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Canadian Union of Public Employees

Brief Submitted to

House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

A study on

Advancing Inclusion and Quality of Life for Canadian Seniors

Submitted October 20, 2017

INTRODUCTION

The Canadian Union of Public Employees (CUPE) is Canada's largest union, with over 650,000 members across the country. CUPE represents workers in health care, emergency services, education, early learning and childcare, municipalities, social services, libraries, utilities, transportation, airlines and more.

Seniors issues, including retirement income, health care, long-term care (LTC), and home care are important issues for our members, their families, and their communities. Hundreds of thousands of CUPE members work in these sectors and have frontline knowledge of the challenges Canadian seniors face in these areas.

CUPE thanks the Committee for its attention to this vital topic. Our union appeared as a witness during this study on October 5, 2017. This brief summarizes those remarks with additional attention to other areas. This brief outlines CUPE's recommendations on the following issues:

1. Retirement Income
2. National Continuing Care Program
3. Health Accord & Funding
4. Pharmacare
5. Housing

1. RETIREMENT INCOME

RETIREMENT INCOME CHALLENGES

Approximately 6 in 10 Canadian workers do not have a pension at work. Those who do have a pension are facing pressure from employers for cheaper, less secure pensions. Canada's system of individualized savings, primarily the Registered Retirement Savings Plan (RRSP) and Tax-Free Savings Account (TFSA) system is not working for most Canadians. These programs generally benefit higher-income, higher-wealth Canadians at great expense to the federal treasury.[1] Most Canadians without a pension plan have wholly insufficient retirement savings. 1 in 3 Canadian seniors receives income from the Guaranteed Income Supplement (GIS). This program keeps many but not all Canadian seniors out of poverty. Senior poverty in Canada (often touted as a public policy success story) has been on a slow and steady rise since the mid- 1990s.[2]

The result of these pressures, is study after study, showing that a majority of middle-income Canadians hoping to retire soon are facing a steep drop in living standards when they retire. This problem is projected to get worse with subsequent generations.[3]

[1] The federal tax expenditure cost of the RRSP is $16 billion. 65% of RRSP contributions are made by Canadians with income above $80,000. The Tax Free Savings Account currently costs $1 billion annually, but the Parliamentary Budget Officer states that "the long-term total fiscal impact [of the TFSA] is roughly proportional to the current fiscal impact of the RRSP." By contrast, the Guaranteed Income Supplement program, which keeps millions of Canadian seniors out of poverty will cost $11.5 billion this year. Department of Finance Canada, "Report on Federal Tax Expenditures: Concepts, Estimates and Evaluations," 2017; Statistics Canada, CANSIM Table 111-0039; Parliamentary Budget Officer, "The Tax-Free Savings Account," February 24, 2015; Jonathan Rhys Kesselman, "Double Trouble: The Case Against Expanding Tax-Free Savings Accounts," Broadbent Institute, February 2015;

[2] Richard Shillington, "An Analysis of the Economic Circumstances of Canadian Seniors," Broadbent Institute, February 2016.

[3] Michael C. Wolfson, "Projecting the Adequacy of Canadians' Retirement Incomes," IRPP Study No. 17, April 2011; CIBC, "Canadians' Retirement Future: Mind the Gap," In Focus, February 20, 2013; University of Waterloo and the Canadian Institute of Actuaries, "Planning for Retirement: Are Canadians Saving Enough?", June 2007; Michael Wolfson, Canadian Centre for Policy Alternatives, "What, Me Worry? Income Risks for Retiring Canadians", July 14, 2015.

CPP EXPANSION: ROOM TO GO FURTHER

CUPE and the labour movement have been strong supporters of Canada Pension Plan (CPP) expansion for more than 50 years. We were therefore very supportive of the 2016 deal between the federal and provincial governments to expand the CPP. A bigger CPP will mean an easier retirement for virtually all working Canadians and their families. However, the deal could have and should have gone much further. CUPE had been pushing for an increase in the CPP replacement rate from 25% (where it has sat since the program was instituted 50 years ago) to 50%. The 2016 deal will see the 25% replacement rate move up to 33% - a meaningful increase, but not one that will make a significant change in the retirement income prospects of Canadians. Even the federal Department of Finance's numbers show that 1 in 5 Canadian families will not have sufficient retirement savings *after the modest expansion of CPP.*[4]

The federal government should continue to prioritize the expansion of Canada's public pension system.

CPP EXPANSION: FAILURE TO INCLUDE CHILD REARING AND DISABILITY DROP OUT PROVISIONS

A major shortcoming of Bill C-26 was the lack of child rearing and disability "drop out" provisions. In the current CPP, a worker's CPP benefits are the product of their earnings throughout their working life. Years of zero or low earnings therefore pull CPP benefit levels down. Governments have long recognized that this mechanism can cause inequities for certain Canadians and have added "drop out" provisions to the CPP to compensate. The "child rearing drop out" provision allows years when a worker is away from the paid workforce because they are raising a small child to be dropped from that worker's CPP calculation. This ensures the worker does not suffer a pension penalty for this socially-valuable work. Similarly, the "disability drop out" provision allows for years when a worker is unable to work due to disability to be dropped from their CPP calculation, so that they do not suffer a pension penalty as a result of a disability.

CUPE was shocked to discover that these important equity provisions in the CPP will not be included in the new, expanded CPP benefits.[5] While the current CPP benefits will be unaffected, workers will now face a CPP penalty for a period of child rearing or disability on the new tier of CPP benefits. The child rearing provision is primarily used by women, who along with Canadians with disabilities, are our most vulnerable seniors. They do not need more retirement challenges.

CUPE urged the federal government to work with the provinces to fix this shortcoming before Bill C-26 was passed. The government did not amend the Bill and passed it without these drop out provisions. The issue has instead been added to the agenda for the 2016-2018 triennial review of CPP. CUPE urges the federal and provincial governments to work together to fix this glaring flaw in an otherwise important and necessary Bill.

OLD AGE SECURITY AND GUARANTEED INCOME SUPPLEMENT INDEXATION

The indexation provisions in the Old Age Security (OAS) and Guaranteed Income Supplement (GIS) programs also represent an ongoing, long-term problem that merits an improvement. Currently, OAS-GIS benefits increase each year to keep pace with the rising prices for goods and services. However, the federal Chief Actuary projects that Canadian wages will grow at 3.1%, faster than the projected rate of price inflation (2%).[6] This means that OAS-

[4] Department of Finance Canada, "Backgrounder: Canada Pension Plan (CPP) Enhancement," 2016.
[5] For more see CUPE testimony at House of Commons Standing Committee on Finance, November 15, 2016 and to the Senate Standing Committee on Social Affairs, Science and Technology, December 7, 2016.
[6] Office of the Chief Actuary, "14th Actuarial Report on the Old Age Security Program as at 31 December 2015," 2017.

GIS falls short by about 1% relative to wages each year. Over several years, the difference is small. But over the long-term, a growing gap emerges as our basic public pension does not keep pace with the rising living standards of Canadian workers. CUPE does not believe it is justified that OAS-GIS should grow only two-thirds as quickly as the economy grows. All Canadians should benefit from standard of living increases.

Indexation provisions for public pensions vary across Organisation for Economic Co-operation and Development (OECD) countries.[7] In the United Kingdom, for example, public pensions increase each year by the greater of: price inflation, wage increase or by 2.5%.

The federal Chief Actuary states that "if benefit rates were increased to partially reflect the growth in real wages, then the [program cost to GDP ratio] in 2060 would increase from 2.65% to 3.60%." Any improvement to the current provision, would of course come with a fiscal cost, but as CUPE has laid out elsewhere, the government can make different taxation choices to pay for these vital programs.[8]

BILL C-27

Federal Bill C-27 would re-write pension law, allowing federally-regulated employers to pressure workers and retirees to "surrender" their claims to defined benefit pension promises and "exchange" them for insecure, target benefit pension claims that can be legally reduced without limit. In short, this Bill would permit employers to legally walk away from pension promises they have already made to workers and retirees.

This offensive legislation would dramatically shift the bargaining goalposts in favour of employers. Workers would suddenly have to defend something that was protected for decades by federal pension law: the pension they were promised for work they have already completed. Workers have held up their end of the employment bargain, and the government should not open the door for employers to retroactively walk away from their commitments to workers.

Bill C-27 would only contribute to the erosion of decent pension coverage in Canada and make our existing retirement income challenges even worse.[9]

Canadians find this Bill offensive, particularly given that it directly contradicts written promises Prime Minister Trudeau made before the 2015 election.[10] The government should withdraw the Bill and sit down with workers and employers to discuss a pension policy all that sides can agree on.

PRECARIOUS WORK

Workers will have a much more difficult time retiring in dignity and security if they do not have access to good and secure jobs throughout their working lives and access to universal social programs. The federal

[7] OECD, "Pensions at a Glance 2015," section 2.5, 2015.
[8] Canadian Union of Public Employees, "Submission to the House of Commons Standing Committee on Finance Pre-Budget Consultations for the 2018/19 Federal Budget," August 2017.
[9] Since similar legislation was passed in New Brunswick in 2012, many defined benefit pension plans in the province have been *downgraded* into target benefit plans. There are now 51,000 members of new target benefit plans and just 15,000 members still in defined benefit plans. CUPE is not aware of any employer who has *upgraded* to a target benefit plan from not having a plan or a defined contribution plan. Bill C-27 would therefore, like New Brunswick, not improve pension coverage in a dramatic way, but would likely contribute to making existing plans less secure, putting further pressure on current and future generations of Canadian seniors.
[10] Signed July 23, 2015 letter from Justin Trudeau, Leader of the Liberal Party of Canada to Gary Oberg, President, National Association of Federal Retirees; *Sage* Magazine, Fall 2015, p. 19.

government must therefore take the growth of precarious employment seriously by taking the following measures:

- Legislate stronger employment standards legislation federally, and encourage the provinces to follow suit.
- Adopt a federal minimum wage of $15 an hour or more.
- Improve Employment Insurance (EI), including a universal threshold for EI access of 360 hours.
- Strengthen and protect existing universal social programs.
- Develop much-needed new universal social programs such as childcare and pharmacare that apply to all Canadians, regardless of employment status.
- Oppose weakened labour standards in trade deals.
- End government austerity.

2. NATIONAL CONTINUING CARE PROGRAM

Continuing care services, which include long-term care, facilities, home and community care, are vital programs for Canadian seniors.

Continuing care services, however, vary across provinces in the availability of services, level of public funding, eligibility criteria, and out-of-pocket costs borne by residents/clients. Most provinces have cut long-term care bed capacity relative to the senior population in the past decade, without sufficiently expanding home and community care or adequately increasing staffing to reflect the higher acuity of the remaining residents.[11] There have been new investments in home and community care, but progress is uneven, and unmet needs are substantial.[12] Overall, access to these services is two-tiered, waits are long, and quality is uneven. Continuing care services are poorly funded and regulated, offered in many places by for-profits, and fall outside of Medicare (for all meaningful purposes, continuing care is currently excluded from the Canada Health Act). Privatization at all levels – financing, ownership, management and delivery – worsens access and quality problems.

As a result, care is often rushed and underfunded, with poor working conditions leading to poor quality of care and quality of life for residents/clients. Continuing care, in the absence of federal standards, is an uneven patchwork of programs which too often fails to meet the needs of Canada's most vulnerable seniors.

CUPE believes that the federal government should respond by creating a national continuing care program, covering long-term care facilities, home and community care, with dedicated transfers financed from general revenue and tied to Canada Health Act standards.[13] The program should include minimum staffing standards and the phasing out of for-profit delivery. Canadians need a national program, with dedicated transfers tied to Canada Health Act standards, minimum staffing levels, and more public, non-profit delivery.

A national continuing care program would be funded through general tax revenue. Pooling risk widely is more efficient and equitable than any of the other recently proposed options: social insurance, registered savings plans, medical savings accounts, and tax breaks for private insurance.

[11] Irene Jansen, "Residential Long-Term Care: Public Solutions to Access and Quality Problems," Health carePapers, 10(4): 8-22., 2011; Canadian Medical Association, "Social Equity and Increasing Productivity: 2018 Pre-budget submission to the House of Commons Standing Committee on Finance," September 21, 2017.

[12] Special Senate Committee on Aging, "Final Report: Canada's Aging Population: Seizing the Opportunity," 2009; Seggewiss, K, "Variations in home care programs across Canada demonstrate need for national standards and pan-Canadian program," Canadian Medical Association Journal, 180(12), 2009.

[13] Allowing for an asymmetrical agreement with Quebec, the program would otherwise fall under one federal transfer and law.

The program should be established through stand-alone legislation, including minimum staffing standards and a program to phase-out for-profit delivery. This legislation should incorporate the criteria and conditions in the *Canada Health Act*, namely: public administration, universality, comprehensiveness, accessibility, portability, and no extra billing or user charges.

Third-party research repeatedly confirms what CUPE's continuing care workers tell us: safe staffing levels and non-profit ownership are two of the most important determinants of quality of care.[14] These two elements must be part of the regulatory framework.

More non-profit delivery will improve quality and access of care while reducing costs. A growing body of empirical evidence, including two systematic reviews, has demonstrated that for-profit long-term care facilities are associated with lower quality of care and poorer resident health outcomes. They also bring higher costs and two-tier access. Home care is even more privatized in Canada, with similar results.

Staffing is the key determinant of quality care, and national standards must include a minimum level. Higher-staffed facilities perform better on a range of quality and outcome measures, for example, rates of pressure ulcers, weight loss, nutrition and hydration, restraint use and violations of care standards. U.S. experience shows that staffing and care will only improve with legislation requiring facilities to employ staff at specified levels.

A major 2011 federal government committee study called for federal action on continuing care. The Parliamentary Committee on Palliative and Compassionate Care recommended that the federal government "implement a right to home care, long term care and palliative care, for all residents of Canada, equal to the current rights in the Canada Health Act."[15]

Nordic European countries have long-standing public (comprehensive, universal, and tax-financed) continuing care programs. Other countries have introduced major public initiatives in the past decade, most notably the United Kingdom, Germany, and Japan.

All Canadian seniors should have access to medically necessary services free of charge at the point of use, whether the setting is a hospital, LTC facility, home, or community agency. Care should be safe and of high quality. To achieve this, the federal government needs to champion a national continuing care program adhering to the principles outlined above.

3. HEALTH ACCORD & FUNDING

Canada's healthcare system plays a vital role in the lives of Canadian seniors. Our public healthcare system cannot deliver for Canadians without a strong federal role in pushing national standards and allocating adequate funding to provincial governments.

From March 31, 2004 to 2014, Canada had a cohesive, nationwide Health Accord that provided federal health care funding to the provinces (called the Canada Health Transfer, or CHT), with committed funding increases of 6% per year. The Health Accord also supported the principles of the Canada Health Act that make Canadians proud: universality, comprehensiveness, portability, accessibility, and public administration.

[14] Irene Jansen, "Residential Long-Term Care in Canada: Our Vision for Better Seniors' Care," Canadian Union of Public Employees, 2009.
[15] Parliamentary Committee on Palliative and Compassionate Care, "Not to be Forgotten: Care of Vulnerable Canadians," Recommendation #8., 2011.

In 2011, the Harper government announced that it would cut the annual CHT increase to the growth rate of the Canadian economy, with a 3% floor. This amounted to a cut of $36 billion in health care funding over 10 years when compared to the funding mechanism in the Health Accord.

In the 2015 election, the Liberal Party promised health care policy that would "provide the collaborative federal leadership that has been missing during the Harper decade." Their platform promised the party would "negotiate a new Health Accord with provinces and territories, including a long-term agreement on funding." Canadians hoped that the federal leadership vacuum and health care cuts of the Harper era were over.

CUPE is disappointed that the Liberal government has abandoned its promises. Instead of negotiating "a new, [national] Health Accord," the government has instead signed 10 year bilateral health deals with each province and territory. These deals continue the Harper-era 3% funding escalator, with additional monies for home care and mental health. No specific measures have been put in place to improve health care for all Canadians.

LESS FUNDING FOR HEALTH CARE

The government projects that federal healthcare funding will grow at little more than 3% per year. However, multiple calculations have shown that funding must increase by 5.2 % per year just to maintain the current level of existing healthcare services.[16] This goes against the wishes of the majority of Canadians who want the federal government to expand health services and to increase funding for health care.[17]

This raises some concerning questions for Canadian seniors: what healthcare services will the provinces and territories cut if they are not getting enough funding from the federal government? How will we be able to support an aging population with increasing health care needs and a further delay to developing a national seniors' strategy? Will major cuts to the system mean less care for seniors? If the system is underfunded now, how much more will have to be invested in the future to 'fix' the system?

The government has invested an additional $11 billion over 10 years for home care and mental health, starting in 2017. This, undoubtedly, is a welcome investment. However, these funds are allocated for programs outside the existing public healthcare system, meaning that the decreased Canada Health Transfer funding offered in the bilateral deals will still leave provinces and territories struggling to maintain current healthcare services, let alone expand existing or create new programs.

These new deals will place increasing pressure on our already overextended health care system. Whether someone lives in Canada will impact the health care that is available to them. People living in poorer provinces will be at a disadvantage and could experience negative health outcomes because of serious funding shortfalls.

PER CAPITA FUNDING IGNORES THE PRICE OF SENIORS CARE

In 2012, the Conservative government unilaterally changed the funding formula for the Canada Health Transfer to a per capita model. This change put provinces with aging populations at a serious disadvantage. According to the Canadian Institute for Health Information, seniors make up 15.7% of the Canadian population, but account

[16] Canadian Health Coalition, ""Health Care Advocates Dismayed with Ottawa's Divide and Conquer Tactics: Hopes for a Canadian Health Accord Dashed as Provinces Signs Deal," March 10, 2017.
[17] Gloria Galloway, "Canadians differ from Trump view of public health care: poll shows," *Globe and Mail*, November 14, 2016; Andrew Russell, "What are top priorities for Canadians ahead of the federal budget?" *Global News*, March 21, 2016.

for 46% of health care spending in Canada.[18] Provinces with aging demographics are therefore seeing their health care costs grow while their federal funding remains the same. The government chose not to re-visit the funding formula when they failed to create a new Health Accord. In the absence of a new funding agreement, the federal government should create a demographic top-up to the Canada Health Transfer which provides additional funding to provinces with more seniors.

OPENS THE DOOR TO FOR-PROFIT SERVICES

The new bilateral funding deals between the federal and individual provincial and territorial governments fail to adequately protect our public healthcare system.

The deal with Saskatchewan, for instance, allows for private MRI clinics to continue operating - if you have money, you can pay to jump the queue. CUPE stands firmly opposed to privatization in healthcare. This is in direct violation of the *Canada Health Act* and our right to universal access – a violation that a new Health Accord, if properly implemented, would have better enabled the federal government to crack down on.

Moreover, there is nothing in the bilateral deals to compel the provincial and territorial governments to put federal transfer monies into public, rather than private, services for home care or mental health. This allows public funds to be spent on private for-profit services, rather than on universally-accessible public health services.

NO OVERSIGHT OF NATIONAL HEALTH STANDARDS

The Health Accord gave the federal government a cohesive framework to uphold the *Canada Health Act*, enabling it to enact financial penalties for violations. With bilateral deals, the federal government has not invested any money towards the enforcement of the *Canada Health Act*, and offers no common framework with which to uphold an equitable national vision and health care goals for all Canadians regardless of where they live. Without the enforcement of national health standards, Canada runs the risk of moving closer towards a fully-privatized healthcare system, extra billing by doctors, and two-tiered structures that favour the wealthy while harming Canadian seniors.

LESS ACCOUNTABILITY

Despite the Liberals' promise of transparency and accountability, the bilateral deals were negotiated behind closed doors. There were no public consultations and details of the agreements are still not available, months after the provinces/territories and the federal government reached agreements with each other. This lack of open public discourse threatens our collective ability to engage and safeguard our public health system.

4. PHARMACARE

One of the top priorities in the Minister of Health's Mandate Letter is to improve Canadians' access to prescription medication. In collaboration with the provincial and territorial governments, the Minister is tasked with finding ways to reduce the costs governments pay for prescription drugs, making them more affordable for

[18] Canadian Institute for Health Information, "National Health Expenditures: How has health spending on seniors changed?", 2016, https://www.cihi.ca/en/nhex2016-topic7.

Canadians.[19] This is crucial given that Canadians currently pay the second highest cost for prescription drugs in the world and millions receive no coverage at all.[20]

The Minister's mandate suggests that governments could work together to buy some drugs in bulk, which would help to reduce the price of those medications. However, this type of plan does not go far enough to serve the needs of all Canadians. A national, single-payer, universal, and publicly funded pharmacare program is needed.

Canada is the only developed country in the world with a universal health care program without a universal prescription drug plan.[21] It is time to complete the unfinished business of Medicare, which was always intended and expected to include access to drugs. Healthcare should not only encompass access to hospitals and doctors. It needs to grow to include the medications Canadians need to be healthy as well.[22]

Canada's current mix of private and public drug coverage is what makes the cost of drugs so expensive. Having a coherent approach to drug pricing, coverage, and purchasing is the best way to reduce the cost of prescription medications and to ensure necessary medications are available to all Canadians.

Countries that have a single-payer, universal pharmacare program "are able to accrue greater bargaining power by making purchases on behalf of the entire population, with one set of negotiations and lower prices spread across a larger population. This results in significantly lower costs for payers…".[23]

This is highlighted in a recent Parliamentary Budget Office (PBO) report, which shows that a national, single-payer drug plan would cost less than what we currently spend and cover all Canadians.[24] "While the report's estimates of medication price reduction are conservative and the formulary used is one of the most extensive available, the PBO *still* found that a national pharmacare plan would result in a net savings of over $4 billion for Canadians."[25]

Pharmacare coverage among seniors is currently covered by a patchwork of provincial programs which subsidize the cost of prescription drugs. However, this coverage is incomplete; too many Canadian seniors fall through the cracks and lack decent drug coverage. A national plan would ensure that every senior benefits from public drug coverage. This is more important than ever before given that Canada's aging population continues to grow.

A national pharmacare program would also bring a measure of security to the 8.4 million Canadian workers who do not have drug coverage.[26] These workers tend to be employed in poorly-paid, precarious jobs. Not surprisingly, these workers go on to face significant challenges and vulnerabilities as seniors. Bringing more security to the lives of workers today will undoubtedly help them to achieve a secure and decent retirement in the future.

[19] Justin Trudeau, "Minister of Health Mandate Letter," http://pm.gc.ca/eng/minister-health-mandate-letter.
[20] Danielle Martin, "Mature Medicare: A Prescription for Canada's 150th", May 2, 2017 , https://mowatcentre.ca/mature-medicare/.
[21] For more, see the Canadian Labour Congress campaign at www.aplanforeveryone.ca.
[22] Ashley Csanady, "Pharmacare is the 'unfinished business of Medicare' and Could Save Canada up to $14 B Annually: Report," June 2, 2015, http://nationalpost.com/news/politics/pharmacare-is-the-unfinished-business-of-medicare-and-could-save-canada-up-to-14-billion-annually.
[23] Danielle Martin, "Mature Medicare," May 2, 2017, https://mowatcentre.ca/mature-medicare/.
[24] Office of the Parliamentary Budget Officer, "Federal Cost of a National Pharmacare Program," September 28, 2017, http://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/2017/Pharmacare/Pharmacare_EN.pdf.
[25] Canadian Doctors for Medicare, "PBO: Universal Pharmacare Costs Less than Current Spending," http://www.canadiandoctorsformedicare.ca/pbo-universal-pharmacare-costs-less-than-current-spending.html.
[26] Hassan Yussuff, "Unions Want Pharmacare Plan for all Canadians," *The Toronto Star*, September 4, 2017 https://www.thestar.com/opinion/commentary/2017/09/04/unions-want-pharmacare-plan-for-all-canadians.html.

A national pharmacare program is widely supported by the public. 91% of Canadians want our health care system to include a universal prescription drug plan.[27] They understand that the benefits of a pharmacare program would help to improve the lives of all Canadians, including seniors.

5. HOUSING

CUPE has almost 3,400 members across Canada working directly in the provision of social housing. This includes members working for municipal or provincial housing corporations or authorities, and private, non-profit housing providers. Affordable housing is a major issue for seniors.

CUPE believes the federal government should establish a national housing strategy that will respect, promote, and fulfill the right to adequate housing as a guarantee under international rights treaties ratified by Canada.

This national housing strategy must include clear objectives for its implementation and ensure housing is safe, secure, sustainable, adequate, affordable, and accessible to all. It should also include financing and creation of new social housing.

This strategy must include specific strategies to address homelessness, with special attention to the needs of Aboriginal Peoples.

In the past, CUPE supported the NDP's Bill C-400, calling for the development of a national housing strategy in partnership with provincial, territorial and municipal governments, and community-based organizations.

We are pleased to see the federal government commit $3.4 billion to social infrastructure over the next five years. Specifically, the commitment to affordable housing is an important step to alleviating poverty, and it is encouraging to see the federal government embrace Housing First initiatives. We call on the government to discourage private, for-profit affordable housing projects – by definition, affordable housing units must be excluded from the competitive housing market that has served to exacerbate the affordable housing crisis. Rent paid by residents of affordable housing should not cushion the profit margins of private companies.

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[27] Brent Patterson, "New Council of Canadians Poll Shows 91% Want Liberals to Implement Pharmacare," May 17, 2017, https://canadians.org/blog/new-council-canadians-poll-shows-91-want-liberals-implement-pharmacare.