Brief to the
House of Commons
Standing Committee on Finance

1995 Pre-Budget Consultation
Canadian Medical Association

Ottawa, Ontario
November 18, 1994

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CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of organized medicine in Canada. Founded in 1867, CMA's mission is to provide leadership for physicians and to promote the highest standard of health and health care for Canadians.

On behalf of its members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/accident prevention policies and strategies, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

CMA is a voluntary organization representing the majority of physicians in Canada through ten provincial and two territorial medical associations (divisions) and 39 affiliated medical organizations.

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I. PURPOSE

While Canada is undergoing significant social, political and economic change, the Canadian Medical Association (CMA) remains committed to the delivery of high quality health care and to safeguarding the national integrity of the health system. However, given the need for the federal government to gain control over our deficit and national debt, it seems clear that putting Canada's fiscal house in order remains a high priority.

In this regard, CMA appreciates the invitation to submit its views on the 1995 pre-budget consultations that are underway. One overriding objective of the brief is to provide the Committee with a better understanding of the current pressures on physicians across Canada that have arisen as a direct result of past government decisions in this area. It is our firmly-held position that the health care system in general, and the medical profession in particular, have paid more than their fair share in terms of contributing to debt management.

This brief focusses on five somewhat distinct areas of concern to Canadian physicians: (1) federal health transfers to the provinces; (2) taxable health benefits; (3) the goods and services tax (GST); (4) Registered Retirement Savings Plan (RRSP) contributions, and (5) the Lifetime Capital Gains Exemption (LCGE) for Small Businesses. In each case, the brief contains specific recommendations as to what the government should do, and more importantly what the government should not do, to balance its short-term deficit reduction targets against longer-term Canadian values.

To summarize, good health policy and prudent economic policy go hand-in-hand provided the principles of fairness and good management practices are observed. If change is to come within an overall policy framework that is strategic, coordinated and fair and which preserves (or augments) the integrity of Canada's health care system, it behooves us to avoid short-term, stop-gap initiatives. As the government's 1994 Throne Speech put it *"...the agenda of the government is based on an integrated approach to economic, social, environmental and foreign policy"*. Accordingly, in establishing an appropriate fiscal framework for health, change must take place within the context of a longer-term integrated view.

II. BACKGROUND...."Medicare Is A Shared Value"

Canada's system of universal health insurance is still one of the best in the world. Experts from around the world travel many thousands of miles to study and, in some cases, emulate our system.

For most Canadians, medicare is a highly cherished, integral component of our social fabric. While Medicare's popularity has not diminished over the past 30 years, it is sometimes taken for granted in these difficult economic times. Recent public opinion surveys indicate that 84% of Canadians (with the highest response in Quebec) see medicare as a defining characteristic of being Canadian. Furthermore, 84% of Canadians are of the opinion that the system provides high quality care.[1]

At the same time, however, 65% of Canadians are concerned about continued accessibility to a full range of publicly-financed benefits. According to the same poll, 83% of Canadians see current financing of the system as being "unsustainable" over the longer-term[2] and they are right.

As much loved as the Canadian medicare system is, there is a large and growing consensus that we need to make changes. This brief is not about maintaining the status quo. Rather, it is about managing the changes required in the long-term best interests of all Canadians and of the physicians who are ultimately responsible for serving those interests, subject to the fiscal realities confronting government.

III. CONSIDERATIONS

CMA acknowledges that there is a pressing need, now more than ever, for the federal government to balance a number of competing social and economic policy challenges. In a time when deficit reduction measures are required, all segments of society are being asked to do more with the same or

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[1] The Angus Reid Group, *The Reid Report*. Vol. 8, No. 7, July/August, 1993 and Vol. 8, No. 8, September, 1993.

[2] Ibid.

less. Health care is no exception, having done so for quite some time. At the same time, we must re-evaluate the variety of services provided or paid for by government.

Deficit Management, but at what Costs?

As of 1993/94, Canada's net public debt stood at $508.2 billion, or $17,484 for every Canadian. Combined with the debts of the provinces and territories, our national debt is in excess of $700 billion. Not to understate the case, currently one-third of each revenue dollar the government collects is allocated to debt service payments on the federal debt.[3] CMA believes enough is enough: we must not pass this burden on to future generations of Canadians.

The federal government has managed to run operating surpluses for five of the past seven years.[4] While this is necessary it is no longer sufficient to meet our fiscal challenges. Maintaining the status quo would mean that debt service payments would further crowd out government expenditures at an accelerated rate.

While the government's first priority should be to get us "out of hock", there is an equally-compelling need to respect the longstanding and fundamental principle of fairness/equity that help define Canadian society. One step toward meeting these twin objectives is to consider all possible methods of repatriating that portion of the national debt held by the international lending community. Some experts have argued that Canada, as a country, can no longer afford to have "massive leakages" in interest payments to individuals/countries abroad.[5] In so doing, we would

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[3] *Agenda: Jobs and Growth: Creating A Healthy Fiscal Climate (The Economic and Fiscal Climate)*, Department of Finance, October 1994.

[4] *Economic and Fiscal Reference Tables*, Department of Finance, September 1994; *Annual Financial Report of the Government of Canada*, Fiscal Year, 1993/94.

[5] Valaskakis K.: *The Debt Monster*, Montreal Gazette, November 5, 1994.

also repatriate our ability as a sovereign nation to set and maintain social policy objectives. This involves guarding against the persistent "tyranny of the deficit" and the influence that international bond rating agencies can exert on the economy.

Facts and Fallacies about Health Spending

In reviewing expenditures in the public sector, some would suggest that health and health care spending are "out of control". This is a myth. While it is true that Canada spends 10.0% (1993) of Gross Domestic Product (GDP) on health care (second highest among OECD countries), the reality is that the public sector share of total health care expenditures has fallen from 76.4% in 1975 to approximately 71.9% in 1993[6] (falling to the lowest third of OECD countries).

This process of reducing real public sector expenditures, in the absence of a well-coordinated and planned framework, has not always been in the best interests of health and health care. Specifically, federal offloading in terms of unilateral reductions in health cash transfers to the provinces have been followed by:

- the elimination of entire programs, such as dental insurance programs for children and universal drug insurance programs;
- hospital closures (e.g., 52 hospitals in Saskatchewan);
- massive regionalization of health programs and the attendant disempowerment of community hospital boards;
- the reduction of total bed capacity by as much as 20% in some provinces;
- the reduction in medical school enrolment by 10% and a planned 10% reduction in post-MD residency slots;
- global medical care expenditure caps in virtually every province in Canada;
- individual physician income thresholds in at least five provinces;
- a moratorium on interprovincial mobility of physicians;

[6] *National Health Expenditures in Canada, 1975-1993*. Health Canada.

- legislative overrides of duly-negotiated contracts for health care providers;
- widespread restrictions on the operation of high technology equipment; and
- the de facto "expropriation" of physician business practices without compensation (e.g., Saskatchewan pathologists).

These repercussions also serve to underline the fact that change is the only constant in the health care system. Many physicians across the country have expressed concerns that such changes or "threats" to our health care system are already beginning to have serious consequences for individual patients in terms of access to needed medical facilities. If the national integrity of medicare is to survive, federal fiscal policy changes must be assessed within a larger and longer-term framework; one that respects the need for innovation and professionalism in the health care system.

Physicians as Responsible Professionals

Some mistakenly argue that physician expenditures are responsible for the increasing costs to the health care system. The reality is that physician expenditures as a proportion of total health care expenditures in Canada have declined from 15.7% in 1975 to 15.1 in 1991.[7] Furthermore, physician expenditures constitute a declining share of GDP. Given the recent round of unilateral reductions in medical care spending in many jurisdictions, this percentage share will continue to drop significantly as more recent data become available.

As health care resources have become increasingly constrained, physicians have taken on added responsibilities at the macro, meso and micro levels to better manage our health resources.

- At the "macro" level, within the provinces and territories, the medical profession has been engaged in formalized consultation structures known as "Joint Management Committees" or "Administrative Councils" with government and other stakeholders to ensure value for money within a diminishing "real" globe of publicly-available resources for health care.

- At the "meso" or institutional level, physicians are working hand-in-hand with health care

[7] Ibid.

administrators and other community stakeholders to "rationalize" services so as to provide the best value for money in all areas. In addition, to give a greater voice for choice and improve overall accountabilities in the system, physicians are providing formal input to governments that are looking to regionalize health system operations.

- At the "micro" or clinical level, physicians have been taking the lead in developing and disseminating clinical practice guidelines (CPGs) to ensure that the care provided is both appropriate and cost-effective. More can and is being done, in collaboration with government, to ensure responsible use of the taxpayer's dollar while meeting the needs of individual patients.

At all levels, physicians will continue to involve themselves as capable and responsible professionals. As the health policy agenda continues its rapid pace, physicians and the organizations that represent them should be viewed as "agents" for, rather than "objects" of, change.

Good Health Policy Means Good Economic Policy

Agencies such as the World Economic Forum,[8] tell us that our system of financing health care is one of Canada's greatest assets in competing in the new world economic order. We should heed this advice, as the Prime Minister recently observed. Compared to the United States, this economic advantage takes the form of 30 percent lower health spending (measured as a percent of GDP or in per capita expenditures) while providing for universal medical benefits and high quality care. In terms of our European trading partners, the fact that health insurance programs are financed primarily through consolidated revenues (rather than employment-based taxes), also confers a unit cost advantage to Canadian exporters. In this sense, good health policy and good economic policy should be mutually reinforcing.

Aside from the complementary nature of the relationship between health and the economy, this fundamental concept also suggests that we need to take a longer-term, more integrated and more strategic approach to managing our collective debt and debt-servicing challenges. The federal government can no longer simply shift its financial obligations onto the backs of lower levels of

[8] World Economic Forum 1991: *The World Competitiveness report 1990*, Institut pour l'étude des méthodes de direction de l'entreprise, Lausanne, Switzerland.

government or individual Canadians without consultation or advance notice.

We need to re-evaluate the full range of government- provided or -funded services. Again, however, if federal fiscal reductions are to take place, the principles of fairness and equity must begin to guide the development of sustainable economic and health policies. While there are no doubt trade-offs that can and must be made, if the price of getting our fiscal house in order is losing a national treasure - i.e., our health care system, it is a price too high to be paid.

To summarize, we have set out a series of principles that should serve to guide the Committee in its decision-making, they are:

- take the longer-term view;
- adopt a system-wide, integrated approach for fiscal management;
- strive for a strategic approach that mutually reinforces health and economic policies; and
- strengthen the fundamental foundation of fairness and equity.

These four principles form the building blocks of the remainder of CMA's submission.

IV. ISSUES

Canada is at a social, political and economic crossroad. The challenge to this Committee and to this Government is to balance short-term fiscal pressures against the longer-term need to re-position Canada to take advantage of economic opportunity while preserving that which is of fundamental importance to Canadian society as a whole. As the Committee looks to striking the right balance, there are five specific areas of concern that the CMA wishes to bring to your attention on behalf of the Canadian medical profession.

The Temptation to Reduce Federal Health Transfers

CMA commends this Government for exempting EPF health transfers from the extended freeze that was applied to other provincial transfer programs in its spring 1994 budget. We would have been surprised had this Government done anything else, given that medicare is the "Liberal legacy" of the 1960s and given the Liberal Party's consistent opposition to the previous government's "policy by stealth" (i.e., Bill C-69; Bill C-96).

The fact is that medicare's contribution to getting our "fiscal house in order" is already large and continues to grow. In specific terms, the Committee will know that over the 1986/87 to 1995/96 fiscal period, it is estimated that $42.108 billion will have been removed via reductions in Established Program Financing for health and post-secondary education. For health alone, over $30 billion will have been removed from the system by fiscal year 1995/96.[9] Even with a resumption of GNP minus three percent growth formula in per capita EPF entitlements for health, beginning next spring, reduced cash contributions to medicare programs will continue to contribute to the attainment of the government's fiscal targets.

Given the unprecedented health reforms taking place across the country, Canadians and the health care system can ill afford another federal fiscal shock. The system is already balkanizing, with poorer regions not being able to fiscally sustain some basic health care benefits. Any further acceleration in the rate of reduction in federal cash transfers will all but assure the demise of the national integrity of medicare programs.

Moreover, any further reductions in federal health-related cash transfers will: (1) significantly hamper or stall the work of the newly-created National Health Forum; (2) further reduce the capacity for enforcement of national health principles under federal law; (3) exacerbate health-related problems of dealing with child poverty and problems of reducing health inequalities by socio-economic class; and (4) increase other areas of federal direct program expenditures in the context of renewed efforts to provincial program "uploading" (e.g., Canada Pension Plan Disability Program).

A propos of health and economy going hand-in hand, it is useful to remind ourselves of the importance of maintaining the comparability of health benefits across Canada in terms of promoting regional development, shared opportunity and efficient resource allocation. Poor regions of this

[9] Thomson A 1991: *Federal Support for Health Care: A Background Paper.* Health Action Lobby, Ottawa, June 1991.

country are already finding it difficult to compete for scarce new business investment capital. The implications of competing from a more uneven playing field in terms of being able to offer only "bare bones" publicly-financed health benefits will further widen the gap between the "have" and "have not" provinces.

It is for these reasons that the CMA joins with other national health organizations[10] in recommending the following:

1. **THAT THE FEDERAL GOVERNMENT AVOID FURTHER CUTS TO THE EPF HEALTH TRANSFER AND LOCK IN THE CASH PORTION;**

2. **THAT THE FEDERAL GOVERNMENT NEGOTIATE A STABLE FIVE-YEAR FUNDING ARRANGEMENT WITH THE PROVINCES/TERRITORIES;**

3. **THAT THE FEDERAL GOVERNMENT MUST ENSURE THAT ACCOUNTABILITY OF THE HEALTH TRANSFER BE SEPARATE AND EXPLICIT.**

Taxable Health Benefits

Canadians have already been dealt one blow with the increasing de-insurance of health care services (e.g., reduction of out-of-country benefits to an unfair and dangerous level, elimination or reduction in drug benefit programs). In the context of funding those services that remain public benefits, only the cruellest government would strike yet another blow to individual Canadians and to Canadian business by taxing the very benefits that taxes were raised to pay. If implemented, this proposal would be tantamount to nothing less than double taxation.

Fairness and equity would suggest that the government should be doing more, not less at the legislative and regulatory levels to promote the availability of private health insurance benefits in areas increasingly vacated by government cutbacks.

This is why CMA makes the following recommendation:

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[10] See the 1995/96 Pre-Budget Submission to the Standing Committee on Finance by the Health Action Lobby (HEAL), November 15, 1994.

4. THAT THE CURRENT FEDERAL GOVERNMENT POLICY WITH RESPECT TO NON-TAXABLE HEALTH BENEFITS BE MAINTAINED;

Goods and Services Tax (GST)

When the GST was introduced in 1991, preoccupation with implementation issues resulted in a number of fundamental injustices at the micro level. One such injustice was dealt to the medical profession. Physicians, like other Canadians, expect to pay their fair share of taxes. We do not however, accept what essentially amounts to double taxation.

Physicians in practice in Canada are in the unique, unenviable and unfair position of being forced to absorb all the GST on business inputs. Unlike all other professions, physicians are precluded from being able to pass on the tax to consumers (with provincial health insurance plans as payment in full) or from claiming input tax credits (ITCs) since insured medical services are deemed to be "tax exempt".

Unlike other professions, physicians cannot claim input credits for the imputed taxes associated with providing needed medical care. In fact, all of the following health professionals are capable of recouping from patients the GST paid on inputs because their revenues are not restricted by government: dentists; optometrists; chiropractors; physiotherapists; chiropodists; osteopaths; audiologists; speech therapists; occupational therapists and psychologists. Physicians are still angrily awaiting remedial steps to correct this injustice.

To be clear, CMA is not asking for preferential treatment for Canadian physicians. What we want is the same fair and equitable treatment from the federal government accorded to other self-employed professional groups. Like physicians, other professions are purchasing inputs and paying GST; but unlike physicians, they are able to recoup the GST.

Given this oversight in the legislation and regulations, physicians have already been asked to pay (over and above the GST paid by other professional groups) a cumulative total of $250 million since its introduction of the tax in 1991. The magnitude of this tax paid is not in dispute (as a result of a study prepared by KPMG).

While the direct effects of the GST are significant and measurable, the indirect effects are even more significant though less measurable. It is estimated that the 55,000 physicians in Canada employ up to 100,000 Canadians. Given the disproportionate effects of the GST on the medical profession as employers, the employment dampening could be at least as high as 1,000 full-time jobs lost.

In addition, the tax-induced distorting effects in terms of efficient resource allocation in the health care system cannot be measured, but are thought to be significant. A goal of health reform in many parts of the country is to move care services out of institutions and into the community. Current federal GST policy, by taxing supplies in a clinical practice setting but not in a hospital setting, acts to discourage this shift in emphasis.

No other issue in recent years has raised the ire of individual practitioners as much as the imposition of this most unfair and inequitable tax on business inputs. Understanding that the Minister of Finance is in the process of consulting with the provinces as to the nature of a replacement tax for the GST, we are confident that this oversight will be remedied.

In the interests of fundamental fairness/equity and allocative efficiency, CMA respectfully recommends the following:

5. **THAT THE COMMITTEE WORK TO ENSURE THAT CANADIAN PHYSICIANS, AS SMALL BUSINESSES, PAY NO MORE THAN OTHER PROFESSIONS UNDER ANY REPLACEMENT TAX FOR THE GST;**

6. **THAT ALL TAXES ON BUSINESS EXPENSES BE FAIRLY AND FULLY REMOVED UNDER ANY REPLACEMENT TAX FOR THE GST;**

7. **THAT IF ANY REMEDIAL STEPS ARE TAKEN TO ENSURE NO TAXES ARE LEVIED ON BUSINESS INPUTS, THESE BE APPLIED UNIFORMLY ACROSS ALL EXEMPT SERVICES.**

Registered Retirement Savings Plan (RRSP)

Canadian physicians, while receiving a large proportion of their professional earnings from the public sector (94%), do not benefit as self-employed individuals from defined benefit plans or from publicly-financed pension benefits that accrue to employed professionals. They, like other self-employed individuals, must plan and fund their own retirement. Fairness/equity once again demands that there be symmetry between money-purchase (MP) and defined-benefit (DB) retirement plans. This is all the more important for physicians because of their compressed period of lifetime earnings in relation to other groups.

This Committee will have heard various calls for either reducing the annual contribution limit or taxing assets within RRSPs. Such arguments are both specious and patently unfair. Both propositions potentially involve double taxation.

Experts both within and outside government argue, quite correctly, that the current policy be maintained, and that equity between employees and the self-employed before the taxman be assured.

It is for these reasons, that CMA has led an unprecedented alliance for the preservation of retirement savings, and recommends the following:

8. **THAT THE FEDERAL GOVERNMENT CONSIDER THE TOTAL COST OF THE RETIREMENT SAVINGS SYSTEM BEFORE MAKING ANY CHANGES TO THE INCOME TAX ACT;**

9. **THAT THE EQUITY ESTABLISHED DURING PENSION REFORM NOT BE DISTURBED BY DISCRIMINATORY CHANGES AND THAT ANY FUNDAMENTAL CHANGES TO THE SYSTEM INVOLVE A PROCESS OF INFORMED AND THOUGHTFUL INQUIRY AND DEBATE;**

10. THAT THE FEDERAL GOVERNMENT FOSTER ECONOMIC DEVELOPMENT BY TREATING RRSP CONTRIBUTIONS AS ASSETS RATHER THAN LIABILITIES AND BY EXPLORING THE REGULATORY CHANGES NECESSARY TO ENSURE INCREASED ACCESS TO SUCH FUNDS BY SMALL AND MEDIUM-SIZED BUSINESSES.

Lifetime Capital Gains Exemption (LCGE) for Small Businesses

Most Canadian physicians are independent, self-employed practitioners. As such, they have the ability if they are incorporated to claim the LCGE when they sell their practices. Over time, several provinces have accorded physicians the right to incorporate (e.g., Prince Edward Island, New Brunswick, Alberta, British Columbia, and the Yukon Territory), in other jurisdictions, physician incorporation is under active review (e.g., Nova Scotia, Quebec, Ontario and the Northwest Territories). While physicians have benefited from incorporation on a limited basis, this issue takes on added importance when one considers the "national" move towards incorporation allowing a greater number of eligible physicians to claim the LCGE.

Recent health reforms have also underscored the importance of maintaining the current policy. Previously, physicians were free to move their practices from one location to another to meet the changing health needs of Canadians. Over the past two years, provincial governments have moved to restrict inter-provincial mobility of physicians and indeed mobility within any given province or territory. These "barriers" not only restrict the number of new entrants into the system in addition to those who wish to move to other areas of the country, but also can be thought of as increasing the capitalized value of established practices. Indeed, with the advent of regional physician resource plans across Canada, the cost of establishing a new practice can be expected to continue to grow at an unprecedented rate. So while some physicians have yet to claim the LCGE, it is reasonable to think that they will some time in the future.

As the health needs of Canadians change, and as people move, medical care services will have to

respond accordingly. The elimination of the LCGE, by significantly increasing the purchase price of a new medical practice, unnecessarily and unfairly raises additional economic barriers to shifting practices in response to changing community health needs.

CMA therefore recommends:

11. THAT THE FEDERAL GOVERNMENT MAINTAIN THE CURRENT POLICY FOR THE LIFETIME CAPITAL GAINS EXEMPTION FOR SMALL BUSINESSES.

V. TRADE-OFFS

To summarize: in broad terms the health care sector has already paid its fair (and to a larger extent unfair) share.

Everyone who has appeared before this Committee will argue that cuts should not occur in their backyard. They can't all be right! The government of Canada must decide where its priorities lie over the longer-term. Deficit reduction targets can no longer be met by simply chipping away at the full range of federally-sponsored programs. The national integrity of national health insurance programs, given their importance to Canada's economic, social and political future must be on the short list of safeguarded social programs.

If further reductions in federal health transfers are deemed appropriate, the Committee should be prepared to publicly acknowledge that the principles of universality or comprehensiveness (i.e., the choice between covering everyone versus everything) will have to be fundamentally re-examined. Given the degree of support for the universality principle, if the federal government is serious about further reducing its direct or indirect contributions to health, then it must reconsider the range of core benefits that will be made available to Canadians. In fact, we may now have reached the point where we need to get back to basics; reminding ourselves of the original medicare promise, which was to protect Canadians from the spectre of personal bankruptcy associated with large and unexpected health care bills. **Not to pay the day-to-day ("grocery") bill of health care.**

The recently-announced National Health Forum, chaired by the Prime Minister, will provide an

important opportunity to assess the breadth and depth of publicly-financed health care.

The contribution of medicine to the health of Canadians and to the economy is just too important to be traded off. Physicians are still feeling the "aftershocks" of recent federal fiscal decisions. They have also had to absorb sharp unilateral reductions at the provincial level. The provinces of Nova Scotia, Prince Edward Island and Alberta - to name only three - have disproportionately singled out the medical profession on a net earnings basis in decreasing health funding.

Taken together, these fiscal forces could trigger an unprecedented exodus of physicians from Canada. As governments move to restrict the ability of physicians to provide needed medical care, CMA is increasingly concerned about the growing number of physicians who are being actively recruited by the United States, and those who feel they have no alternative but to leave the country.

At a macro level, we as a society, must recognize that we are in a North American labour market, and as such, each physician heading south represents both a short-term pain and long-term pain.

VI. SUMMARY OF RECOMMENDATIONS

The CMA offers the following recommendations to the Committee in its deliberations:

1. **THAT THE FEDERAL GOVERNMENT AVOID FURTHER CUTS TO THE EPF HEALTH TRANSFER AND LOCK IN THE CASH PORTION;**

2. **THAT THE FEDERAL GOVERNMENT NEGOTIATE A STABLE FIVE-YEAR FUNDING ARRANGEMENT WITH THE PROVINCES/TERRITORIES;**

3. **THAT THE FEDERAL GOVERNMENT MUST ENSURE THAT ACCOUNTABILITY OF THE HEALTH TRANSFER BE SEPARATE AND EXPLICIT.**

4. **THAT THE CURRENT FEDERAL GOVERNMENT POLICY WITH RESPECT TO NON-TAXABLE HEALTH BENEFITS BE MAINTAINED;**

5. **THAT THE COMMITTEE WORK TO ENSURE THAT CANADIAN PHYSICIANS, AS SMALL BUSINESSES, PAY NO MORE THAN OTHER PROFESSIONS UNDER ANY REPLACEMENT TAX FOR THE GST;**

6. **THAT ALL TAXES ON BUSINESS EXPENSES BE FAIRLY AND FULLY REMOVED UNDER ANY REPLACEMENT TAX FOR THE GST;**

7. **THAT IF ANY REMEDIAL STEPS ARE TAKEN TO ENSURE NO TAXES ARE LEVIED ON BUSINESS INPUTS, THESE BE APPLIED UNIFORMLY ACROSS ALL EXEMPT SERVICES.**

8. **THAT THE FEDERAL GOVERNMENT CONSIDER THE TOTAL COST OF THE RETIREMENT SAVINGS SYSTEM BEFORE MAKING ANY CHANGES TO THE INCOME TAX ACT;**

9. **THAT THE EQUITY ESTABLISHED DURING PENSION REFORM NOT BE DISTURBED BY DISCRIMINATORY CHANGES AND THAT ANY FUNDAMENTAL CHANGES TO THE SYSTEM INVOLVE A PROCESS OF INFORMED AND THOUGHTFUL INQUIRY AND DEBATE;**

10. **THAT THE FEDERAL GOVERNMENT FOSTER ECONOMIC DEVELOPMENT BY TREATING RRSP CONTRIBUTIONS AS ASSETS RATHER THAN LIABILITIES AND BY EXPLORING THE REGULATORY CHANGES NECESSARY TO ENSURE INCREASED ACCESS TO SUCH FUNDS BY SMALL AND MEDIUM-SIZED BUSINESSES.**

11. **THAT THE FEDERAL GOVERNMENT MAINTAIN THE CURRENT POLICY FOR THE LIFETIME CAPITAL GAINS EXEMPTION FOR SMALL BUSINESSES.**