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STUDENT REVIEW

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ADAM SMITH'S "SALINE SOLUTION" FOR CANADA'S HEALTH CARE SYSTEM

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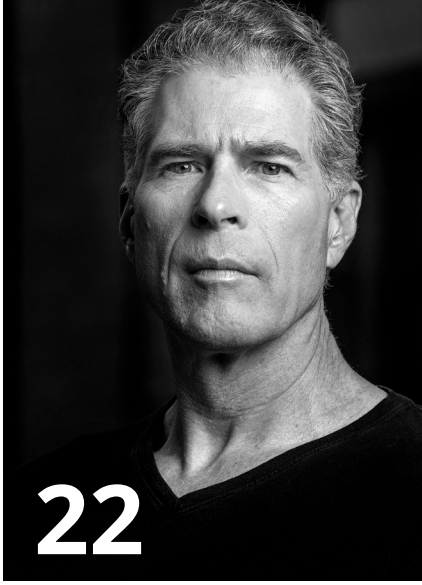

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S PRING 2024

Canadian STUDENT REVIEW

WELCOME

Dear Readers:

Welcome to the latest edition of the *Canadian Student Review*! Our Spring 2024 issue highlights a study underscoring the prevalence of mental illness, combined with the now well-understood impacts on employment, productivity, and social engagement for ill individuals. This study aims to explain the increased attention this area of health care has received in recent years and the numerous calls for additional tax-funded expenditures on mental health care.

This issue also delves into additional essential topics in healthcare reform, community maintenance, trade partnerships, and population growth. Mackenzie Moir and Bacchus Barua recommend reevaluating Canada's single public-health system, proposing cost-sharing measures to improve healthcare despite legal restrictions. Steven Globerman explains why the federal government should refocus attention on its trade relationship with its largest trading partner: the United States of America. In addition to these contributions, this issue also highlights a recent infographic showing a huge disparity between annual housing completions and current population growth. We also have an article from our student contributor, Alicia Kardos, titled "*Adam Smith's "Saline Solution" for Canada's Health Care System*".

You'll also find a podcast video from the Fraser Institute's *Essential Scholars Explained* series, "Women of Liberty—Elinor Ostrom and the Bottom-Up Approach to Community Maintenance." And we're also including some thought provoking insights from Paul Zak, along with two more recordings from the *Explore Public Policy Issues* webinar series for your enjoyment.

Thank you again for taking the time to read and contribute to our magazine. If you or someone you know would like to contribute content to the *Canadian Student Review*, please have them contact me directly Ryan.Hill@fraserinstitute.org.

Best,

Ryan

ADAM SMITH'S "SALINE SOLUTION" FOR CANADA'S HEALTH CARE SYSTEM

ALICIA KARDOS

Canada's health care system is on life support, but many of its patients are still waiting to be as they languish on waiting lists, getting slowly sicker and in many cases simply dying, untreated. With more patients than beds, decades of mismanagement and resource misallocation have left many health care facilities threadbare. Canada-wide, our hospitals are burdened with staffing shortages, budget barriers and administrative antagony. Our sick are frequently subjected to poor care – if they get care at all – while our frontline health care workers are subjected to overwork. We are stuck in a continuing negative feedback loop.

How to break it? Smithian synergy. That's Adam Smith, the famed 18th century Scottish economist and moral philosopher. By shaking Smith's "invisible hand", the Canadian health care system could finally tap into the power of market forces to drive efficiency.

By time they saw a specialist and then actually received treatment was 27.7 weeks, according to the recently published study *Waiting Your Turn: Wait Times for Health Care in Canada, 2023 Report*, by Mackenzie Moir and Bacchus Barua (with Hani Wannamaker).

According to Moir and Barua, Ontario came in with the shortest average waiting time of 21.6 weeks, followed by Quebec at 27.6 weeks and British Columbia at 27.7 weeks. Nova Scotia made these already ridiculous times seem positively enviable, with a staggering 56.7 weeks – a full year plus one month – with the other Maritime provinces nearly as bad. In some parts of Canada, it takes significantly less time to create a human than to treat one. And all these figures leave out the initial waiting time from when a person first contacts their family doctor – if they're lucky enough to have one – to when they receive a referral to a specialist.

Our waiting times are not merely inconvenient and stressful, they are medically indefensible. Research conducted by the Fraser Institute for the above-mentioned study, which surveyed medical specialists for their professional judgment regarding medically reasonable waiting times, concluded that in 90 of the 109 categories of specialization

‘THE WEALTH OF NATIONS’ PROVIDED MUCH OF THE PHILOSOPHICAL FRAMEWORK FOR FREE MARKETS. THE BOOK AND ITS IDEAS HAVE UNDOUBTEDLY PASSED THE TEST OF TIME. BUT CAN THEY STILL LAST LONG ENOUGH TO GET A KIDNEY TRANSPLANT IN THE CANADIAN HEALTH CARE SYSTEM?

[1] *As of June 5th, 2022.*

examined, actual waiting time is much longer than the medical "clock".

Patients' health is deteriorating too fast to wait, but wait they must. Canada has been transformed into a gigantic waiting room with annual casualties in the many thousands. An investigation by the research and advocacy organization SecondStreet has shown that at least 11,581 Canadians died in 2020-2021 while waiting for appointments, diagnostic scans or surgery. Canada's new national headline should be: "Homicidal Health Care".

Statistics don't tell the full story, however. We are talking about an ever-lengthening roster of individual human tragedies. Such as new mother Emer O'Toole's baby boy, who nearly died of respiratory distress – a top triage category – while waiting in a succession of Montreal emergency rooms. Or Alison Cox, who accompanied her 66-year-old husband to Winnipeg's Concordia Hospital after he began experiencing severe pneumonia symptoms, only to be left waiting in a cold, fume-choked ambulance bay for six hours before finally being taken to an examination room. Thankfully, he recovered. Or Karen Totten, who was left to hunt for her blind 88-year-old mother, eventually finding she'd been relocated inside a *supply room* due to space shortages.

Not to mention the other 631,527 Canadians who were waiting for surgery last year. What are their stories? How much are they suffering? Better yet: when will we start doing something about all of this terrible service, incompetence, neglect and needless suffering? As the World Population Review notes, Canada has the world's tenth-largest economy yet, among the approximately 40 countries that make up what is known as the "developed" world, we come eighth-to-last in hospital bed availability, with only 2.5 per 1,000 inhabitants.

That brings us back to Adam Smith. His economic principles are applicable to any system that involves the exchange of goods or services for economic consideration – even a publicly funded, publicly operated monopoly health care system. The antediluvians who still believe health care and competition are an incompatible if not unimaginable combination should consider boarding the Smith ship, and fast, because Canada's current health care system is about to go under. To call our health care universal is to satirize it.

How can we pride ourselves on the notion of "free", when the opportunity cost becomes a matter of life and death? More and more of us don't. As shown in a poll by Angus Reid, three out of every five Canadians consider our health care system poor, with one-in-three agreeing that increased privatization would improve health care delivery. These findings suggest a dramatic amount of potential, currently unmet demand for privatized health care. If Adam Smith were a Canadian living today, he would unquestionably contribute to that statistic.

More to the point, Smith's ageless ideas can contribute in a real-life fashion today, by being applied to Canada's health care system. Born in Kirkcaldy, Scotland in 1723, Smith today remains the *summum bonum* of modern economics: a founding father of modern capitalism. Smith's 1776 magnum opus, *An Inquiry into the Nature and Causes of the Wealth of Nations*, has placed him in the pantheon of enduring figures in moral philosophy and economics. The Wealth of Nations provided much of the philosophical framework for free markets. The book and its ideas have undoubtedly passed the test of time. But can they still last long enough to get a kidney transplant in the Canadian health care system? Let us find out.

In his book *The Essential Adam Smith*, Professor James Otteson of the University of Notre-Dame describes the three major themes of Adam Smith's political economy (using the term's traditional definition). The first is the "Economizer" argument, the proposition that every person will naturally seek out the most economical use of their expendable means to achieve their objective, whatever it may be. Some have said this suggests people are essentially slothful (the "human laziness argument" in economics) while others say this demonstrates that people have the good sense to avoid wasted effort. The Economizer argument, Ottewell

summarizes, "Holds that [one] will assess the limited resources available…[and use them] to look for ways to reach [their] goals in the surest, fastest, most complete ways or with the least cost to any other goals."

Consciously or not, then, we are always looking for the *best* return on our investments. We want efficiency to equal elation. And what could be a better deal, what could make us happier than free? When it comes to health care, that is a problem; the Economizer principle leads us astray. Here we come to the key economic concept of "opportunity cost". Its details occupy whole chapters in economics textbooks but, in brief, it reflects the hard fact that because resources are finite, if we expend some on one thing, we can't expend those same resources on any number of other things. Those other things, the ones not done, are the opportunities we forego: and the best foregone opportunity is known as the opportunity cost.

Publicly funded and delivered health care, however, has no opportunity cost besides time. Since time technically costs zero dollars, many patients rarely think twice about the opportunity costs of going to the doctor, even if it's over an issue Tylenol could fix, since there's no direct cost to them. In doing so, patients effectively divert the precious time our scarce practitioners could spend on more immediate cases. But that is only one of the ways in which hiding the true costs of providing health care – not only from patients, but from the system itself and the people working within it – distorts decision-making in Canada's health care system. Note that I'm not saying Canadians should have to pay for their own health care out-of-pocket, only that the way things are billed and how the money flows should make it clear to all what things actually cost.

CANADIANS ARE LEFT ALONE TO MAKE CRITICAL DECISIONS IN NUMEROUS CATEGORIES OF LIFE: WHERE AND HOW LONG TO STUDY, WHAT FIELD OF WORK TO PURSUE, WITH WHOM TO FORM RELATIONSHIPS. YET WHEN IT COMES TO CARING FOR OUR HEALTH, CANADIAN GOVERNMENTS STEP IN, ROB US OF NEARLY ALL CHOICE AND MICRO-MANAGE.

The second of the three big Smithian claims illuminated by Otteson is the "Local Knowledge" argument. Here it must first be understood that people tend to know the shape and boundaries of their own purposes and desires. In addition, only we ourselves know best what opportunities and resources are available to us. Smith, Otteson explains, recognized the critical economic relevance of the seemingly pedestrian observation that each individual's "personal knowledge of their own situation exceeds that of others." Because it then follows that the individual is in the best position to decide how they wish to allocate and expend their resources – not another person, agent or organization, and least of all the government.

This should hold true for all matters, including health care. Publicly funded monopoly systems like Canada's, however, do not permit such decision-making because critical economic connections have been broken and costs are not transparent. Medicare is funded by first confiscating resources (through taxation) from working Canadians and profitable corporations, then allocating some of those resources to the health care system which, in turn, is charged with providing "free" health care to patients, who have little or no control over how anything is done.

In such a system, patients who come in for a medical consultation will tend to get a systematized "answer". All such answers fall under the same umbrella, the same centralized authority. Of course, a doctor may at times offer several options for

treatment, but these all exist based on varying generalizations concerning the individual patient. Such a system discourages specialized responses based on individual needs and circumstances.

This, in turn, dampens innovation in medical treatments, processes and medications. Thanks to our immediate neighbour to the south, we can see how far Canada has slipped behind. Every year, many thousands of Canadians travel to access the newer treatments readily available in the U.S. – expending their own hard-earned savings to do so. But Canada's health care system, by sticking to outdated and/or less efficient approaches, just keeps on spending money to lose money.

Thus, Smith's Local Knowledge default is displaced. Individuals *should* be at liberty to freely allocate their own resources to serve their own ends, because only they (and perhaps a couple of their close loved ones) are intimately familiar with their situation. (There would always be exceptions, of course, concerning cases in which an individual is not capable of handling their own affairs and requires guardianship, just as we have in other areas such as legal affairs.)

Canadians are left alone to make critical decisions in numerous other categories of life: where and how long to study, what field of work to pursue, with whom to form relationships, and whether to engage in risky behaviour and activity that might threaten their health. Yet when it comes to *caring* for our health, Canadian governments step in, rob us of nearly all choice and micro-manage health care delivery as if we were incapable of engaging with these questions as responsible individuals who understand our own interests and needs.

This brings us to the third key economic idea, the centripetal force of Smithian policy: the "Invisible Hand". It is the most widely admired, most frequently cited and most heavily criticized takeaway from Smith's work. And yet he mentions the concept only a handful of times throughout his writing. Here is the key passage from his treatise *The Theory of Moral Sentiments*:

"Every individual…neither intends to promote the public interest, nor knows how much he is promoting it…he intends only his own security; and by directing that industry in such a manner as its produce may be of the greatest value, he intends only his own gain, and he is in this, as in many other cases, led by an invisible hand to promote an end which was no part of his intention."

A similar notion can be found in *The Wealth of Nations*, but without the famous reference to unseen hands: "It is not from the benevolence of the butcher, the brewer, or the baker, that we expect our dinner, but from their regard to their own interest. We address ourselves, not to their humanity but to their self-love, and never talk to them of our necessities but of their advantages." The free market's dynamics encourage the production of the goods and services that are in demand. The combined effect of all this economizing and personal knowledge yields a whole that is much greater than its parts. "The genius of the Smithian market mechanism was that it could coordinate the disparate individual efforts of indefinitely many persons and manage to derive an overall benefit for the good of society from them," Otteson explains.

The example of the brewer, baker and butcher speaks to the benefits to be had when multiple producers supply the same or similar products. Collectively, each member of a particular trade competes against the other to produce their particular good or service better, cheaper and faster than the others. And so the economy grows and prosperity advances. These benefits go out the window when competition ceases, as in the case of monopolies. A zero competition monopoly is intrinsically handicapped at achieving better standards, because it has few if any incentives to seek better outcomes. This describes Canada's publicly-run health-care monopoly to a tee.

Smith also recognized the critical role of the consuming side in powering economic progress. Smith was no lackey of the wealthy, archly noting their "natural selfishness and rapacity". But in acting selfishly, a curious thing happens: the "invisible hand" leads them to spend their money in such a way that they "without intending it, without knowing it, advance the interest of the society." Smith thus identified the key element of consumption in a market economy. The positive feedback loop it generates – wherein the end of an action creates more of it – applies not only to the rich but to all consumers. We must make money to spend money and spend money to make money. Consumption becomes an investment – and vice-versa.

LIKE A WASH OF SALINE SOLUTION CLEANSING THE BURNING EYES OF HEALTH CARE ADMINISTRATORS, SMITH'S THREE KEY IDEAS WOULD ALLOW US TO THINK BIG, SEEKING EFFICIENT DELIVERY, TIMELY ATTENTION, MORE EFFECTIVE MEDICINE, TECHNOLOGICAL ADVANCEMENTS – THE WHOLE NINE YARDS.

But in the unique way that Canada's monopoly health care system is set up, the most powerful incentive of all – the spending power of consumers – is simply gone. Government-sourced funding that is generally budget-based in nature and thus disconnected from any specific health care-related activity surrenders the usual power of the purse to incentivize performance, quality and operating efficiency. Robbed of this essential economic instrument that in other fields forces providers to serve their customers or risk going out of business, Canadian patients become supplicants, the system free to ignore them – as it habitually does.

While Smith had nothing to say about publicly provided health care, he did explain his thinking on public education in *The Wealth of Nations*. He

thought there was a modest role for government in the provision of schooling, particular to support the "lowest ranks of the people." But he was against government monopoly. As Otteson describes it, Smith "thought the public subsidy [for education] should be less than half the total cost – the rest borne by the students themselves (or their families or sponsors) – to make sure that incentives were aligned properly. Teachers, Smith thought, would, like anyone else, naturally pay more attention to whoever is paying the majority of their fees." Should we expect present-day doctors, nurses or diagnostic technicians to be any different?

Clearly, not all of Smith's free market ideals could be implemented immediately. A mass overnight privatization of all hospitals would almost certainly be infeasible and impractical. But a gradual and continuous increase in the availability of private clinics and procedures would be. These would incrementally alleviate pressure on the public system. Other reforms could also be introduced one at a time or in groups. These would soon begin to project a brighter outlook for the future of Canadian medicine and the health outcomes for Canadian patients.

The nature of the demand for health care means that, on the one hand, a system providing "free" health care will always be short of resources, because people will always ask for more than such a system can provide. On the other, this feature also provides enormous potential for health care to become a booming industry – if reformed in the right ways. The more competition that could be introduced to Canada's health care system, the more the quantity of health care provided could be increased and its quality improved.

A vast amount needs to be done, of course, to start healing the deadly sicknesses in our health care system. But the potential is equally vast. A reformed system that allowed all of its participants to rationally pursue their own interests could, for example, provide far more job openings, especially for skilled immigrants whom the stringent occupational licensing requirements imposed by many provinces have prevented from contributing their talents.

Market principles, once widely applied, could also foster a boom in medical innovation that could become unstoppable. There is no innate reason why Canada's health care system needs to forever lag the U.S. and many European countries in so many technologies, medications and treatments. Like a wash of saline solution cleansing the burning eyes of health care administrators, Smith's three key ideas would allow us to think big, seeking efficient delivery, timely attention, more effective medicine, technological advancements – the whole nine yards.

And, who knows, an unleashed Canadian health care sector might finally be able to find the cure to cancer. And not just that, but to actually treat Canadians with cancer in a timely manner. That would be the actual touchdown pass, caught and carried by none other than the invisible hand. ◆

Alicia Kardos is a student in economics and public policy at the University of Toronto.

ENOUGH TALK, IT'S TIME TO FIX HEALTH CARE IN CANADA

MACKENZIE MOIR AND BACCHUS BARUA

A recent op-ed in the *Globe and Mail* urged Canadians to reconsider the "outdated" idea that a "single high-quality public-health system can be funded out of general tax revenues." Indeed, the authors caution readers about the limitations of indefinite tax hikes, and suggest it might instead be time to consider some aspects of a mixed health-care model, and perhaps even require patients to share the cost of treatment. However, to meaningfully implement these common-sense reforms—particularly patient cost-sharing—Ottawa must first get out of the way.

Let's be clear, Canada's health-care system is failing patients. In 2022, the wait between a specialist visit and treatment reached its peak at 27.4 weeks, while the latest data from 2020 show Canada performing poorly on physician (28th of 30) and bed availability (23rd of 28) compared to other universal systems worldwide.

The usual remedy offered by Canadian governments is to increase health-care spending. However, international data suggest that that additional spending is not the answer. Canada already has one of the most expensive systems in the developed world (when measured as a share of the economy), ranking 1st out of 30 universal health-care systems. And as the authors of the Globe and Mail op-ed correctly note, "Canadians are already among the highest taxed citizens in the world."

So, what's to be done?

One solution proposed by the authors is to consider adopting a means-tested copay. Currently, patients in Canada are fully covered for the costs of insured medical services—that is, they're not asked to pay out-of-pocket directly for any portion of their physician or hospital care. This contrasts with the majority of countries (22 of 28) in the developed world that, like Canada, maintain universal access health-care systems.

Perhaps more interesting from the Canadian perspective—France, the Netherlands and Switzerland are just a few examples of universal systems that perform better than our own on several key metrics including measures of timely

CANADIANS DESERVE MORE THAN ENDLESS APOLOGETICS FOR A SYSTEM THAT HAS, FOR YEARS, BEEN CHARACTERIZED BY HIGH COST AND UNDERPERFORMANCE

access to care. Each one of these countries generally expect patients to share the cost of treatment through the use of deductibles (an amount individuals must pay before insurance coverage kicks in), co-insurance payments (the patient pays a certain percentage of treatment cost) and copayments (the patient pays a fixed amount per treatment).

The French universal system requires co-insurance and a nominal fee for family physician visits, including outpatient and hospital care. In the Netherlands, citizens are generally required to pay a deductible before their universal coverage kicks in. Switzerland uses a blend of a personally chosen deductible before coverage kicks in, and a co-insurance rate (usually 10 per cent paid by the patient, with insurance covering the remainder) up to a second threshold, after which insurance covers the full cost of care.

While the proposal of cost-sharing (e.g. deductibles, co-insurance, co-payments) will certainly generate a strong backlash from the defenders of the status quo in Canada, there's a good reason for their use.

Empirical work has shown that cost-sharing can reduce the use of outpatient care without necessarily resulting in adverse health consequences for a population. Importantly, countries with universal schemes that employ cost-sharing also offer generous protections to ensure specific groups are not disproportionately impacted and retain their ability to access care. Some of these include limiting the maximum amount that can be spent out-of-pocket in a given year or by exempting some populations (e.g. children, pregnant women, low-income individuals, seniors) from cost-sharing entirely.

Despite the potential of cost-sharing, the Canada Health Act (CHA) explicitly prohibits any user fees or extra billing for medically necessary care. In fact, any provinces that implemented these tools would face dollar-for-dollar reductions or an all-out loss

of federal transfers for health care. The result is a disincentive for provincial experimentation outside a narrow range of options. Canada's provinces are effectively locked in an underperforming status quo.

For some Canadians, the consideration of the use of policy tools such as cost-sharing would represent an unprecedented peering into the very heart of our social contract. However, it's clear that the status quo is unsustainable and its high time we considered meaningful reform based on the experiences of other countries. Canadians deserve more than endless apologetics for a system that has, for years, been characterized by high cost and underperformance. ◆

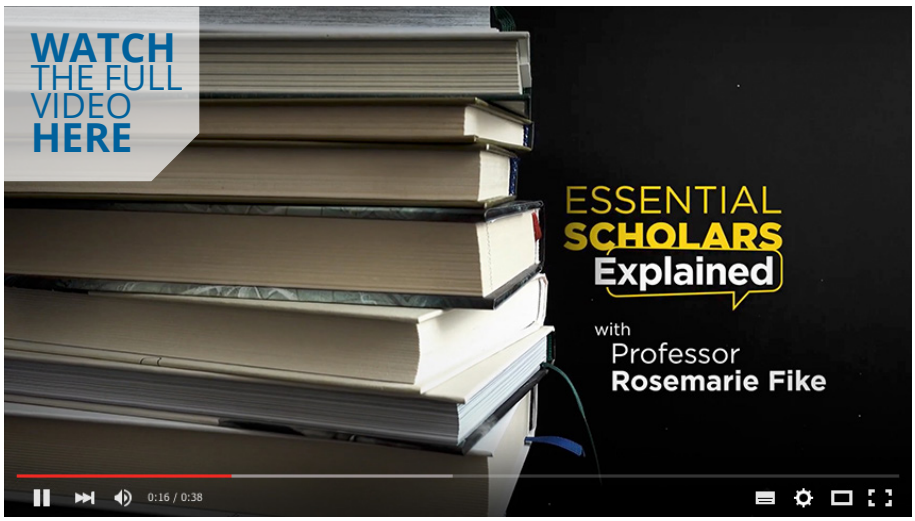
Mackenzie Moir is a Policy Analyst at the Fraser Institute. He holds a Bachelor of Science in Nursing from York University and a Master of Science in Health Policy and Research from the University of Alberta. In addition to several academic publications, his commentaries have appeared in University Affairs, the Financial Post, and Globe and Mail. His research focuses on the performance of health-care systems, patient choice, and health-related quality of life.

Bacchus Barua is Director of the Fraser Institute's Centre for Health Policy Studies. He completed his BA (Honours) in Economics at the University of Delhi (Ramjas College) and received an MA in Economics from Simon Fraser University. Bacchus has conducted research on a range of key health care topics including hospital performance, access to new pharmaceuticals, the impact of aging on health care expenditures, and international comparisons of health care systems.

PODCAST

WOMEN OF LIBERTY—ELINOR OSTROM AND THE BOTTOM-UP APPROACH TO COMMUNITY MAINTENANCE

SENIOR RESEARCH FELLOW JAYME LEMKE JOINS HOST ROSEMARIE FIKE TO DISCUSS NOBEL PRIZE WINNING ECONOMIST ELINOR OSTROM AND WHY COMMUNITY IS BEST SERVED AND BEST EMPOWERED THROUGH GRASSROOTS MOVEMENTS THAT ENABLE SOLUTIONS TAILORED TO THEIR SPECIFIC NEEDS. WATCH NOW.



Jayme Lemke is a senior research fellow and associate director of academic and student programs at the Mercatus Center at George Mason University and a senior fellow in the F.A. Hayek Program for Advanced Study in Philosophy, Politics, and Economics. She specializes in public choice economics, institutional analysis, and the political economy of women's rights.

Rosemarie Fike is an instructor of economics at Texas Christian University and a Fraser Institute senior fellow. She received her MA in economics at George Mason University, and her PhD in economics at Florida State University. Her current research focuses on understanding the effects that different types of economic institutions have on the lives and status of women. She is the author of the Fraser Institute's Women and Progress report.

OTTAWA SHOULD REFOCUS ON CANADA'S LARGEST TRADING PARTNER

STEVEN GLOBERMAN

Prime Minister Trudeau's participation in the recent G20 summit in India, which made headlines due to the prime minister's travel woes, was meant in part to advance the Canadian government's new Indo-Pacific Strategy (IPS). The IPS initiative aims, among other things, to encourage increased Canadian exports to non-U.S.-based importers, particularly those in emerging markets in Asia such as India and Indonesia, and developed economies such as Japan and Korea.

And yet, despite a long-standing government commitment to reduce Canada's trade dependence on the United States, which has seen Canada enter multiple trade agreements with Asian and European Union countries, the importance of the U.S. in Canada's international trade has barely changed over decades. By way of illustration, 75 per cent of Canada's merchandise exports went to the U.S. in 1990, one year after implementation of the Canada-U.S. Free Trade Agreement, compared to 75 per cent (the exact same percentage) over the period 2017-2020.

The continuing dominance of the U.S. in Canada's international merchandise trade flows reflects, in part, the important influence of physical distance on geographical trade patterns. The bulk of international trade in goods around the world is primarily intra-regional, and intra-regional trade is becoming even more prominent in the post-COVID period, as companies seek to shorten their supply chains geographically.

The U.S. is also Canada's dominant partner in services trade. Over the period 2017-2021, approximately 53 per cent of Canada's services exports, primarily commercial services, went to the U.S. market, down slightly from around 54 per cent over the period 2012-2017. In the case of services, differences in language, legal and regulatory institutions and business practises discourage trade flows between countries. Such differences can contribute to greater "cultural distance," which is often exacerbated by physical distance.

The importance of physical and cultural distance as determinants of geographical trade patterns underscores the challenges that Canadian-based

businesses face in diversifying their exports away from U.S. customers to those in the Indo-Pacific region. In addition, successful exporting to countries in the Indo-Pacific region will likely require Canadian-based companies to integrate into regional supply chains currently dominated by Chinese companies, particularly in the electric vehicle (EV) and components sector, which is a priority IPS export target. The fraught political relationship between Canada and China, and concerns on the part of Canada's western allies about tighter business linkages with Chinese companies in activities affecting national security, make closer integration into Asia-based supply chains by Canadian businesses problematic for the foreseeable future.

At the same time, the recent and serious escalation of political tensions between Canada and India, pursuant to the Trudeau government's claim that agents of India's government assassinated a Canadian citizen on Canadian soil, compromises the likely success of a trade strategy built on an assumption that India is a major market for Canadian exports, thereby reducing the importance of closer economic ties with China.

To be sure, exporting liquified natural gas (LNG) to Asia is a major opportunity for Canada. Unfortunately, Canada has lagged behind other countries (particularly the U.S., Australia and Mexico) in approving and constructing LNG export facilities. Canada's first LNG export facility being built near Kitimat, B.C. will only come online in 2025. Furthermore, the Trudeau government's ambivalence to exporting carbon fuels further frustrates the ability of Canadian natural gas producers to sign long-term supply contracts with buyers in the Indo-Pacific region.

So why reduce Canada's trade dependance on the U.S.?

One argument is that it would reduce the economic and political influence the U.S. exerts in the bilateral relationship. But recent experience suggests that China would leverage closer economic ties to Canada on issues affecting China's national interests. Another rationale is that the economies of developing countries in the Indo-Pacific region will grow faster than the U.S. economy going forward, so that profitable export opportunities will be increasingly abundant in the Indo-Pacific region

compared to the U.S. However, this perspective overlooks the potential for a major expansion of Canada's services exports tied to the digitalization of services in areas such as health care, finance and entertainment. The online delivery of services will only become more prominent with the roll-out of AI platforms.

Finally, the potential market in the U.S. for Canadian services exports dwarfs those in Indo-Pacific countries. For example, the size of the U.S. service sector was US$18.2 trillion in 2021 compared to US$1.3 trillion in India. Expanding bilateral trade liberalization in the service sector will require agreement between the Canada and the U.S. on sensitive issues such as taxation of digital advertising, privacy protection and protection of domestic suppliers of news and other content, among other things. However, with the Canada-U.S.-Mexico trade agreement scheduled for trilateral review in 2026, the federal government should refocus attention on its trade relationship with its largest trading partner. ◆

Steven Globerman is a Senior Fellow and Addington Chair in Measurement at the Fraser Institute, and Professor Emeritus at Western Washington University. Previously, he held tenured appointments at Simon Fraser University and York University and has been a visiting professor at the University of California, University of British Columbia, Stockholm School of Economics, Copenhagen School of Business, and the Helsinki School of Economics.

INFOGRAPHIC

POPULATION GROWTH HAS DRAMATICALLTY OUT PACED HOUSING COMPLETIONS IN CANADA

READ MORE HERE

Population growth and housing completions in Canada, 1972-2021

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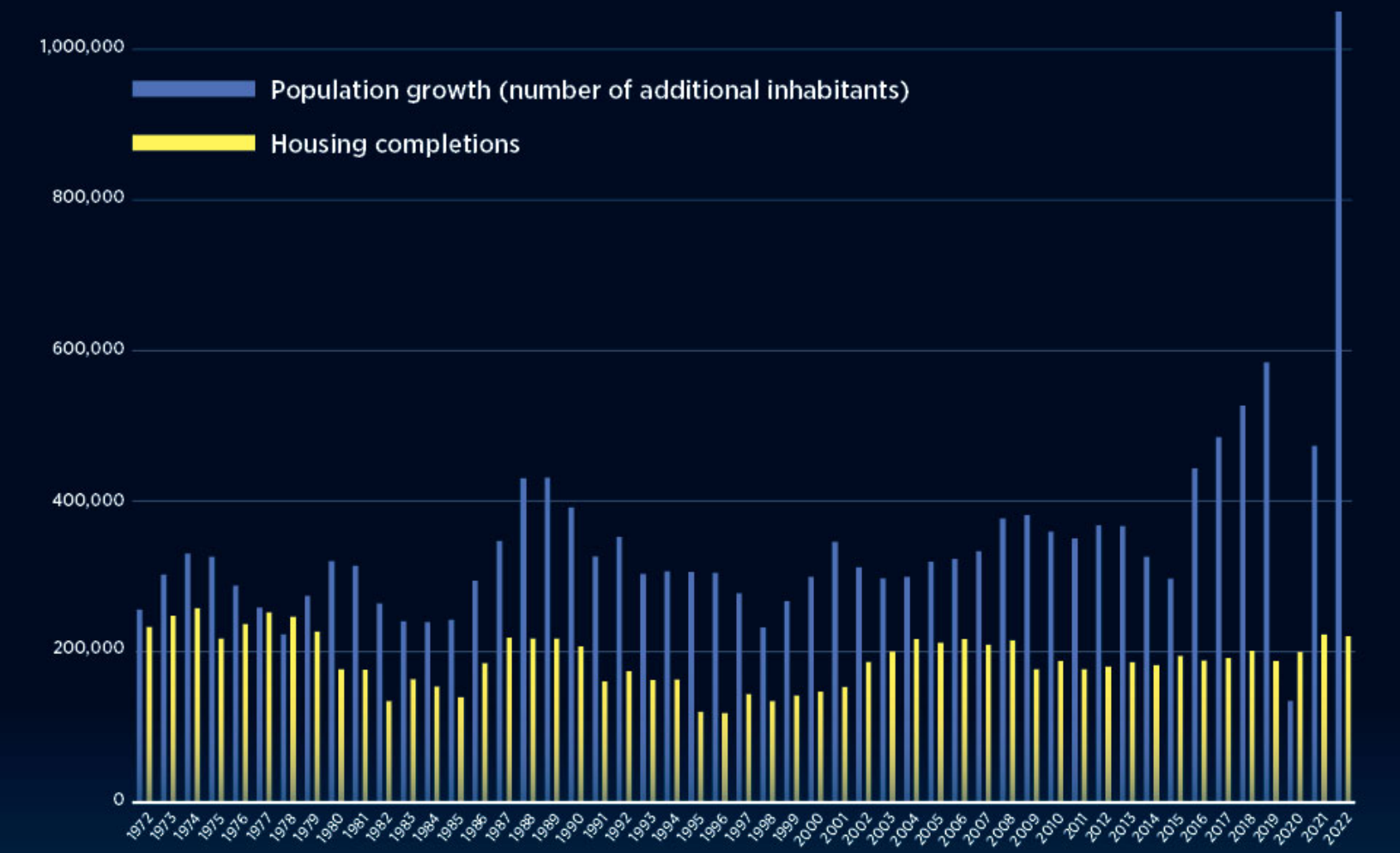


MENTAL HEALTH CARE: HOW IS CANADA DOING?

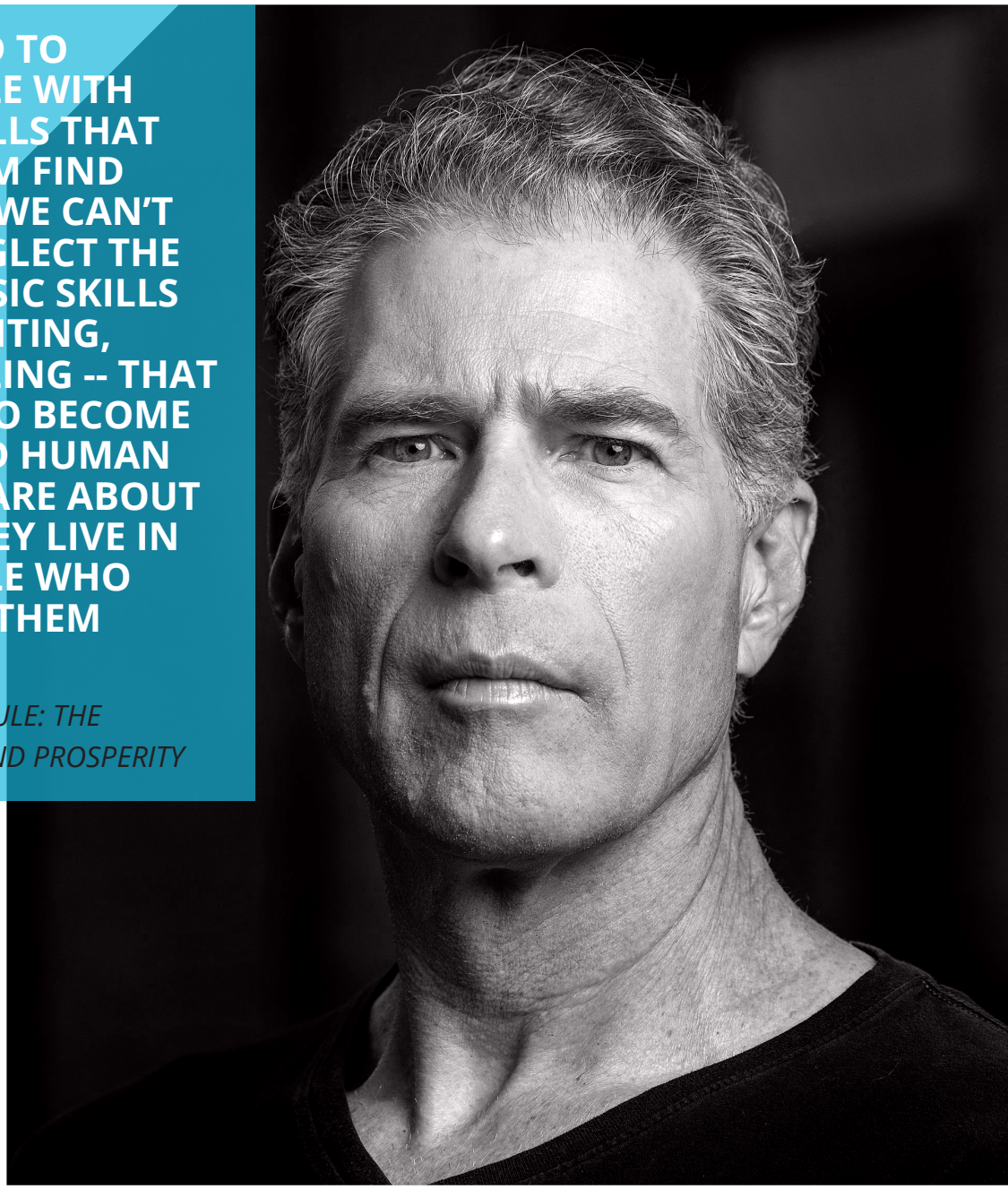
NADEEM ESMAIL

Mental illness is widely recognized to impact a considerable proportion of the population, perhaps affecting as many as one in five Canadians in any given year (Mental Health Commission of Canada, 2013). The prevalence of mental illness, combined with the now well-understood impacts on employment, productivity, and social engagement for ill individuals, helps to explain the increased attention this area of health care has received in recent years and the numerous calls for additional tax-funded expenditures on mental health care. ◆

READ NOW

WHILE WE NEED TO PROVIDE PEOPLE WITH TECHNICAL SKILLS THAT WILL HELP THEM FIND EMPLOYMENT, WE CAN'T AFFORD TO NEGLECT THE EVEN MORE BASIC SKILLS -- READING, WRITING, THINKING, FEELING -- THAT ALLOW THEM TO BECOME FULLY REALIZED HUMAN BEINGS WHO CARE ABOUT THE WORLD THEY LIVE IN AND THE PEOPLE WHO SHARE IT WITH THEM

— PAUL J. ZAK,
THE MORAL MOLECULE: THE SOURCE OF LOVE AND PROSPERITY



Paul Zak is the founding Director of the Center for Neuroeconomics Studies and Professor of Economics, Psychology and Management at Claremont Graduate University in California. He is featured in the Fraser Institute's Explore Public Policy Issues seminar series. His seminar can be viewed, here.

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