CANADIAN Index OF WELLBEING

Measuring what matters

Canada's Shared Destiny and the Future of Medicare

Speaking notes for

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1. INTRODUCTION

I am honoured to speak with you here at the University of Calgary, and would like to thank in particular the Graduate Students from the Department of Community Health Sciences for their kind invitation.

The Department is housed within the University's Faculty of Medicine, one of the youngest Medical schools in Canada, yet one which has quickly achieved the status of international leader in health research, education and delivery.

I am especially pleased to be here because I know that there are many physicians and scientists-in-training among us who will soon lead the next generation of health practitioners.

Throughout your careers you will undoubtedly touch on and improve the lives of many individuals and communities. Yours is a laudable path.

As you travel along this path, you will also be called upon to think about the big picture and the role that you and your profession must play in helping to define what the future of health care will look like.

Because health care is a work continuously in progress. Yes we have much to celebrate in the great triumph of a single-payer system, publicly-funded system. But it is also true that the system as we know it today is by no means a done deal.

In fact, looking at the state of the contemporary debate, what is clear is that there are two visions, two fundamentally competing visions, that seek to shape the next stage of health care.

One view, based on the premise that healthcare is a commodity, believes that markets should determine who gets care, when and how.

The other vision—and let me be clear from the outset, one that I adhere to--believes that healthcare is a "public good", grounded on the Canadian values of fairness, equity, compassion and solidarity.

2. CANADA'S SHARED DESTINY

So today, I want to focus on this current environment for Canada's health care debate. I will examine the challenges and opportunities for fundamental reform so that we can move beyond rhetoric to secure what is--arguably--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 and future 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 fundamental question, namely, what are the values that underpin our society and how can we make decisions and follow through with actions to build a more progressive and united nation.

In confronting these important questions, we should never act as if we are starting from scratch. In fact, the exact opposite is true.
Every nation has a narrative.

Canada's history offers a strong and rich legacy of success that has forged our nation. It is this legacy of a "shared destiny" that is key to understanding our young but dynamic history. And it is this same legacy of "shared destiny" that remains the roadmap to our future, at home, and abroad.[i]

For those like me—and probably many of you--who came of age in our Prairie communities, or know our history, the notion of "shared destiny" was key to our existence. The harsh, often snow-blown conditions, droughts, distance and isolation, and small population, forced us together, like poplar trees huddled on a windswept plain.

And so it is with other regions in Canada, where the geography and demographics may vary, but where 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.

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, best 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…."[ii]

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 this narrative. Today, we feel 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.

Medicare, which is the product of this history, is also now caught up in this so-called "new thinking".

And just like with today's other major issues, how we choose to inform our way forward, and the set of values that we draw upon to shape our progress, will ultimately 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 may determine the future progress of our nation.

3. CANADA'S MEDICARE SYSTEM – SEPARATING FACTS FROM MYTHS

So, keeping this view of 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 1984 federal law called the *Canada Health Act (CHA)*[iii] which outlines the five pillars of Canada's Medicare that I mentioned earlier: 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 increasingly exercises its new grants of autonomy to shape its health care system as 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—*some provinces like this one in fact*--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 as some claim, or a state of "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. 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 add up to about 43 cents on every health care dollar spent in Canada. Essentially, this is the single-payer system, publicly financed through progressive taxation, and which is at the heart of Medicare.[iv]

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.

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 this care at all.[v]

Let's pause and recap: only 43% health of total care expenditures in Canada are solely 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.

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

4. CANADA'S MEDICARE SYSTEM AND SUSTAINABILITY

There is yet another myth that needs to be addressed. It tries to speak to the fact of the rise in total health spending in Canada and says that public health care costs are spiraling out of control. That increases in spending, the myth says, are "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 recently that we should not be surprised if more Canadians believe it to be true.

Once again, however, the facts 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."[vi]

That's Ottawa's Department of Finance examining costs prospectively.

Another study in *Canadian Public Policy*, examined this issues from a retrospective view, namely, what actual expenditures on Medicare were over a given period, in contrast to Ottawa's prospective analysis.

This study looked at provincial 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."[vii]

Add other research and 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 th*e least.*[viii]

Over the past five years, research has consistently demonstrated that it is in the privately-funded sector that growth rates have been climbing much higher and faster than in the public sector, averaging 6% rise in the private sector as compared to 4.5% on the public side.[ix]

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.

But it also 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 - $1,059 (U.S.) per capita, in the United States, compared to $307 (U.S.), per capita, in Canada in 1999.[x]

As many of you will know, until the introduction of Medicare in Canada, health spending as a percentage of GDP in our two countries, grew in lock-step throughout the 50's and 60's.[xi]

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

Today, health spending in Canada amounts to about 10% of our GDP, while in the United States, it amounts to over 15% of GDP, and rising.[xii]

Yet for all of this spending, 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.[xiii]

There's a price to be paid for this state of affairs.

A recent study by the Commonwealth Fund ranking the health of 19 industrialized countries measured "amenable mortality," using the WHO's data on deaths from conditions considered amenable to health care such a treatable cancers, diabetes, and cardiovascular disease.

For the year 2002-03, measuring mortality amenable to health care, the Fund concluded that the United States system resulted in the highest number of deaths per one hundred thousand population of all the countries measured.

The report concluded that:
It is difficult to disregard the observation that the slow decline in U.S. amenable mortality has coincided with an increase in the uninsured population.

In the same study - Canada with its single-payer health care system -- stands in the top echelon in terms of effectively dealing with preventable deaths, ranking in 6th place among industrialized nations.

In fact, according to another study by the OECD published last year, the Canadian system contributes to overall 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.[xiv]

But the payoff of Canada's system is not just felt in better population health outcomes.

Take the economic impact. Canada's health system 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 at least $4.00 per hour, per worker, compared to the U.S.[xv]

The flipside of the economic argument is 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—did it for medical reasons.[xvi]

So it is little wonder that health care reform has become one of the key driving themes in the American election. In the unfolding presidential debate, health care has come to embody our southern neighbours' appetite for change.

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

5. LESSONS LEARNED FROM THE ROMANOW ROYAL COMMISSION

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 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, entitled "Building on Values."

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 reinforce the advantages of a universal single-payer system.

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 the example of 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.[xvii]

We must lay the groundwork now for including catastrophic drug costs, at least, and the other new elements of health care under the umbrella of public funding.

Otherwise, costs will continue to escalate--without restraint and with relentless abandonment of 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.

We also believed that we were introducing preventative policies to improve wellbeing--the so-called "social determinants of health"—into the system. In this respect, we had some successes.

But, 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

Which brings me to my third point: wait times. We must improve timely access to quality services.

While the vast majority of Canadians who have used the system find it highly satisfactory, there continues to be a significant proportion who feel they are waiting an unacceptably long time for care.[xviii] Complaints about access to some types of surgery, specialists or advanced diagnostic tests have become commonplace and have lately occupied a disproportionately high emphasis of political and media attention.[xix]

Moreover, our policy responses, concentrating on only five areas of care, seem misplaced. They are incomplete and reverberate negatively on other needs. We need a more comprehensive strategy.

For example, improving timely access to care requires investments in advanced diagnostic services and efficient information systems. It also means increasing the supply of skilled health care providers to alleviate unnecessary blockages and providing the impetus for a more integrated approach to health care delivery, which remains one of our biggest impediments to reform. And let's always remember that wait times essentially fall within the domain of the doctor and the patient, varying from case to case, thus making the objective of a "one size fits all" answer to wait times extremely problematic.

We arrived at this predicament as the result of a decade of cutbacks to teaching institutions and the healthcare system. We will not get out of it overnight through "quick fix" solutions.

4. Addressing the determinants of health

Fourth, we have to pay more attention to prevention and the social determinants, a message which I am sure will resonate especially with my hosts at the Community Health Sciences Program.

They understand that there are several important pathways to achieving a healthier nation. A quality health care system is certainly part of the answer. But 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.

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.

After all, what we measure and how we measure it is what counts. It determines what makes it onto the front pages of newspapers and the 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 important social issues into economic decisions.

My hope is the CIW will raise our overall understanding of the importance of a holistic response to health. Look for exciting developments later in 2008.

5. Transformative change

Which brings me to my final lesson, namely, that governments must show the will and leadership to achieve what is truly *transformative change*.

How so? Modernizing and transforming the health care system involves the evolution of primary care – people's first point of contact with the health care system. We must tackle the continuing "silos" mentality, which separates general practitioners from other professionals, and a broad range of frontline illness, wellness, and diagnostic health services essential to preventing or mitigating downstream acute and institutional care.

Simply stated, we need to break down traditional barriers among health care providers and reform the local delivery of health care through more efficient and effective integration.

6. SINCE THE COMMISSION – HOW ARE WE DOING?

With these key lessons in mind, what has transpired in the past five years since the release of the final report of the Royal Commission?[xx]

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 upon.

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 2004 "Health Care Deal for a Generation," infused $41.3 billion over 10 years for action in areas of shared priority. This funding increase was a major recommendation of the Royal Commission. The 2004 Accord on health 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 strongly encouraged by Ottawa.

Still, there has been no action on aboriginal health—a national disgrace.

No action on a national catastrophic drug plan.

The entrenchment of asymmetrical arrangements that weaken the implementation of health care reforms and our national unity.

No further protection against encroachments by global trading relations.

Little progress on homecare.

In short, so much remains to be done.

7. PRIVATIZATION – DEBATE RE-IGNITED?

As governments look ahead to these challenges, we know that they face 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 which ruled 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 or Rights and Freedoms. [xxi]

I shall not delve here into the complex legal issues raised by this controversial decision by four of the seven presiding judges.

Let me observe simply that many observers argue that the Supreme Court has made a major and unfortunate intrusion into the development of Canada's history of progressive social policy.[xxii]

In the *Chaoulli* decision, the majority chose to ignore the overwhelming research and evidence, reaffirming the effectiveness of a public model of health care and the perils of private health care.

In fact, the majority seemingly relied on the 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.

This is what Professor Ted Marmor, noted Yale health economist and an international expert on comparative health analysis, had to say in his analysis of the Court's decision:

"Whatever one's preference for what the court should have done, it is crucial to concentrate on what it failed to do correctly, as the Court is likely to be taking up cases of this kind in the future. Not only did it reveal massive ignorance of the conventions of comparative scholarship, but the court also appears to have engaged in what some people term "decision-based evidence": the opinion seems to have preceded the analysis. These critical assessments, then, are directed towards cautioning those who might turn to the Chaoulli decision for guidance on what cross-national research on medical care might offer Canadian jurisprudence."[xxiii]

Whether one accepts Professor Marmor's conclusions or not, what is certain is that the case of *Chaoulli v Quebec* has served to re-energize a small but powerful minority of Canadians who are in favour of a private, market-driven system.

Right here In Alberta, a constitutional group has recently launched a similar challenge of that province's legislative ban on buying private health insurance for medically necessary procedures.[xxiv]

A similar privatization push could happen in Ontario as a result of the recently-filed lawsuit by a cancer patient which cites the 2005 Chaoulli decision as precedent.[xxv]

What a future Court will decide is many years down the road. But these lawsuits signify that the debate continues in Canada.

Citing the Chaoulli decision and other authorities, a 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?

Going as far back as the 1960's, we have heard arguments that competition and choice are the keys to a good health system. That Canada's universal health care system violates the principle of free society and the ability of individuals to exercise freedom of choice.

Sound familiar?

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

Friends, we are indeed, yet again, at a crossroads.

Is there a will by our political leaders to dramatically hasten the pace of reform? Will our history provide a direction? Will Canadians be heard?

8. RETURNING TO "SHARED DESTINY

Monique Begin, author of the Canada Health Act, often 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.[xxvi] 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.

Today, two fundamentally competing visions vie to guide the future of healthcare. And by extension, each would take our nation down two fundamentally different paths.

As we've seen, one view, high on rhetoric but low on evidence, is based on the premise that healthcare is a commodity. That medical needs ebb and flow with markets, and that markets should 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".

Balancing needs, services and resources is difficult. But, Canada's approach affirms that democratically elected governments, as public representatives that are accountable to citizens--not corporate bottom lines--should define the correct balance.

And, most importantly, that Medicare's great contribution is its redistributive value.

A value that affirms fairness, equity, compassion and solidarity.

A value that says 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.

A value manifested through our view that Medicare is a truly national program—a nation-defining and nation-building enterprise.

These are the values that underpin Canada's history of shared destiny.

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.

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.

To draw on the vision of past generations and dream no small dreams.

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

Thank you.

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[vi] Harriet Jackson and Alison McDermott. 2004. *Health Care Spending: Prospect and Retrospect, Analytical Note*, Economic and Fiscal Policy Branch, Department of Finance.

[vii] 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.

[viii] Canadian Institute of Health Information, 2006.

[ix] 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.

[x] 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.

[xi] Organisation for Economic Co-operation and Development. 2006. *A Comparative Analysis of 30 Countries.*

[xii] 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.*

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[xv] Canadian Healthcare Association, 2006.

[xvi] Himmelstein, D., *et al.* 2005. "Illness and Injury as Contributors to Bankruptcy," in *Health Affairs.* N. 24(1). February. Pp. 1.

[xvii] Canadian Health Association, 2006.

[xviii] Statistics Canada. 2005. *Access to Health Care Services in Canada: January to December 2005.*

[xix] For more on the wait times debate see Postl, B. June 2006. *Final Report of the Federal Advisor on Wait Times,* and Canadian Institute of Health Information. March 2006. *Waiting for Health Care in Canada: What We Know and What We Don't Know.*

[xx] 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

[xxi] *Chaoulli v. Quebec* (Attorney General). [2005] SCC 35 (June, 2005).

[xxii] 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*

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