5 Years of True North in Canadian Public Policy

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#3 IN A SERIES

FROM A MANDATE FOR CHANGE TO A PLAN TO GOVERN

Better Health Care for Canadians

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INTRODUCTION

One of the new government's top policy priorities is to negotiate a new health accord with the provinces and territories. Details about what a new accord may comprise remain largely unknown. The Liberal Party platform was mostly silent save for a commitment to "restart that important [health care] conversation and provide the collaborative federal leadership that has been missing". Next week's meeting of federal, provincial, and territorial finance ministers will be the first opportunity to commence these discussions.

The new Liberal government has correctly identified health care as a top priority of Canadians and of its own policy agenda.[1] It currently consumes a significant share of our financial resources – representing more than 10 percent of GDP (CIHI 2015) – and population aging is expected to drive up these costs further (MacKinnon et al. 2012). The need for reform is well documented.[2] The reality is that Canada's health care system is one of the most costly and underperforming among comparable jurisdictions. The federal government must play an important role to spur reform.

The real question though is how the new government can best such support health care reforms to better control costs and improve outcomes for Canadians. As the new ministers of finance and health search for

the right answer, they can draw from experiences around the world and of the Chrétien government's own reforms. It may seem paradoxical to some, but the reality is that true federal leadership on the health care file does not mean Ottawa telling provinces how to run the system, but helping to create the right incentives for the provinces to do so.

The Macdonald-Laurier Institute's mission is to help to inform sound public policy at the federal level. Our goal in this essay series is to help the new government best achieve its top policy objectives.

This third essay in the series will help Canadians better understand the current state of Canadian health care and the role of the federal government in supporting health care reform. The purpose is to help inform policy thinking as the new government sits down with the provinces and territories on a renewed health accord.

We will then offer what we think the Canadian and international evidence establishes as the best policy options not only to better control health care costs but to achieve better health outcomes for Canadians. The ultimate goal, as the Liberal Party (2015) platform rightly puts it, is to ensure that Canada's health care system remains a "source of pride for Canadians" and achieves better results.

CANADIAN FEDERALISM AND HEALTH CARE

Federalism is the foundation of Canada's system of government. It was at the core of what was negotiated at the Charlottetown and Quebec City conferences more than 200 years ago and Liberal politicians – including George Brown, Oliver Mowat, and the first great Liberal prime minister, Sir Wilfrid Laurier – were among its primary proponents.

Laurier, in particular, was a champion of Canadian federalism during his time in politics and his long tenure as prime minister. He saw in federalism (or what he often described as *provincialism*) the basis for reconciling different regional priorities and interests and an "entrepreneurial federalism" whereby sub-jurisdictions could serve as incubators to test new ideas and reforms. As Laurier (1890) once said:

> For my own part, I believe that the federal system is the best of all systems which can be devised to govern this large territory. . . . According to that authority [traditional assumptions], it would be impossible to govern these large territories extending from one ocean to the other, by a single government, unless indeed, that government were despotic, in which case there would be rupture. But our system obviates all these difficulties; our municipal and provincial divisions, our Federal system, all these wheels within wheels constitute a mechanism, which is at once elastic and strong. (166–167)

The history of Canadian health care policy is partly a story about an evolution of Canadian federalism and federal-provincial interaction. Health care is largely a provincial and territorial responsibility.[3] Initially federal involvement was minimal and the role for government more generally was secondary to private and familial responsibility. Slowly the role of government expanded but remained largely limited to the provincial sphere. Public hospital care first surfaced in Saskatchewan and Alberta in 1947 and 1950 and then expanded nationally in the early 1960s. Then the Saskatchewan provincial government expanded the policy to provide for universal health care in 1961–62 and pressure to follow suit nationally quickly followed.

The federal government's first foray into health care was the *Hospital Insurance and Diagnostic Services Act* in 1957, which offered to cost share up to one-half of provincial and territorial costs for certain hospital and diagnostic services. The Pearson government's *Medical Care Act* in 1966 subsequently expanded federal support to include all medical services provided outside of hospitals. This path-breaking legislation formed the basis of Canada's national, universal publicly-funded health care system.

The federal government's financial contribution remained a fixed percentage (one-half) of provincial and territorial health care expenditures until 1977. Thereafter cost-sharing was replaced with block funding comprised of cash payments and tax points.

The *Canada Health Act* was passed in 1984 to further assert federal standards on the provinces and territories. The new legislation enshrined the principles of portability, accessibility, universality, comprehensiveness, and public administration into law. It also prohibited extra billing and user fees for insured services and set out discretionary financial penalties (that is, the withholding of federal transfers) for those provinces and territories that contravened the *Act*.

As will be discussed later, the 1995 federal budget consolidated transfer payments to the provinces and territories for health care and post-secondary education into a single block transfer payment called the Canada Health and Social Transfer. The new transfer payment provided for greater flexibility with respect to provincial social spending but kept the parameters of the *Canada Health Act* intact.

There was some cooperation between the federal, provincial, and territorial governments in 2000 on a set of reform areas, including primary care, pharmaceuticals management, and health information and communications technology. The limited agreement was buttressed by an increase in federal funding.

But the major federal instrument of health care reform was the 2003 *Accord on Health Care Renewal.* The 10-year accord split the Canada Health and Social Transfer into the Canada Health Transfer and the Canada Social Transfer and agreed to grow the former by 6 percent annually. In exchange for this infusion of federal funding the provinces and territories agreed to joint priorities, such as home care and electronic health records, and some conditional payments associated with waiting times. The accord's ambitions were lofty. An accompanying press document claims: "[the accord] marks a turning point in our efforts to renew health care for the 21st century" (Health Canada 2003).

Yet the accord failed to live up to its expectations and proved to be a failure. It did not lead to the transformative change that was promised. Instead it injected billions of dollars into the system and bought stasis.[4] As a 2012 Standing Senate Committee on Social Affairs, Science and Technology report concludes: "[the increased funding] had increased the provision of services, but had not resulted in reform of health-care systems." Lakehead University economist Livio de Matteo (2015) sums it up: "it had pretty much been business as usual."

As the accord's renewal approached, there was considerable speculation about what would succeed it. Expectations were that the federal government would once again sit down with the provinces and territories to negotiate a new agreement in exchange for long-term – and indeed, greater – funding. Yet the federal government adopted a different approach – one that more closely resembled Laurier's vision of federalism.

In 2011, then-finance minister Jim Flaherty announced that the federal government would renew the Canada Health Transfer for a 10-year period following the conclusion of the current plan in 2013/14. The transfer would grow 6 percent annually for 3 years until 2016/17 and then would increase at the rate of growth in the economy thereafter. Another change was that federal transfers to the provinces would be calculated on an equal per capita basis (Department of Finance Canada 2011).

But most importantly the federal announcement was not a negotiating stance. There would be no new accord or the imposition of additional federal conditionality. The *Canada Health Act*'s provisions would still apply but otherwise the administration of health care and the impetus for reform would be left to provincial and territorial governments.

The government's decision attracted immediate criticism from provincial and territorial governments and health stakeholders who had grown accustomed to a more activist federal role. But after the initial shock

dissipated, we began to witness useful reforms. Annual provincial and territorial spending began to subside and governments started to work together to experiment with new approaches and the adoption of best practices. It is a point worth emphasizing: it is during this period of perceived federal inaction that we have witnessed greater movement in the direction of more spending control and structural reform (MLI 2013).

The new government thus inherits a federal policy with respect to health care that is a departure from recent practices. The decision not to pursue a new negotiated health accord, but for Ottawa simply to announce its intentions, remains controversial but it also offers us evidence on which approach to the provinces and territories pays the biggest dividends for Canadians in terms of badly-needed system reform.

THE STATE OF CANADIAN HEALTH CARE

The new government is right to highlight that our health care system is a source of pride for Canadians. Yet the problem is that pride is misplaced when one considers the system's high costs and poor outcomes. There is a considerable gap between perception and reality with respect to Canada's health care system.

Canada's health care system is one of the most expensive among OECD countries that provide universal access, after adjusting for age. Data for 2011, the most recent year currently available, show that Canada's health care system was the second most expensive (measured as a share of the economy) among 27 OECD countries with universal access (Clemens and Barua 2015).

And what are we getting in exchange for our massive spending? Canada's performance relative to other comparable jurisdictions is poor. Consider wait times, for instance. A new study finds a median waiting time of 18.3 weeks between referral from a general practitioner to receipt of treatment. This waiting period for treatment is now 97 percent longer than it was in 1993 (Barua 2015b). And these waiting times are not without cost. One recent analysis estimates that the economic cost (to say nothing of the emotional and social burden or the potential for disability or even death) of lost time and income totaled $1.2 billion in 2014 (Barua 2015a).

How does this compare with other countries? In a comparable sense, Canada's wait lists are among the worst in the developed world. According to the Commonwealth Fund, Canada ranked last on most measures of timeliness of care (behind 10 other countries, including the US). Only 41 percent of Canadians were able to get an appointment the same day (or next) when sick, compared to 76 percent in Germany. And 29 percent of Canadians waited two months or more for a specialist appointment while only 3 percent reported such waits in Switzerland or the Netherlands.

The data also show that Canada trails other jurisdictions with respect to access to medical doctors and technology. For instance, among OECD countries with universal access, Canada ranked close to the bottom of the pack for availability of practising doctors per thousand population (25 of 27), and below the OECD average for availability of MRI scanners per million population (16 out of 24) (Clemens and Barua 2015).

This focus on Canada's health care performance relative to other jurisdictions that provide for universal access is intentional. Often Canada's health policy debate is marred by a tendency to conflate universal access with public provision. Yet research published by the Macdonald-Institute Laurier Institute on other jurisdictions that offer universal access shows that this type of system is compatible with greater competition, more individual choice, and shorter wait times. Countries such as Australia, Germany, and Switzerland have managed to keep Medicare-type coverage while experimenting with subsidized private insurance with better outcomes at lower costs (Laporte 2014; Lundbäck 2013).

The upshot is that Canada is spending more than a large number of countries and producing poorer results. Money is not the issue. If spending were the key determinant, Canada would be a world leader. Instead, Canada is an expensive underperformer. Several jurisdictions spend less, provide universal coverage, and achieve better outcomes. We can and must do better.

THE NEW GOVERNMENT'S PLAN

The Liberal Party was critical of the previous government for its lack of an "activist" agenda with respect to health care (Kennedy 2015). In particular, its predecessor's decision to renew the Canada Health Transfer outside the context of a negotiated federal-provincial health accord was the subject of significant criticism by the then-opposition Liberals who saw it as an abandonment of the federal role in health care.

The new government is committed to reasserting federal involvement in health care. Its election platform committed to negotiating a new health accord with the provinces and territories, including a long-term funding agreement. And as a down payment, the Liberal Party (2015) manifesto promised $3 billion over four years focused on home care.

The incoming minister of health's mandate letter from the Prime Minister reaffirmed this promise and early signals are that preliminary discussions have already commenced. Next week's meeting of finance ministers will be the first opportunity to see how the discussions will ultimately develop.

Early indications from the provinces are not promising. Talk of a new accord and "long-term funding" have created high expectations and placed questions about federal financing seemingly ahead of reform (Canadian Press 2015a; 2015b).

Yet the new federal health minister has signaled that she understands the source of the health care system's problems and the right policy solutions. As she put it in a recent television interview:

> Money isn't necessarily where the problem is. I don't think Canadians necessarily want us to spend more on health care. . . . What we're looking at doing largely will be system reform. What needs to be transformed in the way we deliver care [sic]. In the kinds of incentives that are provided around care . . . I'm hoping we'll be able to do a lot of work without necessarily spending a lot more money, and, in fact, there's a lot of room for saving money. (Bourbeau 2015)

This is precisely the type of thinking that ought to guide health care reform in Canada. It is the right policy objective and the minister should be lauded for articulating it. The question is: what role does the federal government have to help achieve it?

POLICY RECOMMENDATIONS TO IMPROVE CANADIAN HEALTH CARE

The new government has committed to play a greater role – to exhibit "leadership" – in Canada's health care system. Some health stakeholders have tended to equate leadership with activism or greater involvement in directing resources in the system. It is what policy commentators tend to call *conditional funding* – that is, federal funding with strings attached.

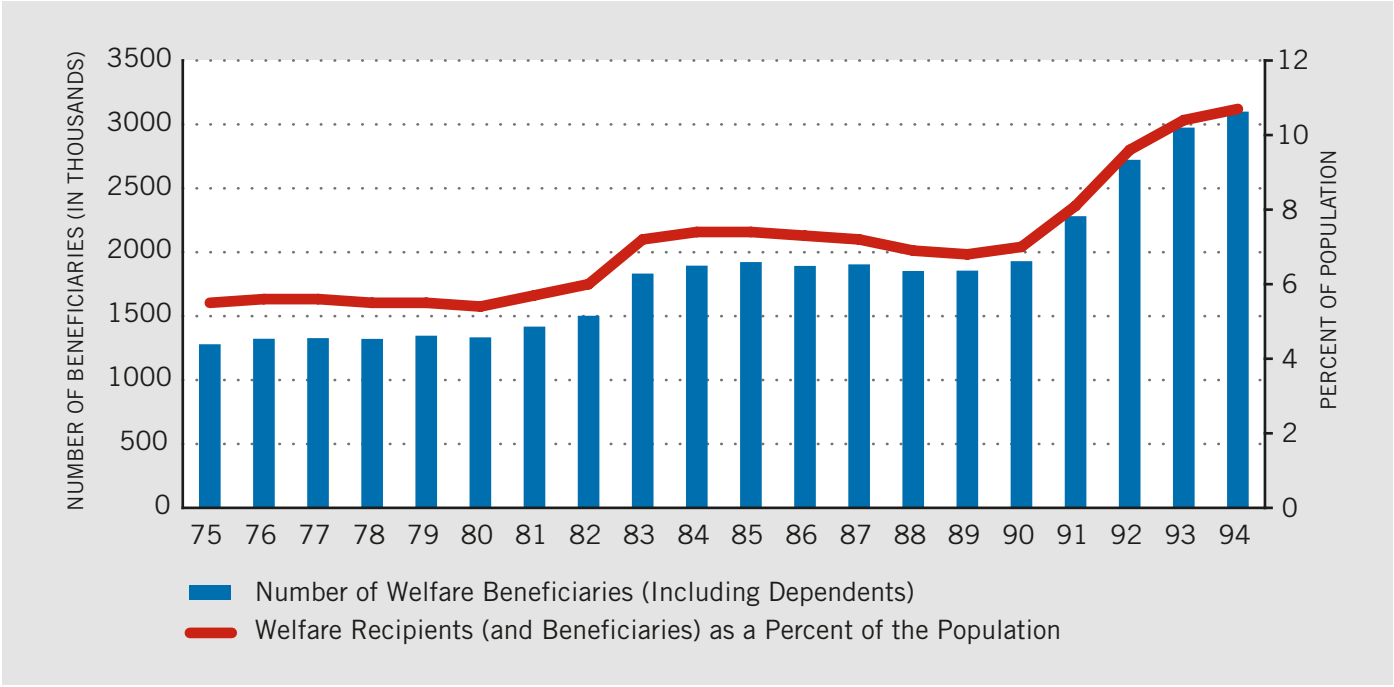
But the reality is this is not the type of leadership that we need to achieve better results. As one of the co-authors of this essay writes, "We make a mistake when we seek the kind of federal leadership that concentrates

on imposing a one-size fits all solution to our health care sustainability problem or that simply throws money at the problem and relieves those responsible of the need to think more carefully about reform" (Crowley 2014).

The recent past shows that federal leadership is best exercised by creating the right incentives for provinces, not by transferring more money or trying to dictate how the system should be run. Welfare reform in the 1990s provides a lesson for health care reform today.

Canada's welfare (or social assistance) system – like health care – is predominantly administered by the provinces and territories. Welfare spending grew out of control by the mid 1990s. Welfare dependency ballooned to 10.7 percent of the population, or 3.1 million Canadians, as a result of loose eligibility criteria, generous payment levels, and little in the way of work requirements (see chart 1).

Chart 1 Welfare beneficiaries, including dependents, 1975–1994



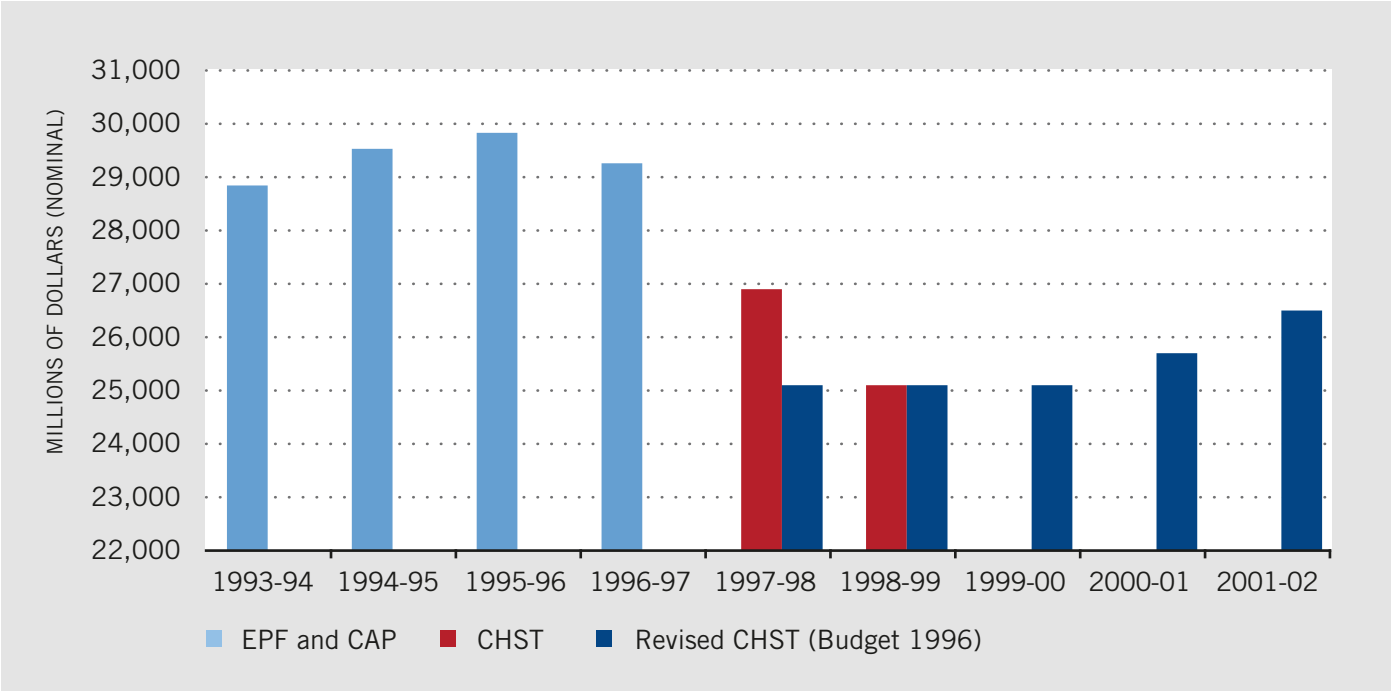
Source: Clemens 2011.

This growth in welfare rates was fueled in part by ever-growing federal transfer payments for social programming. But by the middle of the 1990s the federal government had hit a fiscal wall and was in desperate need of reform. It may not have been obvious at the time but this impetus for fiscal savings became a catalyst for provincial welfare reform. And herein lies the lesson for the new government as it considers how to encourage health care reform.

The 1995 federal budget moved away from cost-sharing provincial social spending to a block grant whereby any extensions or augmentations of provincial benefits were borne by the provincial government with no corresponding federal support. Not only did it shift from cost-shared funding to block transfers, the budget actually cut payments to the provinces and territories in absolute terms. The then-Liberal government consolidated two transfer payments – the Canada Assistance Plan and the Established Program Financing – into the Canada Health and Social Transfer and reduced their combined value from $29.3 billion in 1996/97

to $26.9 billion in 1997/98, and then further cut it to $25.1 billion and froze it there until 2000/01 (see chart 2) (Crowley and Murphy 2012; Clemens 2011).

Chart 2: Canada Assistance Plan and Established Program Financing versus Canada Health and Social Transfer Spending, 1993/94–2001/02



Source: Clemens 2011.

The reduction in federal transfer payments was married with less conditionality on the provinces and territories. In effect, the federal government was offering less money but with fewer strings attached, including repealing a previous prohibition on work requirements for welfare recipients. This greater flexibility was the catalyst for a movement of welfare reform across the country.

It is important to emphasize that while virtually every province (representing governments across the political spectrum) pursued reforms, many of them went about it in different ways, reflecting their own circumstances and priorities. Some reforms were fairly common across the provinces, including curtailing benefit rates, tightening eligibility rules, and promoting employment alternatives. Yet there remained considerable variance between the provinces as envisioned when the federal government lessened its conditionality.

As past analysis published by the Macdonald-Laurier Institute shows, the positive outcomes were staggering (Crowley and Murphy 2012; Clemens 2011). Welfare dependency rates were reduced by more than half and have generally remained at these levels ever since. Employment went up as previous recipients shifted to paid work. Provincial spending on welfare was reduced. It was all made possible by federal leadership that both cost Ottawa less and involved less, not more, federal direction.

This example provides a way forward for the new government as it considers how to catalyse health care reform. Indeed, as one study published by the Macdonald-Laurier Institute puts it: "The basic contours of the welfare reforms of the 1990s should form the basis for health care reform now" (Clemens and Esmail 2012, 2).

In practice this means resisting provincial and territorial calls to increase federal health transfers. The goal ought to be more direct accountability to the provincial and territorial governments to raise the resources to cover health care costs. In exchange the federal government should allow the provinces and territories to maximize their flexibility to design, regulate, and provide health care to their citizens within a universal and portable framework. Analysis published by the Macdonald-Laurier Institute shows that the *Canada Health Act* provides sufficient flexibility to allow for greater competition, including experimenting with more private delivery with public payments (Watts 2013). But the federal government could facilitate greater provincial and territorial experimentation by clarifying the meaning and intent of the five principles of the *Act* in order to establish clearer rules on the road to reform.

Overall these types of reforms would increase accountability and transparency, reward reform, and, based on experiences in other jurisdictions, ultimately help to achieve better health outcomes at a lower cost.

The goal, of course, is not just to cut costs but to improve the quality and availability of health care in Canada. Remember Canada not only spends more than most comparable jurisdictions, but it also achieves poorer outcomes, and the perceived limitations imposed by the federal government are a contributing factor. There are early signs of effective models of reform at the provincial level and the federal government's goal should be to create the conditions for more experimentation and reform. As Janice MacKinnon (2013) documented, Saskatchewan's recent experience with private clinics for specific surgeries produced considerable financial savings[5] and reduced wait times for patients. This is the type of reform that we ought to be pursuing and the new government can play an important role in supporting it by drawing on past experiences of what has worked and what has not.

CONCLUSION

The new government is committed to improving Canada's health care system. That is a laudable objective in principle. The question is how to achieve it in practice.

The government has committed to reaching a new health accord with the provinces and territories and establishing a new long-term funding arrangement, and is set to commence formal discussions as early as next week's meeting of finance ministers.

As the ministers of finance and health consider how best for the federal government to support better health care results, they ought to examine the lessons of the last Liberal government's catalytic contribution to welfare reform. Therein lies the potential to leverage Canadian federalism to encourage province-led experimentation, transformation, and ultimately reform. The lessons of welfare reform can contribute to improving Canada's health care system.

More federal funding or top-down conditionality will impede reform rather than encourage it. It may seem counter-intuitive (and even contrary to what some members of the government have said in opposition) but the reality is, the best way for the federal government to "show leadership" on the file is to focus on the quality of federal actions rather than the quantity of money Ottawa spends or the number of conditions it imposes on the provinces and territories. A reaffirmation of Laurier's vision of federalism would serve the new government well as it sits down with the provinces and territories on health care.

This essay highlights lessons from Canada's history of federalism in general and the federal role in health care in particular and sets out some recommendations – including further removing federal impediments to provincial experimentation and reform – to improve our health care outcomes and to better control costs.

ABOUT THE AUTHORS

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Sean Speer is a Senior Fellow at the Macdonald-Laurier Institute. He previously served in different roles for the federal government including as senior economic advisor to the Prime Minister and director of policy to the Minister of Finance. He has been cited by *The Hill Times* as one of the most influential people in government and by *Embassy Magazine* as one of the top 80 people influencing Canadian foreign policy. He has written extensively about federal policy issues, including personal income taxes, government spending, social mobility, and economic competitiveness. His articles have appeared in every major national and regional newspaper in Canada (including the *Globe and Mail* and *National Post*) as well as prominent US-based publications (including Forbes and The American). Sean holds an M.A. in History from Carleton University and has studied economic history as a PhD candidate at Queen's University.

BRIAN LEE CROWLEY

Brian Lee Crowley has headed up the Macdonald-Laurier Institute (MLI) in Ottawa since its inception in March of 2010, coming to the role after a long and distinguished record in the think tank world. He was the founder of the Atlantic Institute for Market Studies (AIMS) in Halifax, one of the country's leading regional think tanks. He is a former Salvatori Fellow at the Heritage Foundation in Washington, DC and is a Senior Fellow at the Galen Institute in Washington. In addition, he advises several think tanks in Canada, France, and Nigeria.

Crowley has published numerous books, most recently *Northern Light: Lessons for America from Canada's Fiscal Fix*, which he co-authored with Robert P. Murphy and Niels Veldhuis and two bestsellers: *Fearful Symmetry: the fall and rise of Canada's founding values* (2009) and MLI's first book, *The Canadian Century; Moving Out of America's Shadow*, which he co-authored with Jason Clemens and Niels Veldhuis.

Crowley twice won the Sir Antony Fisher Award for excellence in think tank publications for his heath care work and in 2011 accepted the award for a third time for MLI's book, *The Canadian Century*.

From 2006–08 Crowley was the Clifford Clark Visiting Economist with the federal Department of Finance. He has also headed the Atlantic Provinces Economic Council (APEC), and has taught politics, economics, and philosophy at various universities in Canada and Europe.

Crowley is a frequent commentator on political and economic issues across all media. He holds degrees from McGill and the London School of Economics, including a doctorate in political economy from the latter.

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Endnotes

1 An EKOS poll released in final days of the 2015 election campaign showed that health care "dominated the list of public priorities."

2 See, for instance, the Macdonald-Laurier Institute's video series, *Medicare's Midlife Crisis* (2015a and 2015b).

3 The BNA Act stated that among provincial responsibilities were: "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals." See the *Constitution Act, 1867*, specifically at http://laws-lois.justice.gc.ca/eng/const/page-4.html.

4 As Janice MacKinnon says in an MLI (2015b) video: "Finance people said putting money into the system actually prevents change, which is true . . . Why would you make a tough decision if somebody is going to give you more money to keep the status quo? We now know almost 10 years after the money was put that it didn't work. The money did not go to change."

5 A comparison of 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 (MacKinnon 2014).

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- One of the top three new think tanks in the world according to the University of Pennsylvania.
- Cited by five present and former Canadian Prime Ministers, as well as by David Cameron, the British Prime Minister.
- First book, *The Canadian Century: Moving out of America's Shadow*, won the Sir Antony Fisher International Memorial Award in 2011.
- *Hill Times* says Brian Lee Crowley is one of the 100 most influential people in Ottawa.
- The *Wall Street Journal*, the *Economist*, the *Globe and Mail*, the *National Post* and many other leading national and international publications have quoted the Institute's work.

"The study by Brian Lee Crowley and Ken Coates is a 'home run'. The analysis by Douglas Bland will make many uncomfortable but it is a wake up call that must be read."

FORMER CANADIAN PRIME MINISTER PAUL MARTIN ON MLI'S PROJECT ON ABORIGINAL PEOPLE AND THE NATURAL RESOURCE ECONOMY.

Ideas Change the World

Independent and non-partisan, the Macdonald-Laurier Institute is increasingly recognized as the thought leader on national issues in Canada, prodding governments, opinion leaders and the general public to accept nothing but the very best public policy solutions for the challenges Canada faces.

CTV
SUN NEWS NETWORK
corus ENTERTAINMENT
cpac
tvo
CBC news
WALL STREET JOURNAL
FP Foreign Policy
The Economist
THE HILL TIMES
THE GLOBE AND MAIL
CANADA'S NATIONAL NEWSPAPER • FOUNDED 1844
NATIONAL POST

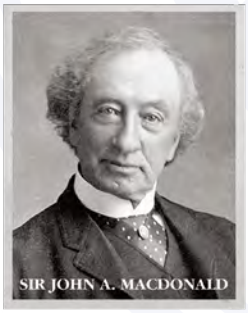
About the Macdonald-Laurier Institute

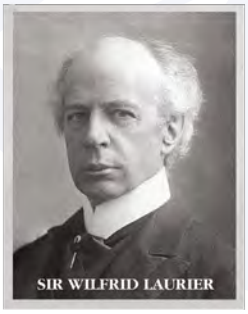
What Do We Do?

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.


SIR JOHN A. MACDONALD


SIR WILFRID LAURIER

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:

- Getting the most out of our petroleum resources;
- Ensuring students have the skills employers need;
- Aboriginal people and the management of our natural resources;
- Controlling government debt at all levels;
- The vulnerability of Canada's critical infrastructure;
- Ottawa's regulation of foreign investment; and
- How to fix Canadian health care.

CELEBRATING 5 YEARS

MLI

5 Years of True North in Canadian Public Policy

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What people are saying about the Macdonald-Laurier Institute

In five short years, the institute has established itself as a steady source of high-quality research and thoughtful policy analysis here in our nation's capital. Inspired by Canada's deep-rooted intellectual tradition of ordered liberty – as exemplified by Macdonald and Laurier – the institute is making unique contributions to federal public policy and discourse. Please accept my best wishes for a memorable anniversary celebration and continued success.

THE RIGHT HONOURABLE STEPHEN HARPER

The Macdonald-Laurier Institute is an important source of fact and opinion for so many, including me. Everything they tackle is accomplished in great depth and furthers the public policy debate in Canada. Happy Anniversary, this is but the beginning.

THE RIGHT HONOURABLE PAUL MARTIN

In its mere five years of existence, the Macdonald-Laurier Institute, under the erudite Brian Lee Crowley's vibrant leadership, has, through its various publications and public events, forged a reputation for brilliance and originality in areas of vital concern to Canadians: from all aspects of the economy to health care reform, aboriginal affairs, justice, and national security.

BARBARA KAY, NATIONAL POST COLUMNIST

Intelligent and informed debate contributes to a stronger, healthier and more competitive Canadian society. In five short years the Macdonald-Laurier Institute has emerged as a significant and respected voice in the shaping of public policy. On a wide range of issues important to our country's future, Brian Lee Crowley and his team are making a difference.

JOHN MANLEY, CEO COUNCIL