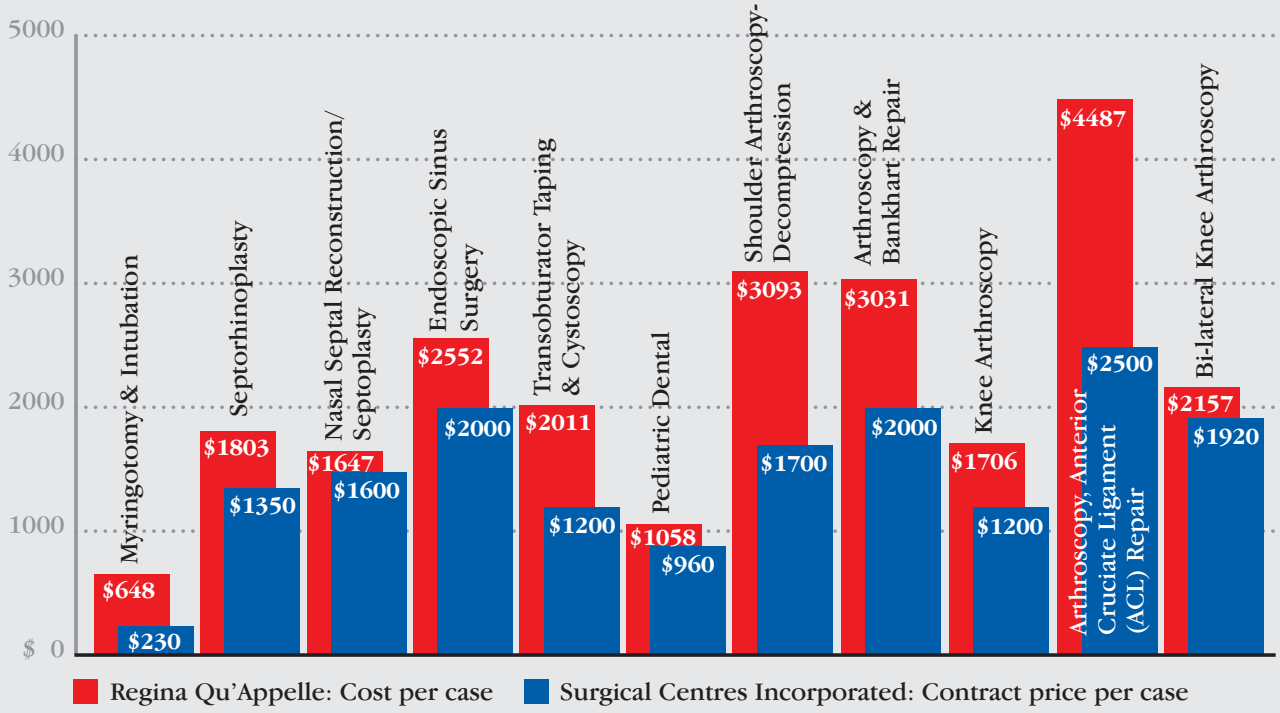
Public sector unions and the Saskatchewan Health Coalition condemned the policy decision using arguments that are often repeated across Canada. They said the decision was "driven by the Saskatchewan Party's privatization ideology" and that the Conservative government of Prime Minister Stephen Harper was complicit since it refused to enforce the Canada Health Act (Regina 2011a). They also alleged that the clinics would "cherry pick" patients by selecting "healthier patients" (Saskatchewan 2010). A recurring theme was that the clinics would be more expensive since part of the revenue would be "siphoned off" by the companies for profits (Saskatchewan 2010; Regina 2011a). They argued that instead, the government should increase capacity in the public system by building a $14 million publicly funded day surgery centre that would be staffed by public sector unionized employees. Underpinning arguments like these was the assumption that health care is a public good and should not be subjected to market forces, like profits or competition for services.

The opponents' arguments are not substantiated by the facts. In terms of ideology, left wing governments around the world use private delivery of health care services. The Canada Health Act specifies only that the system has to be publicly administered. Moreover, "cherry picking" is not possible in the Saskatchewan process since the publicly administered health district chooses the patients who are referred to clinics. More generally, while health care is not a public good in an economic sense,[14] it is true that good health is highly valued and not easily quantified. Of course, the same could be said of education or clean air. Surely, all services should be delivered as efficiently as possible and the focus should be on outcomes or results.

The Saskatchewan Surgical Initiative: The numbers don't lie

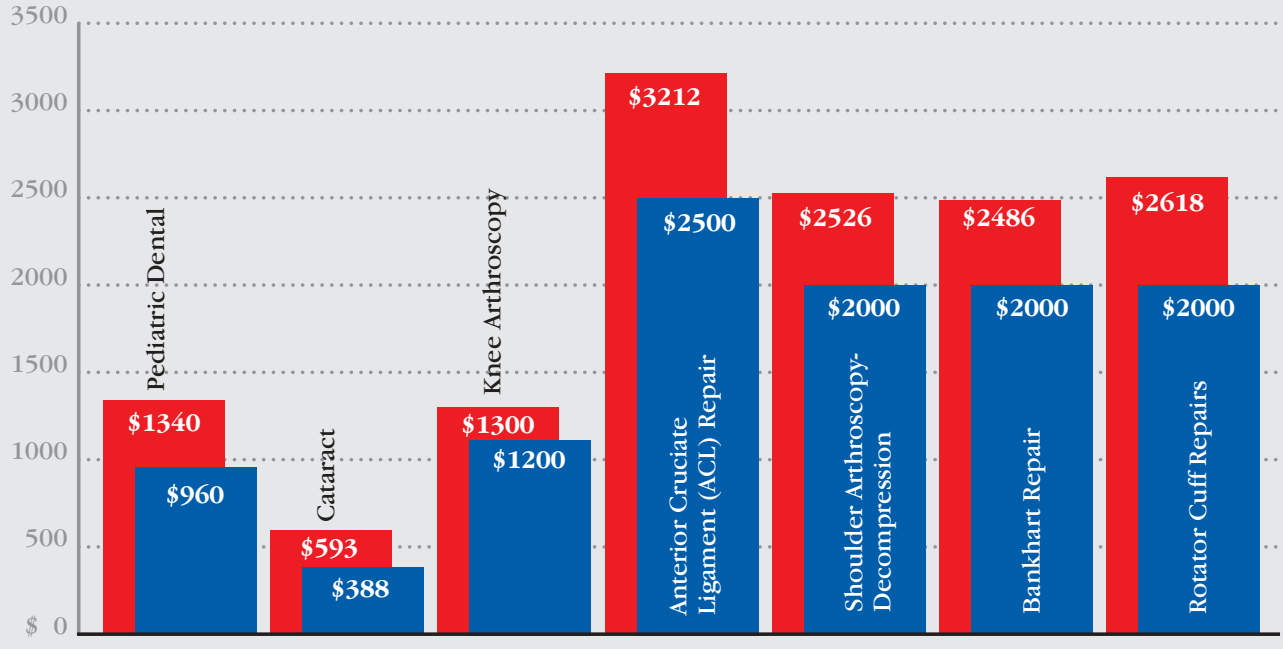
In an effort to reduce wait times, in 2011 Saskatoon and Regina contracted with private clinics to perform specific day surgeries on patients selected by the publicly administered health department. The charts below show that not only did the clinics enable patients faster access to care, the cost to the province was greatly reduced. In 2012, services were expanded at private clinics in Regina, and a greater variety of surgeries were performed.

Figure 1 Cost per case at Regina Qu'Appelle RHA and Surgical Centres Inc., 2011



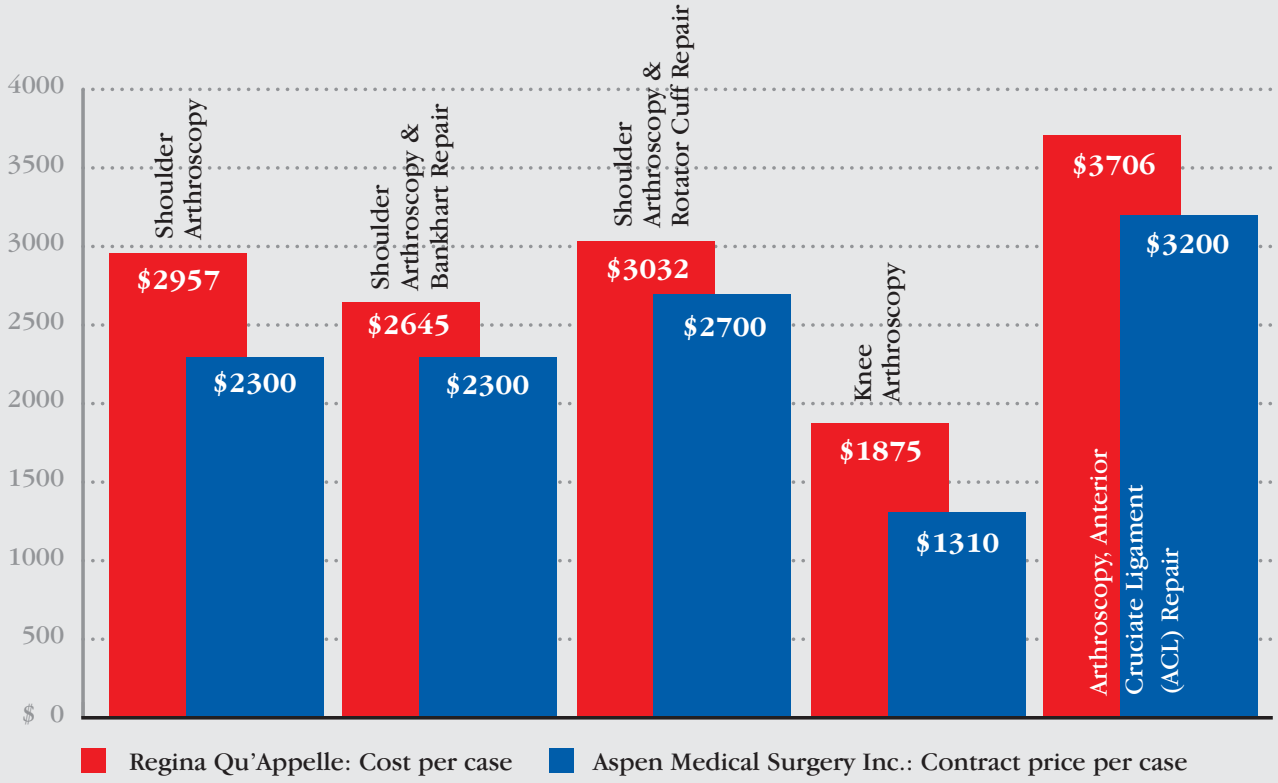
Note: The cost of implanted hardware is the same at both facilities.

Figure 2 Cost per case at Saskatoon RHS and Surgical Centres Inc., 2011



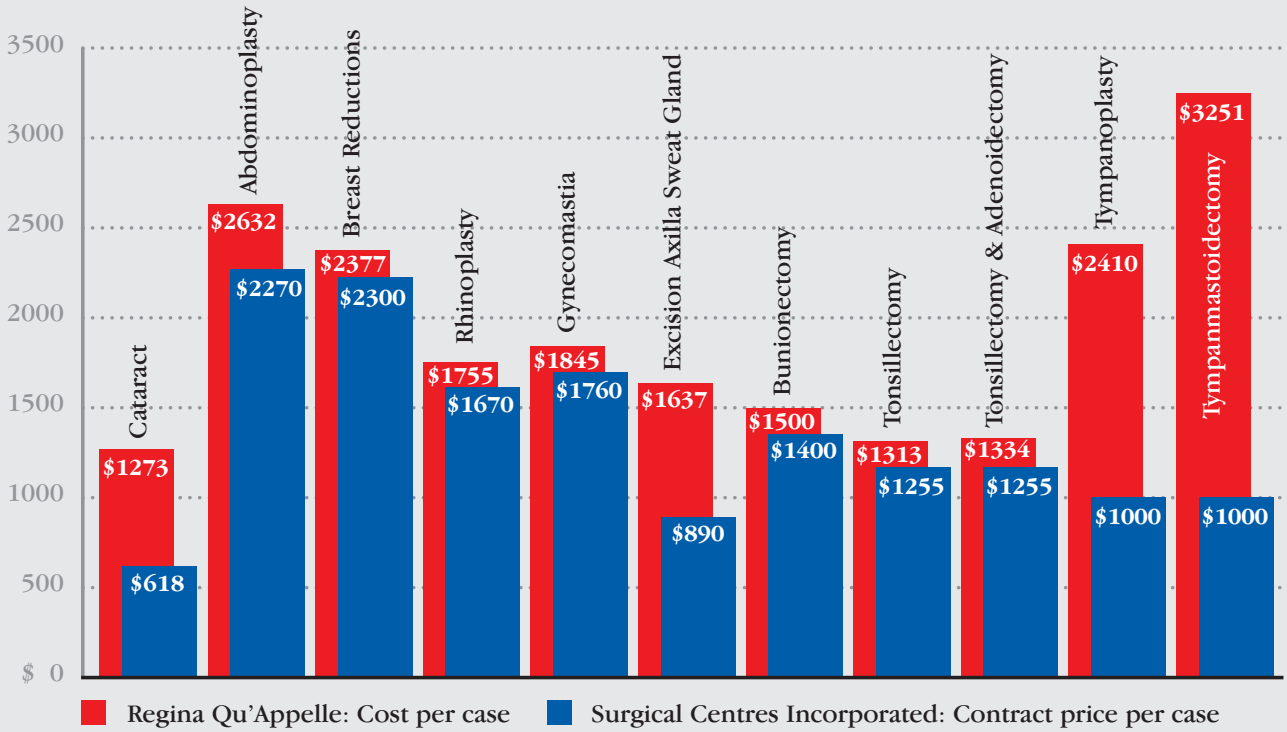
Note: The cost of implanted hardware is the same at both facilities.

Figure 3 Cost per case at Regina Qu'Appelle RHA and Aspen Medical Surgery Inc., 2012



Note: The cost of implanted hardware is the same at both facilities.

Figure 4 Cost per case at Regina Qu'Appelle RHA and Surgical Centres Inc., 2012



Note: The cost of implanted hardware is the same at both facilities.

Glossary of Medical Terms

Abdominoplasty: Cosmetic surgery to make the abdomen firm; "tummy tuck".

Adenoidectomy: Surgery to remove the adenoids (tonsils).

Anterior cruciate ligament (ACL) repair: Surgery to rebuild the center ligament of the knee.

Arthroscopy: Minimally invasive surgery using a tiny camera to examine and/or repair tissues.

Bankhart Repair: Surgery to stabilize a shoulder that habitually dislocates.

Bilateral knee arthroscopy: Arthroscopic examination of both knees the same day.

Bunionectomy: Surgery to remove a bunion, an enlarged joint at the base of the big toe.

Cataract surgery: Removal of the natural lens of the eye and replacement with an artificial intraocular lens.

Endoscopic sinus surgery: Surgery to remove blockages in sinuses (sinusitis).

Excision axillary sweat gland: Surgery to selectively remove sweat glands to treat excessive sweating.

Gynecomastia surgery: Surgery to remove excess breast tissue in men.

Knee arthroscopy: Surgery using an arthroscope (tiny camera) to examine the tissues of the knee. Other instruments may be used during the procedure to repair the knee.

Myringotomy & Intubation: Surgery to cosmetically reshape the nose and remove nasal blockages to improve breathing.

Nasal septal reconstruction/Septoplasty: Surgery to correct the nasal septum.

Rhinoplasty: Surgery to reshape the nose; "nose job".

Rotator cuff repair: Surgery to repair a torn tendon in the shoulder.

Septoplasty: Surgery to correct the nasal septum

Septorhinoplasty: Surgery to cosmetically reshape the nose and remove nasal blockages to improve breathing.

Shoulder arthroscopy: Surgery using an arthroscope (tiny camera) to examine and/or repair tissues in or around the shoulder joint.

Shoulder arthroscopy – Decompression: Arthroscopic surgery to remove scar tissue and bone spurs in the shoulder.

Tonsillectomy: Surgery to remove the tonsils.

Transobturator taping & cystoscopy: Surgery to treat incontinence.

Tympanomastoidectomy: Surgery to remove a growth or infected bone from the ear.

Tympanoplasty: Surgery to repair a torn eardrum.

The outcomes from the Saskatchewan experiment clearly show that private clinics can deliver surgical procedures more cost-effectively than hospitals. (For the data, please see the editorial box on the Saskatchewan Surgical Initiative.) Comparing the cost of performing 34 procedures in private clinics and in hospitals shows that in all cases the clinics were less expensive. The cost savings varied across procedures, but it should be noted that in four cases it was twice as expensive to perform procedures in hospitals relative to the clinics. Comparing the total cost of performing the 34 procedures in the two settings reveals that it is 26 percent less expensive to use clinics than hospitals (Saskatchewan Department of Health 2012).[15]

In all cases in Saskatchewan, private clinics were less expensive than hospitals.

Despite the campaign against them by the unions, the private clinics have generated little adverse public reaction in Saskatchewan, the birthplace of medicare. They have helped to reduce wait times, are more convenient than hospitals, and there is less risk that patients will come in contact with the flu or hospital based infections.

As well as freeing up resources in hospitals, diverting patients to other facilities could also produce significant savings. Hospitals are the most expensive place to care for patients: the average daily cost of a hospital bed is estimated to be $842, while the average daily cost of a long-term care bed is $126 and home care costs about $42 a day (CLHIA 2012, 4). Yet there are many patients in expensive acute care hospitals who could be cared for more affordably and often more effectively in other facilities if they were available (CIHI 2009). Many should be in long-term care facilities; about 7 percent of all hospital beds are being used by patients receiving long-term care (CLHIA 2012, 4). But while hospital stays are covered by medicare, long-term care is a provincial responsibility and financial support for care is usually linked to ability to pay. Also, there is a shortage of long-term care beds, which will only worsen as the baby boomers age.

Home care costs about $42 per day; hospital care costs about $842 per day.

Health care costs could be reduced and patient care improved if governments adopt a long-term care strategy, which includes using public-private partnerships to increase the supply of long-term care beds, educating Canadians about the fact that most will have to pay for at least part of their long-term care, and encouraging Canadians to save for their future care needs. Governments could provide tax credits to Canadians who buy long-term care insurance or they could use a Registered Education Savings Plan (RESP) approach to give people an incentive to save for their long-term care. As with RESPs, investment income would be sheltered until it is withdrawn for long-term care, when people's taxable income is lower (CLHIA 2012, 7-8).

Long-term care waiting lists could also be reduced by providing better home care (CLHIA 2012, 6).[16] There are innovative ways in which services are being delivered in the community rather than a hospital. In Manitoba, for example, a "virtual ward" comprised of a team of health care professionals delivers hospital-type services in the community to those with chronic diseases. Similar teams of medical professionals provide in-home psychiatric services as an alternative to hospitalization in British Columbia. Such innovative approaches reduce visits to emergency rooms and hospitalizations and result in significant savings (Council of the Federation 2012, 15).

There are also people in emergency wards who should be diverted to other, more cost-effective centers that could better address their needs.[17] Some should be in chronic care facilities, others could be cared for at home, and still others have underlying social problems. More emergency wards should be co-located with clinics. Significant savings and better care could be achieved by diverting more patients to Family Care Clinics where various health professionals and others like social workers provide a more holistic, integrated approach to treating the underlying problems that bring people into the health care system.[18]

De-hospitalization, by diverting patients to other less expensive facilities, can be an effective strategy for making the health care system more efficient and effective. Other ways to improve health care include the provision of better data to increase accountability, performance evaluations, and more transparency for citizens and more and better use of information and communication technologies (Prada and Brown 2012, 4, 21). Currently half of Canadians have some form of electronic health record, but the facilitation of timely introduction, adoption, and coordination of electronic records has been an issue.

More emergency wards should be co-located with clinics.

There is also a consensus that health care should be seen in a broader and more holistic way, and more emphasis should be placed on preventing illness rather than merely treating disease. Improving people's health means focusing more on health

More emphasis should be placed on preventing rather than merely treating illness.

promotion, disease prevention, and investing in programs that reduce poverty. Consider the example of obesity. A study done for Statistics Canada in 2010 finds that "[c]hildren are taller, heavier, fatter and weaker than in 1981" (Tremblay *et al.* 2010, 11). Obesity is a "silent epidemic" that will result in increases in many diseases and will cost an estimated $4.6 billion (Hodgson 2012). Tackling obesity, by such simple measures as increasing physical activity and education about diet at schools, can reduce health care costs and enhance population health.[19]

Cost saving and interprovincial co-operation

Two other major costs for the health care system – doctors and prescription drugs – could be reduced by interprovincial co-operation. The federal-provincial dynamic was changed in December 2011, when the federal government announced that starting in 2016 it would reduce health transfers to the rate of economic growth and recognized the provinces' jurisdiction to reform the system. For the provinces, there is no reason to badger the federal government for more funding, and there could be benefits from working together to reduce costs. Hence, in January 2012 the premiers established a Working Group to study health care and its first Report six months later states that "[t]his is the first time there has been this level of engagement and commitment to a provincial-territorial cause from the Premiers" (Council of the Federation 2012, 7).

The Report recommended various ways to move away from the traditional fee for service model where doctors act as gatekeepers of the health care system. In some cases, it was recommended that other health professionals like nurse practitioners or paramedics could deal with less acute medical problems or provide emergency services in rural and remote areas. The report stressed the merits of promoting a primary health care model where a team of medical professionals provide an integrated, patient focused, and less expensive way to deliver health care (Council of the Federation 2012, 14-17).

The Report also made some initial recommendations to deal with one of the main cost drivers in health care – services provided by physicians and other health care professionals and workers. Health care unions and professional associations have been very astute at bargaining with governments to ensure that their members get a healthy share of the spending pie. So, when federal transfers increased by 6 percent, much of that new money went to compensation paid to health care providers. Between 1998 and 2008, the cost of physician services increased by 6.8 percent a year (in 2009 they rose by 9.6 percent), with more than half of the increase coming from higher fee schedules. Also, the salaries of nurses and others in health care grew faster than inflation or comparable public or private sector wage rates (Simpson 2012b, 314-15; Simpson 2012a; CIHI 2011).

A team of medical professionals can provide integrated, patient focused, less expensive health care.

The significant increase in doctor salaries is not driven by international competitive pressures: Canadian doctors are among the highest paid in the world (Simpson 2012b, 313), and they have reaped other benefits from their participation in medicare, including a "high level of clinical autonomy [and] relatively low transaction costs" (Tuohy 2004, 88). The competition that does exist

is among the provinces; as one province increases the salaries of health care professionals, other provinces follow suit. The federal government has no policy levers that it can readily use to contain the interprovincial competition for health care professionals.

However, the provinces have the capacity to work together to constrain the acceleration in health care compensation rates, and with approximately 70 percent of health care costs attributed to human resources, they have a powerful incentive to do so (CIHI 2011, 18). The Report recommends "reducing competition among jurisdictions for resources" and "innovative approaches to managing labour costs and reducing competition" (Council of the Federation 2012, 4, 6). As well as limiting competition with each other, the provinces committed to more co-operation in planning for and training health professionals to avoid shortages that also can drive up costs.

Action to limit the compensation of doctors has been taken by provinces, notably Ontario. After increasing doctor salaries by almost 75 percent since 2003, in November 2012 the government signed an agreement with its doctors that would effectively freeze the cost of physician services for two years. Other provinces have followed suit in limiting health care compensation (Wingrove 2012). Moreover, the Ontario Medical Association and the Ministry of Health committed to work together to implement evidence-based savings (Benzie 2012), which is an important step in making physicians assume some responsibility for the cost-effectiveness of the health care system.

Considering the magnitude of previous cost increases for health care provider compensation, collaborative interprovincial action to reduce competition could bring significant savings.

Provincial and territorial collaboration can also produce savings on prescription drugs, which represent a major and rapidly growing expense for governments and Canadians. The decision in the 1960s to limit medicare's coverage to doctors and hospitals and exclude national coverage for prescription drugs has meant very poor coverage for drugs for most Canadians and a patchwork of coverage from province to province.

In theory, there is a good case that the federal government should assume responsibility for drugs by establishing a national drug plan. It would provide better drug coverage for all Canadians, end the patchwork of provincial programs, and allow the federal government to establish one national formulary and use its buying power to reap significant savings in drug costs. It is not surprising that in 2004 the Premiers agreed to support a national drug plan run by the federal government.

But the question is, why would the federal government assume responsibility for one of the most expensive and rapidly growing areas of health care, especially when it has a sizeable deficit, which it hopes to eliminate in the medium term? It might be argued that in exchange the federal government could reduce or eliminate its transfers to the provinces. But why would the federal government change the way it contributes to health care from transfers, whose cost is known and can be unilaterally decided by the federal government, for a national drug plan whose future costs are unknown and uncontrollable? Moreover, governments responsible for drug plans have to make difficult decisions about which drugs are covered and face intense political pressure when coverage is denied. Why would any government willingly take on such a difficult and expensive responsibility?

If not a national drug plan, some argue the federal government should at least establish a national formulary for drugs to reap the savings from bulk buying. In reality the federal government has no levers, beyond spending money – cost sharing, transfers, the transfer of tax room to the provinces – to compel provinces to join a national health care program and to abide by its terms and conditions. In fact, the outcomes of the 2004 Health Accord, in which the federal government committed to spend more than $40 billion on health care over 10 years, show that even when the federal government does provide funding, it cannot control how it is spent by the provinces. It was never part of the 2004 federal plan to have a significant amount of the new funding go to compensation increases for health care professionals, yet that is exactly what happened. So, what levers would the federal government have to corral the provinces to accept a common national formulary for drugs?

The provinces, on the other hand, have the power to work toward a national approach to purchasing drugs. The significant cost savings that can be captured provide a powerful incentive for them

The provinces, not the federal government, have the power to consolidate procurement of drugs.

to work together, and they have already taken some steps in that direction. In August 2010 the premiers agreed to create a "provincial-territorial purchasing alliance to consolidate public sector procurement of common drugs, medical supplies, and equipment" (Council of the Federation 2012, 20). The goal was to "capitalize on the combined purchasing power of public drug plans" to produce lower costs not just for governments, but also for employer sponsored drug plans and individual Canadians. Another goal was to achieve "greater consistency of listing decisions across participating jurisdictions" (Council of the Federation 2012, 20).

At its July 2012 meeting the Premiers agreed to extend their co-operation on brand name drugs to include generic drugs (Council of the Federation 2012, 20). Six months later it was announced that the provinces (with the exception of Quebec, which has its own drug plan) and the territories had agreed to buy in bulk six generic drugs (representing about 20 percent of the publicly funded spending on generic drugs) at 18 percent of the equivalent brand name drug price. Premier Brad Wall, one of the co-chairs of the premier's working group on health care, declared that the announcement represented "a good day for Canadians" and vowed that this was only the beginning of interprovincial co-operation to trim health care costs (quoted in Couture 2013).

Thus, significant savings can be achieved by addressing two of the original structural problems with medicare: the focus on hospital and fee for service doctor services and the dominance of the federal-provincial relationship. De-hospitalization – moving services out of hospitals to private clinics or other less expensive facilities – and more focus on primary health care models in which physicians are salaried and no longer the system's gatekeepers can produce savings and a more integrated system. At the same time, interprovincial co-operation can help constrain the escalating costs of health care provider services and of prescription drugs. If the Canadian health care system was as efficient as the best in the OECD, it has been estimated that spending would decline by 2.5 percent (Simpson 2012b, 196-96).

However, none of these reforms address the other main structural problem with medicare: the lack of connection between users of the system and its costs, a problem that leads to open-ended demand for services, which in turn is a factor in driving up the costs of health care.

Changing the way medicare is funded

The main fiscal problem with health care is that its costs are rising faster than the revenue of any government in Canada (Dodge and Dion 2011). Consider Ontario, where between 1997-98 and 2002-03 government spending on health care increased by 42 percent while government revenue only went up by 31 percent. Because health spending is growing at a faster rate than government revenue, it is consuming a larger and larger share of the public spending pie. Prior to 1994-95, the Ontario government spent about 32 percent of its budget on health care. By 2003-04, health care accounted for 39 percent of the budget (Ontario Ministry of Finance 2003a, 8; Ontario Ministry of Finance 2003b, 5). Currently, 46 percent of Ontario's budget is spent on health care, and without major changes it is estimated that by 2030 it will consume a whopping 80 percent of the budget (Drummond 2010).

This is a problem because health care is squeezing out funding for other important programs, such as education, poverty reduction, and the environment; areas that also impact health outcomes. Pay-

Health care costs are rising faster than government revenue.

ing for health care by crowding out funding for areas like these does not lead to a healthier population. It has been estimated that only 25 percent of a person's health status depends on the health care system, while 50 percent is related to 'living conditions', which includes factors like lifestyle, diet, income level, education, or the environment (Conference Board of Canada 2004, 15; Brown 2012). In other words, the areas that are being squeezed out to fund Canada's health care system are twice as important to the overall health of the population.

The crowding out problem can be alleviated by using alternative ways to fund health care, raising new revenue as demand increases with the aging of the baby boomers, and technological advances. Raising new revenue to fund increasing demand is an option for the provinces, since the federal government's reduction of the GST from 7 to 5 percent left 'tax room' that they could occupy.

A major consideration is the kind of tax measures that should be used. If medicare continues to be funded exclusively from general tax revenues by, for example, increasing sales taxes, some of the main structural problems with the system will persist: open-ended demand will continue since there will be no link between the costs of the system and those who use it and the "squeezing out" problem will continue since health care will absorb a disproportionate amount of the new revenue.

Another factor is the intergenerational implication of raising taxes like the sales tax to fund health care. If medicare is funded exclusively from general tax revenues, a significant share of the health care costs of baby boomers will be paid for by their children and grandchildren. These are the same young people who are paying taxes for interest on the public debt, most of which was accumulated before they were born, and who have shouldered an increasing share of education costs, often incurring significant debt. Indeed, a major global problem is the limited opportunities for young people who face the prospect of seeing their standard of living decline relative to their parents. Consider the situation of 18 to 24 year olds in Canada. Their unemployment rate (including discouraged job seekers and involuntary part-timers) is 19.6 percent, while 28.6 percent are in temporary jobs, and their average household debt is $74,100 (Grant and McFarland 2010). Is it equitable to expect this generation of future taxpayers to pay a big part of the baby boomers' health care costs?

Beyond equity, is it realistic to expect the future costs of health care to be paid exclusively from general revenues? A recent study projected the tax levels required to continue to provide a publicly

A portion of the costs of health care should be borne by those using it.

funded health care system with similar levels of services (Emery, Still and Cottrell 2012). The study projected the average lifetime taxes paid for health care by individuals in each age cohort relative to the lifetime health care services used. It showed that Canadians born between 1958 and 1967 will consume over $4000 more in health care services than they will pay in taxes for health care; those born between 1998 and 2007 will pay over $18,000 more in taxes for health care than they cost the health care system; for those born between 2008 and 2017, their tax contributions will exceed their health care costs by over $27,000 (Emery, Still and Cottrell 2012, 8, 10). Especially noteworthy is the authors' conclusion that "peak taxes for Canadians born after 1988 will end up twice as high as the peak taxes that the oldest baby boomers paid" (Emery, Still and Cottrell 2012, 1). It is simply not realistic to believe that governments will be able to significantly increase the tax load on a smaller base of taxpayers and maintain a competitive economy.

Rather than relying exclusively on general tax revenues to fund medicare, a portion of the costs of the system should be borne by those using it. In the past, the idea of linking people's use of the

system to what they pay has been criticized as a tax on the poor, a deterrent to use of the system by those who need it, and an administratively complex and expensive way to collect revenue. However, the focus in the past has been on user fees, such as those levied in Saskatchewan in the 1970s. These fees were collected at the time services were accessed and were a deterrent for some who were ill, and since a separate system had to be created to administer and collect them they were complex and expensive (CIHI 2009, 7). Additionally, the flat fees were levied irrespective of income, so they penalized the poor.

However, all of the shortcomings of user fees can be addressed by using the income tax system to collect part of the revenue for health care by linking use of the system to income and ability to pay. There are various options for such a tax. Taxpayers would receive an annual statement of the cost of the health care services they used. Then, these costs could be considered as income, as recommended in the 1960s by Tom Kent, or a co-payment could be implemented whereby individuals would pay for services used up to a ceiling of 3 percent of income, as proposed by a recent study (Aba, Goodman and Mintz 2002; Stabile 2003). A co-payment system to help offset the cost of prescription drugs for high income seniors was recently adopted by Ontario, which is also considering funding other services, like home care, in a similar way (Howlett 2013). Whichever option is used – a co-payment or making some health care services a taxable benefit – the income tax system would be used to collect the revenue. As a result, the administrative costs and complexity would be reduced and the sick should not be deterred from using the system since no fees would be collected when care is accessed. Since the amount paid would be directly related to ability to pay, with a cap of 3 percent of income, the system would be fair and flexible enough to allow certain groups such as those below a certain income to be exempt from payment.

There would be many benefits from using the income tax system to collect part of the revenue for medicare. First, it would raise significant revenue: it was estimated that the co-payment model would collect enough revenue to pay 16 percent of the costs of all physicians, hospitals, and other health care institutions (Aba, Goodman and Mintz 2002, 10). Moreover, there would be savings to the system because of the reduction in utilization; it was estimated that these savings would be equivalent to a 13.5 percent reduction in the cost of physician and hospital services (Aba, Goodman and Mintz 2002, 10). The crowding out problem would be mitigated, aging baby boomers would be responsible for more of their own health care costs, and one of the original structural problems with medicare – the lack of connection between use of the system and its costs – would be addressed.

A final benefit would be the capacity to change the incentives within the system. Using the income tax system allows governments the flexibility to choose the services for which taxpayers are charged. Hence, governments could tax physician and hospital services but exempt services provided by primary health clinics. This would mitigate another of the original structural problems with Canada's health care system – the fact that physician and hospital services, the most expensive parts of the system, are free creates an incentive to use these services. There are many reasons why patients linger in hospitals when they should be in other less expensive facilities, but the fact that hospital stays are 'free' while other facilities like long-term care have to be at least partially paid for, means there is an incentive to stay in the hospital.[20]

Conclusion

The Canadian ideal that no one should be denied access to medical treatment because of their financial resources is a noble one. Too often in politics we try to freeze in time what we cherish most, when, in a changing world, change is what is often necessary to preserve noble ideals. The current health care system created in the 1960s suffers from structural problems that help explain why it is expensive and has mediocre outcomes and long waiting lists. Thus, preserving the ideal will require making fundamental changes in Canada's health care system. The changes required include diverting patients from hospitals to less expensive and more appropriate facili-

ties, moving to a primary health care model, relying more on interprovincial co-operation to deal with the rising costs of health care professionals and prescription drugs, and changing the funding model so that there is a link between use of the system and its costs. Changes like these will make Canada's health care system more affordable and open the door to investments in other services and programs that are more important in promoting the overall health of the population.

About the Author

Janice MacKinnon is a professor of fiscal policy at the University of Saskatchewan, a Fellow of the Royal Society of Canada, and a former Saskatchewan Finance Minister. She has an honours B.A. from the University of Western Ontario and a M.A. and PhD from Queen's. She is the author of three books, *The Liberty We Seek* (1983) published by Harvard University Press, *While the Women Only Wept* (1995), and *Minding the Public Purse* (2004). Between 1991 and 2001 she was a cabinet minister in Saskatchewan and held various portfolios including Minister of Finance, Minister of Social Services, Minister of Economic Development, and Government House leader. During her tenure as Finance Minister, Saskatchewan became the first government in Canada to balance its budget in the 1990s. She is Chair of the Board of Directors of the OmbudService for Life and Health Insurance, and she is on the Board of Directors of the Canada West Foundation. In 2009 she was appointed to the National Task Force on Financial Literacy. In 2010 Federal Finance Minister Jim Flaherty appointed her as Chair of Canada's Economic Advisory Council. She is also a public commentator on fiscal and political issues in Canada. In 2012 she became a Member of the Order of Canada.

Endnotes

1 Seniors in Ontario make up only 14.6 percent of the Ontario population, but account for nearly half of health care spending (Howlett 2013).

2 The OECD (2012) found that in Canada the average in health care spending per capita was $4445 USD; the OECD average was $3268. See also: Simpson, *Chronic Condition*, 157-63 and MacKinnon, *Minding the Public Purse*, 145-50, 236-40, 246-49.

3 It should also be noted that the federal government has recently made changes that will see benefits increase.

4 It should be noted that the health systems in Canada were similar in structure to those that existed in the United States, aside from Medicare and Medicaid.

5 Fred Horne, the Alberta Minister of Health, makes the case for primary health care in "Medicare's Front Door, Primary Health Care, Needs a Remodel."

6 It should be noted that where private sector participation has been incorporated into the system it has been on the supply side; for example, nursing homes or home care providers.

7 The Hon. Hall (1980) worried about the cost-saving practice of closing hospital beds in the summer. As early as 1975 Ontario began restricting the supply of doctors and hospital beds (Perry 1989, 650). Mazankowski *et al*. state "[i]f we restrict ourselves to a system where all the funding comes from provincial and federal taxes we have little choice but to ration services" (2001, 4).

8 In 2010 Canada had 1.7 physicians per thousand population while the OECD average was 3.1; in 2009 Canada had 1.7 beds per 1000 population for curative care, while the OECD average was 3.4; Canada had 14.2 CT scanners per million population, and the OECD average was 22.6; Canada had 8.2 MRIs per million population while the OECD average was 12.5 (OECD 2012). Regarding waiting lists, the Conference Board of Canada found in 2004 that of 24 countries studied, Canada's waiting lists were among the longest. A similar conclusion was reached in 2011 in *The Commonwealth Fund Survey* (The Commonwealth Fund).

9 For a discussion of the transition from cost sharing to block funding for transfer payments, see Coyte and Landon, "Cost-Sharing versus Block-Funding".

10 CIHI estimates that 37 percent of public health care spending went to hospitals.

11 The government that the author was part of in the 1990s was reduced to a minority with a nurse strike being a major factor in its loss of support; a health care strike was also a factor in the defeat of the government of Allan Blakeney in 1982.

12 The study also recommended a cap on billings to avoid oversupply and "strategic behavior".

13 The Shouldice Clinic in Ontario, which specializes in hernia procedures, is another well-known example of a high quality private clinic.

14 Wikipedia defines a public good as "a good that is both non-excludable and non-rivalrous in that individuals cannot be effectively excluded from use and where use by one individual does not reduce availability to others." Available at http://en.wikipedia.org/wiki/Public_good.

15 The comparisons were not specifically controlled for differences in the case mix of patients; in fact, the procedures chosen for delivery at private clinics were those that did not have to done in a hospital setting.

16 A Toronto Balance of Care project concluded that 37 percent of those on the Toronto Central long-term care waiting list could potentially be supported in their own homes.

17 See Chapter One in Simpson, *Chronic Condition*.

18 See Horne, "Medicare's Front Door, Primary Health Care, Needs a Remodel," for a discussion of Alberta's Family Clinics that extend the primary health care model to include other professionals such as social workers and educators.

19 Similar arguments can be made about efforts to reduce the sodium in our diets or reduce smoking.

20 It should also be noted that physicians also may prefer to provide care in hospitals because then they do not bear the cost of overhead and supplies and the time of other health professionals.

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About the Macdonald-Laurier Institute

What Do We Do?

When you change how people think, you change what they want and how they act. That is why thought leadership is essential in every field. At MLI, we strip away the complexity that makes policy issues unintelligible and present them in a way that leads to action, to better quality policy decisions, to more effective government, and to a more focused pursuit of the national interest of all Canadians. MLI is the only non-partisan, independent national public policy think tank based in Ottawa that focuses on the full range of issues that fall under the jurisdiction of the federal government.

What Is in a Name?

The Macdonald-Laurier Institute exists not merely to burnish the splendid legacy of two towering figures in Canadian history – Sir John A. Macdonald and Sir Wilfrid Laurier – but to renew that legacy. A Tory and a Grit, an English speaker and a French speaker – these two men represent the very best of Canada's fine political tradition. As prime minister, each championed the values that led to Canada assuming her place as one of the world's leading democracies. We will continue to vigorously uphold these values, the cornerstones of our nation.

Working for a Better Canada

Good policy doesn't just happen; it requires good ideas, hard work, and being in the right place at the right time. In other words, it requires MLI. We pride ourselves on independence, and accept no funding from the government for our research. If you value our work and if you believe in the possibility of a better Canada, consider making a tax-deductible donation. The Macdonald-Laurier Institute is a registered charity.

Our Issues

The Institute undertakes an impressive programme of thought leadership on public policy. Some of the issues we have tackled recently include:

- The impact of banning oil tankers on the West Coast;
- Making Canada a food superpower in a hungry world;
- Aboriginal people and the management of our natural resources;
- Population ageing and public finances;
- The vulnerability of Canada's critical infrastructure;
- Ottawa's regulation of foreign investment; and
- How to fix Canadian health care.

Macdonald-Laurier Institute Publications

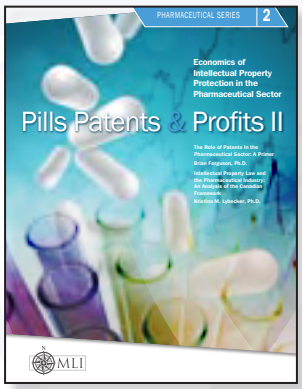
Winner of the Sir Antony Fisher International Memorial Award BEST THINK TANK BOOK IN 2011, as awarded by the Atlas Economic Research Foundation.

The Canadian Century
By Brian Lee Crowley, Jason Clemens, and Niels Veldhuis

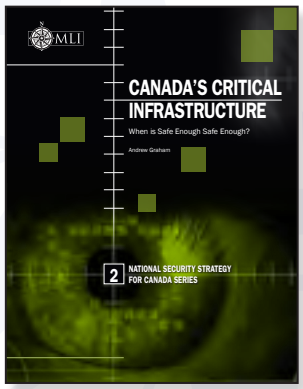
Do you want to be first to hear about new policy initiatives? Get the inside scoop on upcoming events?

Visit our website www.MacdonaldLaurier.ca and sign up for our newsletter.

RESEARCH PAPERS



Pills, Patents & Profits II
Brian Ferguson and Kristina Lybecker

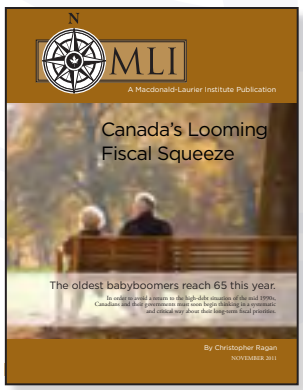


Canada's Critical Infrastructure
Andrew Graham

Reforming the Canada Health Transfer
Jason Clemens

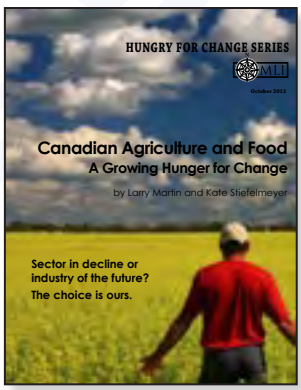
Clarity on the Legality of Secession
Hon. Stéphane Dion

Migrant Smuggling
Benjamin Perrin



Canada's Looming Fiscal Squeeze
Christopher Ragan

Why Canadian Crime Statistics Don't Add Up
Scott Newark



Canadian Agriculture and Food
Larry Martin and Kate Stiefelmeyer

MACDONALD-LAURIER INSTITUTE

True North in Canadian Public Policy

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What people are saying about the Macdonald-Laurier Institute

I commend Brian Crowley and the team at MLI for your laudable work as one of the leading policy think tanks in our nation's capital. The Institute has distinguished itself as a thoughtful, empirically-based and non-partisan contributor to our national public discourse.

PRIME MINISTER STEPHEN HARPER

As the author Brian Lee Crowley has set out, there is a strong argument that the 21st Century could well be the Canadian Century.

BRITISH PRIME MINISTER DAVID CAMERON

In the global think tank world, MLI has emerged quite suddenly as the "disruptive" innovator, achieving a well-deserved profile in mere months that most of the established players in the field can only envy. In a medium where timely, relevant, and provocative commentary defines value, MLI has already set the bar for think tanks in Canada.

PETER NICHOLSON, FORMER SENIOR POLICY ADVISOR TO PRIME MINISTER PAUL MARTIN

The reports and studies coming out of MLI are making a difference and the Institute is quickly emerging as a premier Canadian think tank.

JOCK FINLAYSON, EXECUTIVE VICE PRESIDENT OF POLICY, BUSINESS COUNCIL OF BRITISH COLUMBIA

Very much enjoyed your presentation this morning. It was first-rate and an excellent way of presenting the options which Canada faces during this period of "choice"... Best regards and keep up the good work.

PRESTON MANNING, PRESIDENT AND CEO, MANNING CENTRE FOR BUILDING DEMOCRACY