Health Policy Report

Revisiting the Canadian Health Care System

John K. Iglehart

THE provincial health insurance plans of Canada, still prized by a population that relies on universal coverage of hospital care and physicians' services, nevertheless suffered a dramatic loss of public confidence in the 1990s as a result of sharp cutbacks in the federal budget. These cutbacks have led to restricted access to specialists, longer waiting times for nonemergency surgery, and the closing or merger of many hospitals, resulting in a loss of beds. The reductions, a central feature of the federal government's successful effort in recent years to eliminate the large annual budget deficit, are now being partially reversed, but the system remains shaken by the decline in public support, reduced morale among physicians and nurses, and increased tension between the federal government in Ottawa and Canada's disparate provinces and territories.

In this report, I revisit Canada's health insurance system after almost a decade. In 1990, when I last discussed the subject in the *Journal*,[1] federal and provincial health care payments accounted for 75 percent of the nation's total expenditure for medical care. In 1997, as a consequence of the retrenchment policies, public health care expenditures ($54.1 billion Canadian) represented 69.4 percent of the total, with expenditures by private insurers and patients' out-of-pocket expenditures for outpatient prescription drugs, dental care, rehabilitation services, extra-duty nurses, and other items not covered by the provincial plans ($23.9 billion Canadian) accounting for 30.6 percent.[2] (As of this writing, the exchange rate is $1.49 Canadian to $1 U.S.) Unlike other industrialized nations, Canada has no parallel private insurance system that pays for hospital care and physicians' services, because commercial insurers are barred from selling policies that cover any item that is publicly insured. But the unsettled state of Canada's health care system has rekindled a long-standing debate over the ban on private insurance for publicly insured services.[3]

With a common border, a common culture, and a common capitalist penchant for profit making, Canada and the United States have forged closer economic links than any other pair of independent nations in the world. But when it comes to their respective health care systems, the two countries are a world apart, having sharply diverged over the past three decades. This divergence reflects the strong U.S. belief in individualism and limited government and the great value that Canada attaches to communal obligations and a robust public sector. The difference in the two countries' attitudes toward the role of government is illustrated by the fact that in 1996 taxes levied at all levels of government in Canada accounted for 36.8 percent of its gross domestic product, whereas the comparable figure in the United States was only 28.5 percent — one of the lowest among industrialized nations. Canada's publicly financed provincial health insurance plans consume a substantial portion of these tax revenues and provide all of the nation's 31 million residents direct access to hospital care and physicians' services without cost-sharing requirements. In contrast, since 1965, when the U.S. Congress established Medicare and Medicaid to provide public financing of services for the elderly and for eligible poor persons, the United States has vacillated in deciding what obligation government has to provide coverage for persons who are not insured through their employers. One consequence of this uncertainty is that an estimated 44.3 million people in the United States remain uninsured. That number could reach 60 million by 2008.[4]

Over the past 30 years — during the period when the U.S. Congress has intermittently flirted with the enactment of national health insurance legislation — people in the United States have paid considerable attention to the structure, logic, and history of the Canadian system.[5,6] What caught their attention was the system's universal coverage, its lower costs, particularly its public, nonprofit administration, and the clinical autonomy that physicians enjoy, although their incomes have been appreciably constrained.[7] When reform efforts in the United States failed and competition in the marketplace became the predominant model in the 1990s, the Canadian experience seemed to offer few lessons, and interest waned. But as recent statements by politicians in both countries indicate, the two health care systems remain subjects of condemnation or praise, depending on one's perspective. For example, in articulating the official Republican response to President Bill Clinton's State of the Union address on January 27, Senator Bill Frist of Tennessee, a surgeon, compared the administration's new health care proposals to socialized medicine "in Canada, where patients are fleeing to the U.S. for treatment." About two months later, another Republican senator, Slade Gorton of Washington, unnerved the pharmaceutical industry when he announced that he would introduce legislation designed to reduce price disparities that require consumers to pay much more for prescription drugs in the United States than in Canada or Mexico.[8]

Brian Schweitzer, the Democratic candidate for a U.S. Senate seat from Montana, has made the high cost of prescription drugs a centerpiece of his uphill

campaign. Recently, Schweitzer sponsored a chartered bus trip to Canada for a group of retired people so that they could purchase prescription drugs at a third to half the price of the same products in the United States.[9] Groups of elderly persons from New England states and other states that border Canada have made similar trips in recent months. In Alberta, a wealthy Canadian province, the conservative premier, Ralph Klein, has proposed, amid great controversy,[10] that the provincial health insurance plan contract with private, for-profit surgery clinics to perform procedures that could require overnight stays. Klein and other government officials have been quick to point out that they "will not allow private, American-style hospitals in the province."[11]

The health care systems in Canada and the United States do have one characteristic in common. A recent survey of 1000 adults in each country found that only a minority of respondents were satisfied with their health care system.[12] The loss of public confidence in the Canadian system over the past decade was greater than that in the United States. Canada's health care expenditures crested at 10.2 percent of the country's gross domestic product in 1992. As a consequence of the budget reductions and an improving economy, health care expenditures had dropped to 9.3 percent of the gross domestic product by 1998. The growth in U.S. health care expenditures has steadily slowed since 1990. Nevertheless, total expenditures in 1998 represented 14.0 percent of the U.S. gross domestic product, a much higher proportion than that in any other industrialized country, according to data collected by the Organization for Economic Cooperation and Development (Table 1).[13]

TABLE 1. HEALTH CARE EXPENDITURES IN 23 COUNTRIES IN 1960, 1990, AND 1998.*

COUNTRY	TOTAL PER CAPITA EXPENDITURE			TOTAL EXPENDITURE AS A PROPORTION OF GDP		
	1960	1990	1998	1960	1990	1998
	$			%		
Australia	517	1,647	2,040	4.9	8.2	8.7
Austria	352	1,503	2,000	4.3	7.2	8.3
Belgium	292	1,556	1,850	3.4	7.5	7.6
Canada	600	2,115	2,250	5.4	9.2	9.3
Czech Republic	NA	717	950	NA	5.4	7.2
Denmark	369	1,777	2,100	3.6	8.3	8.0
Finland	297	1,612	1,600	3.9	8.0	7.4
France	396	1,920	2,120	4.2	8.9	9.6
Germany	495	1,999	2,400	4.8	8.7	10.6
Greece	116	876	1,270	3.1	7.6	8.7
Iceland	275	1,714	2,190	3.3	7.9	8.3
Ireland	193	947	1,390	3.8	6.7	6.1
Italy	270	1,648	1,660	3.8	8.1	7.6
Japan	143	1,350	1,780	3.0	6.1	7.4
Luxembourg	NA	1,865	2,440	NA	6.6	7.0
Netherlands	369	1,654	2,030	3.8	8.3	8.6
New Zealand	495	1,169	1,440	4.3	7.0	8.0
Norway	253	1,703	2,090	2.9	7.8	7.5
Spain	77	1,017	1,240	1.5	6.9	7.5
Sweden	490	1,861	1,820	4.7	8.8	8.6
Switzerland	479	2,196	2,740	3.1	8.3	10.2
United Kingdom	407	1,191	1,450	3.9	6.0	6.9
United States	820	3,491	4,270	5.2	12.6	14.0
Median	369	1,648	2,000	3.8	7.9	8.0

*Data are from the Organization for Economic Cooperation and Development.[13] GDP denotes gross domestic product, and NA not available. Expenditures are in 1998 U.S. dollars.

THE EVOLUTION OF THE PROVINCIAL PLANS

The cornerstone of Canada's health insurance system was laid in 1957, when the national government, unable to achieve a consensus with the provincial governments on the acceptability of one overall plan, wielded its spending power to encourage the creation of provincial plans based on a set of key principles. Through federal legislation, the House of Commons provided cash payments to any province that agreed to administer and partially finance a universal hospital insurance plan.[14,15] Medical insurance was added in 1968, again with the federal government offering cash payments to provinces that fell into line. By 1971, all 10 provinces (Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Nova Scotia, Ontario, Prince Edward Island, Quebec, and Saskatchewan) had adopted hospital and medical insurance programs that met the basic requirements established by Parliament to qualify for federal funds covering 50 percent of the programs' costs. At that time, health care costs consumed 7.4 percent of national income in Canada and 7.6 percent in the United States. The House of Commons stipulated that the provincial plans must provide universal access to care on "uniform terms and conditions," cover all medically necessary acute care services as determined by physicians and the provincial governments, provide benefits that would be portable throughout Canada, and be publicly administered on a nonprofit basis.

Parliament's unanimous passage of the Canada Health Act in 1984 reinforced the nation's commitment to the principles on which the plans are based. The act also required that the provinces ban the practice of extra billing by physicians (charging fees to patients in excess of those allowed by the provincial benefit schedule), stipulating that failure to institute the ban would result in the forfeiture of federal funds. Within two years, over the vigorous protests of organized medicine, all the provinces had passed legislation to abolish extra billing, thus underscoring their commitment to a publicly financed system that grants equal standing to everyone regardless of in-

come. The Canada Health Act applies only to physicians' services and hospital care. Drug coverage is limited mostly to elderly and poor people.[16] Most nursing homes are privately owned and draw on a blend of public and private funds, but the provinces are not required to include nursing home care as part of the basic coverage they provide. Publicly funded coverage for community-based care (e.g., home health care services) is increasing but remains uneven in its design and scope from one province to another.

All medically required services provided by licensed practitioners in hospitals, clinics, and doctors' offices are covered by the provincial plans. Covered hospital care includes all inpatient services provided in a standard room, unless private accommodations are considered medically necessary, and all necessary drugs, biologic products, supplies, and diagnostic tests, as well as a range of outpatient services. The services of psychiatrists and psychiatric hospitals are fully covered, but their quality varies widely from one province to another. A majority of physicians are private office-based doctors (32.5 percent of whom were in solo practice in 1999) and are reimbursed on the basis of fee schedules negotiated by the provincial medical associations and the provincial governments. Once the overall level of payment to physicians in a province has been established, the government leaves the setting of specific fees for generalist and specialist physicians — always an exercise fraught with conflict — in the hands of the provincial medical associations.

Payments from government health insurance plans represent virtually all the professional income of Canada's 56,203 active civilian physicians (28,542 family physicians and 27,661 specialists in 1998,[17] 47,000 of whom are members of the Canadian Medical Association), because they must choose to practice within the confines of the public system or accept only those patients who can pay for their care directly out of pocket. Patients are free to select their own physicians, although access to specialists in some areas has become more restricted because of a shortage of anesthesiologists, general surgeons, and psychiatrists. All general hospitals are operated on a nonprofit basis and are funded primarily by global budgets that are negotiated with provincial ministries of health.

Hospital care remains the largest category of health care spending in Canada, although the number of hospital admissions fell by 33 percent between 1986 and 1996. In 1997, hospital care accounted for $25.4 billion Canadian, or 32.5 percent of total health care expenditures, down from a high of 45.4 percent in 1976. This downward trend is expected to continue.[2] Expenditures for physicians' services have also declined as a proportion of total health care spending, from a high of 15.6 percent in 1987 to 14.2 percent in 1997; a further decline, to 13.9 percent, was projected for 1999.[2] In 1997, for the first time, spending for prescription drugs was the second largest category of expenditures, having overtaken expenditures for physicians' services. Drug expenditures as a proportion of total health care spending increased from 8.4 percent in the late 1970s to 14.5 percent in 1997 and were projected to reach 15.2 percent by 1999.[2] An estimated two thirds of the money for prescription drugs comes from private insurance and patients' out-of-pocket spending, because Canada's provincial plans limit drug coverage mostly to elderly and poor people.

EROSION OF PUBLIC AND PROFESSIONAL SUPPORT

The federal government began to reduce its contribution to the provincial health insurance plans more than 20 years ago, but the reductions became larger in the 1990s. In 1977, provoked by concern about rising medical costs, the federal government abandoned its 50-50 cost-sharing arrangement in favor of a new formula that left the provinces to absorb a greater share of health care costs if they grew more rapidly than the overall economy. Ever since, the federal share of payments has declined. To illustrate the changing pattern of funding, the federal contribution amounted to 44.6 percent of the total expenditure of $14.1 billion Canadian by the provincial plans in fiscal year 1980. A decade later, the provincial plans spent a total of $39.2 billion Canadian for health care, only 36.7 percent of which was contributed by the national government. In 1997, the provincial plans spent approximately $54 billion Canadian, with Ottawa providing an estimated 23 percent of the total through a combination of cash payments and tax allowances that enabled the provinces to impose certain levies on their residents for the purpose of funding health care.

Whereas the early budget cuts were implemented to check rising medical expenditures in Canada, the later reductions were enacted to reverse a broad pattern of deficit spending in the 1970s and 1980s under both Conservative and Liberal governments. By the early 1990s, this extravagance had led to an accumulation of debt that placed Canada second only to Italy in this regard among all industrialized nations. To stem the deficit spending, the Liberal government of Prime Minister Jean Chrétien took a number of steps that the competing political parties and most citizens viewed at the time as drastic but necessary. One of the most important was the bundling of federal payments to the provinces for health care, higher education, social assistance, and other social programs. With this consolidation, through a vehicle called the Canada Health and Social Transfer, the provinces had the flexibility to set their own priorities among these broad purposes, but the total annual amount transferred by Ottawa was sharply re-

duced from $18.5 billion Canadian to $12.5 billion by 1998. The provincial health plans absorbed almost half these annual budget cuts. The provinces, also determined to reduce their deficit spending, focused their budget-cutting efforts on health care services, further eroding the capacity of the plans to pay for health care.

As the cumulative impact of the federal and provincial budget reductions mounted, public and professional concern reached a crescendo in the winter of 1999–2000. According to a survey of public opinion conducted in 1999, only 24 percent of Canadians rated their health care system as excellent or good, as compared with 61 percent in 1991.[18] A poll conducted early this year found that, when Canadians were asked what a budget surplus should be spent on, health care was the preference of 72 percent of the respondents, followed by education (58 percent) and lower income taxes (55 percent).[19]

The government's own surveys of public opinion show that even higher proportions of people favor an increased investment in health care. In an interview with Allan Rock, the federal health minister, six weeks before the release of the new federal budget, I asked him how he argued for increased payments to the provincial plans. He responded, "My case is that when you ask Canadians, and we have, they answer in remarkable unanimity (we believe nine out of ten) that the first priority of the government when there's a dollar available should be restoring our iconic health care system to the condition it must be in if it's to provide timely access to high-quality care."[20] The decline in public satisfaction reflects the slowdown in the growth of spending. The average annual increase in total health care spending fell from 11.1 percent between 1975 and 1991 to 2.6 percent between 1991 and 1996.

A SHORTFALL OF CAPACITY

The budget cutting in Canada clearly took its greatest toll on the capacity of the provinces to deliver health care services. Last winter, newspapers and television news programs were flooded with reports of overcrowded emergency rooms that were forced to turn away patients with influenza and other respiratory illnesses, shortages of physicians and nurses, and growing waiting lists for patients requiring certain diagnostic and therapeutic services (magnetic resonance imaging, hip and knee replacements, coronary-artery bypass surgery, and radiotherapy) in many provinces. The policy of restricting supply has been the predominant feature of the Canadian approach to controlling health care costs, but it was taken to an extreme in the 1990s, with unforeseen consequences. Key features were a reduction in the number of students enrolled in Canada's 16 medical schools, tight restrictions on the purchase of expensive medical equipment through a centralized approval process, and the closing or merger of many hospitals, resulting in a smaller number of hospital beds. In addition, many full-time nursing positions in hospitals were converted to part-time and on-call jobs, and between 1993 and 1997, the number of admissions to nursing schools dropped from 12,621 to 5063, according to the Canadian Nurses Association.[21]

The enrollment of first-year medical students peaked in 1983, at 1887 students, and by 1998 had dropped to 1581,[22] in part because provincial health ministers reduced medical school enrollments by 10 percent in 1992, as recommended by a government-funded study.[23] But beyond the loss of training positions, the available pool of physicians was depleted by the increase in the number of practitioners who retired (40 percent more retired during the period from 1990 to 1995 than during the period from 1985 to 1989) and by the emigration (usually to the United States) of about 400 practitioners a year. The Canadian Medical Association believes that there is already a shortage of physicians and that it will worsen. The association estimates that Canada needs approximately 2500 additional physicians a year to replace those who are no longer available to practice. But only about 1750 physicians (who have just completed their training or have moved to Canada from other countries) are going into active practice each year. All provinces except Quebec have been slow to increase enrollment in medical schools, arguing that many health care services can be provided adequately and less expensively by nurses, although nurses are in short supply, too. Rock, the federal health minister, said the provincial medical associations "understand that we have to accelerate the process for accrediting foreign-trained doctors so that in the short term we can meet whatever needs are not being met" by new graduates of Canadian schools.[20]

The acquisition of expensive medical equipment has also been held in check by the requirement that the provincial government approve the purchase of any expensive equipment. With very few exceptions, lithotriptors and magnetic resonance and computed tomographic scanners are approved for use only in teaching hospitals. A recent study reported that of the 29 countries that belong to the Organization for Economic Cooperation and Development, Canada is generally in the bottom third in terms of the number of pieces of sophisticated equipment that physicians have at their disposal.[24]

Hospitals were also major targets of the provincial cost-cutting campaigns. Through a variety of mechanisms, the provinces closed or merged hospitals and reduced the number of available acute care beds. In 1999, there were 877 acute care hospitals with a total of 122,006 beds, as compared with 1128 hospitals with 175,376 acute care beds in 1991, according to the Canadian Healthcare Association.[25] The most

extraordinary mechanism used to pare down the hospital sector was authorized by Ontario's legislature, which created a Health Services Restructuring Commission.[26] The commission was modeled on a commission created by the U.S. Congress to close military bases. In both cases, the purpose was to deflect the inevitable political heat that these actions generate for elected officials. The Ontario commission was granted broad authority to close or merge hospitals in the province.

Although an overall reduction of inpatient capacity made sense because of the rapid growth of ambulatory surgery and other outpatient services, the provinces took few steps to strengthen other essential components of care. In an interview, Rock said:

> We have not recognized the corresponding need to increase home and community care supports. . . . What's more, our system has not, in my view, devoted sufficient resources to the whole spectrum of community care, from preacute to postacute care, to supportive housing for the frail elderly, to long-term care, to palliative care for those who want to die at home. My own parents died at home, one after the other in 1994 and 1995, each from cancer, and I had firsthand exposure to the difficulties of getting access to home care services, the variability in quality, and the lack of connectiveness of home care services to the rest of the system. It was disturbing.

THE DISAPPOINTING FEDERAL RESPONSE

Because the problems of the Canadian health care system are so widely reported and the public holds government accountable for the stewardship of the plans, elected officials are usually anxious to be seen as dealing with the shortcomings of the system. But when finance minister Paul Martin unveiled the new federal budget on February 28, physicians and patients, as well as the 10 provincial premiers, were sorely disappointed. The budget authorized an additional expenditure of $2.5 billion Canadian through Canada Health and Social Transfer payments, which the provinces could use at their discretion over the next four years for higher education, health care, and social programs. The provincial premiers were seeking many times that amount for health care alone. The new federal funds were in addition to the current annual federal contribution of $15.5 billion for health care, education, and social programs. Chrétien chose as his major initiative a reduction of $58 billion in corporate and personal taxes over the next five years, a figure that Martin characterized as "an absolute minimum estimate."

In a letter (unprecedented, I was told) to the prime minister dated March 1, Canada's 10 premiers told Chrétien, "We strongly believe that the federal government is underestimating the scope of the difficulties provinces and territories face in maintaining the integrity and stability of the health-care system. . . . Doctors, nurses and other health-care providers need to know there will be adequate and predictable funding to deliver the services Canadians require." In his response to the letter, Chrétien rejected the call for an emergency meeting, stating that the provincial health ministers should first meet with Rock, the federal health minister, to determine a course of action.

This exchange is typical of the many issues (concerning all manner of subjects) that provoke a prolonged, and often contentious, debate between Ottawa and the 10 provinces. In relation to the health care system, the federal and provincial governments have been engaged over the past several years in public posturing and private negotiations about how to spend the growing federal budget surplus.[3] The provinces have sought major increases in federal payments without new restrictions on how the money is to be spent. Chrétien's Liberal Party, however, wants political victories that would cement its popularity with voters. Recent discussions between federal and provincial ministers have focused on the development of a universal outpatient pharmaceutical benefit and a national home health care program, but concrete proposals supported by both levels of government have remained elusive.

STRIKING NEW BALANCES

Although the Canadian health care system shows clear signs of deterioration, the federal and provincial governments have yet to develop a coordinated plan to address its shortcomings. Many federal and provincial politicians have concluded that an integrated system of primary care must be developed and melded with other community-based and specialty services. Many family physicians (who say they are overworked and underpaid) believe that more integrated delivery systems could reduce the demands placed on emergency rooms and provide broader coverage at night and on weekends.[27] But the development of such systems would require that physicians currently in solo practice join the new organizations (with uncertain financial and professional consequences) and form teams with nurse practitioners, midwives, and other health care providers. Pilot primary care projects sponsored by the Ontario Medical Association and the province of Ontario are experimenting with capitation and reformed fee-for-service payment modes.[28]

Few elected officeholders believe that salvation lies in lifting the ban on private insurance as a means of increasing access to hospital and physicians' services for people who can afford such coverage. The reason Canada imposed the ban in the first place — to prevent private firms from insuring only low-risk patients, supporting the development of multitiered services, or both[5] — still enjoys strong support from the public and elected officials. However, a recent survey of public opinion suggested that many people seem

prepared to support a multitiered system if it would lead to more timely access to care.[29] Canada's largest teaching hospital has begun to explore ways to attract additional private capital, which, according to its recently retired chief executive officer, Dr. Alan Hudson, is "the only way to save health care in Canada."[30]

Canada's physicians, though greatly dissatisfied with the deterioration of the health care system, nevertheless remain remarkably supportive of the public principles on which it is based and are skeptical that they would be better off with a private, market-based model. Several times in recent years, the Canadian Medical Association has debated the idea of supporting privatization of the health care system, but every time it has decided to maintain its support of a publicly funded system. In an interview, Dr. Hugh Scully, a cardiac surgeon at Canada's largest teaching hospital and president of the association, said:

A majority of Canadian physicians continue to support public funding for necessary health care services despite the tight bind governments have placed the provincial plans in financially. We do not think that the injection of private resources necessarily serves the best interests of patients or physicians, but additional funding must come from somewhere. It is a dilemma for the profession, because our patients are demanding better access to care and, particularly, to the latest technology.

The controversy surrounding the role of private insurance is bound to intensify as governments heed the call for tax relief but also seek to accommodate the demand for a modernized health care system. It is uncertain whether Canada will continue to stand alone among industrialized nations in banning the sale of private insurance for publicly covered hospital and medical services. But one thing seems reasonably certain. There is growing concern among Canadians about their beloved health care system. How politicians respond to that concern could well determine the outcome of the next national election, in 2001.

REFERENCES

1. Iglehart JK. Canada's health care system faces its problems. N Engl J Med 1990;322:562-8.
2. National health expenditure database: national health expenditure trends, 1975-1999. Ottawa: Canadian Institute for Health Information, 1999.
3. Naylor CD. Health care in Canada: incrementalism under fiscal duress. Health Aff (Millwood) 1999;18(3):9-26.
4. Health insurance coverage and the uninsured 1990–1998. Washington, D.C.: Health Insurance Association of America, 1999.
5. Evans RG, Lomas J, Barer ML, et al. Controlling health expenditures — the Canadian reality. N Engl J Med 1989;320:571-7.
6. Tuohy CJ. Accidental logics: the dynamics of change in the health care arena in the United States, Britain, and Canada. New York: Oxford University Press, 1999.
7. Fuchs VR, Hahn JS. How does Canada do it? A comparison of expenditures for physicians' services in the United States and Canada. N Engl J Med 1990;323:884-90.
8. Pear R. Drug price issue catching fire in Senate. New York Times. April 6, 2000:A16.
9. Rosenbaum DE. Candidate hits road with health-costs crusade. New York Times. December 15, 1999:A21.
10. Barer M, Evans R, Lewis S, Rachlis M, Stoddart G. Private highway, one-way street: the deklein and fall of Canadian Medicare. (See http://www.chspr.ubc.ca.)
11. Priest L. Stroke of genius or Pandora's box? Globe and Mail (Toronto). March 4, 2000:1.
12. Donelan K, Blendon RJ, Schoen C, Davis K, Binns K. The cost of health system change: public discontent in five nations. Health Aff (Millwood) 1999;18(3):206-16.
13. OECD health data 99. Paris: Organization for Economic Cooperation and Development, 2000.
14. Taylor MG. Health insurance and Canadian public policy: the seven decisions that created the Canadian health insurance system. Montreal: McGill–Queen's University Press, 1979.
15. Naylor CD. Private practice, public payment: Canadian medicine and the politics of health insurance, 1911–1966. Kingston, Ont.: McGill–Queen's University Press, 1986.
16. Freund DA, Willison D, Reeher G, et al. Outpatient pharmaceuticals and the elderly: policies in seven nations. Health Aff (Millwood) 2000;19(3):259-65.
17. Supply, distribution and migration of Canadian physicians, 1998. Ottawa: Canadian Institute for Health Information, 1998.
18. Restore healthcare funding taken from provinces full majority say. News release of the Angus Reid Group, Toronto, February 6, 1999.
19. McIlroy A. Most feel health care should get priority. Globe and Mail (Toronto). February 21, 2000:1.
20. Iglehart JK. Restoring the status of an icon: a talk with Canada's minister of health. Health Aff (Millwood) 2000;19(3):132-40.
21. Ryten E. A statistical picture of the past, present and future of registered nurses in Canada. Ottawa: Canadian Nurses Association, 1997.
22. Canadian medical education statistics. Ottawa: Association of Canadian Medical Colleges, 1999.
23. Barer ML, Stoddart GL. Toward integrated medical resource policies for Canada. Report prepared for Federal/Provincial/Territorial Conference of Deputy Ministers of Health, 1991.
24. Harriman D, McArthur W, Zelder M. The availability of medical technology in Canada: an international comparative study. Public policy source paper no. 28. Vancouver, B.C.: Fraser Institute, 1999.
25. Priest L. Wanted: CEO with entrepreneurial spirit. Modern Healthcare 2000;30(17):22, 24.
26. Health Services Restructuring Commission. Better hospitals, better health care for the future: summary report on hospital restructuring 1996-1999. Toronto: Health Services Restructuring Commission, 1999.
27. College of Family Physicians of Canada. Managing change: the family medicine group practice model. Ottawa, Ont.: College of Family Physicians of Canada, 1995.
28. Graham W. Primary care reform progress report: Thunder Bay, Ottawa, Parry Sound join pilot project. Ontario Med Rev 1999;66(9):21-3.
29. Kennedy M. 73 Percent back private health care: most Canadians in favour of two-tiered system if it means 'timely access' to care, survey finds. Ottawa Citizen. January 22, 2000.
30. Beltrame J. To ease crisis in health care, Canadians eye private sector. Wall Street Journal. April 11, 2000:B1.