Healthcare Systems: Canada

By Benedict Irvine, Shannon Ferguson and Ben Cackett

Updated by Emily Clarke (December 2011) and Elliot Bidgood (January 2013)

Introduction

The Canadian healthcare system, known informally as "Medicare," (although not to be confused with the American scheme), is designed to be universal, portable, comprehensive, accessible, publicly administered and mostly free at the point of use. Universality, accessibility and comprehensiveness are ensured through the principle that all 'insured persons' (defined as residents within a province) are to be provided with medically necessary health care on the basis of need rather than ability to pay.[1] Under the Canada Health Transfer, the funding for health care services is provided by the federal government, which distributes money to the provinces in adverse proportion to the province's wealth.[2] Provinces can supplement this funding with premiums (as in British Columbia[3]), payroll taxes, sales taxes or other revenues. The only caveat is that provinces or territories that levy premiums must also offer financial assistance to low-income residents so that they are still able to pay the premiums, or are exempted from them. In this way, the Canadian healthcare system is privately run, (physicians are not salaried by the government), but publicly funded.

Rather than having a national healthcare plan, Canada's health care is based on its 13 provinces and territories, each of which has its own unique health insurance plan. Canada's 10 provinces and 3 territories have the constitutional responsibility for managing health care finances, evaluating the provision of hospital care, and negotiating fees for physician services. Thus, despite some unifying standards, each province/territory will often have varying hospital wait times and access to private, for-profit clinics.[4] Although the principle of portability means that if you move from one province to another your cover remains intact, it does not allow you to seek treatment in another province simply because it benefits from shorter waiting lists.

History

In 1957 the Canadian Parliament passed the Hospital Insurance and Diagnostic Services Act, guaranteeing federal funding of 50 per cent for provincial hospital insurance programmes.[5] These programmes were based on the model first set up in 1947 by Tommy Douglas and his Saskatchewan government, which guaranteed publicly funded hospital care for most of the province's residents.[6] Tommy Douglas, voted the greatest Canadian in a 2004 CBC poll for his vision of universal medical coverage,[7] ensured that his successor in the Saskatchewan government, Woodrow Lloyd, was able to introduce universal medical coverage to that province in 1962 despite a physician strike.

The cause of universal medical coverage was then taken up in 1964 by the Royal Commission on Health Services, headed by Emmett Hall, which campaigned for a nationwide health insurance plan.[8] This was introduced in 1966 under the Medical Care Act which offered another 50-50 cost sharing arrangement if provinces met four criteria of comprehensiveness, portability, public administration, and universality. To this day the federal government can exercise "fiscal federalism" over the provinces by withholding funds if these principles are not met. Implementation of the Medical Care Act began in 1968 and by 1971 all Canadians were guaranteed access to essential medical services on a prepaid basis, regardless of employment, income, or health.[9]

Reforms to the System

Initially, amid rising costs for health care, accompanied by low compensation for physicians (which caused most to simply increase their daily caseload), many doctors opted out of the newly introduced system and billed patients themselves. By the late 1970s and early 1980s there were calls to ban such extra billing and user fees – some Canadians could hardly find "opted-in" providers. The Canadian Health Act of 1984, which was drafted in response to protests, denies federal support to provinces that allow extra-billing within their insurance schemes and effectively forbids private or opted-out practitioners from billing beyond provincially mandated fee schedules.[10] In other words, doctors cannot accept patients wanting basic medical services who attempt to pay more for faster or more attentive service.

The 1984 Act also defines and solidifies the principles of Medicare, including:[11]

- Comprehensiveness (provinces must provide medically necessary hospital and physician services)
- Universality (100 per cent of provincial residents are entitled to the plan)
- Accessibility (there should be reasonable access to services, not impeded by user charges or extra billing)
- Portability (protection for Canadians travelling outside of their home province)
- Public administration (provinces must administer and operate a health plan on a non-profit basis)

These principles aim to provide a one-tiered service and ensure that essential medical coverage is available to all. The basic package that all provincial and territorial health insurance plans offer includes[12]:

- Hospital services provided to in-patients or out-patients
- Services that are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability
- Medically required physician services rendered by medical practitioners

Additional services such as prescription drugs and dental care may be offered under a provincial health insurance plan, funded and delivered on their own terms and conditions. They will often target a specific demographic, for example children or seniors, and may be partially or fully covered.[13] Uninsured services for which patients may be charged include preferred hospital accommodation (unless prescribed by a physician), prescription renewals by phone, provision of medical certificates for work or insurance purposes and cosmetic surgery.

Health Care Providers

Canada's version of national public health insurance is characterised by local control, doctor autonomy and consumer choice – patients theoretically have a free choice of physician and hospital within their province.[14] Health care providers are predominantly private, but are funded by public monies via provincial budgets:

- Hospital systems are largely private, non-profit organisations that receive an annual global operating budget from the provinces. They have their own governance structures, but are usually supervised by a community board or trustees.
- Physicians are mostly in private practice and remunerated on a fee-for-service basis by the provincial health plan (with an imposed cap to prevent excessive utilization and

costs). The doctor is ultimately responsible for deciding on the treatment undertaken as opposed to the government or the insurance company.

Health Care Expenditure

In 2011 it is estimated that Canada spent approximately $4,553 CDN per person ($4,608 USD adjusted for PPP) on health care, accounting for 11.2 per cent of GDP.[15] This is similar to the percentage of GDP spent on health care by France, Germany and the Netherlands.[16] Since 1997, the public/private split of total health expenditure in Canada has remained stable, with governments spending 70 per cent of the total health care bill and the private sector, which includes private health insurance, private hospitals and out-of pocket expenses, accounted for 30 per cent.[17]

Since 1977, cost sharing has been transformed through several negotiated legislative steps from the 50-50 split between the federal and provincial governments to a reduced single block fund called the Health and Social Transfer.[18] Over the course of time federal contributions to health care have declined, leading some provinces to find additional means of raising funds. Alberta and British Columbia for example ask for a health insurance premium, and other provinces have instituted employer payroll taxes.[19] For all provinces, health care represents one of the most important budget items, representing an average of 38 per cent of total provincial and territorial government spending in 2009.[20] This number has remained fairly consistent for years, although in 2011 variance was noted; Quebec spending was 30.1 per cent, for example, compared to 47.9 per cent in Nova Scotia.

The province of Ontario, facing a CDN $16 billion budget deficit due in part to rising to health costs, has been seeking to reduce and freeze remuneration rates for physician services under the province's health plan. The Canadian Medical Association (CMA) has warned this could lead to higher waiting times in Ontario as a result of doctors moving to provinces with better rates and it has also been suggested such a move could encourage physicians to increase their caseload unnecessarily (as was a problem before the 1984 Canada Health Act, see above), but if the plan is successful it has been speculated that other Canadian provinces may follow suit.[21]

Rationing: "Everything is Free but Nothing is Readily Available"[22]

Like other nations experiencing limitless demand, an ageing population and the costly advance of medical technology, Canada has faced pressure to control health expenditure. It has done so through explicit rationing and research into cost-effective drugs and technology through the Canadian Agency for Drugs and Technologies in Health (CADTH). This body, originally the Canadian Coordinating Office for Health Technology Assessment (CCOHTA), was set up to provide health care decision-makers with impartial advice and evidence on the efficiency of drugs and other health technology. Thus it fulfils the same role that NICE (National Institute for Health and Clinical Excellence) performs for the NHS.

The Fraser Institute think-tank in Canada has been particularly vocal in its criticism of delays and poor coverage within the sector of cutting edge drugs. In a recent report,[23] it was shown that not only did Health Canada (Canadian Department of Health) take longer to approve new drugs than other regulators in Europe in all four years studied (2004-2009), but even when drugs were eventually approved most provincial public drug plans refused to pay for them. Of all the new drugs approved by Health Canada between 2004 and 2009, the average coverage rate across

provincial drug programmes was less than 23 per cent. By contrast, the average coverage under private drug plans over the same period was almost 83 per cent. The author of the Fraser Institute Report therefore advocates opening up prescription drugs entirely to the private health insurance market, with subsidies provided to those on lower incomes. By introducing a price at the point of consumption, it is hoped that the cost-consciousness of consumers will encourage insurers, health care providers and drug manufacturers to supply and use resources effectively. There are risks with this strategy as well: for example some patients may suffer from annual limits, or an unwillingness to pay high premiums based on the morbid possibility that one might need, for example, high end cancer drugs in the future. However, considering the significance of the delays in public provision of drugs and the low level of coverage, opening up drug provision to the private market can probably only improve things.

It is not only drug provision that is marred by long waiting lists. The Fraser Institute also found that the total average waiting time for patients requiring surgery between referral from a GP and delivery of elective treatment rose from 16.1 weeks in 2009 to 18.2 weeks in 2010.[24] Furthermore, median waiting times are higher than the levels deemed 'clinically reasonable' in every category. Waiting lists are made worse by a shortage of personnel as well as equipment: in 2010 the number of doctors per 1,000 population was 2.4 compared with an OECD average of 3.1, and Canada is often cited as having poor access to high-tech and up to date equipment.[25]

An assessment in 2000 by the Canadian Medical Association (CMA) argued that shortages have led to an "unconscionable" delay in the diagnosis and treatment of diseases such as cancer, heart disease, and debilitating bone and joint ailments.[26] "We're not talking about Ferraris and Lamborghinis here," according to Dr Hugh Scully, the head of the CMA. "We're talking about the Chevrolets and the Fords that are necessary to make it [diagnosis] accessible and reasonable for everybody."[27] To use Dr Phil Malpass' phrase, Medicare is "functionally obsolete".[28] Significantly, this is not only encouraging people to seek private treatment in America but is increasing the role of private practice within Canada itself. For example, in 2005 the Canadian Supreme Court ruling in Quebec opened the door to private clinics for patients facing unreasonable wait times.[29] In an attempt to prevent this from being necessary, reforms were also established in 2007 when all provinces and territories publicly committed to establishing a Patient Wait Times Guarantee in one priority clinical area by 2010. This means that patients whose wait times exceed a defined time frame and whose needs are medically necessary must be offered alternatives such as referral to another physician or health care facility.[30]

Creeping Privatisation: The Changing Role of the Private Sector

Despite the provisions of the 1984 Act, private medicine still survived – indeed, in recent years it has flourished. This is partly due to problems such as waiting lists but also partly because health care is becoming less focused on hospital and physician care - the two types of care that are intended to be 100 per cent publicly financed. Hospital and physician care together comprise less than half of total health care expenditure in Canada as care costs shift to community care and drugs. As previously stated, there are also several services which aren't insured publicly, such as some dental work, eye-care, prescription drugs, ambulance services, medical devices, hospital room upgrades and out-of-country insurance. This has allowed for-profit clinics to spring up, predominantly offering services that aren't covered by Medicare. Some clinics are entirely private, whilst others contract with the local health authority. New forms of privatisation have evolved which creatively (and sometimes subversively) attempt to stay within the confines of the Health Act principles. Some private providers have "cherry picked" lucrative,

high volume, and low risk services such as MRI scanning, bone densitometry, cataract and corrective eye surgery, rehabilitation (particularly physiotherapy) and arthroscopic surgery. Another "privatisation by stealth" practice is to combine provision of an insured service with non-insured additions. This may lead to queue jumping, where the patient who books fast access to a non-insured service simultaneously gains access to the insured service, for which others would have to wait longer. These practices erode the principles of the Canada Health Act and suggest a move towards the creation of a two-tiered service.[31]

Massive government re-investments in health care have not brought stability to, or restored confidence in, public care. Consequently the public seem ready for an expansion of the private sector. In 2002 the Canadian Medical Association sponsored a poll on user fees. The results showed that 57 per cent supported user fees.[32] A further 2005 Healthcare in Canada survey by the public opinion research firm POLLARA shows that 49 per cent of the public said they would be willing to make out-of-pocket payments to purchase faster access to health care.[33] A majority also believe that expanding private insurance would:

- Result in shorter waiting times (68 per cent)
- Provide better access to health care (59 per cent)
- Improve quality (60 per cent).

However those who support the public system worry that a two-tiered system will undermine the very foundation of Medicare, increase health inequalities and worsen the shortage of doctors, because physicians in the public sector will simply migrate to private clinics where the remuneration is greater.

A 2010 poll by Ipsos-Reid found that a majority of Canadians had severe concerns about provincial healthcare costs, with a further 44 per cent stating they were "willing to accept" flat $25 fees for all hospital visits, provided low-income people were exempted, as had been proposed by the provincial government in Quebec. Far more, 64 per cent, said they could accept a plan in which people could purchase private insurance for treatment in non-taxpayer-funded private facilities. The Quebec user fees remained controversial, however, with some politicians arguing that they could even amount to a breach of the Canada Health Act, which led to the government of Quebec dropping the plans.

User fees also carry some risks from a standpoint of both cost and patient care, some have argued. Evidence gathered by the Journal of the American Medical Association has suggested that while they may well deter patients from seeking unnecessary treatments, since this relies on the general public being able to adequately judge the severity of their symptoms, additional costs may also persuade people not to seek more necessary treatments at a stage when preventative care is still possible. Therefore, user fees may end up costing the system more overall, presenting the possibility that fees could be 'penny wise and pound foolish' and will cut against efforts to gear national health services towards prevention.[34]

Lessons for the NHS

Privatisation: Like the NHS to Britons, the Canadians tend to view Medicare as a national symbol and prize its principles of universality and fairness. As one doctor puts it, "today a politician in Canada is more likely to get away with cancelling Christmas than he is with cancelling Canada's health insurance program."[35] It is unlikely, therefore, that any major restructuring of Canada's

publicly administered health insurance will occur, as evidenced, for example, by Quebec dropping the proposal for physician user fees at the point of service in the face of broad opposition.[36] However, Canadians do recognise that there are problems in the system, particularly with regards to waiting times. It is possible, therefore, that an increasing acceptance of private insurance will see Canada in fact become more like the NHS: in other words they will have universal health care coverage, but people will also have the option of purchasing private insurance for quicker service or perhaps better drug provision. The problem with this two-tiered system is that if the private health insurance market isn't regulated or subject to restrictions, then all those who cannot afford private insurance, including those with pre-existing conditions, may in the end have a lower standard of care than those with private insurance.

Decentralisation: The provincial set-up within Canada is difficult to compare with Britain. Similarly, the differences between Canadian provinces in terms of geography and population are much greater than the differences between English counties. If Britain was ever to introduce a universal social health insurance programme, it seems likely that it would be administered centrally, which might reduce problems of regional-federal conflict but would not solve other problems associated with a single-payer and management system.

Single-payer healthcare model: Canada often suffers from the problems associated with a single-payer (government) healthcare model. First, accountability and transparency is poor and aggravated by the Federal structure. Second, decision-making is politicised. Third, single-payer government control leads to a lack of innovation. This adds up to a lack of responsiveness to patient needs or wants, some overly-aggressive cost cutting and delays in quality improvement. Having said this, the single-payer and provincial management structure does cut administration costs because bills go straight to the provincial government rather than via the patient or insurance company. As a result Canada only spends 2.4 per cent of its total health care costs on administration compared to 7 per cent in the USA.[37]

Cost-effectiveness: Many complain about a lack of cost effectiveness within Canada because high levels of expenditure do not equate to good accessibility to high quality health care. For example, although Canada is one of the highest spending countries on health by percentage GDP and Canadian provincial governments spend two-thirds of their tax intake on health, 1.9 million Canadians lack a family physician and in a 10-country Commonwealth Fund Study Canada performed worst out on waiting times by several measures.[38] However, this must be put into perspective: the USA for example spends much more of their GDP on health care, yet suffers from poorer infant mortality and life expectancy. Furthermore, Canada achieves universal coverage for less money than America spends on only a proportion of their population.

Research and Innovation: Despite poor availability in Canada of advanced medical technology, international comparison reveals good health care outcomes – generally better than those in the USA and the UK and more akin to those associated with high-spending European systems such as France and Switzerland (see Statfile). Some of the reasons for this are only indirectly related to health care. For example Canada benefits from lower levels of income inequality than the US and UK and tobacco consumption is low in comparison to OECD member countries. Nevertheless the universality of the healthcare system will contribute in part to good health care outcomes.

Conclusions

Publicly funded and managed healthcare systems are unsurprisingly popular in theory. Patients do not have to pay up front or deal with the often stressful situation of claiming back from an insurance company; nor do they have to fear that their conditions or certain treatments might not be covered. Cases of bankruptcy through illness and accident are almost unknown and health inequalities between rich and poor are tempered. However, there are also many problems with the Canadian system, centred on the fact that although provision of medical services is technically given through private physicians and hospitals, the *public* management of funds and principles leads to strict budget restraints and difficulties in balancing quality with cost. This is made worse by the fact that the federal government is also in charge of evaluation and ultimately has control over which services, drugs and equipment can be afforded. Therefore, although the public Canadian system is laudable in its principles and will struggle to 'privatise' in the face of public and political opposition, Canada probably would benefit from greater levels of private health care and insurance and independent quality evaluators. In turn, the NHS might also look towards some elements of market-based reform whereby certain sectors such as prescription drugs are covered by private health insurance with subsidies for low-income families.

Ultimately, there may be little we can learn from the Canadian system, because our systems are both too different (Canada has universal coverage but not a uniform system) and in other ways too similar: both the NHS and Medicare have competition between providers not purchasers and insurance is singly paid for and managed by the government. Therefore the areas that the NHS needs to improve on are likely to be similar to the areas that need to be improved in Canada.

Statfile (most recent figures from the OECD unless otherwise stated, most recent UK figure and OECD average given for comparison)[39]

Funding

Total Health expenditure: 11.2% of GDP (UK: 9.6% OECD average: 9.5%)
$4607.8 per capita (US $, adjusted for PPP) (UK: $3433.2, OECD Average: $3265)

Public expenditure: 70.4 % of total health expenditure (UK: 83.2% OECD Average: 72.2%)

Out of pocket expenditure: 14.4% of total health expenditure (UK: 8.9% OECD Average: 19.5)

Resources

Practising physicians (per 1000 population): 2.4 (UK: 2.8 OECD Average: 3.1)

Practising nurses (per 1000 population): 9.3 (UK: 9.1 OECD Average: 8.7)

MRI scanners (per million population): 8.6 (UK: 5.9, OECD Average: 12.5)

CT scanners (per million population): 15 (UK: 8.9, OECD Average: 22.6)

Waiting Times[40]

Percentage waiting four weeks or more for a specialist appointment (study of 11 OECD nations): 59%, 11th out of 11 (UK: 28%, Average: 37%)

Percentage waiting four months or more for elective surgery (study of 11 OECD nations): 25%, 11th out of 11 (UK: 21%, Average: 13.3%)

Outcomes

Average life expectancy (at birth): 80.8 (2008) (UK: 80.6, OECD Average: 79.8)
- **Female:** 83.1 (2008) (UK: 82.6, OECD Average: 82.5)
- **Male:** 78.8 (2008) (UK: 78.6, OECD Average: 77)

Infant mortality (per 1000 live births): 5.1 (2008) (UK: 4.2, OECD Average: 4.3)

Maternal mortality (per 100 000 live births): 12 (2008)*

Mortality Amenable to Healthcare (OECD, Nolte & McKee Method 37):** 74 per 100,000 deaths (UK: 86, OECD Average: 95)

Mortality Amenable to Healthcare (OECD, Tobias & Yeh Method* 37):** 87 per 100,000 deaths (UK: 102, OECD Average: 104)

+ CIA World Factbook
* UNICEF Data
** Nolte & McKee method: mortality amenable to healthcare defined as "premature deaths that should not occur in the presence of timely and effective health care"

*** Tobias & Yeh method: mortality amenable to healthcare defined as "conditions for which effective clinical interventions exist [that should prevent premature deaths]"

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