

BRIEF

**"RESTORING ACCESS TO QUALITY
HEALTH CARE"**

**Brief Submitted to the House of Commons
Standing Committee on Finance**

1998 PRE-BUDGET CONSULTATIONS

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CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. 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, advocating for access to quality health care, 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.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 42 affiliated medical organizations.

TABLE OF CONTENTS

I.	INTRODUCTION	page 1
II.	BACKGROUND	page 1
III.	FEDERAL HEALTH CARE FUNDING AND THE CANADA HEALTH AND SOCIAL TRANSFER (CHST)	page 2
	(i). <i>Getting the facts straight</i>	page 2
	(ii). <i>Implications for the future of health care inCanada</i>	page 4
IV.	HEALTHY PUBLIC POLICY	page 7
	(i). <i>Tobacco Taxation</i>	page 7
	(ii). <i>Tobacco Control</i>	page 11
	(iii). <i>Non-Taxable Health Benefits</i>	page 11
V.	FAIR AND EQUITABLE TAX POLICY	page 12
	(i). <i>The Goods and Services Tax (GST) & the Harmonized Sales Tax (HST)</i>	page 12
	(ii). <i>Registered Retirement Savings Plan (RRSP)</i>	page 14
VI.	SUMMARY OF RECOMMENDATIONS	page 16

I. INTRODUCTION

The Canadian Medical Association (CMA) commends the federal government, in its second mandate, for continuing the pre-budget consultation process. This open process encourages public dialogue in the finance and economics of the country and the CMA appreciates the opportunity to submit its views to the House of Commons Standing Committee on Finance.

Many issues were raised by the CMA and other health organizations, with members of the Standing Committee, at the "health roundtable" held on October 28, 1997. This brief provides greater detail of those concerns that were discussed by the members of the CMA delegation.

II. BACKGROUND

"Good health is fundamental to the quality of life of every Canadian. In this century, we have learned a great deal about the effective treatment of illness and disease, which requires early access to appropriate and high-quality health care services."¹

Over the past year, Canadians, their physicians and the provincial/territorial governments have all been voicing their concerns about the state of the health care system across the country. In every instance it is a united voice that shares concerns about access to quality health care services as well as the sustainability of the health care system. A consistent theme is "will the health care system be there for me or my family when needed"?

Canadians perceive that access to services has further deteriorated over the past year. CMA surveys undertaken by the Angus Reid Group between the spring of 1996 and 1997 clearly demonstrate that Canadians perceive a deterioration in many critical areas of the health care system. If one looks at indicators such as waiting times over the past two years it is quite clear that Canadians have felt the cutbacks in the health care sector:

- in 1997 65% reported that waiting times in emergency departments had worsened, up from 54% in 1996,
- 63% reported that waiting times for surgery had worsened, up from 53% in 1996,
- 50% reported that waiting times for tests had worsened, up from 43% in 1996,
- 49% reported that access to specialists had worsened, up from 40% in 1996,
- 64% reported that availability of nurses in hospital had worsened, up from 58% in 1996.

Physicians not only provide direct care to their patients but are also concerned about their patients' access to quality health care.

1

Liberal Party, *Securing Our Future Together*. The Liberal Party of Canada, , Ottawa, 1997. p. 71.

In Ontario, more than 16,000 were reported to be waiting for placement in long-term care institutions². In Newfoundland patients requiring heart surgery have had to be sent to other provinces to alleviate growing waiting lists³.

The Conference of Provincial/Territorial Ministers of Health has expressed concerns about the ability of provinces and territories to maintain current services. The Ministers state that "Federal reductions in transfer payments have created a critical revenue shortfall for the provinces and territories which has accelerated the need for system adjustments and has seriously challenged the ability of provinces and territories to maintain current services. Federal funding reductions are forcing the acceleration of change beyond the system's ability to absorb and sustain adjustments".⁴

The concerns of the Provincial/Territorial Ministers of Health about the ability of the system to absorb and sustain adjustments are well founded as demonstrated by the anxieties expressed by the public and by physicians. The CMA has clearly stated and continues to state that "health cuts hurt everyone".

III. FEDERAL HEALTH CARE FUNDING AND THE CANADA HEALTH AND SOCIAL TRANSFER (CHST)

(i). Getting the facts straight

Prior to April 1, 1996 the federal government's commitment to insured health services, post-secondary education and social assistance programs could be readily determined since the federal government made separate payments⁵ to the provinces/territories in each of these areas. However, with the introduction of the Canada Health and Social Transfer (CHST), on April 1, 1996, the federal government combined all of its payments into one transfer payment to the provinces and territories. The net result is that there are no separately identifiable contributions to health, post-secondary education or social assistance programs. The federal government's accountability and commitment to health care have been blurred.

2

Lipovenko, D, 1997: Seniors face shortage of care. *Globe & Mail [Toronto]*; Feb 26 Sect A:5

3

Joan Marie Aylward, Minister of Health, Newfoundland and Labrador, public statement, May 14, 1997

4

Conference of Provincial/Territorial Ministers of Health, *A Renewed Vision for Canada's Health System*. January 1997. p. 7.

5

Thomson, A., *Diminishing Expectations - Implications of the CHST*, [report] Canadian Medical Association, Ottawa. May, 1996.

However, prior to the CHST, the federal government's diminishing commitment to health care could at least be documented. Under the Established Programs Financing (EPF) arrangements the federal government has unilaterally revised the EPF funding formula eight times over the past decade. During the period 1986/87 to 1995/96, it was estimated that \$30 billion in cash transfers has been withheld from health care (and an additional \$12.1 billion for post-secondary education - for a total of \$42.1 billion)⁶.

Federal "offloading" has forced all provinces/territories to make do with significantly less resources for their health care systems.

Table 1: Canada Health and Social Transfer (in \$ billions)							
Year	Total Entitlement (1)	Tax Point Transfer (2)	Cash Entitlement (3)	Quebec Abatement (4)	Cash Payments (5)	Cumulative Reductions from 95/96 (6)	1997 Budget Health Items (7)
1995-96	29.7	11.2	18.5	1.9	16.6	0.0	
1996-97	26.9	11.9	15.0	2.0	13.0	(3.6)	
1997-98	25.1	12.6	12.5	2.1	10.4	(9.8)	0.1
1998-99	25.8	13.3	12.5	2.2	10.3	(16.1)	0.1
1999-00	26.5	14	12.5	2.3	10.2	(22.5)	0.1
2000-01	27.1	14.6	12.5	2.4	10.1	(29.0)	
2001-02	27.8	15.3	12.5	2.5	10.0	(35.6)	
2002-03	28.6	16.1	12.5	2.6	9.9	(42.3)	

The September 1997 Throne Speech stated that the government "... will introduce legislation to increase to \$12.5 billion a year the guaranteed annual cash payment to provinces and territories under the Canada Health and Social Transfer"⁷. Table 1 illustrates what the \$12.5 billion cash entitlement will mean in terms of actual cash payments in 2002-03.

6

Thomson A: Federal Support for Health Care: A Background Paper. Health Action Lobby, June 1991.

7

Speech from the Throne to Open the First Session Thirty-Sixth Parliament of Canada. Ottawa; 1997 Sept 23.

The important point to remember is that this so called "increase" in the cash entitlement (3) is merely a stop in cuts. For 1998-99 the previous cash entitlement would have dropped to \$11.8 billion with a further drop in 1999-00 to \$11.1 billion, whereas cash entitlements are now stabilized at \$12.5 billion.

However, cash payments will continue to drop into the foreseeable future. Cash payments (5) exclude the Quebec abatement which is comprised of tax points not cash payments.

For Canadians the CHST has meant, and continues to mean, less federal government commitment to our health care system and has compromised the federal government's ability to preserve and enhance national standards.

(ii). *Implications for the future of health care in Canada*

The reduction in federal government funding has not only compromised the federal government's ability to preserve and enhance national standards but this continued policy of "under-funding" has compromised access to quality health care for Canadians. As previously mentioned, declining public sector resources allocated to health care has manifested itself in the form of longer waiting times in emergency departments, for surgery, for diagnostic tests and in decreased access to specialists and decreased availability of nurses in hospitals.

In the federal government's 1997/98 budget released this past February much fanfare was made about sustaining and improving Canada's health care system. The government announced three health care initiatives⁸ totalling \$300 million in expenditures over 3 years, or \$100 million per year.

If, on the other hand, one looks at the accumulated reduction in CHST cash payments to the provinces/territories during the same 3 years when the federal government will spend this \$300 million it can be seen that the accumulated reductions total \$18.9⁹ billion. Therefore, during the same 3-year period the "investment" in health care by the federal government represents 1.5% of the reductions to cash payments to the provinces and territories during the same period.

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Health Transition Fund: \$150 million over 3 years - to help provinces to test ways to improve their health system, for example, new approaches to home care, drug coverage, and other innovations.

Canada Health Information System: \$50 million over 3 years - to create a network for health care providers and planners for sharing information.

Community Action Program for Children: \$100 million over 3 years - for support of community groups for parent education for children at risk and for Canada Prenatal Nutrition Program to ensure the birth of healthy babies.

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See Table 1: Cumulative reductions to 1999/00 of \$22.5 billion subtracting \$3.6 billion for 1996/97 gives a cumulative reduction during 1997/98 to 1999/00 of \$18.9 billion.

For the longer term, the federal government can demonstrate its commitment to health care by linking growth in CHST cash payments to factors other than the economy. The factors that are becoming increasingly important are those such as technological change, population growth and aging. Such linkage of cash payments would be less subject to fluctuations in the economy and would be an acknowledgement of the impact of technological and population structure changes on the need for health care services.

From Table 2, which shows 1994 per capita provincial government health expenditures by age group, it can be concluded that as the population of Canada ages the cost structure of health care increases reflecting the fact that as we age we make greater use of the health care system to maintain our health. The age group 65 and over continues to grow, in 1994 11.9% of the population was over the age of 65, in 2016 this is projected to increase to 16% and by 2041 to 23%.¹⁰

Age Group	\$ per Capita	Increase
0-14	514	
15-44	914	77.8%
45-64	1446	58.2%
65+	6,818	371.5%
Total	1,642	

In other areas of health care the CMA commends the federal government for their recent commitments to applied health services research.¹¹

On an international basis however, Canada does not fare very well. In fact, on a per capita basis Canada came in last out of the five G-7 countries for which recent data were available. Figure 1 shows the per capita health R&D expenditures for G7 countries for which 1994 data are

¹⁰

Statistics Canada, Population Projections for Canada, Provinces and Territories 1993-2016. Ottawa: Statistics Canada; 1994. p. 73. Cat no 91-520 [occasional].

¹¹

Organization for Economic Cooperation and Development. OECD Health Data 97. Paris: OECD; 1997.

available. Canada's per capita spending was \$22 (U.S.), compared with \$35 for Japan, \$59 for the U.S., \$63 for France and \$78 for the U.K.¹²

While applied health services research is important, it must be recognized that research is a continuum beginning with basic biomedical research, moving to clinical research and ending with applied health services research. The CMA is concerned with the governments plans to cut the annual budget of the Medical Research Council (MRC) from \$238 million in 1997-98 to \$219 million in 2000-01.

In Prime Minister Jean Chrétien's reply to the Speech from the Throne on September 24, 1997 he states that there is " . . . *no better role for government than to help young Canadians prepare for the knowledge-based society of the next century.*" He then makes a commitment to establish, " . . . *at arms-length from government, a Canada Millennium Scholarship Endowment Fund.*" which is to reward academic excellence. The Government of Canada should also be reminded that a knowledge-based society and scholarship also requires a commitment to research funds. Therefore the CMA calls on the Federal Government to establish national targets for spending and an implementation plan for health care research. Such an approach would buttress the other initiatives as announced by the Prime Minister.

To restore access to quality health care for all Canadians, the CMA respectfully recommends:

- 1. At a minimum, that the federal government restore CHST cash entitlements to 1996/97 levels.**
- 2. That, beginning April 1, 1998, the federal government fully index CHST cash payments through the use of a combination of factors that would take into account: technology, economic growth, population growth and demographics.**
- 3. That the federal government establish a national target (either in per capita terms or as a proportion of total health spending) and an implementation plan for health research and development spending including the full spectrum of basic biomedical to applied health services research, with the objective of improving Canada's position relative to other G-7 countries where we now rank last among the five G-7 countries for which recent data are available.**

¹²

Organization for Economic Cooperation and Development. OECD Health Data 97. Paris: OECD; 1997.

IV. HEALTHY PUBLIC POLICY

The federal role in funding health care is clearly important to physicians and to their patients given its influence on access to quality health care services. However, there are other important issues that the CMA would like to bring to the attention of the Standing Committee on Finance.

(i). *Tobacco Taxation*

Smoking is the leading preventable cause of premature mortality in Canada. The most recent estimates suggest that more than 45,000 deaths annually in Canada are directly attributable to tobacco use.

The estimated economic cost to society from tobacco use in Canada has been estimated from \$11 billion to \$15 billion. Tobacco use directly costs the Canadian health care system \$3 billion to \$3.5 billion annually. These estimates do not consider intangible costs such as pain and suffering.

CMA is concerned that the 1994 reduction in the federal cigarette tax has had a significant effect in slowing the decline in cigarette smoking in the Canadian population, particularly in the youngest age groups - where the number of young smokers (15-19) is in the 22% to 30% range and 14% for those age 10-14.

A 1997 Canada Health Monitor Survey found that smoking among girls 15-19 is at 42%. A Quebec study found that smoking rates for high school students went from 19% to 38%, between 1991 and 1996.

The CMA understands that tobacco tax strategies are extremely complex. Strategies need to consider the effects of tax increases on reduced consumption of tobacco products with increases in interprovincial/territorial and international smuggling. In order to tackle this issue, the government could consider a selective tax strategy. This strategy requires continuous stepwise increases to tobacco taxes in those selective areas with lower tobacco tax (i.e., Ontario, Quebec and Atlantic Canada).

The goal of selective increases in tobacco tax is to increase the price to the tobacco consumer over time (65-70% of tobacco products are sold in Ontario and Quebec). The selective stepwise tax increases will approach but may not achieve parity amongst all provinces however, the tobacco tax will attain a level such that inter-provincial/territorial smuggling would be unprofitable. The selective stepwise increases would need to be monitored so that the new tax level and US/Canadian exchange rates does not make international smuggling profitable. The objectives of this strategy are:

- ▶ reduce tobacco consumption;
- ▶ minimize interprovincial/territorial smuggling of tobacco products; and
- ▶ minimize international smuggling of tobacco products.

The selective stepwise increase in tobacco taxes can be combined with other tax strategies. The federal government should apply the export tax and remove the exemption available on shipments in accordance with each manufacturer's historic levels. The objective of implementing the export tax would be to make cross-border smuggling unprofitable. The ultimate goals for implementing this strategy are:

- ▶ reduce international smuggling of tobacco products;
- ▶ reduce and/or minimize Canadian consumption of internationally smuggled tobacco products.

The federal government should establish a dialogue with the US federal government. Canada and the US should hold discussions regarding harmonizing US tobacco taxes to Canadian levels at the factory gate. Alternatively, US tobacco taxes could be raised to a level that when offset with the US/Canada exchange rate differential renders international smuggling unprofitable. The objective of implementing the harmonizing US/Canadian tobacco tax levels (at or near the Canadian levels) would be to increase the price of internationally smuggled tobacco products to the Canadian and American consumers. The ultimate goals for implementing this strategy are:

- ▶ reduce risk of international smuggling of tobacco products from both the Canadian and American perspective;
- ▶ reduce and/or minimize Canadian/American consumption of internationally smuggled tobacco products.

4. The Canadian Medical Association is recommending that the federal government follow a comprehensive integrated tobacco tax policy:

(a) That the federal government implement selective stepwise tobacco tax increases to achieve the following objectives:

- ▶ **reduce tobacco consumption,**
- ▶ **minimize interprovincial/territorial smuggling of tobacco products,**
- ▶ **minimize international smuggling of tobacco products;**

(b) That the federal government apply the export tax on tobacco products and remove the exemption available on tobacco shipments in accordance with each manufacturer's historic levels;

- (c) **That the federal government enter into discussions with the US federal government to explore options regarding tobacco tax policy, bringing US tobacco tax levels in line with or near Canadian levels, in order to minimize international smuggling.**

The Excise Act Review, *A Proposal for a Revised Framework for the Taxation of Alcohol and Tobacco Products* (1996), proposes that tobacco excise duties and taxes (*Excise Act* and *Excise Tax Act*) for domestically produced tobacco products be combined into a new excise duty and come under the jurisdiction of the *Excise Act*. The new excise duty is levied at the point of packaging where the products are produced. The Excise Act Review also proposes that the tobacco customs duty equivalent and the excise tax (*Customs Tariff* and *Excise Tax Act*) for imported tobacco products be combined into the new excise duty [equivalent tax to domestically produced tobacco products] and come under the jurisdiction of the *Excise Act*. The new excise duty will be levied at the time of importation.

The CMA supports the proposal of the Excise Act Review. It is consistent with previous CMA recommendations calling for tobacco taxes at the point of production.

(ii). *Tobacco Control*

Taxation should be used in conjunction with other strategies for promoting healthy public policy, such as, programs for tobacco prevention and cessation. The Liberal party, recognising the importance of this type of strategy , promised:

"...to double the funding for the Tobacco Demand Reduction Strategy from \$50 million to \$100 million over five years, investing the additional funds in smoking prevention and cessation programs for young people, to be delivered by community organizations that promote the health and well-being of Canadian children and youth".

The CMA applauds the federal government's efforts in the area of tobacco prevention and cessation. However, a time limited investment is not enough. More money is required for investment in this area. Program funding is required for more efforts and programs in tobacco prevention and cessation. A possible source for this type of program investment could come from tobacco tax revenues or the tobacco surtax.

- 5. In the short term, the Canadian Medical Association calls upon the federal government to fulfil the its promise to invest \$100 million, over five years, into the Tobacco Demand Reduction Strategy. In the longer term, the Canadian Medical Association calls upon the federal government to establish stable program funding for its comprehensive tobacco control strategy, including smoking prevention and cessation.**

(iii). *Non-taxable health benefits*

The federal government is to be commended for its decision to maintain the non-taxable status of supplementary health benefits. This decision is an example of the federal governments' commitment to maintain good tax policy that supports good health policy (the current incentive fosters risk pooling).

Approximately 70% or 20 million Canadians rely on full or partial private supplementary health care benefits (e.g., dental, drugs, vision care, private duty nursing, etc.). As governments reduce the level of public funding, the private component of health expenditures is expanding. Canadians are becoming increasingly reliant on the services of private insurance.

In the context of funding those health care services that remain public benefits, the government cannot strike yet another blow to individual Canadians and to Canadian business by taxing the very benefits for which taxes were raised.

In terms of fairness, it would seem unfair to "penalize" 70% of Canadians by taxing supplementary health benefits to put them on an equal basis with the remaining 30%. It would be preferable to develop incentives to allow the remaining 30% of Canadians to achieve similar benefits attributable to the tax status of supplementary health benefits.

If supplementary health benefits were to become taxable, it is likely that young healthy people would opt for cash compensation instead of paying taxes on benefits they do not receive. These Canadians would become uninsured for supplementary health services. It follows that employer-paid premiums may increase as a result of this exodus in order to offset the additional costs of maintaining benefit levels due to diminishing ability to achieve risk pooling. In addition,

6. That the current federal government policy with respect to non-taxable health benefits be maintained.

V. FAIR AND EQUITABLE TAX POLICY

CMA has demonstrated that good economic policy reinforces good health policy in past submissions to the Standing Committee on Finance. The CMA again reiterated the important role that fair tax policy plays in supporting healthy public policy.

(i). *The Goods and Services Tax (GST) & the Harmonized Sales Tax (HST)*

The CMA strongly believes in a tax system that is fair and equitable. This point has been made on several occasions to the Standing Committee on Finance. In particular, the point was stressed as part of the Standing Committee's consultation process leading to the report "Replacing the GST: Options for Canada".

In the case of the GST, however, the reality is that physicians as self-employed Canadians are singled out and discriminated against by virtue of not being able to claim input tax credits (ITCs) since medical services are designated as "tax exempt".

The CMA does not dispute the importance that the federal government has attached to medical services such that Canadians are not subject to GST/HST for having availed themselves of such medical services from their physician. However, the GST/HST are consumption taxes and as such are paid for by the end consumer.

If, however, government determines that such a consumption tax should not be applied to the consumers (in this case physicians' patients) of a particular good or service it behooves government not to implement half measures that bring into question the equity and fairness of the Canadian tax system.

While other self-employed professionals and small business claim ITCs, an independent (KPMG) study has estimated that physicians have "over contributed" in terms of unclaimed ITCs to the extent of \$57.2 million per year. Since the inception of the GST and by the end of this calendar year, physicians will have been unfairly taxed in excess of \$400 million. All this for providing a necessary service that has been deemed so important by government.

Physicians are not asking for special treatment. What they are asking for, however, is to be treated in a fair and equitable manner like other self-employed Canadians and small businesses. Unlike other businesses and professionals, physicians cannot recoup the GST/HST by claiming ITCs or passing the GST/HST onto customers/patients.

The federal government has acknowledged the inequitable impact of the GST/HST on other providers in the health care sector. Municipalities, universities, schools and hospitals have been given special consideration because they, like physicians, are not able to pass the GST/HST on to their clients. Hospitals have been afforded an 83% rebate for purchases made in providing patient care while physicians must absorb the full GST/HST costs on purchases also made in providing patient care. At a time when health policy measures are attempting to expand community-based practices, the current tax policy (and now harmonized tax policy) which taxes supplies in a clinical practice setting but not in a hospital setting acts to discourage this shift in emphasis.

To complicate matters further, the recent agreement between the federal government and some Atlantic provinces to harmonize their sales taxes will make matters worse for physicians. With no ability to claim ITCs, physicians will, once again, have to absorb the additional costs associated with the practice of medicine. It has been estimated that harmonization will cost physicians in Atlantic Canada an additional \$4.7 million each year (over and above the current GST inequity).

In the current fiscal environment, this unresolved issue does not help matters when it comes to physician recruitment and retention across the country. Furthermore, for established physicians who have had to live with the current policy, the GST/HST serves as a constant reminder that

the basic and fundamental principles of equity and fairness in the tax system is not being extended to the physicians of Canada.

To date, the CMA has made representations to the Minister of Finance and Finance Department Officials but yet to no avail. We look to this Committee and to the federal government to not only ensure that the tax system is perceived to be fair and equitable but that it is in fact fair and equitable to all members of society.

The unfairness of the GST/HST, as applied to medical services, has raised the ire of physicians and has made them question their sense of fair play in Canada's tax system.

In the interests of fairness and equity, the CMA respectfully recommends the following:

7. The CMA recommends that health care services funded by the provinces and territories be zero-rated.

The above recommendation could be accomplished by amending the Excise Tax Act as follows:

(1). *Section 5 part II of Schedule V to the Excise Tax Act is replaced by the following:*

5. "A supply (other than a zero-rated supply) made by a medical practitioner of a consultative, diagnostic, treatment or other health care service rendered to an individual (other than a surgical or dental service that is performed for cosmetic purposes and not for medical or reconstructive purposes)."

(2). *Section 9 Part II of Schedule V to the Excise Tax Act is repealed.*

(3). *Part II of Schedule VI to the Excise Tax Act is amended by adding the following after section 40:*

41. A supply of any property or service but only if, and to the extent that, the consideration for the supply is payable or reimbursed by the government under a plan established under an Act of the legislature of the province to provide for health care services for all insured persons of the province.

Our recommendation fulfils at least two over-arching policy objectives: 1) strengthening the relationship between good economic policy and good health policy in Canada; and 2) applying the fundamental principles that underpin our taxation system (fairness, efficiency, effectiveness), in all cases.

(ii). *Registered Retirement Savings Plan (RRSP)*

Experts have stated that there are (at least) two fundamental goals of retirement savings: (1) to guarantee a basic level of retirement income for all Canadians; and, (2) to assist Canadians in avoiding serious disruption of their pre-retirement living standards upon retirement. Looking at

the demographic picture in Canada, we can see that an increasing portion of society is not only aging, but is living longer. Assuming that current demographic trends will continue and peak in the first quarter of the next century, it is important to recognize the role that private RRSPs savings will play in ensuring that Canadians may continue to live dignified lives well past their retirement from the labour force.

This becomes even more critical when one considers that Canadians are not setting aside sufficient resources for their retirement. Specifically, according to Statistics Canada, it is estimated that 53% of men and 82% of women starting their career at age 25 will require financial aid at retirement age - only 8% of men and 2% women will be financially secure.

The 1996 federal government policy changes with respect to RRSP contribution limits run counter to the White Paper released in 1983 (The Tax Treatment of Retirement Savings), where the House of Commons Special Committee on Pension Reform recommended that the limits on contributions to tax-assisted retirement savings plans be amended so that the same comprehensive limit would apply regardless of the retirement savings vehicle or combination of vehicles used. In short, the Liberal government endorsed the principle of "pension parity".

According to three more recent papers released by the federal government, the principle of pension parity would have been achieved between money-purchase (MP) plans and defined benefit (DB) plans had RRSP contribution limits risen to \$15,500 in 1988. The federal government postponed the scheduling of the \$15,500 limit for seven years, that is achieving the goal pension parity was delayed until 1995.

In its 1996 Budget Statement, the federal government altered its course of action and froze the dollar limit of RRSPs at \$13,500 through to 2003/04, with increases to \$14,500 and \$15,500 in 2004/05 and 2005/06, respectively. As well, the maximum pension limit for defined benefit registered pension plans will be frozen at its current level of \$1,722 per year of service through 2004/05. This is a *de facto* increase in tax payable. The CMA is frustrated that ten years of careful and deliberate government planning around pension reform has not come to fruition, in fact if the current policy remains in place will have taken more than 17 years to implement (from 1988 to 2005).

As a consequence, the current policy of freezing RRSP contribution limits and RPP limits without making adjustments to RRSP limits to achieve pension parity serves to maintain inequities between the two plans until 2005/2006. This is patently unfair for self-employed Canadians who rely on RRSPs as their sole vehicle for retirement planning.

CMA respectfully recommends to the Standing Committee:

- 8. That the dollar limit of RRSPs at \$13,500 increase to \$14,500 and \$15,500 in 1998/1999 and 1999/2000, respectively. Subsequently, dollar limits increase at the growth in the yearly maximum pensionable earnings (YMPE).**

VI. SUMMARY OF RECOMMENDATIONS

With the future access to quality health care for all Canadians at stake, the CMA strongly believes that the federal government must demonstrate that it is prepared to take a leadership role and re-invest in the health care of Canadians.

The CMA therefore makes the following recommendations to the Standing Committee in its deliberations:

Canada Health and Social Transfer (CHST)

1. **At a minimum, that the federal government restore CHST cash entitlements to 1996/97 levels.**
2. **That, beginning April 1, 1998, the federal government fully index CHST cash payments through the use of a combination of factors that would take into account: technology, economic growth, population growth and demographics.**
3. **That the federal government establish a national target (either in per capita terms or as a proportion of total health spending) and an implementation plan for health research and development spending including the full spectrum of basic biomedical to applied health services research, with the objective of improving Canada's position relative to other G-7 countries where we now rank last among the five G-7 countries for which recent data are available.**

Tobacco Taxation

4. **The Canadian Medical Association is recommending that the federal government follow a comprehensive integrated tobacco tax policy:**
 - (a) **That the federal government implement selective stepwise tobacco tax increases to achieve the following objectives:**
 - ▶ **reduce tobacco consumption,**
 - ▶ **minimize interprovincial/territorial smuggling of tobacco products,**
 - ▶ **minimize international smuggling of tobacco products;**
 - (b) **That the federal government apply the export tax on tobacco products and remove the exemption available on tobacco shipments in accordance with each manufacturers historic levels;**
 - (c) **That the federal government enter into discussions with the US federal government to explore options regarding tobacco tax policy, bringing US tobacco tax levels in line with or near Canadian levels, in order to minimize international smuggling.**

Tobacco Control

5. **In the short term, the Canadian Medical Association calls upon the federal government to fulfil the its promise to invest \$100 million, over five years, into the Tobacco Demand Reduction Strategy. In the longer term, the Canadian Medical Association calls upon the federal government to establish stable program funding for its comprehensive tobacco control strategy, including tobacco prevention and cessation.**

Non-Taxable Health Benefits

6. **That the current federal government policy with respect to non-taxable health benefits be maintained.**

The Goods and Services Tax (GST)& the Harmonized Sales Tax (HST)

7. **The CMA recommends that health care services funded by the provinces and territories be zero-rated.**

Registered Retirement Savings Plan (RRSP)

8. **That the dollar limit of RRSPs at \$13,500 increase to \$14,500 and \$15,500 in 1998/1999 and 1999/2000, respectively. Subsequently, dollar limits increase at the growth in the yearly maximum pensionable earnings (YMPE).¹³**

¹³

Cunningham R, *Smoke and Mirrors: The Canadian War on Tobacco*, International Development Research Centre, Ottawa, Canada, 1996. p. 8.