Turning Point 2014 Series

A Macdonald-Laurier Institute Publication

Applying the welfare reform lessons of the 1990s to healthcare today

Reforming the Canada Health Transfer

By Jason Clemens

October 2011

The Macdonald-Laurier Institute

"True North in Canadian Public Policy"

Board of Directors

Chair: **Rob Wildeboer**, Chairman, Martinrea International Inc., Toronto
Managing Director: **Brian Lee Crowley**, former Clifford Clark Visiting Economist at Finance Canada
Secretary: **Lincoln Caylor**, Partner, Bennett Jones, Toronto
Treasurer: **Martin MacKinnon**, CFO, Black Bull Resources Inc., Halifax;
Directors: **John Beck**, Chairman and CEO, Aecon Construction Ltd., Toronto; **Erin Chutter**, President and CEO, Puget Ventures Inc., Vancouver; **Navjeet (Bob) Dhillon**, CEO, Mainstreet Equity Corp., Calgary; **Keith Gillam**, former CEO of VanBot Construction Ltd., Toronto; **Wayne Gudbranson**, CEO, Branham Group, Ottawa; **Stanley Hartt**, Chair, Macquarie Capital Markets Canada ; **Rick Peterson,** President, Peterson Capital, Vancouver; **Peter John Nicholson**, former President, Canadian Council of Academies, Ottawa; **Jacquelyn Thayer Scott**, past President & Professor, Cape Breton University, Sydney.

Advisory Council

Purdy Crawford, former CEO, Imasco, now Counsel at Osler Hoskins; **Jim Dinning**, former Treasurer of Alberta; **Don Drummond**, Economics Advisor to the TD Bank, Matthews Fellow in Global Policy and Distinguished Visiting Scholar at the School of Policy Studies at Queen's University; **Brian Flemming**, international lawyer, writer and policy advisor; **Robert Fulford**, former editor of *Saturday Night* magazine, columnist with the *National Post*, Toronto; **Calvin Helin**, Aboriginal author and entrepreneur, Vancouver; **Hon. Jim Peterson**, former federal cabinet minister, now a partner at Fasken Martineau, Toronto; **Maurice B. Tobin**, the Tobin Foundation, Washington DC.

Research Advisory Board

Janet Ajzenstat, Professor Emeritus of Politics, McMaster University; **Brian Ferguson**, Professor, health care economics, University of Guelph; **Jack Granatstein**, historian and former head of the Canadian War Museum; **Patrick James**, Professor, University of Southern California; **Rainer Knopff**, Professor of Politics, University of Calgary; **Larry Martin**, George Morris Centre, University of Guelph; **Chris Sands**, Senior Fellow, Hudson Institute, Washington DC; **William Watson**, Associate Professor of Economics, McGill University.

The Macdonald-Laurier Institute exists to:

- **Initiate** and conduct research identifying current and emerging economic and public policy issues facing Canadians, including, but not limited to, research into defence and security, foreign policy, immigration, economic and fiscal policy, Canada-US relations, regulatory, regional development, social policy and Aboriginal affairs;
- **Investigate** and analyse the full range of options for public and private sector responses to the issues identified and to act as a catalyst for informed debate on those options;
- **Communicate** the conclusions of its research to a national audience in a clear, non-partisan way;
- **Sponsor** or organize conferences, meetings, seminars, lectures, training programs and publications using all media of communication (including, without restriction, the electronic media), for the purposes of achieving these objects;
- **Provide** research services on public policy issues, or other facilities, for institutions, corporations, agencies and individuals, including departments and agencies of Canadian governments at the federal, provincial, regional and municipal levels, on such terms as may be mutually agreed, provided that the research is in furtherance of these objects.

Table of Contents

2 Executive Summary

7 Sommaire

13 Introduction

13 State of Government Finances

20 State of Canada's Healthcare System

36 Welfare Reform: Lessons from the 1990s for Healthcare Today

49 Implications for Healthcare Reform and Recommendations

The author of this document has worked independently and is solely responsible for the views presented here. The opinions are not necessarily those of the Macdonald-Laurier Institute, its Directors or Supporters.

Executive Summary

Canada faces a twin crisis in the form of both short and longer-term deficits coupled with a faltering healthcare system that continues to consume increasing government resources. The First Ministers will meet later this fall to begin the negotiations for renewal of the Canada Health Accord, which expires in 2014. The Canada Health Accord governs the federal transfer payment to the provinces (and territories) in support of healthcare. The federal government has an opportunity to begin the process of meaningful reform to Canada's healthcare system.

Canada faces a twin crisis of both short and longer-term deficits coupled with a faltering healthcare system.

State of Government Finances

Government finances were adversely affected, as were most industrialized countries due to the financial crisis of 2008, with both the federal and provincial governments experiencing reduced revenues (caused by decline in economic growth) and increases in spending.

The federal government is expected to incur a deficit of a little under $30 billion this year while the provinces, collectively, are expected to tally some $25.3 billion in deficits. While most of the provinces as well as the federal government are expected to return to balanced budgets within two to three years, there are worrying signs for provinces like Ontario, which is not expected to return to a balanced budget until 2017-18.

The result of ongoing deficits is the accumulation of debt. Federal debt is expected to peak at $614.5 billion in 2014-15 before beginning to decline again through balanced budgets. Although high in dollar terms, the deficit represents roughly 30 percent of the economy, which is manageable. The debt of most of the provinces gives some cause for concern, particularly when one combines federal and provincial debt. For example, Quebec's provincial debt of $166.1 billion represents a little over half of the provincial economy. Similarly, Ontario's debt of $241.5 billion is approaching 40 percent of the provincial economy. The debt of New Brunswick, Nova Scotia, and Prince Edward Island are all also approaching the 40 percent threshold.

Simply put, the federal government and almost all of the provinces are currently facing deficits and rising debt, which requires better control of government spending. Even if the federal and provincial governments attain a balanced budget in the near term, there is an additional risk of a longer-term deficit due to slower-economic growth in the future (specifically reduced rates of GDP growth due to a slower growing population) coupled with higher spending on healthcare and age-related programs. The implication is that in the longer-term governments face a structural deficit wherein tax rates will have to increase, program spending will be reduced, debt will increase, or some combination of the three options.

State of Canada's Healthcare System

Canada's healthcare system consumes a comparatively high share of national resources but fails to deliver results comparable to other industrialized countries.

Cost of Canadian Healthcare

In terms of the total amount of resources devoted to healthcare, measured as a share of the economy for 2009, the most recent year of comparable data, Canada allocated 11.4 percent of its national economy (GDP) to healthcare. This places Canada 6th along with Switzerland among the 34 OECD countries. The average for the OECD was 9.6 percent. Canada has the highest share of GDP devoted to healthcare when non-universal health countries such as the United States are removed and health spending is adjusted for the age structure of the individual countries.

Canada spent 11.4% of its GDP on healthcare in 2009.

In addition, there is an increasing problem with healthcare spending crowding out other government spending at both the federal and provincial levels. The federal government supports provincial health spending through the Canada Health Transfer. The CHT is expected to increase from a little over $20 billion in 2006-07 to slightly more than $32 billion by 2014-15, an increase of nearly 60 percent in less than a decade. During the same period, total federal program spending (net of the CHT) will increase 34.1 percent. In other words, federal spending on health transfers is increasing at almost twice the rate of all other program spending, which means it is crowding out other federal spending.

Canadian Healthcare Performance

None of the health performance data indicate a level of services commensurate with the resources devoted to healthcare. The following data compares Canada to other industrialized countries in the OECD to assess our comparative performance across a wide range of healthcare indicators.

- Canada ranks 26th in access to physicians, and this is likely an overestimate. In addition, it is more than likely that our access to physicians will decline over the next decade due to inadequate supply coupled with an aging population.
- Canada ranks 16th in access to nurses.
- Adjusted for population, Canada ranks 24th in hospital beds.
- Not surprisingly, given the limited access to health professionals and hospital beds, Canada suffers from wait times for medical services. A longstanding survey of wait times in Canada indicates a worsening trend: in 2010, the latest year for which data was available at the time of writing, the median wait time had increased to 18.2 weeks from 16.1 weeks the year prior.
- Canada's wait times are also long compared to other industrialized countries. A study by the Commonwealth Fund indicated Canada performed the worst among the seven countries analysed. Of the seven questions aimed at wait times, Canada had the worst response in five and the second worst in the remaining two.
- Canada has comparatively middling performance in access to medical technologies. Canada ranked 16th out of 27 participating OECD countries for both access to MRIs and CT scanners.
- Canada ranks marginally better for access to mammograms: 11th of 25 countries.

These performance measures of the healthcare system simply do not comport with the level of resources consumed by the healthcare sector.

Welfare Reform: Lessons from the 1990s for Healthcare Today

Canada suffers from comparatively poor access to health professionals and medical technologies.

In the early 1990s, it was becoming quite clear that Canada (along with countries like the United States) was suffering from increasing and worsening welfare dependency. Welfare dependency reached an almost unimaginable 10.7 percent of the population in 1994, representing 3.1 million Canadians.

The 1995 federal budget implemented fundamental reforms in the federal government. One of the changes introduced was a restructuring (and reduction) of federal transfers to the provinces for social programs. The 1995 budget announced the replacement of both the Canada Assistance Plan (CAP) as well as the Established Program Financing (EPF), which had previously supported social programs on a partial cost-sharing basis with the new Canada Health and Social Transfer (CHST). The new CHST was a block grant with no cost-sharing provisions.

In addition to the elimination of the cost-sharing component and the reduction in the value of the transfer, the federal government also introduced reforms meant to mitigate the changes and realign the incentives the provinces faced in social assistance provision. The new CHST afforded the provinces much greater latitude to experiment and innovate in the design and delivery of welfare and related services. Under the previous cost-sharing arrangements, the federal government imposed national standards for social services in exchange for receiving transfers. Specifically, the federal government required that the provinces provide social assistance to those who demonstrated need while prohibiting work requirements for welfare receipt.

There were a number of common reforms implemented by most, if not all, of the provinces. One common feature of reform was a reduction in benefit levels, particularly for single employable people. There was an increasing understanding that when welfare benefits surpass comparable income available from low-paid work, incentives were created to enter or remain on welfare.

There was also, however, a diverse set of innovations implemented by the provinces. Some of the more unique approaches are highlighted below. Alberta was the first province to undertake broad reform of its welfare programs. The government aimed to change the culture and aim of the ministry from simply processing payments and paperwork to focusing on diverting potential welfare recipients to alternatives such as employment.

British Columbia was one of the last provinces that implemented large-scale reform to do so. In 2001, British Columbia became the first province to limit access to welfare. Specifically, British Columbia limited the use of welfare to a 24-month period in any cumulative 60-month period for employable individuals.

Manitoba introduced transitional programs to aid people moving from welfare to work. A number of targeted pilot programs were introduced across the province tailored to specific groups. For example, the Manitoba Youth Works program was aimed at individuals under the age of 18. The program required participants to either attend school or secure employment.

Ontario`s welfare reforms were probably the most high profile and contentious. The province aggressively implemented administrative changes to tighten eligibility and reduce fraud. In 1998, the Ontario Works program was introduced. Ontario became

the only province with a broad `workfare' program. Three options were available to recipients: employment support (job-search assistance), work experience through mandatory public-sector placements, and employment placement based on wage-subsidies in the private sector. Ontario also transferred funding responsibilities, new cost-sharing agreements, and responsibilities for provincial programs to localities, a critical move resulting in a large-scale decentralization of welfare programs to the municipal level of government.

Like other provinces, Quebec reduced benefit rates, focused more resources on diverting recipients to employment opportunities, and attempted to improve its administration. One innovation was the introduction of liquid-asset exemptions, wherein the province assessed the presence of assets potential recipients could draw on before relying on state assistance.

Newfoundland and Labrador proposed a fairly large-scale reform of all income security programs, including unemployment insurance. The reforms were rejected by the federal government. Nonetheless, Newfoundland and Labrador implemented a number of important changes, including greater focus on employment through the creation of NewfoundJOBS, decentralization to community organizations, and administrative reforms.

Federal reforms to social transfers unleashed a period of provincial innovation and experimentation in welfare.

The provinces were free to pursue different reforms to different extents depending on their own assessment of the needs of their citizens. Some reforms were fairly common across the provinces, including curtailing benefits rates, tightening eligibility rules, enacting administrative and organizational changes, and emphasizing employment alternatives. It`s important to note, however, that even within these generally enacted reforms, quite a bit of variance existed between the provinces.

The results were stunning. The number of Canadians receiving welfare declined from a peak of 3.1 million in 1994 to 1.7 million in 2009, up slightly from 1.6 million in 2008. As a percentage of the population, welfare recipients declined from a peak of 10.7 percent in 1994 to 5.1 percent in 2009.

No Race to the Bottom

An important consideration in the social reforms of the 1990s was the much anticipated "race to the bottom". Many social activists predicted a marked race to the bottom due to the changes in social transfers from the federal government coupled with the removal of national standards.

An important empirical study[1] refuted much of the worry over a race to the bottom in social assistance. The study analysed social assistance expenditures, dependency rates, and social assistance benefit rates over a two decade period that included the federal reforms in 1995 and 1996 to test whether an observed race to the bottom occurred. The study concluded that "virtually nothing in this data suggests that anything of significance took place between 1995 and 1996 when CAP was replaced by the CHST. Certainly, there is no evidence to suggest that this shift precipitated a race to the bottom. The evidence here is clear."

1 Gerard Boychuk. 2006. "Slouching toward the Bottom? Provincial Social Assistance Provision in Canada, 1980-2000." *In Racing to the Bottom? Provincial Interdependence in the Canadian Federation* edited by Kathryn Harrison. Page 178. Vancouver, BC: University of British Columbia (UBC) Press.

Implications for Healthcare Reform and Recommendations

Canada faces both a short- and long-term deficit challenge. One of the explanations, particularly regarding the longer-term deficit, is the continuing rise in healthcare costs. The federal government's commitment to increasing already large transfers to the provinces in support of healthcare may be incompatible with a longer-term balanced budget.

Equally as important, Canada is already a relatively high spending country on healthcare but does not enjoy commensurate healthcare performance. This paper presents a long list of international measures of Canada's performance, which simply does not match up with the amount of resources allocated to support healthcare.

The experience of welfare reform in the 1990s provides a template for the process of reforming Canada's healthcare system. In the mid-1990s, Ottawa decentralized the design, regulation, and provision of social assistance to the provinces by reducing the value of the transfer while concurrently eliminating most national standards previously imposed on the provinces for social assistance. These changes realigned the incentives for the provinces to better focus on the nature of the problems incurred by those relying on social assistance and devising ways to solve or help solve those problems. The increased autonomy and flexibility accorded the provinces led to an explosion of innovation and experimentation with different delivery models and administrative mechanisms. In addition, a set of fairly standardized reforms were also pursued across most provinces without any prescriptive direction from the federal government. The results were overwhelmingly positive in terms of reducing dependency rates, reintegrating large portions of the dependent community back into the labour force, and reducing government spending.

Welfare reform in the 1990s provides a template for healthcare reform today.

The experience of welfare reform at the federal and provincial levels provides a clear framework for starting the process of healthcare reform in Canada.

1. The Canada Health Transfer (CHT) should be stabilized or even reduced, and certainly not increased, in order to bring more direct accountability to the provincial level for the raising of resources used in healthcare while containing cost increases to the federal government.
2. The federal government should allow the provinces the maximum amount of flexibility to design, regulate, and provide healthcare to citizens within a universal and portable framework.
3. The Canada Health Act will have to be amended with respect to cost-sharing and extra billing in order to provide the provinces the requisite amount of flexibility while maintaining and safeguarding the principles of universality, portability, and accessibility. Indeed, the federal government could facilitate provincial innovation and experimentation by clarifying the meaning and intent of the five principles of the CHA.

Sommaire

Le Canada est confronté à une double crise sous la forme de déficits budgétaires autant à court qu'à plus long terme et d'un système de santé défaillant qui continue de consommer une portion grandissante des ressources de l'État. Les premiers ministres vont se réunir plus tard cet automne pour entreprendre les négociations sur le renouvellement de l'Accord canadien sur les soins de santé, qui expire en 2014. Cet accord régit les paiements de transfert fédéraux aux provinces (et aux territoires) pour aider au financement des soins de santé. Le gouvernement fédéral a une occasion de lancer un processus significatif de réforme du système de santé canadien.

Le Canada est confronté à une double crise sous la forme de déficits budgétaires autant à court qu'à plus long terme et d'un système de santé défaillant.

L'état des finances publiques

Tout comme cela a été le cas dans la plupart des pays industrialisés, les finances publiques canadiennes ont été lourdement touchées par la crise financière de 2008. Autant le gouvernement fédéral que les gouvernements provinciaux ont subi une baisse de leurs recettes (provoquée par une chute de la croissance économique) et une augmentation de leurs dépenses.

On s'attend à ce que le gouvernement fédéral encoure un déficit d'un peu moins que 30 milliards de dollars cette année, pendant que les provinces accumuleraient collectivement des déficits totalisant 25,3 milliards de dollars. Bien que la plupart des provinces ainsi que le gouvernement fédéral soient sur la voie d'un retour à l'équilibre budgétaire d'ici deux ou trois ans, la situation de certaines provinces comme l'Ontario, où l'on ne s'attend pas à voir de budget équilibré avant 2017-2018, reste préoccupante.

La conséquence de déficits qui se succèdent est l'accumulation de la dette. La dette fédérale devrait atteindre un sommet de 614,5 milliards de dollars en 2014-2015 avant de recommencer à diminuer grâce à des budgets équilibrés. Même s'il s'agit d'un montant imposant en dollars, le déficit représente en gros 30 % de l'économie, ce qui reste raisonnable. La dette de la plupart des provinces est préoccupante, en particulier lorsqu'on additionne les dettes fédérale et provinciale. Par exemple, la dette de 166,1 milliards de dollars du Québec représente un peu plus que la moitié de l'économie provinciale. De même, la dette de 241,5 milliards de dollars de l'Ontario s'approche de 40 % de l'économie de cette province. Les dettes du Nouveau-Brunswick, de la Nouvelle-Écosse et de l'Île-du-Prince-Édouard s'approchent toutes du seuil de 40 %.

En bref, Ottawa et presque toutes les provinces font présentement face à des déficits et à une dette croissante, ce qui nécessite un meilleur contrôle des dépenses publiques. Même si les gouvernements fédéral et provinciaux reviennent à l'équilibre budgétaire à court terme, le risque de déficits à plus long terme demeure présent à cause d'une croissance économique au ralenti (plus précisément, des taux réduits de croissance du PIB dus à une croissance plus lente de la population) accompagnée de dépenses plus élevées pour la santé et d'autres programmes influencés par la

pyramide des âges. Cela signifie que les gouvernements seront confrontés à plus long terme à des déficits structurels et que les impôts devront être haussés, les dépenses de programmes devront être réduites, et la dette augmentera, ou une combinaison quelconque de ces trois options.

L'état du système de santé canadien

Le système de santé canadien consomme une part relativement importante des ressources nationales même s'il ne réussit pas à livrer des résultats comparables à ceux d'autres pays industrialisés.

> Le Canada consacrait 11,4 % de son PIB aux soins de santé en 2009.

Les coûts des soins de santé au Canada

Si l'on mesure la quantité totale de ressources consacrées aux soins de santé en proportion de l'économie, le Canada a alloué en 2009 – la dernière année où des données comparables sont disponibles – 11,4 % de son PIB aux soins de santé. Cela place le Canada au sixième rang, au même niveau que la Suisse, parmi les 34 pays de l'OCDE. La moyenne pour l'OCDE était de 9,6 %. Lorsqu'on exclut les pays comme les États-Unis qui n'ont pas de régime à couverture universelle et qu'on ajuste les dépenses en santé pour tenir compte de la structure d'âge des différents pays, le Canada se retrouve avec la proportion du PIB consacrée à la santé la plus élevée.

De plus, la place de plus en plus grande prises par les dépenses de santé autant au niveau fédéral que provincial a pour effet d'évincer les autres types de dépenses publiques. Le gouvernement fédéral contribue aux dépenses provinciales en santé par l'entremise du Transfert canadien en matière de santé. Le TCS devrait passer d'un peu plus de 20 milliards de dollars en 2006-2007 à un peu plus de 32 milliards de dollars en 2014-2015, ce qui correspond à une augmentation de près de 60 % en moins d'une décennie. Durant la même période, les dépenses de programmes totales du gouvernement fédéral (excluant le TCS) auront augmenté de 34,1 %. En d'autres termes, les montants qu'Ottawa consacre au Transfert en matière de santé augmentent presque deux fois plus vite que toutes les autres dépenses de programmes, ce qui montre bien qu'ils prennent la place d'autres types de dépenses fédérales.

La performance du système de santé canadien

Aucune des données sur la performance du système de santé canadien n'indique un niveau de services proportionnel à la quantité de ressources consacrées aux soins de santé. Les données suivantes comparent le Canada à d'autres pays industrialisés de l'OCDE pour évaluer notre performance sur une gamme variée d'indicateurs.

- Le Canada se classe en 26e place en ce qui a trait à l'accès aux médecins, et ceci est probablement une surestimation. Par ailleurs, il est plus que probable que notre accès aux médecins diminuera au cours de la prochaine décennie compte tenu d'une offre inadéquate dans un contexte de vieillissement de la population.
- Le Canada se retrouve au 16e rang en termes d'accès aux soins infirmiers.
- Lorsqu'on pondère selon la population, le Canada se classe en 24e place pour ce qui est du nombre de lits d'hôpitaux.
- Les temps d'attente pour les services médicaux sont élevés au Canada, ce qui n'est pas surprenant compte tenu de l'accès limité aux professionnels de la santé et aux lits d'hôpitaux. Une enquête sur les temps d'attente au Canada menée depuis plusieurs années indique que la situation se détériore : en 2010,

la dernière année pour laquelle des données sont disponibles au moment d'écrire ces lignes, le temps d'attente médian était passé à 18,2 semaines, contre 16,1 semaines l'année précédente.

- Les temps d'attente au Canada sont également longs si on les compare à ceux d'autres pays industrialisés. Une étude du Commonwealth Fund indique que le Canada affiche la pire performance parmi les sept pays qui ont été comparés. Sur sept questions concernant les temps d'attente, le Canada a obtenu les pires réponses pour cinq d'entre elles et les deuxièmes pires réponses pour les deux autres.
- Le Canada affiche une performance relativement médiocre sur le plan de l'accès aux technologies médicales. Le Canada se classe 16e parmi 27 pays participants de l'OCDE autant pour l'accès aux appareils d'imagerie par résonnance magnétique que pour l'accès aux tomodensitomètres.
- Le Canada obtient une position marginalement supérieure en ce qui a trait à l'accès aux mammographies, soit 11e parmi 25 pays.

Ces mesures de performance du système de santé ne concordent tout simplement pas avec la quantité de ressources consommées par le secteur de la santé.

Les leçons des réformes de l'aide sociale des années 1990 pour le système de santé d'aujourd'hui

Au début des années 1990, il devenait tout à fait clair que le Canada (de même que d'autres pays comme les États-Unis) était touché par des taux de plus en plus élevés de dépendance envers l'aide sociale. La dépendance envers l'aide sociale a atteint le niveau presque inimaginable de 10,7 % de la population en 1994, ce qui correspondait à 3,1 millions de Canadiens.

Les patients canadiens ont un accès comparativement limité aux professionnels de la santé et aux technologies médicales.

Le budget fédéral de 1995 a mis en œuvre une série de réformes fondamentales du fonctionnement du gouvernement fédéral. L'un de ces changements consistait en une restructuration (de même qu'une réduction) des transferts fédéraux aux provinces pour les programmes sociaux. Le budget de 1995 a annoncé le remplacement du Régime d'assistance publique du Canada ainsi que du Financement des programmes établis, qui avaient jusque-là aidé à financer les programmes sociaux sur une base de partage des coûts, par le nouveau Transfert canadien en matière de santé et de programmes sociaux (TCSPS). Le nouveau TCSPS était une subvention globale sans aucune mesure de partage des coûts.

En plus d'éliminer la composante de partage des coûts et de réduire les montants de transfert, le gouvernement fédéral a instauré des réformes visant à minimiser les changements et à réajuster les incitations des provinces lorsqu'elles doivent fournir des allocations d'aide sociale. Le nouveau TCSPS offrait aux provinces beaucoup plus de latitude pour expérimenter et innover sur le plan de la conception et de la fourniture de l'aide sociale et de services connexes. En vertu des dispositions de partage des coûts des précédents programmes, le gouvernement fédéral imposait des normes nationales pour les services sociaux en échange des transferts. De manière plus spécifique, le gouvernement fédéral exigeait des provinces qu'elles fournissent l'aide sociale à ceux qui prouvaient qu'ils en avaient besoin, tout en leur interdisant d'exiger des bénéficiaires qu'ils travaillent pour obtenir l'aide sociale.

La plupart, sinon toutes les provinces, ont alors mis en œuvre une série de réformes similaires. L'une des caractéristiques communes a été la réduction des niveaux d'aide,

en particulier pour les personnes célibataires aptes à l'emploi. Il devenait de plus en plus largement accepté que lorsque les montants d'aide sociale dépassent les revenus qu'il est possible d'obtenir en travaillant à faible salaire, on crée des incitations à se placer et à rester sur l'aide sociale.

Les provinces ont toutefois également mis en place une gamme variée de mesures innovatrices. Certaines des approches les plus distinctes sont énumérées ci-dessous. L'Alberta a été la première province à entreprendre une réforme ambitieuse de son programme d'aide sociale. Le gouvernement cherchait à modifier la culture interne et les objectifs du ministère pour le faire passer d'une agence uniquement préoccupée par le traitement des chèques et de la paperasse à une organisation qui se consacre à détourner les bénéficiaires potentiels de l'aide sociale vers d'autres solutions comme la recherche d'un emploi.

La Colombie-Britannique a été l'une des dernières provinces à mettre en œuvre une réforme à grande échelle visant les mêmes objectifs. En 2001, elle est devenue la première province à limiter l'accès à l'aide sociale. Concrètement, il n'était plus possible pour les personnes aptes à l'emploi en Colombie-Britannique de demeurer sur l'aide sociale pendant plus de 24 mois pour toute période cumulative de 60 mois.

Le Manitoba a instauré des programmes de transition pour aider les gens à passer de l'aide sociale au travail. Un certain nombre de programmes pilotes adaptés à des groupes spécifiques ont été mis en place à travers la province. Par exemple, le programme Manitoba Youth Works visait des jeunes de moins de 18 ans. Le programme exigeait des participants qu'ils retournent à l'école ou qu'ils trouvent un emploi.

Les réformes de l'aide sociale en Ontario ont probablement été celles qui ont reçu le plus d'attention et suscité le plus de controverse. La province a énergiquement instauré des changements administratifs de façon à resserrer l'éligibilité et à contrer la fraude. En 1998, le programme Ontario au travail a été lancé. L'Ontario est devenue la seule province ayant un programme élargi de « workfare » forçant les bénéficiaires à chercher du travail en échange de leur allocation. Ceux-ci avaient trois options : obtenir de l'assistance dans leur recherche d'emploi, obtenir une expérience de travail par l'entremise d'un stage obligatoire dans le secteur public, ou accepter un stage avec un salaire subventionné dans le secteur privé. Le gouvernement ontarien a également transféré les responsabilités de financement, les ententes sur un partage des coûts, de même que les responsabilités pour la gestion des programmes provinciaux aux administrations locales, une décision cruciale qui a entraîné une décentralisation à grande échelle des programmes d'aide sociale vers les gouvernements municipaux.

Comme d'autres provinces, le Québec a réduit le niveau des allocations, concentré plus de ressources sur la recherche d'emploi pour les bénéficiaires et cherché à améliorer sa gestion des programmes. L'une des mesures innovatrices a été la mise en place d'une exemption pour les avoirs liquides, donnant à la province la possibilité d'évaluer la présence de moyens financiers permettant aux bénéficiaires de subvenir à leurs besoins avant de demander l'aide sociale.

Terre-Neuve-et-Labrador a proposé des réformes plutôt ambitieuses de tous les programmes en matière de sécurité du revenu, y compris l'assurance chômage. Ces réformes ont été rejetées par le gouvernement fédéral. Terre-Neuve-et-Labrador a tout de même instauré un certain nombre de changements importants, y compris un accent accru sur la recherche d'emploi par la création du programme

NewfoundJOBS, une décentralisation au profit des organisations communautaires, ainsi que des réformes administratives.

Les provinces étaient libres de mettre en place des réformes différentes avec des portées variées sur la base de leur propre évaluation des besoins de leurs citoyens. Certaines réformes, incluant une diminution des montants d'allocation, un resserrement des règles d'éligibilité, des changements administratifs et organisationnels, ainsi qu'un accent accru sur la recherche d'emploi, ont été largement adoptées par la plupart des provinces. Il est cependant important de noter que même dans le cadre de ces réformes généralement acceptées, on retrouvait des variations assez importantes d'une province à l'autre.

Les résultats ont été renversants. Le nombre de Canadiens bénéficiaires de l'aide sociale est passé d'un sommet de 3,1 millions en 1994 à 1,7 millions en 2009, légèrement en hausse par rapport à 2008 alors qu'ils étaient 1,6 millions. En pourcentage de la population, les bénéficiaires de l'aide sociale sont passés d'un sommet de 10,7 % en 1994 à 5,1 % en 2009.

Pas de nivellement par le bas

L'une des notions largement débattues lors des réformes sociales des années 1990 a été celle du « nivellement par le bas » auquel plusieurs s'attendaient. De nombreux militants pour les droits sociaux ont prédit qu'il surviendrait un nivellement marqué par le bas des programmes suite aux changements dans les transferts sociaux du gouvernement fédéral et au retrait des normes nationales.

Une importante étude empirique[1] a réfuté la plupart de ces inquiétudes. Cette étude a analysé les dépenses reliées à l'aide sociale, les taux de dépendance et les niveaux des montants d'allocation sur une période de deux décennies qui incluait les réformes fédérales de 1995 et 1996, pour voir si l'on pouvait observer un nivellement par le bas des programmes. L'étude a conclu que « pratiquement rien dans les données ne montre que quelque chose de significatif est survenu entre 1995 et 1996 lorsque le Régime d'assistance publique a été remplacé par le TCSPS. Il n'y a certainement rien qui démontre que ce changement a précipité un nivellement par le bas. Les preuves à cet effet sont claires. »

Les réformes des transferts sociaux instaurées par le gouvernement fédéral ont inauguré une période d'innovation et d'expérimentation provinciales dans la gestion de l'aide sociale.

Les leçons à tirer pour réformer les soins de santé et nos recommandations

Le Canada est confronté à un défi à la fois sur le court et le long terme en ce qui a trait à la lutte au déficit. L'une des explications, en particulier pour ce qui est du déficit à long terme, est la montée constante des coûts des soins de santé. L'engagement du gouvernement fédéral à augmenter ses transferts aux provinces déjà imposants pour contribuer au financement de la santé pourrait être incompatible avec l'objectif d'atteindre l'équilibre budgétaire sur le long terme.

De façon tout aussi importante, le Canada est déjà un pays où les dépenses en santé sont relativement élevées, mais qui ne jouit pas d'une performance correspondante du système de santé. La présente étude propose une longue liste de mesures interna-

1 Gerard Boychuk, « Slouching toward the Bottom? Provincial Social Assistance Provision in Canada, 1980-2000 », in *Racing to the Bottom? Provincial Interdependence in the Canadian Federation*, édité par Kathryn Harrison, Vancouver, University of British Columbia (UBC) Press, 2006, p. 178.

tionales de la performance canadienne, qui n'arrive tout simplement pas à la hauteur des ressources qui sont consacrées au système.

L'expérience des réformes de l'aide sociale dans les années 1990 nous fournit un modèle à suivre pour réformer le système de santé. Au milieu des années 1990, Ottawa a décentralisé la conception, la réglementation et la fourniture de l'aide sociale vers les provinces et a réduit les montants de transfert tout en éliminant la plupart des normes nationales qui étaient jusque-là imposées aux provinces. Ces changements ont permis de davantage inciter les provinces à se concentrer sur la nature des problèmes auxquels font face ceux qui ont recourt à l'aide sociale et d'élaborer des façons de solutionner ou d'aider à solutionner ces problèmes. L'autonomie et la flexibilité accrues qu'on a accordées aux provinces ont mené à une explosion d'innovation et d'expérimentation avec différents modèles de fourniture de services et de mécanismes administratifs. De plus, une série de réformes assez standardisées ont été menées dans la plupart des provinces sans que le gouvernement fédéral n'ait à imposer de voie à suivre. Les résultats ont été extrêmement positifs en termes de réduction des taux de dépendance, ce qui a permis de réintégrer une portion substantielle des personnes dépendantes au marché du travail et de réduire les dépenses de l'État.

L'expérience des réformes de l'aide sociale aux niveaux fédéral et provincial fournissent une direction claire pour entreprendre le processus de réforme du système de santé au Canada.

1. Le Transfert canadien en matière de santé (TCS) devrait être stabilisé ou même réduit, mais sûrement pas augmenté, de façon à rendre les gouvernements provinciaux plus directement responsables de l'augmentation des ressources utilisées dans le système de santé, tout en contenant l'augmentation des coûts pour le gouvernement fédéral.
2. Le gouvernement fédéral devrait accorder aux provinces le maximum de flexibilité pour concevoir, réglementer et fournir les soins de santé à leurs citoyens dans un contexte d'universalité et de portabilité des soins.
3. La Loi canadienne de la santé devra être amendée en ce qui a trait au partage des coûts et à la surfacturation de façon à accorder aux provinces la flexibilité nécessaire tout en maintenant et en sauvegardant les principes d'universalité, de portabilité et d'accessibilité. Le gouvernement fédéral devrait d'ailleurs faciliter l'innovation et l'expérimentation par les provinces en clarifiant le sens et l'intention des cinq principes de la loi.

Les réformes de l'aide sociale dans les années 1990 fournissent un modèle pour les réformes du système de santé d'aujourd'hui.

Introduction

The First Ministers will meet later this fall to begin the negotiations for renewal of the Canada Health Accord,[2] which expires in 2014. The Canada Health Accord governs the federal transfer payment to the provinces (and territories) in support of healthcare. The federal government has an opportunity to begin the process of meaningful reform to Canada's healthcare system based on changes to the transfer payment covered by the Canada Health Accord. Such a change would allow for experimentation and innovation at the provincial level in the financing, regulation, and provision of healthcare.

This study focuses on that opportunity, the fiscal environment in which this opportunity presents itself, and the critical lessons Canada should learn from the reforms enacted to social transfers in the 1990s, particularly with respect to welfare and social services. Indeed, the central premise of this paper is that reforms to the social transfer in the 1990s provide a template for current reform of healthcare. Specifically, the paper will first present a discussion of the fiscal environment currently facing the federal government, and to a lesser extent the challenges being faced by the provinces. The paper will then assess the current state of healthcare in Canada in terms of both costs and performance. Next the paper will summarize the reforms made to federal social transfers during the 1990s and the subsequent experimentation and reforms implemented in provincial welfare programs. Finally, the paper will discuss how the social welfare reforms should act as a template for reforming federal healthcare transfers to the provinces.

An opportunity exists for the federal government to genuinely begin a process of healthcare reform.

State of Government Finances

Before discussing the state of Canada's healthcare system, it is important to understand the broader fiscal context within which public funding for healthcare exists. Public healthcare spending, like all government programs, is constrained by the resources available to the government through taxes, fees, and other revenues. This section summarizes the state of federal finances along with expectations for the future.[3] A brief discussion of provincial finances is also presented.

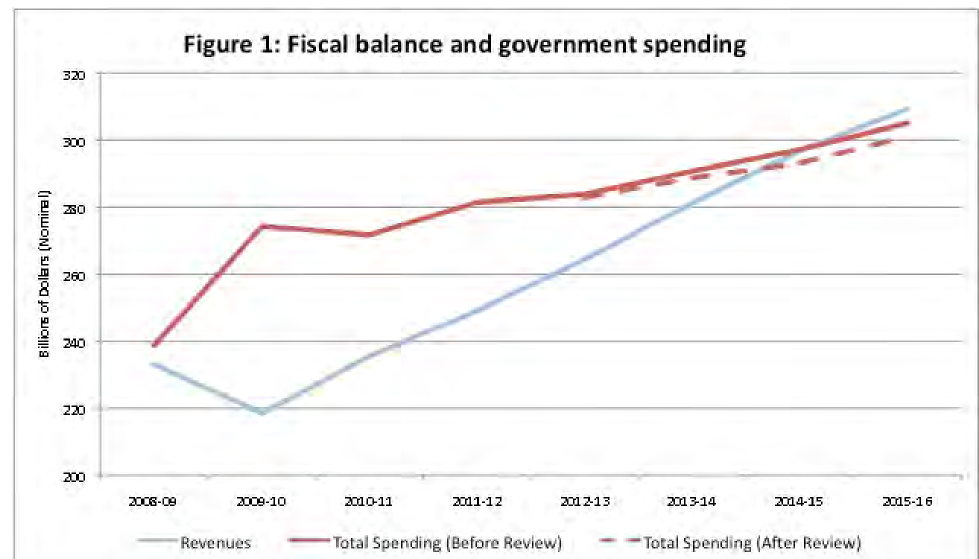
Federal Finances

Like almost every industrial country, Canada's economy suffered during the recent global recession. Government finances were adversely affected by the reduced revenues (caused by decline in economic growth) and increases spending. Figure 1 illustrates federal government spending (both program spending and debt charges) as well as revenues beginning in 2008-09.

2 Through the First Ministers, the federal and provincial governments agreed to an accord in 2003, known as the Canada Health Accord, which constituted a ten-year agreement on federal funding of healthcare to the provinces and territories. See http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php for information and links on the Canada Health Accord.

3 For a more thorough analysis of the federal budget and the effects of healthcare transfers please see: Jason Clemens. 2011. *Turning Point: Balancing the Budget While Confronting Rising Healthcare Costs*. Ottawa, ON: The Macdonald-Laurier Institute.

As depicted in Figure 1, revenues collected by the federal government dropped by $14.5 billion between 2008-09 and 2009-10. Total spending by the federal government increased by $35.4 billion, from $238.8 billion to $274.2 billion (Figure 1) during the same period.[4] The combination of increased spending and lower revenues resulted in a $55.6 billion deficit in 2009-10, representing 3.6 percent of GDP (Figure 2).



Sources:

Department of Finance, Canada (2010), Fiscal and Economic Update 2010;

Department of Finance, Canada (2011), Budget 2011 (June);

There are two spending paths depicted in Figure 1 beginning in 2012-13. The higher level of spending illustrated by the solid line is the current planned program spending and debt charges by the federal government. Under this plan, total government spending will reach $305 billion in 2015-16, the year in which the deficit is expected to be eliminated.

The Conservatives announced a review of strategic and operating spending during the 2011 election campaign, which was formalized in the June 2011 budget.[5] The path of total spending under this revised plan is depicted in Figure 1 with a dashed line.

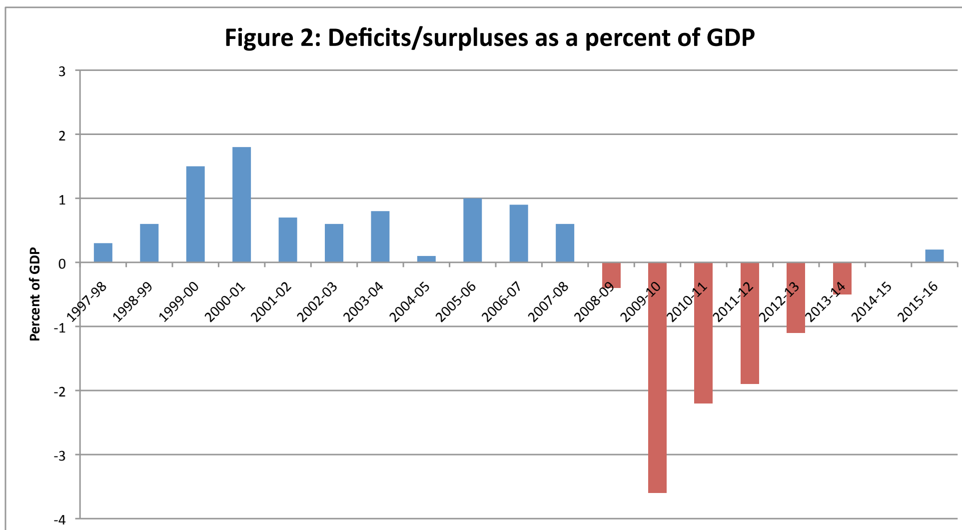
The federal government implemented the strategic and operating review of spending with a specific goal of reaching $4-billion in savings by 2014-15.[6] Beginning in 2012-

4 Some of the increase in spending is explained by programs such as Employment Insurance, which automatically increase in times of economic difficulty—specifically times of higher unemployment. The bulk of the increase, however, is explained by discretionary spending increases initiated by the federal government in an attempt to combat the recession. For information on the 2009-10 stimulus plan please see the 2009 budget, available at http://www.budget.gc.ca/2009/pdf/budget-planbugetaire-eng.pdf. In particular, Table 1.2 provides a broad overview of the stimulus plan and Tables 3.5, 3.6, 3.7, and 3.8 provide summaries of different components of the stimulus program. In addition, Chapter 3 of the budget contains both financial and operational details regarding the stimulus plan.

5 For summary information on the strategic and operating review please see Table 5.2 in Budget 2011 (June), which is available at http://www.budget.gc.ca/2011/home-accueil-eng.html.

6 While the introduction of a spending review to identify and secure savings is a positive step in federal fiscal policy, it falls short on several counts. First, while the program identifies a total for savings, the details of the savings have not yet materialized. Second, the goal is to achieve savings in the future rather than immediately. Third, the review only looks at direct federal spending and therefore excludes transfers to individuals, businesses, and the provinces and territories. And fourth, the overall approach of the government to balance the budget still relies on slowing the growth of spending while hoping that revenues catch up. For more information on the government's approach to balancing the budget please see For a more thorough

13, the plan projects savings of $1 billion rising to $2 billion in 2013-14 before reaching a permanent level of savings of $4 billion in 2014-15. The savings would result in a balanced budget one year sooner (2014-15) than the formal budget plan.[7]



Note: The deficit/surplus figures for 2012-13 to 2015-16 reflect the savings planned from the operational and strategic review.
Sources:
Department of Finance, Canada (2011), Fiscal Reference Tables (Accessed July 2011); and
Department of Finance, Canada (2011), Budget 2011 (June).

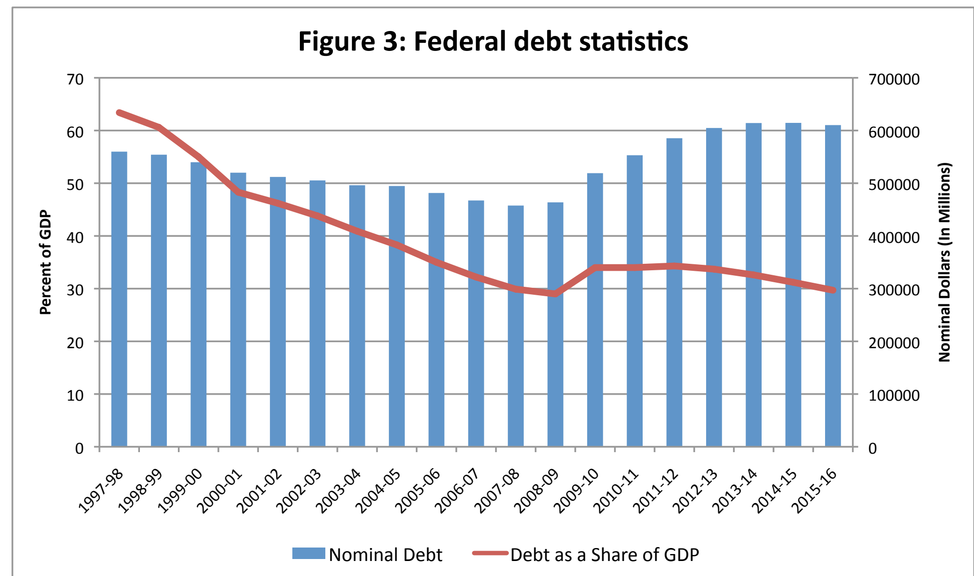
The combination of lower revenues and higher spending resulted in a marked move from consistent surpluses to persistent deficits. Figure 2 illustrates the size of the deficits as a share of the economy, starting in 1997-98 when the federal government recorded the first of its many post-1995 budget surpluses through the final year of the current budget plan (2015-16). As depicted in Figure 2, the federal government expects to record a negligible surplus in 2014-15.

The deficits noted in Figure 2, which start in 2008-09 and are expected to continue until 2014-15, translate into a higher national debt. Annual deficits simply refer to borrowing by the government in a year when spending outstrips revenues. Such deficits accumulate and constitute the national debt. Figure 3 illustrates the nominal value of federal debt as well as its value compared to the size of the economy (GDP).

Except for Saskatchewan, the federal government and all the provinces are struggling, to varying degrees, with deficits and debt.

analysis of the federal budget and the effects of healthcare transfers please see: Jason Clemens. 2011. *Turning Point: Balancing the Budget While Confronting Rising Healthcare Costs*. Ottawa, ON: The Macdonald-Laurier Institute.

7 There are a number of risks to the government's current plan, which relies on slowing the growth in spending, assuming interest rates remain low, and hoping that revenues rebound sufficiently to catch up with spending over the next three years. Any deviation in these assumptions, including higher than expected growth in spending, slowly growing revenues, and/or higher than anticipated interest costs would result in higher deficits and a longer period to achieve a balanced budget. Given the slowing US economy and ongoing turmoil in Europe, it is likely that the government's expectations for revenues and spending are already behind schedule. An example of this slowing in economic activity has already emerged. The report on second quarter GDP (value of all goods and services produced in the country) indicated a 0.1 percent decline in economic activity in the second quarter of 2011 compared to the first quarter. For further information please see: www.statcan.gc.ca/daily-quotidien/110831/dq110831a-eng.htm.



Notes:

The specific measure used for the federal debt is the accumulated deficit. Please see Table 15, Gross and Net Debt in the Fiscal Reference Tables.

Sources:

Department of Finance, Canada (2011), Fiscal Reference Tables (Accessed July 2011), Tables 2 and 15 and

Department of Finance, Canada (2011), Budget 2011 (June).

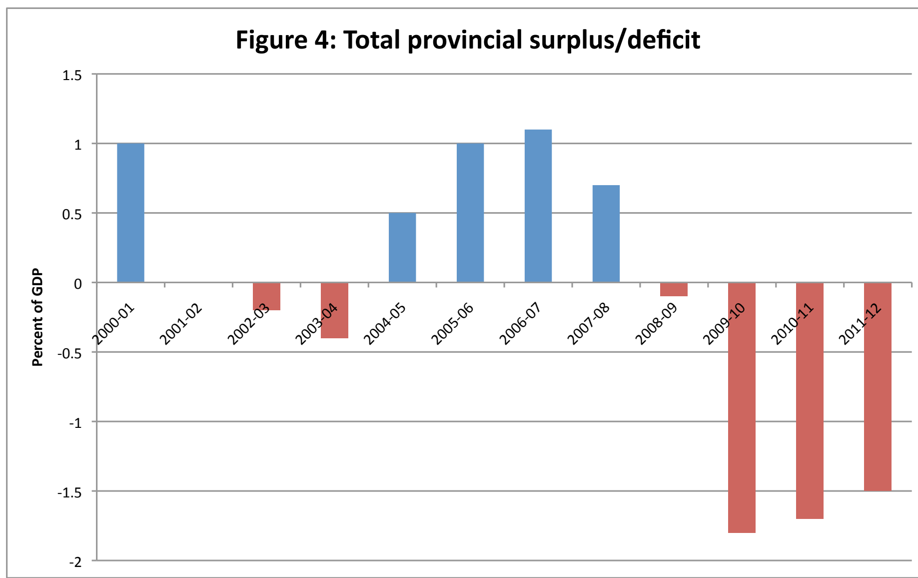
Both the nominal value of federal debt as well as the size of the national debt as a share of the economy were on a steady downward path until 2008-09. Since 2008-09 when the recession began to develop, almost $100 billion in debt (nominal) has been accumulated (Figure 3). According to the government's current plan an additional $58.1 billion will be incurred until 2014-15 when the budget returns to a surplus. Figure 3 shows a slight decline in the nominal value of the national debt beginning in 2015-16.

Thankfully the national debt as a share of the economy has not exploded like in other countries, notably the United States.[8] The national debt as a percent of GDP increased from 29 percent in 2008-09 to 34 percent in 2009-10 (Figure 3). It increased slightly in 2011-12 (34.3 percent) but is expected to begin declining next year (2012-13). The reason for the decline in the national debt as a share of the economy when its nominal value is still increasing is that the government expects the economy to grow faster than the increase in the debt.

8 The latest estimate by the Congressional Budget Office for federal debt held by the public, which is a narrow measure of federal debt in the United States, is that it will reach 71.2 percent this coming fiscal year (2012). See Congressional Budget Office. 2011. *The Budget and Economic Outlook: An Update.* (August 2011). Washington, D.C.: CBO. Table 1. Available at www.cbo.gov/ftpdocs/123xx/doc12316/08-24-BudgetEconUpdate.pdf; See also the summary of the CBO's recent congressional testimony at www.cbo.gov/ftpdocs/124xx/doc12419/CBO_Presentation_to_Macroeconomic_Advisers_9-14-11_Final.pdf.

Provincial Finances

Although the focus of this paper is federal policy, it is nonetheless important to recognize that the provinces face similar fiscal constraints as the federal government. Figure 4 illustrates the total or collective budget balances (surplus or deficit) as a percent of GDP for all the provinces beginning in 2000-01 through to 2011-12, the current fiscal year. There is a clear, pronounced move to deficits beginning in 2008-09, which markedly worsens in 2009-10. While some improvements are noted, there is still a collective deficit for the provinces in 2011-12, which is expected to continue for the next few years.



Notes:

The totals include surplus and deficit figures for the Canadian territories.

Data up to 2009-10 is taken from the Department of Finances' *Fiscal Reference Tables*; the forecasts for 2010-11 and 2011-12 are taken from TD Economics' *Overview of the 2011-12 Government Budget Season*.

Sources:

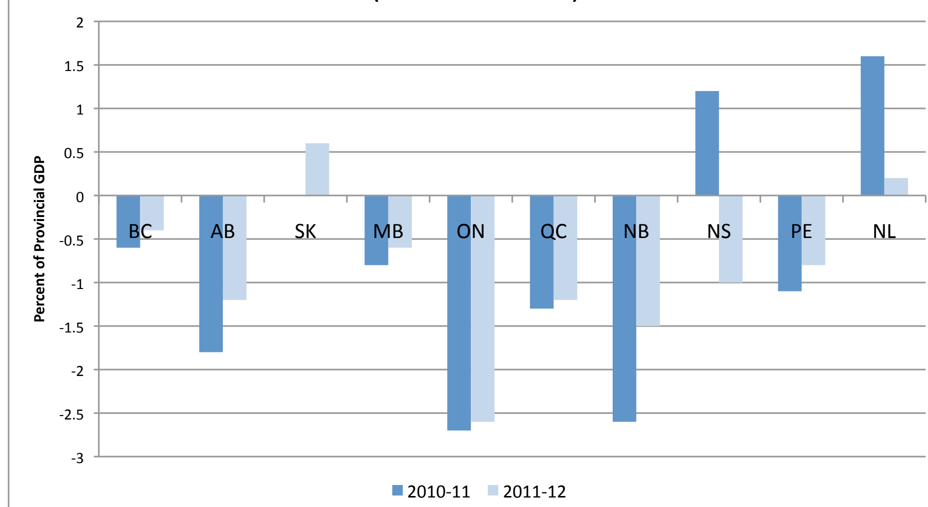
Government of Canada, Department of Finance. (2011). *Fiscal Reference Tables*. Table 31: All Provinces and Territories (Per cent of GDP). Accessed on September 15, 2011. Available at http://www.fin.gc.ca/frt-trf/2010/frt-trf-1005-eng.asp#tbl31.

TD Economics (2011). Overview of the 2011-12 Government Budget Season. (May 25, 2011). Toronto, ON: TD Bank Financial Group. Available at www.td.com/document/PDF/economics/budgets/td-economics-sg0511-budget-reviews.pdf.

Figure 5 provides additional information on provincial fiscal balances by looking at each individual province for last year (2010-11) as well as the current fiscal year (2011-12). Several aspects of Figure 5 are worth noting. First, Saskatchewan is the only province to be consistently in balance or surplus.[9] Second, most of the provinces are improving but none (excluding SK) expect to reach a stable balance within the next two years (see Table 1). Third, the data for British Columbia is likely optimistic given the recent deterioration in the province's deficit.[10] Finally, particular attention should be paid to Alberta, Ontario, Quebec, and New Brunswick given the comparative size of their deficits. It is additionally disconcerting that three of the country's largest provinces (Ontario, Quebec, and Alberta) are facing relatively difficult fiscal situations.

9 Note that while Newfoundland and Labrador are in surplus for both years covered in Figure 5, they expect to return to deficit next fiscal year (2012-13). See http://www.budget.gov.nl.ca/budget2011/estimates/default.htm for more information on the Newfoundland and Labrador budget.

10 In voting down the HST reform, British Columbia will have to return a $1.6 billion payment from the federal government to assist in the tax transition. The reversal of this payment will worsen the province's fiscal position for the current fiscal year and potentially 2012-13.



Source: TD Economics (2011). Overview of the 2011-12 Government Budget Season. Special Report, May 25, 2011. TD Economics. Available at http://www.td.com/economics/special/sg0511_budget_review.pdf.

Table 1: Expected Year of Deficit Elimination

Province	Year
Saskatchewan	N/A
British Columbia	2013-14
Alberta	2013-14
Nova Scotia	2013-14
Quebec	2013-14
Prince Edward Island	2014-15
Manitoba	2014-15
New Brunswick*	2014-15
Newfoundland and Labrador*	2014-15
Federal Government	2014-15
Ontario	2017-18

Notes:

* Please note that the TD Bank Report from which this table was copied categorized NB and NL as N/A based on their surpluses (2010-11). The authors chose to include the 2014-15 date of deficit elimination for both provinces based on their recent budgets.

To obtain the New Brunswick budget for 2011-12 see http://www.gnb.ca/0024/index-e.asp; to obtain the 2011-12 budget for Newfoundland and Labrador see http://www.budget.gov.nl.ca/budget2011/default.htm.

Source:

TD Economics (2011). *Overview of the 2011-12 Government Budget Season*. Special Report, May 25, 2011. TD Economics. Available at http://www.td.com/economics/special/sg0511_budget_review.pdf.

Government of New Brunswick, Department of Finance (2011). Budget 2011-12. Available at http://www.gnb.ca/0024/index-e.asp.

Government of Newfoundland and Labrador, Department of Finance (2011). Standing Strong: Budget 2011-12. Available at http://www.budget.gov.nl.ca/budget2011/default.htm.

A sleeping giant in the form of an aging population threatens the long-term finances of governments.

Table 1 delineates the expected year in which the federal and provincial governments will reach a balanced budget and eliminate their current deficit. As indicated in Table 1, most of the provinces as well as the federal government currently expect to balance their budgets by 2013-14 or 2014-15. Ontario stands alone in terms of its extended timeline to balance its budget in 2017-18.

Clearly the provinces, like the federal government, are constrained in their fiscal options. Almost all of the provinces are struggling with budget deficits and rising provincial debt. These fiscal pressures will continue for the next few years at a minimum.

Some Long-Term Considerations

The federal government has introduced a plan to eliminate the deficit by 2014-15. The federal government has committed to both remain in balance, which means a declining national debt (both in nominal terms as well as compared to the economy), and to tax relief in the future.

There is, however, a long-term issue of fiscal balance that needs to be considered. The Macdonald-Laurier Institute recently published a paper by McGill economics professor Christopher Ragan examining the longer-term pressures on federal and provincial finances represented by an aging population.[11] Ragan's conclusion is that government finances will face a gap of 4 percentage points of GDP by 2040. This gap is the result of a slower-growth economy (specifically reduced rates of GDP growth due to a slower growing population) coupled with higher spending on healthcare and age-related programs.

The implication of such analysis, which has been buttressed by other reports,[12] is that in the longer-term the government faces a structural deficit wherein tax rates will have to be increased, program spending reduced, debt increased, or some combination of the three options. This longer-term pressure on government finances is important to recognize as we review the state of Canada's healthcare system and options available for reform.

Summary

The finances of the federal government and its provincial counterparts are constrained. Almost every government in Canada is struggling to manage the growth in spending in order to achieve a balanced budget within the next few years. This means that governments across the country will be inhibited in their ability to throw more money at healthcare. This constraint, along with the renegotiation of the Canada Health Accord, set the stage for possible reforms aimed at genuinely improving the Canadian healthcare system while simultaneously getting better control of tax-funded healthcare costs.

11 Christopher Ragan. 2011. *Canada's Looming Fiscal Squeeze*. Ottawa, ON: The Macdonald-Laurier Institute. Available at www.macdonaldlaurier.ca.

12 For an example, see: William Robson. 2010. *The Glacier Grinds Closer: How Demographics Will Change Canada's Fiscal Landscape*. Toronto, ON: The C.D. Howe Institute. E-Brief, September. Available at http://www.cdhowe.org/pdf/ebrief_106_Robson.pdf.

State of Canada's Healthcare System

It is first important to differentiate between the state of Canada's healthcare system and the health status of Canadians. These two distinct concepts are too often conflated with one another. The healthcare system refers to the many institutions and participants, such as hospitals, health clinics, doctors, nurses, etc., that provide healthcare services to Canadians as well as the resources used to finance these services. This section of the study is divided into two parts. The first focuses on the cost side of healthcare in Canada, both in an absolute sense as well as comparatively. It begins with a discussion of healthcare spending by Canadian governments in order to highlight the increasingly unsustainable path of public healthcare spending, particularly spending by the federal government in the form of transfers to the provinces. Next, the section examines the comparative performance of Canada's healthcare system to other industrialized countries.[13]

Cost of Canadian Healthcare

Two distinct approaches will be presented in this section regarding the cost of Canadian healthcare. The first looks at government spending and the sustainability of healthcare spending over time. The second approach examines Canadian spending on healthcare compared to other industrialized countries. The aim of this section is to provide readers with a sense of the resources expended in Canada to support healthcare.

Government Healthcare Spending

Healthcare is a provincial responsibility in Canada, however, the federal government provides considerable resources to the provinces (and territories) to support healthcare. The Canada Health Transfer[14] is a federal transfer program that provides the provinces with resources earmarked for healthcare.[15]

The Canada Health Transfer (CHT), which is our primary focus in the study in terms of federal funding of healthcare to the provinces, is growing at rates that will be difficult to sustain over time.[16] Figure 6 illustrates the actual, nominal value of the Canada Health Transfer (CHT) for the past five years, as well as the expected value of the CHT for the next few years.[17] The CHT is expected to increase from a little over $20 billion in 2006-07 to slightly more than $32 billion by 2014-15, an increase of nearly 60 percent in less than a decade.

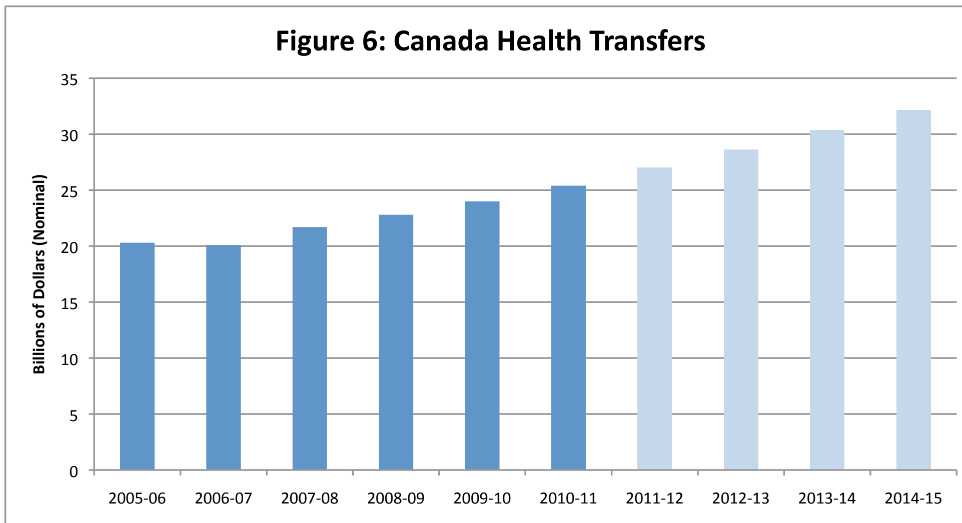
13 Throughout this paper we refer to industrialized countries, which for our purposes include the 34 member countries of the Organization for Economic Cooperation and Development (OECD). For information on the OECD please see www.OECD.org.

14 For a brief summary of the CHT see http://www.fin.gc.ca/fedprov/cht-eng.asp; for a brief history of the CHT as well as the social transfer see http://www.fin.gc.ca/fedprov/his-eng.asp.

15 The federal government provides additional resources to the provinces and territories for healthcare. For example, the Wait Times Transfer currently provides $250 million to the provinces annually. Since 2005-06, it has provided a cumulative $4.4 billion in funding. For further information see http://www.fin.gc.ca/fedprov/mtp-eng.asp.

16 For an excellent discussion of the fiscal pressures being placed on government finances by healthcare as well as the policy options available please see: David Dodge and Richard Dion. 2011. *Chronic Healthcare Spending Disease: A Macro Diagnosis and Prognosis*. Toronto, ON: The C.D. Howe Institute. Available at http://www.cdhowe.org/pdf/Commentary_327.pdf.

17 Please note that the specific values of the CHT after 2011-12 were calculated based on a 6 percent annual increase, which the Minister of Finance has already committed to for the next two years. Precise numbers for CHT payments are only available up to 2011-12. Future CHT payments are combined with the Canada Social Transfer (CST) to form the Canada Health and Social Transfer (CHST), which is specified in the federal budget.



Notes:

CHT payments for 2012-13 and beyond were calculated based on a 6% escalator in previous year funding. Please note that the budget does not break out CHT and CST payments specifically.

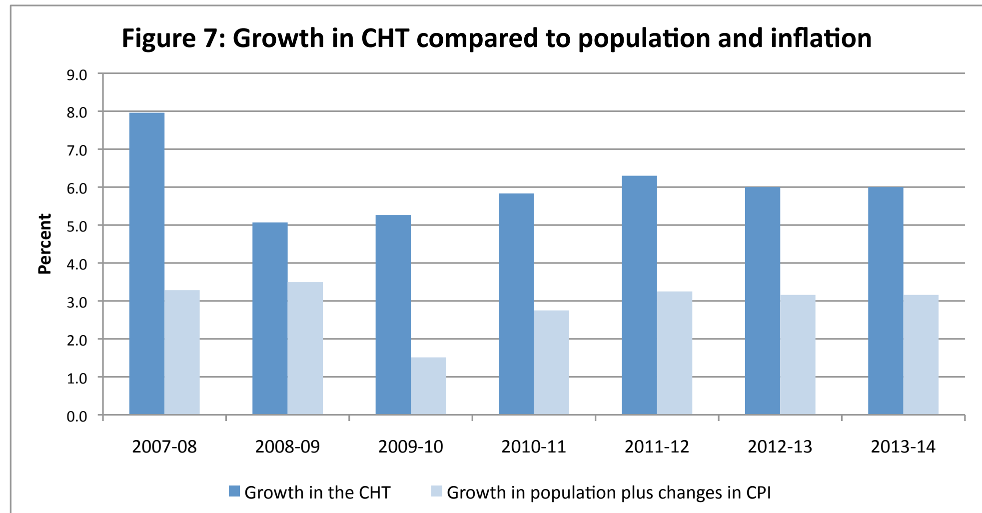
Sources:

Department of Finance, Canada (2011). Federal Support to Provinces and Territories (May 2011 Update). Available at www.fin.gc.ca/fedprov/mtg-eng.asp.

Department of Finance, Canada (2011), Budget 2011 (June);

Figure 6 presents the nominal change in the value of the CHT over the last few years as well as the expectations for the future. It is instructive to compare the growth in the CHT against the change in population and inflation during the same period. Such a comparison indicates whether or not the per person value of the CHT (adjusted for changes in prices) increased, decreased, or remained constant. Figure 7 presents such a comparison. As you can see, in every year in this period the CHT increased at a rate well above the rate of population growth and inflation. Indeed, in one year, 2009-10, the CHT grew by a factor of more than three times the rate of population growth and inflation. Put simply, real per person spending on healthcare transfers by the federal government is increasing dramatically.

The CHT increased by almost 60% in less than a decade.



Note:

Data for 2010-11 to 2015-16 are based on the federal government's most recent forecast and projections for the future.

Sources:

Department of Finance, Canada (2011), Budget 2011 (June);

Department of Finance, Canada (2010), Fiscal Reference Tables (October);

Department of Finance, Canada (2010), Public Accounts 2010;

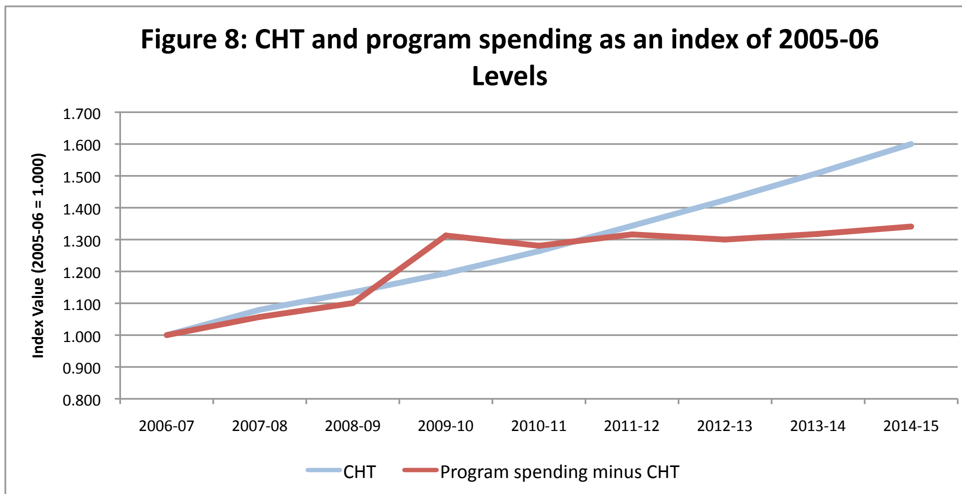
Department of Finance, Canada (2010), Update of Economic and Fiscal Projections (October);

Statistics Canada, Estimates of Population. (Table 051-001).

With Calculations by the author.

Note: population growth was forecasted at 10-year average of 1.06% growth rate.

Another way to think about the growth in federal payments to the provinces to support healthcare spending is to consider the total growth in CHT payments compared to the growth in total program spending minus the value of the CHT. Figure 8 compares the growth in the CHT against the growth in all other program spending by the federal government beginning in 2006-07. From the base year of 2006-07, CHT payments will increase by 60 percent, compared to an increase in total program spending (net of the CHT) of 34.1 percent. That means that federal spending on health transfers is increasing at almost twice the rate of all other program spending.



Notes:

CHT payments for 2012-13 an beyond were calculated based on a 6% escalator in previous year funding. Please note that the budget does not break out CHT and CST payments specifically.

Total CHST payments for 2012-13 and beyond were taken from the 2011 Budget.

Program spending is adjusted to remove the CHT. In other words, the measure of program spending is net of the CHT.

Sources:

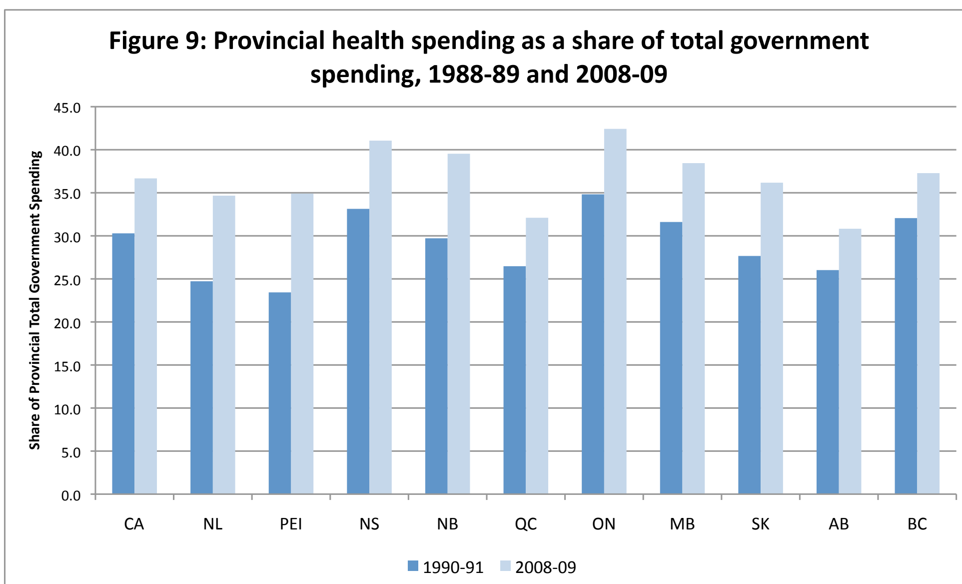
Department of Finance, Canada (2011). Federal Support to Provinces and Territories (May 2011 Update). Available at www.fin.gc.ca/fedprov/mtg-eng.asp.

Department of Finance, Canada (2011), Budget 2011 (June);

Department of Finance, Canada (2011), Fiscal Reference Tables, Table 7. Available at www.fin.gc.ca/frt-trf/2010/frt-trf-1002-eng.asp#tbl7; accessed on July 26, 2011.

Healthcare spending is increasingly crowding-out other government spending.

To understand the impact of relatively high rates of growth in health transfers compared to all other federal spending, one only has to observe provincial spending. Figure 9 illustrates the share of provincial spending, not including interest payments, devoted to healthcare in 1988-89 and 2008-09. (2008-09 is used as the final year of comparison because the data used to calculate this series is no longer available from Statistics Canada.)



Source: Statistics Canada (2010), CANSIM Table 385-0002; calculations by authors.

In every province, the share of total spending devoted to healthcare spending has increased over the time period covered. The share of total spending consumed by healthcare is now over 40 percent in two provinces (Ontario and Nova Scotia) and quickly approaching 40 percent in another four provinces (New Brunswick, Manitoba, Saskatchewan, and British Columbia).

In every province the share of resources collected by the province in the form of transfers, taxes, and fees has increasingly been allocated to fund healthcare. In the absence of additional borrowing or increases in taxes, the result of these disproportionate increases in healthcare spending is that it is crowding out other spending, particularly in critical areas such as K-12 education, infrastructure, transportation, and justice.

The disproportionate increases in healthcare transfers by the federal government to the provinces—recall that health transfers are growing at 60 percent while all other program spending is growing at a little more than half that rate—means that other federal spending continues to be crowded out, whether on defense, transportation, national security, or other vital areas of federal jurisdiction.

Canada spends 11.4 percent of our economy on healthcare, ranking us 6th in the OECD.

International Comparisons

There are a number of ways to compare the cost of healthcare between industrialized countries.[18] This study compares the share of each country's economy dedicated to healthcare based on data provided by the OECD.[19] Figure 10 depicts the share of national economies consumed by healthcare for the OECD countries. Canada devoted 11.4 percent of its national economy to healthcare in 2009.[20] This ranks Canada 6th along with Switzerland[21] among the 34 OECD countries.[22] The average for the OECD was 9.6 percent.

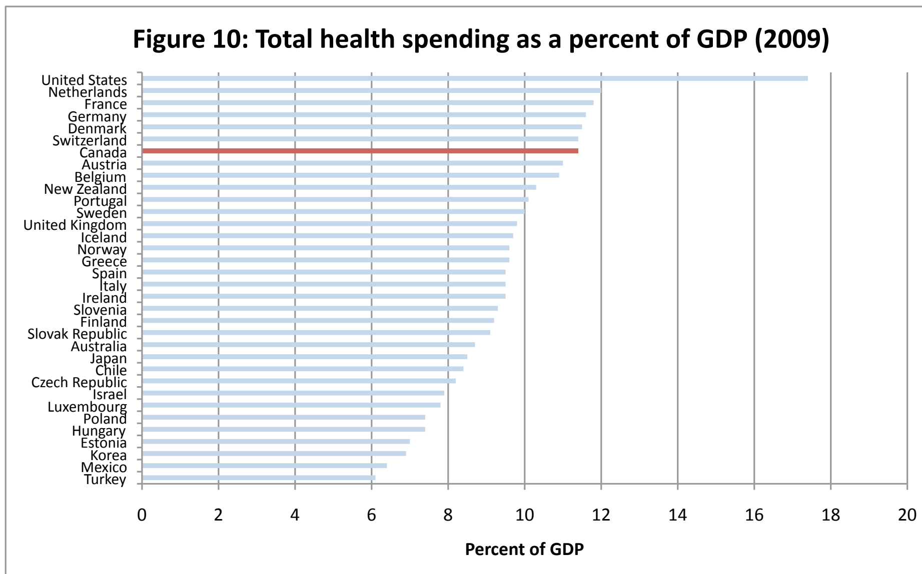
18 Per capita spending on healthcare is an alternative approach to compare spending between countries. In 2009, the latest year for which comparable data is available, Canada ranked 6th with per capita spending on healthcare totalling US$4,363 (PPP). The OECD average was US$3,223. While the results are similiar in terms of rankings, this approach is generally seen as a less accurate method by which to compare international spending. See: OECD. 2010. *OECD Health Data 2011: How Does Canada Compare*. Paris, France: OECD. Available at http://www.oecd.org/dataoecd/46/33/38979719.pdf.

19 The OECD maintains a dedicated project to compiling and comparing healthcare statistics in its member countries. See OECD. 2011. *OECD Health Data 2011*. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html; please note that the OECD maintains a data portal for frequently requested health indicators at http://www.oecd.org/document/16/0,3746,en_2649_37407_2085200_1_1_1_37407,00.html. Its Health Data 2011 publication is available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

20 Canada is one of several countries that reports data for 2010 in the recent OECD Health Data 2011 publication. However, the majority of countries report 2009 data. Thus for consistency and comparability purposes, data for 2009 is used for all countries. Canada's share of GDP consumed by healthcare spending in 2010 was 11.3 percent, down slightly from the 11.4 percent reported in 2009.

21 It's worth noting, however, that the United States ranks first with 17.4 percent of its economy dedicated to healthcare but does not provide universal coverage. Thus, Canada devotes the 5th highest level of national resources to healthcare among the OECD universal healthcare countries.

22 There are two important adjustments that can be made to the data presented in Figure 10 to more accurately illustrate the comparative shares of GDP devoted to healthcare. First, one of the primary drivers of healthcare spending is the age of the population. All else held equal, the older a society, in comparative terms, the higher the level of GDP consumed by healthcare. The reason is that a disproportionate share of healthcare spending occurs in the later stages of life. Adjusting the composition of the age structure of each country so that they are comparable presents a more realistic assessment of each country's healthcare spending relative to the size of their economy. Second, the data presented in Figure 10 includes non-universal healthcare countries, notably the United States. If such age-adjustments are made and non-universal healthcare OECD countries removed, Canada has the *highest* share of GDP consumed by healthcare spending among the universal healthcare countries. Specifically, on an age-adjusted basis, Canada allocates 12.3 percent of GDP to healthcare. For further information and explanation of these changes, see: Nadeem



Notes:

Data for Australia, Japan, Portugal, and Turkey are for 2008.

Data for Greece is for 2007.

Data for 2010 was available for Canada, Finland, Iceland, Italy, Korea, Switzerland, and Mexico but 2009 data was used for consistency.

Source:

Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

Summary

Crowding out of other spending by the provincial and federal governments is occurring now in order to accommodate ever-increasing funding demands of public healthcare. It doesn't seem to be a stretch to conclude that such increases in both provincial direct spending and federal transfers cannot be sustained.[23] In comparative terms, Canada devotes a fairly high share of its economy to healthcare. The real question, however, is how Canada's healthcare system performs relative to the other OECD countries. A bargain where a high degree of national resources are allocated to healthcare but where performance is equally is high is a markedly different deal than a situation in which performance lags. The following section examines a host of performance measures to assess Canadian performance.

Canadian Healthcare Performance

This section examines a host of healthcare indicators to assess the performance of Canada's healthcare system. All of the indicators measure performance within the healthcare system, including hospitals and doctors.

Esmail and Michael Walker. 2008. *How Good is Canadian Health Care? 2008 Report*. Vancouver, B.C.: The Fraser Institute. Available at http://www.fraserinstitute.org/research-news/display.aspx?id=13104.

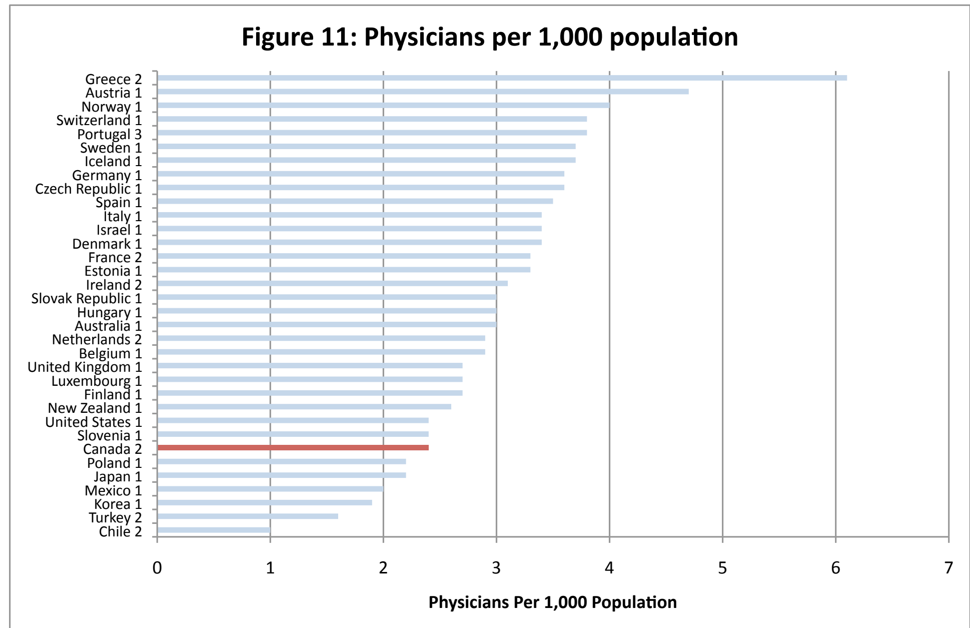
23 For an excellent discussion of this phenomenon and the policy options available to us see: David A. Dodge and Richard Dion. 2011. *Chronic Healthcare Spending Disease: A Macro Diagnosis and Prognosis*. Toronto, ON: The C.D. Howe Institute. The Health Papers. Available at http://cdhowe.org/chronic-healthcare-spending-disease-a-macro-diagnosis-and-prognosis/9268.

Canada ranks 26th in the OECD for access to doctors.

Health Professionals: Doctors and Nurses

Two measures are employed to gauge Canada's relative performance in the area of access to health professions: access to doctors and nurses. Specifically, the study examines physician- and nurse-to-population ratios and compares them with other OECD countries.

Figure 11 illustrates the physician-to-population ratios for the 34 OECD countries.[24] The range of physician-to-population ratios ranges from a high of 6.1 (per 1,000 people) in Greece to 1.0 in Chile. Canada's 2.4 ratio of physicians-to-population ranks 26th (tied) out of the 34 OECD countries.



Notes:

#1 - Data refer to professionally active physicians. They include practising physicians plus other physicians working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).

#2 - Data refer to all physicians who are licensed to practice.

Data for all other countries refer to practising physicians. Practising physicians are defined as those providing care directly to patients.

Data for Australia, Chile, Denmark, Finland, Japan, Netherlands, and Sweden are for 2008.

Data for Slovak Republic is for 2007.

Data for 2010 was available for Austria, France, Iceland, Ireland, Israel, Korea, New Zealand, Portugal, Spain, and the United Kingdom but 2009 data was used for consistency.

Source:

Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

An important caveat to the OECD data is that like a few other countries, Canada includes not only active physicians but also other physicians working in the health-care sector such as educators and researchers who are not involved directly with patient care. The OECD estimates that the inclusion of these additional physicians in the count adds between 5 and 10 percent to the total physician count.[25] In other

24 Access to physicians has consistently been shown to be an important component of a functioning and effective healthcare system. For example, see: Zeynep Or. 2001. "Exploring the Effects of Health Care on Mortality across OECD Countries." *Labour Market and Social Policy*, Occasional Papers No. 46. Paris, France: OECD.

25 OECD. 2011. *OECD Health Data 2011*. See footnote 2 in Health Care Resources: Physicians, Density Per 1,000 Population. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

words, if Canada measured our physicians like most other countries, which include only practicing physicians providing direct care to patients, our physician-to-population ratio would be even lower than depicted in Figure 11.

Our access to physicians is likely to worsen over the next decade.

Canada's poor comparative performance on the number of physicians compared to the size of the population is corroborated by Canada's Ministry of Health report, *Healthy Canadians*.[26] The report found that 83.0 percent of Canadians reported having a regular family doctor in 2007, down from 85.1 percent in 2003. However, it's important to recognize that neither 85.1 percent nor 83.0 percent are terribly impressive given the universal principle underpinning Canadian health care. Similarly, 25.3 percent of Canadians in 2007 reported difficulty obtaining immediate care and 17.2 percent reported difficulty in obtaining routine or ongoing health services, both of which have increased since 2003.[27],[28] Finally, Statistics Canada reported in 2010 that 6.6 percent of Canadians 12 years or older report being unable to find a regular physician.[29]

The expectations for the immediate future of access to physicians in Canada are not encouraging. An analysis by noted healthcare economist Nadeem Esmail concluded that a substantial gap between the number of new physicians trained in Canada required to maintain the current physician-to-population ratio and the actual expected number of new physicians will exist until at least 2018.[30] This gap is the result of a growing population coupled with retiring physicians and a lack of new physicians being trained in medical schools in Canada. Unfortunately, the implications of the analysis are that access to physicians in Canada will actually worsen consistently over the next decade (in the absence of an increase in foreign-trained physicians).

Indeed, part of this physician supply problem can be observed in comparative OECD data. Figure 12 illustrates the number of medical graduates per 100,000 people for 32 OECD countries.[31] Canada ties with Turkey for 26th place (out of 32 countries) in its rate of medical graduates adjusted for population. Specifically, Canada graduated 7 medical students per 100,000 people in 2009. This compares poorly with most other OECD countries.

26 Ministry of Health, Canada. 2008. *Healthy Canadians: A Federal Report on Comparable Health Indicators*. Ottawa, ON: Ministry of Health. Available at www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/system-regime/2008-fed-comp-indicat/index-eng.pdf.

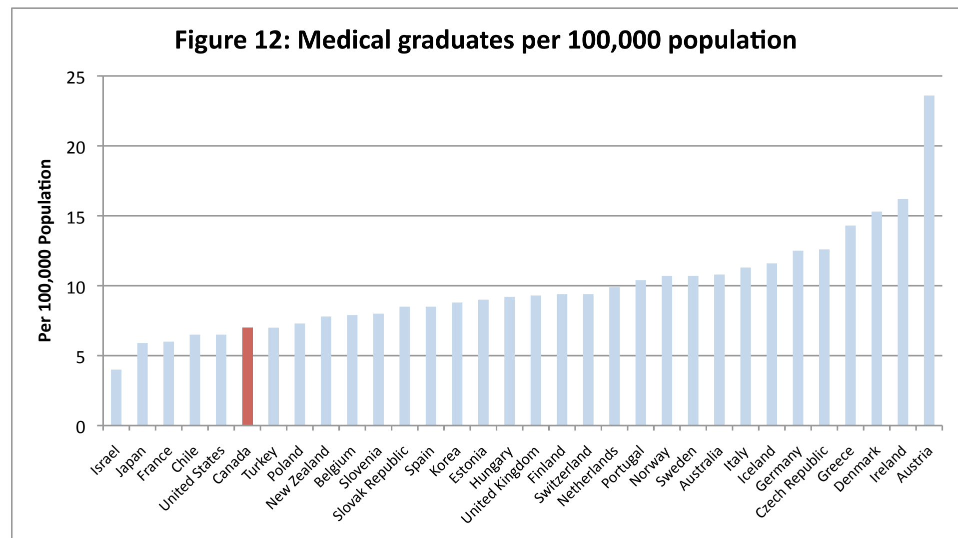
27 Ministry of Health, Canada. 2008. *Healthy Canadians: A Federal Report on Comparable Health Indicators*. Ottawa, ON: Ministry of Health. Figure 3. Available at www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/system-regime/2008-fed-comp-indicat/index-eng.pdf.

28 The figures reported in 2007 represented increases from the 2003 report. Specifically, the percentage reporting difficulty in obtaining immediate care increased from 23.8 percent in 2003 to 25.3 percent in 2007 and the percentage reporting difficulty in obtaining routine or ongoing health services increased from 16.4 percent in 2003 to 17.2 percent in 2007. See: Ministry of Health, Canada. 2008. *Healthy Canadians: A Federal Report on Comparable Health Indicators*. Ottawa, ON: Ministry of Health. Figure 3. Available at www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/system-regime/2008-fed-comp-indicat/index-eng.pdf.

29 Statistics Canada. 2010, June 15. *Canadian Community Health Survey*. Summarized in *The Daily*.

30 Nadeem Esmail. 2011. "Canada's Physician Supply." *Fraser Forum*, March/April 2011. Vancouver, BC: The Fraser Institute. Pages 12-18. Available at http://www.fraserinstitute.org/research-news/research/display.aspx?id=17325.

31 Data was not available for Luxembourg and Mexico.



Notes:

Data for Austria, Hungary, and Portugal are for 2008.

Data for France and Greece are for 2007.

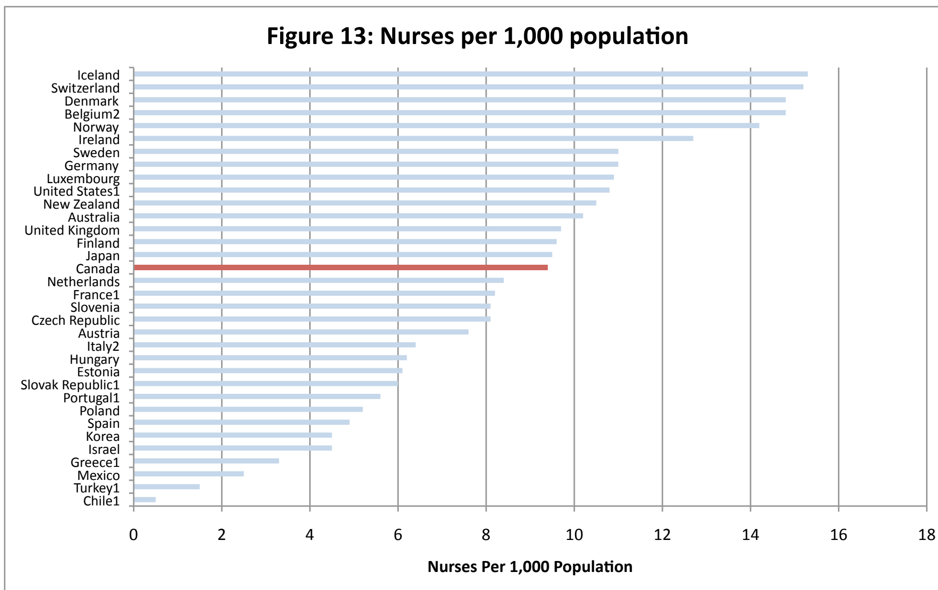
No data was available for Luxembourg and Mexico.

Data for 2010 was available for Belgium, Chile, Denmark, Finland, Japan, New Zealand, and the United Kingdom but 2009 data was used for consistency.

Source: Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

Canada ranked 16th on access to nurses.

The second group of health professionals is nurses. Like the previous analysis, the following data compares the ratio of nurses-to-population to measure access. The range of nurses-to-population (per 1000 people) was 3.3 in Greece to 15.3 in Iceland (Figure 13). Canada had a nurse-to-population ratio of 9.4 (per 1000 people), which ranked Canada 16th in the OECD, an improvement compared to the performance for physicians.



Notes:

#1 - Data refer to professionally active nurses. They include practising nurses plus other nurses working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of nurses).

#2 - Data refer to all nurses who are licensed to practice.

Data for all other countries refers to practising nurses. Practising nurses are defined as those providing care directly to patients.

Data for Australia, Austria, Chile, Denmark, Finland, Japan, Netherlands, and Sweden are for 2008.

Data for Luxembourg is for 2006.

Data for 2010 was available for France, Israel, Italy, Portugal, Spain, and the United Kingdom but 2009 data was used for consistency.

Source: Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

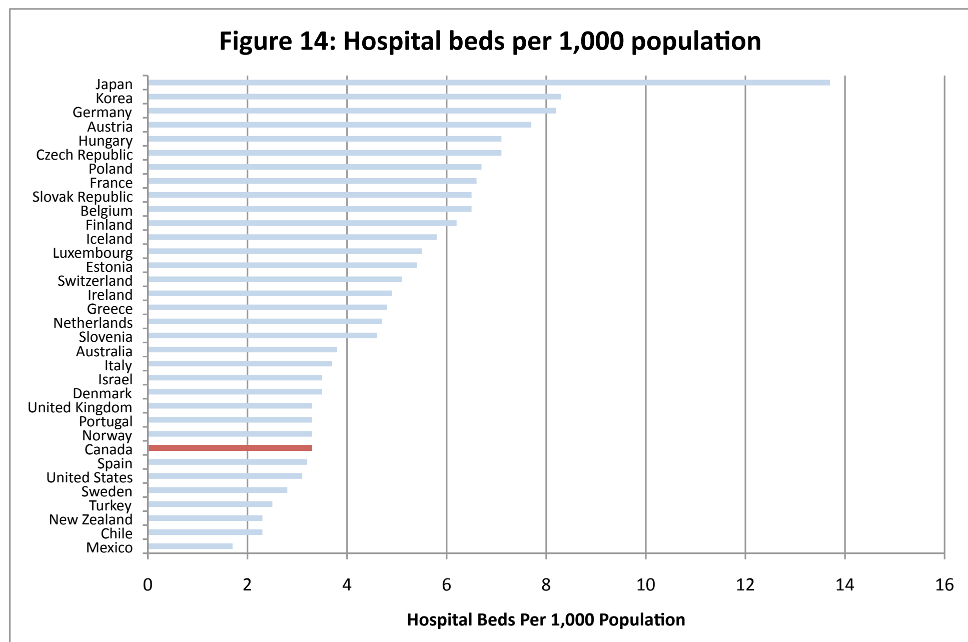
While Canada performed better in its access to nurses, it still only ranked in the middle of the OECD. The poor performance on access to physicians and middling performance on nurses coupled with the expectation for deteriorating performance over the next decade with respect to access to physicians indicate a fairly poor level of performance in providing Canadians access to health professionals.

Hospital Care

Another measure often referred to is hospital beds adjusted for population. Figure 14 illustrates the comparative numbers for the OECD countries. The range of hospital beds (per 1000 population) is 1.7 in Mexico to 13.7 in Japan. Canada, with 3.3 hospital beds per 1000 people ties for 24th position within the 34 OECD countries.[32] The average for the OECD countries was 5.0 beds per 1000 people.

32 Note that the data for Canada for hospital beds was for 2008.

Canada ranks 24th for the number of hospital beds.



Notes:

Data for New Zealand is for 2010 since no other data was available.

Data for Australia, Canada, Chile, and Ireland is for 2008.

Data for Iceland is for 2007.

Data for 2010 was also available for Belgium and Israel but 2009 data was used for consistency.

Source: Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

Wait Times

One consequence of the lack of access to physicians and the dearth of hospital beds, at least comparatively within the OECD, are wait times for medical procedures. A long-standing survey of physicians in Canada[33] has shown not only the widespread presence of wait lists, but also a lengthening time for those waiting.[34] The national survey examines the time between a referral from a general practitioner to the delivery of elective treatment by a specialist across twelve areas of specialties.[35] In 2010, the latest year for which data was available at the time of writing, the median wait time had increased to 18.2 weeks from 16.1 weeks the year prior.[36]

The data from the domestic survey for wait times informs us of the presence of wait times in Canada but provides no comparative context. Perhaps wait times in other countries are even worse. Table 2 presents summary data from a 2010 study

33 Bacchus Barua, Mark Rovere, and Brett J. Skinner. 2010. *Waiting Your Turn: Wait Times for Health Care in Canada, 2010 Report*. Vancouver, BC: The Fraser Institute. Available at www.fraserinstitute.org/uploaded-Files/fraser-ca/Content/research-news/research/publications/waiting-your-turn-2010.pdf.

34 One response to these wait times has been for Canadians to seek care outside of the country. A recent analysis (2010) concluded that over 44,000 Canadians sought healthcare services outside of Canada. See: Nadeem Esmail. 2011. "Leaving Canada for medical care." *Fraser Forum*, March/April 2011. Vancouver, BC: The Fraser Institute. Pages 19-21. Available at http://www.fraserinstitute.org/research-news/research/display.aspx?id=17325.

35 Includes plastic surgery, gynaecology, ophthalmology, otolaryngology, general surgery, neurosurgery, orthopaedic surgery, cardiovascular surgery (elective), urology, internal medicine, radiation oncology, medical oncology.

36 Bacchus Barua, Mark Rovere, and Brett J. Skinner. 2010. *Waiting Your Turn: Wait Times for Health Care in Canada, 2010 Report*. Vancouver, BC: The Fraser Institute. Available at www.fraserinstitute.org/uploaded-Files/fraser-ca/Content/research-news/research/publications/waiting-your-turn-2010.pdf.

by the Commonwealth Fund, which includes measures[37] of wait times for the seven countries covered by the study: Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States.[38]

Canadians suffer from waiting lists for medical procedures.

Table 2: Comparative International Data on Waiting for Healthcare Services

	AUS	CAN	GER	NETH	NZ	U.K.	U.S.
Last time needed medical attention had to wait 6 or more days for an appointment	18	34	26	3	8	14	23
Percent of primary care practices who report almost all patients who request same- or next-day appointment can get one	36	17	57	62	45	64	44
Primary care practices that have an arrangement where patients can be seen by a doctor or nurse if needed when the practice is closed, not including ER	50	43	54	97	89	89	29
Waiting time for emergency care was less than 1 hour (used emergency room in the last 2 years)	54	38	73	73	61	50	52
Waiting time to see a specialist was less than 4 weeks (needed to see a specialist in the last 2 years)	45	40	68	69	45	42	74
Waiting time of 4 months or more for elective/nonemergency surgery (needed services within last year)	18	27	5	7	13	30	8
Percentage waiting less than 1 hour in ER (only those going to ER)	46	38	70	82	56	54	47

Source: Karen Davis, Cathy Schoen, and Kristof Stremikis (2010). Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update. Commonwealth Fund. Exhibits 5 and 7. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf.

37 Data are drawn from the Commonwealth Fund 2007 International Health Policy Survey, conducted by telephone in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States; the 2008 International Health Policy Survey of Sicker Adults, conducted in the same seven countries plus France; and the Commonwealth Fund 2009 International Health Policy Survey of Primary Care Physicians, conducted in the same eight countries plus Italy, Norway, and Sweden.

The 2007 survey focuses on the primary care experiences of nationally representative samples of adults age 18 and older in the seven countries. The 2008 survey targets a representative sample of "sicker adults," defined as those who rated their health status as fair or poor, had a serious illness in the past two years, had been hospitalized for something other than a normal birth delivery, or had undergone major surgery in the past two years. The 2009 survey looks at the experiences of primary care physicians.

Approximately 1000 adults in Australia and New Zealand; 1500 in Germany, the Netherlands, and the U.K.; 2500 in the U.S; and 3000 in Canada were included in 2007. Approximately 750 sicker adults in Australia and New Zealand; 1000 in the Netherlands; 1200 in Germany, the United Kingdom, and United States; and 2600 in Canada were included in 2008. In 2009, 500 to 1000 physicians in Germany, the Netherlands and New Zealand and 1000 to 1500 in Australia, the United States, Canada, and the United Kingdom were included. The total sample across these countries was 11,910 adults in 2007, 8742 sicker adults in 2008, and 6750 primary care physicians in 2009.

The 2007 survey focuses on patients' self-reported experiences getting and using health care services, as well as their opinions on health system structure and recent reforms. The 2008 survey examines sicker patients' views of the health care system, quality of care, care coordination, medical errors, patient–physician communication, waiting times, and access problems. The 2009 survey looks at primary care physicians' experiences providing care to patients, as well as the use of information technology and teamwork in the provision of care.

38 Karen Davis, Cathy Schoen, and Kristof Stremikis. 2010. *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update*. Commonwealth Fund. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf.

The results from the Commonwealth Fund study are not encouraging. The study included seven questions aimed directly at assessing wait times. Canada had the worst results in five of the seven questions, and ranked second-worst in the remaining two questions. For example, one question queried respondents who needed to see a specialist in the last two years whose wait time was less than 4 weeks (higher number indicates better access and less wait time). Forty percent of Canadian respondents indicated they were able to see a specialist in less than four weeks. This ranks Canada last among the response rates with Australia at 45 percent, Germany at 68 percent, the Netherlands at 69 percent, New Zealand at 45 percent, the United Kingdom at 42 percent, and the United States at 74 percent.

A similar question had similar results. It asked those respondents seeking elective or nonemergency surgery within the last year how many waited for more than 4 months (lower number indicates higher access and less wait times). Canada ranked second with 27 percent of people waiting longer than 4 months for elective or nonemergency surgery behind only the United Kingdom, which recorded 30 percent. Three of the five remaining countries recorded percentages in the single digits, indicating very low wait times for elective/nonemergency surgeries.

There are also two questions relating to wait times in emergency rooms. These questions are important in that they can reflect the use of emergency rooms by patients in lieu of regular family practitioner and other services as well as the general availability of medical resources for those who fall suddenly ill or are injured. Both questions measure the percentage of people waiting more than an hour in emergency rooms. In both questions Canada ranks last, and is markedly last compared to the other countries.

Access to Technologies

Canada performs poorly on access to medical technologies.

Another aspect of accessibility in healthcare relates to technology.[39] The OECD collects data on a number of different technologies, including magnetic resonance imaging (MRI), computed tomography scanners (CT scanners), mammograms, and radiation therapy equipment.[40] The following summarizes Canada's performance in these technology areas.[41]

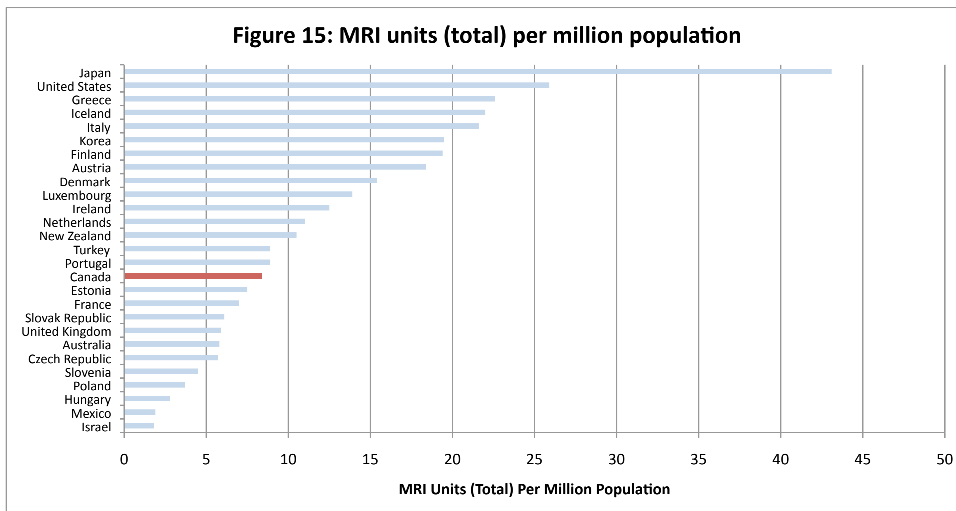
Magnetic resonance imaging or MRIs is the one of the better known healthcare technologies, largely because of its broad application and use. The range of MRIs in the reporting OECD countries is 1.8 per million in Israel to 43.1 per million in Japan (Figure 15). Canada ranked 16th out of 27 OECD countries reporting access to MRIs

39 Please note that the data for access to technologies includes the most recent year of data for all countries. This is a slight change from the methodology used in the previous comparisons, which relied on 2009 data for most countries. There were two reasons for including 2010 data where available. First, a large number of countries reported 2010 data. In the case of MRIs for instance, almost half the countries reported 2010 data. Second, many countries reported improvement in their access between 2009 and 2010, which the study concluded was important to incorporate in the analysis.

40 An additional issue to consider beyond the count of technologie is how functioning and dated the existing stock of technology is, particularly in comparison to industry standards. Thankfully, noted health economist Nadeem Esmail has examined the state of healthcare technologies in Canada: Nadeem Esmail. 2011. "Old and outdated medical equipment." Fraser Forum, May/June 2011. Vancouver, BC: The Fraser Institute. Pages 31-34. Available at http://www.fraserinstitute.org/research-news/research/display.aspx?id=17523.

41 While the OECD collects information on access to radiation therapy equipment Canada has not reported results since 1997 and thus this measure was excluded.

with 8.4 MRI units per million population.[42] The non-weighted OECD average was 12.4, although Japan skews the results slightly.[43]



Notes:

Data for Australia, Canada, Finland, France, Greece, Iceland, Ireland, Israel, Korea, Luxembourg, New Zealand, and the United Kingdom is for 2010.

Data for all other OECD countries is for 2009.

Data for Japan is for 2008.

Data for the Portugal and the United States is for 2007.

No data was provided for Belgium, Chile, Germany, Norway, Spain, Sweden, and Switzerland.

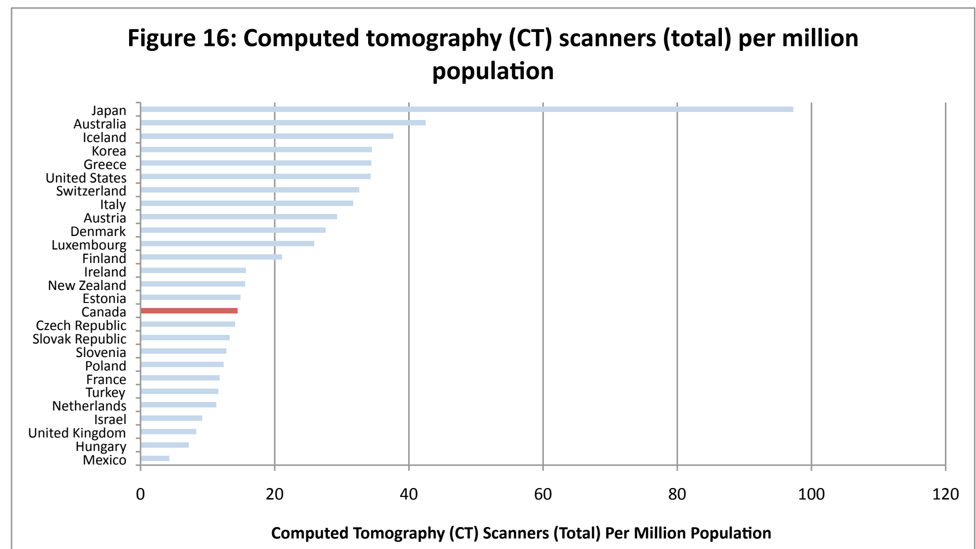
Source: Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

Canada's performance for access to CT scanners is the same: we rank 16th out of 27 OECD countries that report access to CT scanners. Specifically, Canada had 14.4 CT scanners (total) per million population.[44] The range for reporting countries was 4.3 per million in Mexico to 97.3 per million in Japan (Figure 16). The non-weighted OECD average was 23.2, although again Japan's numbers influence the average.

42 Canada's access to MRIs improved from 8 per million population in 2009 to 8.4 per million population in 2010.

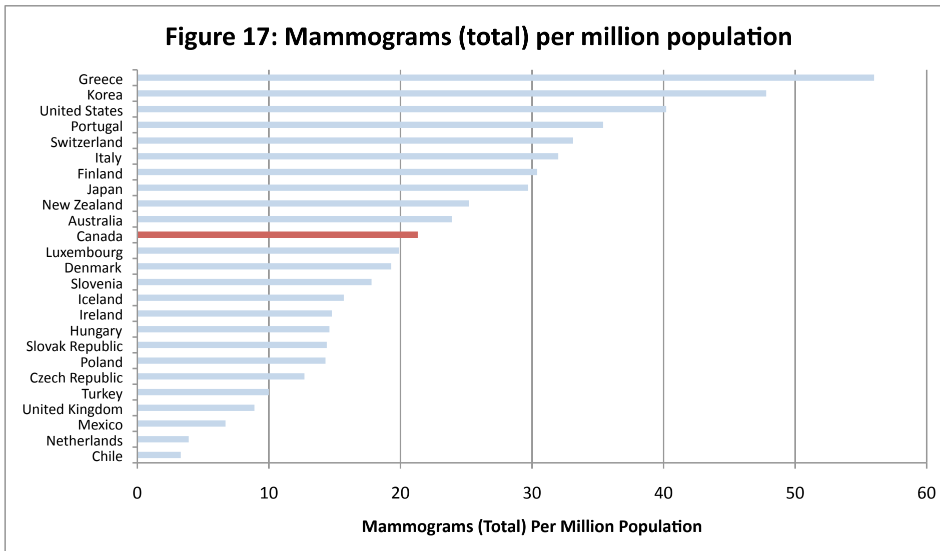
43 The non-weighted OECD average minus Japan would be 11.2 per million population.

44 Canada's performance on access to CT scanners improved from 13.9 per million population in 2009 to 14.4 per million population in 2010.



Notes:
Data for Australia, Canada, Denmark, Finland, France, Greece, Iceland, Ireland, Isreal, Korea, Luxembourg, New Zealand, Slovenia, Switzerland, and the United Kingdom are for 2010.
Data for all other OECD countries is for 2009.
Data for Japan is for 2008.
Data for the United States is for 2007.
No data was provided for Belgium, Chile, Germany, Norway, Portugal, Spain, and Sweden.
Source: Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

Finally, in terms of mammograms procedures (adjusted for population), Canada ranked 11th out of 25 reporting OECD countries (Figure 17). Specifically, Canada performs 21.3 (total) mammograms per million population. Caution should be used with the Canadian data, however, since it has not been updated since 2005. The range of access to mammogram procedures for reporting countries was 3.3 per million in Chile to 56 per million for Greece. Canada was only slightly below the OECD average (non-weighted) of 22.1 per million population.



Notes:

Data for Australia, Denmark, Finland, Greece, Iceland, Ireland, Korea, Luxembourg, New Zealand, Slovenia, Switzerland, and the United Kingdom are for 2010.

Data for all other OECD countries is for 2009.

Data for Japan and the United States is for 2008.

Data for Portugal is for 2007.

Data for Canada and the Netherlands is for 2005.

No data was provided for Austria, Belgium, Estonia, France, Germany, Israel, Norway, Spain, and Sweden.

Source: Organization for Economic Cooperation and Development (2011). OECD Health Data 2011. Paris, France: OECD. Available at http://www.oecd.org/document/30/0,3746,en_2649_37407_12968734_1_1_1_37407,00.html.

Summary

The results of examining the resources provided for healthcare services (as a share of the economy) compared to the services and access received by Canadians are discouraging to say the least. Canada ranks 6th among the 34 OECD countries for the share of our economy devoted to healthcare. This ranking increases if we exclude non-universal healthcare countries like the United States and adjust for the age of the population in each country.

Compared to other countries, Canada spends a lot on healthcare but doesn't perform well on health indicators.

None of the performance data indicate a comparable level of services. Canada ranks 26th in the OECD for access to physicians, and this is likely an overestimate. In addition, it is more than likely that our access to physicians will decline over the next decade due to inadequate training coupled with an aging population. Our access to nurses is slightly better at 16th in the OECD. Neither our access to physicians or nurses is reflective of the resources devoted to the sector.

Canada ranks 24th in the OECD on hospital beds, adjusted for population. Not surprisingly, given the limited access to health professionals and hospital beds, Canada suffers from remarkably long wait times for medical services. A longstanding survey of wait times in Canada indicates that in 2010, the latest year for which data was available at the time of writing, the median wait time was 18.2 weeks.

Canada's wait times are also long compared to other industrialized countries. A study by the Commonwealth Fund indicated Canada performed the worst among the seven countries analysed. Of seven questions aimed at wait times, Canada had the worst

response in five and the second worst in the remaining two. Clearly Canadians are suffering from both absolute and comparatively long wait times for healthcare services.

Finally, we have comparatively middling performance on access to medical technologies. Of the three medical technologies covered by the OECD in which Canada provides information, we ranked 16th out of 27 reporting countries for access to MRIs and to CT scanners. Our performance is only marginally better for access to mammograms: 11th of 25 OECD countries.

These performance measures of the healthcare system simply do not support or comport with the level of resources devoted to the healthcare sector.[45] Thankfully an opportunity to begin the process of reforming our system exists now. The renegotiation of the Canada Health Accord presents a moment to begin the process of changing Canadian healthcare. The following section summarizes the changes made to social transfers in the 1990s and the related reforms undertaken in conjunction with the reduction in transfer payments. We believe this is a model for reforming the Canada Health Transfer, which would fundamentally begin the process of reforming Canadian healthcare.

Welfare Reform: Lessons from the 1990s for Healthcare Today[46]

In the early 1990s, Canada faced a deficit and debt crisis much worse than we face today.

The fiscal situation of the early and mid-1990s resembles current day Canada in many ways (table 3).[47] The federal government was facing a persistent deficit, which in 1994-95 amounted to $36.6 billion or 4.8 percent of GDP. The national debt reached $524.2 billion, or 68.0 percent of the economy. Interest charges on the national debt were $44.2 billion, consuming a little over one-third of available revenues.[48]

45 For examples, see: Canadian Medical Association. 2011. *Report of the Advisory Panel on Resourcing Options for Sustainable Health Care in Canada*, July 2011. Available at www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Annual_Meeting/2011/AdvisoryPanelReport_en.pdf; Canadian Institute for Health Information (CIHI). 2010. *Health Care in Canada, 2010*. Ottawa, ON. Available at http://secure.cihi.ca/cihiweb/products/HCIC_2010_Web_e.pdf; Canadian Institute for Health Information (CIHI). 2011. *Health Indicators 2011*. Ottawa, ON. Available at http://secure.cihi.ca/cihiweb/products/health_indicators_2011_en.pdf; Canadian Institute for Health Information (CIHI). 2011. *Wait Times in Canada – A Comparison by Province, 2011*. Ottawa, ON. Available at http://secure.cihi.ca/cihiweb/products/Wait_times_tables_2011_en.pdf.

46 This section, to varying degrees, relies on previous work completed by the author in collaboration with other researchers, including: Brian Lee Crowley, Jason Clemens, and Niels Veldhuis. 2010. *The Canadian Century: Moving Out of America's Shadow*. Toronto, ON: Key Porter.; and Chris Schafer, Joel Emes, and Jason Clemens. 2001. *Surveying U.S. and Canadian Welfare Reform*. Vancouver, BC: The Fraser Institute. Available at www.fraserinstitute.org/WorkArea/DownloadAsset.aspx?id=3943.

47 For a more thorough discussion of the experience of the 1980s and 1990s, please see: Brian Lee Crowley, Jason Clemens, and Niels Veldhuis. 201o. *The Canadian Century: Moving Out of America's Shadow*. Toronto, ON: Key Porter; a related and shorter synopsis is also available by: Niels Veldhuis, Jason Clemens, and Milagros Palacios. 2011. *Budget Blueprint: How Lessons from Canada's 1995 Budget Can Be Applied Today*. Studies in Tax and Budget. (February 2011). Vancouver, BC: The Fraser Institute. Available at http://www.fraserinstitute.org/uploadedFiles/fraser-ca/Content/research-news/research/publications/BudgetBlueprint.pdf.

48 Federal statistics were taken from: Department of Finance, Canada. 2011. *Fiscal Reference Tables*. Ottowa, ON: Department of Finance. Tables 1 and 2. Accessed September 10, 2011. Available at http://www.fin.gc.ca/frt-trf/2010/frt-trf-10-eng.asp.

The provinces were in similar straits. Collectively, they faced a $16.0 billion deficit in 1994-95, representing about 2.1 percent of GDP. The accumulation of deficits over the years had resulted in large provincial debts. In 1994-95, the collective indebtedness of the provinces reached $209.8 billion, or 27.2 percent of GDP. Interest charges on provincial debt were also increasing, reaching $20.6 billion in 1994-95.[49]

Table 3: COMPARING TODAY to the MID-1990s

	Today (2011-12)	Mid-1990s*
Federal		
Deficit ($)	$29.6 Billion	$36.6 Billion
Deficit (% of GDP)	1.7%	4.8%
Net Debt ($)	$586.0 Billion	$567.5 Billion
Net Debt (% of GDP)	34.1%	73.6%
Interest Cost ($)	$33.0 Billion	$44.2 Billion
Interest Cost (% of Revenues)	13.3%	33.8%
Provinces (Total)**		
Deficit ($)	$25.3 Billion	$16.0 Billion
Deficit (% of GDP)	1.5%	2.1%
Net Debt ($)	$486.8 Billion	$209.8 Billion
Net Debt (% of GDP)	28.4%	27.2%
Interest Costs ($)***	$20.9 Billion	$20.6 Billion
Interest Costs (% of Revenues)***	7.4%	14.3%

* - 1994/95, just prior to the reform budget of 1995-96.
** Includes the Territories.
*** Data for "Today" is for 2009-10, which is the latest consolidated data available.

Sources:

TD Economics. 2011. Overview of the 2011-12 Government Budget Season. Special Report, May 25, 2011. Toronto, ON: TD Economics.

Department of Finance, Canada .2011. Fiscal Reference Tables. Ottawa, ON: Department of Finance. Accessed on September 10, 2011.

Department of Finance, Canada. 2011. Budget 2011. (June). Ottawa, ON: Department of Finance.

Increasing Welfare Dependency

A particular problem recognized in the early 1990s was the seemingly ever-increasing welfare dependency rates across the country.[50] Figure 18 illustrates welfare recipients including dependents both in terms of the absolute number and as a percentage of the population in Canada starting in 1975.

Canada also faced a welfare crisis in the 1990s with 10.7 percent of the population on welfare.

Both measures show a similar trend. Regardless of the state of the economy, welfare beneficiaries, both in absolute numbers and as a share of the population were generally trending upwards. Put differently, it appeared as if the floor of both the number of recipients as well as the percentage increased with each business cycle. For instance, the percentage of Canadians receiving welfare remained fairly constant from 1975 to 1981, hovering between 5.5 percent and 5.7 percent of the population. In terms of absolute numbers, it fluctuated around 1.3 million Canadians (Figure 18).

49 Provincial statistics were taken from: Department of Finance, Canada. 2011. *Fiscal Reference Tables*. Ottowa, ON: Department of Finance. Tables 30 and 31. Accessed September 18, 2011. Available at http://www.fin.gc.ca/frt-trf/2010/frt-trf-10-eng.asp.

50 For one of the earlier alarm bells sounded on welfare dependency and the need for reform, see: John Richards. 1997. *Retooling the Welfare State: What's Right, What's Wrong, What's To Be Done*. Toronto, ON: The C.D. Howe Institute.

The percentage of Canadians receiving welfare (including dependents) increased during the recession of the early 1980s and reached a new plateau, this time ranging between 6.9 percent and 7.4 percent of the population. The new floor of welfare recipients amounted to roughly 1.9 million Canadians. Welfare dependency increased again, quite precipitously in the early 1990s, reaching 10.7 percent of the population in 1994, representing 3.1 million Canadians (Figure 18).

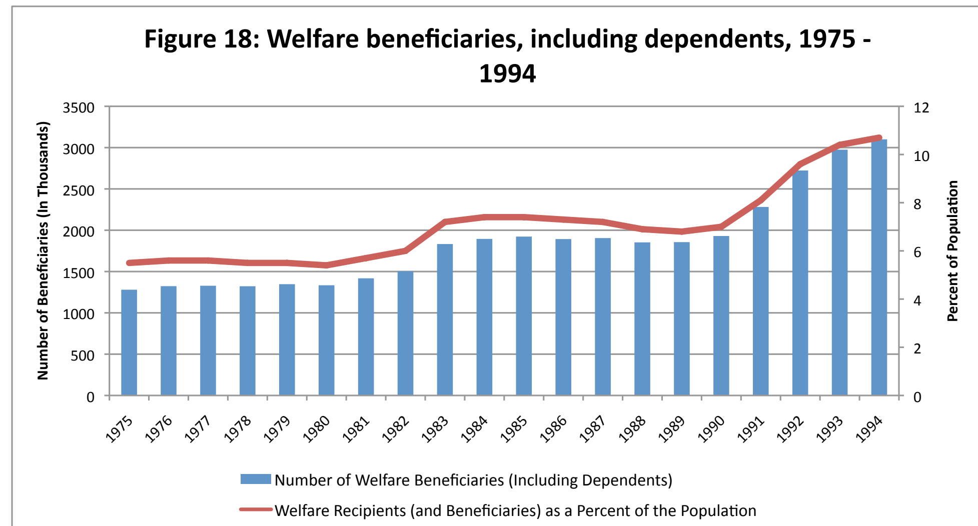


Figure 18: Welfare beneficiaries, including dependents, 1975 - 1994

Note: Welfare clientele statistics are for March of each year. Percentage of population numbers are as at April of each year.

Sources: National Council of Welfare (2006), Welfare Incomes 2005: Number of People on Welfare, 1995-2005, available at http://www.cnb-ncw.gc.ca/l.3bd.2t.1ils@-eng.jsp?lid=160;

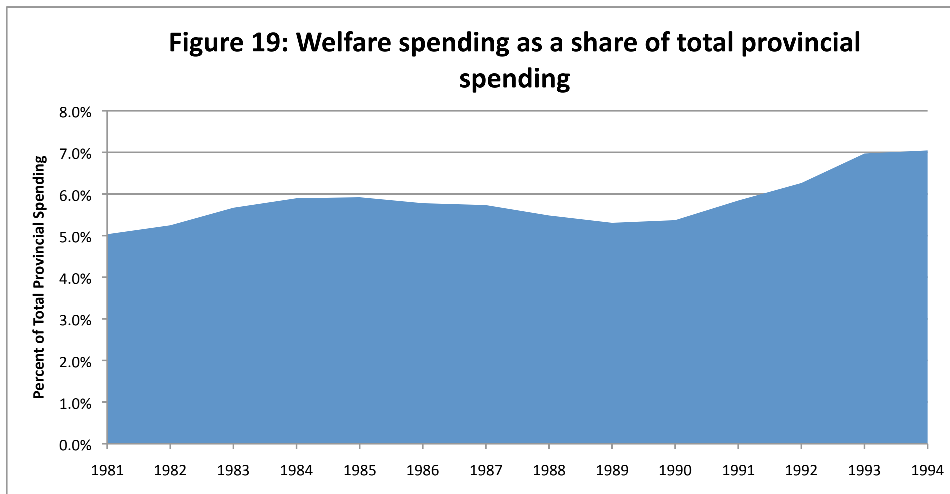
Institut de la Statistique Quebec, Interprovincial Comparisons, Table 5.7: Customer welfare, 2005-2009, available at http://www.stat.gouv.qc.ca/donstat/econm_finnc/conjn_econm/TSC/index_an.htm (updated on June 10, 2011);

Human Resources and Skills Development Canada (2010), Social Assistance Statistical Report 2008, available at http://www.hrsdc.gc.ca/eng/publications_resources/social_policy/sasr_2008/sasr2008_eng.pdf;

Statistics Canada, Estimates of Population, Canada, provinces and territories, CANSIM Table 051-0005.

The spectacle of having over 3 million Canadians on welfare or receiving benefits convinced many that the system simply wasn't working as intended. Further pressure was placed on political leaders as the costs of higher rates of welfare became clearer. Higher rates of welfare usage, like higher rates of unemployment, effect government finances by simultaneously increasing spending and reducing tax revenues.

As Figure 19 depicts, the percentage of total provincial spending dedicated to social assistance, or welfare and related programs followed a similar path to the trends illustrated in Figure 18. The percentage of provincial budgets consumed by welfare spending reached almost 6 percent in the mid-1980s before declining during the latter half of the decade. The percentage of provincial spending on welfare and related programs, measured as a share of total provincial spending, increased again in the early 1990s, reaching 7 percent in both 1993 and 1994 (Figure 19).



Source: Statistics Canada (2010). Provincial and Territorial Economic Accounts: Data Tables - 2009 Estimates, Tables 8, 9, and 14. Available at http://www.statcan.gc.ca/pub/13-018-x/13-018-x2010001-eng.htm

The combination of deficits and increasing debt at the federal and provincial levels with alarmingly high rates of welfare dependency and the accompanying spending required to sustain it set the stage for reform. Put simply, the status quo of the previous two decades simply could not continue.

Reforming Provincial Transfers and Unleashing Experimentation

The 1995 federal budget[51] is quite rightly seen as one of the most important government documents in a generation. It fundamentally changed the federal government and dealt honestly with many of the country's fiscal problems.

In 1995, the federal government reformed transfers to the provinces in support of social programs.

One of the changes introduced in the 1995 federal budget was a restructuring (and reduction) of federal transfers to the provinces. Specifically, the budget introduced a move away from the then current model of cost-sharing transfers to a block-grant. Prior to the reforms, the federal government provided two major transfers to the provinces outside of the equalization program: the Established Program Financing (EPF)[52] and the Canada Assistance Plan (CAP).

The Established Program Financing (EPF) was a block transfer to the provinces to support health and post-secondary education spending in the provinces. It was distributed to the provinces regardless of provincial spending in these areas.

The Canada Assistance Plan (CAP) was a cost-sharing program in which the federal government paid up to half of the amount spent by provincial governments on social programs. A problem with cost-sharing programs generally is that they incentivize recipient jurisdictions to spend more regardless of the merits for or against additional spending. Under CAP, the province could finance additional spending on eligible programs using just 50 percent of their own resources. The remainder was provided by the federal government.

51 For information on the 1995-96 budget please see http://www.fin.gc.ca/toc/1995/buddoclist95-eng.asp.

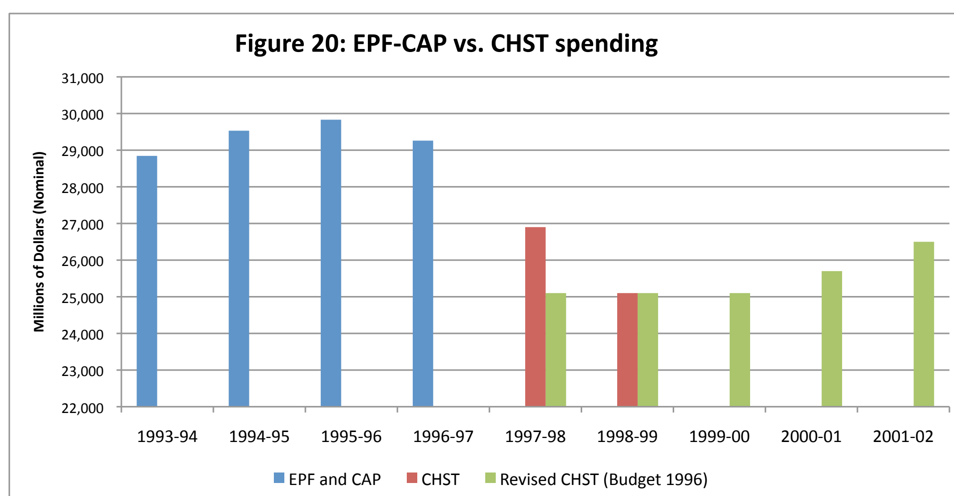
52 For an expansive discussion of the EPF see http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/bp264-e.htm.

Successive budgets prior to 1995 attempted to slow down the growth of these transfers. Specifically, budgets in 1983, 1986, 1989, 1990, 1991, and 1994 all introduced limits to the growth of one or both of the transfers.[53] None, however, introduced fundamental reforms to the transfers.

The 1995 budget announced the replacement of both the Canada Assistance Plan (CAP) as well as the Established Program Financing (EPF) with the new Canada Social Transfer, renamed the Canada Health and Social Transfer (CHST) in the 1996 budget.[54] The new CHST was a block grant with no cost-sharing provisions.

Federal government cut transfers and freed the provinces to experiment.

In addition to the elimination of the cost-sharing component, there were two additional changes. One, the amount of the grant was cut. Figure 20 illustrates the decline in funding experienced by the provinces via the reduction in the new transfer. The 1995 budget reduced the value of the combined EPF-CAP from $29.3 billion in 1996-97 to $26.9 billion in 1997-98. It was reduced further in the subsequent 1996 budget to $25.1 billion and frozen for three years until 2000-01 (Figure 20).



Sources:

Department of Finance, Canada (1994). Budget Plan 1994. Table 9.

Department of Finance, Canada (1995). Budget in Brief. Available at www.fin.gc.ca/budget95/binb/brief.pdf.

Department of Finance, Canada (1995). Budget 1995: Facts Sheets. The Canada Social Transfer. Available at www.fin.gc.ca/budget95/fact/FACT_10-eng.asp.

Department of Finance, Canada (1996). Budget in Brief. Available at www.fin.gc.ca/budget96/binb/brief.pdf.

However, there was a second reform implemented in order to mitigate both the elimination of cost-sharing as well as the reduction in the transfer amounts. The new CHST afforded the provinces much greater latitude to experiment and innovate in the design and delivery of welfare and related services. Under the previous cost-sharing arrangements, the federal government imposed national standards for social services in exchange for receiving transfers. Specifically, the federal government required that the provinces provide social assistance to those who demonstrated need while prohibiting work requirements for welfare receipt.[55] This inhibited the

53 See the Department of Finance's brief history of the CHST at http://www.fin.gc.ca/fedprov/his-eng.asp for further information on the types of limits imposed.

54 For a discussion of the reforms in the federal transfers please see: Niels Veldhuis and Jason Clemens. 2003. "Clarifying the Federal Government's Contribution to Health Care." *Fraser Forum, February 2003*. Vancouver, BC: The Fraser Institute.

55 Other requirements included institutionalized appeals processes, formal accounting procedures to report to the federal government on provincial spending, and residency requirements. See: Ronald D. Kneebone

provinces from implementing changes to reform models that made sense given their particular challenges. Put simply, the federal government changed the relationship with the provinces and allowed them to more singularly determine, manage, and deliver social programs without interference from Ottawa.

Canadian Welfare Reform: Decentralization and Improving Incentives

The 1995 budget and changes to the provincial transfers creating the CHST began a process of provincial innovation and experimentation that spanned the geography and ideology of the country. This section briefly summarizes the reforms undertaken in many of the provinces to highlight how each province addressed issues specific to their problems and populations.

There were, however, a number of common reforms implemented by most, if not all of the provinces. One common feature of reform was a reduction in benefit levels, particularly for single employable people. There was an increasing understanding that when welfare benefits surpass comparable income available from low-paid work, incentives are created to enter or remain on welfare. Many of the reductions in benefit levels and particularly those for single employable people were aimed at re-establishing a balance between welfare benefits and the income available to workers from low-paid work.[56]

The following highlights some of the specific reforms undertaken in different provinces across the country.

British Columbia

Among the provinces that implemented large-scale reform, British Columbia was one of the last to do so. A number of small, incremental reforms were introduced during the 1990s.[57] However, large-scale reform was delayed until 2001 when the newly-elected Liberal Government enacted sweeping changes to the province's welfare system.[58]

British Columbia introduced time limits for some welfare recipients.

The most high profile reform was the ending of welfare as an entitlement. British Columbia became the first province to limit access to welfare. Specifically, British Columbia limited the use of welfare to a 24-month period in any cumulative 60-month period for employable individuals.[59] A number of welfare recipient groups such as single parents and those with disabilities were exempted from the limitation.

and Katherine G. White. 2009. "Fiscal Retrenchment and Social Assistance in Canada." *Canadian Public Policy*, Vol. 35, No. 1 (March). Pages 21-40. Available at http://muse.jhu.edu/journals/canadian_public_policy/summary/v035/35.1.kneebone.html.

56 For an empirical examination of the relationship between benefit levels and welfare rates during the 1990s please see: Joel Emes and Andrei Kreptul. 1999. *The Adequacy of Welfare Benefits in Canada*. Vancouver, BC: The Fraser Institute. Available at: http://oldfraser.lexi.net/publications/critical_issues/1999/welfare_benefits/.

57 For example, a number of changes were introduced following the 1995 Premier's Forum on New Opportunities for Working and Living. In 1996, BC Benefits was introduced, which was designed to approach welfare benefits based on life-cycle needs. Although it aimed to reduce single employable individuals receiving welfare, the results fell far short of the intended goals. In addition, efforts to prevent fraud and misuse of the system were increased after 1996. Benefits were also reduced for employable individuals and greater emphasis placed on work placements and employment alternatives. For further information see: Chris Schafer and Jason Clemens. 2002. *Welfare Reform in British Columbia: A Report Card*. Vancouver, BC: The Fraser Institute. Public Policy Sources, Number 63. Available at http://www.fraserinstitute.org/research-news/display.aspx?id=13592.

58 This summary is based on: Chris Schafer and Jason Clemens. 2002. *Welfare Reform in British Columbia: A Report Card*. Vancouver, BC: The Fraser Institute. Public Policy Sources, Number 63. Available at http://www.fraserinstitute.org/research-news/display.aspx?id=13592.

59 Unfortunately, this reform was essentially nullified in 2006 through administrative changes.

Other reforms were also introduced. For instance, a much greater focus on working and diverting people from welfare was introduced. Those who were deemed able to work were required to do so or face penalties in the form of reduced benefits. The province provided job search assistance and training programs, if required. Indeed, one of the more innovative projects introduced by the BC government was Job Wave BC, which was a joint effort with the BC Chamber of Commerce to provide work placement, training, and assistance to those seeking employment.[60] Finally, the government also expanded its existing diversion program, which attempted to divert people away from welfare initially towards other alternatives, particularly employment.

Alberta

Alberta was the first province to undertake broad reform of its welfare programs. Alberta acted as a catalyst for others so it is worth detailing some changes to a greater extent than in other provinces.[61] Alberta began its reforms in 1993 after the election of Premier Klein and the enactment of the government`s aggressive plans to tackle the province`s deficit and debt.

Alberta focused on alternatives to welfare (such as employment) for potential recipients.

One of the first changes was a marked overhaul of the Alberta Family and Social Services Ministry. Specifically, the government aimed to change the culture and focus of the ministry from simply processing payments and paperwork to focusing on diverting potential welfare recipients to alternatives such as employment. The government also increased its efforts at preventing and detecting fraud and abuse.

A strong, singular focus was placed on employment. Single parents were required to gain work or enter training programs sooner than under previous rules. Employable individuals who refused to work or who quit existing employment without an alternative faced penalties in the form of reduced benefit payments.

Like most provinces Alberta curtailed benefit rates, particularly for employable individuals. The province also eliminated some supplemental benefits. For example, Alberta eliminated the program for paying damage deposits for renters except in cases involving family violence.

Finally, and quite interestingly, Alberta pursued the use of non-governmental agencies, specifically faith-based non-profit organizations to deliver social services.[62]

Saskatchewan

Saskatchewan`s reforms were generally incremental and small in scale compared to those undertaken in several other provinces. However, one aspect of the Saskatchewan reforms worth noting is their consistent attempts to integrate welfare benefits and programs with employment services. More specifically, the province endeavoured to link these programs and services together so that potential welfare recipients were exposed to employment opportunities and supportive services.[63]

---

60 For information on Job Wave BC see http://www.jobwavebc.com/.

61 For an overview and assessment of the early Alberta welfare reforms see: Kenneth J. Boessenkool. 1997. *Back to Work: Learning from the Alberta Welfare Experiment*. Toronto: The C.D. Howe Institute. Available at www.cdhowe.org/pdf/kbkool.pdf.

62 Sass, Bill. 1994. "Province asks Churches to Help Victims of Klein's Cuts". *Edmonton Journal* (May 21).

63 For further information on reforms in Saskatchewan see: Chris Schafer and Jason Clemens. 2002. *Welfare in Saskatchewan: A Critical Evaluation*. Vancouver, BC: The Fraser Institute. Available at: http://www.fraserinstitute.org/research-news/display.aspx?id=13591.

Manitoba

Like most of the provinces Manitoba introduced reductions in welfare benefit rates, particularly for groups like employable individuals who were not deemed at risk. The province simultaneously introduced transitional programs to aid people moving from welfare to work. A number of targeted pilot programs were introduced across the province tailored to specific groups. For example, the Manitoba Youth Works program was aimed at individuals under the age of 18. The program required participants to either attend school or secure employment.[64] Finally, Manitoba undertook a number of administrative reforms in order to streamline delivery and management of welfare programs. For instance, multiple departments were combined into integrated departments focused on welfare and related services.

Manitoba tried to focus programs on the transition from welfare to work.

Ontario

Ontario`s welfare reforms were probably the most high profile and contentious. That is likely due to a combination of the size of the province, the reform-minded nature of the government introducing the reforms, and the scale of benefit reductions implemented as part of the reforms.[65]

The province aggressively implemented administrative changes in order to both tighten eligibility and reduce fraud. Applicants deemed able to work were diverted to employment services. Recipients who quit or lost their job also faced restrictions in welfare benefits for three months.

In 1998, the Ontario Works program was introduced. Ontario became the only province with a broad `workfare' program.[66] The clear goal of the program was to get recipients working again. Three options were available to recipients: employment support (job-search assistance), work experience through mandatory public-sector placements, and employment placement based on wage-subsidies in the private sector.[67] This program was mandatory for all employable adults. Welfare recipients who did not participate in the program or failed to meet its guidelines faced sanctions in the form of denial of assistance for three months.

Ontario also pursued administrative reforms and the use of non-profit organizations to assist in delivering services to affected groups.

Critically, Ontario also transferred to localities funding responsibilities, responsibilities for provincial programs, and new cost-sharing agreements were introduced, resulting in a large-scale decentralization of welfare programs to the municipal level of government.

Quebec

Like other provinces, Quebec reduced benefit rates, focused more resources on diverting recipients to employment opportunities, and attempted to improve its administration. One area in which Quebec was relatively unique was its introduc-

64 National Council on Welfare. 1997. *Another Look at Welfare Reform*. Ottawa, ON: National Council on Welfare.

65 The 1995 reforms in Ontario reduced welfare benefit rates by 21.6 percent for all recipients except seniors and those with disabilities. Even after these reductions, benefit levels remained 10 percent above the average of other provinces. See: OECD. 1999. *The Battle against Exclusion: Social Assistance in Canada and Switzerland*. Paris: OECD.

66 There is some evidence indicating that the Ontario Works program was not as broad-based as initially conceived or interpreted. For example, the OECD published results indicating that "community participation is mainly voluntary in that participants often organize relevant activities by themselves". See: OECD. 1999. *The Battle against Exclusion: Social Assistance in Canada and Switzerland*. Paris: OECD.

67 OECD. 1999. *The Battle against Exclusion: Social Assistance in Canada and Switzerland*. Paris: OECD.

Ontario introduced the first broad workfare program in Canada.

tion of liquid-asset exemptions, wherein the province assessed the presence of assets potential recipients could draw on before relying on state assistance.

New Brunswick

New Brunswick had a mixed record of reform during this period. Specifically, the changes enacted in New Brunswick were not all aimed at reducing dependency. Some important structural changes were made to welfare delivery when the province reformed the Ministry of Family and Community Social Services to align it with the province's existing health regions. The aim was to allow for a more efficient and effective integrated department for both health and community services. A number of programs were also introduced to encourage and assist welfare recipients in the transition from welfare to work.

In 1996, however, New Brunswick altered its focus and increased its benefit rates along with its earnings exemption for employable individuals and childless couples. New Brunswick was the only province to experience an increase in the number of beneficiaries in 1996 and 1997.[68] The point, however, is that the province was free to enact expansionary programs and reforms to welfare based on its increased flexibility from the federal government.

Nova Scotia

Nova Scotia began reforming its welfare system in 1996. The reforms included a host of administrative changes such as ongoing eligibility reviews, fraud prevention programs, increased subsidies for child-care, and greater attention to recovering overpayments. The province undertook several initiatives to promote work rather than welfare use, however none required work or introduced sanctions for non-compliance.

Prince Edward Island

Prince Edward Island's efforts on welfare reform were largely restricted to administrative changes, some limited efforts at promoting employment, and reducing benefit rates, although benefits were actually enhanced in 2000.

Newfoundland and Labrador

Newfoundland and Labrador proposed a fairly large-scale reform of all income security programs, which included the federally-administered Employment Insurance (EI). The reforms were rejected by the federal government, in part because of the requirement to make changes to EI. Nonetheless, Newfoundland and Labrador implemented a number of important changes, including greater focus on employment through the creation of NewfoundJOBS, decentralization to community organizations, and administrative reforms.

Results of Welfare Reforms

What is hopefully clear is that the provinces were free to pursue different reforms to different extents depending on their own assessment of the needs of their citizens. Some reforms were fairly common across the provinces, including curtailing benefits rates, tightening eligibility rules, enacting administrative and organizational changes aimed at improving efficiency, and emphasizing employment alternatives. It's impor-

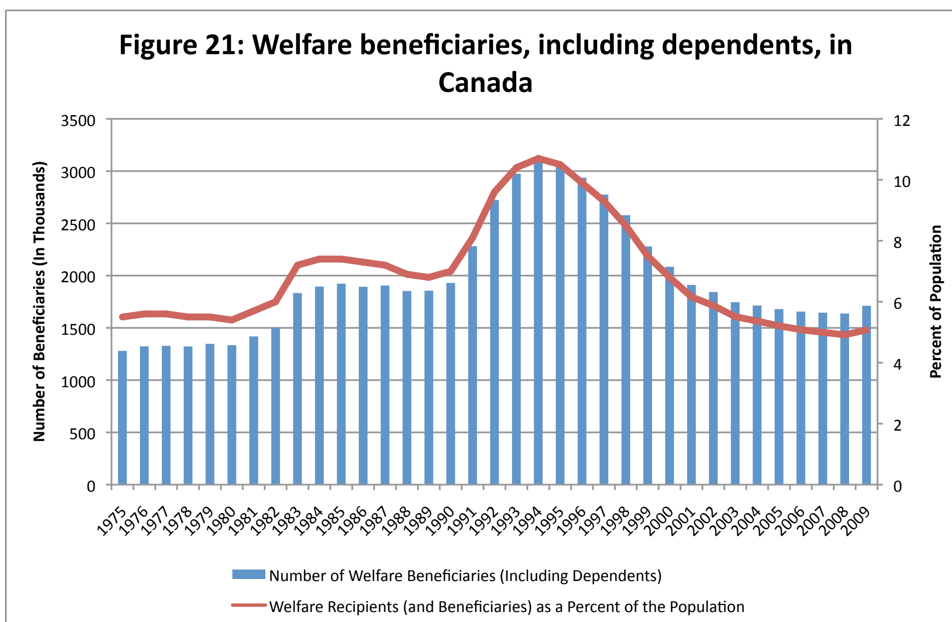
68 The number of welfare recipients increased from 67,100 in 1996 to 70,600 in 1997. All other provinces recorded declines in this period.

tant to note, however, that even within these generally enacted reforms, quite a bit of variance existed between the provinces.

There were also reforms unique to each province. For instance, Alberta was the most aggressive province in pursuing diversion programs that prevented people from using welfare. British Columbia ended the status of welfare as an entitlement and returned it to being an insurance program, although this reform was basically undone later. Ontario implemented the broadest work requirements for welfare. The key, however, is that the federal reforms allowed the provinces to respond to their individual needs through innovation and experimentation. In addition, this allowed provinces to learn from one another with respect to what reforms worked and what changes did not.

The results in terms of welfare dependency rates and welfare spending were stark.[69] Figure 21 extends the data presented earlier for the total number of welfare recipients (including beneficiaries) in Canada as well as the number of recipients as a percent of the population to 2009, the most recent year for which comprehensive data is available. The number of Canadians receiving welfare declined from a peak of 3.1 million in 1994 to 1.7 million in 2009, up slightly from 1.6 million in 2008. Figure 21 shows that as a percentage of the population, welfare recipients have fallen by more than half from a peak of 10.7 percent in 1994 to 5.1 percent in 2009.

Some common reforms were introduced across all or most of the provinces.



Note: Welfare clientele statistics are for March of each year. Percentage of population numbers are as at April of each year.

Sources: National Council of Welfare (2006), Welfare Incomes 2005: Number of People on Welfare, 1995-2005, available at http://www.cnb-ncw.gc.ca/l.3bd.2t.1ils@-eng.jsp?lid=160;

Institut de la Statistique Quebec, Interprovincial Comparisons, Table 5.7: Customer welfare, 2005-2009, available at http://www.stat.gouv.qc.ca/donstat/econm_finnc/conjn_econm/TSC/index_an.htm (updated on June 10, 2011);

Human Resources and Skills Development Canada (2010), Social Assistance Statistical Report 2008, available at http://www.hrsdc.gc.ca/eng/publications_resources/social_policy/sasr_2008/sasr2008_eng.pdf;

Statistics Canada, Estimates of Population, Canada, provinces and territories, CANSIM Table 051-0005.

69 For more information and explanations on the decline in welfare dependency and usage see :Ross Finnie, Ian Irvine and Roger Sceviour. 2005. *Social Assistance Use In Canada: National and Provincial Trends in Incidence, Entry and Exit*, Analytical Studies Research Paper, No. 245. Catalogue no. F0019M1E, (Ottawa: Statistics Canada, May 2005). Available at www.statcan.gc.ca/pub/11f0019m/11f0019m2005246-eng.pdf; Ross Finnie and Ian Irvine. 2008. *The Welfare Enigma: Explaining the Dramatic Decline in Canadians' Use of Social Assistance, 1993–2005*. Toronto, ON: The C.D. Howe Institute. Available at www.cdhowe.org/pdf/commentary_267.pdf.

It's fairly clear from the data presented in Figure 21 that the reductions go beyond simply a rebounding economy. The welfare dependency rates are now comparable or even lower than those witnessed in the 1970s. For example, in 1975, there were 1.3 million Canadians receiving welfare benefits, representing 5.5 percent of the population. In 2009, Canada had 1.7 million people receiving benefits representing 5.1 percent of the population, which is 7 percent lower than the rate observed in 1975 (Figure 21).

Welfare dependency was reduced by more than half.

Evidence beyond the observation of the reduction in welfare rates is thankfully available in the form of a paper by economists Ronald Kneebone and Katherine White.[70] In their paper, Kneebone and White discerned the influences of three factors in explaining the decline in welfare rates: (1) economic recovery, (2) generosity of social assistance benefits, and (3) the rules, regulations, and processes of the social assistance programs themselves. The study concluded that the overwhelming explanation for the reduction in welfare rates was in fact the changes implemented by the provinces regarding eligibility and other administrative processes.[71]

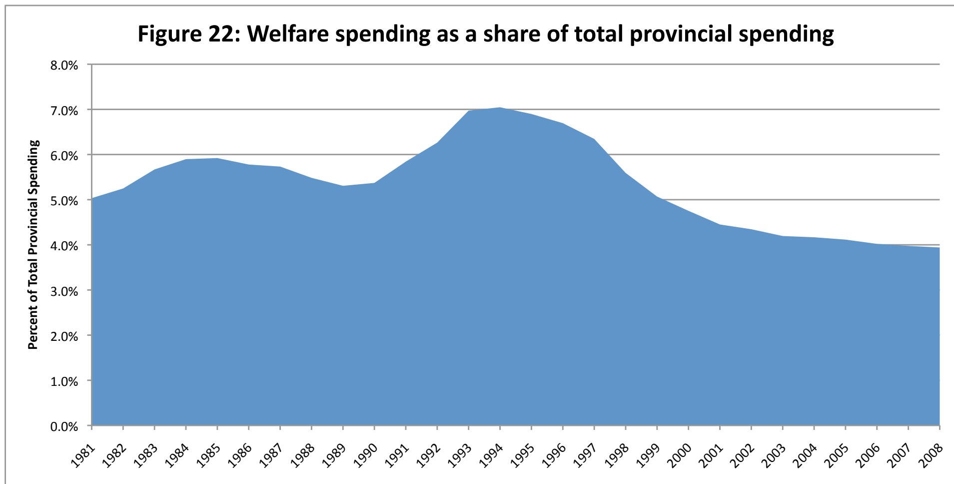
The paper details the experiences of Alberta, Ontario, and British Columbia. In British Columbia, for example, the decline in social assistance use from the peak in 1994 to the low point measured in 2004 was 9.4 percent. The Kneebone and White analysis concludes that 10.6 percent of the reduction was due to falling unemployment, 17.3 percent was due to reductions in benefit rates, 7.5 percent was explained by improvement in earned income for low-wage earners, and 64.6 percent was due to changes in social assistance program administration, including eligibility requirements, diversion efforts, and related program changes.[72]

Given the reduction in the number of welfare recipients, it`s not surprising that spending on welfare was reduced. Figure 22 illustrates the share of total provincial spending consumed by welfare and related programs. Beginning in 2000, the share of total provincial spending devoted to welfare and related programs declines to a permanent level not seen since the 1970s. Figure 22 illustrates the new lower level on the right side of the chart. Specifically, welfare spending as a share of total spending by the provinces peaks in 1993 and 1994 at 7.0 percent (Figure 22). In 2008, the most recent year for which comprehensive data is available, welfare spending as a share of total provincial spending stood at 3.9 percent, a decline of 44.3 percent from the peak.

70 Ronald D. Kneebone and Katherine G. White. 2009. "Fiscal Retrenchment and Social Assistance in Canada." *Canadian Public Policy*, Vol. 35, No. 1 (March). Pages 21-40. Available at http://muse.jhu.edu/journals/canadian_public_policy/summary/v035/35.1.kneebone.html.

71 Other studies examining the same data have come to similar conclusions. For example, Boessenkool (1997) found that between 1993 and 1996 roughly half of the decline in welfare rates in Alberta was due to administrative changes. (Kenneth J. Boessenkool. 1997. *Back to Work: Learning from the Alberta Welfare Experiment*. Toronto: The C.D. Howe Institute. Available at www.cdhowe.org/pdf/kbkool.pdf.) Similarly, Richards (2007) concluded that about 80 percent of the decline in welfare rates in Alberta and 50 percent of the decline in Ontario were due to the combination of benefit reductions and administrative changes. (John Richards. 2007. *Reducing Poverty: What Has Worked, and What Should Come Next*. Toronto, ON: The C.D. Howe Institute. Available at http://www.cdhowe.org/pdf/commentary_255.pdf.)

72 Ronald D. Kneebone and Katherine G. White. 2009. "Fiscal Retrenchment and Social Assistance in Canada." *Canadian Public Policy*, Vol. 35, No. 1 (March). Pages 33 and 34. Available at http://muse.jhu.edu/journals/canadian_public_policy/summary/v035/35.1.kneebone.html.



Source: Statistics Canada (2010). Provincial and Territorial Economic Accounts: Data Tables –2009 Estimates, Tables 8, 9, and 14. Available at http://www.statcan.gc.ca/pub/13-018-x/13-018-x2010001-eng.htm

The federal reforms did not lead to a race to the bottom.

The benefits of the reforms discussed above extended beyond taxpayers and government finances. Indeed, probably the most important benefit from the reforms was the large degree to which former welfare recipients integrated back into the workforce, particularly single employable individuals.[73] As an example of the kind of successes recorded across the country, one study of reforms in Alberta concluded that almost half of the reduction in welfare rates between 1993 and 1996 were due to individuals securing full-time employment.[74]

Considering the Race to the Bottom Argument

An important consideration in the social reforms of the 1990s was the much anticipated "race to the bottom". Many social activists and scholars alike predicted a marked race to the bottom for social assistance due to the changes in social transfers from the federal government coupled with the removal of national standards for social assistance, excluding the prohibition against residency. The rationale for such expectations was twofold. First, observers believed that the national transfers and standards acted as a bulwark against provincial competition for resources, including people and investment. Second, the basic framework utilized by scholars suggested that the increased use and cost of social assistance meant increasing burdens on taxpayers, which would eventually incentivize jurisdictions to begin lowering both the use and cost of such programs in order to attract more taxpayers, businesses, and investment. Such a process, in their mind, then led to a race to the bottom in social assistance.[75]

73 Ross Finnie, Ian Irvine and Roger Sceviour. 2005. *Social Assistance Use In Canada: National and Provincial Trends in Incidence, Entry and Exit*. Analytical Studies Research Paper, no, 245. Catalogue no. F0019M1E. Ottawa: Statistics Canada. (May 2005). Available at www.statcan.gc.ca/pub/11f0019m/11f0019m2005246-eng.pdf.

74 See: David Elton. 1997. *Where Are They Now? Assessing the Impact of Welfare Reform on Former Recipients, 1993-1996*. Calgary, AB: Canada West Foundation; please also see: Canada West Foundation. 1997. *Welfare Reform in Alberta: A Survey of Former Recipients*. Available at www.cwf.ca/V2/files/199713.pdf.

75 For an excellent overview of this framework, please see: Gerard Boychuk. 2006. "Slouching toward the Bottom? Provincial Social Assistance Provision in Canada, 1980-2000." *In Racing to the Bottom? Provincial Interdependence in the Canadian Federation* edited by Kathryn Harrison. Vancouver, BC: University of British Columbia (UBC) Press.

Thankfully Gerard Boychuk empirically tested this very question in his essay "Slouching toward the Bottom? Provincial Social Assistance Provision in Canada, 1980-2000." Boychuck analysed social

assistance expenditures, dependency rates, and social assistance benefit rates over a two-decade period that included the federal reforms in 1995 and 1996 to test whether an observed race to the bottom occurred. His conclusion, while acknowledging the importance of the race to the bottom phenomenon, was fairly strong:

> [V[irtually nothing in this data suggests that anything of significance took place between 1995 and 1996 when CAP was replaced by the CHST. Certainly, there is no evidence to suggest that this shift precipitated a race to the bottom. The evidence here is clear.[76]

In other words, based on Boychuk's empirical analysis, there was not a race to the bottom in social assistance during the 1990s based on the federal reforms of both transfers and national standards in social assistance.

Kathryn Harrison, the editor of the volume in which Boychuk's essay appears provided an even stronger conclusion regarding the issue of the race to the bottom between the provinces:

> The clearest lesson from this volume is that provinces within the Canadian federation are not completely at the mercy of destructive provincial competition. There is scant evidence of provinces' taxes or standards spiralling downward in the most extreme version of a race to the bottom....there is no evidence that provinces are increasingly influenced by neighbours' benefit rates or that the move from matching to block grant federal funding had any effect...[77]

This is a critical consideration in terms of applying the framework from the social reforms of the 1990s to our country's healthcare crisis today. These lessons of the 1990s indicate enormous potential benefits from replicating the reform framework without having to worry about a race to the bottom.

Summary

The 1995 reforms to the provincial transfers ushered in a period of provincial innovation and experimentation with respect to welfare and related programs. The federal reforms freed the provinces to tailor their programs to the needs of their citizens. The welfare reform period was characterized by a set of generally implemented reforms that made sense across the provinces as well as many province-specific reforms that were unique or somewhat unique to the individual province. The results were markedly lower welfare dependency rates and thus lower provincial spending on welfare nationally. It is also noteworthy that some provinces chose to increase welfare benefits or to introduce only limited reforms.

---

76 Gerard Boychuk. 2006. "Slouching toward the Bottom? Provincial Social Assistance Provision in Canada, 1980-2000." *In Racing to the Bottom? Provincial Interdependence in the Canadian Federation* edited by Kathryn Harrison. Page 178. Vancouver, BC: University of British Columbia (UBC) Press.

77 Kathryn Harrison. 2006. "Are Canadian Provinces Engaged in a Race to the Bottom? Evidence and Implications." *In Racing to the Bottom? Provincial Interdependence in the Canadian Federation* edited by Kathryn Harrison. Page 257. Vancouver, BC: University of British Columbia (UBC) Press.

Implications for Healthcare Reform and Recommendations

Canada faces both a short- and long-term deficit challenge. One of the explanations, particularly regarding the longer-term deficit is the continuing rise in healthcare costs. The federal government's commitment to increasing already large transfers to the provinces in support of healthcare may be incompatible with a longer-term balanced budget.

Equally as important, though, Canada is already a relatively high spending nation on healthcare but does not enjoy commensurate healthcare performance. The paper presents a long list of international measures regarding Canada's performance, which simply does not match up with the amount of resources allocated to support healthcare.

The experience of the 1990s with welfare reform provides a template for beginning the process of reforming Canada`s healthcare system. In the mid-1990s, Ottawa decentralized the design, regulation, and provision of social assistance to the provinces by reducing the value of the transfer while concurrently eliminating most national standards previously imposed on the provinces for social assistance. These changes realigned the incentives for the provinces to better focus on the nature of the problems incurred by those relying on social assistance and then devising ways to actually solve or help solve those problems. The increased autonomy and flexibility accorded the provinces led to an explosion of innovation and experimentation with different delivery models and administrative mechanisms. In addition, a set of fairly standardized reforms were also pursued across most provinces. The results were overwhelmingly positive in terms of reducing dependency rates, reintegrating large portions of the dependent community back into the labour force, and reducing government spending.

We have an opportunity to genuinely begin to reform our failing healthcare system based on the successful framework of welfare reform.

The experience of welfare reform both at the federal and provincial levels provides a clear framework for starting the process of healthcare reform in Canada.

1. The Canada Health Transfer (CHT) should be stabilized or even reduced, certainly not increased, in order to bring more direct accountability to the provincial level for the raising of resources used in healthcare while containing cost increases to the federal government.
2. The federal government should allow the provinces the maximum amount of flexibility to design, regulate, and provide healthcare to citizens within a universal and portable framework.
3. The Canada Health Act will have to be amended with respect to cost-sharing and extra billing in order to provide the provinces the requisite amount of flexibility while maintaining and safeguarding the principles of universality, portability, and accessibility. Indeed, the federal government could facilitate provincial innovation and experimentation by clarifying the meaning and intent of the five principles of the CHA.[78]

78 The Canada Health Act and needed reforms to it are the subject of the next instalment in the Macdonald-Laurier Institute's *Turning Point 2014* series. It is expected to be released in the spring of 2012.

MLI Publications

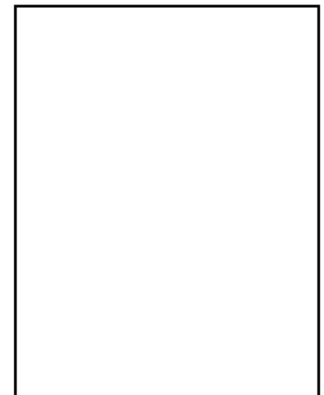
Winner of the
Sir Antony Fisher
International Memorial Award
for excellence in Think Tank
Publications, as awarded by the
Atlas Economic
Research Foundation

The Macdonald-Laurier Institute publishes works of research on a regular basis. We endeavour to work with authors and create publications that mirror our mission and move us closer to our goal. Ultimately we hope that our publications will encourage Canadians to think about public policy issues and ways that these policies can be improved.

Education: Freeing Aboriginal Youth to Learn
Calvin Helin

Citizen of One, Citizen of the Whole
Robert Knox

From Rehabilitation to Recruitment
Alex Wilner

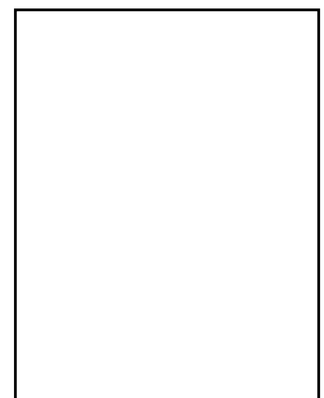


Why Crime Statistics Don't Add Up
Scott Newark

Confederation and Individual Liberty
Janet Ajzenstat

To Stand on Guard
Paul H. Chapin

Mortgage Insurance in Canada
Jane Londerville



Pills, Patents & Profits
Brian Ferguson

The University of Pennsylvania's "Think Tanks and Civic Societies" Program rated MLI one of the top 20 new think tanks in the world in 2009-10.

True North in Canadian Public Policy

The Macdonald-Laurier Insitute for Public Policy exists
to make poor-quality public policy in Ottawa unacceptable
to Canadians and their political and opinion leaders,
by proposing thoughtful alternatives through non-partisan
and independent research and commentary.

The Macdonald-Laurier Insitute is an independent, non-partisan registered charity for educational purposes in both Canada and the United States. We are grateful for support from a variety of foundations, corporations and individual donors. The Institute would not be able to continue making a diffrence for Canadians without the support of people across Canada and the United States for our publications on policy issues from aboriginal affairs to democratic institutions; support for our events featuring thought and opinion leaders; and support for our other activities .

For information on supporting the work of the Macdonald-Laurier Insitute by making a charitable donation, please visit our website at www.macdonaldlaurier.ca/supportMLI

The notion that a new think-tank in Ottawa is unnecessary because it would duplicate existing institutions is completely mistaken. The truth is there is a deep dearth of independent think-tanks in our nation's capital.
- Allan Gotlieb, former Deput Minister of External Affairs and Ambassador to Washington

To surmount the enormous challenges of getting Canada's place in the world right and taking advantage of changing opportunities, we need more ideas, input, discussion and debate in Ottawa - that is where the crucial decisions about our future are made. That's why MLI is so vital to Canada today.
- Hon. James S. Peterson, former Minister of International Trade and Member of Parliament for 23 years

MLI is a registered charity for educational purposes with the IRS and CRA

Sir Antony Fisher International Memorial Awards

Winner, Sir Antony Fisher International Memorial Award

Best Think Tank Book in 2011

as awarded by the Atlas Economic Research Foundation

"Top 20 New Think Tank" in the world for 2010

as rated by the University of Pennsylvania

What people are saying about MLI:

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

Congratulations all for the well deserved recognition. You've come a long way in a very short period of time.

Marc Patrone, Commissioner, CRTC

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 BC

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

Where you've seen us:

THE GLOBE AND MAIL

NATIONAL POST

THE WALL STREET JOURNAL.

HILL TIMES

The Economist

and in other major Canadian and international media

www.macdonaldlaurier.ca