

**PUBLICLY-FUNDED HEALTHCARE:
THE KEY TO CANADIAN COMPETITIVENESS, ECONOMIC GROWTH,
AND EQUITY FOR ALL CANADIANS**

**Brief Submitted to the
House of Commons
Standing Committee on Finance**



Canadian Healthcare Association

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EXECUTIVE SUMMARY

The Canadian Healthcare Association* (CHA) wishes to thank members of the Standing Committee on Finance for this opportunity to contribute to deliberations on the next federal budget. Noting the Committee's questions regarding entrepreneurial, human and physical capital, our Pre-Budget Brief shows how a strong, publicly-funded health system enhances Canadian competitiveness and economic growth, while affirming the core Canadian value of access to health services based on health need rather than the ability to pay.

After substantial reductions in public funding for health during the 1990s, with accompanying serious impacts on the health system, the federal government enacted a series of ameliorative measures culminating in the federal investments found within the September 2004 *Ten-Year Plan to Strengthen Health Care* (hereafter referred to as the "Ten-Year Plan"). Although the Ten-Year Plan makes a significant contribution to enhancing Canada's publicly-funded health system, there is still unfinished business and unmet needs in a number of areas, including wait times, home and community care, health human resources, primary health care reform, access to pharmaceuticals, an electronic health record and enhancement of public health. So while it is important to acknowledge that progress has occurred across the country in various ways, CHA believes that more needs to be done.

Our Brief has two main objectives: first, to present a "report card" on progress in key areas together with commentary on unfinished business and a concluding recommendation for each area – all with a view to addressing unmet needs; and second, to present an analysis of additional areas (not included in the Ten-Year Plan) where work is required to ensure progress and preserve/strengthen our publicly-funded health system.

The federal government has stated that "reducing waiting times has become a litmus test of government's commitment to universal, high-quality, publicly-funded health care. And growing concern over waiting times has increased the likelihood of citizens turning away from the public system." CHA and our members share this concern. Nowhere is this possibility more highlighted than in the June 2005 decision of the Supreme Court of Canada allowing private health insurance for acute care services in Quebec.

Evidence does not support private health insurance as a quick fix to the complex and difficult issue of wait times. In fact, private health insurance would likely drive up costs while diminishing our economic competitiveness and growth, lowering the quality of care, lengthening waiting lists and introducing inequities in access to care.

CHA and its members are strong defenders of Canada's publicly-funded health system. We regard private sector involvement in the funding and delivery of health services as neither inherently evil nor a panacea for the challenges facing our health system. CHA's position concerning the appropriate public-private mix in the funding and/or delivery of healthcare is linked to the principle of access to health services based on health need, not ability to pay. This is a core Canadian value and it cannot be jeopardized. CHA is on record as supporting an evidence-based approach as to when, where, and how private funding and/or delivery can occur.

The Supreme Court's ruling on private health insurance has increased debate on the effectiveness of Canada's health system. Some contend that countries with public and private funding and delivery options for acute care services outperform Canada's single payer system. However, an analysis by CHA of recent data from the Organization for Economic Co-operation and Development (OECD) refutes this claim. CHA compared the most recent OECD data (2003) for Canada, the United States, the United Kingdom, Sweden, France and Germany, examining public expenditures alone. As a percentage of Gross Domestic Product (GDP) and on a per capita basis, Canada's publicly-funded health system is less expensive than

that of other countries to which it is compared; whereas those who contend that Canada's health spending is high typically base this claim on total expenditures (public and private combined), which is misleading.

Our publicly-funded health system is respected internationally for ensuring healthy workers, and affording businesses based in Canada a distinct competitive advantage. (For example, General Motors in the USA spends more on health care for its pensioned employees than on steel for its automobiles.) The health sector is also a potential source of wealth creation, exports, and 21st century jobs for Canadians (Toyota's recent decision to invest in a plant in Canada was based in part on our health system that provides the company with a financial advantage over competitors based in countries without a single-payer system, and on our educational systems that provide learned workers). Our single-payer system provides economies of scale that could drive the development of a domestic export industry by building upon our first class health professional training programs, researchers, delivery systems and information technology development. Rather than viewing investments in health innovation and reform as a burden, we should approach them as investments in product development and recognize the health sector as a potential creator of jobs and exports. As a creator of jobs, the health sector impacts positively on the determinants of health as well as the health status of Canadians.

CHA and its members are committed to monitoring the impact of the Ten-Year Plan as it unfolds, both to chart its contribution to sustainability for publicly-funded healthcare and to advocate for improvements to address unmet needs. This is especially important given that public expectations of immediate progress under the Ten-Year Plan do not fit quite often with the reality of the frontline and with the time that it will take to put the necessary infrastructure, mechanisms and providers in place to significantly improve health system challenges. Certainly there are complex issues facing Canada's health system, but there are solutions – though no one magic bullet or panacea. And CHA is committed to working with governments to meet the health needs of Canadians.

**CHA is the federation of provincial and territorial hospital and health organizations across Canada. Through its members, CHA represents a broad continuum of care. Our mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership, and we are committed to realizing the vision of a publicly-funded health system that provides access to a broad range of comparable health services across the country.*

Summary of Recommendations:

1. CHA recommends that the incremental "flow through" of federal funds to the health system be monitored while respecting provincial/territorial jurisdiction regarding the delivery of health services.
2. CHA recommends addressing a variety of issues related to wait times such as the appropriateness of surgical interventions, best practices related to managing demand for services, managing the waiting process through health maintenance and support programs, an integrated approach to waiting lists, and appropriate information and management systems.
3. CHA supports the establishment of pan-Canadian benchmarks or targets based on current best evidence by the December 31st, 2005 deadline as outlined in the Ten-Year Plan, noting that there needs to be a starting point and that the establishment of best evidence will be an ongoing and iterative process. CHA also supports expedited development of pan-Canadian indicators that will measure health system performance regarding access to care. Above all, it is essential to ensure public reporting and transparency regarding wait times. Citizens have the right to review the timelines regarding their access to care and to be assured their needs are being addressed in a timely way.
4. To enhance the efficiency and effectiveness of our health system and implement a pan-Canadian health record system, CHA recommends additional investments of \$6.2 billion over 5 years to Canada Health Infoway in order to accelerate the development and implementation of an electronic health record and to broaden its scope.
5. CHA recommends that a pan-Canadian health human resource framework or strategy be developed collaboratively with representatives from federal, provincial and territorial governments, and employer and employee stakeholders. Without health human resources the system cannot be sustained regardless of funding invested in infrastructure and technologies.
6. CHA recommends as a start a \$1 billion additional investment over 3 years to expand the home care program to include ongoing /chronic care services linked to pan-Canadian objectives for home and community care while respecting provincial/territorial jurisdiction regarding the delivery of care. In the past, CHA has also signaled the importance of addressing facility-based long term care on a pan-Canadian basis which remains another area of unfinished business and will, in the future, require additional investments to assure access and quality.
7. CHA notes the importance of meeting the targets originally set out in the 2003 Health Accord regarding Primary Health Care Reform.
8. CHA notes the importance of moving ahead expeditiously on the pharmacare strategy and programs with pan-Canadian objectives to address gaps in access, lack of equity and undue financial burden. CHA has also advocated for a commitment to develop and support the optimal use of pharmaceuticals.
9. CHA supports efforts to ensure adequate health system capacity and response to public health emergencies and infectious disease outbreaks.
10. CHA has advocated for enhanced resources targeted to wellness initiatives and is committed to health promotion programs and healthy lifestyle initiatives, as well as investments in the determinants of health. Appropriate chronic disease management programs are also an essential part of this work.
11. CHA advocates for an escalator in the Canada Social Transfer comparable to that in the Canada Health Transfer.
12. CHA supports the principle that the federal role in health is to ensure a broad range of comparable health services for Canadians through appropriate funding, while asserting the Canada Health Act and any other legislative and policy frameworks in place so that pan-Canadian objectives can be achieved.
13. CHA looks forward to efforts to move ahead on the "Blueprint" for Aboriginal health, noting that Aboriginal health issues remain an urgent challenge.
14. To promote the development of capacity for research on a pan-Canadian basis, CHA recommends that the \$500 million Research Hospital Fund under the auspices of the Canada Foundation for Innovation forgo the requirement of 60% funding from other sources. Also, the Fund should remain sufficiently flexible to allow for provincial/territorial priorities as well as federal priorities. In addition, CHA's Brief last year recommended an investment in health research of at least 1% of total health spending. CHA reaffirms this position.
15. CHA recommends clarification concerning which additional health facilities, agencies and services will qualify for the 83% GST rebate, applicable in the past to hospitals only. This is urgently required since

the new provision took effect January 1, 2005. CHA also recommends that the interpretive rules determining which health facilities, agencies and services will now be eligible for the 83% rebate be as inclusive as possible.

16. Given the positive impact of Canada's publicly-funded health system on Canada's economic competitiveness and productivity, CHA recommends that discussion on the public/private mix in the funding and delivery of health services needs to be based on a rigorous assessment of the evidence. CHA's analysis of the evidence demonstrates the efficiency and effectiveness of Canada's health system and points to the negative consequences for the health system and the Canadian economy of quick fix or magic solutions based on an increased role for private insurance.

1.0 INTRODUCTION

The Canadian Healthcare Association (CHA) wishes to thank members of the Standing Committee on Finance for this opportunity to contribute to deliberations on the next federal budget. Noting the Committee's questions regarding entrepreneurial, human and physical capital, our Pre-Budget Brief shows how a strong, publicly-funded health system enhances Canadian competitiveness and economic growth, while affirming the core Canadian value of access to health services based on health need rather than the ability to pay.

CHA is the federation of provincial and territorial hospital and health organizations across Canada. Through our members, CHA represents a broad continuum of care, including acute care, home and community care, long term care, public health, mental health, palliative care, addiction services, children, youth, and family services, housing services. These services are provided through regional health authorities, hospitals, and other facilities and agencies that serve all Canadians, and are governed by trustees who act in the public interest.

CHA and our members are committed to realizing the vision of a publicly funded health system that provides access to a broad range of comparable health services across Canada. CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership. CHA's distance learning programs, conferences and publishing services contribute to this national leadership.

2.0 WHERE WE HAVE COME FROM IN HEALTHCARE

To understand recent significant developments in healthcare such as the September 2004 *Ten-Year Plan to Strengthen Health Care* (hereafter referred to as the Ten-Year Plan) and the June 2005 Supreme Court decision concerning private health insurance, we must consider the impacts of public funding restraint in the 1990s on our health system.

2.1 The Consequences of Restraint, 1993-96

From 1993-96, in their response to deficits, most governments within Canada imposed serious restraint on public sector health expenditures. As a result, total health expenditures (public and private combined) shrank despite considerable increases in private sector expenditures.¹ At the federal level, the implementation of the Canada Health and Social Transfer (CHST) in 1996 saw the reduction of federal transfers for health shrink by \$2.5 billion in 1996-97 and \$4.5 billion in 1997-98.²

In June 1998, CHA expressed serious concern regarding the impact of these cuts in an open letter to the Prime Minister. CHA Past-chair John Baker remarked upon the release of the letter:

These effects are very serious. Public confidence in the healthcare system has plummeted over the past decade. People are concerned they will not have access to the services they need. Privatization of the healthcare system is reaching a level which will affect access to needed health services as people and employers absorb more healthcare costs previously paid for by governments. And frustration amongst healthcare providers trying to cope with constant change has reached critical levels.³

2.2 Ameliorative Measures, 1997-2004

From 1997-2003, the federal government enacted a number of measures to address these impacts:

- Fixing the cash floor of the CHST at \$12.5 billion in 1997. The establishment of a cash floor staved off the erosion of the federal cash transfer to zero which would have meant the end of medicare as a pan-Canadian program.⁴
- The "healthcare budget" in 1999, which was a step in the right direction, but with insufficient funds to meet the health needs of Canadians or to create a sustainable health system.⁵
- The 2000 federal budget, which contained a \$2.5 billion investment in health to be used over four years. However, since this was not added to the CHST base, it did not enhance sustainability.⁶

- Federal investments under the 2000 and 2003 First Ministers Health Accords. While these agreements made some progress toward sustainability, federal investments continued a pattern of being one-time and backloaded.^{7,8}
- In 2003, following the SARS outbreaks, the federal government established the new Public Health Agency of Canada to address gaps in public health capacity and emergency preparedness.⁹ As well, federal, provincial and territorial Ministers of Health, together with key health stakeholder organizations, established the Canadian Patient Safety Institute- an arms-length agency with an interest in all settings where care is delivered.¹⁰

In September 2004, First Ministers agreed to a Ten-Year Plan for Canada's health system that commits to significant progress in key areas.¹¹ However, there remains unfinished business concerning healthcare. The following is a "report card" of progress, with comments regarding unfinished business, followed by recommendations.

- **Funding:**

- *Progress:* The Ten-Year Plan adds substantial federal dollars to the new Canada Health Transfer base that are commensurate with the \$3 billion per year that CHA had recommended. There is also an explicit 6% annual escalator to reflect increases in inflation and health system cost drivers. These funds are ongoing (except \$0.5B in 2004-05 for medical equipment), thus answering CHA's call for predictable and long-term funding with an escalator. CHA would like to remind everyone that all parts of the continuum of care need appropriate funding and Canadians deserve access to comparable health services across a broad continuum. While hospitals need appropriate funding to help address wait times issues and meet the needs of acute care patients, part of the solution is to move forward in other areas as well.
- *Unfinished business:* There is no monitoring of the incremental "flow through" of federal funds to the health system. The Ten-Year Plan envisages a future review of outcomes and the measurement of progress at a future date based on agreed-upon comparable indicators. There will be public reporting and a parliamentary review. The Health Council of Canada has indicated that Canadians want to know whether the increased investments in health care are supporting the kind of change governments have agreed to implement.

CHA supports the Council's position, and further recommends that the incremental "flow through" of federal funds to the health system be monitored while respecting provincial/territorial jurisdiction regarding the delivery of health services.

- **Wait Times:**

- *Progress:* To reduce waiting times, the federal government will invest \$4.5 billion over six years (\$5.5 billion over ten years) through the Wait Times Reduction Fund (WTRF). First Ministers committed to establishing pan-Canadian benchmarks or targets for wait times by December 31st, 2005 and in achieving meaningful wait time reductions in cancer, heart, diagnostic imaging, joint replacement and sight restoration by March 31, 2007. While the 2004 agreement identified these initial areas of focus, CHA's assumption is that the "hot spots" are a beginning and not an end.
- *Unfinished business:* CHA sees the wait times issue in the broader context of a complex health system with multiple issues to be addressed. A focus on quantity is important but so are quality and appropriateness of care. Addressing wait times means addressing the critical issue of appropriateness of care and distinguishing between need and demand. A recent Health Council of Canada paper notes that in Vancouver, "a significant percentage of patients scheduled for cataract surgery scored high on visual acuity *before* their surgery. This suggested that the threshold indications for cataract surgery were very low."¹²

CHA recommends addressing a variety of issues related to wait times such as the appropriateness of surgical interventions, best practices related to managing demand for services, managing the waiting process through health maintenance and support programs, an integrated approach to waiting lists, and appropriate information and management systems.

CHA supports the establishment of pan-Canadian benchmarks or targets based on current best evidence by the December 31st, 2005 deadline as outlined in the Ten-Year Plan, noting that there needs to be a starting point and that the establishment of best evidence will be an ongoing and iterative process. CHA also supports expedited development of pan-Canadian indicators that will measure health system performance regarding access to care. Above all, it is essential to ensure public reporting and transparency regarding wait times. Citizens have the right to review the timelines regarding their access to care and to be assured their needs are being addressed in a timely way.

- Electronic Health Record

- *Progress:* An electronic health record (EHR) is pivotal to moving forward on many of the health renewal priorities established by First Ministers. Issues and challenges related to access to care, quality of services and efficiency and effectiveness of the health system are all linked to an accelerated implementation of an inter-operable, pan-Canadian electronic health record. First Ministers have agreed to accelerate the development and implementation of the EHR and everyone realizes the importance of the EHR in addressing major challenges such as wait times, enhancing patient safety, and increasing efficiency through the reduction of duplicate tests, information transfer and increased information sharing. Canada Health Infoway (CHI) is poised to facilitate and enable all jurisdictions to move an EHR agenda forward together, based on a common accepted blueprint for a pan-Canadian architecture for one EHR that has been accepted by all jurisdictions. And there is the potential for integration of local, regional and jurisdictional based systems. CHI's original investment plan was intended to meet the goal of 50% of the Canadian population being able to access electronic health records by 2009. CHI started with \$1.2 billion and has invested or committed itself to \$1.064 billion as of March 31, 2006. Also, it is facing a shortfall of \$600 million as a result of its decision to supply funding to jurisdictions on a 75:25 basis as opposed to the earlier 50:50 basis, due to the inability of jurisdictions to take up the money at the lower level of support.
- *Unfinished business:* There is a need to continue to accelerate the pace of integrating information and communication systems. 50% access by 2009 is not good enough. Electronic health records will improve access, quality of care and productivity, and while studies have identified substantial savings to be generated by the introduction of appropriate information and communication technologies (ICT), some provinces have only just begun the transformation process. If we are serious about the EHR initiative then additional investments must be made over the next several years. There are investment funding gaps as follows: \$600 million is required to complete the current scope of work at 75:25 funding, \$1.2 billion is required to expand the current scope to include 100% of Canadians in all jurisdictions, and \$4.4 billion is required to expand the scope to 100% of Canadians in all care settings, in all jurisdictions and to automate physicians' offices.

To enhance the efficiency and effectiveness of our health system and implement a pan-Canadian health record system, CHA recommends additional investments of \$6.2 billion over 5 years to CHI in order to accelerate the development and implementation of an electronic health record and to broaden its scope.

- Health Human Resources:

- *Progress:* While there is new funding and a commitment to develop a standardized approach to establish clinically appropriate waiting times, the shortage of health human resources remains a serious problem. The First Ministers agreed that their governments will increase the supply of health professionals based on gap assessments and make their action plans public, including targets for training, recruitment and retention of professionals by December 31, 2006.
- *Unfinished business:* CHA notes that recruitment, retention and other key issues are being recognized and potentially addressed. However, these initiatives need to be coordinated at a pan-Canadian level. **CHA recommends that a pan-Canadian health human resource framework or strategy be developed collaboratively with representatives from federal, provincial and territorial governments, and employer and employee stakeholders. Without health human resources the system cannot be sustained regardless of funding invested in infrastructure and technologies.**

- Home and Community Care:
 - *Progress:* First Ministers agreed to provide first-dollar coverage for certain home care services based on assessed need. The agreement includes acute replacement services, short-term community mental health, and end-of-life care. Health ministers in each jurisdiction are to report on next steps needed to fulfill this commitment by December 31, 2006. (These goals were previously outlined in the 2003 Health Accord.)
 - *Unfinished business:* CHA has long advocated for a home and community care program that provides both acute care replacement services and ongoing continuing/chronic care. CHA has always urged that the Canada Health Act medically necessary services must continue to be publicly funded (single-tier) along with acute care replacement home care services, but has also recognized that there is room for co-payments for some services e.g. home support services for some clients, reasonable accommodation payments for facility-based long term care, and co-payments for pharmaceuticals, provided that this does not reduce access. While there is a commitment in the Ten-Year Plan to provide post-acute home care on a short-term basis, there is no commitment to continuing/chronic care in the community.
CHA recommends as a start a \$1 billion additional investment over 3 years to expand the home care program to include ongoing /chronic care services linked to pan-Canadian objectives for home and community care while respecting provincial/territorial jurisdiction regarding the delivery of care. In the past, CHA has also signaled the importance of addressing facility-based long term care on a pan-Canadian basis which remains another area of unfinished business and will, in the future, require additional investments to assure access and quality.

- Primary Health Care Reform:
 - *Progress:* In order to meet the 2003 Health Accord objective of 50% of Canadians having 24-hour, seven day a week access to multidisciplinary teams by 2011, First Ministers agreed to establish a "best practices network" to share information and find solutions to barriers to primary health care reform, and to report regularly on progress.
 - *Unfinished business:* CHA supports primary health care reform and encourages the identification of "champions" from various organizations and perspectives. CHA also supports training that: fosters team approaches; facilitates communication and community development that engages the public, all health providers and health organizations; and works to ensure client acceptance, satisfaction and confidence.
CHA notes the importance of meeting the targets originally set out in the 2003 Health Accord regarding Primary Health Care Reform.

- Pharmaceuticals:
 - *Progress:* Health Ministers established a Ministerial task force to develop and implement a national pharmaceutical strategy and report on the progress by June 30, 2006.
 - *Unfinished business:* CHA is pleased that catastrophic drug coverage and utilization issues (e.g., costs, appropriate prescribing, etc.) will be discussed as part of the strategy. There is also a commitment to a pan-Canadian process for listing drugs and for assessing the therapeutic benefits and cost-effectiveness of pharmaceuticals.
CHA notes the importance of moving ahead expeditiously on the pharmacare strategy and programs with pan-Canadian objectives to address gaps in access, lack of equity and undue financial burden. CHA has also advocated for a commitment to develop and support the optimal use of pharmaceuticals.

- Prevention, Promotion and Public Health
 - *Progress:* First Ministers committed to collaboration and cooperation in developing coordinated responses to infectious diseases and other public health emergencies through the new Public Health Networks and to accelerate work on a pan-Canadian public health strategy. Governments will set goals and targets for improving the health status of Canadians. The federal government also committed to investments for needed vaccines.

- *Unfinished business:* Recent events in the Gulf Coast area of the USA and the Canadian SARS experience point to the importance of strong public health and treatment systems to minimize the impact of catastrophic events and infectious disease outbreaks on the overall economy and the health of Canadians.

CHA supports efforts to ensure adequate health system capacity and response to public health emergencies and infectious disease outbreaks.

Although chronic diseases are among the most common and costly health problems facing Canadians, they are also among the most preventable. While some risk factors for chronic diseases cannot be changed, many behavioural risk factors can be modified.

CHA has advocated for enhanced resources targeted to wellness initiatives and is committed to health promotion programs and healthy lifestyle initiatives, as well as investments in the determinants of health. Appropriate chronic disease management programs are also an essential part of this work.

Life expectancy and health status depend on more than health system expenditures. Determinants of health such as income status, educational level, housing, social services and healthy lifestyles are all critically important. Since these factors play an important role in ensuring a healthy society, **CHA advocates for an escalator in the Canada Social Transfer comparable to that in the Canada Health Transfer.**

- Accountability and Reporting to Citizens:

- *Progress:* All governments agreed to publicly report on health system performance and to seek advice from experts and health providers on appropriate indicators to measure performance. Governments have begun to report on an annual basis, and the Health Council of Canada has issued its first report as well.

Unfinished business: CHA is pleased with the commitment to develop pan-Canadian indicators and recognizes that public reporting has come a long way. But there is still more work to be done to produce comparable reports to Canadians on health system performance. CHA believes that the federal government cannot write a blank cheque without being assured of achieving pan-Canadian objectives and agreed-upon performance outcomes, while recognizing that the delivery of health services is a provincial/territorial responsibility and some flexibility will be needed to address regional realities.

CHA supports the principle that the federal role in health is to ensure a broad range of comparable health services for Canadians through appropriate funding, while asserting the Canada Health Act and any other legislative and policy frameworks in place, so that pan-Canadian objectives can be achieved.

3.0 ADDITIONAL WORK REQUIRED TO SUPPORT PUBLICLY-FUNDED HEALTHCARE

In addition to the “report card” and recommendations outlined in section 2, CHA notes the following areas where further work is needed to ensure progress and to preserve and strengthen our publicly-funded health system:

- Aboriginal Issues

- The 2004 Ten-Year Plan committed to the collaborative development of an Aboriginal health “Blueprint” to improve the health status of, and health services provided to, Aboriginal peoples.

CHA supports this endeavour and looks forward to efforts to move ahead on the “Blueprint” for Aboriginal health, noting that Aboriginal health issues remain an urgent challenge.

- Research

- **To promote the development of capacity for research on a pan-Canadian basis, CHA recommends that the \$500 million Research Hospital Fund under the auspices of the Canada Foundation for Innovation forgo the requirement of 60% funding from other sources. Also, the Fund should remain sufficiently flexible to allow for provincial/territorial priorities as well as**

federal priorities. In addition, CHA's Brief last year recommended an investment in health research of at least 1% of total health spending. CHA reaffirms this position.

- GST in the health sector

- CHA has long advocated for a single GST rebate rate (83%) for the entire health system and not just hospitals. In the last Budget, there was an announcement to broaden the applicability of the 83% rebate to certain other health services, which CHA and our members acknowledge and appreciate. However, which facilities and services will qualify remains unclear.

CHA recommends clarification concerning which additional health facilities, agencies and services will qualify for the 83% GST rebate, applicable in the past to hospitals only. This is urgently required since the new provision took effect January 1, 2005. CHA also recommends that the interpretive rules determining which health facilities, agencies and services will now be eligible for the 83% rebate be as inclusive as possible.

4.0 THE SUPREME COURT DECISION ON PRIVATE HEALTH INSURANCE

The federal government has stated that "reducing waiting times has become a litmus test of government's commitment to universal, high-quality, publicly funded health care. And growing concern over waiting times has increased the likelihood of citizens turning away from the public system."¹³ CHA and our members share this concern. Nowhere is this possibility more highlighted than in the June 2005 decision by the Supreme Court of Canada allowing private health insurance for acute care services in Quebec.

As Commissioner Romanow noted, "Health care has often been described as the most complex organizational structure in existence."¹⁴ Given this complexity and the evidence concerning the negative effects of allowing private health insurance, the claim by some and endorsed by the majority of justices of the Supreme Court that private health insurance will somehow provide a quick fix to the challenges facing our health system is disconcerting.

In a four to three ruling, the majority justices agreed with Jacques Chaoulli and his patient, George Zeliotis, that delays receiving care within the publicly funded health system deprives patients of personal security or life and therefore the prohibition against private health insurance within Quebec hospital and health insurance laws are inconsistent with the Quebec Charter of Human Rights and Freedoms.

However, while the dissenting justices agreed that wait times could have these effects, they held that the prohibition against private health insurance was justified to protect equity in access:

. . . Quebec wants a health system where access is governed by need rather than wealth or status. Quebec does not want people who are uninsurable to be left behind. To accomplish this objective endorsed by the Canada Health Act, Quebec seeks to discourage the growth of private-sector delivery of "insured" services based on wealth and insurability. We believe the prohibition is rationally connected to Quebec's objective and is not inconsistent with it. (par. 239).

The dissenting justices put a particular emphasis on the validity and weight of the evidence reviewed by the Romanow and Kirby Commissions and other reports concerning the serious effects of allowing private health insurance, including: inequities in access to services based on ability to pay; longer waits and a decline in the quality of services in the public sector; "cream-skimming (siphoning off low acuity patients and avoiding those who pose a higher financial risk to the insurer.) Dissenting judges noted that ". . . There is nothing in the evidence to justify our colleagues' disagreement with her [the trial judge] conclusion that the general availability of [private] health insurance will lead to a significant expansion of the private health sector to the detriment of the public health sector." (par. 168)

CHA and our members are strong defenders of Canada's publicly funded health system. Having said this, we regard private sector involvement in the funding and delivery of health services as neither inherently evil nor a panacea for the challenges facing our health system. CHA's position concerning the appropriate public-private mix in the funding and delivery of healthcare is linked to the principle of access to health services based on

health need, not ability to pay. This is a core Canadian value and it cannot be jeopardized. CHA is on record as supporting an evidence-based approach as to when, where and how private funding and/or delivery can occur.

4.1 Private Health Insurance and Its Impacts

As noted by the dissenting justices, there is considerable compelling evidence indicating that private health insurance will not solve access issues within the public system and in fact has the potential to negatively affect our health system and our economic competitiveness. Consider the following issues and evidence:

- The impact on access and waiting times. According to the OECD, private markets have not solved the challenge of access and private health insurance raises serious concerns regarding equity of access. Where private insurance is allowed, higher-risk individuals often have difficulty obtaining coverage. Even where public coverage is not comprehensive or universal and private insurance has enhanced access "such access is often inequitable because private health insurance is purchased by high-income groups."¹⁵

However, as the OECD also points out, regardless of faster care for those who can afford it, and contrary to claims by advocates for private health insurance that private care supposedly relieves pressure on the public system, "there is no clear evidence that waiting times are also reduced in the public sector, the only choice for those on lower incomes."¹⁶ Indeed, as noted below, patients in countries with parallel private health systems such as Britain, Australia and New Zealand often face waiting times equivalent or longer than Canada's. This is because, as the Canadian Health Services Research Foundation (CHSRF) has observed, "the parallel private theory doesn't quite make sense — more private facilities are not the same as more healthcare providers. The private system doesn't train nurses or doctors; the ones they hire come from the public system. They cannot be in two places at the same time."¹⁷ Furthermore, as Stephen Lewis, Adjunct Professor of Health Policy at the University of Calgary, points out, "There are no surpluses of highly trained health-care workers in Canada. Siphoning off any will reduce public capacity. It takes 10 years to increase the number of specialists. Patients in the public system will therefore wait longer, not less."¹⁸ Indeed, as Colleen Flood, Professor of Law at the University of Toronto and Canada Research Chair in Health Law and Policy has asked, "Sweden, Luxembourg, Greece and Italy prohibit doctors from practicing in both the public and private sectors in an effort to keep most physicians in the public sector. If allowing private insurance doesn't have negative repercussions for the public system, why do these countries take these measures?"¹⁹

As CHSRF reminds us, it is important to remember that Canada, like many countries, "doesn't have standards for defining or measuring waiting times. . . . That's led to a situation where wildly different claims about waiting times are made."²⁰ Noting the complexity associated with issues involving waiting for care²¹, the Health Council of Canada observes that "Wait times are also a normal part of any health care system. No waiting would mean that the system is inefficient [because of excess capacity]. The issue is how to manage wait lists to ensure that patients get care at the right time. . . . Sometimes 'watchful waiting' is the best clinical strategy. *These* waits need to be separated from those that cause harm."²²

- The impact on cost pressures and efficiency. CHSRF reviewed American research concerning that country's Medicare program that shows that "health spending was higher and increased faster in communities served by for-profit hospitals."²³ For-profit hospitals charge in excess of \$600 more for every discharged patient and spent more on administration for each patient day.²⁴ The OECD notes that

private health insurance has added to total health expenditures. Most OECD countries apply less government control over private sector activities and prices, compared to public programmes and providers. Private insurers tend to have less bargaining power over the price and quality of care as compared with public systems, particularly single payer ones. Countries that have multiple sources of primary coverage, including those with significant private health insurance market size, tend to be those with the highest total health spending levels per capita, such as the United States, Switzerland, Germany and France.²⁵

The National Health Service Consultants Association (physicians working within the NHS) knows only too well the cost pressures and inefficiencies associated with two-tiered health systems.²⁶

The New York Times notes:

The great advantage of universal, government-provided health insurance is lower costs. Canada's government-run insurance system has much less bureaucracy and much lower administrative costs than our largely private system . . . single-payer systems don't devote large resources to screening out high-risk clients or charging them higher fees. *The savings from a single-payer system would probably exceed \$200 billion per year, far more than the cost of covering all of those now uninsured.*²⁷
[Emphasis added.]

- The impact on quality of care. Private for-profit care fares no better when it comes to the quality of care. Indeed, research shows that outcomes in American private for-profit facilities are worse than non-profit facilities and these facilities do less preventive services, e.g., mammography and immunization. For example, dialysis patients receiving treatment in for-profit facilities are "significantly more likely to die than those treated in non-profit ones . . . this means that as many as 2,500 premature deaths every year may be due to being treated at for-profit centres. As well, people treated at for-profit clinics are less likely to be referenced for kidney transplants."²⁸

The prospect of for-profit clinics "cream-skimming" the most profitable and low-risk cases, thus leaving higher-risk and more expensive cases to the public system has raised serious concern about quality of care in for-profit clinics by NHS physicians in the UK given that these clinics take

the simple cases and have little responsibility for complications or follow-up. Their clinical governance arrangements are unclear and there are already concerns about the quality of care in ISTCs [independent sector treatment centres]. The removal of much elective surgery from the NHS is putting training in some specialties at risk. Because fewer low-risk cases are being seen in the NHS, young surgeons are no longer getting the training they need . . . the concentration on short-term episodic care is diverting attention and funds from the majority of patients, whose needs are for the longer-term management of chronic disease or disability.²⁹

This is also of concern to the American Hospital Association regarding the growth of physician-owned "limited service" hospitals, i.e., hospitals that specialize in a specific procedure.

Physician-owned specialty hospitals treat the most profitable patients and services, leaving community hospitals to treat a disproportionate share of less profitable cases . . . physician self-referral raises serious concerns about conflict of interest, patient selection, quality oversight, and community access to vital services such as trauma and burn care . . . [it] creates a set of incentives that are not in the interests of the patients and community as a whole.³⁰

- The impact on competitiveness and economic benefits. It has long been known that Canada's publicly funded health system provides a significant competitive advantage to Canadian business due to reduced health benefit costs for Canadian business. For the auto industry, a sector which generates billions of dollars for the Canadian economy, this advantage amounts to about \$4.00 per hour per worker. For General Motors, the cost of providing medical and drug coverage to its American employees amounts to approximately \$1,500 per vehicle. In contrast, benefit costs for Toyota, its largest foreign competitor, are less than \$300 per year. General Motors costs for providing health benefits for its 1.1 million American employees are approaching \$6 billion. This situation is not exclusive to General Motors, which the company's Chairman and CEO characterizes as a "crisis" that undermines the competitiveness of U.S. companies. As a result, the company is in difficult negotiations with its unions concerning benefit plans. Some analysts have stated that GM and other U.S. businesses may have to file for bankruptcy protection.³¹

In May, Standard and Poor's cut the bond ratings of General Motors and Ford to "junk", or below investment grade.³²

Our publicly funded health system is respected internationally for ensuring healthy workers, and affording businesses based in Canada a distinct competitive advantage. (For example, General Motors in the USA spends more on health care for its pensioned employees than on steel for its automobiles.) The health sector is also a potential source of wealth creation, exports, and 21st century jobs for Canadians (Toyota's recent decision to invest in a plant in Canada was based in part on our health system which provides the company with a financial advantage over competitors based in countries without a single-payer system and our educational systems which provide learned workers).

Our single payer system provides economies of scale that could drive the development of a domestic export industry, by building upon our first class health professional training programs, researchers, delivery systems, and information technology development. Rather than considering investments in health innovation and reform a burden, we should approach them as investments in product development and we should recognize the health sector as a potential creator of jobs and exports. As a creator of jobs, the health sector impacts positively on the determinants of health as well as the health status of Canadians.

The introduction of private health insurance as a supposed quick fix to the complex and difficult issue of wait times is not supported by the evidence. In fact, private health insurance will likely drive up costs, harming our economic competitiveness and growth, degrading the quality of care, lengthening waiting lists and introducing inequities in access to care. In short, the introduction of private health insurance for acute care health services is detrimental to the preservation and enhancement of our publicly funded health system and could negatively impact on Canada's economy.

Given the positive impact of Canada's publicly-funded health system on Canada's economic competitiveness and productivity, CHA recommends that any discussion on the appropriate public/private mix in the funding and delivery of health services needs to be based on a rigorous assessment of the evidence. CHA's analysis of the evidence demonstrates the efficiency and effectiveness of Canada's health system and points to the negative consequences for the health system and the Canadian economy of quick fix or magic solutions, based on an increased role for private insurance.

4.2 The Effectiveness of Canada's Health System: The truth behind the numbers

The Supreme Court's ruling on private health insurance has also increased debate on the effectiveness of Canada's health system. Some contend that countries with public and private funding and delivery options for acute care services outperform Canada's single payer system. However, an analysis by CHA of recent data from the Organization for Economic Co-operation and Development (OECD) refutes this claim.³³ In fact, as a percentage of Gross Domestic Product (GDP) and on a per capita basis, Canada's publicly funded health system is less expensive than that of other countries to which it is compared. CHA reviewed the most recent OECD data (2003) for Canada, the United States, the United Kingdom, Sweden, France and Germany and compared public expenditures alone. Those who contend that Canada's health spending is high typically base this claim on public and private expenditures combined, which is misleading; it is crucial to distinguish between public expenditures and total (public and private combined) expenditures.

- **Total Health Expenditures:** In terms of both public and private spending for health, as a percentage of GDP, Canada spent 9.9% in 2003. While this is above the OECD average of 8.6%, so are Sweden (9.2%), France (10.1%), Germany (11%) and the U.S. (15%). At 7.7%, only the U.K is below this average, although it has announced substantial increases. One should not be surprised that wealthier industrialized countries spend more on health.

- **Public Spending:** The OECD average for public spending on health is 72% of total spending. Canada (70%) and the U.S. (44%) are below this. In contrast, France (76.3%), Germany (78.2%), the U.K. (83%) and Sweden (85.3%) are above the OECD and Canadian average.

In its analysis, CHA multiplied the OECD figures for total spending as a percentage of the GDP by the OECD percentage of health spending by the public sector. According to this analysis, while at 6.9% Canada is above the OECD average of 6.1% public spending, France (7.7%), Sweden (7.8%) and Germany (8.6%) are all above the OECD average and higher than Canada.

- **Per Capita Spending:** The OECD average in terms of per capita spending (public and private \$U.S.) is \$2,307. Only the U.K. (\$2,231) is below this. Sweden (\$2,594), France (\$2,903), Germany (\$2,996), Canada (\$3,003) and the U.S. (\$5,635) are all above the OECD average.

CHA multiplied these figures by the OECD percentages of government health spending to calculate healthcare spending per capita based on public funds. The OECD average is \$1,661 and Canada's spending is \$2,012. Only the U.K. (\$1,851) is below Canada's level. Sweden (\$2,212), France (\$2,214), Germany (\$2,342) and the U.S. (\$2,479) are all above the OECD average and the Canadian per capita figure for public spending on health. It should be noted that the UK is now making substantial investments.

- **Health Status:** The OECD average for life expectancy at birth is 77.8 years. The U.S. (77.2 years) is below this while Germany (78.4 years), the U.K. (78.5 years), France (79.4 years) and Canada (79.7 years) are all above the average, and Sweden (80.2 years) has the highest life expectancy at birth of these six countries. It is important to note that some of these countries spend considerably more than Canada on social services.
- **Wait Times:** A recent OECD report on wait times noted that international comparisons of wait times remain limited partly due to the fact that there are many different ways of measuring them. Wait times for elective surgery are a main policy concern in approximately half of OECD countries. This report noted the findings of another study which investigated differences between five countries concerning the percentage of patients waiting for electives surgery. At 38%, the U.K had the worst results. At 27%, the results for Canada were similar to New Zealand (26%) and Australia (23%). The results for the U.S. were 5%, but it should be kept in mind that people without health insurance do not have access to elective surgery and as a result are not part of any wait lists.

5.0 CONCLUSION: CHA'S SOLUTIONS AND RECOMMENDATIONS

The 2004 Ten-Year Plan provides a framework for the future, in terms of funding and objectives. However, there is still unfinished business in healthcare and the objectives and deadlines in the Ten-Year Plan still need to be met. In light of the Chaoulli Supreme Court decision, it is important that we redouble our efforts to ensure this happens.

CHA and its members are committed to monitoring the impact of the Ten-Year Plan as it unfolds, both to chart its contribution to sustainability for publicly-funded healthcare and to advocate for improvements to address unmet needs. This is especially important given that public expectations of immediate progress under the Ten-Year Plan do not fit quite often with the reality of the frontline and with the time that it will take to put the necessary infrastructure, mechanisms and providers in place to significantly improve health system challenges. Certainly there are complex issues facing Canada's health system, but there are solutions – though no one magic bullet or panacea. And CHA is committed to working with governments to meet the health needs of Canadians.

In conclusion, it is useful to recall the words of Commissioner Romanow in his final report: "Medicare has consistently delivered affordable, timely, accessible and high quality care to the overwhelming majority of

Canadians on the basis of need, not income. It has contributed to our international competitiveness, to the extraordinary standard of living we enjoy, and to the quality and productivity of our work force."³⁴

Summary of Recommendations:

1. CHA recommends that the incremental "flow through" of federal funds to the health system be monitored while respecting provincial/territorial jurisdiction regarding the delivery of health services.
2. CHA recommends addressing a variety of issues related to wait times such as the appropriateness of surgical interventions, best practices related to managing demand for services, managing the waiting process through health maintenance and support programs, an integrated approach to waiting lists, and appropriate information and management systems.
3. CHA supports the establishment of pan-Canadian benchmarks or targets based on current best evidence by the December 31st, 2005 deadline as outlined in the Ten-Year Plan, noting that there needs to be a starting point and that the establishment of best evidence will be an ongoing and iterative process. CHA also supports expedited development of pan-Canadian indicators that will measure health system performance regarding access to care. Above all, it is essential to ensure public reporting and transparency regarding wait times. Citizens have the right to review the timelines regarding their access to care and to be assured their needs are being addressed in a timely way.
4. To enhance the efficiency and effectiveness of our health system and implement a pan-Canadian health record system, CHA recommends additional investments of \$6.2 billion over 5 years to Canada Health Infoway in order to accelerate the development and implementation of an electronic health record and to broaden its scope.
5. CHA recommends that a pan-Canadian health human resource framework or strategy be developed collaboratively with representatives from federal, provincial and territorial governments, and employer and employee stakeholders. Without health human resources the system cannot be sustained regardless of funding invested in infrastructure and technologies.
6. CHA recommends as a start a \$1 billion additional investment over 3 years to expand the home care program to include ongoing /chronic care services linked to pan-Canadian objectives for home and community care while respecting provincial/territorial jurisdiction regarding the delivery of care. In the past, CHA has also signaled the importance of addressing facility-based long term care on a pan-Canadian basis which remains another area of unfinished business and will, in the future, require additional investments to assure access and quality.
7. CHA notes the importance of meeting the targets originally set out in the 2003 Health Accord regarding Primary Health Care Reform.
8. CHA notes the importance of moving ahead expeditiously on the pharmacare strategy and programs with pan-Canadian objectives to address gaps in access, lack of equity and undue financial burden. CHA has also advocated for a commitment to develop and support the optimal use of pharmaceuticals.
9. CHA supports efforts to ensure adequate health system capacity and response to public health emergencies and infectious disease outbreaks.
10. CHA has advocated for enhanced resources targeted to wellness initiatives and is committed to health promotion programs and healthy lifestyle initiatives, as well as investments in the determinants of health. Appropriate chronic disease management programs are also an essential part of this work.
11. CHA advocates for an escalator in the Canada Social Transfer comparable to that in the Canada Health Transfer.
12. CHA supports the principle that the federal role in health is to ensure a broad range of comparable health services for Canadians through appropriate funding, while asserting the Canada Health Act and any other legislative and policy frameworks in place so that pan-Canadian objectives can be achieved.
13. CHA looks forward to efforts to move ahead on the "Blueprint" for Aboriginal health, noting that Aboriginal health issues remain an urgent challenge.
14. To promote the development of capacity for research on a pan-Canadian basis, CHA recommends that the \$500 million Research Hospital Fund under the auspices of the Canada Foundation for Innovation forgo the requirement of 60% funding from other sources. Also, the Fund should remain sufficiently flexible to allow for provincial/territorial priorities as well as federal priorities. In addition, CHA's Brief last year recommended an investment in health research of at least 1% of total health spending. CHA reaffirms this position.
15. CHA recommends clarification concerning which additional health facilities, agencies and services will qualify for the 83% GST rebate, applicable in the past to hospitals only. This is urgently required since

the new provision took effect January 1, 2005. CHA also recommends that the interpretive rules determining which health facilities, agencies and services will now be eligible for the 83% rebate be as inclusive as possible.

16. Given the positive impact of Canada's publicly-funded health system on Canada's economic competitiveness and productivity, CHA recommends that discussion on the public/private mix in the funding and delivery of health services needs to be based on a rigorous assessment of the evidence. CHA's analysis of the evidence demonstrates the efficiency and effectiveness of Canada's health system and points to the negative consequences for the health system and the Canadian economy of quick fix or magic solutions, based on an increased role for private insurance.

ENDNOTES

¹ CHA Press. **The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities**. CHA Policy Brief, Ottawa, 2001, p. 16, citing data from the Canadian Institute for Health Information from **National Health Expenditure Trends, 1975-2000**.

² Minister of Finance the Hon. Paul Martin. **Budget Speech 1995**.

³ Canadian Healthcare Association. "Federal government must show leadership to address "atmosphere of crisis" in Canada's healthcare system, says the Canadian Healthcare Association", **Press Release**, June 8, 1998.

⁴ Edward Greenspon. "Ottawa's health plan attacked," **Globe and Mail**, June 5, 1995.

⁵ As CHA noted at the time, "While the money allocated for healthcare in this budget may seem impressive (\$11.5 billion over five years), it will only address some of the most critical problems in our publicly funded healthcare system . . . the additional \$2.5 billion allocated to the cash floor of the CHST that is promised in three to four years is just the amount for health that was cut from federal transfers three years ago. This doesn't take into account inflation or a growing and aging population. Unless there is a sufficient base investment in a broad range of needed health services and the real value of federal transfers is preserved, private healthcare spending will continue to grow and accessibility will be compromised." "Sustainability for healthcare not assured, says Canadian Healthcare Association in reaction to today's federal budget", **Press Release**, February 16, 1999.

⁶ As CHA noted when the budget was delivered, "we are concerned that the budget does not make tangible fiscal commitments to ensure sustainability and improved accessibility to needed health services for Canadians beyond this year." "Sustained federal funding needed to ensure that our healthcare system will be there for Canadians when they need it: Canadian Healthcare Association (CHA) says in reaction to federal budget 2000", **Press Release**, February 28, 2000.

⁷ As CHA noted concerning the September 2000 First Ministers agreement on health, "federal cash transfers to provinces for health won't return to what they were in 1993/94 until 2002/03. And targeted funding to address medical equipment purchases, health information technology and primary care reform are woefully inadequate . . . Plus no targeted investments to address the crisis in health human resources, developing accountability measures to Canadians, or adding a funding escalator to ensure sustainability." "Federal Economic Statement ignores opportunity to immediately increase urgently needed funding for health system, Canadian Healthcare Associations says", **Press Release**, October 18, 2000.

⁸ As CHA noted concerning the February 2003 First Ministers agreement, "Does this Agreement stabilize the existing acute care system? No. While there is a significant increase five or six years from now, this increase doesn't make up for the fact that there is not enough money now. Canadians cannot continue to wait for needed services." "Much Needed Health Agreement Doesn't Go Far Enough: Canadian Healthcare Association", **Press Release**, February 6, 2003.

⁹ CHA and our members have long stressed the need for improvements in our public health system. CHA made the following recommendations to Dr. David Naylor, Chair of the National Advisory Committee on SARS and Public Health: 1) federal legislation to accommodate public health programs and services; 2) the creation of a Canadian Centre for Disease Control; 3) the establishment of a Chief Medical Officer of Health for Canada; and 4) that the health system receive appropriate investment for the health delivery system (in both the acute and community health systems) to accommodate surge capacity. See "CHA letter to Dr. David Naylor, Chair, National Advisory Committee on SARS and Public Health, July 4, 2003".

¹⁰ CHA participated in the Interim Patient Safety Committee (IPSC), a multistakeholder group involving other non-governmental organizations, regulatory bodies, governments, and other stakeholders. The Committee provided organizational continuity from the original stakeholder-led process and oversaw the planning of the CPSI.

¹¹ **First Minister's Meeting on the Future of Health Care 2004: A 10-year plan to strengthen health care**, signed September 16, 2004. Additional communiqués addressed a separate arrangement for Quebec and the issue of Aboriginal health.

¹² Health Council of Canada. **Wait Times and Access**. A background paper to accompany **Health Care Renewal in Canada: Accelerating Change**, January, 2005, p. 6.

¹³ Liberal Party of Canada. **Moving Canada Forward: The Paul Martin Plan for Getting Things Done**, 2004, pp. 15-16.

¹⁴ Commissioner Roy Romanow, QC. **Commission on the Future of Health Care in Canada. Speech to the Canadian Medical Association 134th Annual Meeting**, August 14, 2001.

¹⁵ OECD Policy Brief. **Private Health Insurance in OECD Countries**, 2004, p. 3.

¹⁶ Ibid.

¹⁷ Canadian Health Services Research Foundation. "Myth: A private parallel system would reduce waiting times in the public system", **Mythbusters**, 2001, p. 2.

¹⁸ Stephen Lewis. "Private health care will line doctors' pockets — whether they opt out of the public system or not", **Winnipeg Free Press**, August 14, 2005.

¹⁹ Colleen Flood. "Will private health insurance deliver?" **Toronto Star**, July 3, 2005.

²⁰ CHSRF, op.cit. Noting research from the Manitoba Centre for Health Policy and Evaluation, the Foundation points out that waiting times for some surgical procedures in Manitoba was far less than figures reported by the Fraser Institute.

²¹ Health Council of Canada, p. 2.

²² Ibid, p. 3.

²³ CHSRF. "Myth: For-profit ownership of facilities would lead to a more efficient healthcare system", **Mythbusters**, 2004, p. 1. The research referred to is by E.M. Silverman et al., 1999. "The association between for-profit hospital ownership and increased Medicare spending," **New England Journal of Medicine**, 341(6): 1523-1528.

²⁴ Ibid.

²⁵ **Private Health Insurance in OECD Countries**, op.cit., p. 4.

²⁶ Peter Fisher, NHSC President and Jacky Davis, NHSC Executive Committee. **Letter to Dr. Ruth Collins-Nakai, President-elect, Canadian Medical Association**, August 15, 2005, pp. 2-3.

²⁷ Paul Krugman. "One Nation, Uninsured", **The New York Times**, June 13, 2005.

²⁸ CHSRF, "Myth: For profit ownership of facilities would lead to a more efficient healthcare system", **Mythbusters**, 2004, pp. 1-2. The research referred to concerning mortality of dialysis patients in for-profit hospitals is by P.J. Devereaux et al. 2002. "Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta-analysis," *Journal of the American Medical Association*, 288(19): 2449-2457. The research referred to concerning referral of dialysis patients for kidney transplants at for-profit hospitals is by P.P. Garg et al. 1999. "Effects of ownership of dialysis facilities on patients' survival and referral for transplantation," **New England Journal of Medicine**, 341(22): 1653-1660.

²⁹ Fisher and Davis, op.cit., p. 2.

³⁰ "Community hospital leaders press to keep lid on limited-service hospitals", **AHA News**, Vol. 41, No. 11, May 30, 2005, p. 2.

³¹ Paul Waldie. "How health care costs hurt the Big Three", **Globe and Mail**, March 22, 2005.

³² Danny Hakim. "A U.A.W. Chief Awaits a G.M. Showdown", **New York Times**, June 23, 2005.

³³ See CHA: **The truth behind the numbers: CHA analyses OECD Health Statistics**. Available at: www.cha.ca/documents/CHA_OECD_Analysis.pdf. The analysis reviewed health data within the **OECD Health Data 2005: Statistics and Indicators for 30 Countries**, June, 2005, which contains the most recently available information (2003 data), and information contained with **Explaining Waiting Times Variations for Elective Surgery across OECD countries**, by Luigi Siciliani and Jeremy Hurst, OECD Health Working Papers 7, October 2003.

³⁴ Commissioner Roy J. Romanow, Q.C., **Building on Values: The Future of Health Care in Canada — Final Report**, 2002, p. xvi.