Promoting Equity for a Stronger Canada:
The Future of Canadian Social Policy

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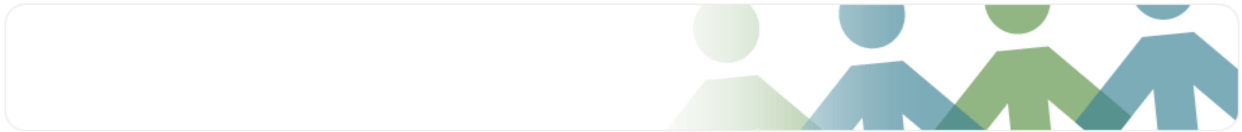

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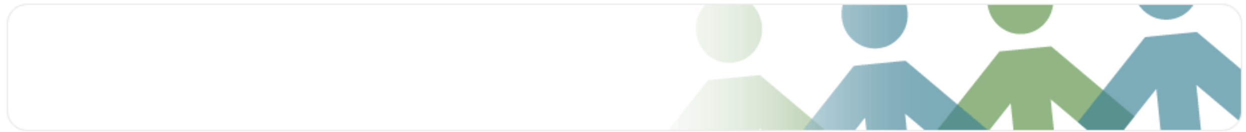

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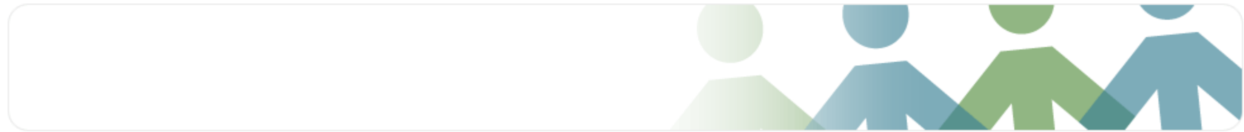

Introduction

In this paper, the Canadian Association of Social Workers (CASW) recommends the adoption of an equity framework for social policy in which the federal government plays a shared role with the provinces and the territories. Based on a concept of income, social, and health equity, the framework is very different from the vision advocated and promoted by the current government.[1]

While the Conservative government has undone some important policy initiatives of previous governments, such as the termination of the Kelowna Accord and the national child care plan, it has also introduced a universal child care benefit, a child tax credit, an employment credit and a home renovation tax credit. Fundamentally though, the Conservative government's vision of social policy differs from CASW in two fundamental ways. Prime Minister Harper and his colleagues promote a diminishing role for the federal government in the development of social programs and envision a restrictive federalism in which programs delivered by different levels of government are distinct within their own jurisdiction.[2]

A diminishing role of the federal government is being achieved by tax cuts. The total tax take has already been reduced from about 16% of gross domestic product (GDP) to 14%. Program expenses are projected to decline further from 2010–11 to 2016–17.[3]

Cuts are one half of the story: restrictive federalism is the other. The current government, unlike previous Conservative governments, is erecting a firewall between the federal government and the provinces.[4]

The current Prime Minister has never met with provincial leaders to discuss social policy. Budgets are drawn up to provide unconditional transfers so that the provinces can run social programs without perceived federal interference. In the future, transfers will be based on population growth and rates of inflation, with little or no provincial input.

The vision of CASW, by contrast, is based on a concept of coordinated federalism in which the federal government negotiates with the provinces and territories and helps to finance social programs under certain guiding principles. It is a vision ensuring that all Canadians have basic rights to a common minimum standard of service across the country.

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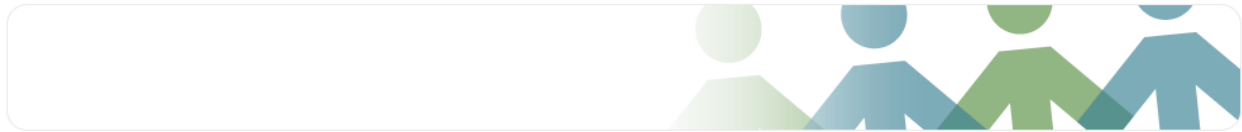
[1] Equity, in this report, refers to access to the distribution of income as well as the provision of social and health services.

[2] Keith Banting refers to three federalisms in relation to social policy and intergovernmental decision making: classic federalism in which programs are delivered by different levels of government acting independently; shared cost federalism in which the federal government offers financial support to other levels of government on certain conditions; and joint decision federalism in which formal agreement of both levels of government is required before programs are developed. Banting, Keith, 2009. "The Three Federalisms: Social Policy and Intergovernmental Decision-Making." in Herman Bakvis and Grace Skogstad, eds., Canadian Federalism: Performance, Effectiveness, and Legitimacy, Don Mills ON: Oxford University Press. The approach we take is slightly different from Banting. Restrictive federalism, as we see it, is based upon the classical model but also draws upon joint decision federalism. Coordinated federalism is more closely related to a combination of shared cost federalism and joint decision making process.

[3] Government of Canada, Budget 2012, Chapter six, The Fiscal Outlook, http://www.budget.gc.ca/2012/plan/chap6-eng.html

[4] Boessenkool, Ken, 2013, "Revealed: Stephen Harper is conservative. Really." Macleans, July 12.



Coordinated federalism does not preclude provinces and territories from administering their own programs or establishing their own goals. It simply supplements their goals with national social programs that are entirely or partially funded by the federal government.

The merits of coordinated federalism are also grounded in two fundamental principles: constitutionality and economic viability.

Constitutionality:

Constitutions outline the rights and responsibilities of governments and citizens and set out legal mechanisms to assure those rights and responsibilities.

Under the Canadian constitution, the federal government is largely responsible for national economic development and related matters including banking, currency, monetary policy, trade and defense. The provinces are responsible for social and educational services as well as matters related to civil and property rights.

As a result of the division of powers in the constitution, Canada is considered to be the most decentralized federal welfare state in the OECD.[5] Federal and provincial governments have relative autonomy within their own areas of jurisdiction. The federal government also has residual powers in order to assure peace, order, and good government.

Restrictive federalism is built on the idea that one level of government should interfere with others as little as possible. A distinct division of powers, in which the provinces had full responsibility for social programs, was the norm in intergovernmental relations from the time of confederation in the nineteenth century to the great depression in the 1930's.

From the 1930s to 1990s however, the federal government became more involved in the direct provision of pensions and employment insurance, as well as in the cost sharing of social and health services. In recent years, the Government of Canada has moved to reverse that trend and minimize federal involvement by increasing unconditional transfers and touting the benefits of tax point transfers.

This reversal, that began under the leadership of Prime Minister Mulroney and that has continued to influence our present government, is regrettable. It undermines a social contract between the federal government and the Canadian people based on a notion of shared rights and responsibilities.[6]

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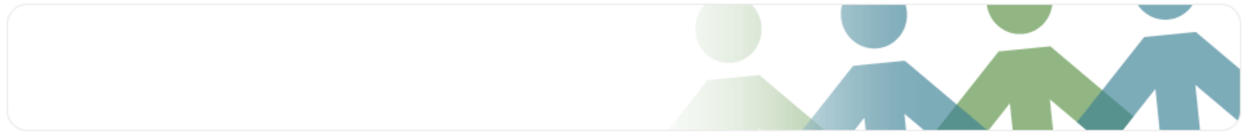
[5] Herbert Obinger, Stephan Leibfried, and Francis Castles, *Federalism and the welfare state: new world and European experiences*, 2005, Cambridge University Press.

[6] With respect to the social contract, we draw upon ideas in a paper by Kenneth Norrie, Robin Boadway and Lars Osberg, "The Constitution and the Social Contract" in Robin Boadway, Thomas Courchene and Douglas Purvis, *Economic Dimensions of Constitutional Change*, Kingston, John Deutsch Insitute, 1991.



A fairly well defined social contract developed in Canada in the latter half of the twentieth century and is partially enshrined in the Charter of Rights and Freedoms and in the Constitution Act of 1982. In terms of social policy, it was accepted that most social and health programs were efficiently administered by the provinces or territories, but it was also recognized that the federal government had an important role to play in promoting national equity.[7]

Increasingly, therefore, the federal government has played a role in the shared funding of health, social, and educational services, as well as the full funding of some income security programs such as pensions, employment insurance, and benefits for families with children.

As a form of cooperation between the federal and provincial governments evolved, it admittedly created friction. Some provinces, like Québec and increasingly Alberta, have viewed it as an unnecessary and unwanted intrusion into matters of provincial jurisdiction. Other provinces complained about the fairness or adequacy of federal funding.

For politicians, federal provincial cooperation has been, at times, a messy affair due to the need for constant negotiation and the potential for open disagreement. For citizens, on the other hand, it broadened the range of political ideologies that have input into the negotiating process and enhanced democratic discourse. It also diminished, even if it did not eliminate, the tendency for either level of government to act unilaterally.

In spite of complexity in navigating differing political perspectives and priorities, the majority of Canadians seem to be satisfied with the outcome of shared responsibility for social policy. In 2002, a public opinion study by a leading research organization found that the top priorities of Canadians were social ones, such as health care, education, employment, and child poverty.[8]

In 2009, a poll by Nanos Research found that Canadians strongly supported the public health system and public solutions to make public health care stronger.[9] In 2013, a poll by Environics Research has shown that a majority of Canadians are willing to pay higher taxes to protect public services.[10]

Coordinated federalism, as CASW envisions it, is not perfect. It leaves room for dispute. It does, however, provide a political framework for current and future social programs. It can accommodate the special status of Québec. It can accommodate provincial and territorial priorities. And it is constitutional.

[7] Kenneth Norrie et al, pp 226-233

[8] Matthew Mendelsohn, Canada's Social Contract: Evidence from Public Opinion, 2002, Canadian Policy Research Networks.

[9] Nanos Poll: *Overwhelming support for public health care*, 2009, Nupge.ca. 2009-08-13.

[10] The poll was commissioned by the Broadbent Institute, http://www.broadbentinstitute.ca/

Economic Viability:

A Californian professor of economics, Peter Lindert, explored the history of tax-based social programs over a long period of time and concluded that social spending contributed to, rather than inhibited, economic development.[11]

The notion that social programs inhibit economic development is particularly strong when the economy is sluggish, as is the present circumstance. In the early 1980s, many western European countries, which already had advanced social programs, experienced slow growth compared to the United States and Canada.

Based on that observation, a theory developed that social programs limited labor market flexibility and leaders like Margaret Thatcher used that belief to shift England away from state provided social and health services to market driven systems of provision.[12]

By the turn of the century, however, the notion that social programs were the cause of an economic slowdown came into question. The case against was based on a one-sided view of cost benefit which looked at the risks, not the advantages. In contrast, a 2002 OECD study found that while some social programs may have had a marginally negative impact on economic output, others actually improved human capital and labor market productivity. [13]

In a more recent study, two epidemiologists found that stimulus spending on social programs can not only stimulate economic development, but also reduce social problems associated with recessions. [14]

A strong determinant of health is a robust safety net. The real danger to health, they found, was not recession, but austerity. When social safety nets were slashed in times of recession, economic shocks turned into health crisis. They found that countries with higher social program expenditures had higher life expectancy. It also seems that the ratio of social service expenditures to health service expenditures is associated with health outcomes, not simply the amount spent on health services.[15]

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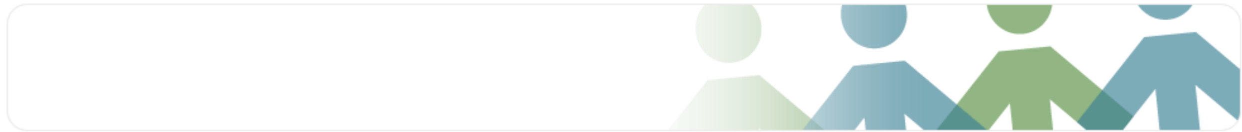
[11] Peter H. Lindert, *Growing Public: Social Spending and Econmic Growth since the Eighteenth Century*, Cambridge University Press, 2004. This summary of the book in this paragraph is derived from Ole Meldgaard, *Social welfare and economic growth*, pdf (internet access), Meldgaard is president of the European National Anti-poverty Network, Denmark. Also, Richard Wildinson and Kate Pickett, *The Spirit Level: Why More Equal Societies Almost Always Do Better*, 2000, Allen Lane.

[12] Rebecca Blank and Richard Freeman, "Evaluating the Connection between Social Protection and Economic Flexibility", in Rebecca Blank, ed., *Social Protection versus Economic Flexibility: Is There a Trade-Off?,* University of Chicago Press, 1994.

[13] The OECD is a unique forum where the governments of 30 democracies work together to address the economic, social and environmental challenges of globalization. Member countries include Canada and the United States as well as most of the countries of western Europe.

[14] David Stuckler and Sanjay Basu, *The Body Economic: Why Austerity Kills*, Harper Collins, 2013.

[15] See Gina Browne, Stephen Birsch, Lehana Thabane, Better Care: *An Analysis of Nursing and Healthcare System Outcomes*, Canadian Foundation of Healthcare Improvement, June 2012.



While social programs enhance economic development and improve health, they are also essential instruments for poverty reduction. In a 2010 Organisation for Economic Co-operation and Development (OECD) study of 14 European countries, it was found that economic growth was not a sufficient condition for poverty reduction.[16] The role of social transfers was more decisive than the role of per capita Gross Domestic Product (GDP) in reducing poverty as well as income inequality.

More generally, social programs also help to sustain economic development by building social cohesion and a sense of citizenship as well as reducing conflict.[17] They do so by increasing equitable access to public services and investment in human capital, particularly education and health, thereby improving the quality of labor and lowering risks for society as a whole during times of economic downturn. [18]

The pursuit of economic growth as a sole or primary solution to societal woes has been, and remains, a dominant ideology of most governments, including Canada's. Increasingly, however, that ideology is being challenged, not only by environmentalists but also by economists, like Jeff Rubin (former economist of CIBC World Markets), who suggests that the high price of fuel will dampen or possibly end growth unless we change the way we traditionally view and promote it. [19]

Whatever path economic development in Canada takes in the future, it should be balanced so that employment creation and social protection go hand in hand with investment. A balanced model approach is actively encouraged by the Global Agenda Council on Employment and Social Protection of the World Economic Forum.

Specifically, the Council proposes the following measures for balanced development: targeted investments in infrastructure; public investment in "green jobs;" shifting taxation from employment to environmental "bads;" tax cuts or increases in cash transfers to low-income households; robust minimum wage floors to prevent wage deflation; greater progressivity in the tax system; higher levels of investment in active labor market programs; and flexible schemes to promote job retention and job sharing. [20]

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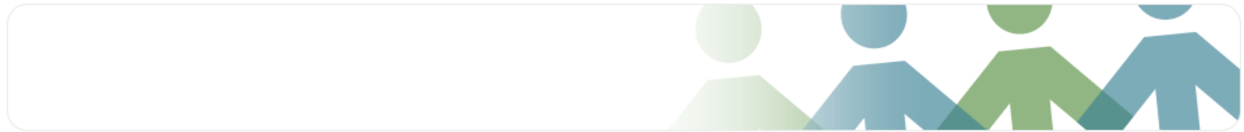
[16] Yannis Dafermos and Christos Papatheodorou, "The Impact of Economic Growth and Social Protection on Inequality and Poverty: Empirical Evidence from EU Countries, *Paper presented at the 1st International Conference in Political Economy*, Rethymno, Crete, 2010.

[17] OECD, *Promoting Pro-Poor Growth: Social Protection*, 2009, 25. The guide has been produced for developing countries but the principles are based on the experience of developed countries with advance programs of social protection.

[18] OECD, *Promoting Pro-Poor Growth: Social Protection*, 2009, 22-25.

[19] Jeff Rubin, *Why Your World is About to Get a Whole Lot Smaller*, Vintage Canada, 2010 and Jeff Rubin, *The End of Growth*, Random House of Canada, 2012.

[20] World Economic Forum, Global Agenda Council on Employment and Social Protection, *The Case for an Integrated Model of Growth, Employment and Social Protection*, 2012, 5. The next few paragraphs draw mainly from this report, 13-15.



While acknowledging that reform of some social programs may be necessary to take into account demographic changes (e.g., an aging population), the Council concludes that the experience of the Nordic countries shows that comprehensive social programs are not an obstacle to good economic performance. By way of contrast, the recent performance of the US suggests that relatively underdeveloped social program protection can be a cause of weakness and instability rather than strength.

It is not, then, an issue of whether comprehensive social programs are affordable but a question of who pays and how much. "Where social protection systems need to be reformed, governments have a choice. They can either impose change or they can negotiate change with the relevant stakeholders. Building consensus with social partners may be slower, but is a more certain [and democratic] way to a durable solution."[21]

CASW proposes three ways in which the government of Canada can encourage pan-Canadian income, social and health equity: (1) the development of a basic income; (2) the use of the Canada Social Transfer to finance income security and promote social inclusion; and (3) the strengthening of federal support of provincial/territorial health care services.

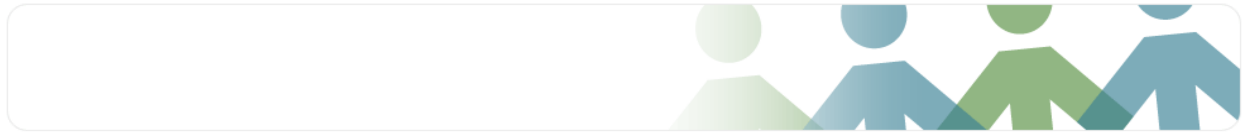
To be more specific regarding income equity, CASW recommends that the federal government initiate a process to review and renew the income security system in Canada with a view to the development of a targeted and affordable basic income.

A basic income could build upon existing negative income tax mechanisms such as the Guaranteed Income Supplement for seniors, the Canada Child Tax Benefit for families with young children, the Working Income Tax Benefit, and the Goods and Services Tax/ Harmonized Sales Tax Credit.

Implementing a comprehensive basic income would require the federal government to engage in careful planning with provincial and territorial governments based on a principle of coordinated federalism as advanced in this report.

Secondly, with respect to social equity, CASW recommends that the federal government follow the lead of the European Union and use a governance technique such as the Open Method of Coordination (OMC) to ensure a pan-Canadian dimension to income security and social services programs. The OMC is a cyclical process involving the development of EU-wide objectives, goals, guidelines and indicators: translation of these into member state national plans; peer review and mutual learning; and public reporting. The process is managed by a highly developed intergovernmental relations system involving the European Commission and the governments of each of the 28 EU member states, as well as EU-wide social partners and civil society organizations.

[21] World Economic Forum, Global Agenda Council on Employment and Social Protection, *The Case for an Integrated Model of Growth, Employment and Social Protection*, 2012, 15.



In Europe, the OMC has proven to be a flexible and effective method of bringing governments of widely different perspectives and persuasion together to tackle common problems like the reduction of poverty or social exclusion.

To move in this direction, the federal government should initiate meetings with the provinces and territories to discuss the future of the Canada Social Transfer. This means not only a discussion about the amount of money transferred, but the conditions under which it will be transferred.

Without initially setting any conditions on the Canada Social Transfer, both orders of government need, first of all, to decide whether they can find common objectives and agree on a policy framework for income security and social programs.

Thirdly, regarding health equity, CASW recommends that the federal government take action to ensure that the conditions of the Canada Health Act (public administration, comprehensiveness, universality, portability and accessibility) are met in order for the provinces and territories to receive federal funding.

In addition, CASW recommends that the federal government take the lead in providing financial incentives for the provinces and territories to transform the health care system into one that is patient centered, community-based and cost efficient. One way to do this is to fund a pan-Canadian initiative to provide benchmarking indicators that will support accountability and stimulate change.

CASW also recommends that, in terms of overall funding, the federal portion of health care costs cover, in the short term, 20% of total public health expenditures and that the proportion of public spending to total health spending should remain around 70%. Both targets are realistic within the current economic environment. They have been achieved in recent years and surpassed in earlier years.

In the following sections of the report, the rationale for these (and related) recommendations is outlined in detail. Each section provides: (i) background information, including relevant research; (ii) a statement on the value and importance of federal leadership; and (iii) a set of recommendations.

Income Equity

Canada has developed a complex and often confusing array of income support programs over the last hundred years. They have developed in a somewhat ad hoc and incremental fashion, and have varied in their purposes and target populations.

Some have been geared to specific age brackets (e.g. children and seniors). Others have provided support to individuals with conditions of sickness, work-related injury, or disability. Still others have been based on economic challenges related to family (e.g. widowhood or single parenting responsibilities) or one's status in the labor market (e.g. insurance against unemployment, workfare programs, and tax credits for the working poor).

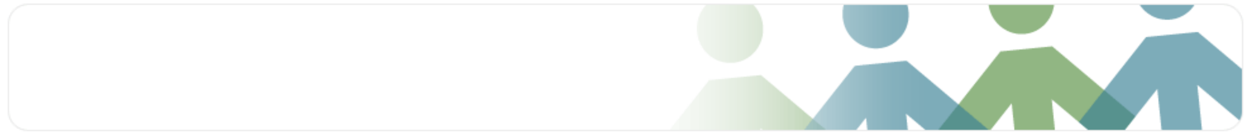
There has also been a division of responsibility in income security between the federal and provincial governments with contributory and more universal programs generally being offered at the federal level, and last resort income security programs such as social assistance being left to the provinces.

Despite this broad array of income security programs in Canada, poverty persists and individuals lacking income and/or economic resources frequently fall through the cracks of our current social safety net. As a result, there are increasingly frequent calls for a broad scheme for a "basic" income to eliminate complexity and overlap in the delivery of income security through the provision of more comprehensive and unconditional support. In its most ambitious form, a basic income aims to provide an adequate income for all with very few if any strings attached.[22]

The background section below defines and outlines components of a basic income and provides a description of its two alternative delivery mechanisms – through a demogrant and through a negative income tax. Next is a brief history of some of the debates about a basic income and proposals which have been made, in the past, in Canada.

Following that are recommendations that the federal government move forward initiatives with the provinces and territories to set in place a version of a basic income that would be constitutionally feasible and both fiscally sustainable and affordable. It is the position of CASW that such an initiative would make a very significant contribution to the reduction of income inequality and the negative consequences of high levels of poverty.

[22] In Canada and elsewhere, a basic income is sometimes referred to as a guaranteed income. We use the term basic income, partly because the term will not be confused with existing programs in Canada like the guaranteed income supplement for seniors.



Background

The Basic Income Earth Network (BIEN) has been a prominent proponent of a basic income over the last quarter century. BIEN defines the term in this fashion:

A basic income is an income unconditionally granted to all on an individual basis, without a means test or work requirement. It is a form of minimum income guarantee that differs from various forms of guaranteed income that now exist in […] three important ways:

- it is paid to individuals rather than households;
- it is paid irrespective of any income from other sources;
- it is paid without requiring the performance of any work or the willingness to accept a job if offered. [23]

In Canada, there have been a variety of proposals for what has usually been labeled a "guaranteed annual income." The proposals for a 'made-in-Canada' basic income have incorporated some but not all elements of the BIEN definition. Some, for example, have been targeted at specific age groups (typically children or seniors). Others have been intended as a supplement to replace labor market income for those unable to work.

Whether comprehensive, as outlined by BIEN, or partial as proposed in Canada, there are two general ways in which a basic income can be paid as a cash transfer to individuals or households – through a universal demogrant or through a negative income tax mechanism.[24]

A universal demogrant involves an up-front payment, typically tax-free, to all (adult) citizens. This version of a basic income is paid regardless of income level, in the same amount to all individuals, and paid out on a predictable and regular (e.g. monthly) basis. A demogrant may or may not be a taxable income.

A demogrant could be linked to progressive income taxation where those with greater income pay higher rates, or it could be tied a tax regime that is somewhat regressive or even flat, where everyone pays the same rate regardless of income. Consequently, the taxation of other forms of income (e.g. wages or salaries) has differing implications for how a demogrant would be financed and how much redistribution would occur. Many argue that more progressive or higher across-the-board tax rates are necessary in order to finance a basic income scheme.

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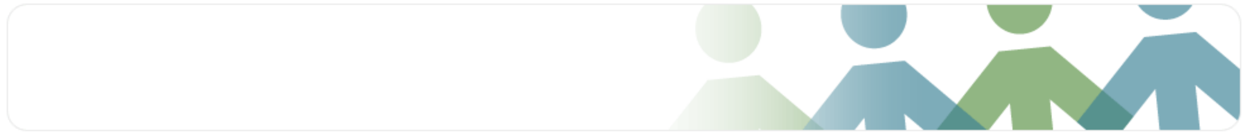
[23] http://www.basicincome.org/bien/

[24] The following discussion is based on the Inset on p. 21 of Young, Margot and James P. Mulvale. 2009. *Possibilities and Prospects: The Debate Over a Guaranteed Income. 2009*. http://www.policyalternatives.ca/publications/reports/possibilities-and-prospects



A *negative income tax* mechanism provides basic income benefits to anyone whose income falls below a predetermined level of minimally adequate income. This threshold can be adjusted to family configuration and size. To use a hypothetical scenario, the threshold could be set at $24,000 per year for a single adult, $36,000 for a couple, with $6,000 added for each dependent child or adult that is part of the family unit. So for a married couple with two children, the threshold of income adequacy would be $48,000 per year.

If the pre-tax household income level was exactly at this threshold, the family would not pay income tax but would also not receive benefits. If the income was above this threshold, they would pay income tax according to the prescribed rates. If the income fell below this threshold, they would be eligible for a 'top up' to the threshold equal to their shortfall. So if their pre-tax income was $30,000, this family would receive a benefit of $18,000. In the rare circumstance in which a family received no income from any other source, a full benefit of $48,000 would be paid.

In principle, a negative income tax benefit targeted to those with low income would be less expensive than a universal demogrant paid to everyone. A disadvantage is that there is a time lag between claiming and receiving a benefit. If payments are based on income tax returns from the previous year, for example, there could be a delay of up to a year before benefits are received. A person in immediate need of income may have to wait, and another person whose economic circumstances have improved may be receiving the benefit when it is no longer really needed.[25]

Basic Income Proposals in Canada

There is a long history of debate about a basic income in modern Western political thought, dating back to the early 1500s.[26] In twentieth century Canada, the idea of a basic income as a means to achieve economic security and equity surfaced in several proposals, studies, and campaigns at various points in time.[27]

In the 1930s, the Social Credit government in Alberta argued for regular cash payments to be paid to individuals by the provincial government, as a means of economic stimulus and redistribution. But the promise of such a universal "social credit" was not implemented due to a lack of funds in the provincial treasury and opposition by the federal government.

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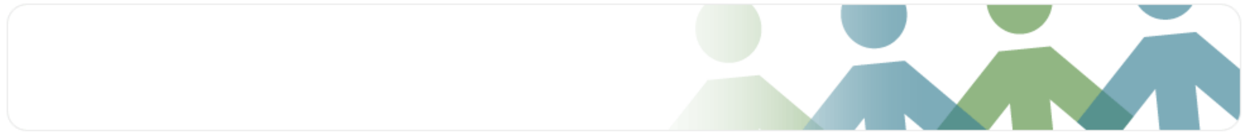
[25] NIT proposals can address this problem with a provision for advance claims by persons whose economic circumstances worsen and who require immediate income support. Such claims can be reconciled in later taxation periods when their circumstances may have improved. In NIT schemes it may also be wise to retain a residual social assistance option for those with urgent and immediate needs, and who have not yet filed an income tax return that would determine their NIT benefit.

[26] See http://www.basicincome.org/bien/aboutbasicincome.html#history.

[27] Young and Mulvale, 2009, pp. 12 – 16. The discussion which follows is based on this source. See also Mulvale, James P. and Yannick Vanderborght. 2012. "Canada: a guaranteed income framework to address poverty and inequality?" In R. Caputo (ed.), *Basic Income Guarantee and Politics*. New York: Palgrave Macmillan.



In 1968, the Economic Council of Canada, a federally funded crown corporation, noted the presence of poverty in Canada "on a much larger scale than most Canadians probably suspected" and pointed to the idea of a basic income as a possible remedy to the problem.

In 1971, a Special Senate Committee on Poverty, chaired by Senator David Croll, recommended a basic income financed and administered by the federal government, and delivered through a negative income tax. This scheme would have ensured a base income of at least 70% of the poverty line, but would not have been paid to single employable adults under age 40.

In the same year, the Castonguay-Nepveu Commission recommended a three-tier income security plan for Quebec, consisting of a basic negative income tax, benefits for "employable" people that would top up low earnings, and better benefits for those "not employable." Around this same time, the Department of National Health and Welfare pointed to a basic income model as a means of fighting poverty, and called for further study and investigation.

In 1970, the Royal Commission on the Status of Women recommended that a "guaranteed annual income be paid by the federal government to the heads of all one-parent families with dependent children." In 1973, a minority federal Liberal government initiated a social security review, which argued for a two-tiered approach to social assistance, including a guaranteed annual income plan for those who could not work and an income supplement for the working poor.

After the early 1970s, discussion of a basic income faded from public policy discourse as concerns grew about inflation, unemployment, and the perceived need for cuts to government spending. However, interest in the idea persisted in certain quarters, and from 1974 to 1979, a basic income pilot project called Mincome was carried out in Dauphin, Manitoba under the auspices of the provincial and federal governments.

Although this experimental project eventually lost political support and published no official findings, recent analysis of population health data by Dr. Evelyn Forget reports a number of positive outcomes attributable to the Mincome scheme. They include: a significant reduction in hospitalization (especially for admissions related to accidents and injuries); a fall in physician contacts for mental health diagnoses; and a greater proportion of high school students continuing on to grade 12.[28]

Hum and Simpson, who were directly involved in the development of the Mincome project, also point out that the Dauphin experiment did not lead to a significant withdrawal of labor supply,

[28] Evelyn L. Forget, *The Town with No Poverty—Using Health Administration Data to Revisit Outcomes of a Canadian Guaranteed Annual Income Field Experiment*, 2011.

which countered a common argument of critics that a basic guaranteed income would cause people to avoid paid work.[29]
In 1982, a Royal Commission on the Economic Union and Development Prospects for Canada (the Macdonald Commission) again recommended a version of a basic income. It was set at a very low level and involved the elimination of other income security measures such as unemployment insurance and old age security. The proposal, because of its restrictive nature, was strongly opposed by the labor movement and other civil society organizations.

During the minority parliament of 2008 – 2011, calls to consider moving towards a basic income model came from committees in both the Senate and the House of Commons.[30] The Senate Sub-Committee on Cities published a report entitled, *In from the Margins.* It recommended a wide range of measures to address poverty, the lack of affordable housing, and homelessness.

In addition, it made two recommendations specifically regarding a basic income:

> … (that) the federal government publish a Green Paper … to include the costs and benefits of current practices with respect to income supports and of options to reduce and eliminate poverty, including a basic annual income based on a negative income tax, and to include a detailed assessment of completed pilot projects on a basic income in New Brunswick and Manitoba (Recommendation 5).
>
> … (that) the federal government develop and implement a basic income guarantee at or above the LICO[31] for people with severe disabilities (Recommendation 53).

A House of Commons committee also made a recommendation to the Conservative government that it should "create a federal basic income program for persons with disabilities and support a disability-related supports program to be delivered by the provinces and territories."

The committee "decided not to make a recommendation regarding a universal basic income, considering it preferable to take one step at a time and begin with a program benefitting only persons with a disability." Although the Commons committee was less supportive of an overall basic income than the Senate committee, the former did refer to the possibility of moving toward the goal of a universal basic income in an incremental fashion.

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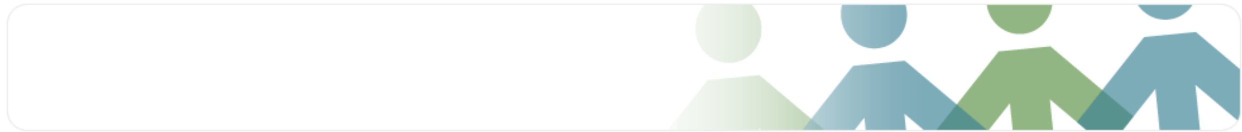
[29] Derek Hum & Wayne Simpson (2001-01/02). A Guaranteed Annual Income? From Mincome to the Millennium”". *Policy Options/Options Politique*, pp. 78–82.

[30] The work of these two Parliamentary Committees is described in Mulvale & Vanderborght, 2012.

[31] The low income cut-off, a measure used by Statistics Canada, and popularly referenced by community organizations as the poverty line in Canada.



Interestingly, one of the most prominent advocates of a basic income on the contemporary political scene in Ottawa has been Conservative senator Hugh Segal.[32] In recent years, Senator Segal has publicly and repeatedly proposed the introduction of a federally initiated basic income, arguing that Canada has the money to ensure that every citizen can live with dignity. According to Segal, "when we look at the billions we now spend on social policy, it's clear we have the capacity."[33]

In February 2008, Segal introduced a notice of motion in the Senate calling for "a fulsome study on the feasibility of a Guaranteed Annual Income […] or Negative Income Tax as a means of reducing poverty and providing a real solution to those currently living below what is considered the Canadian poverty line."[34]

Support for a basic income has been proposed across the political spectrum. In the 1960s, a prominent right wing proponent of a basic income, in the form of negative income tax, was the economist Milton Friedman, a strong advocate of the free market and laissez-faire capitalism.[35]

In a contemporary context in Canada, a centrist think tank like the Conference Board of Canada has also been an advocate. Recently, its senior Vice-President and Chief Economist, Glen Hodgson, wrote that "a guaranteed annual income remains an appealing 'big idea' whose time has yet to arrive politically. There is no better time than right now to heat up the debate."[36]

As part of his support for considering the basic income option, Hodgson points to three advantages of this model of income security:

Existing social welfare programs can be streamlined into one universal system of transfers that are delivered without condition through the income tax system, reducing public administration significantly and providing related savings; –recipients would still have a strong incentive to work if earned income were taxed at low marginal rates, thereby strengthening labor force

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[32] Segal, Hugh. 2008 (April). Guaranteed annual income: why Milton Friedman and Bob Stanfield were right. *Policy Options* http://www.irpp.org/en/po/budget-2008/guaranteed-annual-income-why-milton-friedman-and-bob-stanfield-were-right/

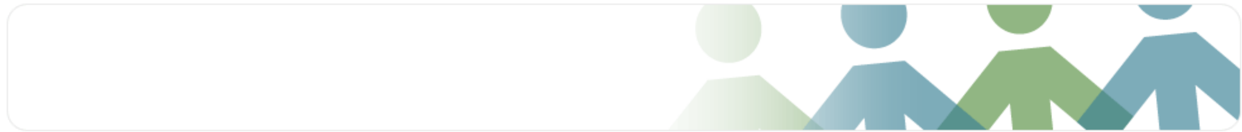
[33] According to the *Toronto Star*, March 5, 2007.

[34] Quoted from a "Communique" and "Notice of Motion" released by the Office of Senator Hugh Segal, Senate of Canada, February 6, 2008.

[35] Friedman, Milton. 1962. *Capitalism and Freedom*. Chicago: University of Chicago Press.

[36] Hodgson, Glen. 2011 (Dec.). A Big Idea Whose Time Has Yet to Arrive: A Guaranteed Annual Income. Ottawa: The Conference Board of Canada. www.conferenceboard.ca/economics/hot_eco_topics/default/11-12-15/A_Big_Idea_Whose_Time_Has_Yet_to_Arrive_A_Guaranteed_Annual_Income.aspx

Hodgson, Glen 2012 (March). *Reinventing the Canadian Tax System: The Case for Comprehensive Tax Reform*. Ottawa: The Conference Board of Canada.



attachment and increasing the availability of labor; and health care spending on low-income Canadians could be lowered if a (basic income) reduced the prevalence of poverty and created better health outcomes.[37]

Hodgson goes on to state that a guaranteed annual income could be constructed through an approach to federal-provincial relations that is similar to what is advanced in this paper: "Since social assistance and publicly funded health care are delivered by the provinces, careful coordination would be required between the federal government and the provinces to make a (basic income) work."

Hodgson further argues that "a realistic next step would be to pilot the impact of a basic annual income in one or more communities, monitoring its fiscal and social impacts and the potential fiscal savings over time, especially as related to publicly fund health care.

Practical and Strategic Matters

If there is sufficient public and political will to move towards a basic income approach to income security in Canada, it will be crucial to develop a practical strategy to maximize the possibility that such efforts will bear fruit. In the past, Canadian governments have introduced new social programs incrementally. For both political and financial reasons, a gradual approach to building a basic income might be the most politically and financially feasible.

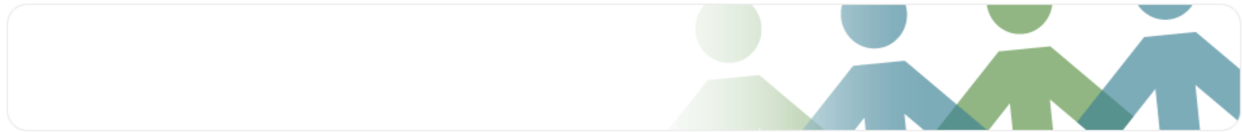
Canada already has mechanisms in place for income support that could potentially be 'stitched together' to create a more comprehensive and coordinated income for all. The existing assortment of programs is largely geared to different stages of the life cycle.

For families with young children, the Canada Child Tax Benefit / National Child Benefit Supplement (CCTB / NCBS) program use a negative income tax mechanism to deliver benefits to parents in low and modest income households. There is also the Universal Child Care Benefit, which resembles a demogrant. It is available to all families with pre-school age children. While the amount paid out is very modest, there are no conditions on how the money can be spent by families that receive it.

The Caledon Institute on Social Policy has developed an interesting proposal that simplifies child benefits and makes them more progressive (i.e. would transfer more money to families in greater economic need). Caledon's model raises the combined Canada Child Tax Benefit/National Child Benefit Supplement to $5400 per child.

The increased cost ($4 billion) of such an enhanced benefit would be covered, according to Caledon, by eliminating the Universal Child Care Benefit and the non-refundable Child Tax Credit (which also cost $4 billion). So, the total cost of child benefits would not increase beyond

[37] See Hodgson above.



the current $19 billion expenditure.[38] Such a reform in the child benefits framework would approximate a partial form of (income-tested and targeted) basic income for families with young children.

In regard to seniors, we have an Old Age Security/Guaranteed Income Supplement program. Old Age Security is paid as a demogrant (albeit a taxable one for seniors with higher incomes) and the Guaranteed Income Supplement is a negative income tax mechanism targeting low income seniors.

Another modestly-scaled negative income tax mechanism currently in place for adults with low incomes is the Goods and Services Tax/Harmonized Sales Tax Credit. Also, the Working Income Tax Benefit is intended to encourage labor market attachment for individuals with low income.

In addition, there is a range of other federal benefits available (e.g. Employment Insurance and the Canada Pension Plan with different subcategories of eligibility), not to mention social assistance and other (usually 'last resort') benefits at the provincial level. The Canadian patchwork quilt of income security programs is complex and multi-layered, and is confusing for persons wanting or needing benefits.

A basic income could reduce this complexity and make the income security system easier to navigate, thereby saving administrative costs. Consequently it would be an important objective in the process of designing a coordinated basic income to reduce, in the long term, the complexity of the current array of programs, which would also help to eliminate duplication and fill gaps.

This exercise, national in scope, would be best accomplished in a spirit of coordinated federalism, in which the federal government takes leadership but coordinates with provinces and territories to tailor national initiatives to local circumstances. Designing a simpler and more effective income security floor for everyone in Canada could also be facilitated by respecting the constitutional breakdown of federal / provincial responsibilities.

Provinces could concentrate their resources in providing social and health services to persons who need additional support beyond having enough income to live on, and the federal

government could play a lead role in providing (or at least cost-sharing) income security that operates in a more seamless and effective manner. An interesting proposal along this line is the proposal from the Caledon Institute on Social Policy,[39] which proposes a federally-delivered

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[38] Sherri Torjman and Ken Battle. *Welfare Re-form: The Future of Social Policy in Canada*. Ottawa: Caledon Institute on Social Policy, November 2013, pp. 7 -8

[39] Sherri Torjman and Ken Battle. *Welfare Re-form: The Future of Social Policy in Canada*. Ottawa: Caledon Institute on Social Policy, November 2013.

"basic income" that is specifically targeted to persons with "severe and prolonged disabilities." With such a program in place, the funding that would otherwise have been spent by provincial/territorial governments on income support for disabled persons can be redirected to "a wide range of disability supports." While Caledon's proposal is more targeted and categorical than the approach proposed in this paper (i.e. the Caledon proposal is only for the "severely disabled"), it does make a clear distinction between federal responsibility for income support and provincial/territorial responsibility for services and support that people need for a life of dignity and independence.

In order to develop and implement a basic income scheme, public support must be gained from various quarters beyond the political sphere and government policy specialists. A broad coalition in favor of a basic income will need to be built. It can draw on the work of academics, policy analysts from the voluntary sector, think tanks, and grassroots activists. [40]

Estimating Costs

Any version of guaranteed income would obviously involve substantial government transfers, although costs would vary considerably depending on the design of the program.

In preliminary work to estimate the actual cost of a basic income in Canada, Lerner, Clark and Needham presented a hypothetical model that would be paid as a universal demogrant to all citizens and permanent residents. They calculated a cost of $198.6 billion in 1999 dollars for a scheme that would pay an income of $7,000 per year to persons age 65 and over, $5,000 to persons aged 21 to 64, $3,000 to persons under 21, with an additional $5,000 paid to each household, to be divided equally among adult members of the household.[41]

They envisioned this scheme as a replacement for federal benefits for elderly persons and children, as well as for unemployment insurance benefits. The net cost of the model was calculated at $161.7 billion in 1999 dollars. [42] Such a scheme would have eaten up most public revenue and thus would be clearly unaffordable.

By contrast, in 1994, Human Resources Development Canada compared the cost of a basic income delivered as a universal demogrant to the cost of a negative income tax version. The demogrant option was estimated to require the expenditure of an additional $93 billion, even though it would pay benefits far below a "livable" level.

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[40] One group that currently brings many of these constituencies together is the Basic Income Canada Network, the Canadian national affiliate of the Basic Income Earth Network.

[41] Lerner, S., C.M.A. Clark, and W.R. Needham. 1999. *Basic Income: economic security for all Canadians*. Toronto: Between the Lines.

[42] As a point of comparison, the total federal government revenue for fiscal year 1999/2000 was just over $178 billon. *See Annual Financial Report of the Government of Canada, Fiscal Year 1999-2000.*

On the other hand, the cost of the negative income tax model was estimated at $37.3 billion. This latter option was judged to be “cost-neutral” as it could be financed by savings in other programs such as unemployment insurance, the child tax benefit, and federal contributions towards social assistance.

Another study by Hum and Simpson estimated the costs of various versions of a universal, non-taxable benefit set at the poverty line, coupled with a tax-back rate on earned income. In one scenario, a basic income was very expensive, costing $217.1 billion; almost triple the amount of federal transfer payments to individuals in 2000. On the other hand, the authors estimated the cost of a more modest and targeted basic income to be much less ($37.8 billion). They also concluded that the cheaper version would in fact reduce poverty more efficiently than the more costly version.[43]

> In 2012, Senator Segal argued that the overall cost of a basic income for Canada would be manageable.[44] As he noted:
>
> If the average top-up per person below the poverty line was $10,000 annually and if all of the three million lowest income people in Canada received the full amount—that would be an upfront cost of $30 billion—roughly 10 percent of the present Canadian federal budget. But that up-front cost would be reduced by savings elsewhere.

Detailed and rigorous costing of a range of contemporary basic income options for Canada is social policy work that has yet to be done. The approximate estimates cited above clearly suggest that a negative income tax model would be more fiscally feasible. Part of this cost estimation could gauge how negative income tax based benefits interact with other federal and provincial benefits, and with federal and provincial income tax. Such an analysis, for example, could shed light on savings in existing benefit programs (e.g. Employment Insurance) that would be drawn upon less with a negative basic income in place.

Thinking longer term, it will also be helpful to do further investigations of how a negative income tax based basic income in Canada would enable us to reduce expenditures in areas such as health care, criminal justice, and special education – given the well-established links between poverty and negative social outcomes such as poor health, entanglement with criminal justice, and impeded learning and development in children.[45]

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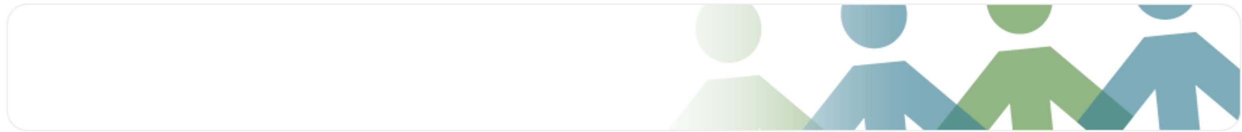
[43] Hum, Derek and Wayne Simpson. 2005. The Cost of Eliminating Poverty in Canada: Basic Income With an Income Test Twist. Pp. 282 – 292 in K. Widerquist, M. Lewis, and S. Pressman (eds.), *The Ethics and Economics of the Basic Income Guarantee*. Aldershot, UK: Ashgate.

[44] Hugh Segal. 2012 (Dec.). Scrapping Welfare: The case for guaranteeing all Canadians an income above the poverty line. *Literary Review of Canada*, http://reviewcanada.ca/magazine/2012/12/scrapping-welfare/

[45] *The Dollars and Sense of Solving Poverty*, National Council of Welfare Reports, Vol. 130. Ottawa: National Council of Welfare, Autumn 2011.



A basic income in Canada that paid reasonable benefits and had a broad reach would enable us to lower poverty and the income gap between the rich and poor. Not only would it enable us to realize some immediate cost savings in existing income security programs, it also could lower government expenditure in the long run by reducing the negative social outcomes of high rates of poverty and economic insecurity.

Need for Federal Leadership

The cost projections outlined above provide approximate ideas of the cost of different basic income scenarios, but clearly more research needs to be undertaken to produce detailed and up-to-date data. Such research would explore different models of delivery, various levels of benefits, and how different government revenue mechanisms would affect affordability. Such hard-headed analysis of public finances would illuminate the way to an achievable and effective basic income across the country.

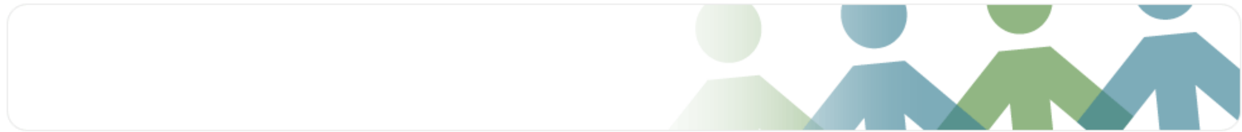
Modernization and improvement in the income security system in Canada cannot occur without federal leadership. Currently, the federal government covers most of the costs of transfer payments to individuals. The provinces and territories are important but secondary players. Furthermore, if a basic income is delivered through a negative income tax mechanism, federal leadership is essential to ensure coordination of intergovernmental tax arrangements and agreements.[46]

An advantage of using a negative income tax mechanism is that it is already a tried and true method of delivery for existing income transfers to individuals and families. A negative income tax mechanism can also be used to determine eligibility and benefit amounts, as is now done for more targeted benefits such the Child Tax Benefit, the Guaranteed Income Supplement for seniors, the Goods and Services Tax/Harmonized Sales Tax Credit, and the Working Income Tax Benefit.

In fact, a comprehensive basic income for low income Canadians could be fashioned from (and partially funded by) these more categorical federal benefits. The existing programs linked to the filing of income tax returns could be 'stitched together' and extended in regard to eligibility and level of benefit.

Whether a basic income takes the form of a targeted benefit or is more universal, federal and provincial/territorial levels of government would have to find common ground. The

[46] Regarding a negative income tax based form of a basic income at the federal level, Senator Hugh Segal (2008) emphasizes that such a program would not only reduce poverty but also eliminate government policing of poor people's lives that is required in means-tested programs such as social assistance.



provinces/territories would have to agree to federal leadership and coordination in income security matters.[47]

The federal government would have to foster (and to some extent cost-share) the provision of a more comprehensive income security system as well as health services and social program supports at the provincial level that would address the longer-term and systemic roots of poverty.

A better defined jurisdictional 'division of labor' between the federal and provincial/territorial levels of government could do a more effective job of reducing poverty and increasing income equality in the short to medium term.[48]

[47] The provinces and Territories called for coordinated social policy reform in the 1990's. See Ministerial Council on Social Policy Reform and Renewal, *Report to the Premiers*, 1995.

[48] Another important but complex question that goes beyond the scope of our discussion here is the best design and delivery mechanisms for income support and service delivery that could be established between the federal and Aboriginal governments. On the income security side, it is interesting to note that select Aboriginal jurisdictions (e.g. the Inuvialuit Regional Corporation) pay their residents a small but universal dividend resembling a basic income from revenues earned from economic development activities, including resource extraction.

CASW Proposal:

CASW recommends that the federal government initiate a process to review and renew the income security system in Canada with a view to the possibility of developing a targeted and affordable basic income.

It should be targeted initially to provide income support for all individuals who are economically insecure and vulnerable because of age, labour market status or disability. It would serve to increase income equity in the country and social inclusion of members of society who are currently excluded from the mainstream.

A comprehensive basic income could build upon existing negative income tax mechanisms such as the Guaranteed Income Supplement for seniors, the Canada Child Tax Benefit for families with young children, the Working Income Tax Benefit, and the Goods and Services Tax/ Harmonized Sales Tax Credit.

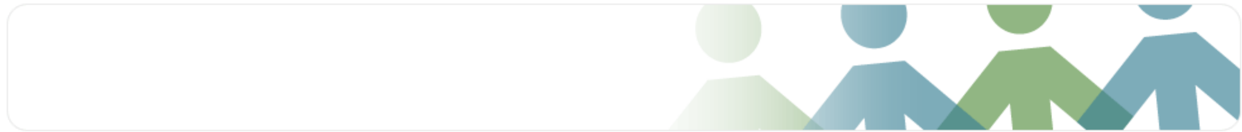
A more comprehensive, integrated, and seamless negative income tax based benefit system for Canadians would have to address issues of income insecurity and precarious employment that affect working age Canadians. Such a system of benefits would also have to introduce improvements to benefit levels and ease of access to our existing program for seniors and children.

A revamped architecture of income security in Canada could be introduced incrementally to preserve fiscal integrity, but should also be planned and implemented as an 'overhaul' rather than tinkering at the margins.

Implementing a comprehensive basic income would require the federal government to engage in careful planning with provincial and territorial governments based on a principle of coordinated federalism as advanced in this report.

A basic income would largely supplement, but not replace completely, the need for provincial and territorial financial assistance to those in immediate and dire need due to circumstances beyond their control. Some sort of social assistance will still be necessary in those cases. However, the bulk of people currently on social assistance would be eligible for a basic income.

In designing a comprehensive basic income, it would also be essential to determine how it would link with other programs at the provincial/territorial level (such as job training and child development services) or federal level (such as employment insurance and the Canada and Québec pension plans). Such a review would be guided by the principle that benefit amounts paid out must not be reduced but, where possible, enhanced in amount and that the overall benefit 'system' should be simplified and streamlined in regard to application and take-up procedures. As a targeted program (as opposed to a more universal demogrant), a basic income



administered through a negative income tax mechanism would ensure an efficient expenditure of public revenue. A targeted basic income would also be partially funded by existing federal programs for children, the disabled, and seniors, as well as by federal contributions to provincial social assistance through the Canada Social Transfer (CST).

As a measure that would significantly reduce poverty in Canada, a targeted basic income would also reduce the long term social and financial costs of poverty in areas such as health care, education and criminal justice.[49]

Social workers are intimately familiar with the struggles of clients who have inadequate income. Every day, social workers experience examples in our professional practice of the social, emotional, and health-related harms of living in poverty.

CASW calls on the federal government to demonstrate leadership in developing a more equitable and just income support system for Canadians. A basic income provides a model for income equity. It merits careful consideration and pragmatic development in Canada and beyond.

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[49] The huge literature on the costs of poverty is usefully summarized in *The Dollars and Sense of Solving Poverty* (Ottawa: National Council of Welfare, 2011). http://publications.gc.ca/site/archivee-archived.html?url=http://publications.gc.ca/collections/collection_2011/cnb-ncw/HS54-2-2011-eng.pdf .

Social Equity

The Canada Social Transfer, first suggested in 1994, was accompanied by the termination of the Canada Assistance Plan and with it all but one of the standards which were a part of that legislation. Since then, there has been a lack of federal leadership. CASW would like to see a renewal.

In announcing the termination of the Canada Assistance Plan, the federal government was signaling its intention to provide the provinces with the flexibility that several provincial governments had been asking for over the previous decade. [50] It was also a partial response to two Quebec government reports recommending greater provincial autonomy particularly in social programs.[51]

This new arrangement, in which provincial governments are regarded as having considerably more latitude in authority over such areas as health, social services, social assistance, and post-secondary education, was initiated by the Liberal party in power after 1993 and was justified by the need to control expenditures.

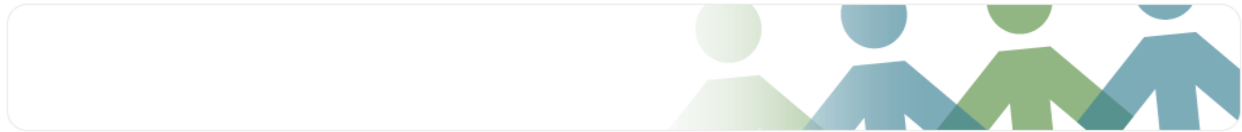
In fact, this economic argument was stretched to initiate a significant transformation in federal provincial relations that culminated in the signing of the Social Union Agreement in 1999. While the federal government has retained its role in program areas that have become constitutionally the authority of the federal government (such as the Old Age Security, Employment Insurance and the Canada Pension Plan), it has devolved its role in areas that were historically the provinces' authority but in which, as previously outlined, it had become involved.

In spite of this trend, the Canada Social Transfer still plays an important role in the funding of income security (particularly social assistance), social services (including child development programs) and post-secondary education. The active engagement of the federal government in future developments is important, not only to ensure funding, but also to encourage pan-Canadian initiatives.

CASW proposes that governments in Canada use a governance technique such as the Open Method of Coordination (OMC) to ensure a pan-Canadian dimension to income security and

[50] The Allaire Report, *A Quebec Free to Choose,* appeared in January 1991. It called for the transfer of 22 areas of governance to become exclusively provincial. It was adopted by the Liberal Party of Quebec in March of that year. http://en.wikipedia.org/wiki/Allaire_Report; Mollie Dunsmuir, Law and Government Division, Library of Parliament, Constitutional Activity From Patriation To Charlottetown (1980 – 1992) November 1995, 23 Available at http://www.parl.gc.ca/Content/LOP/researchpublications/bp406-e.pdf ; Quebec National Assembly, Commission on the Political and Constitutional Future of Quebec, or Bélanger-Campeau Commission, Report, March 1991;

[51] The Quebec referendum on sovereignty in 1995 so frightened the federal government that within a few years, and by administrative means, the nature of the federation was transformed from the regime of fiscal federalism to the present arrangement.



social services programs to further the modernization of income security and social services through the Canada Social Transfer.[52] An Open Method of Coordination is a tested and true method of coordinating sensitive social policies in the European Union, where centralized governing bodies in Brussels have even less formal authority than the federal government in Ottawa.

In short, CASW believes that the federal government can and should play an active role in the development of social programs as it has done in the past. However, CASW is also mindful of provincial and territorial sensitivities and realizes that Ottawa is not able to impose strict conditions over social programs for which it has limited constitutional responsibility. That is why CASW proposes a technique like an Open Method of Coordination.

Background:

In 1941, the federal government assumed exclusive authority for income and corporation taxes by signing a series of agreements with each of the provinces. The provinces would be compensated for the surrender of their rights to the income and corporation tax for the duration of the war and for one year after. Exclusive access to these tax instruments would permit the federal government to raise substantial funds for the war effort.[53]

During the Second World War, largely through the work of its advisory committees, the federal government released three major reports on health, social security and housing. Through the work of the Advisory Committee on Health Insurance, the federal government released a report in March 1943 on the possible post war expansion of publically supported heath care. It became known as the Heagerty Report. [54]

Through the work of the Advisory Committee on Reconstruction, the federal government also released reports on social programs and housing. These were the Marsh Report, also released in March 1943, and the Curtis Report, released in 1944. These reports held out the promise of a

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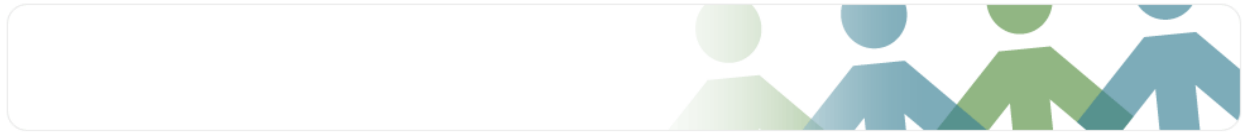
[52] While post secondary education is a component of the Canada Social Transfer, we focus, in this paper, on income security and social services.

[53] This is the origin of what became known as the tax rental agreements. James A. Maxwell, Recent Developments in Dominion-Provincial Fiscal Relations in Canada, National Bureau for Economic Research, 1948, 10-11 http://papers.nber.org/books/maxw48-1 ; A.R. Dobell, Intergovernmental Finance, The Canadian Encyclopedia, http://www.thecanadianencyclopedia.com/articles/intergovernmental-finance

[54]Heather Macdougall, "Into Thin Air: Making National Health Policy, 1939-45," Canadian Bulletin Of Medical History, 26:2 2009, 283-313. Available At Http://Www.Cbmh.Ca/Index.Php/Cbmh/Article/Viewfile/1400/1367 . See also "Making Medicine: The History Of Health Care In Canada 1914-2007", Http://Www.Civilization.Ca/Cmc/Exhibitions/Hist/Medicare/Medic-3h08e.Shtml



major transformation of social and health policy after the war, changes which would involve a transformation in the authority of the federal and provincial governments in these areas.

At war's end, the federal government presented a series of proposals to the Dominion Provincial Conference of August 1945.[55] Known as the Green Book, the federal government's proposals contained ideas for a substantial expansion of social security drawing on the ideas current in the previous 15 years, including the Bennett government's New Deal, the Report of the Royal Commission on Dominion Provincial Relations, and the three wartime reports on healthcare, social security and housing.[56]

The Family Allowance was the first universal program of support for children. It was initially paid out only for children under the age of 16 and later extended to all those under 18.[57] Since 1945, support for children has remained a key part of federal social benefits. While the family allowance was terminated in 1992 by the Mulroney Progressive Conservative government, the federal government has continued a social benefit for children, but delivered through the income tax.[58]

A second key categorical program introduced during the post war period was the Old Age Security in 1951. [59] In addition, the Old Age Assistance Act provided for a means tested and cost shared pension for people between the ages of 65 and 70.[60] A third key and categorical program introduced in the same period was the Disability Assistance benefit. It was also a benefit that was 50/50 cost shared with the provinces and means tested. [61]

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[55] Proposals of the Government of Canada. August 1945.

[56] Meetings throughout 1945 and 1946 did not result in a comprehensive agreement on taxation and on social programs, despite the federal government's offer of funding to the provinces as an incentive to cede exclusive control of income and corporate taxes. Instead the federal government signed 8 individual agreements with the provinces which continued the model of the wartime tax rental agreements. It did not sign an agreement with Quebec. A.R. Dobell, "Intergovernmental Finance," See The Canadian Encyclopedia, http://www.thecanadianencyclopedia.com/articles/intergovernmental-finance.

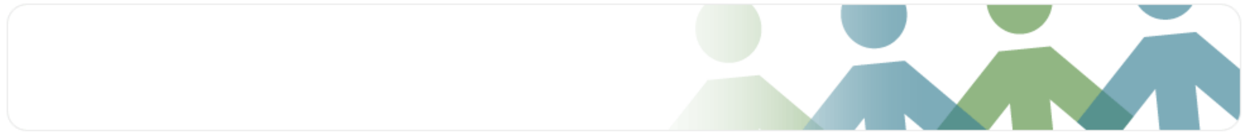
[57] Between 1946 and 1962, there were several federal social program initiatives despite the failure of the negotiations around the Green Book Proposals of 1945. The Family Allowance was brought into being in 1944, and the first cheques under the program were paid out in 1945.

[58] Raymond B. Blake, From Rights to Needs A History of Family Allowances in Canada, 1929-92, UBC Press, 2009. A portion of the text is available at http://www.ubcpress.ca/books/pdf/chapters/2008/FromRightstoNeeds.pdf

[59] First passed into legislation in 1927 as a program to provide some federal funding to those provinces that chose to introduce a means tested pension, it was transformed into a second universal program, through constitutional amendment in 1952.

[60] Dennis Guest, Old-Age Pension, Canadian Encyclopedia, http://www.thecanadianencyclopedia.com/articles/oldage-pension; Historical Statistics of Canada, Section C, Social Security, http://www.statcan.gc.ca/pub/11-516-x/sectionc/4057749-eng.htm

[61] John E. Osborne, T*he Evolution Of The Canada Assistance Plan,* National Health and Welfare, 1985. Available at http://www.canadiansocialresearch.net/capjack.htm



A fourth key federal social program was the 1956 Unemployment Assistance Act, made retroactive to 1955, "whereby provinces with agreements were reimbursed for half their expenditures on assistance to needy unemployed people, with no ceiling on individual benefits or federal expenditures."[62]

The last key federal social program introduced in the period was the Hospital Insurance and Diagnostic Services Act, passed in 1957. The Act "offered to reimburse, or cost share, one-half of provincial and territorial costs for specified hospital and diagnostic services. This Act provided for publicly administered universal coverage for a specific set of services under uniform terms and conditions. Four years later, all the provinces and territories had agreed to provide publicly funded inpatient hospital and diagnostic services."[63]

Tax Sharing and Program Financing

In 1962, the federal government negotiated a new arrangement with the provinces on the major taxes in dispute between them.[64] Instead of renting their taxing powers, the federal government established an agreement with the provinces that became known as tax sharing.[65] The agreement applied to nine provinces; Quebec continued to collect its own taxes.

On the other side of the ledger, during the period from 1963 to 1972, the Canadian welfare state took a distinctive shape and identity. Successive minority Liberal governments from 1963 to 1968, led by Lester Pearson, and a majority Liberal government led by Pierre Trudeau from 1968 to 1972, initiated and/or agreed to the reform of the major federal social programs. By 1972, these social programs constituted a Canadian welfare state.

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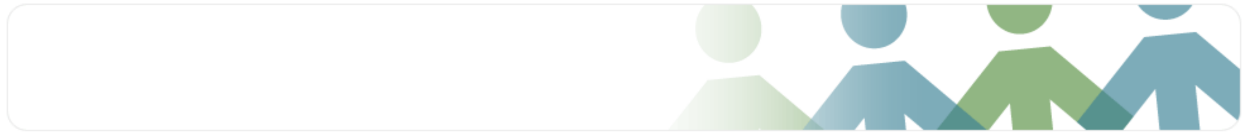
[62] John E. Osborne, The Evolution Of The Canada Assistance Plan, National Health and Welfare, 1985. Available at http://www.canadiansocialresearch.net/capjack.htm The Unemployment Assistance Act introduced the first continuing assistance to those provinces that wanted to take advantage of the funding. The legislation was intended to provide assistance only on behalf of those who were unemployed and employable. The same category of beneficiary that the Report of the Rowell Sirois Commission recommended should be placed under the authority of the federal government.

[63] Historical Statistics of Canada, Section C, Social Security, http://www.statcan.gc.ca/pub/11-516-x/sectionc/4057749-eng.htm; Health Canada, Canada's Health Care System, available at http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php . By the beginning of the 1960s, the federal government had made a modest start, coming some distance down the road towards the development of a Canadian welfare state. It had instituted a universal child benefit paid directly to families, mostly to mothers. It had also instituted several indirect categorical income support programs through offering to support those provinces willing to spend 50% of the cost. Lastly, it had instituted a program to support the availability of provincial hospital based care. It received a significant amount of revenue through "renting" the provinces' claims to the income and corporate taxes and in turn compensating them for the rental.

[64] Auditor General of Canada, Report 1989, Chapter 14, http://www.oag-bvg.gc.ca/internet/English/parl_oag_198911_14_e_4263.html

[65] Under this system the federal government would vacate a percentage of the three taxes in order that the provinces could receive the revenues from the vacated percentage. The percentage was set initially at 16% of personal income tax to be increased by 1% per year; 9% of corporation profits; and 50% of succession duties. See Claude Belanger, Canadian federalism, the Tax Rental Agreements of the period of 1941-1962 and fiscal federalism from 1962 to 1977, http://faculty.marianopolis.edu/c.belanger/quebechistory/federal/taxrent.htm.



The period was marked by the creation of the Canada Assistance Plan, a federal program to cost share social assistance and social services; reforms to the Old Age Security; a federal social insurance based pension plan which would ensure 25% of the average industrial wage; a new wholly federal Guaranteed Income Supplement to provide assistance to people over 65 who would not have access to the new federal pension; a substantial revision to the Unemployment Insurance Act in 1971, under which most of the labor force would be covered by insurance against unemployment; and the universal Medical Care Act passed in 1966 under which the federal government would share half of the costs of provincially administered physician based personal medical care.[66]

In order to receive funding under the Canada Assistance Plan, the provinces had to consolidate previous legislation into one program available to all persons in the provinces who, according to a review of their income and expenditures, could be considered to be in need. Federal programs to assist the provinces with funding for people with disabilities and for unemployed but employable people were terminated. Provincial Mothers' Allowances and pre-existing welfare programs were also terminated and replaced with one piece of legislation.

Under the Canada Assistance Plan, no province could institute residence requirements, nor could any province establish procedures that would involve residents having to accept employment as a condition of receiving assistance. These were among several standards for the provincial administration of social assistance.

The legislation was silent on the question of social services. The legislation did say that the federal government could spend on provincial programs that were intended to prevent poverty. It was under this statement that the federal government initiated spending on provincial child care and social service programs.[67]

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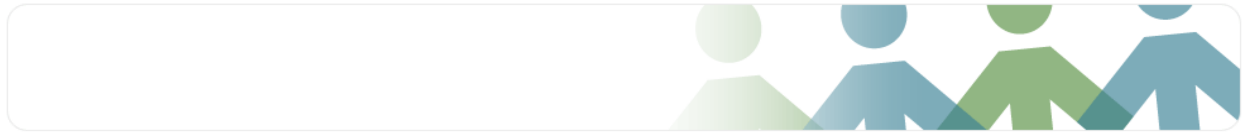
[66] Health Canada, Canada's Health Care System, available at http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php Five principles or standards for the implementation of medicare were articulated in the legislation. After several episodes in which provincial governments implemented practices which appeared to be in contravention, the federal government reiterated the standards in the Canada Health Act passed in 1984. The five Canada Health Act principles provide for:

1. Public Administration: All plans must be operated on a non-profit basis by a public authority accountable to the provincial or territorial government.
2. Comprehensiveness: Provincial and territorial plans must insure all medically necessary services provided by hospitals, and medical practitioners.
3. Universality: Provincial and territorial plans must provide health insurance to all residents on uniform terms and conditions.
4. Accessibility: Provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers.
5. Portability: Provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad.

[67] It should also be noted that under the terms of the Canada Assistance Plan, the provinces could extend social assistance and social services to Aboriginal people living on reserve and receive funding but since this remained a federal jurisdiction, the



Several key issues emerged in the development of these programs. Since at least some of them represented federal involvement in what had been declared to be areas of provincial authority, an agreement had to be reached on constitutional amendments that would support them. The establishment of federal Unemployment Insurance, Old Age Security and the Canada Pension Plan were all established with the support of a constitutional amendment.

Some of the federal programs were intended to provide funds in support of provincial programming and administration. In essence they were conditional programs and were based on 50/50 cost sharing. Funding for conditional grant programs in support of hospital insurance, medicare, and post-secondary education were combined in the Established Programs Financing Acts of the 1960s, and then in, 1977, the cost sharing and conditionality was terminated in favour of a per capita block grant. Provinces were still supposed to continue the programs for which they received funding but there was no further accountability.[68]

A further issue was conditionality. Two programs in particular were based on the establishment of federal conditions for provincial administration: the Canada Assistance Plan and the Canada Health Act. Each required that provincial administration meet a series of standards laid out in legislation. Of these only the Canada Health Act remains in place.

The last issue was federal social programming direct to individuals. Between 1940 and 1995, the federal government obtained provincial agreement to initiate social insurance programs, and direct support programs. Both types of program provide a direct link between the federal government and the beneficiary. The former includes unemployment insurance and public pensions, while the latter includes Old Age Security and child related benefits.

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provinces did not take advantage of the availability of funding. Why cost share when the federal government had full responsibility? Especially after the Federal government agreed to fund on reserve welfare and social services at 100% in Ontario through an agreement signed in 1965. At the same time the federal government did agree that access to welfare should be extended to people living on reserve at the same rates and on the same conditions as those offered by the province in which the reserve was located. This was a dramatic change in the availability of social programs on reserve, coming 12 years after the Old Age Pension was extended to Aboriginal people, and 19 years after the Family Allowance was extended to cover Aboriginal children on reserve.

[68] Amy Verdun and Donna E. Wood, Governing the social dimension in Canadian federalism and European integration, Canadian Public Administration, 56:2, June 2013, 173-84; Nadia Verrelli, The Federal Spending Power, Institute of Intergovernmental Relations, Queen’s University, May 2008; Stephen Laurent and François Vaillancourt, Federal-Provincial Transfers for Social Programs in Canada: Their Status in May 2004, IRPP Working Paper Series, no. 2004-07.

Federal conditional grants were also available to the provinces for the support of Old Age Assistance for persons 65 to 69, Assistance for Blind Persons, and Assistance for Disabled Persons. These programs were combined into the Canada Assistance Plan at its formation in 1966. It remained the only cost-shared conditional grant program until its termination in 1996. By the end of this period cost sharing was no longer on the agenda of federal provincial programming.

Evolution of an Alternative

During the postwar era up until the 1970s, Keynesian ideas of demand management dominated. In this context, social programs were the solution to the problem of cyclical economic growth by saving for a rainy day when economic conditions were good and unemployment lower, and paying out more benefits when unemployment was higher, which would help maintain demand and keep the economy moving.

Post 1980, social programs became the problem, not the solution. The solution was to reduce government expenditure, lower taxes and free the business sector to innovate and create jobs. Business and government were unified during the period in support of lower taxes, while simultaneously arguing that government deficits and debt also had to be lowered. [69]

The 1990s were a period of substantial change in the organization of social programs as a result of several changes taking place in the country. The election of the Progressive Conservative Party in 1984 marked the advent of neo-liberal ideas in national government.[70]

While some of its early attempts at curbing or terminating social programs were unsuccessful, the Progressive Conservative government of Brian Mulroney was later able to make some significant changes such as the termination of the Family Allowance, a program which the Prime Minister had declared to be a sacred trust during the 1984 election.[71]

After the 1993 election, the federal Liberal government decided to radically change the system of funding of provincial social programs. The two major remaining funding programs were the Canada Assistance Plan and the Established Programs. The government decided to terminate both and replace them with a single funding program called the Canada Health and Social Transfer. In doing do, the government ended the conditionality that helped to maintain a set of national standards in the provision of social assistance and social services, leaving only those standards incorporated into the Canada Health Act.

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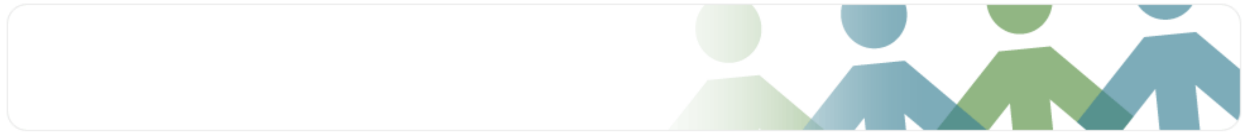
[69] Government regulations were regarded as a significant problem that formed a barrier to successful innovation. In general the point was to rely more private initiative and private enterprise and to do this government was to get smaller.

[70] The new government began its period in power symbolically by officially repudiating full employment as a goal of government, and adopting many of the ideas emanating from the Report of the Macdonald Commission, the Royal Commission on the Economic Union and Development Prospects for Canada.

[71] This period was also marked by political conflict over the 1982 constitution, a document that did not have the approval of the province of Québec. In the province there was debate about the range and extent of autonomy the province should be seeking. Two reports on the subject both suggested that the government of the province have responsibility for a much wider range of program areas including social programs. Externally there was debate about whether the federation could have differing conditions for Québec and for the other provinces.



Presented as a cost and deficit reduction measure, it also marked a major change in the construction of the federation. In Québec it meant that the federal government was less involved in provincial affairs, and in all of the provinces it meant that neo-liberal governments could introduce the social assistance measures they had wanted to legislate for some time. It also meant no further redistribution through social measures.[72]

The provinces and the federal government did attempt to establish a new basis for moving forward in the Social Union Framework Agreement signed in February 1999.[73] Under the agreement, the federal government can no longer introduce conditional program funding without the agreement of the majority of provinces. While this has not made new programming impossible, it does mean that the federal government cannot proceed as it did in the past by introducing a program and then trying to obtain individual provincial cooperation.

At the same time, the agreement does recognize that the federal government can continue to have a direct relationship with individuals in the country. The federal government can introduce new benefits to individuals as it sees fit. While the agreement appears to have fallen into disuse, these principles appear to have remained a guiding force in relation to new federal provincial social programs.

Now that the provinces have a much wider range of responsibility for providing social programs in areas in which the federal government previously had an involvement, it is appropriate to ask what was gained and what was lost. Was the federal involvement helpful? Was it appropriate?

For those who have supported strong federalism, the answer is clearly yes. For those who supported either Quebec's right to go its own way or the rights of all provinces to regain authority for social programs which they believe were allocated to the provinces under the British North America Act, the answer is no. Post 1999, it is perhaps best to characterize the new arrangement as one of restrictive federalism in which the rights of the provinces in the social area are in the ascendency.

Supporters of this approach believe that the provinces are in the best position to judge what is needed in their part of the world and therefore national programs are neither desirable nor useful.

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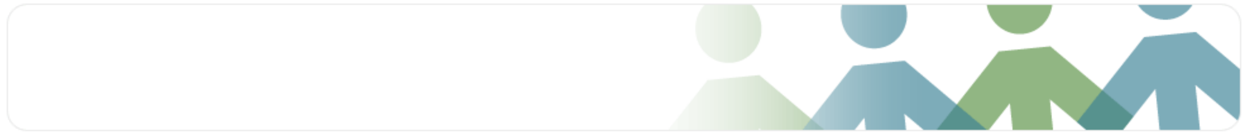
[72] All provinces would receive only per capita grants for health and social programs. And no province would have to pay attention to federally enforced standards – except one, no residence requirements for social programs. In 2004, the federal government decided to separate the transfer into two parts – a health transfer and a social transfer. See Report Of The Council Of The Federation Working Group On Fiscal Arrangements, Assessment Of The Fiscal Impact Of The Current Federal Fiscal Proposals, Main Report, July 2012; Hamish Telford, Peter Graefe and Keith Banting, Defining the Federal Government's Role in Social Policy: The Spending Power and Other Instruments, IRPP, September 2008,Vol.9, no. 3.

[73] A Framework to Improve the Social Union for Canadians: An Agreement between the Government of Canada and the Governments of the Provinces and Territories, February 4, 1999



The present Conservative government, a majority government freed from the restraints of five years in its previous minority status, is one that shares this view of federalism.

It is very unlikely to support an approach to negotiations in 2014 that will involve a return to the view of social programs entailed in fiscal federalism. It is also unlikely that it will engage in any new federal social policy initiative beyond what has been done already: the Universal Child Care Benefit,[74] and the gradual change in the age of eligibility for the Old Age Security from 65 to 67 to take effect in 2023.[75]

If the current Conservative government's perspective prevails into the future, the Canadian welfare state for citizens who are not First Nations and do not live on a reserve will in future consist of two parts: a core of national programs legislated by and administered by the federal government, and a series of health, social assistance, and social service programs in each province and territory. Each will have a different array of health and social programs, and a differing set of services and conditions associated with them. Social citizenship will be qualified by the province of residence, not by the national government. [76]

Need for Federal Leadership:

The Conservative government's support for the rights and autonomy of the provinces is coupled with two other key principles: a core belief in the value of private markets in the provision of health and social programs, as well as a belief in small government.[77]

Accordingly, there is, from this perspective, no role for the federal government in either shaping provincial policy or in creating a sense of shared citizenship through the availability of health and social programs of more or less the same standard across the country.[78] The only role for the

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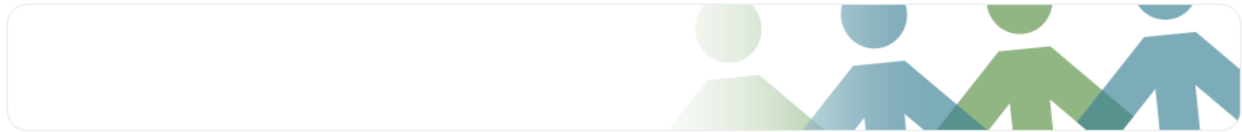
[74] http://www.cra-arc.gc.ca/bnfts/uccb-puge/menu-eng.html

[75] http://www.servicecanada.gc.ca/eng/services/pensions/oas/changes/index.shtml .

[76] For First Nations Peoples living on reserve, the same conditions will, in principle, prevail as those off reserve. In practice, however, the federal government has not guaranteed the same conditions on reserve as those available to other citizens in the same province. Funding has often not been sufficient to provide the same standard. Although the federal government has apologized for the residential school system they have not ensured that those in need in reserve communities have the necessary services available to them.

[77] A core belief in private markets and private enterprise will colour their approach to federal support for medicare. While it is unlikely that the principles of the Canada Health Act will be changed because of their symbolism, the federal government will be prepared to continue the present policy of neglect of enforcement. The number of private clinics will grow in the provinces despite being in direct violation of one of the five principles. The delisting of procedures will also continue as neo-liberal oriented provincial governments attempt to reduce expenditures on health care in the face of demographic pressures from an aging population.

[78] The belief in small government, when linked with restrictive federalism, will keep them from formulating a more positive role for the federal government in the Canadian welfare state. Neither will they wish to introduce a collaborative role with the provinces. This in spite of the fact that section 36 (1) (2) of the Constitution Act of 1982 states that "Parliament and the Legislatures….are committed to promote equal opportunities for the well-being of Canadians…..and providing essential public



federal government is in providing some share of the funds and in requiring the provinces to be broadly accountable for how funds are spent. It is in this area alone that the Conservative government may be prepared to act.

CASW, by contrast, proposes that the federal government needs to play a more active role in providing leadership in the promotion of pan-Canadian social policy and the furtherance of a sense of shared citizenship. CASW also believes that federal leadership can be achieved without overriding, or appearing to override, provincial and territorial authority. This could be achieved by using a technique such as the Open Method of Coordination adopted by the EU. [79]

In 2012, CASW explored, along with a group of scholars and practitioners, several historical, current, and potential roles, policies, and practices related to the Canada Social Transfer, which have major implications for the well-being of all Canadians and for the sustainability of Canada's social programs.[80]

Each of the participants in the project was aware of the current debates about the limited role of the federal government in relation to health care as well as the virtual lack of federal leadership with respect to the Canada Social Transfer. Currently the Canada Social Transfer provides funds in three broad areas: post secondary education, social assistance, and various social services (including child care). CASW focuses on the latter two areas.

A major concern of the participants was the lack of accountability in relation to the Canada Social Transfer, either on the part of the federal government or the provinces and territories. One participant hoped that the Canada Social Transfer would be used to further human rights standards as a backdrop to social programs since Canada is a signatory to the International Covenant on Economic, Social and Cultural Rights, which guarantees individuals an adequate standard of living. [81]

Another participant suggested that some aspects of the Canada Social Transfer, particularly the component related to income security and poverty reduction should be transferred in its entirety to the federal government since the federal government is currently responsible for the bulk of

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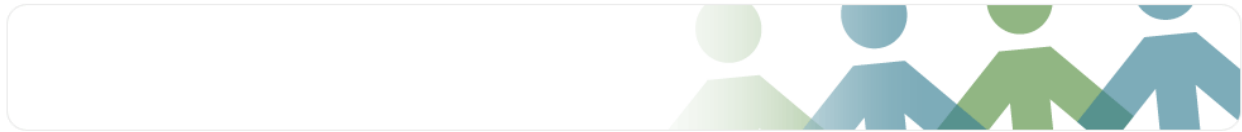
services of reasonable quality to Canadians". The 1982 Constitution also affirms the federal government's commitment to the principle of making equalization payments to ensure that provincial governments had sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.

[79] The Open Method of Coordination was launched in Europe in 2006 as a mechanism for coordinating social policies in areas where the European Union has limited authority. See Bart Vanhercke and Peter Lelie, Benchmarking social Europe a decade on: demystifying the OMC's learning tools, in Fenna, A. and Knuepling, F. (Eds.), *Benchmarking in Federal Systems: Australian and International Experiences*, Productivity Commission : Melbourne

[80] CASW, Canada Social Transfer Project: Accountability Matters, 2012, http://www.defendingsocialprograms.ca/

[81] Shelagh Day, Executive Director of the Centre for Poverty and Human Rights as quoted in CASW, Canada Social Transfer Project, 2012.



income transfers to individuals.[82] The Caledon Institute of Social Policy believes that before conditions and standards are applied to a financing instrument like the Canada Social Transfer, there is a need for a shared vision of what Canada's income security system should look like.[83] CASW agrees with that position.

More broadly, participants in the project felt that there were several options that could be introduced by the federal government in order to ensure some degree of accountability for the billions of dollars transferred to the provinces through the Canada Social Transfer, including a clarification of objectives, principles, standards and conditions.[84]

Overall, though, participants thought that both the federal government and provincial/territorial governments could play leadership roles: the federal government in relation to the development of a vision for income security programs with respect to the Canada Social Transfer; the provinces (and the territories) by coordinating a forum for the renewal and modernization of social policy.[85]

Some participants, however, said that *restrictive* conditions should not be attached to the Canada Social Transfer since adequate levels of income security and social protection could be brought about by other means in order to ensure that Canadians experienced similar levels of access wherever they lived. [86]

One way forward would be to follow the lead of the European Union - an economic and political union of 28 member states. In terms of social policy, the Union operates primarily through voluntary coordination, not through restrictive measures. Therefore, the European parliament, and other related supranational bodies, cannot impose conditions on member states.[87]

[82] John Stapleton, social policy consultant, Open Policy Ontario, as quoted in CASW, Canada Social Transfer Project, 2012, page 37.

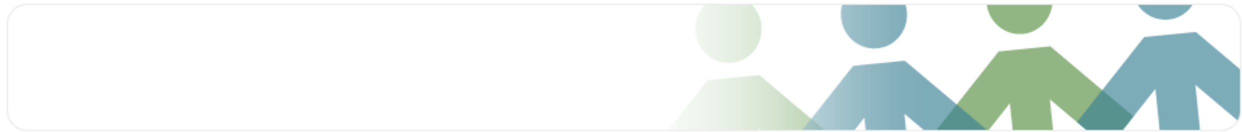
[83] See for example, Torjman, S., & Battle, K. (1995). Can we have national standards. The Caledon Institute of Social Policy. Ottawa, ON, and more recently Ken Battle, Sherri Torjman and Michael Mendelson, The 2014 Unbalanced Budget, 2014, Ottawa ON.

[84] CASW, Canada Social Transfer Project: Accountability Matters, 2012, section on available policy tools, pages 39ff.

[85] CASW, Canada Social Transfer Project: Accountability Matters, 2012, section on available policy tools, p 63.

[86] CASW, Canada Social Transfer Project: Accountability Matters, 2012, section on available policy tools, page 55.

[87] The governance of the European Union is far more complex and decentralized than the Canadian federation. At a supranational level, it includes The European Commission (responsible for legislative initiatives); the European Parliament (representing citizens in the legislative process); the Council of the European Union (representing each of the European states in the legislative process); the European Council (representing heads of states); and the Council of the European Union (representing different ministries of the member states).



Instead, the union uses a 'soft governance technique,'[88] as a mechanism for coordinating sensitive social policy areas where the European Union has very limited, if any, authority. At the same time, there is relatively broad recognition of the need for some degree of adequacy and accessibility in three social policy areas: social protection, social inclusion and health care.

Essentially, the European Union uses a set of coordinating measures to encourage pan European social policy rather than hard legislation. It is governance by persuasion, not by fiat.[89] Like our provincial and territorial governments, member states of the EU maintain their authority over sensitive policy issues.

To promote some degree of convergence of social policies, a technique called the Open Method of Coordination is invoked. An Open Method of Coordination is a means of spreading best social practices in member states and achieving sufficient social policy convergence to ensure economic goals of smart growth, sustainable growth and inclusive growth.[90]

The six steps of coordination are: the development of a framework of common objectives; the selection of key issues; the building of common indicators; the involvement of governmental and non-governmental stakeholders in the process; benchmarking; and the production of joint reports.

The European Union's 2020 social strategy revolves around <u>three</u> broad policy goals which are widely accepted by member states: social inclusion; social protection; and health care. They are the same areas covered in this report, and the first two – social protection and social inclusion – correspond to two of the three components in the Canada Social Transfer – income security and social services.

If Canada is to achieve something similar – CASW believes it can and should - the federal government has to work with other levels of government to ensure financial sustainability and modernization of social protection and social inclusion programs across the country. To achieve this, both orders of government need to develop some common objectives, social indicators, stakeholder involvement and joint reporting mechanisms.

Interestingly, this approach to funding and policy has been developed in Canada through the benchmarking of health care. Benchmarking is a way of making comparisons based on an agreed

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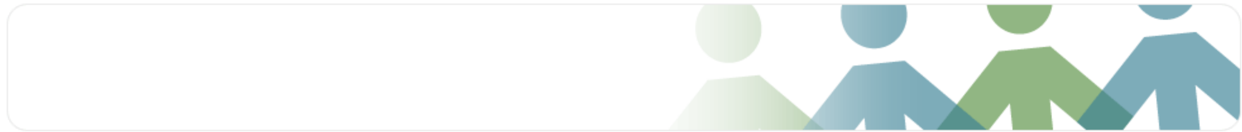
[88] See Donna Wood, The Canada Social Transfer and the Deconstruction of Pan-Canadian Social Policy, page 28. http://www.vibrantcalgary.com/uploads/pdfs/Canada_social_transfer_Wood_brief.pdf.

[89] Bart Vanhercke and Peter Lelie, "Benchmarking social Europe a decade on: demystifying the OMC's learning tools", in Fenna, A. and Knuepling, F. (Eds.), *Benchmarking in Federal Systems: Australian and International Experiences*, Productivity Commission : Melbourne\\

[90] Bart Vanhercke and Peter Lelie, page 173.



upon set of indicators.[91] The Canadian Institute for Health Information has been an important player, at the national level, in the development of pan Canadian performance indicators. Similar organizations exist in some of the provinces.

More specifically, the Health Indicators Project is an example of a performance benchmarking approach to the improvement of health care across the country. The project provides reliable and comparable data on the health of Canadians, the health care system and the determinants of health. National consensus conferences have provided a mechanism to develop a common performance indicator framework. Similar initiatives have been undertaken with respect to hospital reporting.

According to Baranck, Veillard and Wright, the Canadian system of benchmarking is paving the way for future health care practices. They also think that performance indicators are increasingly a basis for policy discussions concerning ways to improve health systems.[92] They seem, in other words, to provide information about standards and practices that not only inform but also influence intergovernmental cooperation and coordination.

[91] Baranck, Patricia, Jeremy Veillard and John Wright, "Benchmarkding health care in federal systems: the Canadian experience", in Fenna, A. and Knuepling, F. (Eds.), *Benchmarking in Federal Systems: Australian and International Experiences*, Productivity Commission : Melbourne

[92] Baranck, Patricia, Jeremy Veillard and John Wright, "Benchmarkding health care in federal systems: the Canadian experience", page 108.

CASW Proposal:

A benchmarking approach to the improvement of income security and social programs is also possible. Income security provides a measure of social protection to citizens. Social programs encourage their social integration into the larger society. Both require federal leadership to develop a modern policy framework that stretches across the provinces and territories. Both require federal leadership to ensure accountability

CASW recommends that the federal government follow the lead of the European Union and initiate discussion about the future of the Canada Social Transfer using a technique such as the Open Method of Coordination to ensure some level of convergence of programs across the country. In Europe, an Open Method of Coordination has proven to be a flexible and effective method of bringing governments of widely different perspectives and persuasion together to tackle common problems such as the reduction of poverty or social exclusion.

To move in this direction, the federal government should initiate meetings with the provinces and territories to discuss the future of the Canada Social Transfer. This means not only a discussion about the amount of money transferred, but the way in which it will be transferred.

In other words, without initially setting any conditions on the Canada Social Transfer, both orders of government need, first of all, to decide whether they can find common objectives and agree on a policy framework for income security and social services programs.[93]

They then need to build an intergovernmental knowledge base through the development of common indicators and quantitative benchmarking, as is currently being done in health care. The development of indicators could also involve experts and non-government stakeholders in the process in order to be as inclusive as possible.

Finally, CASW recommends that a technique such as an Open Method of Coordination in modernizing income security and social services programs be guided by the following principles: need; comprehensiveness; accessibility; fairness; portability; universality; and public or non-profit administration. [94]

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[93] In the European case, income security measures and social programs have been considered a multidimensional domain. Therefore, they worked initially on the development of consensus around the main challenges. In terms of social protection, key issues were income adequacy and financial sustainability. In terms of social inclusion, key issues were child poverty and homelessness.

[94] In what follows here we have outlined an approach to income security and social programs which parallels wording in the Canada Health Act. In that Act, however the principles are in effect a set of conditions on the transfer of funds from the federal government to the provinces. In our proposal, however, the seven principles which we outline are intended only as guides to preliminary discussion for the development of a framework. They may or may not become conditions for federal transfers.

- A principle of **need** presupposes income security and social programs will be made available according to a personal and/or financial assessment of an applicant;

  A principle of **comprehensiveness** means that an agreed range of income security and social programs are available within each province and territory and funded through public expenditures. Any province or territory is free to initiate new programs that are beyond an agreed range of programs;

- A principle of **accessibility** means that an agreed range of publicly funded income security and social programs will be available to all Canadians when they need them;

- A principle of **fairness** presupposes that all citizens have the right to apply for any publically supported program, and to have their application reviewed by an appropriate body within a reasonable period of time. Applicants have the right to a written decision within a reasonable period of time and the right to appeal any decisions, to have an appeal heard within a reasonable period of time and to receive a written decision within a reasonable period of time. During the period of appeal, applicants have the right to temporary financial support and/or services.

- A principle of **portability** means that all Canadians are covered by publicly funded income security and social programs wherever they travel or live within Canada.

- A principle of **universality** means that income security and social programs will be available to all Canadians in need of them.

- A principle of **public and not for profit administration** presupposes that publicly funded income security and social programs will be managed by a public agency on a not-for-profit basis and delivered by either public or private organizations on a not for profit basis.

Health Equity

The health care system is one of the hallmarks of equitable social policy in Canada. Without ongoing federal leadership and funding, its future is at stake.

The question of how to fund and address growing health costs is the topic of significant debate and discussion across the country. In response to that debate, the federal government has drawn a line in the sand and unilaterally announced that its contribution to health care spending will substantially decline over the next 30 years.

CASW proposes that this position is fundamentally flawed, not only because it passes the burden of health care funding to the provinces and territories, but also because it undermines the capacity to achieve national health care standards that enable Canadians to be treated fairly and similarly across the country regardless of where they live.

Without significant federal leadership and funding, there will be no pan-Canadian health care system. Without a national vision, Canada's international ranking in health care performance will continue to slide. Without federal leadership, the conditions of the Canada Health Act will be undermined. Without adequate federal funding, the health care system is unsustainable.

Our proposal to fix the current abrogation of national leadership and funding is simple. The federal government – this one or another – needs to step up to the plate, enforce the conditions of the Canada Health Act, restore federal transfers relative to provincial/territorial health spending to what they were prior to the cut backs of the 1990s, and provide financial incentives to promote reform and economic efficiencies in health care delivery.

The proposal, which we outline in further detail below, is affordable and sustainable. The federal government has the fiscal capacity to be involved. It also has the constitutional right. The decision is one of political choice and priority, not affordability and sustainability.

Background:

Since the late 1950s, the burden of health care funding has fallen on both levels of government. The first implementation of funding at the federal level was the Hospital Insurance and Diagnostic Services Act in 1957. The second was the Medical Care Act in 1966.

Under the Constitution, health is not exclusively assigned to one level of government.[95] While the constitution grants the provinces primary jurisdiction in health care delivery, the federal government has primary responsibility for health care to some classes of people (e.g., aboriginal

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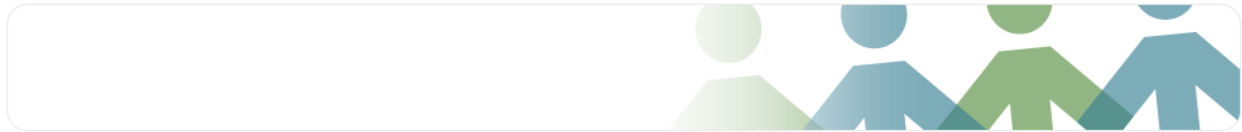
[95] The following few paragraphs are drawn primarily from Canada Senate, Study Committee on Social Affairs, Science and Technology, *Time for Transformational Change: A Review of the 2004 Health Accord,* 2012: and Marlisa Tiedemann, *The Federal Role in Health and Health Care*, Social Affairs Division, Parliamentary Information and Research Service, Library of Parliament, 2011.



people, military, and inmates of federal prisons), control of public hazards and matters related to national emergencies.

With respect to health care funding, however, federal jurisdiction stems from its jurisdiction over public debt and property and its general spending taxing power, which allows it to raise money and spend it as it sees fit, as well as any conditions it may set for the receipt of that money.

As a consequence of the overlap of responsibilities, in 1982, the Supreme Court of Canada stated that "health is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case on the nature or scope of the health problem in question."[96]

In 1977, the Hospital Insurance and Diagnostic Services Act and the Medical Care Act were replaced by the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act and, in 1996, the transfers were combined with the Canada Assistance Plan to form the Canada Health and Social Transfer.

During this process, the federal government changed both the nature of the entitlement and the funding arrangement so that federal transfers were divided between cash and tax points and declined from about 35% of provincial health care costs in the 1960s to about 23-24% where it was in the 1980s.[97]

Due to the merger of the different programs, the government also passed the Canada Health Act (CHA) in 1984 in order to ensure that the terms and conditions established under the original hospital and Medicare acts were not lost. The genesis of the act was recognition that the federal government's influence on health care standards had been reduced due to changing funding arrangements.

The purpose of the CHA was to establish criteria and conditions in respect of insured health services provided under provincial law that must be met before a full cash contribution may be made. It is further stated that the primary objective of Canadian health care policy is to facilitate reasonable access to health services without financial or other barriers.[98]

Within a decade of the passage of the act however, Canada was faced with a serious recession. In response to growing budget deficits, and looming health care expenditures, the federal government took action. "The result was a round of significant cuts both to the operating budgets of departments and to their grants and contributions — many in the range of 15 percent to 25

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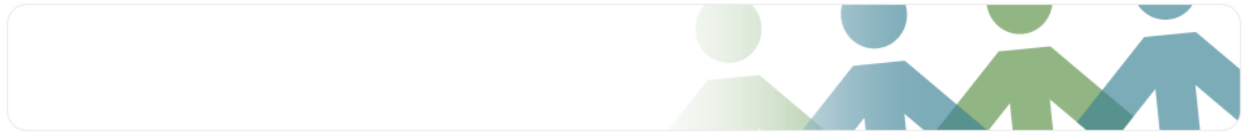
[96] *Schneider v. The Queen* [1982] 2 S.C.R. 112 at 142. Quoted in Marlisa Tiedemann, footnote one.

[97] Office of the Parliamentary Budget Officer, Renewing the Canada health Transfer: Implications for Federal and Provincial-Territorial Fiscal Sustainability, p 3, Figure 3-02. Officially, the cost sharing arrangement was 50-50 but that applied to hospital and physician services, not to all provincial health care costs.

[98] Canada, *Canada Health Act Consolidation RSC, 1985*, last amended on June 29, 2012.



percent and some even higher. Transfers to the provinces were also cut sharply — by more than 21 percent over a two-year period."[99]

A major consequence of the cuts was a significant reduction in health transfers to the provinces such that the level of cost sharing relative to provincial health spending fell as low as 10%. The impact on the provinces was severe. It led to cuts in hospital budgets, physician reimbursement, increased wait times, reductions in elective services, and layoffs across health human resources.

The severity of the cutbacks served to undermine Canadian confidence in health care and in government leadership. Faced with mounting public pressure, the federal government established the Royal Commission on the Future of Health Care.[100] It reported in 2002 and recommended sweeping changes to ensure health system sustainability.

In 2003, federal and provincial leaders got together and agreed upon priorities to restore public confidence. They agreed on an action plan based on the following principles:

- universality, accessibility, portability, comprehensiveness, and public administration;
- access to medically necessary health services based on need, not ability to pay;
- reforms focused on the needs of patients to ensure that all Canadians have access to the health care services they need, when they need them;
- collaboration between all governments, working together in common purpose to meet the evolving health care needs of Canadians;
- advancement through the sharing of best practices;
- continued accountability and provision of information to make progress transparent to citizens; and
- Jurisdictional flexibility.[101]

In 2004, the Prime Minister announced $41 billion over 10 years of new federal funding in support of the action plan on health. The new funding was to be used to strengthen ongoing federal health support; meet the financial recommendations of the royal commission; improve the quality of care; and reduce wait times among other system reforms.

The government also split cash transfers, which had been previously merged, into the Canada Health Transfer and the Canada Social Transfer. In 2005, an automatic escalator was introduced which had the effect of increasing the health transfer by 6% annually.

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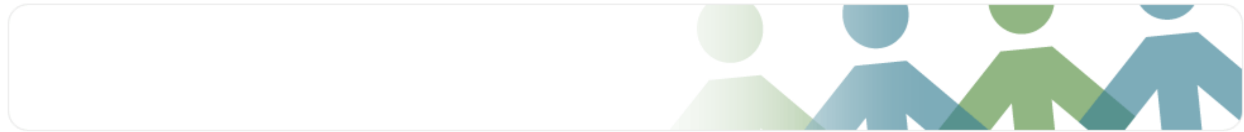
[99] Ontario Ministry of Finance, Commission on the Reform of Ontario's Public Services, *Public Services for Ontarians: A Path to Sustainability and Excellence*, Chapter 2, *The Fiscal Challenge in Context*, http://www.fin.gov.on.ca/en/reformcommission/chapters/ch2.html

[100] Royal Commission on the Future of Health Care in Canada (Romanow), *Building on Values: The Future of Health Care in Canada, Final Report,* 2002.

[101] Health Canada, *A ten year plan to strengthen health care,* http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php



In 2011, however, three years before the end of the 10-year agreement, the federal government unilaterally announced that the 6% increase would only continue until 2017, after which federal funding would be based on a three year moving average of the Gross Domestic Product (GDP) with a minimum of at least 3% each year.

Reaction of the provinces and territories to this unilateral federal action was swift. Premiers are calling on the federal government to avoid unilateral changes to programs affecting provinces and territories, "and particularly measures involving cutbacks in financial support, including offloading or downloading responsibilities."[102]

Physicians and other health professionals also do not like the proposal, not only because it leads to the underfunding of health care but also because it is perceived as an abdication of federal leadership in promoting equitable and fair access to high quality health care services across the country.[103]

Sustainability of Health Care

The sustainability of health care has been an issue in public policy since its inception. The 1964 Royal Commission on Health Services (Emmett Hall) focused on public financing and priorities and opted for a limited range of insured services to contain costs.[104] The 2002 Royal Commission on the Future of Health Care in Canada led by Roy Romanow addressed the issue of long-term sustainability.[105] Each commission concluded that public funding of health care was preferable to private funding.

In spite of the commission's recommendations however, a debate still rages today about the affordability or sustainability of public funding of health care services. While it is not a new debate, it grows louder as governments grapple with budget shortfalls, slow economic growth and declining revenues.

Opponents of the current system of financing argue that healthcare costs are being progressively pushed to levels of expenditure that cannot be sustained. They largely base their analysis on the fact that the growth in health care costs is outstripping total government revenues and unchecked they will absorb an increasing share of all expenditures.

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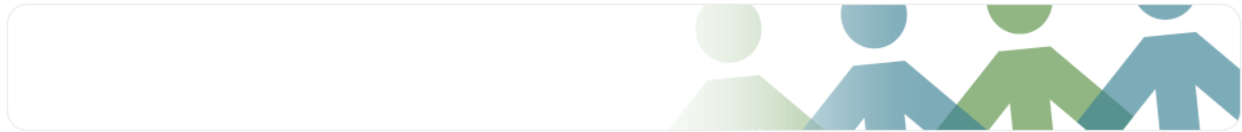
[102] Council of the Federation, Communiqué, *Canada's Premiers continue to work on modernizing fiscal arrangements*, July 26, 2013.

[103] In 2012, Dr John Haggie, then president of the Canadian Medical Association, is quoted as saying that: Ottawa has an essential oversight role, ensuring that similar care is available across the country. ---- what Canadians have told us is they would rather like some standards, equity and equitability across the country." In article by André Picard, Aglukkaq defends Ottawa's hands-off role in health care funding, *Globe and Mail*, August 13, 2012.

[104] Royal Commission on Health Services, *Volume 1*, 1964.

[105] Royal Commission on the Future of Health Care in Canada (Romanow), *Building on Values: The Future of Health Care in Canada, Final Report,* 2002.



An example is a 2011 report of the Fraser Institute. It dramatizes the problem in the following way: total provincial health spending has grown at an average annual rate of 7.5% over the previous ten years, compared to only 5.7% for total available provincial revenue (including federal transfers): health expenditures in Canada's two largest provinces (Ontario and Quebec) consume more than 50% of total revenues; and most provinces actually spend more that 60% of their own sourced revenue on health care if federal transfers are excluded from the calculation.[106]

Raising the same concerns, a 2001 Conference Board of Canada report comes to some of the same conclusions. Although the percentage of expenditures to revenues is calculated differently, the trend is the same. The Conference Board concludes that "public health care expenditures will increase from 31 cents of every provincial and territorial tax dollar in 2000 to 42 cents by 2020," and that per capita health care spending is projected to increase by 58% in the same period while other government services will increase by only 17%. [107]

Looking at government health expenditures in relation to government revenues, however, is only part of the equation. A more balanced picture can be obtained by comparing expenditures to gross domestic product or GDP and economic growth (which are better measures of our overall capacity to pay).

The Canadian Federation of Nurses Unions, for example, states that organizations like the Fraser Institute and the Conference Board overstate the problem. Canada's total health expenditures in 2011 were 11.6% of GDP and public health expenditures were 8.1%. Health expenditures were in line with most other developed countries and considerably less than the USA. [108]

The Canadian Foundation for Healthcare Improvement (formerly Canadian Health Services Research Foundation) makes the same point, claiming that the argument about public health care being unsustainable is a myth. When measured against GDP, the foundation acknowledges that health expenditures have increased over time but notes that the increases have been in line with other developed countries and in fact, more moderate than many.[109]

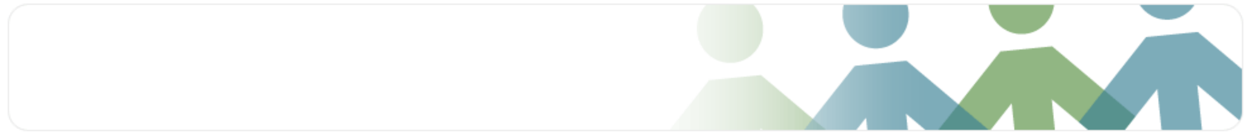
Canadian Doctors for Medicare states that the myth of health care being unsustainable is neat and plausible but wrong. They distinguish between medicare costs (i.e., medically insured services) and total government health care spending. While Medicare costs have remained remarkably stable at 4% to 5% of GDP over the last 35 years, other health care expenditures have increased more substantially. But even with these increases, total expenditures only

[106] Brett Skinner and Mark Rovere, *Canada's Medicare Bubble: Is Canada's Health Spending Sustainable without User-based Funding?*, Studies in Health Care Policy, 2011, See also, Brett Skinner, *Canadian Health Policy Failures: What's Wrong? Who Gets Hurt? Why Nothing Changes*, Fraser Institute, 2009.

[107] The Conference Board of Canada, *The Future Cost of Health Care in Canada, 2000 to 2020, Balancing Affordability and Sustainability* Detailed Findings by Pedro Antunes, Glenn Brimacombe, and Jane McIntyre, 2001.

[108] Canadian Federation of Nurses Unions, *Health Care Sustainability, Backgrounder*, November 2011.

[109] Canadian Health Services Research Foundation, *Myth: Canada's System of Healthcare Financing is Unsustainable, 2010.*



increased from 5% of GDP in 1980 to 7% in 2009, which, according to them, is hardly unsustainable.[110]

Robert Evans, a well known health economist, suggests that public health care is as sustainable as we want it to be; it is a matter of the political choices we make. He acknowledges that provincial spending on health care has taken an increasingly larger share out of provincial budgets in recent years but that this shift is a simple consequence of substantial cuts in personal and corporate income taxes, leading to lower revenues. Tax cuts between 1997 and 2004 alone led to $470.8 billion in lost government revenue.[111] There have been more tax cuts since then.

For a comprehensive international comparison of health care expenditures in Canada and other developed economies, it is helpful to look at statistics provided by the Organisation for Economic Cooperation and Development (OECD). The most recent comparative statistics in 2011 indicate that Canada's total health expenditures as a percentage of GDP at 11.2% were above the OECD average and fifth highest of thirty-eight countries. However, public health expenditure, at 70.4% of total health expenditure, was below the OECD average and lower than twenty-one other countries.[112]

Interestingly, countries with higher public expenditures generally had lower overall health expenditures. Hence, if the federal government remained actively engaged in funding, it could continue to encourage cost containing strategies. Also, in 2010 and again in 2011, the growth rates in health expenditures in OECD countries began to stagnate. In Canada health spending growth slowed by 3.0% in 2010 and 0.8% 2011.[113]

This pace of slower growth in expenditure since 2010 is also noted by the Canadian Institute for Health Information (CIHI). Overall, though, health care costs from 2000 to 2010 grew at a faster rate than the economy.[114] The institute identifies three distinct phases in the growth of total health expenditures (public and private): a growth phase from 1975 to 1991; disinvestment and retrenchment from 1991 to 1996; and another growth phase from 1996 to 2010. [115]

[110] Canadian Doctors for Medicare, Neat, Plausible and Wrong: The Myth of Health Care Unsustainability, February, 2011. If private as well as public health expenditures are included, however, the proportion of GDP devoted to health care is considerably higher. See C.D. Howe Institute Commentary: The Health Papers, *Chronic Healthcare Spending Disease*, authors David Dodge and Richard Dion, 2011.

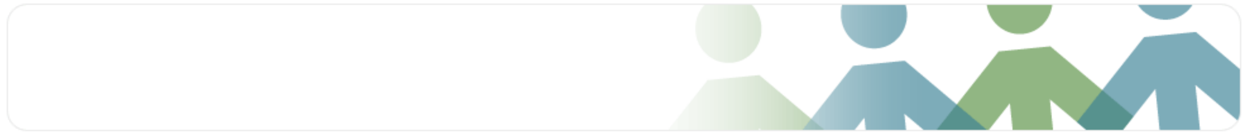
[111] Robert G. Evans, *Public health care as sustainable as we want it to be*, The Star, Editorial Opinion, June 1, 2010. See also Robert G. Evans, *Economic Myths and Political Realities: The Inequality Agenda and the Sustainability of Medicare*, UBC Centre for Health Services and Policy Research, July 2007.

[112] *OECD Health Data 2013*, Website, Frequently Requested Data

[113] OECD Press Release, *Health spending continues to stagnate*, 27/06/2013

[114] Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2012, Figure 7.

[115] Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2012, Figure 2



The recent slow pace in health care expenditures does not mean that they will not increase in the future. A report by the C. D. Howe Institute projects health care spending (public and private) from 2013 to 2031. Based on factors known to drive up costs (such as demographic changes, technology, and personnel), the study suggests that by 2031, health care costs will bring the ratio of expenditure to GDP to a range of 15% to 19%.[116]

The implication of this increase is not that it is overwhelming; the increases do not eat up "all or even a majority of the gains in income" over that same period of time.[117] And the lower projected range is even less than the percentage of GDP currently spent on health care in the United States. But it does suggest that governments are going to have to increase their revenues, and improve health care delivery, if they want to continue financing health care at current or higher levels of service.

Most worrying in that respect is the recently announced shift of the burden of health care costs from the federal to the provincial and territorial governments. If federal contributions to health care were maintained at the rate of increase provided in the 2004 health accord (6% annually), the Parliamentary Budget Officer estimated that the federal cash transfer would average 21.6% of provincial territorial health spending from 2011 to 2035 and even higher after that.

By contrast, the federal government's unilateral decision to change the cash transfers means that the share of federal funds to the provinces and territories will only grow 3% to 4% annually and payments to provincial-territorial spending will decrease substantially from 20.4% in 2010-11 to an average of 18.6% from 2010-2011 to 2035-36 and even less (13.8%) over subsequent years.[118]

Need for Federal Leadership:

There is a deficit of federal leadership in health care. The deficit is intentional. Speaking to the Canadian Medical Association in 2012, the former health minister, Leona Aglukkaq, defended the hands-off role of the government this way: "Decision-making about health care is best left to the provincial, territorial and local levels. I will not dictate to the provinces and the territories how they will deliver services or set their priorities."[119]

As we suggested earlier, the hands-off approach to health care and other social programs has served the present Conservative government well in political terms. Because constitutional responsibility for health and social services belongs to the provinces (and territories), it has

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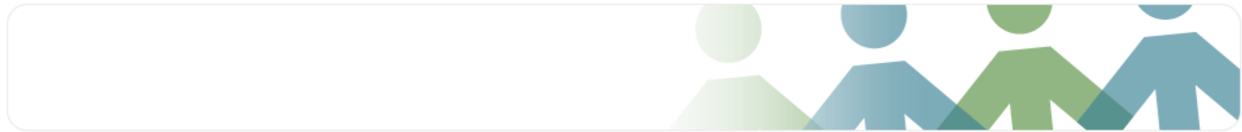
[116] C.D. Howe Institute Commentary: *The health Papers, Chronic Healthcare Spending Disease*, authors David Dodge and Richard Dion, 2011.

[117] C.D. Howe Institute Commentary: *The Health Papers, Chronic Healthcare Spending Disease*, authors David Dodge and Richard Dion, 2011, page 8

[118] Office of the Parliamentary Budget Officer, *Renewing the Canada Health Transfer: Implications for Federal and Provincial – Territorial Fiscal Sustainability,* Ottawa, January 12, (Revised January 19) 2012,

[119] Globe and Mail, *Aglukkaq defends Ottawa's hands-off role in health care funding*, August 13, 2012.



lessened, to some degree, tensions between the different levels of government, particularly in relation to Quebec.

CASW thinks that this political choice is in fact an abrogation of responsibility on the part of the federal government to commit to national equity, both horizontal and vertical. Horizontal equity implies that citizens, wherever they reside, should be provided with similar levels of health care. Vertical equity is more general in nature, implying at a minimum that health care has to be portable and accessible across jurisdictions so that individuals are free to move as appropriate to enhance equality of opportunity.

The federal government is moving away from a principle of national equity. Instead, it seems to be bent on a strategy that will unravel Canada's health care system and balkanize health care delivery within the provinces and territories.

In 2011, it unilaterally announced that the 10-year health accord would not be renewed upon expiry in 2014. A concept of a national pharmaceutical strategy, which was part of the accord, was also ruled out. There is no federal involvement in the Health Care Innovation Working Group of the Council of the Federation (representing the provinces and territories). And in March 2014, the Health Council of Canada was closed.[120]

Over the past decade, many professional and non-governmental organizations have tried unsuccessfully to persuade the federal government to revitalize its commitment to health care and promote health care reform.

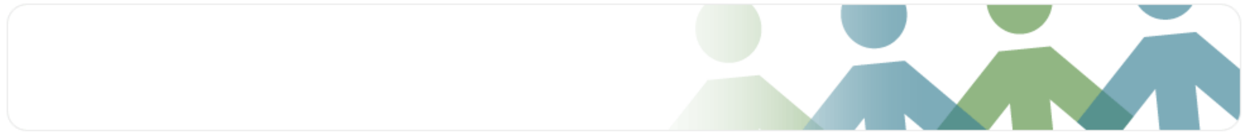
The Canadian Medical Association and the Canadian Nurses Association outlined six principles to guide health care transformation in Canada. The principles have been supported by over 125 organizations including CASW.

Among the principles is an affirmation that "the health care system has a duty to Canadians to provide and advocate for equitable access to quality care and multi-sectoral policies to address the social determinants of health." Another is that "sustainable health care requires universal access to quality health services that are adequately resourced and delivered along the full continuum in a timely and cost-effective manner."[121]

The Medical Reform Group is another professional group emphasizing the need for a strong federal role in setting health policy. It believes, as CASW does, that "the issue of whether the federal government should be involved in setting and maintaining standards for the delivery of

[120] Jeff Morrison,"Health care in Canada and the role of the federal government", *Canadian Pharmacists Journal*, July/Augus 2013.

[121] *Principles to Guide Health Care Transformation in Canada,* Canadian Nurses Association and Canadian Medical Association, July 200, pages 2 and 3. The six principles are: patient centered; quality; health promotion and illness protection; equitable; sustainable; and accountable.



social services is fundamentally an issue about the model of society we want for Canada."[122] In health care, it is a debate about whether we want to maintain a single payer model which is universally accessible, move toward American style privatization or incorporate user co-payments.

The disadvantages of the American system are well known. It is the most expensive system in the developed world and the least universally accessible. For that reason, there are not too many organizations in Canada that openly advocate for it. Advocacy of co-payments or European style insurance, however, is another matter.

Janice MacKinnon, former Minister of Finance in Saskatchewan, is a strong advocate of co-payments. In a recent report issued by the MacDonald Laurier Institute, she proposes a tax based co-payment scheme that would link the use of the health care system and the ability to pay. It would, she claims, be equitable in so far as low income citizens would be exempt. The advantage of using the income tax system is that it would raise revenue and lead to a reduction of utilization. The disadvantage to patients is that those who most use the system, through no fault of their own, would be most penalized.[123]

MacKinnon's other recommendations are, in the judgment of CASW, more propitious. They include recommendations about putting greater emphasis on homecare, relocating, where feasible, emergency services to community clinics and improved pharmaceutical coverage.[124] What is missing from MacKinnon's analysis is a pan-Canadian vision of health care.

By contrast, the Health Action Lobby Group (HEAL), a coalition of 34 national health and consumer organizations of which CASW is a member values an active federal role in health care. In a report entitled "Functional Federalism and The Future of Medicare in Canada," HEAL found that there was strong support by the stakeholders they interviewed for a practical federal approach of doing what works best to improve access to, and improve the quality of, the health system.[125] In terms of health care reform, HEAL places strong emphasis on the need for chronic disease management, home care, long-term care, access, and mental health.

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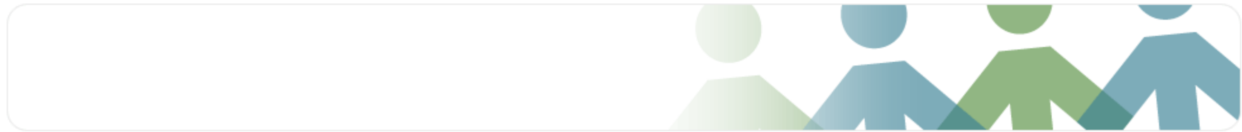
[122] Medical Reform Group, Principles and Policy Statements, *Statement on the Necesssity for a Strong Federal Role in Setting Health Policy*, http://www.medicalreformgroup.ca/principles/federal_role_in_canadian_health_policy/

[123] Janice MacKinnon, *Health Care Reform from the Cradle of Medicare*, MacDonald Laurier Institute, 2013, pages 15-17. MacKinnon bases her recommended reform on two studies: Aba, Shay, Wolfe D. Goodman, and Jack M. Mintz. 2002. "Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System." *Health Law Canada* 22 (4): 85-100; and Stabile, Mark. 2003. "The Role of Benefit Taxes in the Health Care Sector." *University of Toronto Working Paper*. http://www.law-lib.utoronto.ca/investing/reports/rp14.pdf

[124] She does not recommend a national pharmaceutical plan and instead suggests that the provinces work together to create savings and better provision. She argues that the federal government cannot afford to develop a national plan without increasing debt. It is not clear why the provinces are in any better position. Moreover, her concern about rising costs is based upon excess expenditures over revenues, not the overall capacity of the economy.

[125] Tholl, Bujold & Associates, *Functional Federalism and the Future of Medicare in Canada, A Report to the Health Action Lobby*, 2012. p iv. By functional federalism, they mean shared leadership between the federal and provincial/territorial governments



The Canadian Health Coalition, a public advocacy organization dedicated to the preservation and improvement of Medicare, is even more forthright in its support of federal leadership. In a 2011 report to a Senate committee, the coalition recommends a renewed ten year plan with adequate funding including the continuation of the 6% escalator; a comprehensive plan to deal with an Aboriginal health gap; a national pharmaceutical strategy; comprehensive home and continuing care; and reforms to reduce wait times.[126]

John Millar, a clinical professor in the School of Population and Public Health at the University of British Columbia, also highlights the need for federal leadership to transform the health care system. Noting that rising costs are driven by technological advances, drugs and human resources, he says that we need to provide community based resources that will improve population health, reduce inequities, and reduce health care expenditures. In his judgment, "an essential step in this transformation would be a coordinated pan-Canadian effort to develop indicators and data bases that will support accountability in health care and drive the required changes."[127]

CASW is in general agreement with many of these suggestions. Taken together, they round out the health care system of this country to bring it closer to the range of comprehensive services provided in some of the developed countries of Europe.

CASW is opposed to more privatized financing of the system because there is limited evidence to show that private financing leads to significant public savings or better health care.[128] Furthermore, it seems that our health care system is sustainable in relation to our overall economy or capacity to pay. The major gap is a lack of political will to finance it.

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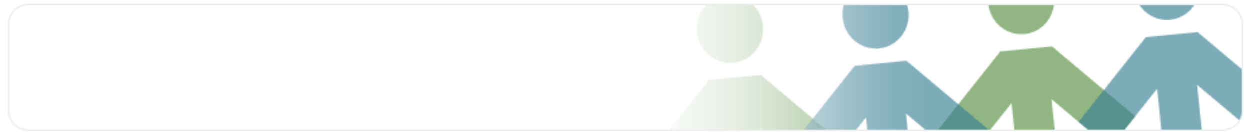
[126] Canadian Health Coalition brief to the Standing Senate Committee on Social Affairs, Science and Technology on its Review of the progress in implementing the 2004 health Accord, *Secure the Future of Medicare: A Call to Care*, November 10, 2011.

[127] John Millar, *Canadian health care needs a massive transformation*, Editorial Opinion, The Star, Wednesday March 14, 2012.

[128] Some evidence on this issue is reported in an article by R. Sacha Bhatia, "Alternative Financing for health care: A path to sustainability?", *Canadian Medical Association Journal*, April 17, 2012See, for example, See also D. Drummond and D. Burleton, "Charting a path to sustainable health care in Ontario: 10 proposals to restrain cost growth without compromising quality of care", *TD Economics Special Reports.* Toronto, TD Bank Financial Group*;* 2010. :**www.td.com/economics/special/db0510_health_care.pdf**



CASW Proposal:

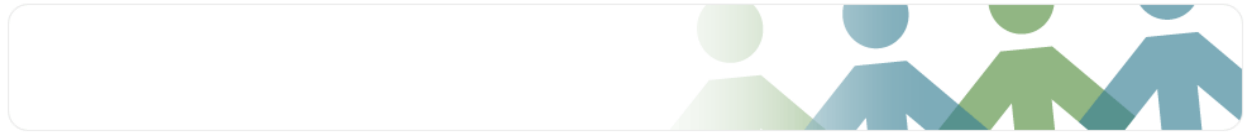
Active federal leadership and significant federal funding is essential if our health care system is to survive. Without both, health care will be increasingly balkanized.

CASW recommends that the federal government take action to ensure that the conditions of the Canada Health Act (public administration, comprehensiveness, universality, portability and accessibility) are met in order for the provinces and territories to receive federal funding.

In addition, CASW recommends that the federal government take the lead in providing financial incentives for the provinces and territories to transform the health care system into one that is patient centered, community-based and cost efficient. One way to do this is to fund a pan-Canadian initiative to provide benchmarking indicators that will support accountability and stimulate change.

More fundamentally, CASW recommends that, in terms of overall funding, the federal portion of health care costs cover, in the short term, 20% of total public expenditures and that the proportion of public spending to total spending should remain around 70%. Both targets are realistic within the current economic environment. They have been achieved in recent years and surpassed in earlier years.

In the long term, CASW recommends that the federal increase its portion to 24% of total public health expenditures, a level that was achieved in the 1980s, and a target that is realistically manageable if the federal government were to continue the 6% escalator beyond 2017. At the same time, the proportion of public spending to total spending on health care could be increased to 72% - the current average for OECD countries.



Conclusion

Since the 1990s, tax cuts and restrictive federalism have diminished the federal government's role in social programming, and federal fiscal contribution to provincial social programs is expected to decline.

The current Conservative Government envisions a restrictive federalism in which programs delivered by different levels of government are distinct within their own jurisdiction. This decentralization will reduce the federal government's accountability to the provinces and create discrepancies between provinces' services. Furthermore, it undermines a social contract between the federal government and the Canadian people based on a notion of shared rights and responsibilities.

CASW is deeply concerned about the impact these 'hands off' policies and practices will have on the health care, social inclusion, and social protection of Canadians. CASW envisions coordinated federalism in which the federal government negotiates with the provinces and territories and adopts an equity framework for social policy. Such a vision would ensure that all Canadians have basic rights to a common minimum standard of service across the country.

CASW asserts such an approach would be supported by adopting and enforcing national standards, as well as building upon negative income tax mechanisms to provide a comprehensive basic income. Noting that countries with higher public expenditures generally had lower overall health expenditures, CASW's suggestions would ensure efficient expenditure of public revenue and reduce the long term social and financial costs of poverty in areas such as health care, education, and criminal justice.

To achieve these ends, CASW proposes that the federal government adopt a policy on health and social issues guided by the principles of need, comprehensiveness, accessibility, fairness, portability, universality, and public or non-profit administration.