

# **Canada's Shared Destiny and the Future of Medicare**

**Speaking notes for**

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To SOS Medicare 2: Looking Forward

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## **INTRODUCTION**

This conference, being held in the birthplace of Canada's greatest social program, is an extremely important one, since its objectives are to highlight the challenges and the opportunities for Medicare.

Permit me to congratulate the organizers, sponsors and all of the participants. These two days, indeed have served to achieve a high purpose, namely, the reinvigoration of our shared commitment to Medicare.

## **CANADA'S SHARED DESTINY**

As we approach the conclusion of our work here, it is clear, nonetheless, that our ongoing task will be to work harder than ever to advance the momentum for progressive Medicare reforms.

In this respect, I have been asked to identify the challenges and opportunities so that we can move beyond rhetoric to secure our Canada's most treasured social program.

But, to place the debate over Medicare in its full context; to come to terms with the importance of the task which is ahead of us -- I would like to also put Canada's values on the table.

Because, I see the choice that we as Canadians make about Medicare as one which is fundamentally intertwined with our nation's values and its future.

Everyday, Canada faces new challenges that ask questions about what kind of people we are, and what kind of future we wish to shape. Today, we are wrestling with the renewal of Medicare. But, we could just as easily be discussing the integrity of our ecological environment, our role in Afghanistan and the world at large, or our domestic choices with respect to other social and economic policies.

Because what all these debates have in common is that they all return to a basic and fundamental question – what are the values of Canada and how do we build a more progressive and united nation?

In seeking to answer these important questions, we should never act as if we are starting from scratch. In fact, the very title and purpose of this conference—SOS 2—illustrates that the exact opposite is true.

Every nation has a narrative. Canada's offers us a strong and rich legacy of success that has forged our nation.

It is a legacy which I describe as a "shared destiny"— a legacy that is key to understanding the future of our yet young country. It is this same legacy of "shared destiny" that remains the roadmap to our future, at home, and abroad.<sup>1</sup>

For those of you, who like me, came of age in our Prairie communities, I don't have to tell you about the importance of the notion of "shared destiny." The harsh, often snow-blown conditions, droughts, distance and isolation, and small population, forced us together, like poplar trees huddled on a windswept plain.

We all learned to see survival and progress as a test of our ongoing ability to organize collectively and to remain united around shared values.

Although Canada has other regions with their own challenges, I suspect the same is also true. And so through the years, as we lived together, worked together and built together, this notion of "shared destiny" was transformed into the foundation of a nation.

Generation after generation of Canadians have seized on the cornerstone idea that our future and our society is frequently best shaped through community action. That the sum of Canada is often greater than its remarkably diverse parts.

John Whyte, in making the Saskatchewan government's argument to the Supreme Court of Canada in the post-1995 Quebec Secession reference case, summed up this notion of "shared destiny" when he said:

"A nation is built when the communities that comprise it make commitments to it, when they forgo choices and opportunities on behalf of a nation...when the communities that comprise it make compromises, when they offer each other guarantees, when they make transfers, and perhaps most pointedly, when they receive from others the benefits of national solidarity. The threads of a thousand acts of accommodation are the fabric of a nation...."<sup>2</sup>

This, then, is our nation's narrative and it resides in our collective DNA.

In recent years, however, the soil has been tilled for the sprouting of views at odds with "shared destiny." Today, we witness a palpable momentum toward individualism, decentralization, and privatization.

All of these are described as the “new ways” to deal with today’s world, but, in truth, they represent an abandonment of our accomplishments and a parting of the ways with the belief in our collective capacity to meet our future challenges and to forge a stronger and more unified nation.

Medicare, which is the product of this narrative, is also now caught up in this so-called “new thinking”.

And just like with today’s other major issues, it is the manner in which we choose to inform our way forward, the set of values that we draw on to shape our progress that ultimately will become an expression of who we are as a nation.

That is why the debate over Medicare is not just about effectiveness and efficiency. It is not simply about the irrefutable evidence showing that our single-payer, public system delivers excellent outcomes, which it does. The Medicare debate is not even just about basic Canadian values like equity and fairness for all citizens.

Yes, it is about all these things. But it is also about much more.

For, Medicare holds such a central role in our narrative of “shared destiny” that how we deal with our social programs will determine the future progress of our nation.

## **CANADA’S MEDICARE SYSTEM – SEPARATING FACTS FROM MYTHS**

So, keeping this history in mind, what is the road to progress on Medicare?

Well, let’s begin by making sure that we separate what are truths and what are myths.

First, there is a myth that we have one big, monolithic public health-care system. Some even believe it to be an overly expensive and unwieldy behemoth unable to keep up with the demands of today, and utterly unfit for tomorrow.

We don’t have one system. We have 13 health care systems: one for each province and territory. And if you add in the federal government as a deliverer, we actually have 14 systems.

All are, however, bound together by the shared principles enunciated in a federal law called the *Canada Health Act (CHA)*<sup>3</sup>, thanks to the leadership of Monique Begin, which outlines the five pillars of Canada’s Medicare: universality, comprehensiveness, portability, accessibility and public administration.

The CHA also states that all patients are entitled to “medically necessary services,” delivered by doctors and hospitals and paid for from the public purse. And, while the federal government can enforce the CHA by withholding from the provinces the cash transfer payments it makes for health service delivery, in recent times it has rarely done so. Thus, each province and territory exercised its new grants of autonomy to shape its health care system in whatever way it sees fit.

In fact, outside of the core basket of CHA services that covers doctors and hospitals, provinces can and do—in varying degrees—fund, subsidize and deliver a range of other programs.

Lately, some provinces have become increasingly more bold in implementing important changes to Medicare, with impunity.

As a result, we don’t have a single public health care monopoly.

And it’s certainly not “socialized medicine” or “state-run medicine” in the common understanding of those terms.

It is not “state-run” because many hospitals and other health care institutions are community-based non-profit bodies. And, moreover, the vast majority of doctors are effectively independent contractors paid according to fee schedules.

And there is another second myth – that the whole thing is publicly funded. In fact, it’s a complex structure of three main categories of financing.

At the first—or core CHA—level, are those services to which all Canadians are entitled as a right of citizenship, rooted in the fundamental Canadian value that health care is a “social good.”

These core CHA services, as Greg Marchildon has documented, add up to 43 cents on every health care dollar spent in Canada. Essentially, this is the single-payer system, publicly financed through progressive taxation, which is at the heart of medicare.<sup>4</sup>

The second level, worth about a quarter of our total health care bill –or 28 cents out of every health care dollar-- represents a mixture of public and private spending and delivery.

Drug costs are a prime example of expenditures in this segment. They are covered by the provinces in the case of seniors or low income people, employment-based group plans or private insurance. But the coverage is highly variable from region to region.

Home care, rehabilitation, and long-term care, offer similar examples of mixed, or blended, public and private funding. The provisions of the CHA cover none of the services in this second-tier, except as they relate directly to doctors and hospitals.

Yet, another, third level of health care services is paid for almost entirely by private funds.

Most dental and vision care, as well as a range of other services ranging from chiropractic to psychological, are not covered by Canada's public plans even though Emmett Hall in his seminal report urged this over forty years ago.

About fifty to sixty percent of Canadians are fortunate to have work-based insurance programs to cover some of these costs. Others, pay directly out of their own pockets... or don't receive them at all.<sup>5</sup>

So to recap, only 43% health of total care expenditures in Canada are publicly funded through the single payer system, approximately 28% involve a mixed public/private model; and 30% are paid for completely by private schemes, or directly out of our own pockets.

As we can see, it is a myth to argue that Medicare system is entirely financed by public funds.

## **CANADA'S MEDICARE SYSTEM – TOWARDS SUSTAINABILITY**

There is yet another myth that needs to be addressed. It tries to speak to the very real rise in total health spending in Canada... which must be acknowledged, and says that public health care costs are spiraling out of control. That, the myth says, is "unsustainable" – that the spending is crowding out other areas of public programming.

So, it says, we must look to even greater private financing and private delivery of care to ensure Medicare's sustainability.

This mantra has been repeated so frequently that we should not be surprised if more Canadians believe it to be true. Once again, the facts, however, prove otherwise.

The federal finance department, in projecting health care costs into the year 2040, discounted “theories that rising health-care costs will bankrupt federal and provincial governments ... Governments’ share of total health care spending for the country will likely remain less than 10% of the size of the Canadian economy.”<sup>6</sup>

That’s Ottawa’s Department of Finance.

A recent study in *Canadian Public Policy*, examined this issues from a retrospective view, namely, what the actual expenditures were over a given period, as opposed a prospective analysis as Ottawa’s was. This study looked at public spending from 1988/89 to 2003/04 and concluded that “there is no evidence that increased provincial government health expenditures resulted in lower levels of spending on other categories of government provided goods and services.”<sup>7</sup>

So, the evidence demonstrates both prospectively and retrospectively that public financing does not cause limitations on other essential governments. Then what does?

To answer this question, we must clearly understand this extremely important, but little reported, fact -- among the three tiers of service that I described earlier -- publicly funded, privately funded, and mixed groups of services --it is in the publicly funded system that the costs have actually risen the *least*.<sup>8</sup>

Over the past five years, the Canada Health Care Association says that in the privately-funded sector that growth rates have been climbing much higher and faster, averaging 6% rise in the private sector as compared to 4.5% on the public side.<sup>9</sup>

So, why have public-service costs not grown as fast as expenditures in other sectors?

One explanation is that a lot of care has shifted out of hospitals, because of technical advances, and is being moved to home-based and ambulatory care. Many interventions are now being handled by prescription drugs which means, as I have explained, that more costs are being passed directly on to individual Canadians. The second reason--and perhaps most important one -- has to do with the administrative efficiency of the single-payer, public insurance model.

While private insurance and multi-payer systems, as in the United States, spend a lot of money on the extensive infrastructure required to deal with multiple

insurance companies, by contrast, a single insurer for the “core services” in Canada is spared most of these administrative outlays.

And the paperwork costs are considerable. Writing in the *New England Journal of Medicine*, Harvard University researchers estimated that total administrative costs per capita in the US, were well over three times the difference in Canada - US\$1,059 per capita, in the United States, compared to US\$307, per capita, in Canada in 1999.<sup>10</sup>

As many of you will know, until the introduction of Medicare in Canada, health spending as a percentage of GDP in the two countries grew in lock-step throughout the 50's and 60's.<sup>11</sup>

But, after Medicare, health spending here began to grow at a very different pace.

Today, health spending in Canada amounts to under 10% of our GDP, while in the United States, it amounts to over 15% of GDP, and rising.<sup>12</sup>

And on top of all of this, the latest 2006 U.S. census shows that nearly one in six Americans, or 15.9% of the country, were uninsured for some or part of the census year.<sup>13</sup>

And that half of the 1.5 million of American families who filed for bankruptcy in 2001—many of whom, by the way, had private insurance that just ran out or was inadequate—cited medical causes as the reason for filing bankruptcy.<sup>14</sup>

In contrast, according to a study of the OECD last year, the Canadian system contributes to health outcomes that are, on the whole, more often than not, better than those produced by the United States, and in fact, much of the rest of the world.<sup>15</sup>

And let's not forget that Canada's publicly-funded health system also provides significant economic advantages thanks to reduced health costs to Canadian employers. For example, the auto industry, a sector that generates billions of dollars for the Canadian economy, holds an advantage that amounts to about \$4.00 per hour per worker compared to the US.<sup>16</sup>

So, friends, instead of viewing public spending in health innovation and reform as unsustainable and as a burden, let's acknowledge that it is both sustainable and crucial to our nation's social and economic wellbeing. It is a re-enforcement of our values. And I repeat, an investment in the future of a stronger Canada.

## **THE ROYAL COMMISSION'S SOLUTIONS FOR REFORM**

So, there is much at stake in this debate. The good news is that the solutions are at hand, ready to be seized by our policy makers, just as soon as they can gather the political will to act.

Today, I will not walk you through the 47 recommendations that emerged from my work with the Royal Commission on the Future of Health Care. Allow me simply to outline five enduring lessons that I believe remain central to the Canadian debate about health care reform.

### ***1. The universal single-payer advantage***

My first point is to reinforce the advantages of a universal single-payer system for all the reasons that I advanced.

Our task is clear, if not without difficulties. Namely, we must bring aspects of homecare, access to advanced diagnostic services and catastrophic drug coverage—the areas of fastest rising costs—within the single-payer system.

Let me illustrate using pharmaceuticals. Since 1990, the cost of prescription drugs as a percentage of total health expenditures has increased to 14.6% from 8%. Canada's private spending on prescription drugs now outpaces that of most other OECD countries.<sup>17</sup>

So we must lay the groundwork now for including these and other elements under the umbrella of public funding, or will continue to escalate without restraint and relentlessly abandon those in need.

### ***2. Keeping the focus on total costs***

This brings me to my second point. Our concern here should be to control *total* health care costs and to avoid shuffling expenditures between the public and private sectors of the health care system.

Until the mid-90s, some provincial governments, including my own in Saskatchewan, were successful in restraining the growth of public health care costs. We rationalized our services and improved efficiencies, while trying to preserve access to quality services. Our fiscal position obligated us to do this.

It turned out, however, that we pushed some of these costs out of our own provincial budgets, and onto the personal budgets of the residents. It was, in other words, a *false economy*.

Because, in the end, the total bill for health care is paid by all citizens, whether through their taxes, their premiums on insurance policies, or out of their own pockets, through direct payment.

### **3. Tackling wait times**

My third point is that we must do everything possible to improve timely access to quality services within the public system. Although we have focused too much on this to the detriment of other areas of concern, still, wait times represent one of the significant proxies of public trust in Medicare. And while the vast majority of Canadians are happy with the service they receive, there continues to be a significant proportion who feel they have wait too long.<sup>18</sup>

Improving timely access to care will require, above all, a more integrated approach to health care delivery, as opposed to attempts to target only selected categories.

### **4. Addressing the determinants of health**

Fourth, we have to pay more attention to prevention.

There are several important pathways to achieving a healthier nation. A quality health care system is certainly part of the answer. But as we have heard, equally important in achieving this goal is attention to prevention and to the so-called “determinants for a healthier population” – from income status, to education, early learning and childcare and housing, the state of the environment and, yes, the quality and accessibility of our health care system.

I’ve been working with a group of exceptionally dedicated and talented national and international experts on the important task of creating a Canadian Index of Wellbeing, the CIW. It’s our hope that the CIW will be accepted as a credible barometer on the social, health and environmental conditions that shape our communities. What we measure is what counts. It determines what makes it onto the front pages of newspapers and front desks of decision makers.

Right now, we tend to measure our wellbeing primarily through a narrow set of economic indicators, like the GDP.

Imagine, however, if every time we heard about the GDP, we also heard the results of the Canadian Index of Wellbeing. Perhaps it would help us integrate this information into the economic decisions.

My hope is the CIW will raise our overall understanding of the importance of a holistic response to health. It is a bold vision, and a first step will be the launch of the CIW in October of this year – look out for it.

### **5. *Transformative change***

Which brings me to my final point, namely, that governments must show the will and leadership to achieve what I call *transformative change*.

They must do so based on our values, and they must respond to the public will. Perhaps our conference today will move us closer to making meaningful change.

### **SINCE THE COMMISSION – HOW ARE WE DOING?**

Some of you may be asking yourselves, what has transpired since the release of the final report of the Royal Commission.<sup>19</sup>

The short answer is that while we are making some slow progress in some areas, Canada still has a long way to go. There are some positive developments that we should acknowledge and build on.

For instance, we now have a Health Council of Canada to monitor and publicly report upon our successes and failures, even though Alberta and Quebec have not agreed to participate.

Primary health care reform is slowly taking shape and some positive work can be highlighted. Information technology and telehealth are being developed.

Wait times are being addressed, as difficult as this is proving to be.

Hospital and other health services are being reorganized, in order to become more responsive to patient's needs.

We are slowly—perhaps too slowly--breaking down the silos within our health care system.

And, the so-called “Health Care Deal for a Generation,” infused \$41.3 billion over 10 years for action in areas of shared priority. This was a major recommendation of the Royal Commission. It restores financial cutbacks to the provinces by Ottawa. Sufficiency of public funds should no longer be an obstacle for our provinces to implement the reforms... especially if they are encouraged by Ottawa.

### **PRIVATIZATION – DEBATE RE-IGNITED?**

Yet, we know that there continues to be a hard hitting debate about the appropriate balance between public and private funding and delivery.

In fact, the most recent development of note was the Supreme Court’s decision in the *Chaoulli* case. There, four of the seven presiding Supreme Court justices ruled in favour of Dr. Chaoulli and his client/patient, Mr. Zeolitis, declaring that the Quebec government’s ban on private health insurance was in violation of the Quebec Charter of Rights and Freedoms and, by direct implication, the constitutionally entrenched Canadian Charter of Rights and Freedoms.<sup>20</sup>

I shall not delve here into the complex legal issues raised by this controversial decision, except to say that many observers argue that the Supreme Court has made a major and unfortunate intrusion into the development of Canada’s social policy.<sup>21</sup> The majority seemingly relied on the evidence and arguments provided by some members of the Senate of Canada, the Canadian Medical Association, and individual physicians who long ago chose to practice private for-profit care outside the medicare system.

It is notable however, that all these interveners steered clear of the American experience in their arguments and pointed instead to Europe and a so-called “blended” system of public and private care.

But what of the European Model?

Testifying at the trial level of this particular case, noted Yale health economist Ted Marmor described the European model as follows:

“... the experience of private supplementary insurance in Europe is that parallel financing persistently raises questions of fairness. They are never ending sources of

complaint as illustrated by the controversies over pay beds in British NHS hospitals, private insurance coverage of co-payments in France, and the exiting from the public insurance “pool” of those in Germany’s top ten percent of income earners.”<sup>22</sup>

This description confirms the overwhelming findings of many other studies, and supports the evidence and conclusions contained in my Royal Commission Report.<sup>23</sup>

In fact, while Canada’s total health care bill remains higher than the OECD average, at 9.9% of GDP, our health care costs are well in line with those of other wealthy nations. Total health spending as a percentage of GDP remains above 9% in Australia, France, Sweden, the Netherlands among others.<sup>24</sup>

Furthermore, if we accept the argument that the best road to sustainability is to contain the spiraling costs of pharmacare and home care by bringing them into the public system, then Canada still has plenty of room to maneuver. Canada, at 70% public funding, falls below the OECD average of when it comes to health spending financed by public dollars as a share of the total pie.<sup>25</sup> This share is more than three quarters in France and Germany, and well above 80% in the UK and Sweden.

This evidence, however, was ignored by the majority of the Supreme Court, which appears to have given undue weight to those who clamour for privatization, for the markets to rule, for more private delivery, for more private payment, for more private choice.

Thus the case of *Chaoulli v Quebec* has re-energized a powerful group of Canadians.

Citing the *Chaoulli* decision and other authorities, this market-based vision for health care is being portrayed as something new, as “out of the box,” innovative thinking. But just how “new” is this particular approach?

Let me read you a quote, and then pose a question. The quote reads: "What is meant by 'universal' is that the plan arbitrarily includes everybody, whether they need the benefits and whether they wish to be included or not. It is a compulsory program in which participation is compelled by the state and not left to the voluntary choice of the citizen himself ... This violates a fundamental principle of free society, namely, the right of each citizen to exercise freedom of choice."

Do you know who said that and when? It was former Alberta Premier Ernest Manning in 1965!

Suddenly, the “old” has once again become “the new”. Suddenly, we witness decisions driven by ideology masquerading as evidence.

Well... just ask the parents or guardians of the millions of American children who are not covered by health insurance if they are enjoying their exercise of freedom of choice!

Friends, we are indeed, yet again, at a crossroads. And that’s why this conference is so important.

### **RETURNING TO “SHARED DESTINY”**

Monique Begin, author of the Canada Health Act, reminds us that the true guardians of Medicare—this most cherished expression of what it means to be Canadians—are the people of Canada.

She is right. Today, the overwhelming majority of Canadians continue to support the universal, single-payer, approach to public health care.<sup>26</sup> Few buy the argument that things will improve if we move to a categorical, multi-payer system.

Deep down, Canadians know that choice in such a system would be based on ability to pay.

Friends, there are two fundamentally competing visions and guiding values about healthcare. Each would take our nation down two fundamentally different paths.

As we’ve seen, one view, high on rhetoric but low on evidence and masquerading as something new, is based on the premise that healthcare is a commodity. That medical needs ebb and flow with markets, and they determine who gets care, when and how.

The other vision, rooted in our narrative as a nation, backed by evidence and public opinion, strongly believes that healthcare is a “public good”.

It believes that democratically elected governments, as representatives of the public, not corporate bottom lines, should define common needs, provide equitable services, and reasonable allocation of resources.

Fairness, equity, compassion and solidarity. These are the values that were spawned throughout Canada's history of shared destiny.

These values gain their expression in our core belief that everyone should have access to our health care system on the same terms and conditions, and that this access is ultimately a right of Canadian citizenship.

These values are manifested through our view that Medicare is a truly national program—a nation-defining and nation-building enterprise.

Ultimately, the success of medicare reforms will be determined by whether we recognize the central importance of values in this debate.

I was a premier once. I know the pressures that mitigate against taking the longer view of things and of reaching beyond one's particular place at a particular point in time. It's not easy and, among other things, it does indeed require leadership that is committed and responsive to a progressive society.

But... now, more than ever, is the time to recapture the moral and political strength to see ourselves in our own place, in our own time, informed by our own values, and within our own actual narrative, as an independent nation, worthy of the respect of a world that needs an even better Canada.

In doing so, we shall once again put our nation's policies on track and resume the task of building an even greater Canada.

I thank you for your time and look forward to the panel's discussion.

- <sup>1</sup> Roy J. Romanow. 2006. "A House Half Built" in *The Walrus*. Available from: [http://www.atkinsonfoundation.ca/files/Walrus\\_RJR\\_pack\\_light.pdf](http://www.atkinsonfoundation.ca/files/Walrus_RJR_pack_light.pdf)
- <sup>2</sup> Attorney General of Saskatchewan. 1998. Cited in Supreme Court of Canada's *Reference re Secession of Quebec*, [1998] 2 S.C.R. 217. Available from: <http://csc.lexum.umontreal.ca/en/1998/1998rcs2-217/1998rcs2-217.html>
- <sup>3</sup> Government of Canada. *Canada Health Act* [R.S. c-6 1985].
- <sup>4</sup> Canadian Institute of Health Information. 2006. *Health Care in Canada 2006*.
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- <sup>6</sup> Harriet Jackson and Alison McDermott. 2004. *Health Care Spending: Prospect and Retrospect, Analytical Note*, Economic and Fiscal Policy Branch, Department of Finance.
- <sup>7</sup> Landon, S., M.L. McMillan, V. Muralidharan and M. Parsons (2006), *Does Health Care Spending Crowd Out Other Provincial Government Expenditures?*, Canadian Public Policy 32:2, 121-42.
- <sup>8</sup> Canadian Institute of Health Information, 2006.
- <sup>9</sup> Cited in Canadian Health Care Association. 2006. *A Strong Publicly-Funded Health System: Keeping Canadians Healthy and Securing Our Place in a Competitive World*. October.
- <sup>10</sup> Woolhandler S., Campbell T., and Himmelstein D. 2003. "Costs of Health Care Administration in the United States and Canada," in *New England Journal of Medicine* 349, no. 8, pp. 768-775.
- <sup>11</sup> Organisation for Economic Co-operation and Development. 2006. *A Comparative Analysis of 30 Countries*.
- <sup>12</sup> Some estimates project that U.S. health care spending will increase to 20 percent of GDP in the next decade, see Borger, C., et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs Web Exclusive* W61: 22 February 2006. For Canada and U.S. health spending figures see, Organisation for Economic Co-operation and Development. 2006. *OECD Health Data 2006: Statistics and Indicators for 30 Countries*.
- <sup>13</sup> U.S. Census Bureau. 2006. *United States Census 2000*.
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- <sup>15</sup> Organisation for Economic Co-operation and Development, 2006.
- <sup>16</sup> Canadian Healthcare Association, 2006.
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- <sup>18</sup> Statistics Canada. 2005. *Access to Health Care Services in Canada: January to December 2005*.
- <sup>19</sup> For an excellent analysis of contemporary debates about health care in Canada, see Marchildon, G. March 2006. *Health Care in Canada and the United States: Consumer Good, Social Service or Right of Citizenship*. Presented during the Roatch Global Lecture Series on Social Policy and Practice. Arizona State University. Available from: <http://www.asu.edu/xed/roatch/index.html>
- <sup>20</sup> *Chaoulli v. Quebec* (Attorney General). [2005] SCC 35 (June, 2005).
- <sup>21</sup> For a more in-depth discussion on the Chaoulli case, see Colleen M.Flood, Lorne Sossin, and Kent Roach, eds. 2005. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada*. University of Toronto Press & Marmor, Ted. September 2005. "An American in Canada: Making Sense of the Supreme Court Decision on Health Care," in *Policy Options*. Montreal: Institute for Research in Public Policy. Pp.42.
- <sup>22</sup> Marmor, Theodore. 2006. "Canada's Supreme Court and its National Health Insurance Program: Evaluating the Landmark Chaoulli Decision from an Imperative Perspective," "in *Osgoode Hall Law Journal*, Vol.. 44.
- <sup>23</sup> Romanow, 2002.
- <sup>24</sup> OECD, 2006.
- <sup>25</sup> The 44% U.S. figure excludes the value of tax breaks that are provided to offset the costs of purchasing private health insurance (see footnote 12 for more information).
- <sup>26</sup> See, for example, Commission on the Future of Health Care in Canada. June 2002. *Report on Citizens' Dialogue On the Future of Health Care in Canada*.