Preface

The political, cultural, and economic ties we share with Canada are most important for the U.S. and the state of Ohio. The Reddin Symposium reaches beyond the borders of the university to help Americans better understand Canada. The topic selected each year is chosen to improve knowledge of Canada by bringing together academics, government officials, and community members for informed discussion, policy debate, and exploration of the different and shared values of our two nations.

This year's topic, *Work, Family, and Health Policy in Canada* looks at the intersection of work and family life. Family and work responsibilities frequently interfere with one another. This often spills over into employee-employer relations as individuals seek personal balance, companies strive to be competitive, and governments struggle to manage costs.

Government standards and programs can alleviate some trade-offs through policies designed to assist with family issues such as child and elder care, parental leave, and pension plans. In a competitive global environment unintended consequences of higher taxes and government transfer programs may hinder the very segments of the population they are designed to help.

Our speakers consider how well Canadian standards for benefits and work incentives serve society. Our first speaker, Anne Westhues, professor of social work at Wilfrid Laurier University, sheds light on differences between Canadian and United States social policy. She compares the so-called activist orientation of the Chrétien government with regard to social spending outlined in the most recent throne speech to that of the Bush administration's state of the union address.

Next, Céline Le Bourdais, professor at University of Montréal, presents data on the changes taking place in what constitutes the North American family as seen through divorce, cohabitation, and fertility rates, and the environment of blended families. The various life trajectories in these newly defined family units are changing the fabric of Canadian and U.S. society.

Finally, Gregory Marchildon, professor at University of Regina, who recently served as executive director of the Commission on the Future of Health Care in Canada, explores the political and economic realities of providing health care in the Canadian system. After outlining the process of a Royal Commission Marchildon discusses how the immediate challenges and the health care goals of Canadians can be brought together in a comprehensive program.

Special thanks are extended to the many groups and individuals who make the symposium possible. The Reddin family of Bowling Green, through the vision of Daniel and Evelyn Reddin and with the continuing support of Mark Reddin, have fostered a legacy of cross-cultural understanding. The many generous donations of the Friends of the Reddin Symposium help insure its ongoing success. Generous support from the Canadian government is greatly appreciated.

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Social Policy in Canada—Return to an Activist Agenda?

by Anne Westhues

Introduction

In Canada, the Throne Speech sets out the work plan for the government in a given session of Parliament, a parallel to the State of the Union Address, the Budget Message of the President, and Budget Highlights released by the Office of Management and Budget in the United States. The media was full of comments about the "activist" social spending agenda of the Chrétien government that this speech signalled when I received the invitation to speak here today. Activist compared to what? Compared to recent history? Compared to the usual pattern of spending of Liberal governments in Canada? Compared to social spending in the United States?

Background

Before delving into the content of the Throne Speech, Prime Minister Chrétien's response to it, and the financial commitments that have been made in support of promised initiatives, some background material would be useful to understand how the current government of Canada comes to be in a position where it could be considering "activist" social spending.

Influenced by Keynesian thinking, Canada adopted the practice of deficit budgeting in the post World War II era. With the exception of 1969, 1973, and 1974, deficits were the norm, ranging from 0.1 percent of the GDP in 1966 to 9.1 percent of GDP in 1992.[1] Canadian governments made a shift to a neoliberal perspective later than either the U.K. or the U.S., electing a Conservative government led by Brian Mulroney from 1984-1993. While the Mulroney government wrestled with the challenge of reducing the deficit during its tenure, the deficit remained at $41 billion, or 8.7 percent of GDP in 1993.[2] The Chrétien government was elected in 1993 with a promise to get Canada's fiscal house in order.

One of the strategies by which cost containment was achieved was to restructure the way in which money is transferred from the federal to provincial and territorial governments for human services. Prior to 1996, the Canada Assistance Plan (CAP) provided the framework for transferring money to the social service sector and the Established Programs Financing Act (EPF) provided the framework for transferring money to the health and education sectors. Funding under the EPF was a block grant, meaning that the amount transferred was fixed for health

and education. Funding under CAP was provided on a cost-shared basis, meaning that the federal government matched provincial/territorial spending on approved social programs.

The nature of this agreement made it impossible for the federal government to accurately project their spending under the CAP. When Ontario increased its social assistance rates by 25 percent between 1986 and 1992,[3] for instance, the federal government was obligated to match this spending. Since Ontario is home to about a third of the population of Canada, the financial impact was substantial. The legislation introduced in 1996, called the Canada Health and Social Transfer (CHST), eliminated cost sharing and replaced it with a block grant that placed social services in the same "envelope" with health and education.

This new transfer payment mechanism meant that the federal government would now be able to control their spending on transfer payments to provincial and territorial governments for human services. They were positioned to begin the work of eliminating deficit budgets. It also meant that provincial or territorial governments would now decide which share of the federal money transferred to them would be spent on health, education, or social services. Poll after poll tells us that Canadians are most willing to spend on health care, then education, and only thirdly on social services. So, while all areas of government spending were reduced from the mid-1990s, the fear in social service circles was that social programs, both income security and services, would be hit harder than either education or health services.

While this action created considerable friction between the provinces and the federal government—with the premiers of the provinces calling on the federal government to restore spending to pre-1995 levels—along with other cost-cutting measures, the strategy allowed the Liberal government to successfully balance the budget in 1997, and in each of the 5 years since. Not only have the budgets been balanced, but also the economy in Canada has performed more favorably than forecast, resulting in surpluses, which have been used to pay down the federal debt by $45 billion.[4] It now stands at $581 billion, including both market and nonmarket debt. At its peak, the federal debt-to-GDP ratio in Canada was 71 percent. By 2001, it had fallen to 50 percent.[5] Total government sector net debt, including that of the provinces and territories, is currently the third lowest among G-7 countries, with only the U.S. and the U.K. having lower debt burdens.[6]

Jean Chrétien has been leader of the Liberal Party and Prime Minister of Canada since 1990. He was first elected as a Liberal member of parliament in 1963 and served continuously until 1986, through the Pearson and Trudeau years when Canada's social safety net was crafted.

He served as Minister of Indian Affairs and Social Development as well as Finance and showed himself committed to the vision of a "Just Society" which shaped social policy during this time. With the budget balanced, and debt being paid down, Chrétien was in a position to once again address issues of social justice. The announcement that he will retire in February, 2004, led many to speculate that he was looking for the opportunity to leave a legacy that was more consistent with his commitment to equity than the substantial achievement of leaving the country in good financial order.

Current Policy Priorities

The Throne Speech of September 30, 2002, shows that he took up this opportunity. Six priorities, or strategic directions, are identified in the speech. These include:

1. working with our allies to ensure the safety and security of Canadians;
2. putting in place the health care system for the 21st century;
3. helping children and families out of poverty;
4. the challenge of climate change and the environment;
5. creating a magnet for talent and investment; and
6. fostering a new partnership between government and citizens.

Social policy can be understood to cover a narrower, or a broader range of policy. Narrowly, it includes what might more appropriately be called social welfare policy, or social service policy. More broadly, it might simply be defined as "a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems which deal with human health, safety, or well-being".[7] This broader definition recognizes the impact of economic and environmental policy on social well being, as well as income security, social services, health and education policy and programs. This broader definition informs government thinking about social policy in Canada now, as reflected in the language and priorities of the recent Social Union Framework Agreement.[8] By this broad definition, almost every initiative identified in the Throne Speech might be considered "social policy."

The broadly defined social aspect of the first of the six strategic directions is titled **Canada and the World**. It includes initiatives related to heightened concerns about safety and security since the September 11th terrorist attacks in the U.S. These were formulated as increased attention to safety and security issues within Canada; working with the U.S. to address shared security needs, through the development of a Smart Border, for instance; and working through organizations such as the United Nations to ensure that the rule of international law is respected

and enforced. An amount of $1.1 billion was allocated to this envelope in 2001-02 and $1.5 billion in each of the next two years.[9]

In addition, a commitment was made to help reduce poverty in less-developed countries by doubling expenditures on development assistance by 2010. This will entail an expenditure of an additional $1 billion over the next three years.[10] Half of that increase will be directed to Africa as part of Canada's support for the New Partnership for Africa's Development. Tariffs and quotas on most products from the least developed countries will also be eliminated as a stimulus to trade with those countries.

The second direction is **Putting in Place the Health Care System for the 21st Century**. Four policy initiatives were introduced in this area in addition to the Romanow Commission. These include pesticide legislation to protect the health of Canadians; development of a national strategy for healthy living, including physical activities and sports; introduction of programs to close the gap in health status between Aboriginal and non-Aboriginal Canadians; and modification of existing programs to ensure that Canadians can provide compassionate care for a gravely ill or dying child, parent, or spouse without putting their jobs or incomes at risk. A 25 percent increase was committed in expenditures under the CHST from 2001 and 2005, for a projected total of $40 billion in 2005.[11]

The third direction is **Helping Children and Families Out of Poverty**. Twelve initiatives were identified in the area of child and family. They include an increase in the national child benefit; access to early learning opportunities; access to quality childcare, particularly for poor and lone parent families; targeted measures for low-income families caring for disabled children; expansion of Aboriginal headstart program; a program to provide communities with tools to address fetal alcohol syndrome and its effects; a national working group being created to improve educational outcomes for First Nations children; the criminal code revised to increase penalties for abuse and neglect; providing more sensitive treatment for children who take part in justice proceedings as victims or witnesses; reform of family law, putting greater emphasis on the best interest of the child; expansion of the unified family courts; and ensuring that appropriate child and family services are available.

A transfer of $2.2 billion was promised for early childhood development over the next five years; $100 million over two years for Aboriginal headstart and child care; $25 million over two years to reduce the incidence of fetal alcohol syndrome; $60 million over two years for children living on reserve with special learning challenges because of fetal alcohol syndrome or fetal alcohol effect.[12]

There were a number of initiatives under the fourth direction, **The Challenge of Climate Change and the Environment**. I will mention only ratification of the Kyoto Protocol here because of its potential positive impact on health. Like the U.S., Canada has an unprecedented number of people, especially children, suffering from asthma, for instance. While there was strong opposition to this decision by Alberta and the oil industry, in part because the economic consequences are unknown, the Government of Canada did ratify this agreement on December 17, 2002.[13]

A Magnet for Talent and Investment is the label given to the fifth direction. It is included as a social policy because it reinforces the oft-repeated maxim that the best social policy is a job. The initiatives here are directed toward investment in human capital to ensure a skilled labor force, with programs targeting groups that might need special supports, like youth, immigrants, or Aboriginal people. Initiatives include a literacy program; increased funding to granting councils to support graduate education and research; promotion of a lifelong learning perspective in the workplace; a youth employment strategy which has been refocused to meet current employment needs and with special emphasis on youth with disabilities; promotion of entrepreneurial skills and job creation among Aboriginal people through support for Aboriginal Business Canada; making Canada attractive to immigrants by working on increased recognition of foreign credentials; reducing barriers for immigrants in settling into the social and economic life of their new communities; recruitment of skilled workers outside Canada at key universities and embassies; adding to the stock of affordable housing through the Supporting Communities Partnership Initiative; and providing supports for Aboriginal people living in cities.

The final direction promotes active citizenship, and is titled **A New Partnership Between Government and Citizens**. It includes reforming the citizenship legislation to "reassert the rights and reinforce the responsibilities that go with being Canadian;"[14] putting into action the accord signed with the voluntary sector last December to enable the sector to contribute to national priorities and represent the views of those often excluded; renewal of legal aid; promotion of the linguistic duality of Canada by doubling within ten years the number of high school graduates who speak both English and French; reintroduction of legislation to strengthen First Nations governance institutions; building capacity for economic and social development among First Nations; expanding community-based justice approaches for Aboriginal people, especially on reserve and in remote areas; and preserving and enhancing Aboriginal languages and cultures.

Values Underlying Policy Initiatives

In summary, policy is always made within a value, or ideological, context. The values that shape these directions might be formulated as follows:

- Investment in human capital is the key to a strong economy, social well-being, and peace, both at home and abroad.
- Investing in children and youth brings not only individual, but also social, or collective benefits. This is especially important as we face a potential labor shortage.
- Early intervention or prevention is a better investment than remedial action. Longitudinal studies on early intervention programs suggest benefit-cost ratio can be as high as 8:1.
- There are historic commitments that we honor like the protection of the French language.
- There are new social realities that have to be acknowledged, for instance the large number of recent immigrants to Canada, changes in family structure, and providing support to children who testify in court.
- Equity considerations related to Aboriginal people, people with disabilities, visible minorities, and women are infused throughout our policy directions rather than a specific focus. Particular emphasis is being placed on Aboriginal children currently.
- Liberal pragmatism is evident in the decision to increase social spending, but to also maintain a balanced budget. This centrist position appeals to both the "soft" left and the "soft" right.

A Comparison with American Priorities

A review of the February 4, 2002, Budget Message of the President[15] shows that many of the social policy priorities identified by the American government are the same as those identified by the Canadian government. The directions are titled:

- protecting the homeland;
- winning the war on terrorism abroad;
- returning to economic vitality;
- governing with accountability; and
- fund other priority initiatives while moderating the growth in spending.

Both countries have identified safety and security, at home and abroad, as priorities. Both are engaged in "fixing" their health care systems—strained by an aging population and the cost of new technology. Both are committed to ensuring that their economy is strong and that there is increased accountability and "transparency" in

government. And both countries are trying to reenergize "civil society" by engaging more people in volunteer work.

But important differences reveal themselves as well. First is the weaker performance of the American economy than the Canadian over the past year. The unemployment rate in the U.S. had risen to 6.0 percent in November, 2002, and 2001 showed almost no growth in GDP at a 0.3 percent increase, though an increase of 3.0 percent was projected for 2002. This compares with 7.5 percent unemployment in Canada in November, 2002, an increased GDP of 1.9 percent in 2001 and a projected increase in GDP of 3.4 percent in 2002. Budgets were balanced between 1998 and 2000 in the U.S., though a deficit was the reality in 2001 and 2002, and this is expected to continue until 2005.

While the unemployment rates might suggest that the Canadian economy is actually the weaker, historically there has been a larger gap in unemployment between the two countries, and the Canadian unemployment rate has been falling, while the American has been rising. This is the context that has led the American government to define their objective as restoring vitality to their economy, while the Canadian objective is to maintain the vitality of an economy that is creating more jobs and showing good growth in GDP.

Second is defence spending. Canadian defence spending, at $12.3 billion in 2002-03 makes it the 6th highest military spender in NATO and the 16th highest in the world.[16] The increase in 2002 was 2.5 percent over 2001, following a 4.3 percent increase the previous year. By contrast, for 2002 the U.S. plans the biggest increase in defence spending in 20 years—a 12 percent increase. This increase will bring military spending in the U.S. to $396 billion, six times more than the next largest spender—Russia—and more than the combined spending of the next twenty-five nations.[17] While both countries have identified security at home and abroad as a priority, the proposed spending in the U.S.—and the President's own words—shows this to be the supreme priority of the Bush government. It was the first direction discussed in the Throne Speech as well, but did not receive the same emphasis as in the U.S. budget. In addition, the Canadians defined international social development as part of their security strategy, committing to double international aid over ten years, and making specific mention of Africa. The only mention of foreign aid in the Budget message of the President was assistance to war-torn Afghanistan, to ensure the return to stability.

In the more narrowly defined area of social welfare policy, there are five further notable differences between the two countries. So, the third Canadian-American difference I observed is the American initiative to involve faith-based groups in the delivery of social services. Canada has

a tradition of faith based service delivery, as in the United States. But Canada has moved away from it over the past thirty years in an effort to make services more accessible to a concomitantly increasingly religiously diverse population and an increasingly secular population, and to deter the tendency that this encourages to provide parallel service systems, with the inefficiencies that this entails. While faith-based groups may still be involved in service delivery, and are often involved in the start up of new services in Canada, organizations tend to secularize as they become established.

This difference in policy orientation is almost certainly a reflection of the divergence between Americans and Canadians on the importance of religion that was found in the recent Pew Research Center survey of forty-four countries. Fifty-nine percent of Americans said that religion was very important to them, compared to 30 percent of Canadians.[18] Consistent with these values, we see the traditional American position of church-state separation is blurred in recent policy directions, while in Canada there is a continuation of a secularizing trend.

A fourth Canadian-American difference is the commitment of funds in the U.S. budget to reduce unplanned teen pregnancies through allocations to programs that educate solely about abstinence.[19] While Canadians are also concerned about unplanned pregnancies, especially among teens, and abstinence is one way to do that, they do not restrict public funding to programs that only educate about abstinence. Again, this seems to reflect the greater religiosity of the United States. Perhaps this policy choice is also related to the teen pregnancy rate in the U.S. for 15 to 19 years olds (94.3/1000) being almost double what it is in Canada (41.7/1000 in 1998).[20]

Fifth, the Budget Highlights released by the Office of Management and Budget, under the “Other Priorities” direction, mention international drug control and funding for drug treatment. There is no specific mention of drug treatment programs in the Canadian Throne or Budget speeches. The mention of funding for drug treatment may suggest some moderating of the “War on Drugs” or criminalization model in the U.S. but the funding to control international sources does not. By contrast, recent court rulings in Canada,[21] and the federal government’s intention to introduce legislation that would decriminalize possession of up to thirty grams of marijuana, suggest that Canada is moving toward the adoption of a harm reduction model in formulating policy with regard to drug use, rather than a war on drugs model.

The harm reduction model acknowledges that there is always likely to be some level of drug use, and looks for ways to minimize the harm resulting from it through policies and programs offered by the health and

social service systems. This model supports policies like decriminalizing possession of drugs, development of needle exchange programs to reduce HIV rates, and provision of a safe supply of drugs.[22] European countries like Germany, Switzerland, and the Netherlands adopted this harm reduction model in the early 1990s.

Sixth, Canadian spending on the early child development strategy, including specific initiatives for Aboriginal and disabled children, demonstrates a shift in the thinking shaping policy in this area from what has been called a family responsibility paradigm to an investing in children paradigm.[23] The family responsibility model understands the role of the family to be primary in meeting the needs of children, with as little assistance from government as possible. Government's role is to increase options for parents through policies such as parental leaves, subsidies for childcare, and tax deductions for children, but it remains the family's choice how they will care for their child. One of these choices would be to have one parent at home caring for children full time. With female labour force participation rates predicted to continue at about 70 percent, and to vary little by age of child,[24] the investing in children model recognizes that one parent at home is not an option, especially for lower income families, and so programming needs to focus on developmental outcomes for children as well as supports for parents.

Finally, there is an explicit emphasis on equalizing the life chances of Aboriginal people in the Canadian documents that is absent in the American ones. This difference may reflect the higher percentage of the population that is Aboriginal in Canada (3.8 percent) than in the United States (0.9 percent). It may also be a recognition in Canada of the failure of earlier policies with respect to Aboriginal people which have resulted in a population characterized by disadvantage on all social indicators. These initiatives follow completion of a Royal Commission on Aboriginal Peoples in 1991.

Conclusion

This paper began by considering the characterization of the Throne Speech of September 30, 2002, reflecting an "activist" social spending agenda by the Chrétien government. Is this characterization accurate? Compared to what health and social justice advocates want? No. Compared to American social spending? Yes. Compared to social spending in Canada over the past five years? Yes. This is only possible, however, because of the deficit-fighting work that has given Canadians a balanced budget for the past five years and an economy that is working well. Canadians are clear that they do not want a return to deficit budgeting, with only 8 percent in the recent *Maclean's* poll agreeing to

this approach. Liberal pragmatism, the preferred orientation in governments in Canada, has prevailed.

Given that the Americans have chosen to pursue their security goals at a cost of continuing with a deficit budget while the Canadians have opted for a balanced budget, George Bush's budget could be construed as more activist than Jean Chrétien's. In the classic trade-off between spending more on guns or butter, the Canadians have opted for butter over guns, while the Americans have opted for guns over butter. But the Chrétien activism is pragmatic, or tempered. Social spending will only occur as long as the budget is balanced. Unless some major upheaval occurs—like a war in Iraq or North Korea—it will be a long time before the Canadian public again supports deficit spending.

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Question and Answer Session for Anne Westhues

Mike Unsworth, Michigan State University: Since it is actually the provinces that are the implementers, what carrots and sticks go along with Federal government proposals; i.e. are these unfunded mandates from the government or are the resources provided?

Anne Westhues: There are resources going along with the proposals. This CHST is the largest, though not the only, mechanism for transferring money from the federal government to the provinces and they are committed to a 25 percent increase in spending under that legislation over the next five years. In addition, there are specific envelopes for specific programs such that if a province puts in place, for example, an Aboriginal headstart program, there are X amount of dollars available for that. If a province chooses not to offer such a program, which is its right, then it foregoes the opportunity to access that money. With CHST, a province can take that money and, if it is not allocated to a particular program, can decide that even though it is a 25 percent increase it is all going to go into health or post-secondary education. For instance, in Ontario right now we are having the "double cohort" year where we are eliminating grade 13 so we have twice as many applications for university this year as last year. There has been some preparation for this, but we are short

thousands of spots. I would guess the Ontario government might be shifting some money into post-secondary education.

Thomas Blaha, Wood County Economic Development Commission: Your statement about the penalties for child abuse being stiffened and your observation later on about Canada's more secular society with it's declining emphasis on religion prompted me to wonder whether Canada is undergoing the epidemic proportions of child abuse by clergy that we are in the U.S.?

Anne Westhues: The short answer is yes. One of the biggest issues right now for Canada is residential schools. The residential schools for Native people and the abuse that occurred in them when they were run by different religious denominations. Even if they had been secular, who knows if the same thing would not have happened.

Howard Katz, Cuyahoga County Treasurer's Office: A couple of reasons that are given in the U.S. for resistance to social welfare spending are: one, our long tradition of a libertarian, antigovernment strand which is obviously much stronger in this country than in Canada; and second, the racial aspect of social welfare programs. How strong or weak is the resistance to increased social spending in Canada given that you do not have those two factors animating the opposition?

Anne Westhues: I think you are correct in your characterization of Canada as not as individualist as the U.S. We are neither as collectivist as countries like Sweden or Finland. We are somewhere in between. Our history has been different than the American history. There is not the same racial factor. The closest thing to that is the Aboriginal stereotyping rather than any other visible minority group. If there is resistance to spending, and of course there is a neoliberal group who would like to see the same kind of very punitive welfare policies that have been introduced in some states, it is not racially based. It is based on the belief that there are many opportunities in Canada and one does not need to be supported. If one has had all kinds of disadvantage in life—tough, get it together.

It is probably the combination of French and Catholic influences that gave us the tradition we seem to have stayed with so far in terms of being a little more comfortable with government intervention. And the fact that we have always had a small population, spread over a large geographic area, in a climate that is far from benign for many months of the year. It has been argued that this has made us band together for survival.

Kristie Foell, Bowling Green State University: What is the Throne Speech?

Anne Westhues: Canada is a constitutional monarchy meaning that, theoretically, the Queen is still the head of state. The Queen's delegate is called the Governor General, currently Adrienne Clarkson, who reads the speech from the throne that opens the session of parliament. It is basically a work plan outlining what is important for this government and what they are going to address. It is the parallel to the budget speech that the U.S. President gives saying here is what we are going to do and here is how much we are going to spend on it, although the throne speech does not get into spending focusing instead on policy.

Arnold Oliver, Heidelberg College: I have a respectful disagreement about transparency and the U.S. government. They have just announced they are denying access to Presidential papers as they are normally supposed to be released. They are stonewalling on the freedom of information act which has been a wonderful source of access for academics, not even to mention the energy task force. There has been a radical decrease in transparency.

Anne Westhues: We have had similar skirmishes around transparency or the freedom of information act where supposedly there is access to all kinds of government information, but we find that it is not forthcoming. The idea of accountability in the U.S. is demonstrated in one way by report cards and performance indicators. Canada is just starting to use that language and to monitor what actually is delivered in education or health care, but not so much in social services.

Mike Unsworth, Michigan State University: Going back to faith-based initiatives, have any Canadian commentators or academics pointed out to U.S. policy-makers the pitfalls that happened with the residential schools and other actions where private organizations acted as government agencies?

Anne Westhues: I am not aware of any such efforts. The U.S. has a long tradition of what is called the voluntary sector, or third party payment agreements. Here in the U.S. as well as in Canada, especially Ontario and Nova Scotia, the delivery of social services can occur not through government agencies but through organizations with community boards that are supposedly closer to the community, know what it wants, and are more cost-effective. They are mostly more cost-effective because they pay less and do not give their staff any benefits. The bottom line for government is that it costs less to deliver that way. In Canada, the

counter observation has been an equal issue in terms of reform schools or detention centers for youth that were government run, had government employees, and were secular where there has also been physical and sexual abuse.

In the cases of abuse by members of institutions that were faith-based, one of the ongoing negotiations is who is responsible to pay the judgment awards. The Canadian government has accepted some liability, but it is bankrupting some churches.

Family Life in a Changing World: The Evolution of the Canadian Family in a Context of Marital and Economic Instability

by Céline Le Bourdais, Nicole Marcil-Gratton and Heather Juby

Introduction

Families have undergone major changes during the past thirty years. The decline of fertility, the increase of divorce joined to the postponement of marriage and the rise of common-law union, as well as the increased participation of women to the labor market have profoundly altered both the structure and functioning of contemporary families. These changes, often referred to as the "second demographic revolution" (Van de Kaa, 1987), have occurred throughout all industrialized countries, but their timing and rhythm varied widely across countries. Compared to the U.S., Canada was relatively slow in undertaking this path of transformation, but the intensity and the pace of changes were greater than those observed across the border, mostly due to the course taken by the province of Québec (Le Bourdais and Marcil-Gratton, 1996).

Looking at the evolution observed in Canada might help interpret and put the American experience in perspective. This presentation aims to draw a broad portrait of the demographic changes that affected Canadian families in the last quarter of the 20th century. These changes will be discussed in the context of the modifications that took place in the labor market, and in relation with the economic consequences they have for individuals and families. Our presentation borrows largely from the results of several studies we conducted earlier, and makes an extensive use of recent survey data collected by Statistics Canada.

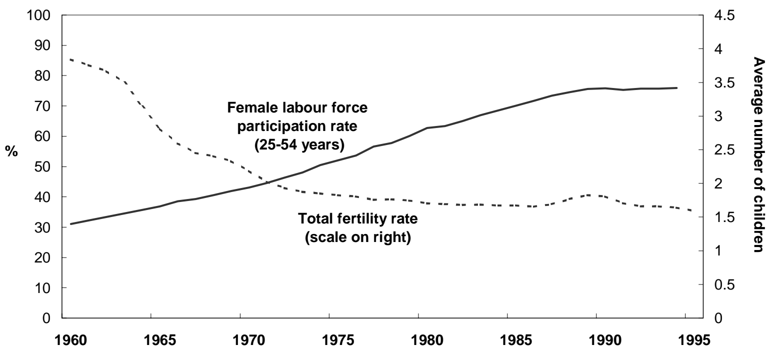
This paper is divided into four sections. The first one briefly documents the decline of fertility and the rise of female labor force participation. The second focuses on the evolution of conjugal unions, and, more precisely, examines the rise of divorces and separations and the diversification of union types. The third and, by far, largest section aims to document the multiple changes that transformed family life, and points to the question of the stability of parent-child relationships in a context of high conjugal instability. Finally, the last section raises the issue of family time, i.e. the moments during which family members are

available to spend time together, as dual employment and atypical working schedules have become pervasive.

The Decline of Fertility and the Rise of Female Labor Force Participation

Let us first look at the evolution of phenomena for which we have long data series, such as fertility and labor force participation. The total fertility rate measures the number of children that a woman is likely to have during the course of her life if the trends observed during a given year were to last. As shown in Figure 1, for Canada as a whole, this number fell from nearly 4.0 children per woman at the beginning of the 1960s to around 1.6 in 1995. The decline was slightly more abrupt in Québec where the total fertility rate reached a floor of 1.37 children per woman in 1987, before stabilizing at approximately 1.5 children per woman in the 1990s (Le Bourdais and Marcil-Gratton, 1997).

Figure 1 - Total fertility rate and female labor force participation rate, Canada, 1961-1996



Source: Adapted from Marcil-Gratton et.al., forthcoming.

This decrease in the number of children born to women is linked to the development of efficient contraceptive methods that became widely available at the end of the 1960s. With methods such as the pill or the IUD, the issue faced by couples then became reversed: couples now have to decide when to stop contraception in order to conceive a child, while before they had to plan what to do in order *not* to have a child, a reversal that had important repercussions.

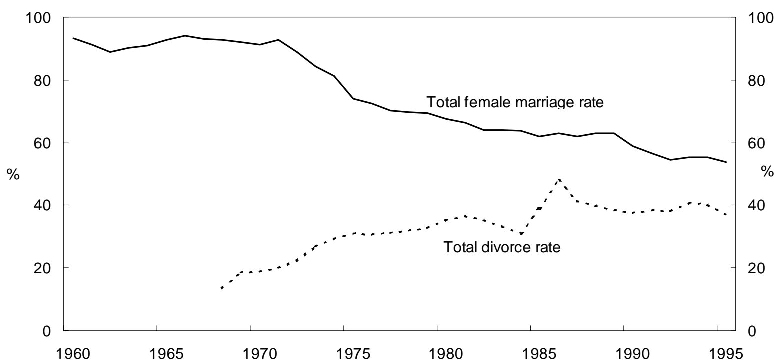
During the same period, females' participation in the labor force increased markedly and continuously. In 1960, 30 percent of women aged 25 to 54 years old were present in the labor market; 35 years later, this

proportion had more than doubled and reached 76 percent (Figure 1). Most women no longer stop working when they become mothers or that those who do so come back to work more rapidly after the birth of a child. Dual income has become a necessity for families to maintain their standard of living. Is the increased participation of women in the labor market the cause or the effect of the decline of fertility? Scholars still debate about the direction of the causal relations observed. But one thing is sure: the development of a service economy, joined to the drop of fertility, both encouraged and facilitated the progression of women in the labor force.

The Rise of Conjugal Instability and the Diversification of Union Types

Figure 2 presents the evolution of both the total female marriage rate and the total divorce rate in Canada. The former provides the proportion of women that are likely to marry at least once before reaching the age of 50, if the trends observed were to last, and the latter, the percentage of marriages that are likely to break up before their 26th anniversary.

Figure 2 - Total female marriage rate and total divorce rate, Canada, 1961-1996



Source: Adapted from Marcil-Gratton et.al., forthcoming.

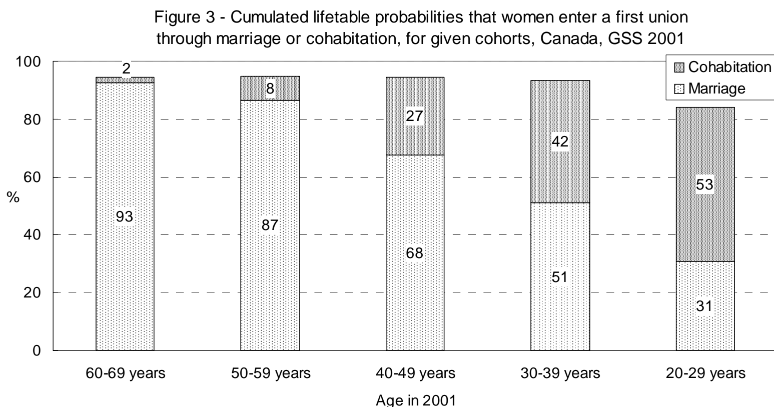
As seen in Figure 2, throughout the 1960s, marriage was still very popular in Canada, with more than nine women out of ten who would marry in the course of their life. At the turn of the 1970s, marriage progressively started to lose its appeal and, by 1995, only slightly more than half of women were expected to marry at least once, if the trends observed that year prevailed. In Québec, the drop of marriage was even more drastic, and the total female marriage rate had fallen to 40 percent in 1995 (Marcil-Gratton et al., forthcoming).

While marriage was receding, divorce, on the contrary, saw its popularity increase importantly. The total rate of 13.7 percent in 1968, the year in which the Canadian Parliament adopted the Divorce Law, nearly tripled to attain 36.9 percent in 1995. The rate increased continuously over the 30-year period, except around 1985, when a fraction of couples postponed their request for divorce, in order to take advantage of the reform that shortened the duration since separation required to obtain a no-fault divorce. At the turn of the 21st century, approximately 40 percent of marriages are now expected to end in a divorce.

Although marriage is on the decline and divorce is on the rise, the "formation of a durable couple" still represents the most important element for individuals to feel happy in their lives. This fact is reflected in the relatively stable proportion over time of individuals living in couples; this stability results from the progression of common-law unions that have offset the decline of marriage both as a way to start conjugal and family life, a change that has multiple consequences, as we shall see later.

Data taken from a recent Statistics Canada's (2002a) publication, presented in Figure 3, show the cumulated probabilities that women, from five 10-year cohorts, form a first union, either through marriage or cohabitation. Nearly all women aged 60 to 69 years in 2001 (i.e. those born roughly in the 1930s) chose marriage as a way to start conjugal life, with 93 percent who did so out of the 95 percent who experienced at least one union. This proportion decreased continuously across cohorts. Among those aged 20 to 29 years in 2001 (born in the 1970s), only 31 percent of women had married directly, without first cohabiting, by the age of 30; however, this proportion is likely to be slightly higher

Figure 3 - Cumulated lifetable probabilities that women enter a first union through marriage or cohabitation, for given cohorts, Canada, GSS 2001



Source: Reproduced from Statistics Canada, 2002a, p.4.

since women now marry later, even past age 30. By contrast, the percentage of women who started their conjugal life by living with a common-law partner has increased drastically, from 1.9 percent among the 60 to 69 cohort to 26.7 percent in the 40 to 49 cohort and over half (53.3 percent) in the youngest (20 to 29) cohort.

The progression of common-law unions has been very different across the country. For example, among women aged 30 to 39 years in 2001 (i.e. born in the 1960s) who had experienced a union, three Quebeckers out of four have opted for a common-law union when they started living with a partner; by contrast, in Ontario, two women out of three chose to marry directly (Statistics Canada, 2002a).

How can we explain the progression of cohabitation and the decline of marriage as a way to start conjugal life? Nobel-Prize winning economist of the family, Garry Becker (1981), would argue that these changes are linked to the increased participation of women to the labor force that gave them economic independence and, thus, reduced the attractiveness of marriage for them. But, not all economists agree with Becker. According to Valerie Kincade Oppenheimer (1993), the explanation for the delay of marriage among recent cohorts might be found in the deterioration of the labor market conditions of young men and women who can no longer afford to marry. Both explanations have received support to some extent in past research; this might be due to the fact that the processes influencing union formation have been changing over time. Hence, recent studies showed that in the older generations, less educated women were more prone to marry, while the more educated ones were more likely to choose cohabitation when starting to live with a partner; in younger generations (i.e. women born in the 1950s and on), the situation has reversed, with more educated women showing a higher propensity to marry (Mongeau et al., 2001; Turcotte and Goldscheider, 1998).

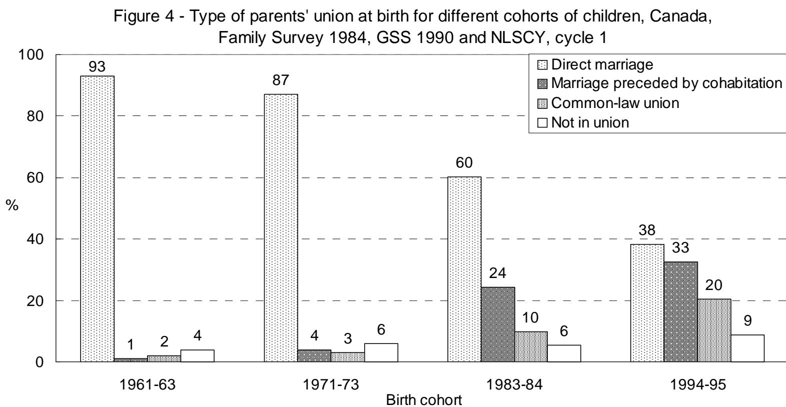
Common-law unions have been shown to be more unstable than marriages. However, it might not prove relevant to directly compare these two types of unions that are based on very different forms of engagement. By definition, marriage requires a formal commitment from both partners, which is not required for common-law unions; the latter comprise a wide variety of situations, ranging from the “going steady” relationships of yesteryear to long-term committed couples who have decided to raise their family outside the legal frame of marriage. While the breakup of short childless common-law unions is a sad event in the individual’s life, it surely does not have the same long-term implications as that of unions involving children. The proportion of children born to cohabiting couples has been on the rise over the past ten years,

especially in Québec where the percentage of children born "out-of-wedlock" has increased importantly. Therefore, from now on, we will adopt a family perspective, i.e. place ourselves from the point of view of children, who are likely to undergo a series of changes in the case of their parents' separation.

The Transformation of Family Life

Figure 4 gives a picture of the family environment at birth—in terms of the conjugal relationship existing between parents—for different cohorts of Canadian children. As Figure 4 shows, more than 90 percent of children born in the early 1960s were born within a "traditional" (direct) marriage, not preceded by cohabitation, and 4 percent in a single-parent family. Ten years later, i.e. at the beginning of the 1970s, the picture slowly started to change: 87 percent of children were still born into a direct marriage, but 4 percent had married parents who had previously cohabited. Ten years later, in 1983-84, 10 percent of children were born to cohabiting parents, and 24 percent to married parents who had first cohabited, showing that, even though common-law unions were becoming more common, cohabiting couples still predominantly married when a child was on the way. By the mid 1990s, the picture has become much more diversified: one child out of five was born into a common-law union, one out of three in a marriage preceded by cohabitation, one out of ten from parents not living together, i.e. in a single-parent family, and only 38 percent were born into a traditional marriage.

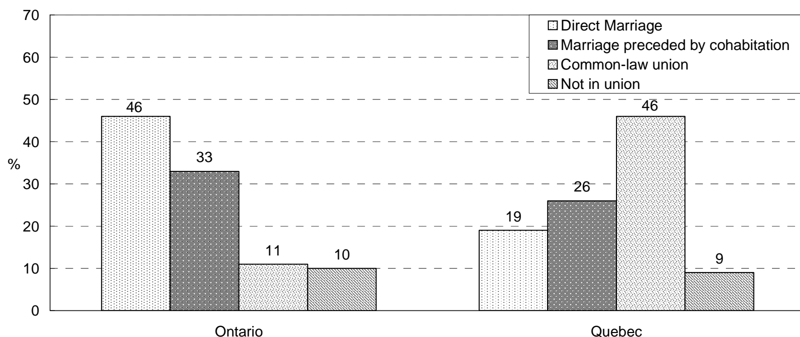
Figure 4 - Type of parents' union at birth for different cohorts of children, Canada, Family Survey 1984, GSS 1990 and NLSCY, cycle 1



Source: Adapted from Marcil-Gratton and Le Bourdais, 1999, Figure 1.

Again, large contrasts exist within the country concerning the conjugal situations of parents at the birth of children. Figure 5 now compares the situation observed in Ontario and Québec, two geographically neighboring provinces that are, however, quite opposite in terms of family behaviors.

Figure 5 - Type of parents' union at the child's birth, Ontario and Québec, 1997-98 cohorts, NLSCY, cycle 3

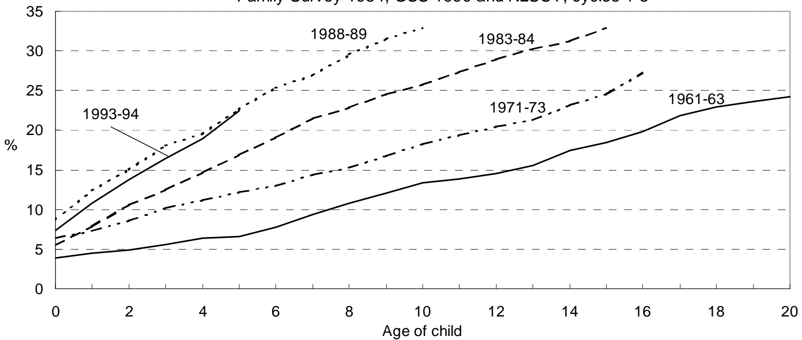


Source: Juby et al., forthcoming.

Nearly 80 percent of children born in Ontario in 1997-98 were born to a married couple: 46 percent were born to directly married parents, and 33 percent to parents who had first cohabited together. By contrast, less than half (45 percent) of children born in Québec during the same years were born within wedlock, and only 19 percent to parents who married directly. A similar proportion (46 percent) of children were born into a common-law union, that is, four times the percentage (11 percent) of children born within such an environment in Ontario. In the early 2000s, one can estimate that over half of children are born into common-law unions in Québec (ISQ, 2002). In the 2001 population census, 30 percent of couples and of children aged under fifteen years old were found to be living in a common-law union, a situation far more frequent than in the rest of Canada and similar to that observed in Sweden (Statistics Canada, 2002b).

The increase in the percentage of births outside a union, joined to the rise of conjugal instability, means that a growing proportion of children are likely to experience single-parent family life, and to do so at younger ages. Figure 6 presents the cumulated probabilities that Canadian children experience such a family situation through either birth or their parents' separation.

Figure 6 - Cumulated lifetable probabilities that children experience single-parent family life through birth or parental separation, for various birth cohorts, Canada, Family Survey 1984, GSS 1990 and NLSCY, cycles 1-3



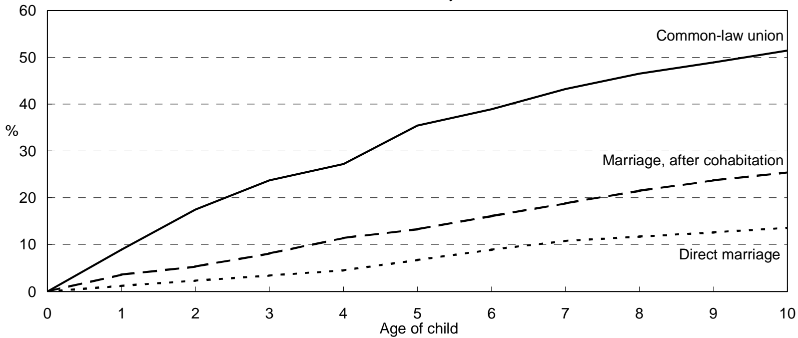
Source: Updated from Marcil-Gratton and Le Bourdais, 1999, Figure 3, using NLSCY cycle 3 data.

As can be seen in this Figure, slightly less than 25 percent of children born in the early 1960s had lived in a single-parent family by the age of twenty: 4 percent did so at birth (i.e. were born outside a union) and the rest following the breakup of their parents' union. Among children born ten years later (i.e. in 1971-73), the same proportion (25 percent) was reached by the age of fifteen, and by the age of nine among children born in 1983-84. In the 1988-89 cohorts, one child out of four had already lived in a single-parent family as early as the age of 6, and the proportion is quite similar among the 1993-94 cohorts. This evolution is not without consequences for the economic conditions of families in which children live, since single-parenthood is often associated with lower incomes and poverty.

The conjugal history of parents before the birth of a child appears to be closely linked to the family experience of children. Among children born in 1983-84 to two parents living together, 14 percent of those born into a "traditional" marriage saw their parents separate before they reached age ten; 25 percent had experienced parental separation among those whose parents had married after first cohabiting; and over half of children born into a common-law union had witnessed this event (Figure 7). Even when children are present, common-law unions thus appear to be more unstable than marriages, and the gap between the two is larger when the marriage was not preceded by cohabitation. However, one should note that the differences between union types are much less pronounced in Québec, where common-law unions have become the favored way to start conjugal and family life. In that province, families formed through a marriage preceded by cohabitation no longer appear to be more unstable than those formed within direct marriage, when we

control for various socio-demographic characteristics, and the gap separating married and cohabiting-couple families is narrower than elsewhere in Canada (Le Bourdais and Juby, 2001).

Figure 7 - Cumulated probabilities that children experience parental separation, according to their parents' union status at birth, 1983-84 cohorts, Canada, NLSCY, cycle 1



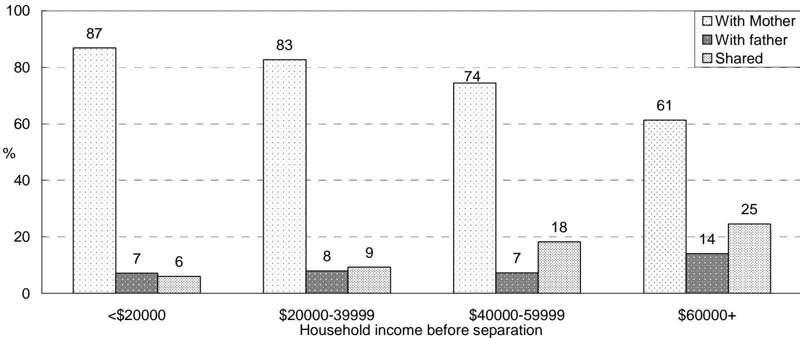
Source: Adapted from Marcil-Gratton and Le Bourdais, 1999, Figure 4.

Again, the fact of being born to cohabiting rather than married parents is not without consequences for the economic well-being of children. In Canada, children benefit from the same protection after parental separation, no matter the conjugal situation of their parents at birth, and there is no distinction between legitimate and illegitimate children. However, if they did not sign a contract or written agreement, upon separation, common-law partners cannot count on sharing 50-50 most assets accumulated through the union, as married spouses are required to do. In the past, some provincial courts had imposed property division to unmarried couples upon separation, based on equality of rights under the Charter of Rights and Freedom. However, last December, a ruling of the Supreme Court of Canada invalidated this approach and argued that the free choice of individuals not to marry should be respected (Bailey, 2002). Consequently, children born into a common-law union could suffer greater economic loss upon separation than those born to married parents, although both their parents remain responsible to provide for them.

Another way to show that family type and economic conditions are intertwined is to look at how the employment patterns of parents and family income before separation affect custody arrangements made after separation. To do so, we used data on children whose parents were still together when the first cycle of the National Longitudinal Survey of Children and Youth (NLSCY) was conducted in 1994-95, and examined

the living arrangements existing at cycle 2, in 1996-97, for those whose parents had separated in the preceding two years.

Figure 8 - Living arrangements in 1996-97, for children aged 2-13 years whose parents separated in the past two years, according to the household income before separation, Canada, NLSCY, cycles 1-2



Source: Juby et al., 2003, Figure 8.

Figure 8 presents the distribution of children, aged 2 to 13 years old in 1996-97, whose parents had separated in the past two years, according to whether they were living with their mother, their father, or in shared custody. The results show that as family income before separation increases, the proportion of children living with their mother decreases, from 87 percent in families having an income of less than $20,000 to 61 percent in families with $60,000 or more. The percentage of children living with their father does not appear as closely linked to family income; it fluctuates around 7-8 percent in broken families with an income less than $60,000, and doubles to 14 percent past this income threshold. By contrast, the percentage of children living in shared custody increases constantly as family income rises, from 6 percent in poorer families to 25 percent in better-off families, a result that is not surprising given the higher costs associated to the maintenance of two family households. Further analysis has shown that custody agreements are also linked to the education levels and employment patterns of parents prior to separation, with shared custody agreements being more frequent among better educated parents and in dual earner families (Juby et al., 2003).

We also know from previous studies (Le Bourdais et al., 2001; Seltzer, 1994), that fathers who have higher incomes are more likely to maintain regular contact with their children after separation and to pay child support on a regular basis. By contrast, fathers who cannot

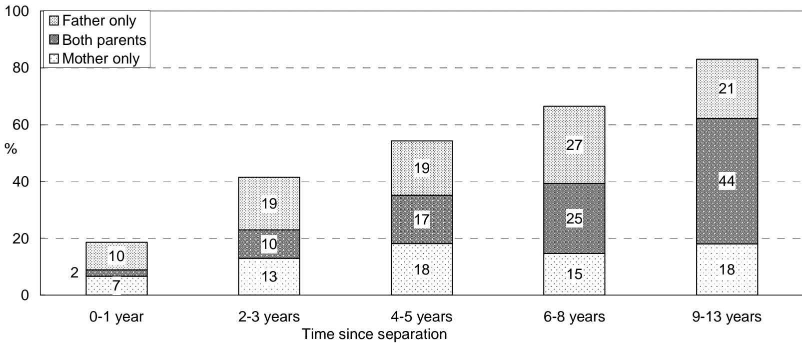
“afford” child support payments will more likely give up and progressively lose contact with their children.

Of course, income is not the sole factor that affects custody, child support payments and the maintenance of contact between children and the noncustodial parent, most often the father. Children are better off when the level of conflict surrounding parental separation is minimized and when parents can reach an agreement (Marcil-Gratton et al., 2000). In order to promote this goal, the Government of Canada recently announced a new initiative, called the **Child-Centred Family Justice Strategy**. This initiative comprises three pillars that aim to reduce the level of conflict between parents and to focus on the needs of children. The first one promotes the development and provision of family justice services (mediation, parent education courses) designed to minimize conflict and to help parents work out child-focused parenting arrangements. The second pillar consists of legislative reforms that will be brought by adding a list of child’s best interest criteria to the **Divorce Act**. The reforms proposed to do away with the terms “custody” and “access” in the Divorce Act, and to use instead “parental responsibilities” to refer to parenting time and decision-making responsibilities. Here, the objective is to eliminate the idea of a “winner” and a “loser” over a battle and, again, to reduce the level of conflict between parents. Finally, the third part calls for the creation of **Unified Family Courts** that will bring together both federal and provincial law in one single and more easily accessible environment and for the increase in the number of family expert judges, in order to provide a more efficient and less adversarial system (Department of Justice, 2002).

Once the parental separation is resolved, the family trajectories of parents and children do not necessarily stop with the ending of this union. In fact, this ending often constitutes the beginning of a series of transitions that will start with the conclusion of a new union and, possibly, continue with the birth of a new child. The earlier parental separations occur within the life of individuals and families, the more likely is the formation of a step-family. Let us thus look at the distribution of children, aged 2 to 13 years old in 1996-97, whose parents were separated according to whether their father, their mother, or both parents had formed a new union, depending upon the time elapsed since separation.

Of course, Figure 9 shows that the percentage of children who have seen one or both of their separated parents enter a new union increases as time goes by. Within the first two years following separation (duration 0-1 year on Figure 9), 19 percent of children saw one of their parents start living with a new partner, 12 percent (10 + 2) saw their father, and 9

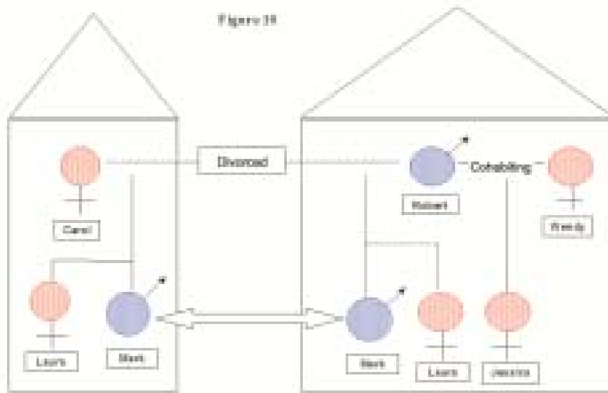
Figure 9 - Distribution of children aged 2-13 years, whose parents were separated in 1996-97, according to whether the mother, father or both parents had entered a new union, by the time elapsed since separation, Canada, NLSCY, cycles 1-2



Source: Adapted from Juby et al., 2001, Figure 6.

percent (7 + 2) saw their mother enter a new union, while 2 percent saw both parents starting to live with a new partner. After nine years past parental separation, 83 percent of children had seen at least one parent entering a new union, and for more than half of them (44 percent out of 83 percent), both parents had started living with a new partner. This percentage may slightly overestimate the proportion of children who will eventually see at least one of their parents form a new union, since children aged 2 to 13 years old whose parents separated more than nine years ago were very young at the time of parental separation and, thus, more likely to experience a new parental union. As can be seen in Figure 9, fathers more rapidly form a new union after separation, but mothers tend to catch up as time goes by.

In the prevailing context of high conjugal instability, the formation of stepfamilies has become a frequent phenomenon that occurs rapidly after parental separation, as we have seen; this phenomenon has been shown to affect the level of contact between parents and children (Cooksey and Craig, 1998; Manning and Smock, 1999). The relationships existing between stepfamily members who live under a same roof, but who have experienced different family trajectories, are complex. Economic resources are often spent across households as, for example, fathers pay child support for children with whom they do not live on a daily basis. The organization of stepfamily life is also complicated with children circulating between two different households, and it often needs to be readjusted due to changes induced in the other household. The next figure illustrates this complexity and the difficulty of approaching stepfamily environments because of their fluidity.



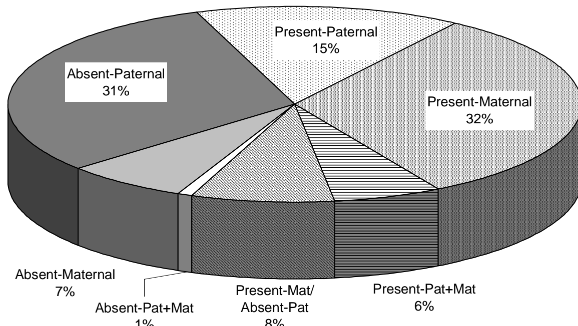
Here is the short story that Figure 10 aims to tell. Once upon a time, Carol and Robert married after first cohabiting for a few years. Together, they had two children within this marriage, Laura and Mark. A few years after the birth of Mark, they separated and, later on, divorced. At first, they had shared custody of their children, who were spending half of their time with each of them. However, this arrangement varied though time, as Laura and Mark grew older, but also when Robert started dating Wendy. Later on, Robert began living with Wendy in a common-law union, as most couples do after their first union dissolves, and, together, they had a common child, Jessica, as half of stepfamily couples do. This story is quite simple. Carol has not yet (?) formed a new union with a partner who could have children, and Wendy had no children from a previous union who could circulate between her household and that of their father, as Mark and Laura do every two weekends. Here, only two households are linked through the circulation of children and resources, but several households could be related to one another as the story becomes more complex.

It is difficult to identify stepfamilies in statistics. Survey data are usually collected at the household level. This prevents the double count of children who share their time between two households, as Laura and Mark do, but precludes the identification of those children born from a previous union in Robert's life, although this situation might have important implications for him, and for Wendy and Jessica. Financially, Robert needs a bigger house with separate bedrooms for Laura and Mark who come every other weekend; he also transfers money, on a monthly basis, towards Carol's house through child support payments. The fact that her father had children from a previous union means that

Jessica is not an only child and that she has to interact with half-siblings, and her mother with stepchildren. Does the fact of being born to a parent who had children from a former union, who live in a different household but for whom this parent remains responsible, influence the future family history that a child is likely to experience in the course of his or her life? This is the question to which we now turn.

NLSCY data allows us to identify not only children born into a family including half-siblings with whom they live on a regular basis, but also those, like Jessica, who from a strict residential definition were born into an intact family, i.e. who have half-siblings with whom they do not live daily. The percentage of children having half-siblings at birth, with whom they might or might not live, is quite important: by the end of the 1990s, 13 percent of children were born into a stepfamily environment, i.e. had at least one half-brother or sister present or not in their household. This figure now surpasses the percentage (8 percent) of children born to a single mother (Juby et al., 2001).

Figure 11 - Among children (aged 0-11 years in 1994-95) born within a stepfamily environment, residential status and origin of half-siblings (maternal or paternal), Canada, NLSCY, cycle 1



Source: Adapted from Juby et al., 2001, Figure 8.

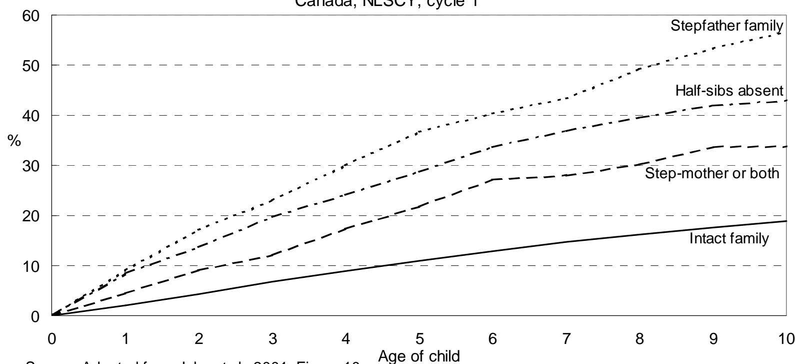
Figure 11 presents the distribution of the children born into a stepfamily environment, according to the residential status and origin (maternal or paternal) of their half-brothers and sisters. Among these children, 32 percent have half-siblings born to their mother and with whom they live most of the time; a similar proportion (31 percent) have half-siblings from their father's side, with whom they do not live daily, just like Jessica. If we had not looked at the past history of both their parents, but only at the household composition at the time of the survey, 39 percent (31 + 7 + 1) of children born into a stepfamily

environment would have been ignored and considered as living in an "intact" family.

Previous studies have shown that stepfamilies are more unstable than intact families (Cherlin and Furstenberg, 1994; Desrosiers et al., 1995; Ferri, 1995). One might thus ask if children born into a stepfamily environment, whether or not their half-siblings live with them on a regular basis, are more likely to experience parental separation than those born into a "true" intact family, that is, to two parents who did not previously have children. To examine this question, we grouped children born into a stepfamily environment into three categories:

- the first one comprises children born into a stepfather family, that is, who have half-siblings from their mother side only, with whom they live (32 percent);
- the second includes children having half-siblings born to their father or to their father and mother, with at least some residing with them (15 + 6 + 8 = 29 percent); and
- the third category comprises children having half-siblings with whom they do not live (39 percent).

Figure 12 - Cumulated lifetable probabilities of parental separation by children's family environment at birth, for children aged 0-11 years in 1994-95, Canada, NLSCY, cycle 1



Source: Adapted from Juby et al., 2001, Figure 10.

We thus calculated the cumulated probabilities that children in each of these categories experience the separation of their parents and compared these probabilities to that of children born into truly intact families.

As can be seen in Figure 12, 19 percent of children born into an intact family are likely to experience parental separation before they reach the age of ten. Although significant, this proportion is far lower than that observed for children born into a stepfamily environment. Among the latter, 34 percent of children born into a stepmother (or stepmother and

stepfather) family are likely to have seen their family break up by the age of ten, and more than half (57 percent) of those born into a stepfather family (i.e. living with their maternal half-siblings) are likely to have witnessed this event. These results confirm those obtained in past studies that have shown that stepfamilies, formed around the mother's children, are more unstable than stepmother families (Desrosiers et al., 1995; Ferri, 1995). More surprising is our finding that children, with half-siblings living elsewhere, and who from a strict residential definition are born into an intact family, are more than twice as likely to experience parental separation by age ten than those born to parents who did not have a child from a previous union (43 percent compared to 19 percent). For children whose half-siblings live elsewhere, the risk of parental separation is closer to that of children born into stepfamilies. The differences observed remained statistically significant, even after we controlled for a series of variables likely to influence the risk of family breakup, such as the number and the age of children, the type and duration of the parental union, etc. (Juby et al., 2001).

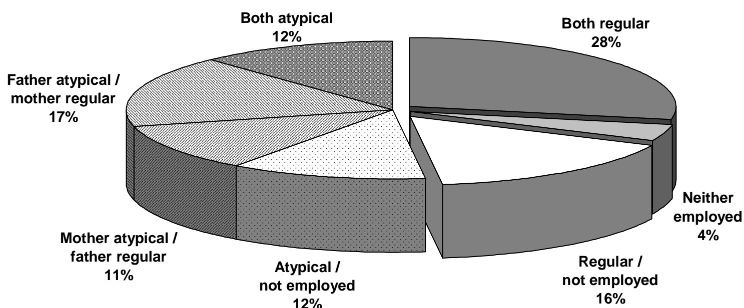
To summarize this section on family transformations, the "traditional" family of the early 1960s was characterized by stability and the sharing of resources within one household; it comprised one family unit, residing under the same roof, and living off the income of one income earner, usually the father, that was spent on household costs. By contrast, the "new" family of the 21st century is characterized by change and the exchange of resources across households. It stems from an initial family unit that will break apart and lead to the formation of new, and often unstable, units; its members will live under different roofs, with some of them circulating between households, and will experience different family trajectories; the initial unit depends on dual earner incomes that will be shared across households after parental separation. In short, the traditional family was marked by stability, while the contemporary family faces constant changes to which it needs to adapt. One source of these changes comes from the labor market that has undergone profound modifications in the last thirty years, with important repercussions on family time and organization to which we now turn.

Family Time in a Context of Dual Employment and Atypical Work Schedules

With the increased participation of women in the labor force, dual employment has become widespread and a way for families to maintain their standards of living. The growth of atypical work schedules (work on evenings, at nights, on weekends) associated with the development of a "24-hour service economy" (Presser, 1999), in a way, facilitates the

care of young children within dual-earner families, but, sometimes, to the detriment of family time, i.e. those moments during which all family members are available to be together. To get a grasp of this reality, Figure 13 presents the distribution of two-parent families with at least one child under the age of twelve, according to the mother's and father's work schedule during the year before the NLSCY in 1994-95.

Figure 13 - Work sharing patterns among couples with children under 12 years in 1994-95, according to the mother's and father's work schedule, Québec, NLSCY, cycle 1



Source: Adapted from Marcil-Gratton, 2000.

Parental work patterns are increasingly diversified and often involve atypical work schedules. On the right side of the figure are found 48 percent of families in which parents combine regular work schedules and/ or no employment. Of these:

- 28 percent: both parents are working regular hours, i.e. nine-to-five o'clock schedules from Monday to Friday;
- 16 percent: one parent working regular hours and one parent, usually the mother, who is not working; and
- 4 percent: neither parent is employed.

In the other half of the families, at least one parent has an atypical schedule:

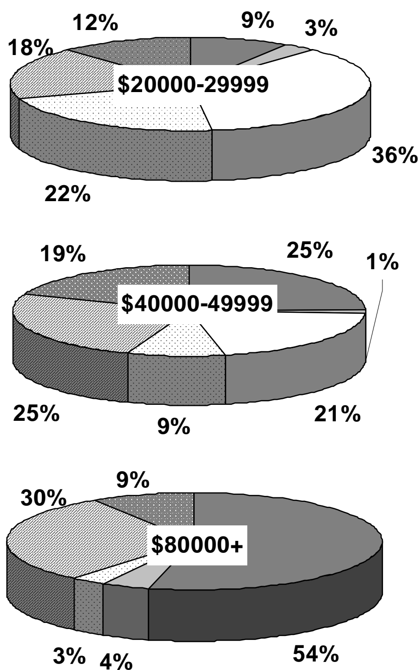
- 12 percent of families: both parents are working atypical hours;
- 28 percent: one parent has a regular schedule, and the other has an atypical one, the father in 17 percent of cases, the mother in 11 percent.

Interestingly, the prevalence of given work sharing patterns varies according to the income level of families, with regular employment schedules being more common among the higher income group. In over half (54 percent) of the families enjoying an income of $80,000 or more,

the two parents are both working on regular schedules; only 7 percent of families count a parent who is not working, and 42 percent at least one parent who is working in the evening, at night, or during the weekend (Figure 14; same legend as Figure 13). The percentage of families with both parents working regular hours falls to 25 percent in the $40-49,999 income category, and as low as 9 percent in the $20-29,999 income category. By contrast, the proportion of families relying on solely one income increases to 30 percent in the middle income category and to 58 percent in the lower one, and the proportion of families counting at least one parent working atypical hours is of 53 percent and 52 percent respectively. On the one hand, higher income families have a greater need for daycare, but they have resources that allow them to afford such services. On the other hand, they are more likely to be free when their school age children are available, i.e. in the evenings and on weeks-ends, and thus to have more family time.

Atypical employment schedules, when chosen by parents, might help them balance work and family requirements. It can also promote a more equal division of child care related tasks between men and women, as Presser (1994) has shown that fathers spend more time taking care of their children when mothers work on evenings or during weekends. Atypical work patterns are often dictated by labor market demands rather than chosen by parents. They have also been shown to be associated to mothers' higher levels of stress and depression, and to higher risk of parental separation, even when controlling for a series of characteristics, such as the number and age of children, the type of union, etc. (Marcil-Gratton and Le Bourdais, 2000). Clearly, the development of a 24-hour economy with stores open seven days per week, and services provided on a continuous basis,

Figure 14 - Work sharing patterns among couples with children under 12 years in 1994-95, by income category, Québec, NLSCY, cycle 1



Source: Adapted from Marcil-Gratton, 2000.

while facilitating the life of some dual earner parents, complicates the life of others who have to adapt to and juggle with the working schedules imposed by the labor market.

Conclusion

In this paper, we have tried to document the profound changes that Canadian families have undergone in the last three decades. These changes have occurred rapidly, more so in Québec than in the rest of Canada, in a period of rising economic instability and precariousness, thus putting stress on family members and forcing them to find strategies to adapt to new demanding situations. Several of these changes came unexpected, and policy development often lagged behind the new needs induced by these transformations. In such a context of rapid and multiple changes, it is often difficult to comprehend the forces at work and to disentangle the causes from the consequences. Interdisciplinary work, combining demography and economics, social and economic approaches, as well as comparative studies across regions and countries, are becoming a necessity if we are to better understand and predict the family and professional trajectories that individuals pursue and to develop better adapted policies. This paper constituted a first step in that direction.

Acknowledgments

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QUESTION AND ANSWER SESSION FOR CÉLINE LE BOURDAIS

Mark Kasoff, Bowling Green State University: I have heard that there is a very reasonable childcare program of high quality in Québec. Do you care to talk about that?

Céline Le Bourdais: This is a family policy program that was put together in 1997. One important point of the package was to create affordable daycare policy costing $5 per day. When it was started in 1997 is was only for four year olds, the following year for three and four year olds, and so on. There are two things that happened. The demand was underestimated. Parents wanted this program because they could be sure

of its quality and price. Within two years the provincial government decided to open it to all ages of children. There still are not enough facilities to answer all the demand.

Dini Schut, Home-Based Child Care Provider: What about children born to same sex marriages? What is the incidence and how do the children cope with that?

Céline Le Bourdais: How the children cope with that I cannot answer. For the first time in the 2001 census there was a clear question on the census about homosexual couples and we found that about .05 percent were gay couples. Some say this is underestimated. It may be really more like 1 percent. In Canada, marriage is regulated at the federal level. The Chrétien government has said that marriage is for heterosexual couples. The provinces regulate common law unions so Québec decided to create what it calls civil unions. At first that was to respond to the request of gay couples, but then they said if civil unions are restricted to gay couples they will face discrimination by being identifiable through marital status. Civil union is open to both gay and hetero couples. Then the issue of parenthood followed. On birth certificates if a child is born to or adopted by a gay couple it will say for example, mother and mother, or if the gay couple is male the certificate will say father and father. Now there is a question that while there will not be any discrimination to the parents, the children are going to carry this all their lives because the birth certificate is utilized throughout one's life.

Renee Agress, Bowling Green State University: Do you have any numbers to compare on cohabitation rates, single parent households, marriage rates, etc. between the U.S. and Canada?

Céline Le Bourdais: The rest of Canada, meaning all but Québec, compares very similarly to the U.S. There is an Anglo-Saxon pattern. In Québec there is a pattern that is more similar to something like France or Sweden. Common law is much more prevalent. Children are born into common law settings. In terms of policy, Québec has been trying to neither force nor penalize marriage but to respect free choice and diversity and the only important thing is to make sure that children do not suffer from that. Terms like illegitimacy do not exist anymore. It is simply that one is born into a particular situation but that all are equal before the law.

Frank Goza, Bowling Green State University: I have two questions. Could you tell us what factors you believe best explain the rather unique demographic situation in Québec? Second, what about immigrant families?

Céline Le Bourdais: Regarding immigrant families and the patterns they exhibit we found some interesting parallels when we first began looking at cohabitation. Where did cohabitation start emerging—in urban regions like Montréal. Then at some point not too long ago we started looking at where the greatest proportion of couples having children in cohabiting unions was. We found that it was in very small, rural, French communities. In Montréal, the French community that mostly lives in the east part of the city was where the high percentage of cohabiting couples having children was. In the west of Montréal, the predominately more immigrant and Anglophone communities were much more like the rest of Canada and the U.S.

Your first question is why is it different for the French? Part of it can be attributed to la révolution tranquille. Through this process French society changed 180 percent. However, this is only a partial explanation. In comparing Québec and Sweden these cohabitation rates are quite similar, but certainly Sweden did not undergo a revolution where it pitched away the Catholic Church. Part of it is that Québec is more egalitarian in terms of family role, the feminist movement was much more important in Québec than in the rest of Canada. A comparison between Québec and Italy could be relevant because, as in Québec, Italy went from high fertility, high marriage, and very Catholic to one of the lowest birth rates. However, in Italy if a couple wants children they still have to marry.

Laura Sanchez, Bowling Green State University: Could you comment on the demographic perspective of aging and longevity and how Canada is addressing its rising elderly population?

Céline Le Bourdais: Canada is facing the same problem as the U.S. There are two sides to the debate. The pessimistic side is that this is a real crisis. The optimistic side claims that the 65 years and older group of today is more dynamic and open and can play a very important role in changing society. There is also debate about how to pay for this population. Many people born towards the end of the baby boom and younger are anticipating working into their seventies. The heavy departure of older skilled workers who were encouraged to take early retirement has now created a shortage in certain occupations, especially in nursing and in education. Many of these people are being asked to come back.

Susan Brown, Bowling Green State University: I have a two-part question. First, given the dramatic increase of cohabitation, what are your expectations about the future of marriage in Canada? Second, concerning the reaction of the demise of marriage, have you begun to see the emergence of marriage promotion such as we see now in the United States?

Céline Le Bourdais: The increase of cohabitation, as long as there were no children involved, did not provoke much of a reaction. Now, people who are marrying are more educated and have higher incomes, so that might change. So far though we do not see cohabitation as a problem as long as couples and children are supported. In 1995, at a Population Association of America meeting in San Francisco Linda Waite was showing all the damage that was done because of the decline of marriage. A few of us from Québec were horrified because part of the story that was not told is that there were a lot of unhappy marriages before. There were things that happened behind the closed doors of those married couples. In some part of Canada we might possibly begin to see some sort of marriage promotion, I do not think that we will see it in Québec. What is being promoted is reducing conflicts, helping people, supporting them, and maybe married or not they will stay together and lead a happy life.

Public Health Care in Canada: Political and Fiscal Sustainability

by Gregory P. Marchildon

Introduction

This text explores the political and fiscal sustainability of public health care in Canada in terms of three comparative questions:

1. What are the differences between Canada and the U.S. in terms of the respective shares and roles of the public sector versus the private sector in health care?
2. How well does public health care in Canada serve society relative to its economic contribution?
3. What does the future hold in terms of the sustainability of Canada health care relative to the U.S.?

While I suspect that the Canadian debate concerning the future of public health care has had only a modest impact on Americans, there is little question that the American experience always exerts great influence on Canadians. It can be summarized in what some Canadians only half-jokingly told the Commission during its public hearings. Why bother consulting? We all know what Canadians want. They want Canadian public health care and American tax levels.

To begin, I would like to provide a little background on the Royal Commission on the Future of Health Care in Canada, popularly known as the Romanow Commission because of Roy Romanow, the former Premier of Saskatchewan and the sole chair of the Commission. Second, I will then briefly review the reasons that Royal Commissions are resorted to. Third, I will outline the basic direction of the recommendations in the Romanow Report. Fourth, I will summarize the performance of public health care in Canada including its contribution to the Canadian economy. I will then conclude with three observations based on the evidence examined by the Commission.

Background to the Romanow Commission

Without doubt, the last decade has been tough on public health care. In the early to mid-1990s, there were concerted efforts by many provinces to contain costs across the board after years of accumulating public debt. Since health care constituted the single largest provincial expenditure, this restraint also applied to spending in health care. Some of the cost cutting led to simple cost shifting, from governments to health organizations and individual citizens while some led to real health reform. During these years, through the effort of the provinces (which

bear the lion's share of responsibility for health care under the Canadian constitution), Canada managed to slow down the rate of public health care expenditures far more than almost all other OECD countries.

Beginning in 1996, this trend suddenly went in the opposite direction when the country recoiled back into high health spending. There were at least three reasons for this. First, there was pent-up demand after years of cost constraint. Second, health human resource surpluses suddenly became shortages. Third, governments lost their discipline to continue cost containment as their respective publics rejected "reform" initiatives as a cover for cost cutting and ultimately, cost shifting to them.

This was followed by a protracted period of federal-provincial conflict initially triggered by federal cuts to health and other social program transfers in 1995-96 that also saw the creation of omnibus transfer for health, post-secondary education, and social service/social assistance called the Canada Health and Social Transfer (CHST). As public concern about health care began to rise, a number of governments began to reexamine their own systems through various means. By the time, in 1999, that a Senate Committee was established to reexamine the federal role in health care, some provinces had begun to reconsider their own positions. Between June and August 2000, three provinces—Québec, Saskatchewan, and Alberta—set up task forces to review the future of public health care in their respective jurisdictions.

While these task forces were doing their work, Ottawa and the provinces engaged in a war of words over who was to blame for the deteriorating situation. Meanwhile, the public was increasingly losing confidence in both orders of government to fix the situation. As public opinion surveys illustrated the crisis of confidence month by month, new voices and options never seriously considered before this time began to be raised adding to the policy cacophony. As the task force reports rolled in between December of 2000 and January 2002, it seemed that at least some provinces were prepared to experiment with radically different approaches.

It was in this turbulent environment that the Romanow Commission was created in April 2001. To quote from the Order-in-Council, it was "to inquire into and undertake dialogue with Canadians on the future of Canada's public health care system, and to recommend policies and measures respectful of the jurisdictions and powers in Canada required to ensure over the long term the sustainability of a universally accessible, publicly funded health system, that offers quality services to Canadians and strikes an appropriate balance between investments in

prevention and health maintenance and those directed to care and treatment."

Why a Royal Commission?

Royal commissions are unique to Parliamentary systems of government. Certainly, there appear to be few, if any, parallels in the U.S. system of government. The main characteristics of royal commissions are that they are independent, external advisory bodies with autonomous budgets as well as staff and research capacities that are separate from government and the partisan influences of the parties in power. They are temporary, time-limited, bodies built with only one purpose in mind. They are quasi-judicial and have powers and authorities bestowed by legislation.

Royal commissions are less used now in part because of problems associated with their high cost, lack of timeliness, and sweeping interpretation of mandates experienced in the past. As a consequence, Roy Romanow insisted on his appointment that his Commission would be on time and under budget while making sure that his mandate was broad enough at the inception to do the job he felt was necessary. It is interesting to note that all the other recent commissions, committees, and task forces on health at the federal or provincial level were not royal commissions.

A royal commission is, without doubt, an extraordinary instrument. In general, it should only be used when:

- the policy problem at hand is so fundamental in nature that it requires a basic directional decision by government;
- the policy problem and its potential solutions would benefit from being fully aired in public;
- the policy problem and its proposed solutions would benefit from drawing on research and analysis outside government;
- extensive consultations with the general public and interested stakeholders are better conducted by a legally independent third party from government;
- the government itself has fundamental questions about the directions and options surrounding the policy problem; and
- the government desires a creative road map of how to get from the status quo to a new policy destination.

By 2001, Canadians and their governments were at a fork in the public health care road. In one direction, they could expand universal, public coverage beyond hospital and physician care to meet new and growing health care needs including prescription drug care, home care, mental health care, outside institutions, and hospitals. In the other

direction, they could limit public coverage for hospitals and doctors through a number of means including the introduction of user fees (through flat or tax-based copayments or medical savings accounts) or limiting coverage to the very poor and those 65 or older. You will recognize the latter as the Medicaid and Medicare model developed right here in the U.S.

One fork in the road involves a heightened public role, the other, an increased private role. Canadians had been at this fork in the road before. In the early 1960s, the Royal Commission on Health Services under Justice Emmett Hall was established to help Canadians make a similar directional decision. It came on the heels of two major events. The first was the federal government's decision to help all provinces introduce hospitalization throughout Canada in 1957. The second was the polarizing debate in Saskatchewan about extending universal coverage from hospitals to physician care from 1960 to 1962. By the time of Hall's final report in 1962, there were two working models of "Medicare" in Canada. One was in Saskatchewan that had taken the road of universal Medicare covering all physician care. The other was in Alberta that had taken the targeted (means-based) route often called "Manningcare" after the then Premier of Alberta—Ernest C. Manning. Hall chose Medicare over Manningcare in his report and that was the directional recommendation accepted by the federal government of the day.

While Hall's report went well beyond physician care—he recommended that prescription drugs and home care be integrated into a universal system for example—the physician care portion was as far as governments of the day were willing to go. Indeed, it would take until 1970s for the full implementation of Medicare in the provinces. As a result, prescription drug coverage, home care, and other areas of health care were left to the provinces with many targeted (rather than universal) programs springing up in the 1970s. These programs now constitute close to 40 percent of provincial expenditures in health care.

The Romanow Report ***Building on Values***

The Romanow Commission came to the same directional decision as Hall; that is, to take the road of working towards a more universal, more comprehensive public health care system, but to do so cautiously, in as fiscally prudent way as possible. This expansion should be staged over time, with the immediate establishment of a national platform of home care services in three targeted areas:

- home mental health case management and behavior intervention;
- post-acute rehabilitation and recovery (out of hospital); and
- palliative home care services during the last six months of life.

In the short term, ensure catastrophic drug coverage for that chronically-ill 5 percent of the population that are having to use 40 percent of all medications but under a protocol that monitors prescription and utilization behavior. For the medium and longer term, the Romanow report recommended a new National Drug Agency that would regulate generic as well as brand-name prescription drugs and would be responsible for spearheading a national formulary. It was also recommended that the federal government review pharmaceutical industry practices related to evergreening (efforts to extend patent protection beyond the first term of protection) and notice-of-compliance regulations that currently place the burden of proof on generic companies to demonstrate that their drugs do not infringe patented products.

The Romanow Commission also recommended that major short-term changes should be made to implement major change in primary care as well as targeted investments in prevention including a national immunization strategy and a concerted effort to deal with the pandemic of obesity.

The basic argument in the Romanow report was that carefully targeted public reinvestment is the most effective way to keep total health care costs reasonable. Canada's spending on total health care on both a per-capita basis and as a share of GDP is slightly higher than the OECD average but comparable to the G-7 average. In fact, total health spending amounts to 9 percent of GDP in Canada whereas it is close to 14 percent in the U.S. Historically, Canadian spending tracked U.S. spending until the introduction of universal health care in the 1960s and with it the single-payer health insurance systems in all provinces.

Performance of Public Health Care in Canada

At a minimum, the single-payer system has proven its efficiency. Steffie Woolhandler and David Himmelstein of Harvard Medical School have done a number of studies comparing Canada and the U.S. Their earlier work showed that Canadians spent two-thirds less than Americans on health care administration in 1991. Their latest work, using data for 1999, showed that each Canadian paid the equivalent of $325 per year compared to the $1,151 paid by each American per year for health administration.

One important reason for this is that a system of multiple private insurers has very high administrative costs related to billing, contracting, reviewing, utilization, and marketing. They have large infrastructures required to:

- assess risk;
- set premiums;

- design complex benefit packages;
- review claims; and then
- pay (or deny) individual claims.

It is important to keep in mind that the single-payer system is restricted to hospital and physician care, which in turn amounts to just over 42 percent of total health care expenditures in Canada. This 42.4 percent is what the rest of the world thinks of as the "Canadian model" of health care. However, the rest of the Canadian health care system looks very much like the U.S. system. Indeed, prescription drugs in Canada are a microcosm of the U.S. system, with most provincial drug plans filling in the gaps for employer-based private insurance coverage, mainly the very poor and those 65 or older. For such programs, Canadians have all of the administrative costs of a multi-payer insurance system. These and other provincial health care services—outside of hospital and physician services covered by the Canada Health Act—amount to about 25.4 percent of total health expenditures. If you subtract out the 5 percent of health expenditures made directly by the federal government, the remaining 27.4 percent of health expenditures are in fact private health care services such as dental and vision care. This sector is a significant and growing part of the Canadian health care system.

In other words, almost 58 percent of Canadian health care differs little from the way that American health care is financed and delivered, a very important fact to keep in mind when making comparisons between the two countries. Add to this the increasing cross-border mobility of health providers, the number of Canadian health providers educated in the U.S., the close research linkages among individuals and institutions on both sides of the border, and you can readily see that it is difficult to overstate the influence of the U.S. approach to health care in Canada. The influence of that 42.4 percent that constitutes the unique (at least for the Americas), single-payer part of the Canadian system on the U.S. is debatable. My view is that Canada does have modest influence despite its small size because it is so proximate to the U.S.

Beyond the administrative efficiencies of the "Canadian model" is the performance of public health care in terms of health outcomes and indicators. After all, administrative efficiency is hardly important if the system is not delivered in a timely fashion with access to quality services and does not systematically improve health outcomes.

In terms of population health indicators, Canada scores reasonably well on some of the most robust and comparable indicators, including:

- life expectancy (OECD rank 5);
- potential years of life lost (OECD rank 8);

- disability adjusted life expectancy (OECD rank 9);
- a little lower on perinatal mortality (OECD rank 10); but
- quite poor in terms of infant mortality largely due to the marginalized position of many of Canada's Aboriginal peoples.

At the same time, it scores better than the U.S. on all the above indicators.

In terms of equity, which is a test of the extent to which access is based on need as opposed to economic means, social status, age, gender, ethnicity, or place of residence, the outcomes range from good to very good, but this is expected of a well-funded universal system. In terms of responsiveness to specific illnesses, the Canadian system's performance ranges from good to excellent. Nonetheless, there are a few areas that Canada should perform better such as the treatment of cardiovascular and respiratory diseases. In terms of quality, there are currently no truly useful cross-country comparisons but the domestic evidence indicates that the quality of Canadian health care is good with, of course, room for improvement in a few targeted areas.

Access is another matter. Waiting times, particularly for specialists and advanced diagnostics, have become real problems over the past ten years. To meet this challenge, the Romanow Commission recommended additional public investment to deal with health provider and diagnostic equipment shortages as well as improving access for Canadians living in rural and remote areas of the country. Part of the reason for this recommendation is that Canadians are not prepared to accept more public sector rationing if it further reduces their access to health care. Canadians expect more and are willing to pay for more if they receive some guarantee that it will improve service. Their point of comparison is the U.S., and they expect both quality and access to be broadly similar to that which is available in the U.S. Indeed, continuing public support for Canadian Medicare hinges to some considerable extent on seeing performance improvements in access over the next few years.

As for the contribution to the Canadian economy, it has been demonstrated that properly targeted public health care investments do lead to longer and more productive working lives. This raises the question of whether public health care provides Canadian businesses with a competitive advantage vis-à-vis their competitors in the U.S. and the rest of the Americas.

In this respect, the Canadian Council of Chief Executives' submission to the Romanow Commission stated the following: "Canada's business leaders have been strong supporters of Canada's universally accessible public health care system" because it provides "a significant

advantage in attracting the people and investment that companies need to stay competitive." Although this statement hardly proves the point, the fact that it comes from an organization representing the 150 chief executive officers of Canada's largest companies is significant.

It is supported by the recent action of the Canadian branches of the "big three" automakers recently signed joint letters with their largest union (the Canadian Auto Workers or CAW) expressing support for Canada's publicly funded health care system. In the letter, they noted that it provides an important competitive advantage to the Canadian auto and auto-parts industries relative to their American counterparts.

Conclusion

Three final observations serve to summarize aspects about the public sector role in Canadian health care and reasonable expectations regarding funding and service provision. First, there remains room for expanding the role for the public sector in Canadian health care beyond hospitals and physicians through the provincial single-payer systems. Indeed, to improve fiscal sustainability, the Romanow Commission recommended a staged expansion beginning with targeted home care services moving to prescription drugs over time. Second, universal public health care has served Canadian society well although there are some important exceptions and reservations. These deficiencies must now be addressed—quickly and effectively—or public confidence in the entire system will inevitably erode. This new investment will rebound to Canada's competitive advantage if the benefits of universal health care are greater than the extra cost through taxation. The hard truth remains that we cannot have Canadian-style universal health care at U.S. tax rates. Third, sustainability in the long-run will require federal-provincial agreement on basic direction, broad priorities, and funding. It will require disciplined focus by governments to properly target the reinvestments while continuing to contain costs and reform basic aspects of health care delivery and organization. Finally, it will require continued efforts in strengthening the role of prevention and improving population health.

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Question and Answer Session for Greg Marchildon

Alan Kepke, Wood County Alcohol & Drug Addiction Mental Health Services Board: I have heard very little about treatment and consequences of treatment for alcoholism and drug abuse particularly, but mental illness comes into play as well, especially as it relates to the differences between the Canadian and U.S. incarceration rates. Canada's are much lower and I expect that has to do with the fact that we imprison people for drug possession in the U.S., but also the economic and family consequences of alcohol and drug abuse. What is the commitment on the part of the Canadian health care system for this kind of treatment?

Greg Marchildon: There are programs in most provinces for alcohol and drug treatment either through public health offices or through the regional system that most provinces have. These are long established programs. I have not studied this area intensively and do not have the data at hand to talk about how successful they are. I do know that they are certainly available. There are non-governmental kinds of help for drug and alcohol abuse through voluntary organizations.

As a practicing criminal lawyer in the early 1980s, I am familiar with the way in which court systems work in most provinces and the extent to which pre-sentence reports recommend alcohol and drug treatment. This is very commonly a part of sentencing. Working in communities that were predominately Aboriginal—with very high rates of alcoholism and drug problems—this was often an integral part of sentences. There are also programs right in correctional centers (for people sentenced for two years less a day) in which inmates would be encouraged to use this type of program. In the court system, what I faced from day to day was not so much the success rate but the failure of these programs. Certainly, these types of programs were a fairly major part of the criminal justice system.

Betty Woods, Wood County Board of Health: I have family living in Nova Scotia and I would like to make a few comments. Access to health care, surgeons or specialists, and certain diagnostic procedures is absolutely ridiculous. In the U.S., I can get a CAT scan (Computerized Axial Tomography) in about three days while my sister in Canada waits weeks. There just are not enough facilities there. Canadians certainly do pay a lot for health care with the 17 percent sales tax. I get real excited when I get $1.53 Canadian for every American dollar I exchange then I go out and pay 17 cents on most every dollar I spend. It is quite high. Did I

also understand that you say there is resistance to privatizing certain areas of health care?

Greg Marchildon: Regarding privatization, there is a huge debate that covers a number of different issues. One issue is the extent to which private companies, as opposed to not-for-profit organizations and government organizations, should deliver hospital care and other forms of care directly. There are questions about the extent to which government should contract out for services including the building of hospitals, etc. Another issue involves the extent to which individuals should pay for part of their health care and therefore share the burden with government for financing the system. Finally, a position held by a small minority is that we should move from a single-payer system to a multi-payer insurance system similar to the U.S. The loudest debate involves the issue of private delivery and whether it will lead to improved or poorer quality outcomes. Comparisons are often made to the U.S. in terms of managed care and the relative performance of for-profit and not-for-profit HMOs.

Regarding diagnostics, the Romanow Commission recommended a major investment in diagnostic services, both the equipment and the human resources necessary. Based on the evidence, there appears to have been a very clear underinvestment in advanced diagnostic technology during the 1990s at the very time provinces were trying to cost contain. When public institutions cost contain, capital budgets are the easiest to cut or defer. Capital budgets were deferred at the very time when there was substantial change in diagnostic services and when they were being incorporated into new protocols and new uses. As a consequence, Canada fell in terms of the number of diagnostic imaging equipment relative to the OECD and it is now at one of the lowest levels, resulting in the waiting times that you have talked about. There needs to be a very substantial reinvestment. This equipment is not just capital intensive, it is skill intensive and we need the right set of human resources. There is a human resource shortage that has occurred at the very same time. Even with the money to invest in equipment we still need the people. This has really been a log jam in the Canadian system and there needs to be real focus on it over the next two years or people will be come increasingly dissatisfied with the system.

Hans Rosebrock, FirstEnergy Corporation: What percentage of revenues does the Canadian government receive through sales tax and other means from corporations versus individuals paying into the medical system? In the U.S., our costs are going up astronomically and more burden is being

shifted to employees. Individuals are paying more and more of the cost as opposed to taxes on our corporations.

Greg Marchildon: The first point to make is that none of the taxes are earmarked or hypothecated. They flow into the general revenue fund of either the federal government or the provinces and then are redistributed based on priority setting and the program envelopes. It is very difficult to follow the money because it is fungible. Second, Canada has become much more like the U.S. It has less corporate tax to individual income tax than it once did. Income tax is the single largest revenue source in the average province and is also the largest revenue source for the federal government. It varies from province to province but, generally, corporate tax is quite low. It is not a major part of any government's revenues and it is not nearly as important as it used to be. Second, there has been a trend away from corporate taxation as most tax economists have argued that this type of tax is effectively passed on and therefore does not work. The greatest revenue stream is income tax. The second greatest revenue stream is consumption tax. It is not the Nova Scotia tax that is 17 percent; it is a combination of a 7 percent GST (goods and services tax) plus a provincial sales tax that varies considerably from 0 percent in Alberta to 9-10 percent in some provinces. That consumption tax, particularly since the introduction of the GST in the late 1980s by the federal government, has turned into the second most important revenue source for provinces and Ottawa. That money is shoveled into health care.

Hans Rosebrock, FirstEnergy Corporation: The costs of operating in the auto industry are much lower in Canada than in the U.S., in part, because of the costs that the American companies have to pay for health benefits. What is the actual value that can be assigned to this advantage?

Greg Marchildon: We did a major study reviewing the literature to see if we could assign a value. We know that the companies have done it. We know that the unions have done it. We could not get the information that would allow us to put a precise value on it. The auto industry is not a microcosm of everything out there but it is certainly representative of big companies that pay health benefits. There is another sector where companies do not pay benefits, and the same kind of advantage is not found in that sector.

PANEL DISCUSSION

Howard Katz, Cuyahoga County Treasurer's Office: Could you talk a little bit about the immigrant experience and the provision of services to the immigrant communities, the integration of immigration communities into the mainstream, and the persistence or non-persistence of differences between the immigrant communities and the non-immigrant communities.

Anne Westhues: I am currently serving on the board of a community voluntary organization called Focus for Ethnic Women that supports newcomer immigrant women to establish themselves within the community. There has been a long-term debate between federal and provincial government about whose job this is. It seems to have been agreed that this is a primarily provincial responsibility. There are settlement services to help with things like English as a second language, job readiness programs—helping people understand how to get work, how to put together a resumé, where to find advertised jobs, and large, mostly voluntary organizations that give the ongoing support for socialization once people are somewhat established. There are different classes of immigrants. Refugees are eligible for social assistance immediately. If you are an independent immigrant, you are also eligible for social assistance meaning financial assistance in addition to services. Sponsored immigrants, meaning somebody has agreed to take financial responsibility (for three years), are not eligible for financial assistance in that period of time unless a sponsorship breakdown can be demonstrated. Services increasingly are available in a number of languages because it is preferable to provide services in a person's first language. We do that, partly, by recruiting people of different cultural and linguistic backgrounds to the social work schools and the health system.

As far as differences, Canada is very careful about who it admits. We tend to cream or admit people who have good skills and are likely to be independent. Longitudinal research shows it is about ten years before people re-achieve the standard of living that they had in their country of origin. People tend to find work and have a place in the community. The initiative to engaging immigrants more in decision-making has to do with representation and encouraging immigrants to take out citizenship, gain the right to vote, and be active in political parties. There are challenges. Increasingly, since the 1970s, there has been a big shift in the most likely countries of origin. Until then, people were coming largely from European countries or the United States. There is much more diversity now with people coming from China, South Asia, and the Caribbean. We are working through the challenges of greater cultural difference. By most

indicators that compare countries Canada is doing pretty well, but not without tensions around those issues.

Céline Le Bourdais: A panel survey conducted in Québec in 1989 literally stopped immigrants at the borders when they arrived either by plane or crossing the border. Interviewers asked them if they wanted to participate in this survey. They were followed for ten years. The 1999 report was titled *Ils sont maintenant d'ici* (*They Are Now From Here*). Those who decided to stay felt that they belonged, that they were no longer immigrants. We learned some lessons from that survey. For many years in Québec the immigrants were joining the Anglophone community because business was there. Children of immigrants that come to Québec now are required to go to French schools where they learn French as a second language. It was learned that it was very important for immigrant integration not only to learn the language, but also to learn the way to do things in our society. When one comes from another society one does things differently. What the authorities have decided to do is rather than give the French immersion course in government offices, they teach the language close to where the people are. For example, immigrants of university age are given the integration classes within university. The language is a tool to learn how to integrate.

Greg Marchildon: Some of the immigrant associations were highly critical of the extent to which there were not services available in the health care system. Their communities, both culturally and linguistically, were not able to obtain services.

Murray Saffron, Medical College of Ohio: I live four months of the year in the small town of Ste. Agath de Monts, sixty miles north of Montréal in the middle of a bunch of ski hills. There is a community hospital in Ste. Agath and in the wintertime they are very busy. They did not have a CAT scan so the people in the area decided to get one on their own. They petitioned the Québec government and proposed that if they raised half the cost of the equipment the province could give the rest. The province said yes. They mounted a campaign among the inhabitants of Ste. Agath, including those of us who live there part of the year, and in no time at all they gathered up the necessary funds to go to Québec and request the rest. Now they have a CAT scan.

Greg Marchildon: Québec is an interesting example because it has the largest number of private CAT and MRI (Magnetic Resonance Image)

scans. On a fairly regular basis then, people are accessing diagnostics outside the publicly administered system, meaning that queue jumping is occurring. This situation was generated by the extreme shortage of equipment. There are two other provinces that have private imaging available. This is not talked about too much in Canada but I know that in many places hospitals or organizations have emerged that have tried to raise money for this sort of equipment and the provinces kicked in money and lo and behold the equipment is there. This is not the way in which to conduct public policy.

Jane Steffel, Defiance Regional Medical Center: I have two questions. First of all, in the U.S. I have seen how the self-determination act (that allows a person to determine the level of care such as a code status) has assisted people in end of life care. Does Canada use such a system? Secondly, I have had the opportunity to sell long-term care insurance and they are projecting an enormous need for nursing homes. Do you foresee the percent of the Canadian budget for long-term care increasing in the future?

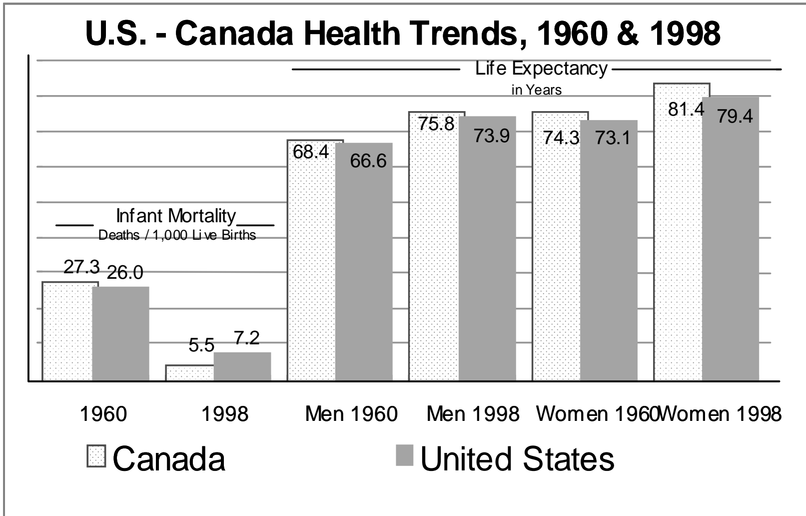
Greg Marchildon: Long-term care is a subsidy or targeted program aimed at the very poor. In most provinces it is means tested, one has to demonstrate a lack of income and wealth sufficient to qualify. There are stories of people running through their wealth or transferring it very quickly in order to gain the benefit of this kind of subsidized, free long-term care. It is a very substantial problem because of the perverse incentives it creates.

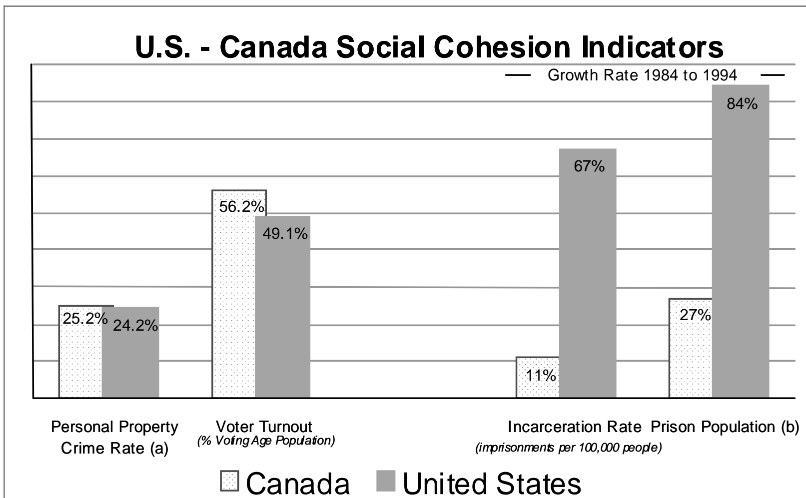
There is no legislation in Canada regarding end of life levels of care, but there are certain practices that allow patients to declare what they want in terms of the end of their lives. The Commission recommends a protocol be set up in which the patient's wishes are honored. It is a practice honored in the breech, so quite often patients do not get their wishes respected because family members or doctors make decisions that override the wishes of individual patients. It is certainly a moral problem. We recommend a more determined and explicit approach. We do not recommend in this report moving to a piece of legislation that would define in very precise terms right and responsibilities. We actually never really reviewed the situation in the U.S. This would be something that would be regulated and decided at the provincial level rather than at the federal level.

Hans Rosebrock, FirstEnergy Corporation: I learn a lot from taxi cab drivers when I travel. In Toronto I had a very interesting cab ride with a driver from Eastern Europe who was extremely intelligent. When I mentioned it to a U.S. Department of Commerce person based in Toronto the response was that he is probably a doctor who could not find a job in Canada. Why was that comment made?

Greg Marchildon: The issue deals with the respective provincial Colleges of Physicians and Surgeons that determine the rules concerning entry into the profession. These associations regulate entry under laws passed by the provinces that give them the right to regulate. The Colleges have concluded agreements and understandings and schedules regarding which countries they will accept credentials from and which they will not. Many east European countries fall into the latter category. It is a serious problem because there has been a wave of immigrants from those countries. I know of one doctor who I think it is a crying shame that he cannot practice in Canada. It is an all or nothing situation. If your credentials are accepted you are fast-tracked in, you write a quick exam and that is it. If your credentials are not accepted, in most provinces you are out completely and have to go back to medical school. There is no in-between. It is a devastating situation for those immigrants. Moreover, some of these individuals are asked to sign documents before they immigrate to Canada promising never to practice medicine. Some are political refugees so they often do not have a lot of choice if they want to come quickly to Canada. They sign the document. It is a situation that needs to be looked at very carefully but it is not something the federal government can act on alone or even principally, it is something that the provinces in concert with their Colleges of Physicians and Surgeons have to work on.

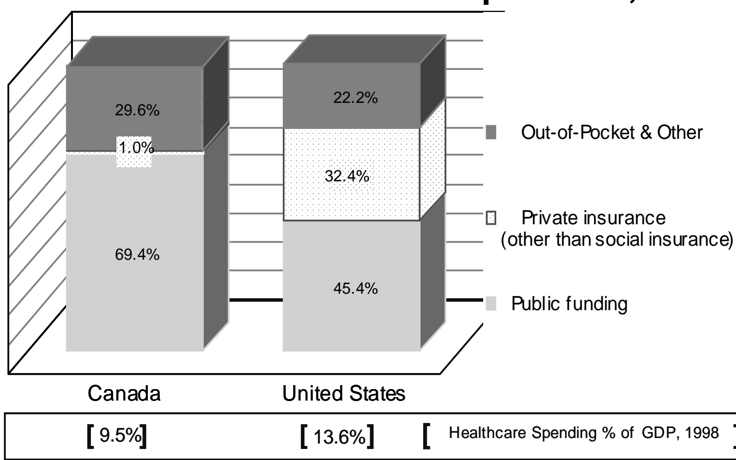
APPENDIX A: COMPARISON OF U.S. AND CANADIAN SELECTED SOCIAL INDICATORS





(a) Proportion of respondents to International Crime Victim Survey who were victims of crime in a given year.

(b) Percentage change in number of prisoners (1984-1994).



Economic Context of the Late 1990's		
Category	**Canada**	**U.S.**
GDP Per Capita ($ purchasing power parity)	$26,424	$33,836
Unemployment Rate	7.6%	4.3%
Income Tax Burden plus Employee Contributions	21.7%	18.1%
Unemployment Benefit(c)	69.0%	62.0%
Public Social Spending (as a % of GDP)	17.0%	16.0%
Private Social Spending (as a % of GDP)	4.5%	8.6%

(c) Maximum net percent of average production worker wages replaced by unemployment benefit.

Data Source: OECD Social Indicators, 2001.

APPENDIX B: SUGGESTED READING LIST

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