
Six Pillars of Social Policy: The State of Pensions and Health Care in Canada

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Introduction and Overview¹

This paper surveys the state of Canadian economic policy in two key areas: pensions and health care. The occasion for this volume provides one justification for what might appear an over-ambitious survey. The impressive range of topics that David Slater has tackled over his career includes important work in both areas. In view of his consistent attention to the big picture and the long term in his work, it seems probable that if Dr. Slater were just starting now, the *festschrift* he could look forward to in 60 years' time would make reference not just to his contributions to understanding and management of pensions and health systems separately, but also to their complementarities and interactions.

As government involvement in pensions and health care in Canada has expanded, a second reason for exploring the two topics together has become more compelling. Pensions and health care are major spending programs that are strongly related to the life cycle of citizens. An aging population and rising ratio of program beneficiaries to workforce participants presents each with important challenges. And, especially in the face of demographic changes, design issues in each and in their interaction need attention if Canada is to provide beneficiaries with money and services while encouraging behaviour that will support a strong economy and keep the programs sustainable.

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There are, of course, also key contrasts. Income support through pensions is formally closely tied to old age, whereas many government-supported health services are available on much the same terms throughout life. Pensions are money income, whereas health-related indemnity payments are relatively small relative to the services that are provided in kind. These contrasts affect the targeting of benefits and give provider groups a different influence on policy. As this review will attempt to show, however, these contrasts are often questions of degree rather than kind, and do not prevent an examination of interactions between the two that makes parallel treatment fruitful.

The Three Pillars Framework

For Canadians, there is one further justification for attempting a parallel discussion of pensions and health care. Commentary on pensions around the world makes much use of a metaphor of three pillars in describing a comprehensive system: a safety net to guard against destitution in old age, a mandatory employment-related system to provide basic replacement income, and a voluntary system supported by provisions that reduce double-taxation of saving. The distinction among different objectives of pension programs that inspires this metaphor is helpful in evaluating the performance of national systems (World Bank, 1994; ACPM, 2000).

In Canada, the main elements of public policy related to pensions — the Old Age Security and Guaranteed Income Supplement (OAS/GIS) and various provincial transfers for low-income seniors; the Canada and Quebec Pension Plans (CPP/QPP); and tax rules and regulations related to employer-sponsored and individual retirement saving plans (RSPs) — address these different objectives with an efficacy and precision that many other countries might envy.

The same precise matching of objectives with instruments, however, is not evident in health care. The 2000 federal election campaign provided a vivid example of Canadians' preoccupation with a confused debate over public versus private financing and public versus private provision of health services.¹ So a joint survey that discusses health care with respect to the three

¹This confusion is partly deliberate, with advocates for government-produced services arguing that private production goes with private financing. In fact, physician services in Canada are nearly exclusively privately produced, as are the bulk of inputs such as drugs and laboratory services. Hospitals are still nominally independent not-for-profit organizations,

objectives that inspire the pillars metaphor — a safety net for those who need it, a contributory system that obliges those who can provide for themselves up to a basic level to do so, and a voluntary system that reduces double-taxation of saving — might accomplish two things. It might facilitate constructive responses to the pressures that will confront Canada's health system in the future. And it might illuminate some interactions between the pension and health systems that require attention if both systems are to be sustainable.

Outline of the Paper

The rest of the paper has four main parts. The first part provides background. It gives an overview of the pillars' concept, discussing its application to pensions and health care, and outlining the implications of each pillar's objectives for the way it is financed.² It also discusses the challenges of Canada's current situation, in particular the aging of the population and the need to ensure that the incentives the pension and health-care systems create — both individually and together — are compatible with long-term sustainability.

The second section turns to a more detailed discussion of the pillars of Canada's pension system, covering the motivations of the programs, their financing, recent developments and future prospects. The third section discusses health care in the same framework.

The fourth section draws out some parallels between the two systems, discusses gaps in our understanding of how they affect behaviour, and speculates about how future policy changes, especially in health care, may affect their interaction. One observation is that more pre-funding to cover the cost of the aging baby boom is desirable, both in government budgets generally and in specific pension and health programs. A second is that gradual increases in the normal age of eligibility for pension benefits makes sense, and to the extent that health benefits become available at the same age, a coordinated approach would be desirable. A third major point is that allowing the current generous and largely non-means-tested health system to

although many would argue that they have become *de facto* arms of provincial health ministries.

²Some commentary uses the term “tiers” to distinguish different elements of pension systems (Robson, 1997). In connection with Canadian health care, however, the term “tier” has become so politically charged as to inhibit intelligent discussion. So it seems prudent to forestall some of the more reflexive, less reflective reactions by avoiding the word.

evolve into an equally generous but strongly means-tested system would exacerbate disincentives for many Canadians to work and save; creating a second pillar in the health system is likely a better route to long-term sustainability. Similar considerations underlie a fourth recommendation: creation of a new type of saving vehicle that provides tax-relief on distributions rather than contributions, so that modest-income Canadians can save in a form that avoids the high marginal effective tax rates that means-tested pension and health programs will otherwise impose on them.

In summary, parallel treatment of pensions and health in the three-pillars framework highlights some useful steps Canadians can take to ensure that the two systems work together in the service of solid and sustainable benefits.

Concepts and Context

This section gives an overview of the pillars concept: the objectives of each pillar and their implications for its design and financing. It also discusses the challenges of interactions among elements of each pillar and between the pillars themselves. It then surveys the continuing transformation of Canada's population to older, more intensive users of the pension and health systems, a transformation that makes decisions about how the pillars of each system will evolve all the more important.

Distinguishing Pillars

Classifying different elements of public policy towards transfer payments and in-kind services in the pillars framework is useful because it forces attention to their different motivations.

The First Pillar: The Safety Net. The first pillar is most straightforwardly thought of as a safety net. Like social assistance and in-kind services for the destitute, first-pillar programs seek to protect citizens from circumstances that are so miserable as to threaten life itself, or would be widely regarded as intolerable.

From a traditional public finance point of view, government involvement in safety net programs arises for two main reasons.³ In the case of the

³Rosen *et al.* (1999, chs. 10 and 9) provide a helpful overview of positive and normative considerations in these areas.

currently needy, such as the disabled, free-riding may prevent a private charity providing support on the scale that collective utilitarian motives would suggest. And in the case of potential recipients, who would insure themselves against disaster if they could, information failures — adverse selection and moral hazard — may prevent private insurers from providing the necessary coverage.⁴ Students of public choice will point out also that actual and potential recipients of such programs have an interest in voting for them, as do actual and potential providers of services and transfer inter-mediaries.

Design of safety net programs inevitably requires trading off competing imperatives. One key question is the level of support. Programs that are relatively generous will relieve hardship more effectively. Their higher expense, however, will typically impose efficiency costs through the tax system. More generous programs are also likelier to raise concerns about horizontal equity, both between less fortunate members of society who do or do not qualify for the program, and between those who do or do not pay for it.

Targeting, whether through means-testing (by income, or assets, or both), provision of in-kind services,⁵ or characteristics such as age that serve as proxies for need, is also a key conundrum. Programs that are broadly targeted are likelier to provide support to all intended beneficiaries and will reduce incentives to change behaviour to create entitlement. Narrowly targeted programs, by contrast, are likelier to exclude people who are not intended to benefit. They thus make less acute the efficiency and horizontal equity issues just noted, and — to the extent that targeting is accomplished through providing services in kind — respond to paternalistic desires to constrain the use recipients make of their support.

Their redistributive motivation makes first-pillar programs strong candidates for financing from current general government revenue. Pay-as-you-go tax financing reflects the dual nature of judgements about deprivation.

⁴Adverse selection refers to the fact that potential insurers against mis-fortunes with a likelihood closely bound up in the personal characteristics of the potential buyer typically know less about the likely payout than the buyers do themselves. They may, therefore, only be able to offer policies at average prices that will be unattractive to the best risks, with the result that no market develops. Moral hazard refers to the possibility that purchasers of insurance will change their behaviour in ways that increase the likelihood of a claim, but which the insurer cannot observe — another obstacle to widespread provision by private insurers.

⁵For an exploration of type 1 and type 2 errors — inadvertently excluding intended beneficiaries and inadvertently including unintended ones — as factors in the design of redistributive programs, see Boadway and Keen (2000).

Most people would not wish relief of absolute deprivation — a level of well-being so low as to threaten life itself — to be contingent on the existence of, say, a pool of dedicated income-earning assets. Giving such relief a high-priority claim on general public sector resources makes sense. Deprivation is also a relative concept, however: the material living standards of the average Canadian family four generations ago would be widely regarded as intolerable for a poor person (particularly a poor, elderly, sick person) today. Gearing support for safety net programs to current general prosperity through pay-as-you-go financing makes adjusting its level as society-wide living standards change relatively straightforward.

These considerations do not rule out pre-funding these obligations indirectly by raising governments' net worth through general budget surpluses. If the rate of return on financial assets exceeds the rate of economic growth, pre-funding new or enriched programs will impose lower taxes for a given level of benefits.⁶ In situations where an initiative is intended to transfer resources from the young to the old and/or from a presumably more prosperous future to a needier present, however, policymakers and potential recipients may not give that consideration much weight.

The Second Pillar: Mandatory Income/Lifestyle Maintenance. The second pillar is a mandatory contributory social insurance system that requires all eligible citizens to purchase a basic package of benefits, such as insurance against unemployment. Traditional public finance perspectives stress two reasons for extensive government involvement in such systems.

One of them is moral hazard created by the first-pillar safety net. It is hard for administrators of safety net programs to deny benefits to people whose deprivation is of their own making. Such judgements are always contentious, and when the deprivation results from irrevocable past choices, the desire to set a good example for others may be too weak to produce time-consistent policy. So it is attractive to force all who could provide for themselves at least up to the level of first-pillar support to do so.

Even if the safety net did not affect behaviour and people would be willing to buy insurance against misfortune at an actuarially fair price, adverse selection may mean that such insurance is not widely available. Individuals

⁶Moving an ongoing program from a pay-as-you-go to a pre-funded footing is a trickier call. In present value terms, the first-round impact of such a change imposes costs on losers that are equal to the benefits to winners, making second-round impacts and judgements about the appropriate sharing of costs and benefits among generations key to the decision (see Sinn, 2000, on the inter-generational point).

are worse off without a kind of insurance they would like to buy, and their defensive behaviour may have further adverse consequences.⁷ Compulsory pooling overcomes this difficulty. As far as efficiency is concerned, it is not clear that the gains from compulsory pooling outweigh the cost of increasing the scope for moral hazard to operate within the second-pillar system. Deductibles and co-payments can curb moral hazard, however, and if a desire to shift costs among participants is a key motive for establishing a social insurance program. The resulting externalities are an intentional product of policy.

Another often-cited justification for second-pillar programs is that individuals may judge their needs poorly. They might, for example, be myopic, underestimating their future requirements and failing to save enough on their own. They might save in inappropriate forms. Or recipients might respond to plans that provide unrestricted indemnity payments rather than restricted ones or in-kind services by spending foolishly. Whether policy-makers are better at looking after participants' interests than the participants would be on their own is bound to be a matter of debate. Since compulsory participation on similar terms is a general feature of social insurance programs, experiments that would allow judgements about, say, relative time horizons among private and public decisionmakers tend not to occur.

The financing of second-pillar systems reflects their insurance aspects. Most such plans collect contributions from participants (often through their employers) whose benefits are related in some fashion to their history in the plan. Many second-pillar systems can produce records of individual participation that resemble those that private insurers would provide. To the extent that participants see their contributions as actuarially fair — no different, say, from deductions from pay to finance fringe benefits — they will impose no tax and provide no subsidy, promoting an efficient labour market.

This mimicking of private insurance policies or retirement plans does not typically extend to the handling of assets inside the plan. The usual approach is a government-administered fund. If such a fund is administered separately from other government assets and liabilities, and the program's cash flows are segregated from other items in a government's budget, there may be economically meaningful pre-funding of the program's obligations. As noted earlier, such pre-funding may be desirable when returns on financial assets

⁷A frequently provided example is the possibility that without insurance against unemployment, over-hasty job-search will impede good matching of employer needs and employee skills.

exceed economic growth rates or — as is likelier with second- than first-pillar programs — when policymakers wish to keep each cohort’s costs in line with its benefits. At the other extreme, the fund may be a meaningless bookkeeping entry that signifies no segregation of plan cashflows and assets from the rest of the government’s budget — a misleading mask on a pay-as-you-go system.

The Third Pillar: Tax-Recognized Saving. Third-pillar systems are sets of tax laws and regulations that provide a framework for individuals, either on their own or pooled (generally through employers), to self-insure.⁸ Their key feature is relief from double-taxation of saving. There are two principal approaches. The more common one exempts contributions to and earnings within a saving plan from the tax base, but includes distributions. This approach is often referred to as EET — for “exempt”, “exempt” and “taxed”. The other, less often used, includes contributions to a plan in the tax base, but exempts accumulations and distributions. This approach is often referred to as TEE.

From a public finance point of view, these systems serve several ends. They reduce distortions in the current-salary/deferred-benefit balance of employee compensation by evening out the tax treatment of, say, pension-plan contributions and wages.⁹ Relatedly, they mitigate the bias that a pure income tax creates in favour of consumption over saving (see Mintz, 2001). Although such plans may pay taxes or receive subsidies, they are usually self-funding. Tax deferral in third-pillar systems also promotes horizontal equity by making it easier for private sector employees to obtain pension and insurance arrangements like those enjoyed by public sector employees, whose employers — being formally or effectively non-taxable — find provision of generous deferred benefits less costly. They can also level the playing field between employees and the self-employed.

The voluntary nature of these systems weakens the case for restricting the services that participants can buy or the indemnities they can enjoy. Nevertheless, paternalism in third-pillar systems finds expression in regulations that, for example, attempt to ensure that saving ostensibly undertaken for retirement is actually used for that purpose.

⁸The presumption here is that contributions to such plans are from participants themselves, although the possibility of government top-ups exists.

⁹If the third-pillar framework promotes employer-sponsored or other private pooling arrangements that have an insurance element, it can reduce the problems that public finance economists point to in justifying second-pillar programs.

From a public choice point of view, third-pillar plans might be seen to respond to the desire of citizens for deferred compensation under their own control. Some observers see the forward-looking behaviour such control induces as a source of positive externalities, and count this effect as a benefit of such plans. A less favourable assessment, typically reflecting a view that annual income is a suitable metric for assessing well-being, sees these plans as undermining vertical equity — allowing savers, who in a given year will tend to have higher incomes than non-savers, to avoid tax on part of their incomes — and may consider some kind of *quid pro quo* on the part of participants, such as an obligation to invest their savings in certain ways, to be appropriate.

Conundrums

As this brief review reveals, programs in each pillar present challenges: the first pillar's trade-off between generosity and efficiency; the second pillar's overcoming of adverse selection at the cost of increasing the scope for moral hazard; the third pillar's conflict between horizontal and vertical equity. The fact that developed democracies typically have a number of programs that provide safety-net, social insurance, and self-insurance services, moreover, means that sorting out the combined impacts of and interactions among different programs can be a major challenge.

Interactions. Where first-pillar benefits are geared to assets or income, for example, problems can arise when benefit-reduction schedules — popularly known as clawbacks — affect a given recipient overlap. The “welfare wall” encountered by people moving from social assistance to work who lose various transfer payments and in-kind benefits is a well-known instance. Interactions among different pillars are also important. If clawbacks in first-pillar programs create confiscatory marginal effective tax rates, for example, they will hurt incentives to work and save in general. Discouraging work is unhelpful to the contribution base for second-pillar programs, while an expectation of higher marginal effective rates in retirement may outweigh the encouragement that third-pillar programs provide for individuals in the relevant income range to save.

Finally, interactions among entire systems can matter. If the income and substitution effects of systems in one area discourage workforce participation, for example, the consequent reduction in output will adversely affect the financing of other systems.¹⁰ Alternatively, improvements in well-being as a

¹⁰The lower workforce participation may have implications for the spending side of

result of one safety-net or social insurance program may have favourable repercussions for others.¹¹

Demographic Change and Fiscal Sustainability. Of course, the functioning of pillars and the interactions among them occur in real time, and the evolution of these programs and the changing circumstances that surround them have tended to confront countries with specific types of challenges.

The second half of the twentieth century was remarkable for a number of developments in the developed democracies. The first 25 years were a period both of rapid productivity growth that gave rise to unprecedented prosperity, and of dramatically higher fertility amid a long-term downward trend. Governments grew rapidly, with first- and second-pillar programs playing major roles in the expansion. Then the second 25 years witnessed a reversion to the historically normal growth rates and a resumption of the previous trend towards fewer children.

Canada shared in this experience. The boom gave rise to economic growth rates well in excess of rates of return on financial assets, encouraging pay-as-you-go financing and government deficits. The expansion of government obligations and an end to the productivity boom then created large fiscal deficits. When the historically more common situation where rates of return on financial assets exceed economic growth rates returned, high debt levels kept tax rates up even as program spending came under control. Ever since, accumulating obligations in the areas of both pensions and health care have created concern about fiscal sustainability and inter-generational fairness (Robson, 1996, pp. 3-4 and 7-9).

The central fact underlying current concern about Canadian pension and health systems is that the aging of the baby boom and the post-boom return to a longer term downward trending fertility rate is on the verge of changing the ratio of older to working-age Canadians in a massive, unprecedented fashion. Over the years from 2000 to 2020, the share of the total population that is 65 or over will go from its current level of 12.5 per cent to more than 18 per cent, while the ratio of working-age people to seniors will drop from

other programs as well.

¹¹Interactions that help shape the parameters of the systems are also possible. For example, Bethencourt and Galasso (2000) investigate the possibility that redistribution through public health expenditures will increase the size of the constituency that supports redistribution through the pension system.

5.5 to 3.6.¹² More speculatively, with constant fertility rates and age-specific mortality rates continuing to decline at the rates suggested by experience from 1971 to 1991, the share of the population that is 65 or over will rise to 25 per cent, and the ratio of working-age people to seniors will fall to 2.4 by 2040 (Robson, 2001, pp. 4-6).

Since the older population is likelier to receive payments and services from the pension and health systems, while the working-age population is likelier to contribute to them, Canada's fiscal and economic future will be highly sensitive to the interactions and overlaps among the various pillars of pension and health policy.

Pensions

The current structure of Canada's retirement income system conforms closely to that suggested by the pillars framework. The safety-net, mandatory income-replacement, and voluntary components of the system are easily distinguishable. These separations have assisted Canadians in adjusting these programs in the past, and should prove helpful in making adjustments that will keep the system functioning well in the years ahead.

Old Age Security and the Guaranteed Income Supplement

Together, Old Age Security (OAS) and Guaranteed Income Supplement (GIS) payments make up the bulk of the income-supporting safety net for older Canadians.¹³

The OAS was Canada's first national income-support payment for the elderly. It started as a modest flat transfer to all Canadians aged 70 or over in the early 1950s, grew in real value through enrichment and lowering of the eligibility age to 65, and then shrank again through inflation until being

¹²Consistent with the usual labour-force definition, the working age is defined here as from 15 to 64.

¹³The spouses' allowance introduced in 1975 also falls under this heading, but is too small to rate separate discussion. See Burbidge (1996) for a fuller description of these programs and their history.

indexed to the consumer price index in the early 1970s. It is taxable and since 1990 has been subject to a special clawback of 15 per cent that reduces it to zero for seniors with net incomes above about \$80,000.

The GIS was introduced in the mid-1960s as a non-taxable income supplement for Canadians who would receive little or no benefit from the Canada and Quebec Pension Plans (CPP/QPP) established at the same time. It was enriched at intervals during the 1980s, and is indexed to consumer price inflation. It is clawed back at a rate of 50 cents per dollar of (most) other income.¹⁴

The OAS and GIS are clearly first-pillar programs, providing a floor below which no senior's income will go. They are largely responsible for the virtual elimination of severely low incomes among Canadian seniors (Osberg, 2001). Together, they represent a compromise between the objective of a lightly distorting, but less generous, universal safety-net program, and the more heavily distorting and more generous alternative. The durability of this compromise was evident when the 1996 federal budget proposed to combine the two programs into a new "seniors benefit" that would have enriched benefits marginally at the lower end and clawed back transfers to higher-income recipients more energetically. This proposal attracted a number of criticisms, among them dislike of the higher effective marginal tax rates it would have imposed on middle-income seniors (Slater, 1998), and was quietly dropped in the summer of 1998.

The OAS originally had some trappings of a contributory plan, with a notional allocation from both the personal and corporate income taxes into a dedicated account. For some early participants, this cosmetic gesture created a sense that the transfer was an earned entitlement along second-pillar lines. These earmarked taxes and the account disappeared in the early 1970s, however. Since then, the OAS and the GIS have been financed from general federal taxation — a pay-as-you-go approach that gives these programs a high-priority claim on core government resources and effectively gears them to general prosperity. Since the ratio of federal government debt to gross domestic product (GDP) has risen from around 20 per cent in the mid-1970s to more than 50 per cent currently — and the last enrichments of the GIS in the mid-1980s occurred when the federal deficit was running around 8 per cent of GDP — this financing approach can be reasonably seen as a deliberate transfer of resources from the young to the old.

Looking ahead, two contrary forces affect the claim of these plans on national resources. The more rapid growth of the recipient than the working-

¹⁴Importantly, OAS payments are not included.

age population will exert upward pressure on OAS and GIS payments as a share of the economy. But since benefits are indexed to prices rather than wages, productivity growth tends to reduce their share of GDP. Recent projections from the Chief Actuary (OSFI, 1999) showed expenditures under these plans falling from around 2.6 per cent of GDP at the time to 2.4 per cent after a decade, then climbing again, regaining their then-current share by 2015, and peaking at 3.3 per cent of GDP by 2030.¹⁵

Discounted over the next 50 years at 6 per cent, the net increase in the share of GDP projected to flow through these plans represents a liability of about 9 per cent of GDP.¹⁶ The fiscal consolidation that has brought the ratio of the federal government's net debt to GDP down by nearly 20 percentage points from its peak above 70 per cent in the mid-1990s might be seen as, in part, a move to offset this liability and the associated resources transfer.

Except for the aborted seniors benefit just mentioned, the only significant attempt to rein in growth of the first-pillar programs was a proposal in the 1985 federal budget to limit the indexation of OAS payments to inflation over 3 per cent — a measure also dropped in the face of opposition from seniors. Many observers have suggested that the increase in the average healthy life expectancy of Canadians since these programs were introduced makes it reasonable to expect people to work for longer, and that some increase in the age of eligibility for receipt would make sense. Although many developed democracies, including the United States, have recently undertaken or scheduled such moves (OECD, 1998, p. 53), no such moves are currently in view in Canada.

One equity-oriented concern about the generosity of the OAS/GIS system is that, especially combined with provincial supplements, it provides an after-tax income guarantee that is quite high relative both to the safety nets available to younger Canadians and to the levels at which working individuals

¹⁵The Chief Actuary illustrated the potential impact of ad hoc increases to keep the generosity of these programs more closely in line with the income of the working population by calculating that indexing benefits to inflation plus 60 per cent of the difference between wage growth and inflation would raise the ratio of their expenditures to GDP by about two-thirds of a percentage point above the base case by 2030 (OSFI, 1999, pp. 86 and 102).

¹⁶Fifty years is roughly the average life expectancy of every living Canadian. A 6 per cent nominal interest rate is equal to the roughly 4 per cent real interest rate used by the Chief Actuary in the most recent projections for the CPP, plus the 2-per cent inflation rate specified in the Bank of Canada's targets. This rough-and-ready valuation is used for the sake of consistency with the valuation of the health-care liability below (as in Robson, 2001).

and families begin paying taxes (ACPM, 2000, pp. 12-13). With indexation to prices rather than wages eroding the relative value of these payments, and increases in tax thresholds and reductions in bottom tax rates easing the burden on lower-income workers, these concerns will likely become less acute over the next few years. For the foreseeable future, then, the first pillar of the Canadian pension system is unlikely to change significantly.

The Canada and Quebec Pension Plans

The Canada and Quebec Pension Plans are second-pillar programs: mandatory social insurance, income-replacement plans that cover most employed Canadians.¹⁷ They provide a variety of benefits: a retirement pension that, at the normal retirement age of 65, starts at roughly one-quarter of covered earnings; widow and orphan benefits; disability benefits; and a small death benefit. Contributions are levied as a proportion of earnings between \$3,500 and the lower of actual earnings and a maximum roughly equal to the industrial average. Participants receive periodic statements of their status in the plans, and benefits are linked, albeit somewhat loosely, to contribution history.

The CPP/QPP have many trappings of funded plans, but they were originally intended to be largely pay-as-you-go. The CPP began paying full benefits after a decade in operation, and although the QPP's phase-in was two decades, the larger pool of assets this delay allowed was desired more for industrial policy and provincial-government financing purposes than to secure the benefits of pre-funding (Vaillancourt, 2000, p. 24). The assets under administration in both plans were dramatically short of the actuarial liabilities of the plans by the mid-1990s, and since the CPP's assets were at that time almost exclusively provincial government debt paying below-market rates of interest, one can argue that there was no economically meaningful pre-funding at all.

The fact that the CPP does have some assets under administration, however, meant that when financial market returns moved back above growth rates in the 1980s, the plan's financial projections readily highlighted the advantages of pre-funding. As at year-end 1997, the Chief Actuary estimated the total accrued entitlement of the CPP's participants to date at

¹⁷The principal exceptions, as is common in this type of plan, are for certain government employees: members of the armed forces and the Royal Canadian Mounted Police are not required to belong.

\$465 billion, versus assets of \$37 billion, for a funding ratio of about 8 per cent, and an unfunded liability of \$428 billion (OSFI, 1998, p. 191). The Quebec government does not produce comparable actuarial valuations of the QPP, but if the ratio between the QPP and CPP liabilities is proportional to the respective covered populations, the unfunded liability of both plans at the end of 1997 would have been \$566 billion.

By the mid-1990s, concern that the existing plan would require contribution rates above 15 per cent by 2030 inspired action to shore up the CPP. The reform package implemented in 1998 trimmed benefits slightly and ramped up the contribution rate markedly. The actuarial projections on which the reforms were based suggest that the CPP's funding ratio will rise to about 20 per cent over the next 20 years, allowing the contribution rate to stay at a politically palatable 9.9 per cent of covered earnings for the foreseeable future.¹⁸ The package also created an arm's-length CPP Investment Board (CPIB) to manage the CPP's assets, an institution that represents a state-of-the-art attempt to deal with some of the well-documented problems of government-run provident funds (Slater, 1997b; Robson, 1998).

The 1998 reform package also provided for more frequent reviews of the CPP's financial state than previously.¹⁹ More frequent scrutiny will encourage faster adjustments in the face of adverse developments. The assumptions underlying the 1998 reform package were reasonable on the whole, and positive surprises, with regard to productivity growth, for example, are possible. Importantly, however, inflation of 3 per cent — significantly above the Bank of Canada's target of 2 per cent — was needed to make the package work. Moreover, the formula used to calculate the "steady-state" contribution rate will, even if the projections on which the 1998 package was based are borne out, tend to yield higher rates during the next few reviews,²⁰

¹⁸A coherent theoretical case can be made that the additional saving in the CPP/QPP will be offset by reduced saving outside it, and that the reform package will therefore produce no net increase in national saving. As Pesando (2001) notes, however, such an offset is unlikely in actuality.

¹⁹The results of the first triennial review will be out shortly after this volume is published.

²⁰The current formula for calculating the "steady-state" rate is an odd one. It specifies essentially that the rate should make the ratio of CPP assets to annual expenditures the same 63 years after the evaluation date as it is 13 years after it. Since the asset-expenditure ratio peaks between those two dates — and therefore is on its way up at the 13-year mark and on its way down at the 63-year mark — the next few evaluations will use progressively higher 13-year benchmarks for the ratio, and will therefore find that higher

increasing the chances that one of them will inspire fresh ideas about better funding the plan. Further reforms are not beyond the realm of possibility in the coming decade, and proposals to raise entitlement ages (see Pesando, 2001) can and should get a hearing.

More frequent review — especially following a strong economic performance such as occurred during the 1998–2000 period — might also expand the opportunity for enriching current or soon-to-be beneficiaries at the expense of later participants. Another threat to the plan's integrity may be industrial-policy advocates attracted by the growing pool of financial assets under CPPIB administration. Importantly, however, the CPP Act provides for other provinces to follow Quebec's lead and establish their own plans, and the province of Alberta has shown interest in doing so if the principles of the reform package are threatened, a threat that may help keep the package intact. To the extent that confidence among younger CPP participants that they will actually receive future benefits remains low, repackaging part of the plan into individual retirement accounts may be an attractive option (Robson, 1996; Pesando, 1997).

Pension Plans and RRSPs

The modern shape of Canada's registered pension plans emerged from two forces. One was the desire to ensure that private employer-sponsored pension plans were properly funded. The other was the desire to level the playing field between employees who had such plans and those who did not. Accomplishing these goals meant removing the obstacles to employer funding of pension plans, and then providing analogous provisions for individuals who wished to contribute to their own.

The essential characteristic of Canada's third pillar is that it relieves contributions to employer-sponsored or individual retirement plans from current taxation, and does the same for income earned inside the plans. Withdrawals are taxed at regular personal income tax rates.

Concern about the possibility that higher income earners will avoid too much tax on contributions, as well as the federal government's fiscal difficulties in the mid-1990s, resulted in limits on contributions that in recent

contribution rates are needed to push the 63-year ratios up to that level (Slater and Robson, 1999, pp. 14-15). Of course, another possible reaction to this problem would be to change the regulation that specifies the formula, and choose two new dates that yield a 9.9 per cent rate.

years have become tighter.²¹ Withdrawals from and conversions of the assets in these plans into annuities or combined return-on/return-of capital arrangements (registered retirement income funds) are regulated in several ways and are obligatory after age 69.

As noted already, a key rationale for relieving contributions to pension plans from current taxation is that failing to do so would discourage employers from funding their pension promises. Passing the bill for the first cohort of recipients forward in time through pay-as-you-go financing is attractive to private companies as well as to governments, but unless growth in company revenues and profits out-paces returns on financial assets indefinitely, such arrangements tend to lead to defaults. Unfunded private defined-benefit plans have essentially been illegal since the 1960s; nowadays, the obligations of defined-benefit plans are by and large completely backed by assets. Full backing of defined contribution plans, whether employer-sponsored or individual, is of course intrinsic to their structure.

In general, the third pillar of Canada's pension system appears, like the other two, to be well suited to its purpose of facilitating voluntary retirement saving. Slightly over one-half of Canadian families have claims on defined-benefit plans (Statistics Canada, 2001), and some one-third of Canadians have Registered Retirement Saving Plan (RRSP) assets. Contributions to contributory Registered Pension Plans (RPPs) dropped somewhat between 1986 and 1997, but increased contributions to RRSPs more than offset the decline (Morissette and Drolet, 2001, p. 115). By international standards, the assets held in Canada's third-pillar Registered Saving Plans (RSPs) are large, amounting to some \$730 billion, or almost three-quarters of GDP, in 2000 (Andrea Davis, 2001).

There is ongoing debate over the justification for RSP contribution limits. Those who dislike seeing individuals with higher annual incomes defer tax tend to argue for lower limits, an argument that has recently carried the day. The maximum contribution for which tax deferral is available has been frozen at the lesser of 18 per cent of income or an amount sufficient to provide \$1,722 per year of pensionable service (to a maximum of 35 years) for

²¹See Slater (1997a). Income-tax provisions concerning Canadian RSPs limit foreign investments by their owners. This restriction is unusual among developed countries, and seems to reflect a view that those enjoying deferred taxation should pay a price for the privilege. If binding, such limits can force savers into inferior risk-return positions (Fried and Wirick, 1999). For large plans with cost-effective access to derivatives, circumventing these limits is easy and inexpensive; for small individual savers, on the other hand, vehicles offering above-the-limit foreign exposure tend to be relatively costly.

defined-benefit pension plans, and 18 per cent of income or \$13,500 annually for defined-contribution plans or RRSPs. After allowing for inflation over the period of the freeze (1996 to 2004), these provisions will reduce the opportunity to save 18 per cent of income in this manner to individuals with annual incomes under about twice the average, although unlimited carry-forwards of unused room reduce the impact of these limits on taxpayers whose incomes are volatile (Slater, 1997a). Those who favour consumption taxation, on the other hand, tend to favour higher limits (Mintz, 2001), and many would also favour liberalization of the terms under which funds from these plans can be withdrawn.²²

A further area of concern that has, as yet, attracted less attention relates to the fact that income-based means-testing in the pension system's first pillar — and, as is discussed further below, in the health-care system — results in marginal effective tax rates for modest-income older Canadians that are typically far higher than the tax rates they faced while working (Davies, 1998). For these people, especially when they are older and the period of tax-free accumulation is less significant, EET-type vehicles that defer taxes may be an unwise choice (Shillington, 1999).

To judge from current behaviour, the implications of this problem are not yet clear to many of those affected: the share of income devoted to pension contributions increased more among low- than high-income workers from 1986 to 1997 (Morissette and Drolet, 2001, p. 116). Many of these contributors, especially the younger ones, are undoubtedly people whose low-income status is temporary. For those whose long-term prospects for income gains are not good, however, the disadvantages of saving in this form raise two concerns. First, it would make sense to create a TEE-type vehicle, in which contributions would be taxed but accumulations and withdrawals would be tax-free, in which lower income Canadians could more effectively save (Kesselman and Poschmann, 2001). Second, if more of the lower income population comes to understand the implications of high future-clawback/current-tax-saving ratios and save less as a result (as Hamilton, 2001, suggests they should), the first-pillar system and the taxes that pay for it will both be adversely affected.

²²Age limits on receiving pensions or converting the assets in a plan to an annuity or Registered Retirement Income Fund would also need re-examining in the event of an increase in eligibility ages in the first- and second-pillar systems.

Health Care

In contrast to the pension system, the formal organization of Canadian health care scarcely reflects a three-pillar framework. It is nevertheless straightforward to distinguish safety-net, mandatory basic lifestyle maintenance, and voluntary saving motivations behind different components in the system.

Distinguishing these components is helpful for two reasons. It breaks the system's successes and challenges down more clearly than does the confused debate over public versus private financing and delivery that currently dominates health-care discussions. And it highlights features of the health-care system that can interact with features of the pension system in desirable and undesirable ways.

Coverage against Medical Catastrophe

Public financing of hospital treatments and other responses to life-threatening conditions is the clearest mechanism by which Canadian health systems provide safety nets to citizens. Hospital insurance was the first area of extensive public financing of health care in Canada, being brought almost entirely into a system where services are free at the point of delivery, with no co-payments or deductibles, by the early 1960s. Hospitals remain both the single biggest category of public health expenditures and also the category of health expenditures in which the share of public money is largest.²³ Both motivations for safety-net programs — ensuring that free-riding does not limit the resources available for rescue, and compulsory pooling to provide insurance of a type that adverse selection and moral hazard make it difficult for private insurers to cover — are evident in this arrangement.

Since the early 1970s, most physician services have also been effectively part of the safety net. Like hospital treatments, physician services have first-dollar coverage under provincial medicare plans. To a lesser but still considerable extent, many services that are ancillary to hospital and physician treatments, in particular laboratory services and pharmaceuticals, often come into the safety-net category. But the extent to which this type of coverage corresponds to what most people would think of as safety-net functions is

²³Figures on the public and private shares of health spending by use of funds are available from the Canadian Institute for Health Information at www.cihi.ca/facts/nhex/nhex2000/NHEX_Fig1-5.shtml#figure%205 (as of 10 July 2001).

erratic: while patients' hospital stays are covered, the ambulance that takes them there may not be.

For the most part, Canadian safety-net health services are targeted only in the implicit sense that, after the point of first contact — the primary-care physician, walk-in clinic or hospital emergency room — their provision is contingent on a medical condition that warrants treatment. Unlike the common practice in other countries, access to hospital and physician services in Canada is not subject to means-testing and there are no mechanisms for cost-recovery after the fact.

Some targeting of first-pillar-type services, however, does exist. Tax credits for out-of-pocket medical expenses provide full relief from taxation of income devoted to health care above specified limits (3 per cent of net income or a prescribed amount, \$1,637 in 2000) for people in the bottom tax bracket, but less than full relief for those in higher brackets. The provinces that still charge health-related premiums — British Columbia and Alberta for hospital, physician and pharmaceutical services; Nova Scotia for pharmaceuticals alone — provide partial or complete relief from premiums based on factors such as age, income, or medical condition. Access to provincial pharmacare programs is also contingent on age, income and/or medical condition.²⁴ And importantly for subsequent discussion, public subsidies for long-term care are typically subject to income-based means tests and fierce clawbacks.

When hospital and physician services were first covered by public insurance programs, individual or family premiums notionally related to the insurance programs were common. As with the OAS, this approach appears to have responded to a sense in the population that these were, to some extent, second-pillar-style contributory programs.²⁵ In many cases, these provincial revenues were directed into special accounts, and the terminology of pre-payment suggested at least a minimal level of pre-funding.

Federal subsidies to the provinces — at first under cost-sharing agreements and later through block-funding — were always from general revenues, however, and over time, provincial health programs became largely or completely tax financed. Nowadays, as just noted, only Alberta and British Columbia charge premiums in respect of hospital and physician services, and

²⁴Drug plans for seniors typically involve income-tested co-payments and deductibles.

²⁵The fact that packaging them this way enabled governments to levy special taxes to cover their costs made the fiscal decisions easier.

the amounts raised amount to some one-eighth to one-tenth of health-envelope spending.²⁶ As with first-pillar pension programs, it seems reasonable to view the increase in provincial government net debt — from around 5 per cent of GDP in the early 1970s to around 27 per cent more recently — as indicative of an implicit desire to transfer resources to current recipients of these services.

Tax-financed medical services that are a *de facto* part of the Canadian safety net currently amount to some 6 per cent of Canada's GDP. Because older people absorb medical services in larger amounts than younger people,²⁷ the intensity of their use will likely rise in the future even as the number of working-age Canadians so important to their financing grows more slowly and then shrinks. Unlike the price-indexing that provides some automatic offset to the upcoming shrinkage of the share of the population that is working, most observers expect current trends to increase the cost to taxpayers of the health safety net.

Projections that assume constant relative age-specific utilization rates, moderate increases in age-adjusted utilization and costs, and historical increases in output per person of working age suggest that the claims of provincial health spending on the economy will rise markedly in the coming decades. Expressing these increases over current shares of GDP — or equivalently, if governments' tax shares of GDP stay constant — over current own-source revenues in present-value terms over a 50-year period yields a measure of the liability represented by higher health spending ranging from \$500 to \$800 billion (Robson, 2001, pp. 11 and 16).²⁸ Although governments have reduced their debt-to-GDP ratios since the mid-1990s, the *de facto* pre-

²⁶In 1999–2000, Alberta raised \$653 million in health-care insurance premiums, and spent \$5.1 billion in the “health and wellness” envelope (Alberta, 2001). In British Columbia, medical services plan premiums were \$868 million, and \$8.1 billion was spent under health (British Columbia, 2000, pp. 79 and 81). In Alberta, premiums are collected by large employers. Certain categories of citizens are exempt from premiums, including seniors in Alberta; low-income families in both provinces are eligible for lower premiums.

²⁷Estimates from the Canadian Institute for Health Information for 1998 show per capita use of provincially funded health goods and services some 5.4 times higher for those 65 and over than for those under 65 (Robson, 2001, pp. 4–5).

²⁸Projections that assume that mortality, rather than age per se, is the key driver of costs produce figures that are somewhat more challenging. In a typical projection, the number of deaths rises more slowly than the number of seniors, but more quickly than a utilization-by-age weighted index of the entire population.

funding provided by these reductions is fairly small alongside a liability of some 50–80 per cent of GDP.

The fiscal pressures of the 1990s resulted in some narrowing of the variety of medical services covered by the tax-financed safety net, and mostly informal quantitative limits on the supply of covered services. The current period of buoyant fiscal results has eased these pressures but, while there is doubtless room for more efficient use of resources in the system through more adept planning (Evans *et al.*, 1994; Donaldson *et al.*, 2001b) or internal markets (Jérôme-Forget and Forget, 1998; Donaldson *et al.*, 2001a), it is safe to predict that they will mount again in a few years' time.

When they do, the outcome of choices about what services to continue covering in the tax-financed system will doubtless largely reflect the same desire to protect Canadians against catastrophic events — which, if paid for privately, would be financially ruinous — that led to hospital and physician services being covered publicly in the first place. The process of choosing might be somewhat less contentious if the safety-net motivation behind this pillar were more explicit in the debate. Age will doubtless continue to be a criterion for eligibility for certain types of services; a straightforward way of adjusting this type of targeting to cope with financial pressure and acknowledge the trend towards longer life expectancy and healthier old age would be to raise the eligibility age for such coverage.²⁹

As far as moves towards means-testing are concerned, the dilemma familiar from the discussion of first-pillar systems generally and the OAS/GIS system in particular — between providing a generous level of support and avoiding punitive effective tax rates — will come to the fore. Thus far, the fierce clawbacks that generous but tightly targeted safety-net programs create have been mostly limited to the area of long-term care, where they already create powerful incentives not to save or to convert assets to forms that are immune from clawbacks. The recent increase in the importance of drugs in treatments means that provincial drug programs, which typically gear deductibles, co-payments and (where they exist) premiums to income, increasingly raise the same type of concern.

More general co-payments geared to income are one possible response to financial pressure. Recovering part of the cost of medical services through the personal income tax (Reuber, 1980, ch. 8) would be less problematic than adding to the existing panoply of income-tested benefits. Provided that the

²⁹It would be more elegant if eligibility ages for pensions and health care rose in tandem. Since both systems are essentially areas of shared federal-provincial jurisdiction, some lead by the federal government would be necessary in both areas.

recovery was at the same tax rates that would apply to individual income in the relevant range, such recoveries would push some taxpayers into higher tax brackets, but would not create effective marginal effective rates higher than those in the personal income-tax system itself.

Mandatory Coverage

As just noted, when health “premiums” were relatively more important in funding hospital and physician services in Canada, one might have argued that these programs reflected, at least in part, second-pillar motivation. The public systems had replaced private not-for-profit pre-paid insurance, with the explicit objective of making coverage universal and compulsory.³⁰ In this respect, Canada might have been said to have a second-pillar system that provided medical services in kind, funded on a largely pay-as-you-go basis by individual and family levies.

By now, most publicly funded services are financed almost completely from general revenue.³¹ The sort of second-pillar system that is common in other countries — by which people who are able to protect themselves against foreseeable health risks are obliged to do so in either a social insurance program or through mandatory private insurance — scarcely exists in Canada. There are, however, examples of this type of program: workers’ compensation programs, sickness benefits under the employment insurance (EI) program, and the disability components of the CPP/QPP.

With the exception of workers’ compensation programs, which purchase medical benefits that they provide their participants in-kind — effectively a little-noticed second tier within the publicly funded system — Canada’s second-pillar programs essentially provide indemnity payments: income replacement in the event of ill-health. About three-quarters of workers’ compensation expenditures are indemnity payments, and EI sickness and CPP/QPP disability benefits are entirely provided in cash.

³⁰Taylor (1978, ch. 6) discusses the gradual displacement of non-government insurers of physician services after the coming into force of the *Medical Care Act* in 1968.

³¹Newfoundland, Manitoba, Ontario and Quebec levy payroll and other taxes with names that include the word “health”. This, however, is no more than an attempt to make these taxes more palatable to the population: they are in no sense hypothecated for health-related spending, and there is no link (as there still is in provinces that charge premiums for certain health services) between payment of the levy and access to health services.

All three of these programs are run exclusively by governments, and depart in important ways from insurance principles. Workers' compensation programs, which are financed exclusively through payroll taxes levied on employers, resemble insurance programs most closely in that they are partially experience-rated on the basis of employers' accident records, and have *de facto* deductibles in the form of waiting periods.³² EI and CPP/QPP are financed by taxes on wages and salaries the obligation for which is formally split between employers and employees: neither is experience-rated in any meaningful way, and neither has co-payments.³³ The two-week waiting period for sickness benefits under EI constitutes a token deductible; the four-month waiting period for CPP disability benefits constitutes a more substantial one.

For the most part, these programs have been run on a pay-as-you-go basis. By the mid-1990s, all three had sizeable unfunded liabilities. Part of the concern over Canada's fiscal predicament at that time was directed at these liabilities, with the result that workers' compensation programs have become better funded, the EI program has built up a substantial cumulative surplus, and the CPP and QPP are, as noted already, on a path to partial funding.³⁴

Canada's second-pillar system is unusual in international terms, both in its relative thinness, and in its exclusion of private insurers. While workers' compensation in the United States, for example, is a state monopoly in some

³²Being provincial programs, they pool risk over smaller populations than the EI program, but involve less chronic regional cross-subsidies that does EI.

³³The EI program's provision of longer benefit periods in high-unemployment regions acts, in fact, as a kind of reverse experience-rating. There is a special clawback of EI payments to higher-income earners through the personal income tax.

³⁴On the wisdom of fuller funding for workers' compensation programs, see Vaillancourt (1995, p. 84); and Bogyo (1995). CIA (1996); and Robson (1996) were among the advocates of a more fully funded CPP. The EI program is a more debatable example of fuller funding. The contribution the EI Account has made to the federal government's fiscal turnaround since the mid-1990s is so large — a cumulative swing of around \$33 billion since 1995, during which time the entire reduction in federal debt has been only \$26 billion — that it seems unlikely that the turnaround could have occurred without it. For that reason, one might regard it as incremental saving. A contrary view, however, would see the fiscal turn-around as driven by necessity: if the EI program had not played its part, other parts of the budget would have made up the difference. For that reason — and noting also that the EI account is consolidated with the rest of the budget and its assets are simply federal debt — one might argue that there is no meaningful pre-funding in the program.

states, it is provided by private or a mix of private and public insurers in most (Thomason, 1995, p. 59). Many European countries and Japan go much further, obliging most or all citizens to enroll in sickness funds that pool risks by industry, geographic area, occupation, and/or in self-selected categories.³⁵ These programs have safety-net features — they often provide relief from premiums, deductibles and/or co-payments to those with low incomes, and there is coverage from general government revenues for treatments too expensive for the normal insurance system to cover — but in much of the world, the second pillar represents the principal source of health coverage for the typical citizen.

Not surprisingly, given the state of Canada's current debate over health care, there appears to have been very little discussion of the merits, or even the possibility, of establishing a second pillar in the health system. In the early 1980s, the Canadian Medical Association floated a proposal that each Canadian family pay \$1,000 a year in premiums to support what would have amounted to a substantial second-pillar system carved out of what is now the first-pillar system (Begin, 1984, p. 82). That proposal died a quick death, however; Canadians are largely unaware that their health system contains a second pillar, and do not — especially now that the last period of liberalization of CPP/QPP disability benefits is well in the past — much debate the possibility of expanding it.

Total indemnity benefits paid under workers' compensation, EI sickness, and CPP/QPP disability are significant — at nearly \$8 billion annually, they amount to close to 1 per cent of GDP, and equal about 13 per cent of the value of health services provided in-kind by provincial and territorial governments — and administrative practices have tended to increase the generosity of these systems over time. But the expansion of EI and CPP/QPP benefits related to health problems has rarely been explicitly advocated as a supplement to or substitute for the general-revenue-financed safety net, and the possibility of their becoming significant buyers of health services along WCB lines would strike most Canadians as peculiar.

³⁵See Gliberman and Vining (1996, p. 25). The Swiss system is remarkable for its lack of conformity with much of the economic theory that justifies social insurance generally and a government monopoly on it particularly. Swiss ambulatory care insurance is privately provided, and not only differs by region within each canton, but offers a choice of four deductibles (with premiums adjusted accordingly) above the mandatory minimum (Schellhorn, 2001, p. 13). Japan mandates participation in medical insurance plans organized in a variety of ways, including employer-based plans financed from payroll taxes and regional (municipal) plans financed from income and wealth taxes (Blomqvist, 2001).

Another way of carving a second pillar out of part of the existing first pillar, and possibly out of part of the existing third pillar as well, would be to require Canadians not currently covered, or not well covered, by private insurance to buy more. Despite the extensive use of this approach abroad, this suggestion might appear beyond the pale in Canada's current political climate — as was noted above, non-government insurance in Canada has been historically associated with the principle of voluntary purchase, and was supplanted by compulsory government coverage as a matter of policy.³⁶ But the *Canada Health Act's* prohibition of private insurance extends only to coverage of services that are provided by provincial health programs. In that sense, there is nothing that would prevent a province from requiring, for example, that all citizens purchase a basic package of insurance for drugs, dental care, or other services outside the currently defined safety net.

The usual justifications for preferring single public plans to competing private ones are the greater ease of integrating public plans with other public services (Vaillancourt, 1995, p. 83), the administrative costs of private plans (Evans *et al.*, 1989), and the ability to hold costs down with monopsony power (Richards, 1997, pp. 123-124; Hurley, 2000). Against these advantages can be cited the benefits of competition among private insurers in providing better coverage at lower cost (Globerman and Vining, 1996, pp. 82-83), and the advantages of involving the consumer of services more directly in treatment decisions — a motivation lying behind the suggestion that a mandatory second-pillar system might be organized around individual medical saving accounts.³⁷ The stakes in allowing such an experiment outside the safety-net system might seem sufficiently low to permit this type of approach in some of the more entrepreneurially minded provinces.

A notable feature of Canada's second-pillar health system is that — being either oriented around working people (workers' compensation and EI) or providing benefits to working-age people and seniors that are mutually exclusive (CPP/QPP) — it contains no provisions that are specific to the elderly.³⁸ As the Quebec Commission of Study on Health and Social Services

³⁶It would have been possible, as is done in other countries, to subsidize low-income purchasers of private insurance, but the federal government was unenthusiastic about such subsidies and designed its cost-sharing proposals to discourage them (Blomqvist, 1994, p. 409).

³⁷Ramsay (1998) presents some arguments for and against mandatory MSAs. Gratzner (1999, pp. 189-208) surveys a variety of options for MSAs, most of which are voluntary.

³⁸Although premium-based drug coverage for seniors is available in some

(the Clair Commission) recently noted, Canada is increasingly out of step with international practice in this regard.³⁹ The Clair Commission proposed a new provincial plan in Quebec that would cover a range of home and institutional care services — providing either indemnity payments or buying services directly — for people suffering from long-term incapacity. The plan would be pre-funded from a dedicated tax on personal income, through an account administered by an arm's-length body.⁴⁰

Private Saving for Health-Related Consumption

Turning to the third pillar, Canada's tax system has no widespread systematic provisions relieving saving for health-related expenses from double taxation. This absence is not currently a major concern. The *de facto* incorporation of hospital treatments, physician services, and many drug and specific-disorder-related expenses in the safety-net system, and the effective prohibition of private purchase of many of these services or insurance to cover them, makes dedicated saving vehicles a low priority for most people.⁴¹ Indeed, the idea that there is a third pillar in Canada's health system would strike many as a novel one.

Nevertheless, a discernable third pillar does stand alongside the first and second pillars just outlined. Favourable tax treatment exists for some saving that is implicitly or explicitly for medical purposes. RSPs, for example, can clearly be used for medical expenses. Some health insurance pays for services that are essentially outside the safety-net system, such as dental care. Other

provinces, there is no obligation to enroll.

³⁹The Clair Commission cited Austria, Germany, France, Luxembourg and Japan as examples of countries that established compulsory plans to fund various home support services, residential and long-term care services for the elderly (Quebec, 2000, p. 183). The most familiar example for Canadians is probably U.S. Medicare, which provides coverage for hospital services from a payroll-tax-financed trust fund similar in structure to the U.S. Social Security system. (This is Part A; Part B, supplementary medical insurance, is financed by user fees and general revenues.)

⁴⁰Quebec (2000, pp. 181-185). The commission left open the possibility that the new plan would cover all people suffering from long-term incapacity, rather than seniors only.

⁴¹Around half of Canadians have at least partial insurance coverage for eye-wear, closer to 60 per cent have it for dental care, and around three-quarters have it for prescription drugs (CIHI, 2000, p. 21).

insurance provides complementary inputs, such as drugs. And — remarkably, in view of the reductionist all-or-nothing debate over public versus private financing — other insurance supplements services covered by the first pillar, such as semi-private or private hospital rooms, or by the second pillar, such as disability indemnities.

As already noted, public policy might relieve saving for health-related expenses from double taxation for several reasons. Exempting employer contributions to health, life or disability insurance from taxation by allowing employers to deduct them as a cost of compensation but not including them in employees' taxable income makes sense if the distributions from such plans are subject to tax (the EET model). Otherwise, employers will be discouraged from funding such plans, and private sector employees will be at a disadvantage relative to their public sector counterparts whose employers do not pay tax. Alternatively, governments might grant no tax relief in respect of contributions to such plans, but exempt distributions from tax (the TEE model).

Some of Canada's existing provisions for health-related saving conform to this motivation. Disability insurance, for example, is available in either EET or TEE form. As noted already, to the extent that RSPs are used for medical expenses, they fit the pattern as well. Other provisions, however, do not. Some vehicles, such as employer-paid health and dental insurance (and their equivalents for the self-employed), attract no tax on either contributions or distributions, and others, such as life insurance, are taxed only above certain thresholds or in part — although recent changes to the personal income tax have tended to reduce the importance of these exemptions.⁴²

The financing of current contractual health-related saving does not raise any special concerns. Regulation and actuarial oversight of private defined-benefit plans appears to be sufficient to ensure that they are properly funded, and defined-contribution plans by definition promise no more than they can pay. Because the safety-net component of Canadian health care is so broad and deep, employer-funded health plans are relatively modest, and the continuity of coverage of retirees in the event of an employer's bankruptcy, which has been a concern in the United States, is less so in Canada. The prospect of a larger elderly population, however, and the inability of employers to tax-effectively fund post-retirement benefits, may result in pressure for more accommodative policies in the future.

⁴²In passing, it bears noting that the treatment of social insurance premiums by the tax system reflects incoherent thinking about double taxation. Despite the fact that EI and CPP/QPP benefits are taxable, with the former also subject to a special clawback, the employee-paid part of the premiums is not deductible from income, but instead earns only a credit at the lowest tax rate.

Privately purchased health goods and services are quite important in Canada — at about 2.7 per cent of GDP, or \$850 per person (CIHI, 2000, pp. 18-19) the private share of health spending is relatively high in international terms. It grew steadily during the 1990s while public spending was more constrained, and on recent evidence, it will continue to rise.⁴³ If this is so, and this increase is reflected in greater demands for saving vehicles related to health, at least two issues merit note.

First, the RSP system already provides the infrastructure for a substantial expansion of the “indemnity” part of the health system’s third pillar. Such an expansion would be easier to achieve if long-delayed increases in the amounts of income for which tax sheltering is available finally came about. Liberalization of the provisions regarding withdrawals could also help convert RSPs into a third-pillar type of medical saving account.⁴⁴

Finally, even without measures to facilitate its use for medical purposes, the rising stock of pension savings is a harbinger of an older population that is likely to be willing and able to pay for medical services that, while covered by the public safety net, are not available in a timely way or in a customer-friendly setting. If the legislative response is to seek to erect tighter barriers to private provision, some likely short-term consequences will be more cross-border shopping, recourse to the courts by patients and providers chafing under the restrictions, and under-the-table purchases. Longer term, some have questioned whether support for the current framework of medical care in Canada will erode among such a population (Globerman and Vining, 1996, pp. 38 and 66).

Design Issues, Interactions and Challenges

Looking at pensions and health care together highlights some key design issues, especially interactions between the pillars of the two systems that may

⁴³There is some debate about the relationship between public and private spending on health care as revealed by international experience (Tuohy *et al.*, 2001). Canada’s unique practice of prohibiting private insurance for, and effectively purchase of, services covered by the safety net, however, means that offsetting movements evident in other countries may be misleading as signals of what Canadians can expect, since publicly and privately purchased health services are less ready substitutes.

⁴⁴As is noted below, however, EET vehicles are not suitable for many modest-income Canadians.

need attention as larger numbers of older Canadians draw more heavily on them, or contemplate actively the time when they will do so.

Motivation and Design

Starting with first-pillar systems, it is clear that the balance between generosity and tolerable marginal effective tax rates is easier to strike when policymakers are monitoring the combined effects of different safety-net programs. Like the “welfare wall” that eliminates immediate financial rewards from leaving social assistance for paid employment, overlapping income-tested transfers in the pension system’s first pillar already subject low-income seniors in provinces such as Ontario to effective marginal rates of 100 per cent or even more.

Income supplementation programs for the elderly are reasonably well monitored, and the decision to supply a fairly generous level of support at the cost of imposing punitive tax rates on those with private incomes below it, while open to question, can reasonably be regarded as a choice Canadians have deliberately made.⁴⁵ Absent policy changes, the projected evolution of the first-pillar pension programs offers some comfort in this regard — increases in other incomes are projected to increase the share of relatively lightly clawed-back OAS payments in the total from 77 per cent recently to 83 per cent by 2030 (OSFI, 1999, p 9), which will make the punitive effective tax rates under GIS less important.

There is, on the other hand, very little monitoring of the health system’s impact. For more than 15 years, targeting of the safety-net health services has occurred almost exclusively through control of access to in-kind benefits. But there are areas where means-tested health services and subsidies are producing problems. In some provinces, income-tested drug and long-term care subsidies create marginal effective tax rates that, stacked atop other means-tested programs, impose confiscatory tax rates on the private income

⁴⁵It is important not to overstate the coherence of policy in this area. Effective tax rates of over 100 per cent result from the calculation of the GIS clawback on the basis of grossed-up dividend income, which means that seniors such as GAINS recipients in Ontario experience marginal effective tax rates well over 100 per cent on dividend income. Lack of concern about this inequity among policymakers might be attributable to their supposition that few GIS recipients have dividend income. In fact, across the country, almost 70,000 do so (Shillington, 1999, p. 7).

of seniors who use them. Ontario's nursing-home fee scale, for example, imposes effective tax rates of 100 per cent on modest-income seniors.⁴⁶

We currently know little about how Canadians respond to the incentives these programs create, and comments about how they may respond in the future are necessarily highly speculative. Intuition and casual empiricism suggest that generous safety-net and income-replacement programs have tended to lower the participation rates of older people from the workforce. Efforts to calculate marginal benefits from staying in the workforce longer suggest that modifications to first- and second-pillar pensions might raise the average age of retirement (Baker *et al.*, 2000). The United States, where Medicaid covers nursing-home expenses only for those with very low financial assets and incomes and insurers have designed annuities to allow seniors to qualify for this coverage,⁴⁷ provides hints about what more widespread understanding of health- and pension-related clawbacks might produce in Canada. Prudence suggests that policymakers should monitor carefully the impact of further changes to the medical safety net that target it to the less well-off, in order to avoid discouraging the work and saving that the Canadian pension and health systems will both require in the future.

One way of muting the disincentives created by heavily means-tested first pillars, of course, is to oblige those who can provide for themselves to do so through a second-pillar system. The CPP and QPP show that Canadians accept such arrangements in the pensions and disability areas. WCBs and EI are further testimony to the acceptability of contributory schemes that at least look pre-funded, even if the economic reality is some-what different. Outside these plans, however, Canada has almost nothing by way of a second pillar in its health system.

For the sake of building on existing foundations, it is tempting to suggest expanding one or more of the CPP/QPP, WCB and EI to accommodate the foreseeable increase in health-related demands by an older population in the future. But entitlement to the benefits of these programs and the obligation to fund them are contingent on workforce participation, and the prospect of a

⁴⁶Horizontal inequities also arise in situations where, for example, assets in an RRSP would disqualify a senior from receiving a subsidy while a defined-benefit plan of equivalent value would not.

⁴⁷For couples, the annuities transfer income from the spouse requiring care to the one not requiring care; in the case of singles, the mechanism is a "balloon" annuity that pays small monthly amounts and one large final payment at the end (Ann Davis, 2001).

relatively scarce workforce is what makes the fiscal implications of an aging population so daunting.

An attractive, if institutionally more challenging, alternative is to think — along Clair Commission lines — of new provincial social insurance programs funded by, say, individual or family premiums. Such programs could provide participants with health coverage up to a threshold close to the current average per-capita amount spent by provincial governments on health services.⁴⁸ In the current period of reduced fiscal pressure, creating room for the required premiums by cutting personal income taxes would be straightforward. The extent to which entitlements in such plans would be earmarked for individual or family accounts would presumably vary depending on the proclivities of each provincial government.

Funding

The question of how much pre-funding makes sense for Canada's first- and second-pillar pension and health systems is another area where gaps in knowledge make definitive judgements impossible. The current margin of rates of return on financial assets over rates of economic growth suggests that higher national saving would be good in general and that pre-funding is appropriate for new entitlement programs in particular.

If this margin persists or widens as aging populations in Canada and abroad lower saving rates and slow economic growth, continued general budget surpluses and accumulation of funds in existing and new programs makes sense. If, on the other hand, an aging population reduces the demand for new capital investment, lowering rates of return and allowing higher current consumption, pre-funding would be less attractive.⁴⁹ In view of these uncertainties, total elimination of regular government debt and full funding of all pension and health programs would be inappropriate goals. But prudence

⁴⁸Nationally, per-capita spending on health services by provincial governments is around \$2,000 annually. If entitlement cumulated in such plans, as it does in the CPP and QPP, older participants would, over time, build larger claims, matching in direction, if not in precise magnitude, the tendency for older people to use more health services.

⁴⁹Elmendorf and Sheiner (2000) provide a recent survey of U.S. debate over this issue, as well as some simulations. Their analysis is pertinent to Canada not only because U.S. and Canadian demographic prospects are broadly similar, but because the outcome of these forces in the United States will be critical in determining the environment in Canada.

and equity considerations — matching costs and benefits more fairly among generations (Sinn, 2000) — make pre-funding the extra costs associated with the baby boomers' old age attractive.

As noted already, some such pre-funding is arguably occurring with regard to OAS/GIS and the health safety net, and is definitely occurring in the CPP/QPP. Setting aside a portion of future budget surpluses in a designated health account could, if the saving in these accounts were not offset in other parts of the budget, extract some of the resources for their future health care from the boomers in advance, reducing the burden that would otherwise fall on their successors.⁵⁰ Similarly, ensuring that any new second-pillar health programs were pre-funded would ensure that they did not simply become a vehicle for the boomers to vote themselves new benefits at the expense of their descendants and immigrants.

Prospects

Two other foreseeable challenges for public policy in connection with pensions and health in the coming decades have to do with moving the age of eligibility for various transfers and services up from the current 65 benchmark, and managing the incentives surrounding voluntary saving.

Raising the standard age of eligibility is easy to envision, though overlapping programs and jurisdictions would make it complex to implement.⁵¹ As other jurisdictions have done, Canada should prepare for a staged increase in the standard age of full eligibility for first- and second-pillar entitlements — two months per year over a 30-year period, say, or three months per year over a 20-year period, to increase it to age 70.⁵² Matching increases would be

⁵⁰Robson (2001) suggests that the federal government set up a Seniors Health Account in which to set aside part of its budget surpluses. In that proposal, income from these assets would flow to the provinces to help cover the health-related costs of their aging populations.

⁵¹For the sake of completeness, it is worth noting that a philosophically coherent case for eliminating all reference to age in pension and health programs exists. Age has proved, however, to be such a useful marker of eligibility for all manner of benefits and privileges, that it is hard to imagine doing away with it in the foreseeable future.

⁵²As was suggested by the Canadian Institute of Actuaries in the early 1990s (CIA, 1993, pp. 17-19). Calculations using summary weighted dependency ratios to create an intergenerational wealth transfer index suggest less aggressive increases (Brown, 1995; Brown *et al.*, 2001).

appropriate in provisions affecting RSPs. Such a co-ordinated increase would reduce disincentives to work for those approaching or past the age of 65, and should mitigate saving disincentives as well, by postponing the period of life when overlapping clawbacks essentially confiscate wealth.

The second challenge is more multifaceted. Even more so than in the case of raising the eligibility age, there is a prior need for policymakers and Canadians generally to recognize the nature of the problem that looms. In private conversation, this author has encountered dismissals of the seriousness of his and others' calculations of the implicit liability of future health care on the grounds that it is roughly offset by the stock of pension assets — a line of argument that implicitly assumes that those assets will be effectively confiscated by taxes and means-tested clawbacks of health benefits when they are converted into income. Effective tax rates close to 100 per cent already affect many individuals: it would be a grave mistake to increase their numbers. And if the bulk of services currently covered by the medical safety net continue to be effectively unavailable for private purchase, a key motive for saving — the desire for a reasonable level of consumption of health goods and services in old age — will be undermined by the fact that there will effectively be nothing to buy.

A multifaceted challenge naturally requires a multifaceted response. A good way of avoiding high and thick welfare walls for low- and middle-income Canadians is to seek, as much as possible, to recover health-related benefits through the personal income tax at standard rates. Establishing a TEE alternative to the existing EET saving vehicles would allow modest income earners who are too old to enjoy a long period of tax-free compound-ing to save in a form that makes sense for them, foregoing tax relief on contributions during their working years when their marginal effective rates are comparatively low for the sake of relief on distributions during retirement when their marginal effective rates may be very high (Kesselman and Poschmann, 2001).

As for the debate over private purchase of health care, suffice it to note again that patients can buy services the same as the public system covers, and providers can sell their services to both public and private purchasers, in many other countries where governments fund a larger share of total health-related expenditures than they do in Canada. The extraordinary alarm these prospects raise among many Canadians inhibits intelligent debate. There are legitimate concerns about crowding out and cross-subsidization under these circumstances. Many Canadians are going to want to buy services they see as medically necessary, however, and at the time of writing, the coincidence of chronic labour unrest in the publicly funded system and sizeable funding increases makes it hard to see them accepting existing prohibitions

indefinitely. Under those circumstances, learning how other countries control these problems makes more sense than simply insisting that no modifications to the current arrangement are possible.⁵³ For potential purchasers of medical services, moreover, an early start to refining the border between services that are publicly and privately purchased would be helpful for the simple reason that it will help them save wisely for their future needs (Globerman and Vining, 1996, p. 57).

Concluding Thoughts

Rather than attempting a detailed summary of this joint exploration of Canadian pension and health policy in a three-pillars framework, it seems best to close with a straightforward, perhaps obvious, observation. A good mixture of support and incentives in each of the pension and health systems is likely to produce beneficial effects in the other. Lifestyle maintenance programs that boost saving and encourage workforce participation will add to the resources that pay benefits and buy services. And a tax system that avoids penalizing saving for retirement or future health needs is likely to increase the proportion of the population that is willing and able to provide for themselves.

Canada's pension and health systems are currently a source of pride to policymakers and citizens alike. The pension system has over the past several decades benefited from ample resources and also from a precise matching of its various elements to its different objectives. The health system has benefited from even more ample resources and, as a result, has not undergone close scrutiny about the different purposes such social programs serve. Refocusing the debate over health care in a framework that distinguishes, as pension policy already does, three key objectives — a safety net, mandatory basic social insurance, and a framework for voluntary saving — offers two benefits. It promises a more fruitful resolution of current conundrums than does the confused and artificial debate over public versus private financing and delivery. And it can help ensure that the future evolution of Canada's pension and health systems work in complementary fashion to deliver effective benefits in a sustainable way.

⁵³The often-heard argument that any “two-tier” system will inevitably lead to wholesale privatization ignores the obvious fact that dual systems exist everywhere, and that the dominant trend of the past half-century has been for the share of health spending that is financed by governments to increase.

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