



**RENEWING CANADA'S
SOCIAL ARCHITECTURE**

**UNFILLED PRESCRIPTIONS:
THE DRUG COVERAGE GAP IN
CANADA'S HEALTH
CARE SYSTEMS**

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PROBLEM STATEMENT

While Canadians have universal access to public insurance that covers hospital and medical care, there is no universal public coverage for the drugs that doctors might prescribe as part of treatment. Canada is the only country with universal health care coverage that excludes coverage for prescription drugs.¹ The lack of adequate coverage creates barriers to access, as costs are one of the major causes of about 1 in 10 Canadians not filling their prescriptions or taking medications as prescribed.² The increasing cost of, and demand for, prescription drugs makes this missing component of the public health care system a glaring gap in Canada's social architecture, and can lead to issues for population health, household finances and downstream costs to the health care system.

POLICY OBJECTIVE

A renewed approach to prescription drug coverage would see Canada's federal and provincial governments work together to ensure improved access to prescription drugs in a way that does not create a financial burden for households, and complements the principles of the Medicare system and the Canada Health Act.

CURRENT STATUS

While there is no universal public coverage for prescription drugs in Canada, that does not mean governments do not spend any money on medications. Provincial health plans cover drugs when they are administered in hospitals. Provincial governments also provide some limited drug coverage based on age, employment, income or a combination of these factors, with each province having its own unique formulary (list of drugs eligible for coverage). Federal health plans provide similar coverage for on-reserve First Nations and Inuit populations, the Canadian forces and eligible veterans, and inmates in federal

1 Steven Morgan and Jamie Daw, "Canadian Pharmacare: Looking Back, Looking Forward," *Healthcare Policy* 8, no. 1 (2012): 16.

2 Michael Law, Lucy Cheng, Irfan Dhalla, Deborah Heard and Steven Morgan, "The effect of cost on adherence to prescription medications in Canada," *Canadian Medical Association Journal* 184 no. 3 (February 2012): 297.

prisons. Catastrophic drug coverage, generally defined as the provision of a level of coverage that protects patients and their families from “undue financial hardship” (set at either a fixed dollar figure or a percentage of personal or household income)³, is also available in most provinces.

However, the extent of an individual’s publicly-funded coverage for prescription drugs in Canada depends primarily on his or her province of residence, means and age. It is a system largely designed to be a subsidy for the elderly and social assistance recipients. Apart from public coverage, many Canadians rely on employer-based or privately-purchased group insurance plans to avoid paying for medications out-of-pocket. These employer-based plans indirectly receive public support through tax deductions. Taken together, the current system has significant gaps that leave cost as a major barrier to access for many Canadians.

This patchwork coverage runs counter to the five principles that ground Canada’s public health care system and are enshrined in federal law by the Canada Health Act (1984). The Act requires provinces to insure services that are medically necessary, but prescription drugs are not specifically included in its definition of medically-necessary care and are in many ways left out of publicly-funded provincial health insurance. The inconsistency and shortcomings of coverage as a result of drugs being left out of the Act undermine the principles of the Canada Health Act; in particular, those of universality (covering all people) and portability (transferable coverage between provinces). The report by the Institute for Competitiveness and Prosperity for this project looks more broadly at ways that the health care system has struggled to keep pace with changes in Canadian society.

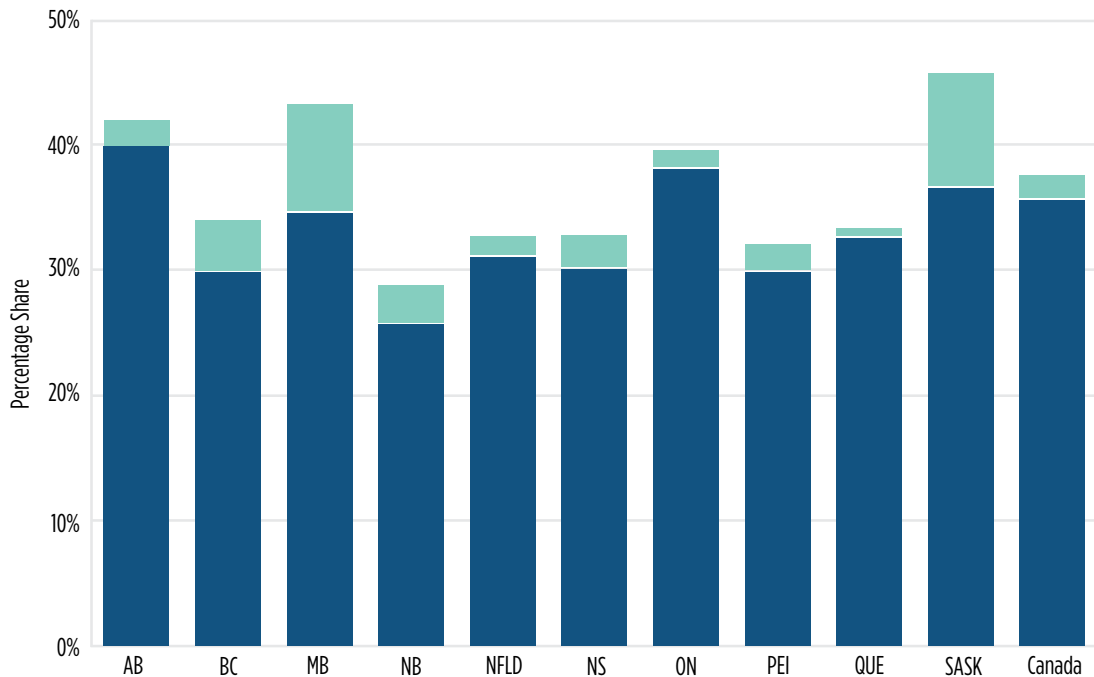
Coverage for prescription drugs has evolved inconsistently across the provinces and territories over time. For example, in 2012, a couple 65 years of age or older with an income of \$35,000 and in need of \$1,000 worth of prescription drugs per year would have paid the entire cost of these drugs in New Brunswick or Newfoundland and Labrador. By comparison, they would pay two-thirds in Quebec, one-third in Ontario or British Columbia, and nothing at all in the Yukon or Northwest Territories.⁴ Although prescribed drugs amount to 84.9 per cent of total drug expenditure, only 36.1 per cent of that spending is attributed to public sector drug plans. Average forecasted out-of-pocket spending per person on prescription drugs in 2014 ranged from \$644 in Nunavut to \$1,145 in New Brunswick.⁵

3 Karen Phillips, “Catastrophic Drug Coverage in Canada,” Government of Canada, Social Affairs Division, September 2009.

4 Canadian Health Coalition, “The Case for Pharmacare.” Canadian Health Coalition, accessed via <http://healthcoalition.ca/wp-content/uploads/2012/11/MP-KIT-EN.pdf>.

5 Canadian Institute for Health Information, “National Health Expenditure Trends, 1975-2014.” Canadian Institute for Health Information, October 2014.

SHARE OF TOTAL PRESCRIPTION DRUG COSTS COVERED BY PUBLIC SPENDING



Source: Mowat Centre, based on National Health Expenditure Database 2013, Canadian Institute for Health Information.⁶

Public drug plans funded only 38.3 per cent of total drug expenditure (including non-prescription) in Canada in 2012, the second lowest share among OECD countries (the United States had the lowest share).⁷ No provincial drug plan provides universal coverage, and every provincial drug plan involves considerable patient charges in the form of deductibles and co-payments. About two million Canadians incur more than \$1,000 in prescription drug costs per year.⁸ More than three million Canadians are under-insured or uninsured for prescription drugs⁹, and 10 per cent cannot afford to fill a prescription.¹⁰

Perhaps most striking is the fact that Canadians without private health insurance are four times more likely than their counterparts to not fill a prescription

⁶ The federal share of spending is significantly higher in Manitoba and Saskatchewan due to proportionately higher First Nations populations in those provinces. This federal spending does not include indirect support through the Canada Health Transfer (CHT).

⁷ "Drug expenditure in Canada, 1985 to 2012," Canadian Institute for Health Information, April 2013.

⁸ Steve Morgan and Jae Kennedy, "Prescription Drug Accessibility and Affordability in the United States and Abroad," *Issues in International Health Policy* 1408, no. 89 (June 2010): 5.

⁹ "The Case for Pharmacare."

¹⁰ Angela Mulholland, "One in 10 Canadians cannot afford prescription meds," CTV News, 16 January 2012, accessed via <http://www.ctvnews.ca/one-in-10-canadians-cannot-afford-prescription-meds-1.754716>.

PROVINCIAL DRUG PLANS: BRITISH COLUMBIA, ONTARIO, AND QUEBEC

Coverage under provincial plans is generally based on age, employment or income. The drug plans in Ontario, British Columbia and Quebec illustrate these different approaches.

In *Ontario*, the Ontario Drug Benefit (ODB) program covers most of the cost of 3,800 prescription drug products. In addition, there are several niche programs to fund specific diseases. The province offers relatively comprehensive coverage for seniors and social assistance recipients, and a related program for those with high drug costs relative to their income. Most of the provincial funds go to support seniors.

In *British Columbia*, coverage for prescription drugs is provided through several different provincial drug plans. Fair PharmaCare, the largest of those plans, is adjusted annually to provide coverage based on household net income. The portion of drug costs covered under the plan is calculated at the point of purchase, with residents paying any remaining cost.

In *Quebec*, residents are required by law to hold insurance coverage for prescription drugs. Coverage is based on employment, and all private insurers must meet minimum conditions regarding coverage and the financial participation required of the resident. Only those not eligible for a private plan through their employer are permitted to register with the provincial drug plans.

because of costs.¹¹ Even with an estimated 60 per cent of Canadians covered by private insurance (primarily through workplace benefits),¹² an estimated two-thirds of Canadian households incur out-of-pocket expenses each year.¹³ Not being able to cover those costs has consequences, as prescription drugs can improve patient health and reduce costs elsewhere in the health care system (e.g., number of emergency room visits and hospitalizations). Failure to take medication also contributes to a higher patient mortality rate.¹⁴ The total

11 Michael R. Law, Lucy Cheng, Irfan A. Dhalla, Deborah Heard and Steven G. Morgan, "The effect of cost on adherence to prescription medications in Canada," *Canadian Medical Association Journal* 184 no. 3 (January 2012): 298.

12 Claudia Sanmartin, Deirdre Hennessy, Yuqian Lu and Michael Robert Lae, "Trends in out-of-pocket health care expenditures in Canada, by household income, 1997 to 2009," Statistics Canada, accessed via <http://www.statcan.gc.ca/pub/82-003-x/2014004/article/11924-eng.htm>.

13 "The effect of cost on adherence to prescription medications in Canada," 297.

14 J. Kennedy and S. Morgan, "Cost-related prescription non adherence in the United States and Canada: a system-level comparison using the 2007 International Health Policy Survey in seven countries," *Clin Ther* 31, no. 1 (January 2009): 217.

financial cost of non-adherence to prescription drugs in Canada is estimated to be \$7 to 9 billion per year.¹⁵

Today, most medical treatment plans involve prescription drugs. New drugs are improving health outcomes and quality of life, replacing surgery and other invasive treatments, and speeding up patient recovery times. The inability to afford these medications adds significant preventable costs to the health care system each year. As the costs of prescription drugs continue to rise, it is increasingly important to address the gap between the treatments that people need and what they can afford.

¹⁵ Dr. Monika Dutt, "Affordable Access to Medicines: A Prescription for Canada", Canadian Doctors for Medicare — Canadian Centre for Policy Alternatives, December 2014.

DRIVERS OF CHANGE

When prescription drug coverage was left out of Medicare in the 1960s, drugs played a much less significant role in the health care system. The delicate bargain made to secure universal access to public health insurance for hospital and medical care has since come under considerable pressure from the increasing cost and usage of prescription drugs, changing demographics and population health needs, and innovations in health care technology.

Inflation-adjusted spending on prescription drugs in Canada increased to \$27.7 billion in 2012 from \$2.6 billion in 1985. During the same period, average spending per capita increased to \$795.32 from \$99.31.¹⁶ Prescription drugs are the second largest component of health care spending in Canada, accounting for 15.8 per cent in 2014, behind only hospital costs (29.6 per cent) and above physician costs (15.5 per cent).¹⁷

Population aging is one of the key drivers of increased drug spending. By 2036, Canadians aged 65 or older are projected to account for 25 per cent of the total population, up from 16 per cent today.^{18,19} As this happens, many Canadians will gain access to public drug programs and see their drug costs shift from being a largely private liability to a primarily public one.²⁰ Today's population is living longer, and seniors are more likely to have chronic conditions – such as high blood pressure and diabetes – that are regularly treated with prescription drugs. British Columbia moved from age-based to income-based eligibility for public drug coverage in 2003 in direct response to the risk of high costs associated with this demographic shift.

The volume of prescription drug use per person has also increased. This change can be attributed to a combination of the greater availability of

16 “Drug expenditure in Canada, 1985 to 2012,” Canadian Institute for Health Information, April 2013.

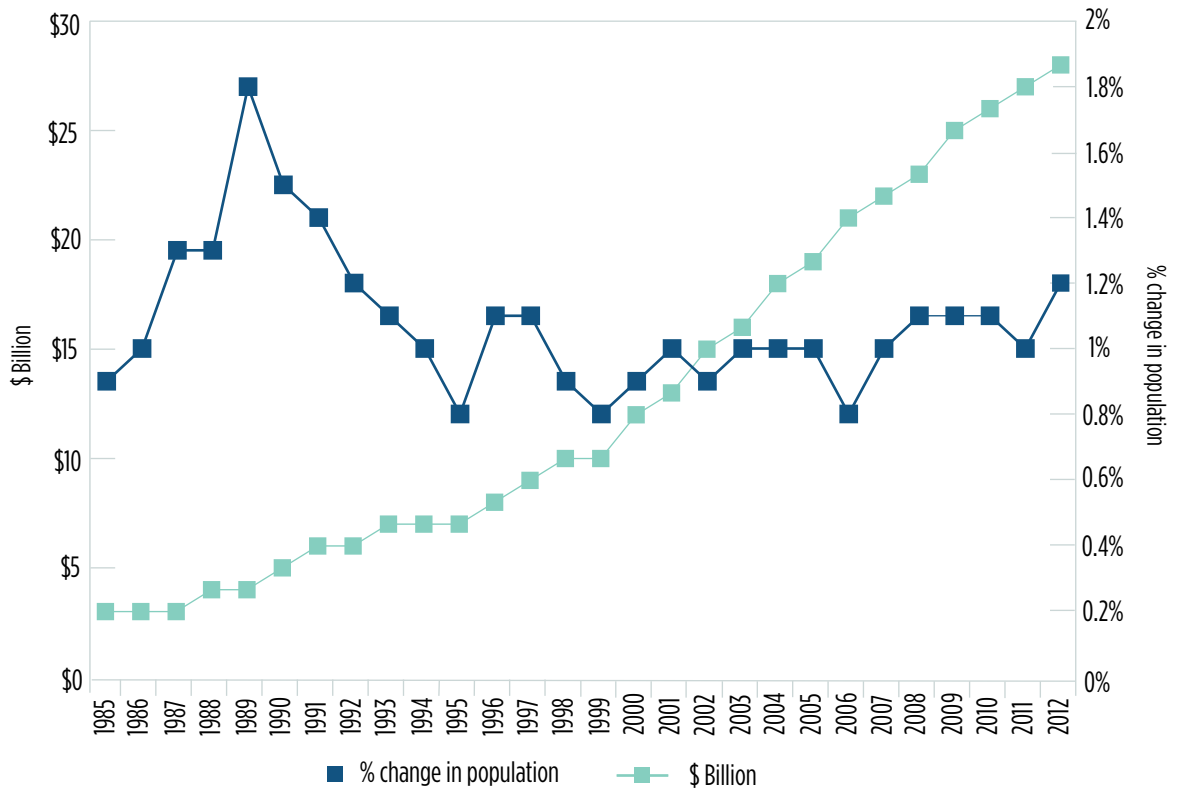
17 “National Health Expenditure Trends, 1975 to 2014.”

18 “Population Projections for Canada, Province and Territories,” Statistics Canada, accessed via <http://www.statcan.gc.ca/pub/91-520-x/2010001/aftertoc-aprestdm1-eng.htm>.

19 “Canada’s Population Estimates: Age and Sex 2014,” Statistics Canada, accessed via <http://www.statcan.gc.ca/daily-quotidien/140926/dq140926b-eng.htm>.

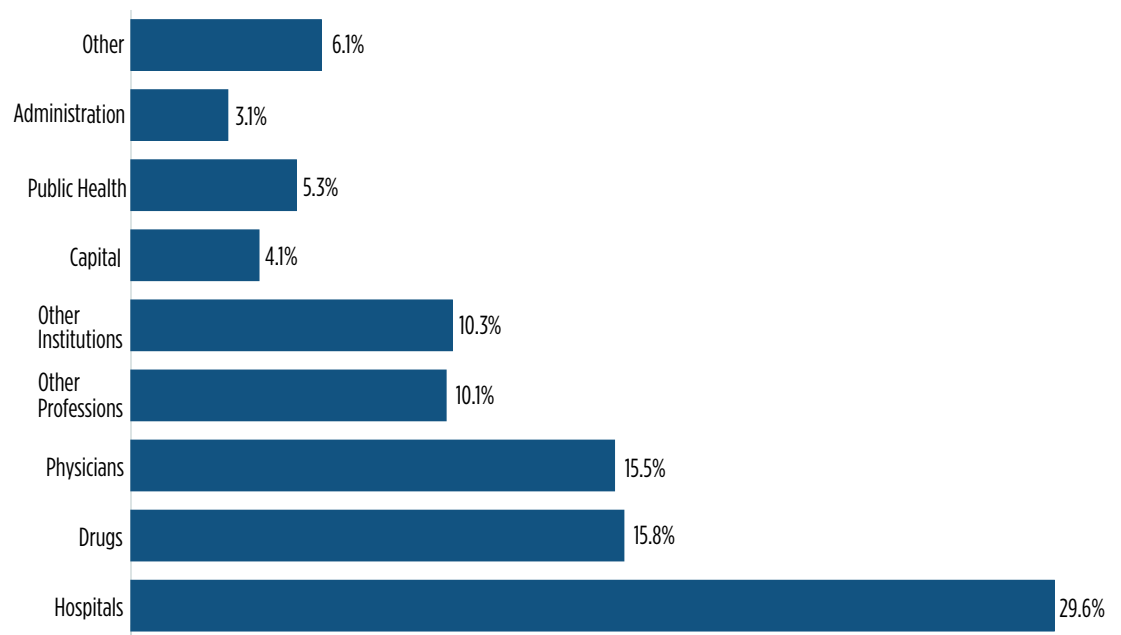
20 “Canadian Pharmacare: Looking Back, Looking Forward.”

INFLATION-ADJUSTED SPENDING ON PRESCRIPTION DRUGS AND PERCENT CHANGE IN POPULATION, 1985-2012



SOURCE: MOWAT CENTRE BASED ON NATIONAL HEALTH EXPENDITURE DATABASE 2012, CANADIAN INSTITUTE FOR HEALTH INFORMATION; WORLD BANK, WORLD DEVELOPMENT INDICATORS, POPULATION CANADA.

PERCENTAGE SHARE



Total Health Expenditure by Use of Funds , Canada, 2014 (Percentage Share)

SOURCE: MOWAT CENTRE BASED ON NATIONAL HEALTH EXPENDITURE TRENDS 1975-2014, CANADIAN INSTITUTE FOR HEALTH INFORMATION

prescription drugs (and therefore to a higher proportion of the population taking prescription drugs, and those patients taking a greater number of drugs for longer periods), as well as cases of overprescribing.²¹ During the 1990s, new drugs for common conditions such as heart burn and high cholesterol helped drive up volume of use. More recently, new treatments for less common conditions such as rheumatoid arthritis and some types of cancer have done the same. Between 2005 and 2010, the average annual growth rates of spending on immunosuppressant and cancer drugs were 21.5 per cent and 13.4 per cent, respectively.²²

The cost of prescription drugs has also increased significantly over the last few decades. Innovations in health care technology mean that medications can now cost tens of thousands of dollars per year per patient, creating insurmountable financial barriers if a patient is not covered adequately by insurance. Breakthrough HIV drugs brought to market by the pharmaceutical industry in the 1990s cost \$5,000 to \$10,000 per year per patient.²³ Today, some specialized treatments can cost \$100,000 or more. For example, Kalydeco, approved in 2012 for the treatment of cystic fibrosis in patients with a rare gene, costs \$306,600 per year per patient. The drug's high cost can be attributed in part to its very limited market — roughly 0.06 per cent of Canadians with cystic fibrosis.²⁴

Although the realities of health care have shifted considerably since the introduction of Medicare, much of that shift has not been reflected in Canada's social architecture. Provincial governments finance about the same percentage of total spending on prescription drugs as they did more than two decades ago. In 1992, the provinces financed 45 per cent of total spending; in 2012, they financed 42 per cent.²⁵

21 "Drivers of Prescription Drug Spending in Canada," Canadian Institute for Health Information, December 2013.

22 "Drivers of Prescription Drug Spending in Canada."

23 "Canadian Pharmacare: Looking Back, Looking Forward."

24 "Cystic Fibrosis 'breakthrough' pills have \$300K plus price tag," CBC News, 06 December 2013, accessed via <http://www.cbc.ca/news/canada/nova-scotia/cystic-fibrosis-breakthrough-pills-have-300k-price-tag-1.2453058>.

25 "Drug expenditure in Canada, 1985 to 2012."

COMPARATIVE CASE STUDIES

Many other countries face similar demographic trends, usage rates and technological barriers as Canada, but are addressing these issues and successfully containing costs. If, for example, per capita spending on prescription drugs in Canada was reduced to the same level as Germany, Canada would spend \$4 billion less per year; if it matched the rates of the United Kingdom or New Zealand, savings would reach \$14 billion per year.²⁶ These countries, along with others including Australia and the Netherlands, have national drug plans and pay between 15 and 60 per cent less for prescription drugs (roughly 50 per cent on average). They have not experienced the high annual increases in costs that have been common in Canada.²⁷

In Germany and the Netherlands, universal coverage for prescription drugs is provided through social health insurance mechanisms that mandate participation and regulate minimum standards of drug coverage. In the United Kingdom and New Zealand, coverage is provided through a universal program integrated into a broader system of public health insurance and delivered via regional boards. In Australia, coverage is financed through universal public programs administered at the national level. While the structures of these national drug plans vary, each applies similar mechanisms to manage spending on prescription drugs, including reference pricing, tendering for sole-supply and generic products, and rebates and discounts.

26 Steven G. Morgan, Jamie R. Daw and Michael R. Law, "Rethinking Pharmacare in Canada," C. D. Howe Institute Commentary no. 384 (June 2013): 19.

27 OECD Health Data 2013.

CASE STUDY: NEW ZEALAND

Health care in New Zealand is rooted in universal public health insurance. Similar to the regional authorities in some Canadian provinces, it is delivered through District Health Boards that are responsible for the funding and provision of health care services. Prescription drugs are financed through a universal drug plan integrated into the broader system of public health insurance.

Prescription drug costs in New Zealand increased dramatically during the 1980s and early-1990s and threatened to crowd out other health care funding. To improve access and curtail spending in an era of new medicines for common conditions, the government formed the Pharmaceutical Management Agency (PHARMAC). The agency's mandate is to "get better value for medicines so that the best health outcomes could be achieved from public money spent on medicines."¹

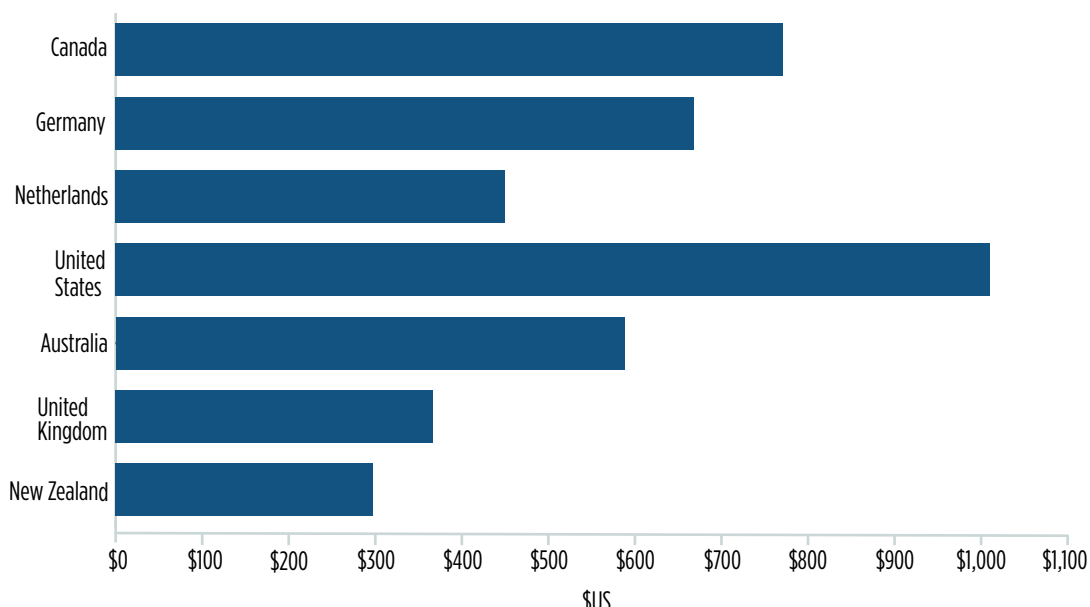
PHARMAC has since used various measures to contain costs – including reference pricing, tendering for generic drugs and requiring companies to cut prices for drugs already on the national formulary in order to list new ones. Now a Crown Corporation, it has been credited for much of New Zealand's success in managing spending on prescription drugs while maintaining universal access.

By consolidated negotiating power, New Zealand has successfully tripled its purchasing power. It has also cut public spending on prescription drugs by almost 50 per cent.²

1 PHARMAC, "Our History," <http://www.pharmac.health.nz/about/our-history/>.

2 *ibid.*

TOTAL SPENDING ON DRUGS PER CAPITA, 2012



SOURCE: MOWAT CENTRE BASED ON NATIONAL HEALTH EXPENDITURE TRENDS 1975-2014, CANADIAN INSTITUTE FOR HEALTH INFORMATION. DRUGS INCLUDE PRESCRIBED AND NON-PRESCRIBED DRUGS, AS WELL AS OTHER MEDICAL NON-DURABLES (PERSONAL HEALTH SUPPLIES).

OPTIONS

Federal and provincial governments should work together to develop and implement policies that will expand access to prescription drugs at reasonable affordability. Moving forward, a number of proposals should be considered, ranging from the transformational measure of universal pharmacare to interim measures such as creating a national institute for evaluating medicine, bulk purchasing and catastrophic drug plans.

TRANSFORMATIONAL APPROACH

Given the current gaps in Canada's public health care system in the area of prescription drugs, and considering some of the success highlighted in comparable jurisdictions, the development of a universal pharmacare program should be a serious consideration for the federal and provincial governments.

Moving to a publicly-funded, single-payer system for prescription drugs would ensure equitable access to necessary medications, and would reflect the principles of Medicare as articulated in the Canada Health Act. It would also generate significant savings over the long-term by enabling government to lower the price of prescription drugs through coordinated purchasing and by improving patient health. Universal pharmacare would save up to \$11.4 billion per year, with about \$1 billion in annual savings achieved by simply eliminating the duplication of technical and administrative costs associated with the current patchwork system.²⁸

SHORTER-TERM MEASURES

Universal pharmacare program would provide the best possible access to prescription drugs, but it may not be politically or fiscally feasible to implement at this time. There are numerous other measures that could be used to increase access in the interim, some of which are complementary to universal pharmacare.

²⁸ Marc-André Gagnon, "A Roadmap to a Rational Pharmacare Policy in Canada," Canadian Federation of Nurses Unions, 2014.

A NATIONAL INSTITUTE FOR EVALUATING MEDICINE

The creation of a national institute for evaluating prescription drugs would streamline the current patchwork of evaluative systems managed by provincial drug plans, private insurers and pharmaceutical manufacturers. It would also serve as a necessary pre-requisite for establishing an evidence-based national formulary of preferred drugs (proven and cost effective) free of both political and industry influence. This would in turn provide the foundation for bulk-purchasing mechanisms that have been used to significantly reduce spending on prescription drugs in comparable jurisdictions.

The institute could also act as a resource for provincial health care systems on appropriate and consistent standards for drug prescribing and use. While ad hoc efforts for cooperation between governments can be helpful, they cannot offer the same level of expertise or consistency as a permanent and independent body. Creating a single national institute for evaluation would help to depoliticize the process and inject much needed rigor into drug policy development.

BULK PURCHASING

Strong political leadership would be required to work with private health care insurers and pharmaceutical manufacturers on key reforms necessary for an eventual transition to a universal pharmacare program. This would include tendering for lower drug prices for generic drugs. A bidding process in which pharmaceutical companies compete against one another for the business of pooled provincial drug plans would leverage competition to get better prices for Canadians. Similar initiatives have significantly reduced per capita spending on prescription drugs in comparable jurisdictions.

As of April 1, 2013, provinces combined their purchasing power to fix the price point of the top six generic drugs — which make up about 20 per cent of publicly-funded drugs in Canada — at 18 per cent of the price of the equivalent brand name drug. These drugs previously cost about 25 to 40 per cent of brand name costs. Independent of a universal pharmacare program, provinces should continue to work together and with the federal government to concentrate purchasing power to further lower the fixed price point of other generic drugs.

UNIVERSAL PHARMACARE FOR A LIMITED SET OF DRUGS

Selecting 20, 50, or even 80 of the most commonly used prescription drugs and providing universal coverage for those drugs would improve access to necessary medication while limiting governments' financial commitment in the short term. Savings earned through coordinated purchasing of these drugs would increase access through the public health care system at little to no out-of-pocket cost to Canadians, while simultaneously reducing public spending on health care.

In Ontario alone, it has been estimated that bargaining the best international price for 82 of the most commonly prescribed generic drugs would save the provincial government \$129 million annually. Applied to private drugs plans within the province, the same action is estimated to result in an additional \$116 million in savings.²⁹ A policy of limited pharmacare would serve as a first step toward universal coverage, but one that is more fiscally feasible in the short-term.

MANDATORY COVERAGE

An individual mandate to carry coverage for prescription drugs, combined with subsidies for those in need, would offer another route to achieving the goal of universal coverage. This is the approach currently used in Quebec, where residents are required by law to hold coverage linked to their employment, and only those ineligible for private insurance through their employer are permitted to register with the provincial drug plan.

To fund the necessary subsidies, federal and provincial governments could consider taxing the benefits received by employees for prescription drugs on private health care insurance plans administered through employers. While employer contributions are already considered taxable benefits in Quebec, employees in the rest of Canada are generally not taxed for benefits received. Implementing such a tax nation-wide could raise significant sums. In 2010, employers spent \$200 million per week, or \$10.2 billion total, on prescription drug coverage.³⁰

CATASTROPHIC DRUG COVERAGE

The current patchwork system of prescription drug coverage provides only limited protection against severe burdens from drug costs. Although catastrophic drug coverage is now available in a majority of provinces and territories, the sustainability and cost-effectiveness of each model varies significantly. There is no nation-wide protection from severe drug costs.

The federal government could build on the existing Medical Expenses tax credit to offer some relief from prescription drug costs through the tax system. Currently, total expenses that exceed either \$2,171, or 3 per cent of net income, can be claimed as a non-refundable tax credit. Lowering this threshold to make the tax credit more generous, and making it refundable, would improve the value of this tool for Canadians. However, because this approach would create a significant administrative burden and involve significant wait times for refunds, a more direct approach would do a better job of meeting the growing need for prescription drug coverage.

29 Dr. Monika Dutt, "Affordable Access to Medicines: A Prescription for Canada." Canadian Doctors for Medicare, Canadian Centre for Policy Alternatives, December 2014.

30 Helen Stevenson, "An End to Blank Cheques: Getting More Value out of Employer Drug Plans," White Paper (2011): 3.

INCOME-BASED PROVINCIAL DRUG PLANS

As the ratio of seniors to working-age Canadians continues to grow, several provinces have or are considering switching from age-based to income-based public drugs plans.³¹ Income-based plans are based on ability to pay and apply to all individuals equally, including seniors and social assistance recipients, and are exposed to a lesser degree to the cost pressures associated with demographic shifts. A collective move to income-based provincial drug plans could slow rising per capita public spending on prescription drugs in the absence of a universal pharmacare program.

There is some debate over the merits of income-based drugs plans relative to age-based plans. As an income-based plan would require seniors to cover the full cost of prescription drugs before reaching an annual deductible, or charge premiums and co-pays on a sliding scale, it would result in an increase in direct charges for many high-needs users when replacing an age-based model. This could lead to lower rates of access and adherence to medications as a result.³² Any switch from an age-based to income-based public drug plan would have to be carefully designed to limit costs to Canadians.

31 Colin Busby and Jonathan Pedde, "Should Public Drug Plans be Based on Age or Income?" C.D. Howe Institute Commentary no. 417 (December 2014): 2-3, 7.

32 Steven G. Morgan, Jamie R. Daw and Michael R. Law, "Are Income-Based Public Drug Benefit Programs Fit for an Aging Population?" Institute for Research on Public Policy no. 50, December 2014.

CONCLUSION

Canada's public health care system provides universal access to public insurance for hospital and medical care regardless of ability to pay, yet this system continues to have important gaps. As per capita spending on prescription drugs increases – driven by aging populations, increased volume of use and innovations in health care technology – many Canadians are unable to afford necessary medications without significant financial hardship. One in 10 Canadians forego filling prescriptions, a reality that has impacts for population health and brings increased costs to bear on the health care system.

Governments seeking to overcome this challenge will face the perennial problems of political willingness, budgetary pressures, path dependency and managing the existing patchwork of provincial drug plans. But it is important that the process start now, and be guided by present Canadian realities and lessons from abroad. Canada's federal and provincial governments should move together towards a publicly-funded, single-payer system for prescription drugs that would ensure equitable access for all Canadians.

UNFILLED PRESCRIPTIONS: THE DRUG COVERAGE GAP IN CANADA HEALTH CARE SYSTEMS

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RENEWING CANADA'S SOCIAL ARCHITECTURE

Renewing Canada's Social Architecture is a collaborative project involving researchers from the Mowat Centre, the Caledon Institute for Social Policy, the Institute for Competitiveness and Prosperity and the Institute for Research on Public Policy. The purpose of the project is to advance public dialogue on our social architecture, and highlight areas where our core social programs and policies require modernization to meet Canadians' needs. Each report contributed to the project is the responsibility of the authors alone, and does not necessarily reflect the views of the other contributors or organizations.

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