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DUPLICATE PRIVATE HEALTH CARE INSURANCE: POTENTIAL IMPLICATIONS FOR QUEBEC AND CANADA

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20 March 2006

PARLIAMENTARY INFORMATION AND RESEARCH SERVICE
SERVICE D'INFORMATION ET DE RECHERCHE PARLEMENTAIRES

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DUPLICATE PRIVATE HEALTH CARE INSURANCE: POTENTIAL IMPLICATIONS FOR QUEBEC AND CANADA

INTRODUCTION

On 9 June 2005, the Supreme Court of Canada ruled that Quebec's prohibition on private health care insurance, and the resulting limits on its residents' ability to buy privately delivered health care, violates Quebec's *Charter of Human Rights and Freedoms*.(1) This judgment on the Chaoulli case may open the door to a market for "duplicate" private health care insurance in Quebec and – perhaps – in the rest of Canada.(2)

Duplicate private insurance provides coverage for health services already included under the public health care insurance plan. Individuals holding duplicate private insurance pay twice for health care – through their income taxes and again through their private premiums – as they are not allowed to opt out of the public plan.(3) They then have the opportunity to choose where to be treated: either through the publicly funded health care system or through the privately delivered system.

This paper examines the experience of Australia, New Zealand and the United Kingdom – where duplicate private health care insurance is permitted – to assess the potential implications of duplicate private insurance for Quebec's (and Canada's) health care system.

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(1) *Chaoulli* v. *Québec (Attorney General)*, 2005 SCC 35.

(2) See: Ministère de la santé et des services sociaux du Québec, *Garantir l'accès : un défi d'équité, d'efficience et de qualité, document de consultation*, Government of Quebec, February 2006; Roger Chafe, "Ruling on Private Insurance Has Far-Reaching Impact," *Nexus Online*, Newfoundland and Labrador Medical Association Newsletter, Fall 2005; Valentin Petkantchin, "Using Private Insurance to Finance Health Care," *Economic Note*, Health Series, Montreal Economic Institute, November 2005; Working Group on Quebec's Health Care System, "The Chaoulli Judgment and Private Health Insurance: Seven Proposals to Address the Supreme Court Decision," Press Release, Montreal, 21 November 2005; Colleen M. Flood, Mark Stabile and Sasha Kontic, "Finding Health Policy Arbitrary: The Evidence on Waiting, Dying, and Two-Tier Systems," in *Access to Care – Access to Justice: The Legal Debate Over Private Health Insurance in Canada*, ed. Colleen M. Flood, Kent Roach and Lorne Sossin, University of Toronto Press, 2005, pp. 296-320.

(3) See: OECD, *Private Health Insurance in OECD Countries*, The OECD Health Project, 2004; Elias Mossialos and Sarah Thompson, *Voluntary Health Insurance in the European Union*, European Observatory on Health Systems and Policies, World Health Organization, 2004.

BRIEF COMPARISON OF THE SYSTEMS

As in Quebec and the other Canadian provinces, the health care system in Australia, New Zealand and the United Kingdom is financed mainly through general taxation. Unlike Quebec and five other provinces (British Columbia, Alberta, Manitoba, Ontario and Prince Edward Island),[4] Australia, New Zealand and the United Kingdom do not prohibit duplicate private health care insurance.[5] Although such insurance is permitted in the four other provinces (New Brunswick, Newfoundland and Labrador, Nova Scotia and Saskatchewan), this has not led to the development of a parallel private system as seen in Australia, New Zealand and the United Kingdom. In these provinces as well as in the others (except Newfoundland and Labrador), economic disincentives (discussed in more detail below) explain the lack of a flourishing private health care sector operating side by side with the publicly funded system.[6]

Australia is the most significant case of duplicate private health care insurance among OECD countries. Duplicate private insurance is allowed for hospital services, but is prohibited for doctors' services rendered outside of hospitals. A large proportion of the population benefits from such insurance, and the Australian government strongly encourages its residents to purchase it by offering a 30% rebate on private premiums. The government also requires that private health care premiums be community rated: private insurers must charge the same premium to all purchasers regardless of income or health status.[7]

Duplicate private health care insurance plays a less significant role in the funding of health care in New Zealand and the United Kingdom, although population coverage has grown steadily in recent years. Unlike the situation in Australia, duplicate private health care insurance in New Zealand and the United Kingdom is allowed for both hospital and doctors' services; it has, however, remained more concentrated in the hospital sector. In contrast to Australia, New Zealand and the United Kingdom neither subsidize nor regulate private health care insurance premiums.[8]

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(4) Colleen M. Flood and Tom Archibald, "The Illegality of Private Health Care in Canada," *Canadian Medical Association Journal*, Vol. 164, No. 6, 20 March 2001, pp. 825-830.

(5) OECD (2004); Mossialos and Thompson (2004).

(6) Flood and Archibald (2001).

(7) OECD (2004).

(8) OECD (2004); Mossialos and Thompson (2004).

In Australia, as in New Zealand and the United Kingdom, doctors are allowed to work in the publicly funded system while at the same time practising in the private sector (this is usually referred to as "dual practice"). Moreover, doctors in these three countries receive a higher remuneration in the private sector.(9) The possibility of working in both sectors, combined with higher payment in the private sector, has provided an economic incentive for serving private patients.(10)

This contrasts sharply with the experience of Quebec and all the other provinces (except Newfoundland and Labrador) where dual practice is either prohibited or strongly discouraged. Doctors cannot obtain remuneration in both the public sector and the private sector at the same time; they must either work in the public sector or "opt out"(11) of it entirely in order to take up practice in the private sector. And even though every province permits doctors to opt out, provincial health care insurance legislation often uses economic disincentives to deter doctors from doing so. In Manitoba, Nova Scotia and Ontario,(12) doctors who opt out of the public plan cannot charge privately more than the amount payable under the public plan; there is, accordingly, no additional gain from serving private patients. In Quebec and five other provinces (Alberta, British Columbia, New Brunswick, Prince Edward Island and Saskatchewan), doctors who opt out can charge more than the fee schedule under the public plan but their patients cannot obtain reimbursement from the public plan. In other words, patients must pay out of their own pockets the full cost of the health service they receive. The demand for services provided by doctors who have opted out is thus small, in that it is restricted to those who can afford to pay.(13)

As a result of provincial health care legislation, the number of doctors who have opted out is very limited in Canada. As of 31 March 2004, no doctors had opted out of the public plan in Alberta, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia,

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(9) It should be noted that, in the United Kingdom, doctors working full-time in public hospitals are limited in the amounts that they may bill in the private sector to supplement income earned in the public sector.

(10) OECD (2004); Mossialos and Thompson (2004); Carolyn Hughes Tuohy, Colleen M. Flood and Mark Stabile, *How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations*, University of Toronto, October 2000.

(11) Physicians "opt out" when they choose to give up their rights to bill the public health care insurance plan, and take up practice in the private sector.

(12) In Ontario, opting out is no longer generally allowed since May 2004. Doctors who had opted out prior to that date may, however, continue to practise privately.

(13) Flood and Archibald (2001).

Prince Edward Island and Saskatchewan. In comparison, 6 doctors had opted out in British Columbia, 129 in Ontario and 97 in Quebec.(14)

Newfoundland and Labrador is the only province that does not use any economic disincentives to discourage doctors from opting out of the public plan. And as mentioned above, this province also allows dual practice as well as duplicate private health care insurance.(15) The health care system in Newfoundland and Labrador therefore appears somewhat similar to that of Australia, New Zealand and the United Kingdom. Nonetheless, the province has not seen the development of a significant private sector in health care insurance and delivery, probably because the small population size and lower income levels do not generate sufficient patient demand.

Despite the prohibition on duplicate private health care insurance and the economic disincentives that discourage doctors from opting out of the public plan, a small parallel private health care system has nonetheless developed in recent years in Quebec as well as in some other provinces. This parallel private system has been supported by some clients' ability to pay. Canadians who can afford to pay the full cost of health care have better access to diagnostic imaging services(16) and some surgical procedures provided in Canada or out of country (mostly in the United States). Lifting the prohibition on duplicate private health care insurance would further stimulate this parallel private system.

THE EVIDENCE: LITERATURE REVIEW

What could be the potential implications of duplicate private health care insurance for Canada's health care system? In theory, there are a number of economic arguments in favour of duplicate private health care insurance. First of all, duplicate private insurance increases individuals' choice; all other things being equal, this increases overall social welfare. Second, those who can purchase duplicate private health care insurance can obtain faster treatment in the

(14) Health Canada, *Canada Health Act Annual Report 2003-2004*, December 2004; Ministère de la santé et des services sociaux du Québec (2006).

(15) Flood and Archibald (2001).

(16) Odette Madore, *Private Diagnostic Imaging Clinics and the Canada Health Act*, PRB 05-02E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 17 May 2005.

private sector; this, in turn, reduces waiting times for those who remain in the publicly funded health care system. And third, duplicate private health care insurance not only reduces the demand in the public sector; since those who obtain privately funded health care still continue to pay taxes to support the publicly funded system, this also increases the resources available on a per capita basis in the public sector. What does the evidence from Australia, New Zealand and the United Kingdom say? An overview of the recent literature on this issue suggests the following:

- The demand for duplicate private health care insurance is associated with reduced quality (either actual or perceived) of publicly funded health care, which is often measured by waiting lists.(17)

- The demand for duplicate private health care insurance is strongly related to income. Individuals with high income and education levels are more likely to purchase duplicate private insurance.(18)

- Those who can afford to pay for duplicate private health care insurance benefit from a wider choice of providers and faster access to care. This has generated inequity in terms of access to care and coverage according to insurance status.(19)

- Duplicate private health care insurance may allow individuals to "jump the queue." This is particularly so when individuals obtain a diagnosis privately and then – should care be required – return to the publicly funded health care system for treatment one step ahead of patients still waiting to obtain publicly funded diagnostic tests.(20)

- While privately insured individuals receive faster access to care, this does not necessarily reduce waiting times in the public sector, the only choice for those with no private insurance coverage. Some recent Australian data show a decline in waiting times associated with an increase in the purchase of private insurance, but other sources show little improvement.(21)

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(17) OECD (2004); Mossialos and Thompson (2004); Jeremiah Hurley, Rhema Vaithianathan, Thomas F. Crossley and Deborah Cobb-Clark, *Parallel Private Health Insurance in Australia: A Cautionary Tale and Lessons for Canada*, Institute for the Study of Labour (Bonn, Germany), Discussion Paper Series, No. 515, June 2002.

(18) OECD (2004); Mossialos and Thompson (2004).

(19) OECD (2004); Mossialos and Thompson (2004); Stephen J. Buckett, "Living the Parallel Universe in Australia: Public Medicare and Private Hospitals," *Canadian Medical Association Journal*, Vol. 173, No. 7, 27 September 2005, pp. 745-747; Robert G. Evans, "Preserving Privilege, Promoting Profit: The Payoffs from Private Health Insurance," in Flood, Roach and Sossin (2005), pp. 347-368; Tuohy, Flood and Stabile (2000); Herb Emery and Kevin Gerrits, *The Demand for Private Health Insurance in Alberta in the Presence of a Public Alternative*, Department of Economics, University of Calgary, Institute for Advanced Policy Research, Technical Paper No. 06001, 1 November 2005.

(20) Mossialos and Thompson (2004).

(21) OECD (2004).

When waiting times declined in the publicly funded health care system in the United Kingdom, this was in response to an infusion of public funding and not the result of an increase in the uptake of private insurance.(22)

- Although duplicate private health care insurance is permitted in Australia, New Zealand and the United Kingdom, these countries have historically faced similar or longer waiting times than those in Canada.(23)

- The development of a parallel private sector can increase waiting times in the public sector, particularly when doctors can work simultaneously in both the public and private sectors.(24)

- When doctors are allowed to practise in both the public and private sectors and receive higher remuneration through duplicate private health care insurance, this encourages high service volumes and productivity in private health care delivery. Conversely, this may result in a reduction in the quantity and quality of doctors' time devoted to patients in the publicly funded health care system.(25)

- Higher remuneration in the private sector also provides some incentive to delay surgery in the public sector, that is, to maintain long waiting lists in the public sector, so that patients may be attracted or forced to move into the more lucrative private sector. These concerns appear to be more critical when there are shortages in the supply of doctors.(26)

- Ethical concerns may arise within the private system also where doctors become entrepreneurs in the private clinics or firms to which they refer privately insured patients.(27)

- Duplicate private health care insurance has provided financing for capacity development in the private hospital sector, most notably in Australia. Duplicate private insurance also generates additional revenue for public hospitals which, in Australia and the United Kingdom, are allowed to treat private patients.(28)

- Public and private health care sectors are not perfect substitutes for one another. Private hospitals and facilities tend to specialize in less complicated, elective procedures. Therefore, individuals holding private insurance must still rely on the public sector for their emergency

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(22) Flood, Stabile and Kontic (2005); Tuohy, Flood and Stabile (2000).

(23) Tuohy, Flood and Stabile (2000); Luigi Siciliani and Jeremiah Hurst, *Explaining Waiting Times Variations for Elective Surgery Across OECD Countries*, OECD Health Working Papers, No. 7, 7 October 2003.

(24) Hurley *et al*. (2002); Buckett (2005).

(25) OECD (2004); Buckett (2005).

(26) Buckett (2005); Flood, Stabile and Kontic (2005); Trudo Lemmens and Tom Archibald, "The CMA's Chaoulli Motion and the Myth of Promoting Fair Access to Health Care," in Flood, Roach and Sossin (2005), pp. 323-346; Siciliani and Hurst (2003).

(27) Lemmens and Archibald (2005).

(28) OECD (2004).

services. Privately insured individuals continue to use publicly funded health care even if they hold private coverage. A privately financed surgical procedure is often associated with a variety of related pre- and post-operation health services, such as visits and diagnostic tests, many of which are obtained from the public system. It has been suggested that private facilities "cream off" the less complicated cases, leaving public hospitals with a relatively more complex and expensive case mix.(29)

- The potential of duplicate private health care insurance for shifting demand and cost from the public to the private sector has proven to be small. Perhaps more importantly, the evidence suggests that duplicate private insurance has promoted an increase in overall utilization and treatment intensity, rather than just shifting demand from the public to the private hospital system.(30) In Australia, the cost saving in public funding is also offset by public subsidies for private insurance purchasers.

- The potential for cost savings in the public sector is further limited by health care inputs. The supply of many health care resources – such as physicians, nurses, and technicians – is relatively inelastic in the short run. The private and public sectors must therefore compete for these limited resources, and the resulting competition can increase input prices. Physicians in Australia and the United Kingdom can earn 3-4 times more working in the private sector than in the public sector.(31) The net result is that, in the presence of duplicate insurance, the publicly funded sector must either provide fewer resources or increase funding to maintain the previous real service levels.(32)

- Overall, the evidence suggests that duplicate private insurance has added to total health care expenditures and has not significantly reduced public spending.(33) It is, however, unclear whether duplicate private insurance has led to decreased support for the publicly funded health care system.(34)

POTENTIAL IMPLICATIONS FOR QUEBEC AND CANADA

The Chaoulli decision has opened the door to duplicate private health care insurance, at least from a legal perspective. As a result of this ruling, it is no longer possible to simply debate the question of whether or not a private market for health care insurance should exist. Rather, the question now is how best to make use of the duplicate private health care insurance market given the lessons learned from other countries' experience.

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(29) Buckett (2005); Tuohy, Flood and Stabile (2000).

(30) OECD (2004); Mossialos and Thompson (2004).

(31) OECD (2004).

(32) Hurley *et al.* (2002).

(33) OECD (2004).

(34) Tuohy, Flood and Stabile (2000).

For one thing, it is still unclear whether an active duplicate private health care insurance market will develop in Quebec. No such market exists in Saskatchewan, New Brunswick, Nova Scotia or Newfoundland and Labrador, although there is no legislative prohibition against private insurance for health services that are publicly covered. Should a market for duplicate private health care insurance develop in Quebec, it would be reasonable to expect that court challenges similar to the Chaoulli case may be undertaken in the five other provinces where duplicate private insurance is currently prohibited. It is also likely that some of these provinces may decide to lift their ban on duplicate private insurance in order to ensure that their approach to health care remains consistent with the Supreme Court's ruling in Chaoulli.

Quebeckers and other Canadians alike who currently self-finance private care would be the first willing to purchase duplicate private health care insurance. Beyond this group, the proportion of the population that would be interested in buying duplicate private insurance would depend on the level of the premium charged by private insurers.(35) The literature review suggests, however, that duplicate private insurance would not be readily available to individuals with pre-existing health conditions, nor would it be available to those who cannot afford it. Although it is still unclear how many residents in Quebec and elsewhere in Canada would purchase private health care insurance, it appears more likely to benefit those with a higher income and better health status, as evidenced in Australia, New Zealand and the United Kingdom.

Canadians' ability to purchase duplicate private health care insurance would certainly increase the demand for privately delivered health care and, as the experience in Australia, New Zealand and the United Kingdom indicates, this would encourage further investment in capacity development in the existing parallel private system. This, in turn, would create incentives for doctors to opt out. The number of doctors deciding to opt out as a consequence of duplicate private health care insurance would depend on whether provincial health care legislation maintained or removed the current economic disincentives with respect to dual practice. Given that there is currently a shortage of doctors in all provinces, there is a risk that the expansion of the parallel private system resulting from the introduction of duplicate private insurance might reduce the availability of doctors in the publicly funded system, as experienced in Australia, New Zealand and the United Kingdom.

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(35) Should duplicate coverage be provided through employer-sponsored health care insurance, the proportion of Canadians covered by private insurance would be larger than if duplicate insurance were provided only through the individual insurance market.

With respect to waiting times, some contend that a private health care sector – to be financed by duplicate private insurance – could serve as a "safety valve" and fill in when waiting times in the public system grow too long. The publicly funded system could turn to this private sector by referring patients instead of sending them to the United States, as it sometimes does now. These commentators maintain that the existence of a private sector in health care is thus likely to benefit not only those who are privately insured but also those who remain in the publicly funded system.(36) These views, however, are not supported by international evidence. Based on the experience in Australia, New Zealand and the United Kingdom, it is unclear to what extent duplicate private insurance can reduce waiting times in the public sector.

It has been suggested that provincial governments could intervene in order to make the best use of, and to alleviate the negative impact generated by, duplicate private insurance. Possible areas of intervention include the following:

- regulating private health care premiums by requiring community rating (this would respond to inequity concerns);
- limiting the fees that doctors can charge their private patients to the amounts that they would receive if they billed the public plan (this would discourage opting out);
- encouraging private patients not to rely on the public system for privately covered services (this would maximize cost shifting between the public and the private sector);
- maintaining a single waiting list for both publicly and privately insured patients (this would ensure equity of access to health services no matter where care is provided);
- reserving equipment in public hospitals for the exclusive use of patients covered by the public plan (this would reduce the risk for government of indirectly subsidizing privately delivered health services).(37)

The intervention of the federal government has also been recommended to prevent a growth in private health care resulting from the Chaoulli decision. The New Democratic Party has proposed that the *Federal-Provincial Fiscal Arrangements Act* be amended to: prohibit the provinces from using federal funds to subsidize private providers; prohibit provinces from allowing doctors who deliver publicly funded care to also provide privately funded services; and require provinces to report annually on the allocation of federal

(36) Petkantchin (2005).

(37) OECD (2004); Working Group on Quebec's Health Care System (2005).

transfer payments to the public system.(38) For his part, Ujjal Dosanjh, former federal minister of health, proposed that the accessibility criterion of the *Canada Health Act* be interpreted as precluding "the practice of physicians providing the same services on both a publicly insured and a privately paid basis."(39) These two proposals would effectively prevent doctors from engaging in dual practice.

QUEBEC'S AND ALBERTA'S RESPONSES TO THE CHAOULLI DECISION

In response to the Chaoulli ruling, the Government of Quebec has proposed two interrelated solutions: a wait time guarantee of six months, combined with a partial lifting of the prohibition on duplicate private health care insurance.(40) A six-month wait time guarantee would apply to some elective surgeries defined by regulation. Initially, these surgeries would be limited to hip, knee and cataract procedures. Duplicate private insurance would be permitted only for these targeted elective surgeries and would be limited to health services obtained from doctors who have opted out. The process would work as follows. The guarantee would provide that patients not treated within the prescribed wait time of six months would be given the opportunity to have their operation performed in another establishment – either in the region or outside of the region – or in a specialized clinic affiliated with the public sector. Should the wait time exceed nine months, patients would have their operation performed outside Quebec or Canada or by private providers, but the full cost of the surgery would be covered under the provincial health care insurance plan. At any time, patients holding duplicate private insurance could give up the right conferred on them by the wait time guarantee and obtain faster access to the needed elective surgery through the privately funded sector; this surgery could be performed only by doctors who have opted out.

To preserve the integrity of its publicly funded health care system, the Quebec government has also proposed that duplicate private health care insurance should be limited to health services obtained from doctors who have opted out. In addition, the current prohibition on

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(38) New Democratic Party, "Layton Outlines Chaoulli Response Law to Protect Public Medicare," News Release, 6 October 2005.

(39) Health Canada, "Canadian Public Health Care Protection Initiative," News Release, 3 November 2005.

(40) Ministère de la santé et des services sociaux du Québec (2006).

dual practice would be maintained. The proposals also indicate that duplicate private insurance should cover the entire care episode, including rehabilitation and home care. The Quebec government holds the view that the solution it has proposed in response to the Chaoulli decision ensures that the private sector will play a complementary role to that of the publicly funded health care system, as opposed to a competitive one.(41)

The role envisioned for duplicate health care insurance within Quebec's health care system appears to be much more limited than is the case in Australia, New Zealand and the United Kingdom. The provincial government could, in the longer term, decide to extend duplicate private coverage to a wider range of health services, thus moving away from a complementary and towards a more competitive role. Preserving the ban on dual practice would help limit the potential for growth in the parallel private system.

In comparison, the Alberta government is considering the possibility of removing the current ban on duplicate private insurance as a result of the Chaoulli decision. Perhaps more importantly, it is also considering the possibility of lifting the prohibition that currently prevents doctors from opting out, so as to encourage dual practice. The proposed reform would bring Alberta's health care system somewhat closer to that of Australia, New Zealand and the United Kingdom. Unlike doctors in those three countries, however, doctors in Alberta who engage in dual practice would be required to commit a minimum amount of time to the public system.(42)

CONCLUSION

The Chaoulli decision opens the door to duplicate private health care insurance not only in Quebec, but also in some other provinces, notably Alberta. Duplicate private insurance is currently permitted in Australia, New Zealand and the United Kingdom. Such insurance, combined with doctors' ability to engage in dual practice (that is, to work in the publicly funded system while at the same time practising in the private sector), has encouraged the development of a viable parallel private system for health care in these three countries. Duplicate private health care insurance has brought two substantial benefits: a wider choice of

(41) Sylvie Bourdeau, "Chaoulli Opens the Door to Private Clinics and Private Insurance in the Health Sector in Québec," *Health Law Bulletin,* Fasken Martineau DuMoulin LLP, February 2006.

(42) Alberta Health and Wellness, *Health Policy Framework,* Government of Alberta, February 2006; Government of Alberta, *Removing Barriers to Private Funding and Private Delivery of Health Care Services in Alberta*, November 2005.

providers and faster access to care for those who can afford private insurance; and additional funding for capacity development in the hospital sector. At the same time, however, it has raised concerns about inequity of access and length of waiting times. It may be useful for Quebec and the other provinces to examine the lessons learned from the experience of Australia, New Zealand and the United Kingdom in order to maximize the advantages offered by duplicate private health care insurance.

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