

CHEPA WORKING PAPER SERIES
Paper 08-04

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Private Health Insurance in Canada

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October 15, 2008

This paper is forthcoming as a chapter in *Private Health Insurance and Medical Savings Accounts: Lessons from International Experience*, S. Thomson, E. Mossialos and R. G. Evans, Eds, London: Cambridge University Press.

Acknowledgements: We thank members of the health Polinomics seminar for helpful comments, and we acknowledge funding from the Ontario Ministry of Health and Long-term Care to the Centre for Health Economics and Policy Analysis. The views expressed in this paper are those of the authors and do not represent the views of the CHEPA or the Ontario Ministry of Health and Long-term Care.

Introduction

Although a majority of Canadians hold some form of private health care insurance -- most commonly obtained as an employment benefit -- private insurance finances only 12% of health care expenditures in Canada and its financing role is essentially limited to complementary coverage for services not covered by public insurance programs. Private supplementary insurance for services covered by the public insurance system does not exist in Canada. This limited role for private insurance in health care reflects the core policy vision for health care financing in Canada, which emphasizes equal access to medically necessary health care, especially physician and hospital services. Compared to many other countries, Canada's private health insurance market is relatively uncomplicated, viewed in terms of either the products offered or the regulations imposed. Although Canadians regularly debate the relative split between public and private finance overall, and a small set of advocates have persistently pressed for a greater role for private insurance, private insurance has not figured prominently in Canada's health care policy debates, which since the late 1960s have focused on the publicly funded health care system.

Three Canadian health care policy challenges, however, are drawing the role of private health insurance into the centre of policy debate. The first has been the emergence in the last ten years of long wait times for some common, high-profile services such as orthopaedic surgery, eye surgery, diagnostic imaging, and cancer treatments. These wait times have fuelled advocates for parallel private finance alongside public insurance and for loosening restrictions on supplementary private insurance. Such advocates were emboldened by a landmark 2005 Supreme Court of Canada ruling (*Chaoulli vs. Government of Quebec*) that, in the presence of excessive wait times in the public system, Quebec's statute prohibiting private insurance for publicly insured services violated Quebec's Charter of Rights. Though the ruling has only narrow application to Quebec, the judgement has given momentum to those advocating for a fundamental change in the role of private insurance in Canadian health care.

The second element drawing private insurance into the centre of policy debate is the growing importance of pharmaceuticals in the modern pantheon of medically necessary therapies. Prescription drugs are excluded from the core services covered by Canadian Medicare, so the majority of pharmaceutical costs are privately financed. Many Canadians, however, are either uninsured or underinsured for prescription drugs. This has prompted many to call for an expansion of public financing for prescription drugs (National Forum on Health 1997; Commission on the Future of Health Care in Canada 2002; Senate of Canada 2002). Some proposals call for full public coverage that would supplant the currently large role of private insurance in this sector; others, call for various types of public-private partnerships to ensure universal coverage. All of them force the question of the desired role for private insurance in this increasingly important and expensive sector of health care.

Finally, policy makers and system analysts increasingly appreciate the interactions between the publicly and privately financed components of the overall health care system. Unequal access to privately insured services can lead to unequal access to and use of publicly insured services. Both Stabile (2001) and Allin and Hurley (2008), for instance, find that other things equal, those with private drug insurance use more publicly financed physician services (an effect unlikely to be driven by selection). This type of evidence prompts hard questions regarding the scope of policies necessary to achieve objectives set for the publicly financed health system.

This chapter reviews the role of private health insurance in Canada. It begins with a brief overview of the Canadian health care system; considers the historical path that led to the current role for private health insurance; examines the current market for private health insurance; assesses the evidence for how private insurance contributes to or detracts from health financing goals; and offers some concluding comments on private health insurance in Canada.

Canada's Health Care System

Canada is a federation, so the design of the Canadian health care system derives from the allocation of responsibilities in Canada's constitutional documents between the federal government and the provincial governments. The British North America Act of 1867 and the 1982 Constitution assign responsibility for health care to provincial governments and provide the federal government extensive revenue-raising power. Consequently, Canada's health care system comprises 13 distinct provincial/territorial¹ health care systems. Each provincial system, however, conforms to national standards embodied in the 1984 Canada Health Act, which the federal government enforces through a system of conditional federal transfers (the Canada Health Transfer) to the provinces (Table 1). By international standards, Canada spends an above-average amount on health care (Table 2). Per-capita health care spending in 2005 was \$3,326 (US\$ PPP), which places it ninth internationally behind France, Belgium, Iceland, Austria, Switzerland, Norway, Luxembourg and the United States (OECD 2007). Health care spending in Canada represents 9.8 % of GDP (OECD, 2007). After slowing in the mid-1990s during a period of unprecedented fiscal restraint in the public sector, spending has been increasing at a rate of 6% for the last 10 years (CIHI, 2006).

¹ Canada includes 10 provinces and 3 territories. We refer to them generically as provinces.

Table 1: Canada Health Act National Standards

To be eligible for the full federal transfer, a provincial public insurance plan must conform to each of the following five Canada Health Act principles.

- (1) **Accessibility:** the plan must not impede, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured health services
- (2) **Comprehensiveness:** the plan must cover medically necessary physician and hospital services, including surgical-dental services that require a hospital setting¹
- (3) **Universality:** the plan must cover all provincial residents on uniform terms and conditions²
- (4) **Portability:** the plan must not impose a minimum period of residence in excess of three months for new residents, it must cover its own resident when temporarily in another province (or country in the case of non-elective services) and during the waiting period in another province for residents who have moved permanently.
- (5) **Public administration:** the provincial plan must be administered and operated on a not-for-profit basis by a public authority.

Source: (Government of Canada 1984; Marchildon 2005)

¹Insured services excludes services covered by the worker's compensation system, which are financed through employer contributions to the workers' compensation fund

²The insured population excludes certain sub-groups such as members of the military, Royal Canadian Mounted Police, prisoners and aboriginals, who are covered by the federal government.

Table 2: Health Care Spending in Canada and Selected OECD Countries, 2005

	%GDP				Per capita (US\$ PPP)		
	Total	Public	Private		Total	Public	Private
United States	15.3	6.9	8.4	United States	6401	2884	3517
Switzerland	11.6	6.9	4.7	Luxembourg	5563	5043	520
France	11.1	8.9	2.2	Norway	4364	3647	717
Germany	10.7	8.2	2.5	Switzerland	4177	2493	1684
Belgium	10.3	7.4	2.8	Austria	3519	2665	854
Austria	10.2	7.7	2.5	Iceland	3443	2842	602
Portugal	10.2	7.4	2.8	Belgium	3389	2451	914
Greece	10.1	4.3	5.8	France	3374	2693	680
Canada	9.8	6.9	2.9	Canada	3326	2337	989
Australia*	9.5	6.4	3.1	Germany	3287	2527	760
Iceland	9.5	7.9	1.7	Australia*	3128	2110	1018
Denmark	9.1	7.7	1.4	Denmark	3108	2614	494
Norway	9.1	7.6	1.5	Greece	2981	1277	1703
Sweden	9.1	7.7	1.4	Ireland	2926	2281	644
New Zealand	9.0	6.9	2.0	Sweden	2918	2469	449
Italy	8.9	6.8	2.1	Netherlands**	2775	1733	1042
Spain	8.3	5.9	2.4	United Kingdom	2724	2371	352
United Kingdom	8.3	7.2	1.1	Italy	2532	1938	593
Netherlands**	8.2	5.5	3.3	Japan*	2358	1927	431
Japan*	8.0	6.6	1.5	Finland	2331	1813	518
Luxembourg	7.9	7.1	0.7	New Zealand	2330	1803	527
Finland	7.5	5.9	1.7	Spain	2261	1615	646
Ireland	7.5	5.8	1.7	Portugal	2041	1476	565

Note: * data from 2004; ** data from 2002

Source: OECD (2007)

Health care in Canada is predominately publicly financed (Table 3). In 2005, 70.1% of health care was financed publicly, a level that is a bit lower than the peak of 77% in 1976 but which has remained relatively constant for the last decade. The Canada Health Act's focus on physician and hospital services, however, leads to a unique pattern of public financing across health care sectors. Public financing for physician and hospital services, commonly referred to as Canada's Medicare program, constitutes 98.6% and 90.3% of expenditures in these sectors. Outside these two sectors the role of public insurance is markedly smaller and more variable. Public finance is next most important for other institutions, such as long-term care facilities. Public finance is least important for dental care, for which the only universally publicly insured dental care is inpatient oral surgery and the public sector finances less than 5% of all services. In between is the drug sector, for which the public sector finances 39% of all drugs (and 44% of prescription drugs). *De facto*, therefore, Canada's "single-payer, universal" system of public finance accurately applies only to physician and hospital services.

Table 3: Health Care Expenditures in Canada by Source of Funds, 2005

	Total Health Care Spending	Public Health Care Spending	% of Total Spending	Private Health Care Spending	% of Total Spending
Total	141,241	99,073	70.1%	42,168	29.9%
<i>Physician Services</i>	18,536	18,280	98.6%	256	1.4%
<i>Hospital Services</i>	40,363	36,464	90.3%	3,899	9.7%
<i>Drugs</i>	23,340	9,099	39.0%	14,241	61.0%
<i>Dental Care</i>	9847	449	4.6%	9398	95.4%
<i>Other Health Professional</i>	5,361	678	12.7%	4,683	87.3%
<i>Other Institutions</i>	14,759	11,077	75.1%	3,681	24.9%
<i>Other</i>	29,035	22,026	79.3%	6,009	20.7%

Source: CIHI (2007)

All figures in
000,000's

The public insurance programs are financed primarily through personal income and consumption taxes levied by both the federal and provincial governments. Three provinces — British Columbia, Alberta and Ontario — retain national health care "premiums" for the core Medicare services.² The premiums vary according to income in all three provinces and by

² Alberta will eliminate its health care premium as of January 1, 2009.

household composition in British Columbia and Alberta; none of the provinces risk-adjust the premiums. An individual cannot be denied service for failure to pay the premium, so they are, *de facto*, simply taxes.³ Three provinces (Quebec, Alberta and Nova Scotia) charge premiums to some beneficiaries of their public drug insurance programs. The premiums depend on income and beneficiary status: Quebec and Nova Scotia exempt those on social assistance; Alberta exempts seniors and those on social assistance (Canadian Institute for Health Information 2008). Four provinces (Newfoundland, Quebec, Ontario and Manitoba) collect a health-specific payroll tax (rates up to 4% depending on the size of a firm's payroll), but in general, neither local taxes nor payroll taxes contribute meaningfully to health care finance.

Private finance encompasses a mixture of direct, out-of-pocket payments for care (48.2%), private insurance coverage (41.3%), and "non-consumption" spending (10.5%), which includes non-patient revenue to hospitals (ancillary operations, donations, and investment income), expenditures on research, and capital expenditure in private sector (Table 4).⁴ Overall, private out-of-pocket spending is a larger source of finance than is private insurance, though again, this varies by sector. Private insurance plays an important role only outside the physician and hospital sectors. In 2004, for instance, although 12.3 % of health care was financed through private insurance, this proportion ranged from a low of effectively 0% for physician services and 2.3% for hospital care to over 54.4% for dental services (Table 4). Dental care is the only sector for which private insurance finances a majority of care. Private insurance is next most important for drugs, for which it finances 28.7% of expenditures. Insurance for dental care and drugs are the largest sources of revenue for the private insurance industry: private insurers derived 38.6% of premium revenue from drug insurance and 30.1% for dental insurance (Canadian Institute for Health Information 2007).

Provincial health care systems are governed, with the exception of Alberta and Prince Edward Island, through regionalized systems of governance. Regionalized health authorities generally control institutional care (acute hospital and long-term care), community care (home care services), public health, and a variety of smaller programs. In no instance does their authority extend to public, community-based drug programs or physician services, which in all provinces are administered by the provincial Ministry of Health. Provincial governments allocate

³ In British Columbia, many employers pay the premium on behalf of employees as one component of health-care-related benefits provided to employees. Just under half of BC residents have their premium paid by an employer (Hanley et al. 2007)

⁴ Private insurance does not, in general, cover cost-sharing requirements within public insurance program. One exception to this is large deductibles that apply for higher income, working age populations within some provincial public drug insurance programs. It is also possible for an individual to hold private insurance in parallel to public drug coverage, though such insurance is relatively rare.

Table 4: Private Health Expenditures, Canada 2005

	Out-of-Pocket	% Total Health Care Spending	% Private Health Care Spending	Private Insurance	% Total Health Care Spending	% Private Health Care Spending	Non-Consumption	% Total Health Care Spending	% Private Health Care Spending
Total	20,306	14.4%	48.2%	17,245	12.2%	41.3%	4,617	3.3%	10.5%
<i>Physician Services</i>	249	1.3%	97.3%	7	0.0%	2.0%	0.0	0.0%	0.0%
<i>Hospital Services</i>	725	1.8%	18.6%	995	2.5%	25.6%	2,179	5.4%	56.1%
<i>Drugs</i>	7,473*	32.0%	52.5%	6,769	29.0%	46.5%	0.0	0.0%	0.0%
<i>Dental Care</i>	4190	42.6%	44.6%	5208	52.9%	57.1%	0.0	0.0%	0.0%
<i>Other Health Professional</i>	3,452	64.4%	73.7%	1,231	23.0%	25.8%	0.0	0.0%	0.0%
<i>Other Institutions</i>	3,682	24.9%	100.0%	0.0	0.0%	0.0%	0.0	0.0%	0.0%
<i>Other</i>	535	1.8%	8.9%	3,036	10.5%	53.9%	2,438	8.4%	37.8%

Source: CIHI (2007)

All figures in \$000,000

*This includes out-of-pocket on both prescription drugs and over-the-counter medications. Out-of-pocket costs for prescription drugs constitutes approximately 60% of this total.

budget envelopes to regional health authorities based on a mixture of historical funding levels and need criteria, and each regional health authority allocates its budget among the services, programs and providers over which it has authority. Although regional health authorities increasingly use contractual approaches in their relationships with providers of services, nowhere is the relationship between the regional authorities and providers in their region formally structured as a purchaser-provider split designed to foster an internal market.

Hospitals in Canada are most commonly funded through annual global budgets. The basis for the global budget varies across the provinces and regions. In most settings a hospital's budget includes a large purely historical component, but hospital funding methods increasingly incorporate factors based on a hospital's case-mix adjusted volume. Physician services are funded predominately by fee-for-service, though the role of alternative payment methods including capitation, salary, programmatic funding, and incentive-based payments has been increasing in recent years, especially within the primary care sector. Long-term care is funded either through global budgets for public facilities or, for private facilities, through per-diem public subsidies to facilities based in many cases on standardized assessments of the severity of residents in a facility.

All provinces offer a public drug-benefit plan for community-based drug purchases.⁵ Public drug coverage is concentrated among the elderly and individuals on social assistance, but all individuals are potentially eligible for coverage in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Quebec, albeit with high deductibles for working-age and/or high-income individuals (Canadian Institute for Health Information 2008). British Columbia and Manitoba recently changed from age-based coverage criteria to income-based criteria. In 1996, Quebec introduced a novel public and private financing arrangement for its universal drug coverage scheme, Canada's only explicit public-private insurance partnership (See Box 1). Public expenditure on drugs varies across the provinces, ranging from a low of 36% of prescription drug expenses in Prince Edward Island to 53% in Manitoba (Canadian Institute for Health Information 2008).

Canadian health care, like health care systems around the world, faces a number of difficult challenges. Some of the prominent current policy challenges include long wait-times for selected services, shortages and a maldistribution of some health professionals, an out-moded primary care delivery system dominated by physicians in solo or small group practice, a drug sector with ever rising costs and increasing access problems for some Canadians, and dated

⁵ All prescription drugs obtained while inpatient in a hospital are free.

information systems that impede information sharing and the creation of an electronic health record.

Box 1: Quebec's Mixed Public-Private Universal Drug Plan

In 1997, the province of Québec introduced a compulsory prescription drug insurance plan for all its residents designed on a social insurance basis. Universal coverage is achieved through a coordinated mixture of private insurance plans, most often available through employment, and a public plan, administered by the Régie de l'assurance maladie du Québec. All residents under age 65 who are eligible for a private plan must obtain at least its prescription drug coverage component for themselves, their spouse and children, provided their spouse and children are not already covered by another private plan. Insurance plans provided by employers may have eligibility requirements (e.g., exclude part-time, temporary or contractual employees) and may not provide coverage to all employees. However, risk selection based on age, sex or health status is not permitted. The premium is negotiated between the policyholder (i.e., typically a group plan sponsor such as an employer, union or association) and the insurer, but are paid by persons insured.^a The Régie sets the maximum annual individual contribution to the cost of such insurance (\$904 in January 2008). The Régie, in collaboration with Revenu Québec, conducts eligibility verifications to ensure that those who have access to a private plan do not obtain coverage from the public plan. When turning 65, those who have access to a private plan with basic prescription drug coverage can choose to retain their private plan coverage or join the public plan.

The public prescription drug insurance plan provides coverage to persons age 65 and over, social assistance recipients, persons who do not have access to a private plan, and children of persons covered by the public plan. The public plan charges a premium collected through income tax; the premium is capped at \$557 per adult per year (effective July 2007 to June 2008), depending on net family income.^b The public plan covers prescription drugs listed on a formulary published by the Régie. Individuals must register for the public plan. Failure to register does not exempt individuals from paying the premium and payment of the premium is not a substitute for registration. Individual who fail to register receive no drug coverage. See Pomey *et al.* (2007) for additional details on the introduction of and design of Quebec's program.

^aAs of January 1, 2007, employers are obligated to deduct premiums for prescription drug insurance private plan from employee remuneration unless the employee is covered under another private insurance plan.

^bThe following individuals are exempt from paying the premium: children of insured persons; social assistance recipients; low-income seniors; seniors who have a private prescription drug plan whose benefits exceed those contained in the public plan. (Seniors who have private coverage more limited than that of the public plan must pay the premium.)

Private Health Insurance in Canada

The Development of Private Insurance in Canada

Canada's current financing and delivery arrangements largely derive from a series of policy decisions made in the 1950s and 1960s, which themselves reflected an assessment at that time of the contribution private insurance could make to achieving key policy goals.

The 1930s witnessed both the emergence of private health care insurance as a marketed commodity and some of the first initiatives to provide public insurance. A survey conducted by the Canadian Medical Association in 1934 identified 27 hospital pre-payment plans operating in six provinces (Hall 1964). Under pre-payment plans (akin to modern HMOs in the US), the hospital was both the insurer and provider: an individual paid a fixed premium to a hospital in return for the provision of specified services should they be needed during the period covered. The first “Blue Cross” pre-paid plan for hospital services was established in Manitoba in 1937 (Hall 1964).⁶ This was quickly followed by Blue Cross plans in Ontario in 1941, Quebec in 1942, the Maritimes and British Columbia in 1943 and Alberta Blue Cross in 1948. Profession-sponsored (and controlled) pre-payment plans for medical services developed in parallel with the spread of hospital insurance. The first such plan was offered in Toronto in 1937, followed by plans in Windsor, Ontario and Regina, Saskatchewan in 1939, and then a series of plans across Canada during the 1940s. The Medical Services Association of British Columbia, established in 1940, was the first province-wide medical plan. Life insurance companies and casualty insurance companies (which insure all risks other than life) also began offering various types of health care and disability insurance during this period, with life insurance companies tending to focus on the group market while casualty insurers concentrated on the individual market. Finally, insurance co-operatives played an important role, especially in the early part of this period and in the west.

During this same period, calls for public insurance programs grew as well, especially in the western provinces that were particularly hard hit by the depression. These initiatives often found considerable support within the medical profession, in part for purely economic reasons: many patients could not pay for care privately, making it difficult for a physician to maintain a practice. The public efforts included municipally-based initiatives, such as the municipal doctor program and the creation of hospital districts to finance and oversee hospitals, and provincial initiative to introduce public insurance. Both Alberta and British Columbia passed public health insurance plans in the 1930s, though neither plan was implemented. National health care insurance was a central element in the federal government’s vision for post-war social programs. The federal plan, however, was scuttled in the breakdown of the federal-provincial Dominion talks in 1945, leaving provinces to act alone. In 1946 Saskatchewan became the first province to implement a provincial hospital insurance plan. Saskatchewan was followed in 1949 by British Columbia and Alberta.

⁶ Blue Cross is an association of independent, regionally operating health insurance plans that conform to defined plan criteria. Blue Cross began as an association of hospital pre-payment plans in the US. Blue Cross Canada is organizationally distinct from its US counterpart, though they operate on the same model.

By the 1950s voluntary insurance had made considerable in-roads into the Canadian middle class. This had a number of important impacts *vis-à-vis* public and private financing. It reduced the pressure for large-scale public action since a substantial proportion of the population had access to at least some insurance. It also weakened physician support for public insurance, especially public medical insurance. The medical profession strongly advocated for private plans, particularly physician-sponsored plans, which retained control and power for the profession. These developments altered the nature of the debate regarding public health insurance. Rather than public insurance, many analysts now advocated limiting the public role to public subsidy for low-income individuals that would enable them to purchase private insurance. The success of both the voluntary private insurance plans and the few existing provincial public plans demonstrated the soundness of such insurance plans and the value people placed on insurance. The gaps in private coverage (even in urban Ontario) suggested, however, that private insurance could never provide universal coverage, and the increasing demands on provincial and local resources and on hospitals themselves provided an opportunity for the federal government to act on its national vision. The result was the Hospital Insurance and Diagnostic Services Act of 1957 (HIDS 1957). This legislation provided universal public insurance for inpatient hospital services financed through a combination of provincial revenue (raised through a variety of specific instruments across the provinces) and matching federal grants. The provincial hospital insurance plans supplanted private insurance for medically necessary inpatient services. Hospital benefits offered by private insurance shrank to complementary, mostly non-medical, services associated with a hospitalization (e.g., room upgrade from ward to semi-private).

The huge success of public hospital insurance, the growing importance to Canadians of access to a wide range of health care services and, ironically, concern by the medical profession over growing support for public universal insurance (rather than public subsidy to private insurance) prompted the establishment in 1961 of the Royal Commission on Health Services led by Justice Emmett Hall (hereafter the “Hall Commission”). The Hall Commission was given a broad mandate with respect to the planning, delivery and financing of health care in Canada. The starting point for the Commission’s assessment of private and public insurance options was the principle that all Canadians should have access to necessary health care, a principle agreed to by all major stakeholders — the medical profession, private insurers, business, consumer groups, etc. Major stakeholders, however, differed on the best policies for achieving this objective. The medical profession, private insurers and private industry argued that this could best be achieved through private insurance supplemented with public subsidies to those who

otherwise could not afford such insurance; others argued for a system of universal public insurance. The Commission judged three issues as central to the policy choice: the ability of voluntary insurance to provide universal comprehensive insurance; the costs associated with means-testing to determine eligibility for a public subsidy; and the legitimacy of compelling individuals to participate in such a public insurance scheme. In the end, the Commission recommended a system of universal public insurance for medical services, dental services, drugs and home care. This recommendation was based on the judgement that a system of private insurance, even accompanied by public subsidies, could not achieve universal coverage and access;⁷ that the number of persons requiring subsidy under a private system would be large and that means-testing would require a large, expensive and unnecessary administrative infrastructure; and that compulsory membership in a universal public plan would not violate fundamental rights. The Commission viewed universal public insurance as a less costly way to achieve universal coverage than a system based on private insurance (Hall 1964).⁸

Based on the Commission's recommendations, the federal government passed the Medical Care Act of 1966 which, like the 1957 HIDS Act, provided for a system of matching federal grants to provincial medical care insurance plans that met defined criteria of universality, comprehensiveness, public administration and portability. By 1972, all provinces had public plans that complied with these principles. Because of fiscal concerns, the legislation excluded drugs, dental care and home care services. The 1957 HIDS Act and the 1966 Medical Care Act, later consolidated in the 1984 Canada Health Act, defined the basic roles of public and private insurance in Canada that exist to this day.

The Current Market for Private Health Insurance in Canada

Who has Private Health Insurance Coverage?

No single source summarizes the number and characteristics of Canadians who hold private health insurance. Figures regarding various aspects of private insurance coverage demonstrate that a large majority of Canadians hold some type of private health insurance. The majority of those covered obtain insurance as a benefit of employment (of themselves, a spouse or a parent). The data are most comprehensive for private drug coverage. Self-reported data from

⁷This conclusion was based on the observation that private insurance had left a substantial portion of Canadians uncovered at that time and the experience of Australia, which since 1953 had been unable to achieve universal through a system of private voluntary insurance and public subsidy.

⁸In regard to the administrative costs of means testing, it observed that: "The health services will make enough demand on our resources. We must not waste them." (p. 743). It also noted that the administrative costs of private voluntary insurers would exceed those of a public insurer (such costs were estimated to be 22% higher), again wasting valuable resources better allocated to health care itself.

the 2005 Canadian Community Health Survey indicate, for instance, that 60% of Ontarians hold employer-based prescription drug coverage and 5% hold individually purchased drug insurance (Allin & Hurley 2008).⁹ These self-report data suggest somewhat lower coverage than other sources. An earlier study conducted by Health Canada estimated that 60% of all workers and their families were covered by employer-sponsored plans, 26% of retirees over age 65 had coverage from an employer-sponsored plan, and that only 1% of adults under age 65 held an individual drug plan (Health Canada 2000).

Among those who are employed, the rates of coverage for health-related benefits vary substantially according to the sector of employment, workplace size (employers with over 500 employees are three-times more likely to offer such benefits than those with fewer than 20), part-time/full-time status (full-time three times more likely to receive benefits), earnings (those earning \$20/hour or more 2.5 times more likely than those earning less than \$12/hour) and union status (unionize about 50% more likely than non-unionized) (Statistics Canada 2004).

Insurance Organizations

Three types of insurers in Canada sell private health care insurance: for-profit health and life insurance companies, non-profit insurance organizations whose primary business is health coverage and for-profit property and casualty insurers whose primary business is not health-related. The market is dominated by for-profit life and health insurers, which nationally account for approximately 80% of the private health insurance market; non-profit health insurers rank next; property and casualty insurers constitute less than 5% of the market.¹⁰ The relative market shares of these different types of insurance organizations vary by province, and the non-profit insurers in particular have a strong regional structure. A little more than 80% of insurers operate in more than one province and are subject to both federal and provincial regulations; the remainder operate in a single province and are subject to provincial regulation only (Vella & Faubert 2001).

The primary source of information on private insurers comes from an annual Factbook published by an industry trade organization, the Canadian Health and Life Insurance Association Inc. (CLHIA) (Canadian Life and Health Insurance Association 2006). Although the CLHIA membership is made up of life and health insurance companies, and does not include as

⁹An additional 11% reported government-provided coverage.

¹⁰ Estimates vary by source and time period; good, comprehensive data are not readily available. A publication from the Department of Finance suggests that for-profit life and health organizations account for up to 90 percent of private health insurance sold in Canada (Department of Finance 1999). The Director of Statistical Services at the Canadian Life and Health Insurance Association estimated that the large not-for-profit insurers account for about 20% of the market, though she noted that this was based on limited data available (Freeburn 2007).

members property and casualty insurers, the data reported in the annual CLHIA Factbook includes property and casualty insurers. Consequently, the data reported represents over 99% of the for-profit insurance organizations (Klatt 2008).¹¹

The CLHIA reported that in 2005, for-profit 126 insurance organizations sold health insurance products in Canada (Canadian Life and Health Insurance Association 2006). Nearly all were incorporated in Canada (90) or the United-States (29). The sector has been subject to a number of mergers and acquisitions in the last decade, which has increased concentration of the industry. Among the 126, 81 life and health insurance companies sold over 96 percent of all complementary health care and disability insurance products and 45 property and casualty companies sold the balance. Of the 81 life and health insurance companies, 72 are incorporated as publicly traded stock companies and 9 are mutual companies formally owned by the policy owners. Since 1997 many insurance organizations have changed status from mutual companies to for-profit stock companies traded on stock exchanges. This transformation was allowed by regulatory changes in 1997 and 1998 and has been motivated by the companies' desire to gain access to equity capital (Vella & Faubert 2001). The non-profit sector has only one firm that operates nationally, and is dominated by regional Blue Cross organizations, including Blue Cross Pacific (British Columbia and the Yukon), Alberta Blue Cross (Alberta and the Northwest Territories), Saskatchewan Blue Cross, Manitoba Blue Cross (Manitoba and Nunavut), Ontario Blue Cross, Québec Blue Cross and Medavie Blue Cross (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland). Canadian Blue Cross Plans are associated with the Blue Cross and Blue Shield Association in the United States (Blue Cross 2007).¹²

Insurance Products

Private insurers in Canada offer nine basic types of health-related insurance: (1) extended health care insurance; (2) hospital supplemental insurance only; (3) prescription drug insurance only; (4) dental care insurance; (5) disability income insurance; (6) accidental death and dismemberment; (7) critical illness insurance (8) long-term care insurance; (9) travel insurance (Table 5).

¹¹ CLHIA Factbook includes data from all life & health insurers and nearly all of the health insurance business of property and casualty insurers, regardless of whether or not they are members of CLHIA. As noted, the major exception is not-for-profit health benefit providers that constitute approximately 20% of the overall market. Casualty insurers, such as automobile insurers, also finance health care required as a result of accidents covered by auto insurance policies. Such coverage is excluded from data reported by the CLHIA; we also exclude such coverage from consideration because it is not associated with health insurance policies.

¹² This regional structure is beginning to blur. Medavie, for instance, sells both individual and group policies in New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland, but also sells group policies only in Quebec and Ontario.

Table 5: Private Health Insurance Products, Canada

Insurance Product	Description	Population Covered in 2005 (thousands)		Comment
		Group Policies*	Individual Policies	
Extended Health Care Insurance	Covers the following services where they are not publicly insured: hospital services, prescription drugs, non-physician providers, vision care, travel insurance and miscellaneous other services ^a	29,900 (91.6%)	711 (2.2%)	The set of included services varies across policies. The defining feature is that a single policy covers multiple types of services that are not publicly insured. All policies include hospital services; most include prescription drugs; the variation is largest for other services
Hospital Only	Covers only non-medically necessary hospital ancillary services	854 (2.6%)	171 (0.5%)	
Prescription Drug Only	Covers community-based prescription drugs	113 (0.3%)	3 (0.0%)	
Dental	Covers community-based dental services	19,600 (60.0%)	21 (0.1%)	
Critical Illness Insurance	Provides a lump-sum cash payment on the first diagnosis of one of several contractually specified conditions		620 (1.9%)	A small number may be group; group policies are increasing in popularity
Long-term Care Insurance	Provides contractually specified payments for those who can no longer function independently due to physical or cognitive impairment and/or aging		53 (0.2%)	A small number of these may be group
Long-term Disability Insurance	Provides income replacement at a contractually specified rate in the event of long-term disability.	10,268 (31.3%)	966 (3.0%)	
Accidental Death & Dismemberment	Provides a contractually specified cash payment in the event of death or loss of one or more body parts as a results of an accident	14,600 (44.7%)	1,700 (5.2%)	
Travel Insurance Only	Covers the costs of emergency medical services (that are not publicly insured) required when travelling outside of Canada	Most coverage is obtained as part of extended health policies	Most individual policies sold at time of travel on trip-by-trip basis	

Figures in parentheses indicate the number covered as a proportion of the Canadian population.

*Includes an unknown amount of double-counting when two (or more) members of a household each obtain coverage for themselves and dependents from different group policies. Hence, the figures over-estimate the extent of private insurance coverage.

Source: Coverage figures obtained from Canadian Life and Health Insurance Association (2006)

Extended health care (EHC) plans insure a range of hospital and other health care expenses not covered by a provincial public insurance plan, including hospital amenities, prescription drugs, non-physician providers, vision care, medical devices, travel insurance, and ambulance service. Extended health care policies normally include deductibles and coinsurance provisions as well as annual and/or lifetime maximums for specific types of services. The details vary by plan, and cost-sharing is in general increasing, but cost-sharing provisions are usually relatively minor for hospital services and prescription drugs. Private prescription drug coverage, for example, typically has an annual individual or family deductible of \$25/individual or \$50 per family; requires 20% cost-sharing above the deductible; and might have out-of-pocket payment limit of approximately \$2000. The coverage may be more limited for other services in the plan, depending on the coverage purchased by the plan sponsor. Coverage for non-physician services such as physiotherapy, chiropractic care, or counselling may be limited to a specific number of visits annually or a maximum dollar amount (e.g, \$500-\$600) depending on the plan sponsor's selection (Klatt 2008).

The market for extended health care insurance is heavily dominated by group contracts provided by employers to employees or purchased through professional orders, associations and unions by members. Group contracts dominate for the usual reasons: for workers, the value of such an employment benefit is tax exempt (more on this below); for others, access to a group policy through an association (e.g., a farm cooperative) offers substantially lower premiums than those available in the individual market; and for insurers, group contracts incur lower overhead costs and reduce the potential for adverse selection. In 2005, revenue from group contracts constituted 91 percent of total premium revenue (Canadian Life and Health Insurance Association 2006). At the end of 2005, out of a population of approximately 30 million individuals, about 112,000 group contracts provided extended health care coverage to 7.9 million workers and 11.2 million dependents.¹³ A more limited number of Canadians (710,000) were covered through individual contracts (Canadian Life and Health Insurance Association 2006).

Most supplemental hospital and prescription drug is obtained through extended health care benefits, so the markets are considerably smaller for policies that provide only supplemental hospital coverage or only prescription drug coverage. 170,800 individuals had supplemental hospital care coverage only; 112,600 individuals had group coverage providing

¹³ Figures on the number of individuals covered include an unknown amount of double-counting from families in which individuals may have coverage through more than one policy.

prescription drug insurance only and about 3000 held individual coverage for prescription drugs only (Canadian Life and Health Insurance Association 2006; Klatt 2008).

Dental plans cover community-based dental services only. Dental coverage is normally through stand-alone policies and is not included in an extended health care policy. At the end of 2005, dental plans covered 11.1 million workers and their dependents through 81,000 group contracts while only 21,000 individuals held non-group, individual policies (Canadian Life and Health Insurance Association 2006). Dental policies also normally include modest deductibles and cost-sharing in the range of 20% above the deductible.

Disability income insurance plans insure against lost income if one becomes unable to work due to accident or ill health.¹⁴ At the end of 2005, 39,200 group contracts provided short-term income replacement to 2 million workers, 98,600 group contracts provided long-term income replacement to 8.4 million workers, and nearly one million individual contracts provided short and/or long term coverage.

Both accidental death and dismemberment insurance and critical illness insurance are indemnity policies that pay a pre-specified amount of money when a specified health-related event occurs. Accidental death and dismemberment insurance pays the predetermined amount (which varies according to the injury) to those who die or are dismembered in an accident. 14.6 million Canadians hold such insurance through over 100,000 group contracts. Critical illness insurance provides a pre-determined payment if any of a pre-specified set of critical illnesses occur, such as heart attack, stroke, and cancer. Critical illness insurance is one of the fastest growing types of private insurance in Canada because it avoids restrictions on private insurance for publicly insured services (it does not cover any services *per se*) while providing resources to purchase private care if necessary in the event of a serious illness. By the end of 2005, 620,400 Canadians possessed critical illness insurance sold by private, for-profit insurers (Canadian Life and Health Insurance Association 2006). Nearly all of this coverage is through individual policies, although critical illness insurance is beginning to be included in extended health care policies

Long-term care insurance has emerged in recent years as a new private insurance product in Canada. At the end of 2005, approximately 52,000 Canadians possessed long-term-care insurance (Canadian Life and Health Insurance Association 2006).

¹⁴Disability income insurance typically supplements income provided by the Canada or Québec Pension Plans, Workers' Compensation and/or Employment Insurance.

Travel insurance covers costs associated with emergency medical services required while travelling outside Canada.¹⁵ Travel insurance is most commonly obtained as part of an extended health care policy, but can also be purchased on a trip-by-trip basis from travel-related agencies.

In addition to standard group insurance plans, some employers offer a type of defined contribution plan called Health Spending Accounts. Such accounts can either substitute for or complement standard insurance benefits depending on the overall set of benefits provided by an employer. Under health spending accounts, each year an employer makes a pre-determined contribution to an employee's health spending account (the amount must be specified before the start of the year). These funds are then available to an employee to fund eligible health-related services, defined as the services that would qualify for the medical expense tax credit in the tax code. Unspent balances at the end of the first year can be rolled over into the second year, but at the end of the second year after a contribution is made tax regulations require that the employee forfeit unspent balances (which revert to the employer). The employer's contributions are tax deductible for the employer and non-taxable to the employee. The market for health spending accounts is very small.

Finally, private insurers in Canada also sell administrative services to governments and to private sector organizations that self-insure their members. Medavie Blue Cross, the Atlantic Canada Blue Cross organization, for example, provides administrative services to a number of public insurance programs. Under contract with the federal government Medavie Blue Cross administers health claims for veterans, members of the Canadian Forces and members of the Royal Canadian Mounted Police (RCMP). In Nova Scotia, Medavie Blue Cross administers the Nova Scotia Medical Services Insurance, the province's public insurance plan for physician services and Nova Scotia's Senior's Pharmacare and Family Benefits Pharmacare programs. In New Brunswick, Medavie Blue Cross has since 1975 administered the province's Prescription Drug Program. Similarly, Alberta Blue Cross administers the province's palliative-care drug program, prescription drug benefit program and dental program for seniors. In addition, it offers, on contract with the Ministry of Health, non-group, individual complementary health insurance plans (Alberta Blue Cross and Alberta Health and Wellness 2007). Plans which private insurers administer on behalf of private companies are called "uninsured plans", for which employers accept the financial risk but contract out the administration of the benefits. At the end of 2005

¹⁵ Provincial coverage must be portable within Canada, and most provincial public plans provide some coverage for emergency care required while traveling. But the provincial plans usually reimburse at Canadian rates, which are considerably lower than charges incurred in other countries, especially the United States, which is a popular destination for Canadians.

such plans covered more than 10 million individuals (4 million workers and 6.1 million dependents) with extended health care insurance, 8.5 million (3.4 million workers and 5.1 million dependents) dental care coverage and 2.4 million and 970,000 workers with long and short term disability income insurance. Premium income from these uninsured plans constituted 35 percent of all premium income for group insurance plans (Canadian Life and Health Insurance Association 2006).

Health Insurance Regulation in Canada

Private health care insurers in Canada are subject to two types of government regulation: regulation intended to ensure the financial solvency of insurers and regulation of the types of policies offered by private insurers and the terms and conditions under which the policies are sold.

Financial Regulation

Financial regulation is conducted by the Office of the Superintendent of Financial Institutions (OSFI) at the federal level and, in the province of Quebec, by the Autorité des marchés financiers (AMF). The OSFI and AMF conduct regular inspections and insurers are required to submit annual returns to document solvency. All insurers (for-profit and not-for-profit) are required by federal government regulations to be a member of Assuris, an industry-funded not-for-profit organization that protects policyholders in the event that an insurer becomes insolvent. Assuris guarantees policyholders recovery of 100 percent of the promised benefits for health expenses below \$60,000 and 85 percent of health expenses above \$60,000.¹⁶

Regulation of Insurance Products

Provincial governments regulate the market for private health insurance both directly, by regulating the provision of private health insurance, and indirectly, by regulating the provision of private health care services. Canadian regulation of the design of insurance products, their pricing and their sale are for two reasons relatively weak by international standards. First, as has been emphasized, private insurance has for 40 years played a minor role in health care financing, and no role for core hospital and physician services. Second, most people obtain private insurance through group contracts in which they face little or no choice. Hence, the

¹⁶ The Canadian Life and Health Insurance Association created a private, non-profit organization – Canadian Life and Health Insurance Corporation, or CompCorp -- funded by the insurers themselves, that provides additional coverage of health expenses up to \$60,000 in the event a bankruptcy by a life and health insurance company.

private insurance sector in Canada has not been subject to the kinds of policy focus found in settings where people rely on private health insurance as a major source of financial protection and people must obtain such insurance through individual policies. Undoubtedly some negative effects of market failure, discrimination, strategic policy design and other phenomenon exist in some Canadian markets, but to date they have been rare enough or small enough to escape policy concern.

The most important product regulation is that which prohibits private insurers from covering publicly insured medical and hospital services. Six provinces (British Columbia, Alberta, Manitoba, Ontario, Québec and Prince Edward Island) prohibit private insurers from covering publicly insured physician and hospital services. Provincial governments have indirectly limited the growth of private insurance through regulation of physicians and the fees they charge for private services, which has made the provision of privately financed services also covered by the public plan financially non-lucrative. For publicly insured physician services, most provinces require that a physician either fully opt into the provincial plan or fully opt-out; a physician cannot choose to charge privately for some patients but publicly for others.¹⁷ A physician would therefore have to support an entire practice through private, out-of-pocket payment by patients, which is not feasible for most physicians. In addition, many provinces also regulate the fees that can be charged by physicians who opt-out of the public plan (Flood & Archibald 2001). Manitoba, Ontario and Nova Scotia prohibit opted-out physicians from charging private fees greater than the fees paid by the public plan. Other provinces permit opted-out physicians to charge fees higher than those in the public plan, however, all but Newfoundland and Prince Edward Island prohibit such patients from receiving any public subsidy. Newfoundland is the only province that currently allows private health insurance coverage for publicly insured physician and hospital services, allows opted-out physicians to charge more than the public fee, and allows patients to receive public coverage for a service even when the fees charged are higher than those of the public plan. In such cases, the physician must bill the patient directly and the patient must subsequently obtain reimbursement from the province as is applicable. As noted above, few physicians are opted-out of the public

¹⁷Since September 2004 physicians in Ontario have been prohibited from opting-out of the public plan and receiving payment from a private third party, though physicians opted-out as of September 2004 were grandfathered in the legislation. Four provinces (Alberta, Saskatchewan, New Brunswick and Prince Edward Island) do allow physicians to opt-out for specific patients and bill the patients directly rather than bill the provincial plan. In Alberta and Saskatchewan physicians billing patients directly cannot charge a fee higher than the fee in the public plan (so there is no incentive to direct bill); patients can also seek reimbursement from the provincial plan. New Brunswick and Prince Edward Island allow physicians to charge a higher fee, but if the physician does so, the patient cannot seek reimbursement from the province. Prince Edward Island does not allow private insurance to cover such services; private insurance could cover such costs in New Brunswick (Boychuk 2006).

plan: recent estimates are that no physician are opted-out in 7 of the 10 provinces — Alberta, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland — while 6 are opted out in British Columbia, 129 in Ontario, and 97 in Quebec (Health Canada 2007).¹⁸

Regulation of Private Health Insurance Premiums and the Terms of Sale

Neither the federal government nor any provincial government regulates the premiums that private insurers can charge for health insurance.

Tax Regulations and Private Health Insurance

A number of regulations within the federal and provincial tax codes support private health insurance in Canada. Currently, both the federal government and all provincial governments allow firms to deduct the cost of health benefits provided to employees.¹⁹ The federal government and all provinces but Quebec exclude the value of such benefits from the employee's taxable income. The exclusion of health insurance benefits from taxable income dates from 1948, and the current value of this tax expenditure is estimated to be \$2.6 billion in 2008 for the federal government alone (Department of Finance 2008). Total public health expenditures in Canada were estimated to be \$113 billion in 2005 (Canadian Institute for Health Information 2007), suggesting that combined federal and provincial tax expenditures associated with private health insurance constitute about 3% of public health care spending in Canada. A number of provincial governments have attempted to remove this tax provision, and the federal government last debated removing it in 1994. Only the government of Quebec succeeded in doing so: since 1993 Quebec includes the value of employer-provided health insurance in taxable income.

Both the federal government and provincial governments also provide a set of health-related tax credits. The two most important are the medical expense tax credit (value of approximately \$1.1 billion in 2008) and the disability tax credit (value of \$435 million in 2008). The medical expense tax credit allows individuals to claim a tax credit for eligible medical expenses greater than 3% of their income or \$1844 (in 2006), whichever is greater.²⁰ Premiums paid by individuals for private insurance qualify as a medical expense under this

¹⁸ The figures for Ontario and Quebec are for 2004.

¹⁹ Most provinces, however, now charge a "premium tax" equal to 2-4% of the premium costs employers incur.

²⁰ The list of eligible expenses is quite varied, ranging from the expected such as eyeglasses, ambulance expenses, dental and drug expenditures to, under defined circumstances, air conditioners and furnaces for those with respiratory problems, vehicle and home modifications, the incremental cost of gluten-free products for those with celiac disease and note-taking services for the disabled.

provision.²¹ This provision affects private insurance in three ways: it reduces the net cost of out-of-pocket payment, damping demand for private insurance; it subsidizes insurance by making an insurance premium an eligible expense; and the set of services eligible for the tax credit also defines the services eligible to be paid from a health spending account. The disability tax credit applies to individuals with a severe and prolonged mental or physician impairment. In 2007 it equalled \$6890 for qualifying individuals.

Assessment of market performance

Because private health insurance plays a relatively limited, complementary role in financing health care in Canada, with the exception of a few sectors its overall effects on market performance are correspondingly small. As has been emphasized, by policy design private insurance plays no meaningful role for medically necessary physician and hospital services; its role in these sectors is limited to inpatient amenities and a small set of non-publicly covered services. It has also played no meaningful role for long-term care and home care services because until recently insurance products in these sectors have been virtually non-existent.

Private insurance has had the largest impact on system performance through its operations in the drug and dental sectors. But even here its impact on overall performance has historically been limited by the small size of these sectors and, in the case of dental care, the absence of a strong substitute or complementary relationship between dental services and other health care services and a lack of public concern regarding access to dental care beyond a small set of specific services such as serious oral surgery or specific groups such as children. Drug financing, however, emerged as a central policy concern during the 1990s as drugs became both a growing component of overall health expenditure (crossing a psychological barrier in 1997 when they first exceeded expenditures on physician services) and an essential therapeutic agent for an expanding set of medical conditions. In 1996 Quebec established its universal drug coverage in Quebec through its mixed public/private approach; in 1997 the National Forum on Health recommended national universal publicly financed drug coverage (National Forum on Health 1997), and in 2002 both the Romanow and the Kirby Commissions recommended publicly financed national catastrophic drug coverage (Commission on the Future of Health Care in Canada 2002; Senate of Canada 2002).

²¹ In Quebec, a premium paid by an employer, which counts toward taxable income, is also eligible to count toward the tax credit.

Private insurance's limited role in financing health care means that the private insurance sector in Canada has been little-studied.²² Policy and research attention have focused overwhelmingly for the last 35 years on the publicly financed system. We know surprisingly little about either the operation of the private insurance sector or the effects of its activities. This is changing because the role of private insurance is central to some of the current policy challenges facing Canadian health care, but there remains a relative dearth of publicly available data and information upon which to study the private insurance sector.

Financial Protection

Private insurance in Canada contributes in only a minor way to universal protection against financial costs. Public insurance covers fully medically necessary physician and hospital services. Private insurance coverage is a trivial source of finance for long-term care and home care. Extended health care insurance generally covers at least some non-physician providers, but such coverage is often restricted to a small number of visits annually or to low maximum annual coverage limits. Indeed, the policies are structured so as to provide minimal financial protection: they cover occasional use of such providers for routine services while doing little to help those who may need regular, on-going, more intensive care. While private insurance finances a majority of community-based dental care, such services are generally not a large source of financial risk. The bulk of insurance payments cover routine visits and minor procedures that are both modest and quite predictable. Private insurance contributes the most toward financial protection in the drug sector, where it covers a large number of individuals not covered by public insurance programs. Drug expenditures are becoming an increasing source of financial risk to individuals as the use of drugs in treatment expands and the costs of new drugs march ever upward. Private drug insurance policies generally include small deductibles and cost-sharing provisions (though they are increasing), maximum out-of-pocket spending limits and relatively high maximum coverage limits, so the plans provide important financial protection.

Equity in Finance

Canadian health policy is strongly committed to equity in health care finance. Policy documents explicitly interpret equity in finance as horizontal equity, which requires equal contributions by

²² A relatively small group of strong advocates of a greater role for private insurance, however, has ensured that it has remained part of the policy debate, and the iconic and media value of private insurance — conveyed primarily through anecdote and story — is disproportionately large given its limited role in financing health care in Canada.

those with equal ability to pay, and vertical equity, which requires contributions to be directly related to ability-to-pay. Policy statements are less clear as to whether vertical equity implies progressivity in finance whereby contributions increase as a proportion of income. The Romanow Commission offered one of the few explicit judgments on this in positing that vertical equity implies progressivity (Commission on the Future of Health Care in Canada 2002).

Only a limited number of studies have empirically assessed equity of health care finance in Canada. Fewer still have examined private finance. Nonetheless, findings across studies are generally consistent and a few conclusions are possible from existing evidence.

Public finance to support health care appears to be essentially proportional or perhaps mildly progressive. The two largest sources of public revenue are income and consumption taxes, which have counter-acting effects: income taxes are progressive but consumption taxes are regressive. McGrail (2007) estimated that public financing for physician and hospital services in British Columbia in both 1992 and 2002 was effectively proportional (Kakwani Indices = 0.021 and 0.026 respectively). Hanley *et al.* (2007) found that public finance for prescription drugs in British Columbia over the period 2000-2005 was proportional (annual Kakwani indices of -0.002 to 0.008 over period). Mustard *et al.* (1998) similarly found that public finance in Manitoba in both 1986 and 1994 was essentially proportional. Smythe (2002), however, found public financing in Alberta to be more strongly progressive. Provincial public contributions as a proportion of income, for example, rose from 4 % to 8% between the lowest and highest income deciles.

Two studies (McGrail 2007 and Mustard *et al.* 1998) conducted net fiscal incidence analyses for the health sector that considered both tax payments to finance health care²³ and benefits received in the form of publicly financed health care services. Utilization of health care services is highly regressive – the value of services received by low income individuals is a much higher proportion of their income than it is for high-income individuals. Hence, both found that, because contributions are roughly proportional to income but use is highly regressive, the incidence of net benefits is highly regressive: on net, for low income groups in Canada the value of publicly financed services received far exceeds their contribution, so the health care system redistributes economic resources from high-income groups to low-income groups.

Studies of the incidence of private insurance financing are more limited. Private insurance coverage is strongly related to income, causing contributions for private insurance to increase with income. Smythe (2001), for instance, estimated that in 1994 only 4% of households with incomes less than \$5000 had access to employer-sponsored private insurance;

²³ Excluding tax expenditures – see below.

the proportion rose to 54% for those with incomes between \$20,000 and \$30,000, and was over 90% for households with incomes greater than \$60,000. Bhatti *et al.* (2007) found a substantial positive income gradient with respect to holding private dental insurance. Controlling for a range of demographic and health factors, the probability that those with income over \$80,000 held private dental insurance was 34 percentage points greater than those with income less than \$15,000. Hanley *et al.* (2007), however, estimated that prescription drug financing through private insurance in British Columbia was mildly regressive (Kakwani index of progressivity (K) = -0.10) in both 2000 and 2005. Smythe (2002) estimated that private financing (including both out-of-pocket and private insurance payments) in Alberta was regressive (K = -0.12). We are not aware of any net incidence studies for private health insurance in Canada.

The exclusion of the value of employer-provided health insurance from employee's taxable income generates substantial regressive tax expenditures. This tax exclusion reduces a person's income tax payments in proportion to their marginal tax rate; for middle and low income individuals its exclusion from income reduces payroll taxes for the Canadian Pension Plan and Employment Insurance; and for low-income workers it increases eligibility for rebates of the General Services Tax (GST). Smythe (2001) estimated that the value of these tax expenditures in 1994 was less than \$0.50 per household for households with incomes below \$5000 and \$250 for households with incomes over \$100,000. Hence, the tax treatment of private insurance generates a strongly regressive element in health care finance.

Equity of Access

Both federal and provincial governments in Canada identify allocation according to need as the explicit distributional health policy goal for health care services. The primary, though not exclusive policy designed to achieve this goal is removal of financial barriers at the point of service, especially for physician and hospital services. Equity of utilization of health care has been extensively studied in Canada, reflecting both a strong concern for equity and the availability of population health survey data upon which to assess equity. Here we emphasize recent work that employs the concentration index approach pioneered by the ECuity group (Wagstaff & van Doorslaer 2000) to estimate income-related equity of utilization. Most of this work has focused on physician and hospital services, although studies of other sectors are increasingly available. A general finding consistent with the international literature is that greater reliance on private finance, including private insurance, is associated with less equity in the utilization of health care services.

Overall, the pattern of findings suggests that, controlling for need, use of GP services is not strongly related to income in Canada. A first generation of studies that tested for an income gradient using regression methods consistently found that, controlling for need, the coefficient on income was not statistically significant (Birch & Eyles 1992; Birch, Eyles, & Newbold 1993). More recent studies based on concentration indices obtain a mixture of point estimates that, although statistically different from zero (due in part to large sample sizes) are small in absolute magnitude suggesting little income-related inequity. Both van Doorslaer *et al.* (2007) and Jimenez-Rubio *et al.* (2007), for instance, obtain slightly pro-poor horizontal equity indices while Allin (2006) obtains a slightly pro-rich horizontal equity index. Studies consistently find offsetting effects for the likelihood of any visit and the conditional number of visits: the likelihood of any visit to a GP is generally estimated to be pro-rich, but conditional on seeing a GP, the number of visits is distributed pro-poor.

In contrast, controlling for need, analyses consistently find a pro-rich income-related gradient in the use of specialist services in Canada (Alter, Austin, & Tu 1999; Van Doorslaer *et al.* 2005; Allin 2006; Alter *et al.* 2006; van Doorslaer 2007). The income-related gradient is modest by international standards, but it nonetheless clearly exists. We do not have a good understanding of what causes this gradient.

Hospital services are distributed in a strongly pro-poor manner even after controlling for need (Allin 2006; Jimenez-Rubio, Smith, & Van Doorslaer 2007; van Doorslaer 2007). By international standards, the gradient is large. Once again, we do not have a good understanding of what drives this income-related gradient.

Sectors that rely heavily on private finance, including private insurance, tend to exhibit strong income-related gradients in use. Dental care, which is almost entirely privately financed, exhibits the largest income-related gradient (van Doorslaer 2007). Access to drugs has been less studied, but Zhong (2008) found a large impact of drug financing arrangements in Ontario on income-related equity: income-related use of drugs was pro-poor among the elderly who are covered by the public insurance program but pro-rich among working age individuals who must finance drugs privately; furthermore, the introduction of co-insurance provisions in the public program was associated with a reduction in equity among the elderly.

Rewarding good quality care and providing incentives for efficiency in the organisation and delivery of services.

To the best of our knowledge, the private insurance industry has undertaken almost no efforts to improve the quality and efficiency of health care services in Canada. The private insurance

industry continues to function largely as bill payers. Increasing costs for privately insured services (especially drug costs) is a growing concern for employers, but the most prevalent response has been demand-side cost-sharing. In addition, employers increasingly rely on benefit managers to advise them on how to control such costs.

Administrative Costs

Private insurers in Canada incur greater administrative costs than do the public insurers. Woolhandler, Campbell and Himmelstein (2003) estimated that administrative overhead costs for Canadian private insurers were 13.2 percent of expenditures while those of the public system were 1.3 percent. Indeed, administrative costs for Canadian private insurers slightly exceeded those of US private insurers.

Interactions between the publicly and privately financed health systems

Wherever private insurance and public insurance systems co-exist, they inevitably interact. Policy debate has centred most on interactions when public and private insurance cover the same services and providers are able to work in both systems. Such a situation can lead to privileged access to those with private insurance, providers playing each system to their advantage, and potentially longer wait times in the public system as the private system draws scarce resources away.

By prohibiting or making unprofitable private insurance (and private finance more generally) for publicly insured physician and hospital services Canada has successfully minimized such interactions. Canada, however, faces increasing pressure to relax its insurance prohibitions. As noted earlier, a June 2005 Supreme Court ruled that, in the presence of “unreasonable” wait times (though it did not define “unreasonable”), Quebec’s prohibition on private insurance for publicly insured services violated the Quebec Charter of Rights and Freedoms. The long-run implications of this decision are not clear. The ruling applied only to Quebec. The government of Quebec responded by passing legislation that: guarantees maximum wait-times for three procedures that in recent years have had long wait time: hip replacement, knee replacement and cataract removal; enables the creation of private, for-profit clinics; and allows private insurance for only the three above-noted procedures when they are provided by a physician who has opted-out of the public plan (Quebec National Assembly 2006). Similar lawsuits, however, are now underway in other provinces (Talaga 2007), raising the chances of additional decisions against such laws and, eventually, a ruling with respect to the Canadian Charter of Rights with national implications. However, the effects on private insurance

and private finance even if such bans are struck down nationally remain uncertain because complementary regulations that inhibit the development of private finance would remain in force (Boychuk 2006) .

The growth of the market for privately financed non-medically necessary services (paid mostly out-of-pocket) that fall outside the Canada Health Act increasingly generates interactions with the public system. Such services include traditional cosmetic procedures and an increasing array of “lifestyle” health care services that do not address an underlying health problem but which must be provided by a health professional. Such services constitute one of the fastest growing components of health care spending. The expansion of such services does not raise equity concerns – they are non-medically necessary services – but it does generate all of the other potentially negative effects of supplementary private insurance. Specifically, the expansion of such services draws health care inputs (e.g., provider time and effort) away from the public system and bids up their prices, compromising the ability of the public system to ensure access to medically necessary services.

The growth of this market in non-medically necessary services also has more subtle effects. By regulating a physician’s ability to opt out and charge fees greater than the public fee, Canada has successfully inhibited the growth of privately financed markets. However, these regulations do not apply to these services, which are not publicly insured. Furthermore, because the financial and physical capital invested to provide such services can often be used to provide both non-medically necessary and medically necessary publicly insured services, the growth of this sector can: make private practice opted out of the public system increasingly viable through the provision of a mixture of privately financed medically necessary and non-medically necessary services; and further develop the privately financed sector as this entrepreneurial capital seeks out profitable uses. These forces are still relatively minor in Canada outside a small number of cities, but they are growing.

The heavy reliance on private finance and private insurance in particular, in the drug sector creates at least three types of policy-relevant interactions between the public and private systems. The first two arise from complementarities between privately financed drugs and publicly insured medical services. Obtaining a prescription drug requires a medical visit, and for many individuals, the expected outcome of a medical visit is a drug prescription. Hence, when a person is ill, if the expected outcome of the visit is a prescription for a drug that must be paid privately, the full cost of the visit is not zero, but rather the free medical visit plus the cost of the prescribed drug. Inability to purchase the resulting prescription may inhibit individuals from making some physician visits. Hence, private finance for drugs distorts the use of publicly

financed physician visits toward those with greater ability-to-pay, either because of higher income or private insurance coverage. Indeed, Stabile (2001) found that those who have drug insurance are more likely to visit a physician than are those who do not have insurance. Furthermore, Allin and Hurley (2008) found that private insurance contributes to income-related inequity in visits to general/family practitioners in Canada.

The second interaction rooted in complementarities arises in the cancer sector. The publicly funded cancer system in Ontario (as in other provinces) has chosen not to cover some of the new, very expensive cancer drugs that are judged to not be cost-effective. Because they have been approved for sale, individuals are able to purchase these drugs privately. Such intravenous drugs, however, must be infused in suitable facilities by trained professionals. Such settings are generally found only in the publicly funded hospital facilities that treat cancer patients. A number of publicly funded hospitals currently administer privately purchased IV-cancer drugs and infuse those drugs for private payment, guided by the following recommendations of a Provincial Working Group: (1) the practice does not contravene the Canada Health Act or relevant provincial legislation because the drugs are not publicly funded; (2) hospitals should administer only drugs for which Cancer Care Ontario's Program in Evidence-based Care has not recommended against use of the drug for the specific indication; (3) all drugs administered should be prepared the hospital pharmacy – a hospital is not to infuse a drug purchased elsewhere and brought to the infusion clinic; (4) patients are to be charged for the costs of the drug only, with no mark-up; and (5) patients are to be charged a fixed infusion fee to cover non-drug costs and for certain radioimmunotherapies that are more complex to administer hospitals can charge and additional fixed fee per patient (Provincial Working Group on the Delivery of Oncology Medications for Private Payment in Ontario Hospitals 2006). The working group also recommended that privately funded treatment should not displace publicly funded patients from treatment, though it offered no guidance on policies and practices to ensure this. The recommendations were first implemented at the 16 regional cancer centres, but ultimately the decision to provide such privately financed services and the precise policies followed rests with individual hospitals.

The third interaction arises when public and private insurers structure benefit plans strategically in an attempt to shift costs on to the other. The Nova Scotia government, for instance, has explicitly made the public pharmacare program second payer for seniors who have private drug coverage through their previous employer's retirement benefits. It also requires companies operating in both Nova Scotia and other jurisdictions to offer such retiree benefits to Nova Scotia employees if they are offered to employees in other locations. In Quebec, where

residents aged 65 or over are automatically covered by the provincial drug insurance plans, businesses have increased the premium they charge retirees for drug coverage to encourage retirees to rely on the public plan rather than the company-provided retirement benefit.

Lastly, arguments about the unsustainability of publicly financed health care in Canada are often based on the observation that health care costs have been rising “too fast” to be sustainable. Ironically, however, the fastest growing component of health care for the last number of years has been drugs, a sector for which private finance and private insurance play a dominant role. Hence, the fast rate of growth for privately financed services can undermine confidence in the long-run sustainability of the public system.

Discussion

Perhaps the most striking aspect of private insurance in Canada has been the virtual policy neglect of the sector since the introduction of public hospital and medical insurance. Public insurance relegated private insurance to a small role on the periphery of policy concern: covering non-medically necessary physician and hospital services, drugs, dental care and assorted other services. The private insurance was, to a large extent, seen as irrelevant to achieving the core health policy objective of universal access to necessary health care.

This view, however, is changing. Private insurance is back in the Canadian health policy debate, though for many different reasons. On the one hand, the limited scope of Canada's public insurance programs fails to ensure access to all medically necessary care, particularly prescription drugs. Ensuring such access will require an expanded role for public finance in the drug sector, with proposals ranging from universal, first-dollar public insurance just as Canadians enjoy for physician and hospital services, to universal public catastrophic coverage, to mixed public-private systems such as in Quebec. Because there is little appetite at the moment for universal, first-dollar public drug coverage, in the near term policy will likely have to grapple with the difficult challenges of mixed systems of finance that Canada has largely avoided to date.

On the other hand, pressure to introduce private supplemental insurance is growing. The pressure emanates from two principal sources: the sustainability debate noted above and wait times. In Canada, as in nearly all developed countries, many claim that publicly financed health care is unsustainable and therefore we must inject more private finance. In Canada this is coupled with frustration over the restrictions on private options for publicly financed services, especially where long waits exist for those services, leading to calls for supplemental private insurance as the best particular way to expand private finance. Those who argue that the public

health care system is unsustainable as currently financed cite in particular the increasing proportion of government program spending devoted to health care and the implied crowding out of other programs, such as education (e.g., Task Force on the Funding of the Health System 2008). Opponents argue that conclusions drawn from such trends ignore at least three things: there is much confusion about how to measure program spending, and the trends differs notably depending on the definition chosen (Beland 2008); in the last decade tax cuts, which presumably represent a policy choice, have had a far larger impact on the ability of governments to fund program spending than has increases in health care spending (Evans 2005;Evans 2007); finally, correlation does not imply causation, and more rigorous analysis suggests, for example, that increases in health care spending do not necessarily crowd out other government spending (Landon et al. 2006). We discussed above the lack of evidence that parallel private insurance decreases wait times in the public system. Good evidence, however, often plays a small role in such debates. Canadians still strongly support the public health care systems and its principles, but the power of such superficially compelling arguments among a worried public can not be underestimated toward building a popular view that even if private insurance is second-best it may nonetheless preferred policy among feasible alternatives.

The debate about the role of private insurance in Canada marshals powerful forces on each side, and regardless of the specific ways in which these and related policy debates turn out, two things are certain: Canada can benefit by drawing on the wider international experience with health care finance to craft policies that advance its public policy objectives and minimize the extent to which the development of private insurance detracts from these objectives; and private insurance will figure more prominently in Canadian policy debates in the coming decades than it has since the founding of Medicare.

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