The Canada Paradox: The Public-Private Divide in Health Insurance and Pensions

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INTRODUCTION

In recent years, academic attention has returned to an issue highlighted by Richard Titmuss half a century ago: the intersection of public and private social benefits (Titmuss 1958). This renewed interest in the public-private divide reflects an understanding that the structure of private benefits can have a significant impact on the development of public programs. It also reflects a growing realization that the balance between public and private benefits is critical to the distribution of risk in contemporary society, and that current changes in private benefits in many countries are triggering a privatization of risk that is not being offset by public benefit programs.

Recent research on the politics of the public-private divide has tended to focus on the experience of the United States. This chapter focuses on Canada, another liberal welfare state. The primary purpose is to examine the evolution of the relationship between public and private benefits in health care and pensions, focusing on two distinct stages of development: the initial setting of the public-private balance, and its evolution in the decades that followed. In addition, the chapter highlights important contrasts between the developmental patterns in Canada and those in the United States, in order to contribute to the comparative analysis of the deep embrace between public and private social benefits.

The basic Canadian pattern can be summarized succinctly. In the case of health insurance, private benefits were well-developed before public benefits emerged. Nevertheless, in two major steps, the state simply displaced private benefits, establishing a virtual public monopoly in core hospital and medical services, in some cases taking over private organizations to deliver the new public programs, and relegating private

benefits to a supplementary role. In the case of pensions, however, the state was the first mover and had the field largely to itself for at least four decades. Yet private pensions eventually expanded to become an equal pillar in the retirement income system.

These contrasting starting points had a powerful impact on the trajectory of development in the decades that followed. Dominated by public programs, the field of health insurance has been remarkably stable, following a pattern of 'punctuated equilibrium,' with major changes being followed by a long period of lock-in and relatively little change. Pensions, where private benefits have played a much larger role, have followed a different trajectory. Although there has been impressive stability in public programs, there has been more scope for incremental change which – paradoxically – has tended both to entrench the historic public-private balance more firmly and to facilitate the redistribution of risk within the private sector in worrying ways.

Canadian experience thus stands in contrast to that of the United States. In the United States, the prior existence of private benefits strongly constrained the development of public programs, helping to explain the dominant role of public pensions and the supplementary role of public health insurance in that country. By this standard, the Canadian case presents a paradox. Public health-care benefits came to dominate where private benefits were already strong; but public pensions have come to share the field with private benefits which did not expand significantly until well after the introduction of public programs.

The comparison of the subsequent policy trajectories in Canada and the United States is slightly more complex, revealing both similarities and contrasts. Pensions in

Canada have seen some of the dynamics that characterize US experience: policy drift, policy conversion and subterranean policy shifts. But health care has seen much less incremental change, pointing to powerful limits on such processes in public-dominated systems.

To develop this analysis, the paper proceeds as follows. The second section provides a brief summary of the existing literature, especially that dealing with the United States, to identify key points for comparison. The third section turns its attention to Canada, examining the public-private divide in health insurance, both in the early decades and through its later evolution. The fourth section provides a similar analysis of the field of pensions. Finally, the fifth section summarizes the findings about Canada, and reflects on their implications for comparative analysis.

THE LITERATURE ON THE PUBLIC-PRIVATE DIVIDE

Recent research on US experience has generated an interesting set of propositions regarding the relationship between private and public benefits at the inception of public programs. A related literature emphasizes the importance of the relationship between private and public benefits to the evolution of policy over time.

In the United States, the scope of private benefits at the inception of public programs is argued to have had a strong role in determining whether public programs predominated or were relegated to a supplementary role. Hacker provides the fullest statement of this interpretation in regard to pensions and health insurance:

> *Divergence emerged between the two areas, however, because of the relative timing and sequence of public and private developments in the two areas. The*

> *passage of Social Security before private plans were widespread...created strong path-dependent processes in favor of the program... In contrast, the failure of health insurance during the New Deal and then after World War II created a path of policy development far less conducive to the eventual expansion of public authority. Subsidies for employment-based health benefits and for high-technology medicine created an expensive, fragmented system of health care finance and delivery that undercut the constituency for reform while raising the political and budgetary costs of policy change…* (Hacker 2002: 277-78).

In the US context, public programs which emerged after private benefits had come to play a core role in social protection were '...more likely to be limited to subsidizing private social provision and filling the gaps it creates' (Béland and Hacker 2004: 47). In contrast, public benefit programs implemented in the absence of a strong system of private benefits were more likely to be comprehensive and universal. Private benefits are argued to have constrained public programs in at least three ways: they fostered vested interests, they shaped public expectations, and they embedded institutions of private provision (Béland and Hacker 2004: 43). Private benefits created vested interests both among providers (leading to the rise of organized interest groups) and beneficiaries (due to their habituation to private benefits). Private benefits shaped not only public expectations but also 'policy-makers' governing conceptions of the appropriate shape and scope of *public* social programmes' (Béland and Hacker 2004: 47). Finally, a direct challenge to private benefits, which have become a core source of social protection, 'entails large social dislocations and fiscal costs' (Béland and Hacker 2004: 47).

A second literature has extended this work by tracking the public-private divide over time. This literature proposes an alternative to the 'punctuated equilibrium' model of policy change, which emphasizes path-dependency and the locking in of policies for long

periods of time. Drawing on Thelen's evolutionary models of institutional change (Thelen 2004), this literature focuses on incremental policy change, identifying ways in which policy can shift even in the context of relative program stability. Such changes can occur through *policy conversion* (where existing programs are re-oriented toward new policy ends without major program reconstruction), *subterranean policy shifts* (where changes in regulation and tax subsidization of private benefits result in major shifts without fundamental redesign of public benefits), and *policy drift* (where the effects of major public programs are deliberately allowed to fade by failing to adjust the programs in response to changing conditions). Hacker draws on US experience to make a 'strong case' that policy drift and subterranean policy shifts are important and have likely been overlooked in other national contexts (2004: 244).

This chapter also takes up this challenge, and explores more fully the factors that define the scope for such evolutionary change. While Hacker demonstrates the importance of policy conversion, subterranean policy changes, and policy drift, he does not identify the circumstances under which these processes are likely to occur. Our expectation is that the initial public-private divide is critical in defining the scope for such evolutionary policy change. The greater the reliance on private benefits, the greater the potential for subterranean policy shifts in regulatory standards and subsidization through tax expenditures (see Howard 1997, 2006). Similarly, the larger the role of private benefits, the more sensitive the field is to changes in private decision-making, especially decisions by employers. As Hacker and others have demonstrated, such processes increase the venues for pursuing retrenchment. Moreover, if such trends are not offset by concomitant changes in public benefits, the result can be a growing privatization of risk.

However, fields strongly dominated by public programs are unlikely to create the same opportunities for evolutionary change. The difficulty of retrenching major public programs even in the face of strong pressures for change is now widely recognized (Pierson 1996). But the dominance of public programs also forestalls processes of evolutionary change that depend on the role of private benefits. Without substantial private benefits, there is simply less scope for subterranean shifts in the regulation and subsidization of private benefits, and less sensitivity to changes in employers' approach to private benefits. As a result, policy fields dominated by public programs are likely to approximate the model of punctuated equilibrium, with episodic periods of major change being followed by long periods of relative stasis.

To test these expectations, this chapter examines the relationship between private and public benefits in health insurance and pensions in two phases: the period in which major public programs were first implemented, and the subsequent period of evolution of the public-private balance.

HEALTH INSURANCE

a) Setting the Initial Public-Private Divide: Displacing Private Benefits

A national system of public health insurance was introduced in Canada in two major steps, with the introduction of a federal cost-sharing program for universal hospital care insurance in 1957 and the introduction of a similar program for medical care insurance in 1966.

From the outset, the federal system conditioned the development of health insurance, with provincial governments establishing precedents for federal action. The social-democratic government of Saskatchewan implemented a program of universal hospital insurance in 1947 and, shortly afterwards, British Columbia implemented a similar plan. Both provinces then launched campaigns for a national initiative that would provide federal financial support for their programs. Federalism thus magnified the importance of the ideological trends developing in these provinces. In Maioni's classic statement of this argument, the federal system not only 'encouraged the formation of a social-democratic third party' (the Cooperative Commonwealth Federation which would later become the New Democratic Party) but also provided opportunities to innovate at the provincial level, and thereby 'enhanced its efficacy in promoting health policy reform' (1998: 6).

While much attention has rightly been paid to developments in Saskatchewan, the politics of the public-private divide in Ontario, the largest province, were also critical. The federal government was only willing to implement a national plan if the program included a majority of the provinces representing a majority of the Canadian population – thus effectively requiring the participation of Ontario. While the scope of private benefits for health services was significant across Canada, this was especially the case in Ontario. On the eve of the advent of a national program in 1956, 70 percent of the population of Ontario had hospital insurance coverage (see Figure 1). Private benefit plans constituted just under half of all hospital revenues (46 percent), making private benefits a much larger source of hospital revenue than either government funding (22 percent) or out-of-pocket payments (29 percent).

Figure 1 about here

Crucially, the existence of private benefits in Ontario did not forestall the province's support for a national public program. The growth of private benefits had certainly created commercial interests that were strongly opposed to universal public hospital benefits. But the Conservative premier of the province, Leslie Frost, did not seem particularly concerned with their opposition and took several opportunities to publicly challenge the industry.[1] Indeed, in several ways, the existence of a well-established set of private benefits in Ontario facilitated the adoption of a system of public benefits.[2] First, it established public acceptance of the collective insurance principle. Second, it created a ready-made revenue source as the Ontario government viewed private premiums as a pre-existing self-imposed tax. Third, the extent of private benefit coverage assuaged concerns on the part of policymakers about compliance and achievement of universal coverage. The Ontario government proceeded in the belief that the large portion of the population that was already covered could be easily moved over to public coverage – resolving, in advance, the problem of adverse selection. Finally, private benefits helped address the critical issue of administrative capacity as the province simply converted the largest non-profit voluntary insurance plan (Blue Cross) into the public agency responsible for administering the new public program. Had Ontario faced a relatively clean slate in terms of private benefits as had Saskatchewan in 1947, the obstacles to moving ahead would have been much more difficult (Taylor 1978: 119-20).[3] It is therefore not surprising that hospital insurance developed earlier than

medical insurance for doctors' services, despite the fact that private hospital coverage was much higher than private medical coverage (see Figure 1). In 1955, Ontario announced its support for a national public insurance program, and the federal government acted soon afterwards. "By assuming leadership of those pressing the federal government in 1955…, the Ontario government was clearly the determinative force that brought the nationwide system we now have" (Taylor 1978: 158).

A universal public program for medical care, including physician services, did not emerge until the 1960s, by which time private benefit coverage had reached levels comparable to those for hospital care at the inception of national hospital insurance. Once again, federal-provincial dynamics mattered. Because Saskatchewan already had its own hospital insurance program, the advent of federal cost-sharing for hospital insurance provided Saskatchewan with a large financial windfall which allowed the province to move ahead on public medical care insurance. Doing so required confronting the medical profession and expropriating its major revenue source – its near monopoly control of private medical care benefits which in 1960 extended coverage to just under 40 percent of the Saskatchewan population through plans directly controlled by the Saskatchewan College of Physicians and Surgeons (Taylor 1978: 328). Nevertheless, after an intensely bitter confrontation and strike by doctors, Saskatchewan established a public medical care plan.

In this case, conservative provincial governments tried – unsuccessfully in the end – to block the spread of Saskatchewan's approach across the country. The three largest English Canadian provinces (Ontario, BC, Alberta), which had the highest levels of surgical and medical care coverage in Canada, almost immediately introduced plans

that would rely primarily on employer-provided medical care insurance and subsidized (or government offered) insurance for those with low incomes – thus incorporating a very strong role for private benefits in conformity with the positions of both the medical profession and insurance industry (Taylor 1978: 328). With this level of provincial support, it appeared that the private benefit model would dominate: 'With three of the four most powerful provincial governments adopting CMA-CHIA policy, the odds in favour of the market economy approach and against the political economy philosophy...had shifted most favourably' (Taylor 1978: 348).

In the end, however, the federal government opted for universal public insurance, and that choice predominated. A variety of factors tipped the federal choice. The interaction between developments in pensions and health insurance was crucial, with the province of Québec playing a catalytic role. Québec, home to the vast majority of Canada's French-speaking minority population, had embarked on an aggressive program of asserting provincial dominance in social policy. As discussed in the next section, Québec announced its intention to build a separate provincial pension program at a federal-provincial conference of September 1963. This decision was perceived as a major loss for the federal government and raised serious concerns about the integrative capacity of national social policy. When combined with related decisions on other programs, Québec was effectively opting out of all major national universal social programs including youth allowances, pensions, and hospital insurance.[4] However, opting-out need not necessarily apply to new programs, and a national system of public medical care insurance provided a new opportunity to help redress the perceived imbalance between provincial and federal predominance in social policy. Under a federal shared-cost

program, the link with individual citizens would be indirect but, nevertheless, a universal program certainly reflected the idea of pan-Canadian social rights of which the federal government could cast itself as guarantor. It was in this context that the federal government announced its intention to move forward with medical care insurance in the Speech from the Throne in April 1965. Legislation was to be passed in 1967 and came into effect in 1968. By 1971, all provinces had opted in to the universal program.

Thus, in the crucial case of Ontario in the mid-1950s, debate over hospital insurance, pre-existing private benefits, rather than having constraining effects, contributed to the development of public hospital insurance benefits. In the 1960s debate over medical insurance, such constraints seemed to be emerging, as the three provinces with the highest levels of private benefits pushed to preserve a much larger role for the private sector. But the opposition was trumped by the federal government's desire to use medical care insurance as a tool of nation-building. As a result, the public-private divide in health insurance in Canada emerged in a much different form than in the United States.

b) The Public-Private Divide Over Time: Stability and Limited Drift

The centrality of public programs in health insurance established in the 1950s and 1960s has represented a powerful anchor, limiting the impact of evolutionary processes that have been critical elsewhere. There has been remarkably little drift in response to changes in private benefits, and subterranean shifts in the subsidization and regulation of private benefits have been limited.

Public Consolidation Without Expansion

In the decades following adoption, the Canadian system of universal hospital and physician care insurance was consolidated. The *Canada Health Act, 1984 (CHA)* tightened the existing principles adding the principle of accessibility (provincial plans must provide reasonable access to health services) as well as imposing non-discretionary penalties for provinces allowing user fees or extra-billing.[5] This legislation was essentially a federally-imposed mechanism to stem a drift at the provincial level to allow private funding in the form of user fees and extra-billing to increasingly permeate the public system..

Consolidation, however, took place without expansion either of national programs or in the scope of public expenditures relative to private ones. While public benefits increased rapidly as a proportion of total expenditures after the implementation of national programs, the trend did not continue (see Figure 2). More importantly, public insurance at the national level has not been extended to other expanding areas of health provision such as prescription drugs and long-term care.

Figure 2 about here

Public unresponsiveness in these areas cannot be attributed primarily to the existence of private benefits. Private insurance plans do cover about one-third of expenditures on pharmaceuticals but are nonexistent in long-term care (see Table 1). Yet there has been no expansion of universal public insurance coverage in either area, despite prolonged and numerous debates especially in the 1990s and early 2000s. Clearly, the prevalence of private benefits provides little explanatory leverage on this shared fate.

Even in the case of pharmaceuticals, where private benefits are significant, the primary source of the blockage to an expansion of public insurance has been fiscal constraints and intergovernmental relations. Provincial governments are very reluctant to enter into expensive new programs without a significant federal financial contribution. For its part, the federal government is reluctant to make open-ended spending commitments, especially as it faces heavy pressure from the provinces to make large infusions of funds for existing health programs (see Boychuk 2002, 2003, 2005, 2006, 2007). As a result, provincial governments have responded primarily with non-universal programs targeted on specific groups such as social assistance recipients. Thus, while private benefits undoubtedly have some effect in dulling pressure for the expansion of public insurance, their constraining role is not the central explanation for the failure of national programs to expand.

Table 1 about here

Limited Drift within Existing Public Programs

The failure to expand public coverage has created space for a limited amount of policy drift, with private insurance benefits coming to represent a larger portion of total health expenditures. This drift has primarily resulted from the growing significance of pharmaceuticals. From the early 1970s until the mid-1980s, spending on pharmaceuticals remained constant at around 10 percent of total health expenditures; and during this period there were significant increases in the proportion of expenditures borne by public (primarily non-universal) programs. From 1985 to 2005, however, the proportion of total

health expenditures devoted to pharmaceuticals more than doubled to over 20 percent, but related public spending grew more slowly. As a result, the overall growth in pharmaceuticals in health spending has had an effect on the overall public-private expenditure mix. A second trend has been in the mix of private spending itself: private insurance benefits have come to make up a larger proportion of prescription drug expenditures relative to private out-of-pocket expenditures (see Table 1).

The overall result of these two trends has been the increasing significance of private insurance expenditures in the overall health system (see Figure 3). While out-of-pocket payments remained at exactly the same level between 1988 and 2005, the proportion of total health expenditures comprised by private insurance payments almost doubled from 1988 (7.4 percent) to 2005 (13.2 percent). In the absence of the expansion of public programs, this represents a modest policy drift and a modest privatization of risk.

Figure 3 about here

Subterranean Policy Change and Policy Conversion

Subterranean policy change both in terms of public regulation and subsidization of private benefits has also been limited. Provincial regulation of private insurance has not dramatically altered to encourage greater private insurance coverage. The Canada Health Act does not actually require provinces to prohibit third-party insurance for otherwise publicly-insured services. Nevertheless, all provinces regulate private benefits to a much more stringent degree than is actually required under the CHA, and private

benefits have, in most cases, not developed even to the degree allowed by provincial legislation. To be sure, the public-private boundary in health insurance has been actively contested and the federal and provincial governments have been the central antagonists in these battles. Intense politics and considerable intergovernmental brinkmanship have revolved around the issue. However, the challenge has not been generated by the existence of private benefits. Rather, most of these issues have revolved around the use of private financing to access publicly-insured services (for example, user fees or extra-billing). There has been much less contestation over the role of third-party insurance coverage for otherwise publicly-insured benefits.

One exception to this pattern emerged in 2005, when the Supreme Court challenged Quebec's blanket ban on private insurance for publicly-insured services.[6] The Supreme Court highlighted a gap in the Canadian system caused by the combination of regulatory prohibitions on private insurance in areas ostensibly covered by public insurance on one side, and insufficient public provision, often resulting from funding restraints and retrenchment, on the other. The result is the potential for gaps between what is publicly provided and what private insurance is allowed to cover. These gaps manifest themselves in terms of unmet needs or private out-of-pocket expenditures that are covered by neither public nor private benefits – a potentially important form of subterranean policy change.[7]

In response to the court's judgment, Québec accepted a greater role for private insurance for a limited number of procedures such as joint replacement, cataract surgery, and cardiac care. However, the Québec response seems unlikely to presage a wholesale shift in the role of private benefits for several reasons. First, third-party insurance is only

allowed for these procedures. Second, the public health sector is trying to improve its performance by adopting a maximum wait-time guarantee for these procedures, reducing the appeal of private insurance. Finally, the new Québec law requires that private insurance cover the full cost of the entire medical intervention, allowing no scope for public benefits to subsidize private provision.

The potential for subterranean policy shifts through changes in tax policy is also circumscribed due to the limited overall role of private insurance in the Canadian health care system. There simply is no large hidden welfare state underwriting private health insurance coverage in stark contrast with the US example (for the latter, see Howard 1997; 2006). The minimal public subsidization of private benefits through tax expenditures that does occur takes two forms: the exemption of premiums for employer-provided health insurance from the calculation of personal income tax; and a personal income tax deduction for private insurance premiums and medical expenses. In the latter case, these costs must comprise three percent of net income to qualify for tax exemption, and comparatively few Canadians benefit from the provision.[8] Moreover, these tax exemptions for health care have also not been liberalized. Indeed, they were reduced in the mid-1960s and the mid-1980s.[9]

Despite the fact that tax provisions have not been liberalized, tax expenditures have been growing as a proportion of total health expenditures because private insurance expenditures have grown. (Figure 4 sets out the general pattern.) Tax expenditures relative to private insurance expenditures were actually slightly lower in the mid-2000s than they were in the early 1990s. However, due to growth in overall private insurance expenditures, tax expenditures increased from just under three percent of direct public

outlays to nearly five percent in 2005. Nevertheless, tax expenditures remain small relative to the overall system. In 2005, tax expenditures comprised roughly 3.5 percent of total health expenditures. Because their scope is limited, policy conversion or drift in tax expenditures is unlikely to lead to significant change in the overall public role in the provision of health benefits.

Figure 4 about here

Summary: Limits on the Privatization of Risk

Public benefit programs have been impressively resistant to retrenchment efforts. Governments have struggled to ratchet down the rate of growth in public expenditures. But they have not widely delisted services (which has occurred only at the margins), changed the eligibility criteria away from universal access, or expanded the role of extra-billing or user fees. The basic pattern has been expenditure restraint within the existing policy model. Thus, the privatization of risk has been limited. There has not, for example, been any sustained trend toward higher levels of out-of-pocket payments over the past thirty years.

There are undoubtedly conflicting pressures on the future balance between private and public benefits. On one side, the growth of prescription drugs as a tool of medical interventions and as an expensive component of the health care system will generate greater pressure to expand public coverage. On the other side, federal-provincial fiscal arrangements have created counter pressures. Although health care is not consuming a dramatically greater proportion of GDP than in the past, the increased costs have been

primarily borne at the provincial level due to the idiosyncrasies of federal-provincial fiscal arrangements (Boychuk 2004), generating increasing pressure on provinces to allow a greater privatization of health risk. Similar conflicting pressures surround the gaps in coverage which emerge when provinces simultaneously restrict the provision of health services though budgetary restraint while continuing to prohibit private insurance from filling the gap. How this set of pressures is resolved remains to be seen. Whether the recent re-injection of public funds into provincial health care systems and efforts to reduce wait times will be sufficient to address these demands is not yet clear. If not, there will be significant pressure to allow a greater role for private funding through private insurance.

Despite all of these theoretical possibilities, the striking reality is that the existing system and the current public-private divide have been impressively resistant to change. To this point, a major shift in the balance between private and public benefits does not seem imminent. But if such change does come, it is more likely to represent a case of punctuated equilibrium than steady evolutionary change.

PENSIONS

a) Setting the Initial Public-Private Divide: Preserving Space for Private Benefits

In the early stages of pension politics, a private pension industry barely existed. Private pensions were available to a tiny minority of employees, and those that did exist were ‘top hat’ benefits for senior executives. When the state moved into the pensions field, it entered largely empty terrain. The first step came in 1926-27, with the

introduction of the Old Age Pension (OAP), a means-tested pension of $20 per month for those 70 years of age and older. Full implementation took time. The OAP was a federal-provincial program and provincial adoption took nine years to produce country-wide coverage, with many poorer provinces joining only after 1931 when Ottawa raised its contribution from 50 to 75 percent. By the late 1930s, however, a national system was in place, with reasonably comparable benefits prevailing across the country as a whole (Banting 1987; Orloff 1993).

Despite the smallness of this first step, which targeted only the poorest and oldest, the expansion of private pensions remained slow. A survey in 1938 suggested that less than ten percent of the labor force enjoyed some form of private pension (Industrial Relations Centre 1938). The terrain was still largely unoccupied in 1951 when the public sector took its second step. A constitutional amendment gave the federal government authority to provide old-age pensions directly to citizens, and the government introduced Old Age Security (OAS), a universal, flat-rate pension of $40 per month paid to all citizens aged 70 and above, funded through general tax revenues.

The final step, which came in the mid-1960s, sparked more intense political conflict. OAS did not fully meet the income-replacement needs of the middle class, which was expanding rapidly in the postwar era. Coverage of the labor force by private pensions expanded during the 1950s and early 1960s, especially after changes in prevailing interpretations of tax regulations provided greater flexibility (Latimer 1964). Figure 5 tracks growth in coverage by various forms of private pensions. As many covered individuals had multiple forms of savings, it seems unlikely that the proportion of the labor force with some type of private benefit in 1965 was much greater than a

quarter (Bryden 1974). Nevertheless, a private pensions industry was emerging, and the days of uncontested state action were over.

Figure 5 about here

Returning to power at the federal level in 1963, the Liberal Party was committed to the introduction of a contributory pension plan, which would be layered on top of the universal Old Age Security. Their proposal was supported by organized labor, a wide range of social groups, and the social-democratic New Democratic Party, whose support the government needed to maintain a majority in the House of Commons. However, the federal government also faced two powerful challenges. First was opposition from a conservative alliance consisting of the business community and its provincial allies. Business opposition was led by representatives of the financial and insurance industries, but received substantial support from general business organizations (Banting 1985; Bryden 1974). Throughout this battle, industry's most important ally was the government of Ontario, which was governed at the time by the Conservatives. The province was also home to the headquarters of much of the insurance and finance industry, and industry representatives were deeply involved in Ontario's planning. In contrast to the Liberal's emphasis on a public program, Ontario advocated a private-sector strategy, which would require employers above a certain size to provide occupational pensions, massively expanding the role of the private sector in the retirement income system.

Because full contributory public pensions required an additional constitutional amendment for which Ontario's support was essential, the province was in a strong

position. In the end, however, the provincial government recognized that the federal proposal was popular both with Ontario voters, and accepted that contributory pensions of some sort were inevitable. But the province and the financial industry held out for a limited plan that left ample scope for private pensions and minimized redistribution by relating individual contributions and benefits closely. In addition, the province insisted on a formula governing future changes in the plan which would give the government of Ontario a veto.

The second major challenge came from the province of Quebec, which chose to invoke its constitutional paramountcy in the field and introduce its own contributory plan. Implementing its own pension program not only enhanced the province's role in social policy. It also gave the Quebec government control over pension funds which it would use powerfully in shaping economic development in the province. As a result, the Quebec Pension Plan (QPP) operates in parallel with the Canada Pension Plan (CPP). As we saw earlier, the symbolism of this move was crucial in setting the stage for the later politics of medical care insurance.

The politics of their birth shaped the design of the Canada and Quebec Pension Plans, which began operation in 1966. The C/QPP are contributory programs financed through employer and employee contributions. Benefits are earnings-related but, critically, are limited to a maximum of 25 percent of average earnings, leaving considerable room for private plans. In addition, as a result of the original federal-provincial agreement, changes in the CPP require the consent of the federal government and two-thirds of the provinces representing two-thirds of the population of the country, a requirement which is more demanding than the amending formula for most parts of the

Canadian Constitution. Critically, as just noted, the formula gives the province of Ontario a veto.

The introduction of the new contributory plans was accompanied by related enrichment of public pensions. Critics of the contributory pensions argued that they would do nothing for those already retired or about to retire, and the federal government responded in two ways. First, the universal OAS was increased, the benefit was indexed for future changes in the cost of living, and the age of eligibility was reduced in a series of steps from 70 to 65. Second, the government introduced the Guaranteed Income Supplement (GIS), an income-tested supplement that is added to the OAS payment for elderly citizens with middle and low incomes. The GIS supplement is, in effect, a guaranteed income for the elderly with a 50 percent tax-back rate: the benefit is reduced by 50 cents for every dollar of other income beyond the OAS itself. At the time, the GIS was widely seen as a provisional program, which would naturally wither away as the contributory C/QPP matured and started to pay significant pensions. As we shall see, however, its introduction was to have substantial, unexpected consequences for the public-private balance in retirement income.

Thus, despite the first mover status enjoyed by the public sector for almost half a century, the pension system that emerged was relatively ‘liberal’ in nature. In combination, the universal OAS and the maximum contributory benefit from the C/QPP replace approximately 40 percent of earnings for the average wage earner, a modest amount by European and even US standards (Béland and Myles 2005). Consistent with this liberal ethos, the strength of the Canadian system is at the bottom of the income distribution, and the replacement rate is much higher for low-income workers (Brown

and Ip 2000). The primary constraint on the development of public benefits was first posed by the complications inherent in the Canadian constitutional division of powers, and only later did the presence of private benefits expand to rival public benefits.

b) The Evolving Public-Private Divide: Conversion, Drift and Risk

The evolution of pensions in Canada since the mid-1960s has more closely followed the incrementalist patterns evident in health insurance and pensions in the United States. Efforts at bold reform of public pensions in Canada have been regularly defeated, and change in the field has tended to be evolutionary. While the balance between the private and public sectors has changed little, incremental shifts have had important and sometimes unexpected consequences.

Stability in Contributory Public Programs

In the years following the introduction of the C/QPP, the public plans and the private sector settled into a relatively stable equilibrium. Private plans adapted to the introduction of the C/QPP fairly speedily. Existing plans moved to a two-tier formula, with a lower level of private benefits and contributions up to the C/QPP ceiling and a higher level of benefits and contributions on earnings over the ceiling. Thereafter, the public and private sectors fell into self-sustaining balance. On one side, the introduction of the public plans slowed the formation of new private ones. As the trend line in Figure 5 confirms, the expansion of coverage in the early 1960s stalled with the introduction of the C/QPP in 1966 and stagnated for the following decade. On the other side, the

existence of private plans also constrained efforts to expand the role of the public programs, and the two sectors have remained locked in a relatively stable embrace

The constraints on the dramatic *expansion* of public programs became clear during the Great Pensions Debate of the 1970s and early 1980s (Banting 1985). In 1975, the Canadian Labour Congress, supported by pensioners groups, women's organizations and social bodies such as the National Welfare Council, launched a campaign for such an expansion. Their proposal would have ensured that, in combination, the universal OAS and the contributory C/QPP would provide 75 percent of pre-retirement earnings for average income earners. The main element of the proposal called for a doubling of the C/QPP benefit levels, making it make it the basic retirement income vehicle for the bulk of the population.

The private sector spear-headed opposition to the proposal. All segments of the private sector – businesses which sponsor plans and the financial industry which manages them – united in the fight, and proposed an alternative strategy based on improvements in private pensions. Initially, they had difficulty in finding consensus on a specific package of reforms. The financial institutions strongly supported the extension and enrichment of private plans, making them compulsory if necessary. Not surprisingly, however, the businesses that actually contribute to such plans were much more cautious about increasing their pension costs. Agreement was further complicated by the large gulf between large and small business over such critical issues of the day, such as mandatory coverage and inflation protection.

These difficulties, however, were more than offset by powerful reinforcement from the veto-wielding government of Ontario. The formidable alliance of business and

Ontario was able to stall the expansionist campaign during the 1970s. By the 1980s, economic recession and an increasingly conservative political climate led all governments to oppose expansion of the C/QPP. In August 1982, nine business organizations agreed to a common package of marginal improvements in existing pension plans: earlier vesting, compulsory spousal benefits, and improvements in portability. In its 1984 budget, the federal government explicitly deferred expansion of public programs and settled for a similar set of improvements in private plans and tax changes designed to improve personal retirement savings through RRSPs. The outcome of the Great Pensions Debate thus stabilized the role of the private sector.

The next phase of the political cycle in the late 1980s and 1990s revealed equally powerful constraints on dramatic *retrenchment* in public programs. In keeping with the theory of the 'new politics' of the welfare state, public expectations and electoral sensitivity protected the OAS-GIS program (Pierson 1996). In 1985, the newly-elected Conservative government proposed partial deindexation of the universal OAS, but backed down quickly in the face of angry voters. A decade later, the Liberal government proposed to replace the OAS and GIS with a new, enlarged income-tested program called the Seniors Benefit, but the proposal faced attacks from both the left and the right. From the left, women's groups and the social-democratic New Democratic Party objected to the family-based income-test for the proposed program; in contrast to the universal OAS, many women's payment from the Seniors Benefit would have been reduced or terminated in light of their husband's income. From the right, investment brokers worried about eroding the incentive to save for retirement through a larger income-tested benefit. Not surprisingly, the proposal was dropped. The only change that survived was a more

stealthy measure to 'claw back' OAS from high-income seniors through the tax system. However, the measure affects barely 5 percent of seniors (Battle 2001).

Contributory pensions were protected by the same electoral sensitivities, reinforced by the consensus-driven, incremental logic inherent in joint federal-provincial control (Banting 2005). During the 1990s, actuarial reports raised questions about the long-term financial status of the C/QPP, triggering extensive rhetoric about unsustainability in the media and political debate. However, intergovernmental politics took substantial cuts off the table. The province of Québec announced that it would not consider significant reductions in benefits, a position supported by NDP governments in Saskatchewan and British Columbia. In the end, the federal and provincial governments agreed to accelerate increases in contribution rates from 5.5 percent to 9.9 percent of earnings over a ten-year period, and to invest the additional revenues in the equities market. There was a modest trimming of some benefits, especially disability benefits, and the two NDP governments refused to sign the final agreement. But governments did not even try for more dramatic retrenchment, such as an increase in the retirement age, and the final changes largely stabilized the role of contributory pensions in the retirement income system (Béland and Myles 2005).

While both major expansion and major retrenchment of public benefit programs were both off the table, the pension sector has seen evolutionary changes through policy conversion, policy drift and subterranean policy shifts.

Policy Conversion and the GIS

The income-tested benefit, the GIS, has undergone a process of unintended policy conversion. During the1960s and 1970s, political parties regularly competed for seniors' votes with pension promises. However, the provincial vetoes governing contributory plan deflected these expansionist pressures away from the C/QPP towards the exclusively federal GIS. In 1972, both the OAS and the GIS were indexed to increases in consumer prices. But promises for additional boosts in the GIS became a central feature of electoral politics, with increases preceding or following virtually every federal election. Moreover, when automatic indexing of the OAS was suspended for several years in the mid-1980s, the government maintained full indexing of the GIS. As a result, the GIS rose steadily in real terms. By the mid-1980s, the maximum GIS payment was considerably larger than the OAS payment which it was meant to supplement, and its reach crept further up the income scale.[10] At that time, close to half of retired Canadians were receiving a full or partial payment. The role of such income-tested benefits was further extended in the 1980s with the introduction of the Spouses Allowance for the spouses aged between 60 and 65 years who were married to retired individuals.

This development reinforced the existing public-private divide, constraining change in both sectors. On the private side, the rise in the real value of the GIS generates a disincentive for modest income earners to save for retirement, as the value of any additional private retirement income would be partially offset by reductions in the GIS payment they otherwise would receive. As we have seen, this disincentive effect explains why the financial industry opposed the proposal for an even larger income-tested benefit, the Seniors Benefit, in the late 1990s. As a result, the GIS forestalls any effort to revive the idea of mandatory private pensions, which Ontario favoured in the 1960s. However,

the same logic applies on the public side. The benefit of a significant increase in the C/QPP system, such as that advocated by organized labor in the 1970s, would be mitigated by reductions in the GIS benefit received by many of the very people organized labor worries about. In effect, the GIS creates a political wall surrounding low- and modest-income Canadians, reducing both the incentives for private savings and the benefits of an expansion to the C/QPP for these groups.

Subterranean Policy and Private Benefits

While incremental change led to an unplanned outcome in the case of the GIS, successive federal governments since the 1980s have deliberately tried to encourage the growth of private retirement benefits through regulatory and tax policies. In contrast to debates over changes to major public pension programs, which mobilize social movements and the wider public, debates over the regulation of private plans tend to be an elite conversation between industry representatives and public officials, with media coverage limited to the business pages of major newspapers. Although significant changes in regulatory legislation are normally debated publicly within this community, the ongoing process of interpreting and refining regulations made pursuant to legislation tends to be a largely 'subterranean' process, to borrow Hacker's apt phrase (Hacker 2002: 43).

Changes in regulations have certainly led to improvements in pension standards. With the exception of a small number of industries falling under federal jurisdiction, regulation of private pensions is a provincial responsibility. The province of Ontario led the way in introducing pension standards as part of its larger campaign to enhance the

role of the private sector during the 1960s. Its Pension Benefits Act of 1965 imposed minimum requirements for vesting and locking-in of pension benefits, and set rules governing the funding and investment of pension funds. Legislation soon followed in other major provinces. In the words of an experienced commentator, 'the pioneer days were over' (Coward 1969: 4). By the end of the decade, legislation covered 90 percent of pension plan members in the country, and refinements in technical regulations have occurred in successive waves since then.

Governments have also relied on tax policy to stimulate the expansion of private pensions and personal retirement savings, and the process here is even more secretive. In the Canadian policy process, changes in tax provisions flow from a particularly closed process. Consultations are limited and highly formalized; policy development is dominated by the Department of Finance; decisions are made by the Minister of Finance and the Prime Minister, usually with little discussion even with other members of cabinet; changes are announced in the Minister's annual budget statement; and in a majority parliament the enabling legislation is passed without amendment. The contrast to the politics of changing major public pensions is dramatic.

Tax support flowing through this process has been important to both occupational plans, known as Registered Pension Plans (RPPs), and personal tax-assisted retirement savings accounts, known as Registered Retirement Savings Plans (RRSPs). As early as 1917, employer contributions to pension plans became deductible as business expenses, and deductibility was extended to employee contributions in 1919 (Statistics Canada 2004). In 1957, RRSPs were introduced, initially to provide a parallel tax-assisted vehicle for self-employed people to save for their retirement. Changes in these provisions,

especially increases in the ceiling on the total amount individuals can contribute to their RPP and/or RRSP each year, have taken place regularly.[11] In 1991, the government restructured its approach in order to equalize treatment of the two private vehicles. As Table 2 indicates, however, the reforms also significantly increased the combined deduction limit. The initial 1991 proposal also planned to raise the ceiling in a series of steps to $15,500 by 1995 and then introduce automatic indexation of the ceiling (Cloward 1991: 143). The intense fiscal pressures generated by the federal government's massive debt in the mid-1990s set back the schedule, and the ceiling was actually lowered and frozen for six years. But with the return of federal financial health, the original policy reasserted itself in 2003, and the ceiling was indexed to changes in average wages and salaries in 2005. In addition, changes to RRSPs allowed recipients to use the funds for a wider range of purposes. In the aftermath of the increase in 1991, contributions to RRSPs in particular grew significantly as a proportion of earnings. These tax provisions provide a major subsidy to the sector, and the resulting tax expenditures represent a significant and rapidly growing public commitment, as Figure 6 confirms.[12]

Table 2 and Figure 6 about here

However, enhanced subsidization has had limited success in expanding the overall role of private retirement vehicles, especially in recent years. As Table 3 records, overall membership in private pension plans (RPPs) has been in decline since the late 1970s, especially in the case of men. Women's participation followed a separate trajectory, converging to the male rate in the 1980s, but then stagnating and declining

gently thereafter. So far, the decline in RPPs has largely been offset by the growth in contributions to RRSPs. But the overall role of private sector has been stable.

Table 3 about here

Thus, the main story is the stability in the overall balance between private and public benefits in the retirement income system. One indicator of this is the sources from which elderly Canadians derive their income. The maturation of both public and private programs set in place in the postwar era has changed the flows *within* each sector, as Figure 7 confirms. But the division of the overall retirement income system *between* the public and private sectors remains equal. The C/QPP, which paid out its first pensions in 1976, has raised its share to about 20 percent of all retirement earnings; in combination with the OAS/GIS/SPA, public programs provided about 45 percent in 2005. Private instruments, RPPs and RRSPs,[13] have risen to be the largest single source of income at almost 35 percent. When combined with other investment income, private instruments also represent about 45 percent of total income.

Figure 7 about here

Conversion, Policy Drift and the Privatization of Risk

This overall pattern of stability obscures conversions *within* the private sector, which are generating a slow but clear trend towards the privatization of risk. One conversion is drift from private pensions to individual savings. As we have just seen, the

decline in RPPs has been largely offset at the aggregate level by the growth in RRSPs. However, RRSPs lack the protection of collective pooling of risk inherent in pension plans. Individuals relying on RRSPs bear the risk of poor investment returns, as well as the uncertainty about the strength of the annuity that can be purchased at the time of retirement. Increasing life expectancy is deepening these risks: on one hand, greater longevity increases the costs of life annuities; on the other hand, where retirement savings are not annuitized, longevity increases the chances of an individual outliving his or her savings.

A second conversion is a shift among private pensions from defined benefit (DB) plans to defined contribution (DC) or money-purchase plans. DB plans promise a specific pension benefit for each year of service, and normally any shortfall in the funds necessary to finance the promised benefits is the responsibility of the plan sponsor. Under DC plans, the contribution rates of the employer and employee are defined, but the benefit is determined only at retirement, based on an annuity that may be purchased with the accumulated contributions and associated investment income. Figure 8 suggests that the drift to DC plans is relatively moderate, but the direction of change is clear.

Figure 8 about here

These two conversions represent a privatization of risk in retirement income, with the burden being highly concentrated in Canada. High-income earners have the resources to secure their retirement years; low-income Canadians benefit from the redistributive strength of the public programs, especially the GIS. It is those at modest earnings levels

that face the greatest vulnerabilities. Modest income earners, especially those who do not have an RPP, are at the greatest risk of not saving enough in RRSPs.

This privatization of risk has not triggered a public response. In combination, these shifts in the private sector and the lack of a robust response from the public sector represent a classic instance of policy drift. The ethos of social insurance and the collective pooling of risk that characterized postwar thinking about social policy have faded, and Canadian policymakers seem content with a world in which individuals bear the growing risks inherent in a turbulent global economy. This approach has never been formally announced in a major policy statement, or introduced as a new policy initiative. Rather the shift has emerged quietly through an evolutionary process marked by policy conversion and drift.

CONCLUSIONS

Canadian experience in health insurance and pensions presents a paradox. In the field of health insurance, private benefits were well-developed before public benefits emerged. Nevertheless, the state simply displaced private benefits, establishing a virtual public monopoly in core hospital and medical services, in some cases taking over private organizations to deliver the new public programs, and relegating private benefits to a supplementary role. In the case of pensions, in contrast, the state had the field largely to itself for at least four decades. Yet private pensions eventually expanded to become an equal pillar in the retirement income sector. Hence the Canadian paradox: public benefits dominate in the field where private benefits had already emerged strongly before the state

entered; and private benefits expanded most in the field in which the public sector was unrivalled for close to half a century.

These contrasting starting points shaped the developmental pattern of the two fields, setting them off on different trajectories. The pension field, where private benefits play a larger role, has seen significant evolutionary change. Despite impressive stability in the major public programs, the scope of private benefits has created room for subterranean policy shifts and policy drift. While these processes of evolutionary change have actually reinforced the balance *between* the public and private sectors in the retirement income system, they are redistributing risk *within* the private sector in worrying ways. Health insurance, however, presents a different pattern. The dominance of public programs has limited the scope for subterranean policy change and policy conversion. Overall, health insurance benefits have been remarkably stable, following a pattern of 'punctuated equilibrium' in which the major changes of the 1950s and 1960s have been followed by a long period of lock-in and relatively little change.

Clearly, Canadian experience stands in contrast to that of the United States, where pre-existing private benefits did constrain the expansion of public benefits, and both health insurance and pensions have been marked by evolutionary change. The comparative perspective on the two countries generates a number of qualifications about the role of the public-private divide in social policy.

First, strong pre-existing private benefits do not always constrain public benefits. The introduction of hospital insurance in Canada demonstrates that pre-existing private benefits can actually spur rather than limit the expansion of public programs. Of course, the Canadian history also reveals instances when the existence of private benefits did

constrain the expansion of public benefits. But whether private benefits stimulated or constrained public action was not determined by the nature of the relationship between public and private benefits, independently of the larger institutional and political context in which they operate. Politics and context could trump, and in the Canadian case, dynamics embedded in the federal system were critical., During the battle over the introduction of medicare in the 1960s, the three conservative provinces whose populations had strong pre-existing private coverage fought hard against universal public insurance, but they lost. Their concerns were washed away by broader political realities. In the end, the federal government was driven by the interaction between health and pension policy and the imperative to use health insurance as a mechanism of nation-building.

Second, Canadian experience reminds us that there are multiple constraints on the expansion of public benefits, and we should be careful about over-emphasizing the role of private benefits. In the case of pensions, the constraining effects of federalism were considerable even where public programs faced a relatively open terrain. That powerful constraints existed even in the absence of private benefits serves as a reminder that other constraints may be at work in cases where private benefits do exist. In the case of health insurance, the failure to expand coverage to include newer and expanding medical needs cannot be laid exclusively at the door of the private sector. That failure flowed more directly from a history of fiscal pressure on Canadian governments and the peculiarities of federal-provincial fiscal relations. Attributing the limited development of public benefits primarily to the existence of private benefits would seriously overestimate their effects.

Third, the public and private sectors are not always locked in a competitive struggle to occupy policy terrain. The Canadian case highlights the emergence of medical gaps, where both the state and the private sector tread with caution. Neither governments nor private insurers are moving strongly to meet the need for long-term care insurance. Similarly, the weakening of public benefits, in the form of lengthening waiting times, has so far not triggered an aggressive movement of private insurers into the core hospital and medical care sectors. The existence of such gaps is a reminder that the politics of social policy are shaped by factors beyond the public-private divide.

Finally, Canadian experience adds to our understanding of evolutionary processes of change. Hacker draws on US experience to emphasize the importance of policy drift, policy conversion and subterranean policy shifts, and correctly suggests that these phenomena have often been overlooked in other national contexts (2004: 244). However, the contrast between health insurance and pensions in Canada suggests that it is precisely where private benefits are more central – as in pensions in Canada and both health insurance and pensions in the United States – that one would expect the high levels of drift, conversion and subterranean shift. Rather than being endemic in all welfare states, the degree of policy drift which Hacker discovers in the US may be a result of its own distinctive features. In Canada, the more mixed nature of the welfare state results in the more mixed applicability of this model of policy development. Considering the role of private benefits in shaping the development of the public-private divide remains important. In countries and policy areas where private benefits play a substantial role, there is more scope for evolutionary processes. But in countries and policy areas where public programs strongly dominate, shifts in public benefits are likely to remain the

primary driver of social policy change, with punctuated equilibrium the most likely pattern of development.

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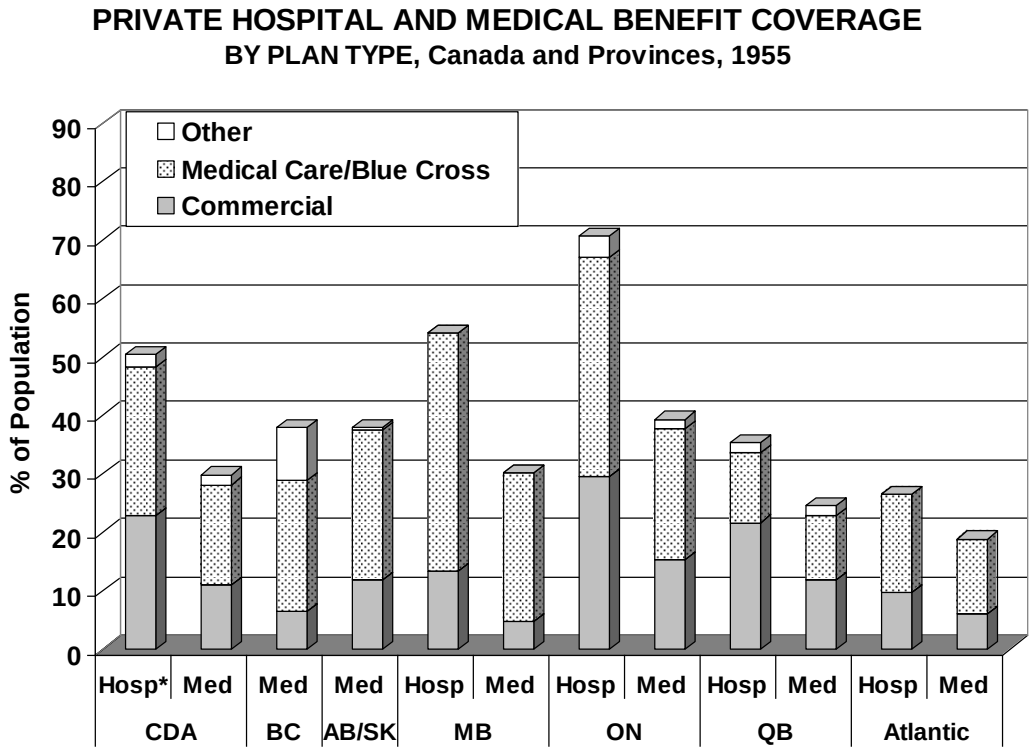
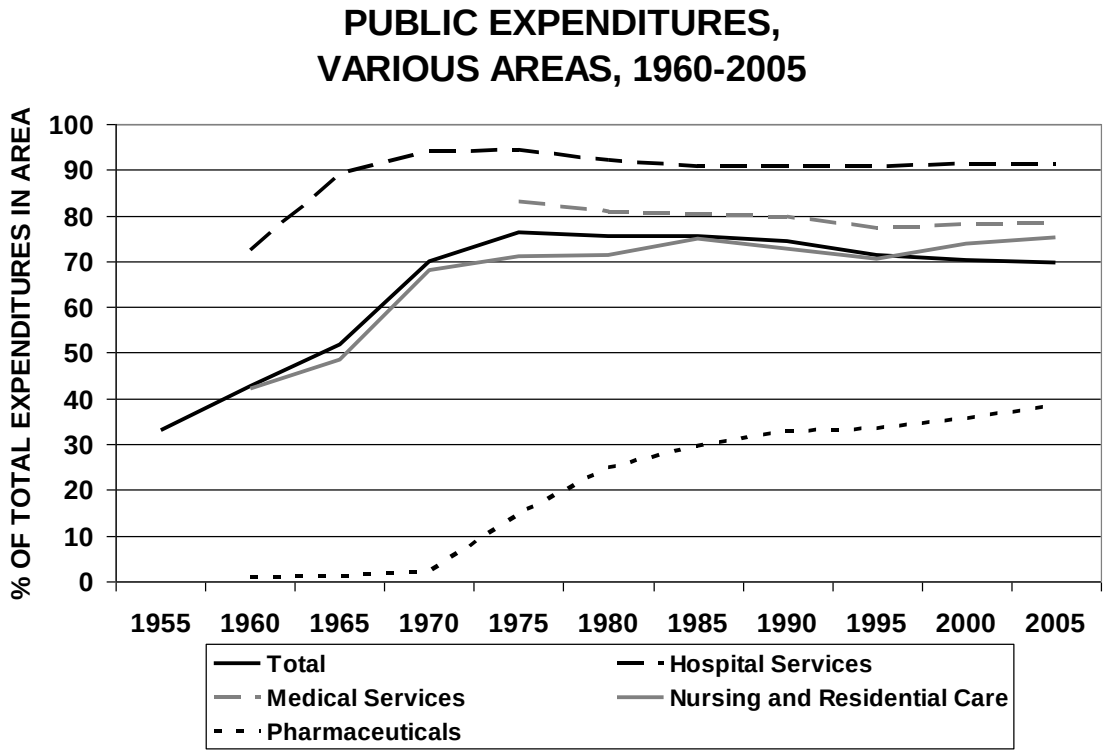
Figure 1: Private Hospital Benefit Coverage, By Plan Type, 1955



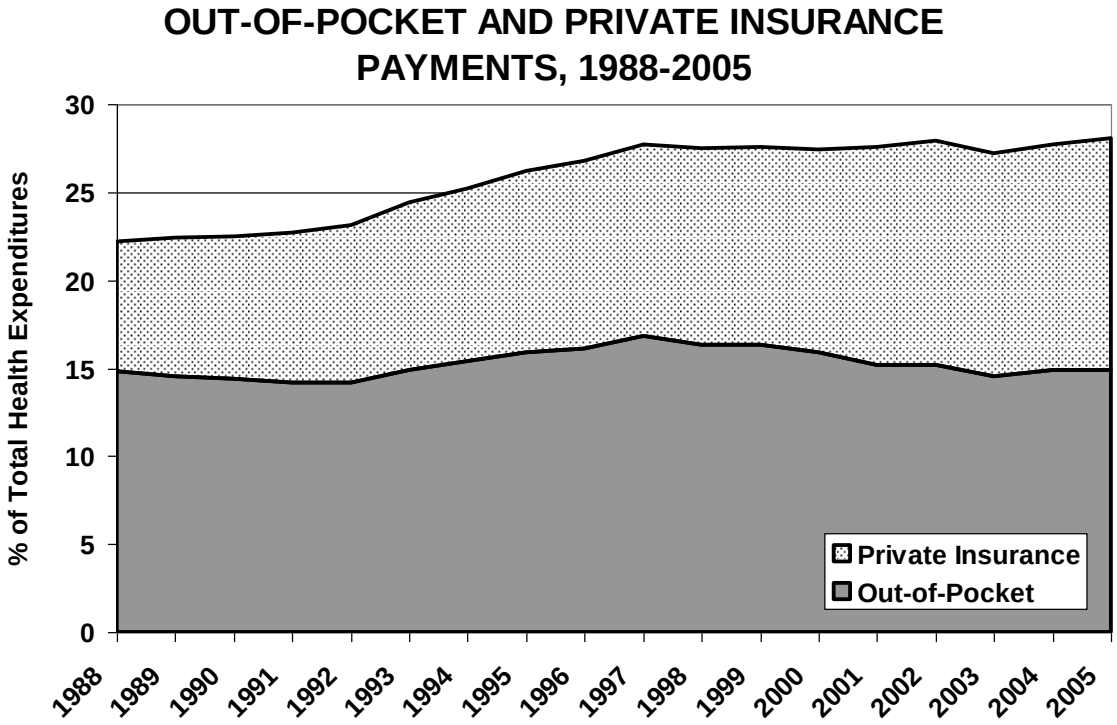
*Average hospital coverage for Canada includes the six provinces without an existing public hospital insurance plan – Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia and Prince Edward Island.

Figure 2: Public Health Expenditure as Proportion of Total Expenditure, By Area of Provision, 1955-2005



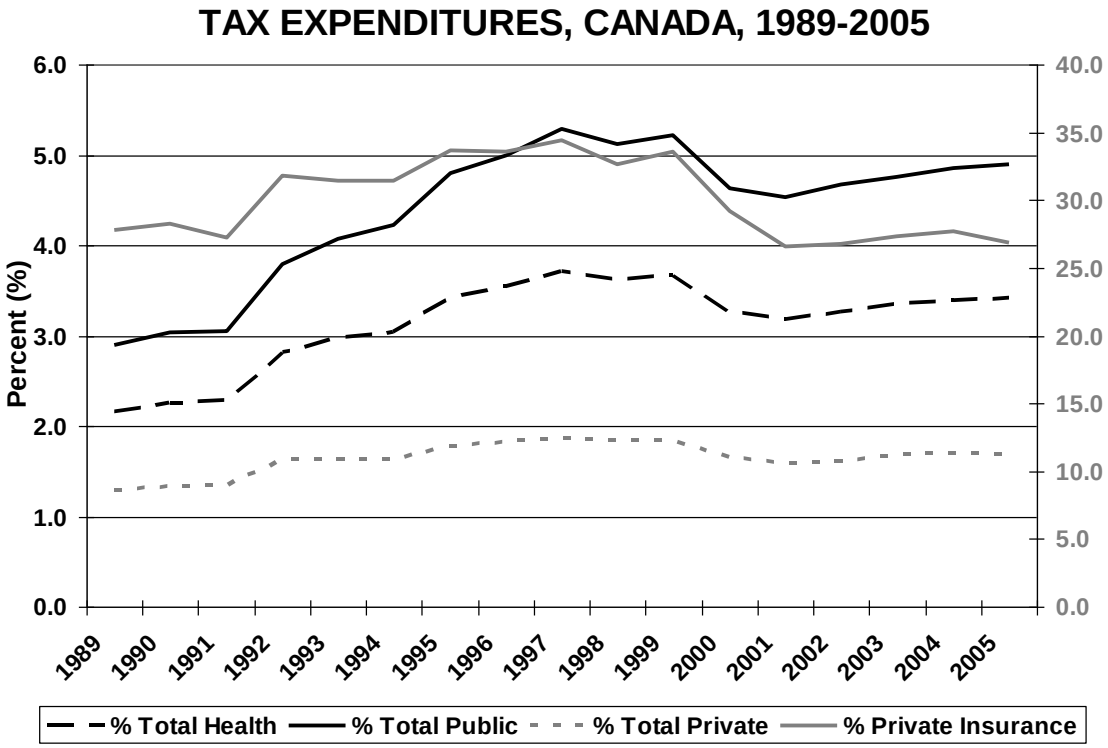
Source: Canada, National Health and Welfare, 1955; OECD, 2006. Pharmaceuticals include prescription drugs as well as other personal health non-durables. A breakdown in public-private funds for medical services is not available prior to 1975.

Figure 3: Sources of Private Expenditure (as % of Total Health Expenditures), 1988-2005



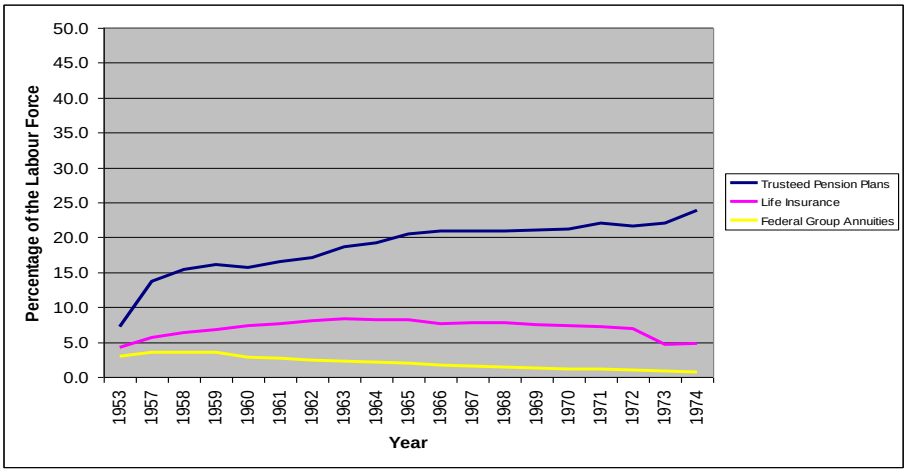
Source: OECD 2006.

Figure 4: Tax Expenditures as Percent of Total Health Expenditures, Total Public Health Expenditures, Total Private Health Expenditures and Private Insurance Expenditures, Canada, 1989-2005



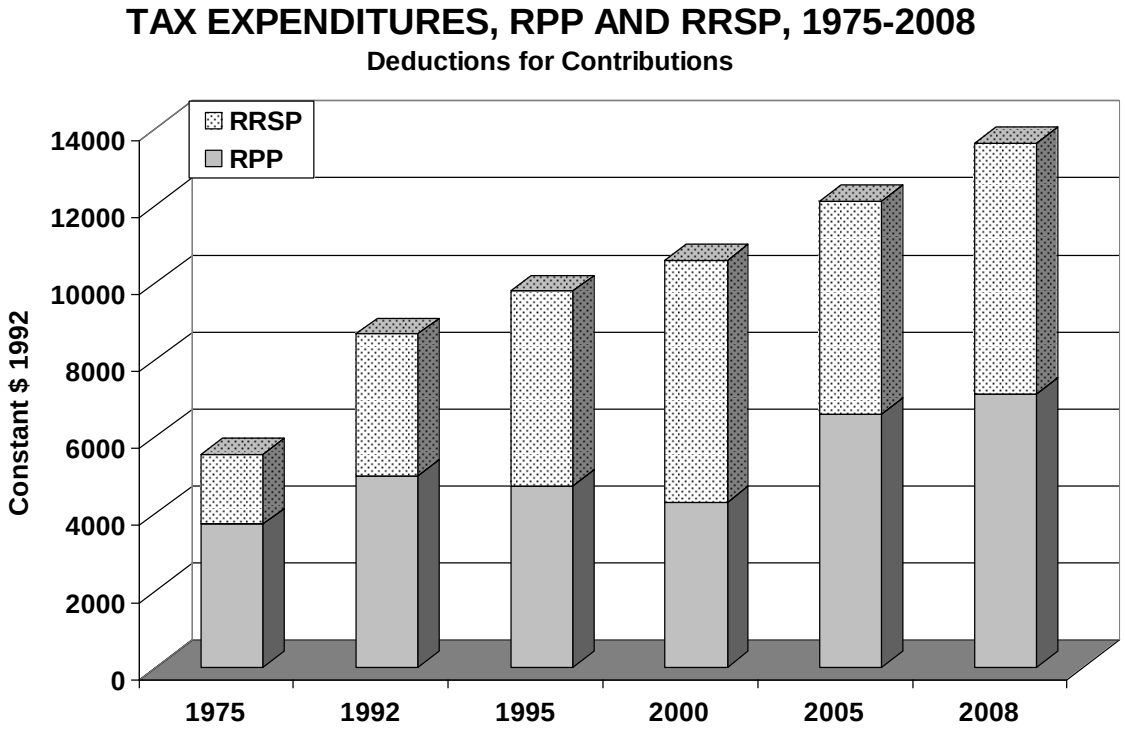
Source: Department of Finance. *Tax Expenditures*. Ottawa: Department of Finance, various years; Canadian Institute for Health Information, online database, OECD 2006 for total private health insurance expenditures.
Notes: Provincial tax expenditure calculated by author.

Figure 5: Members of Private Pension Plans as Percent of Labor Force, 1953, 1957-77



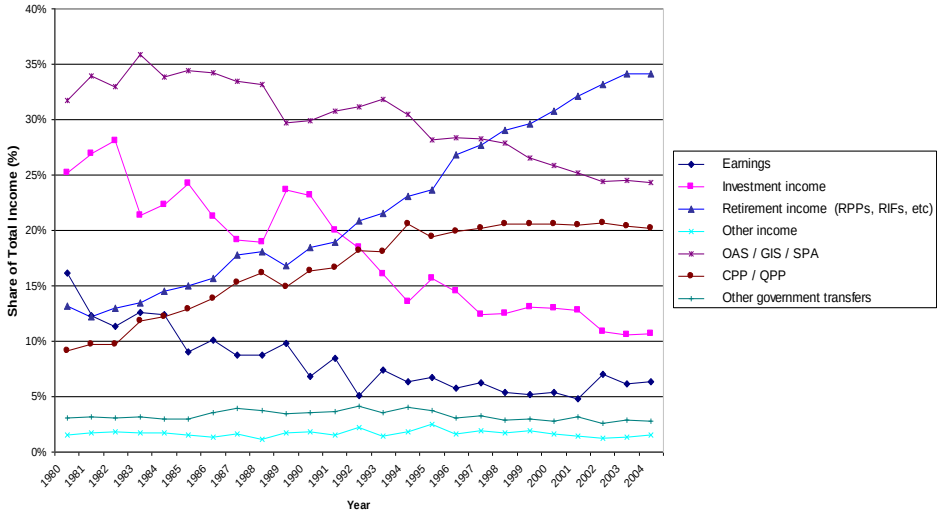
Source: Data on memberships in private plans from Dominion Bureau of Statistics (1952-1974); data on the labor force from Urqhart 1965 and Statistics Canada 1980.

Figure 6: Tax Expenditures; deductions for contributions to Registered Pension Plans and Registered Retirement Savings Plans, 1975-2008, Millions of Dollars, Constant 1992 Dollars



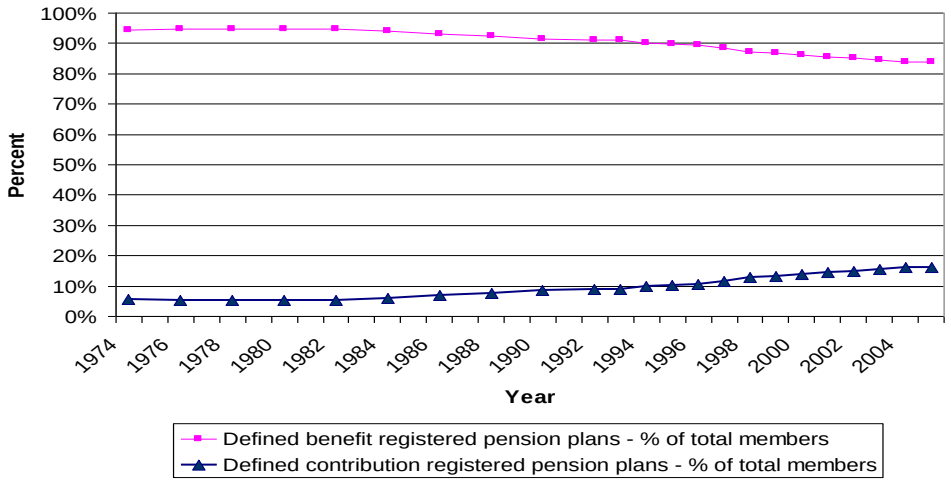
Source: Department of Finance. *Tax Expenditures.* Ottawa: Department of Finance Canada. Various years.

Figure 7: Income Sources of the Elderly, as a Percent of Total Income, 1980-2004



Source: Based on data from Statistics Canada CANSIM, Table 202-0407.

Figure 8: Defined Contribution Versus Defined Benefit Pension Plans, Number of Members as Percent of Total Plan Membership



Source: Statistics Canada, CANSIM Table 280-0012.

Table 1: Private Health Insurance Benefit Payments and Out-of-Pocket Payments (OPP) as a Proportion of Total Health Expenditures, 1988-2005

		1988	1990	1995	2000	2005
Hospital Accommodation	Private Expenditure (% of Total)	9.3	9.4	9.3	8.7	8.7
	OPP (% of Total)	2.5	2.2	2.2	1.9	1.6
	Private Insurance (% Total)	1.3	1.4	1.7	2.3	2.4
Nursing Home Care and Other Accommodations	Private Expenditure (% of Total)	26.8	27.5	29.5	27.6	28.1
	OPP (% of Total)	26.8	27.5	29.5	27.6	28.1
	Private Insurance (% Total)	0.0	0.0	0.0	0.0	0.0
Physician Care	Private Expenditure (% of Total)	1.0	1.0	1.0	1.4	1.1
	OPP (% of Total)	1.0	0.9	1.0	1.3	1.1
	Private Insurance (% Total)	0.0	0.0	0.0	0.0	0.0
Prescription Drugs	Private Expenditure (% of Total)	54.4	53.2	54.5	54.6	54.0
	OPP (% of Total)	24.2	23.1	22.8	21.8	19.6
	Private Insurance (% Total)	30.2	30.1	31.8	32.9	34.4
Dental Care	Private Expenditure (% of Total)	91.0	90.7	92.3	94.1	95.3
	OPP (% of Total)	45.5	42.4	41.6	41.6	40.9
	Private Insurance (% Total)	45.5	48.3	50.6	52.5	54.3
Eye Care	Private Expenditure (% of Total)	84.7	83.9	89.1	91.1	91.7
	OPP (% of Total)	74.0	71.7	72.2	72.3	75.5
	Private Insurance (% Total)	10.7	12.3	16.9	18.9	16.2
Other Practitioners	Private Expenditure (% of Total)	58.5	58.7	64.7	67.4	76.7
	OPP (% of Total)	38.9	39.5	40.1	39.4	56.0
	Private Insurance (% Total)	19.7	19.2	24.7	28.0	28.4

Source: Data supplied to author by CIHI courtesy of Daniela Panait. Available from author upon request.[14]

Table 2: Deduction Limits for RPPs and RRSPs, 1990-2005

RPPs		RRSPs	
1990	7,000*	1990	7,500
1991-92	12,500	1991	11,500
1993	13,500	1992-2003	12,500
1994	14,500	1994	13,500
1995	15,500	1995	14,500
1996-2002	13,500	1996-2003	13,500
2003	14,500	2004	14,400
2004	15,500	2005	15,500
2005	indexed	2006	indexed

Note: Until 1990, the deduction limit for RRPs was split equally between employer and employees at $3500 each. Beginning in 1991, the equal division was eliminated.

Source: Statistics Canada 2004.

Table 3: Proportion of the Labor Force Covered by a Registered Pension Plan (RPP), 1979-2003

Year	All %	Men %	Women %
1979	38.3	43.5	30.2
1985	35.3	39.9	29.0
1991	36.7	38.9	34.0
1997	33.5	34.1	32.7
2003	32.7	32.3	33.2

Source: Statistics Canada 2004.

ENDNOTES

[1] While Frost was philosophically predisposed toward private market options, he was particularly inimical to health insurance carriers after two of his own personal health insurance policies were cancelled. See Taylor 1978, esp. 154.

[2] The following draws from Taylor 1978: 110-24.

[3] These factors mattered less in Saskatchewan because of its small size and strong municipal system which could be used to collect premiums.

[4] 'Opting-out' of established federal programs and running separate provincially-defined programs was an option which the federal Liberal Party had espoused while in opposition in the early 1960s.

[5] Penalties for provincial breach of the five national principles (universality, comprehensiveness, accessibility, portability, and public administration) are discretionary. While there have been numerous penalties levied under the non-discretionary clauses related to user fees and extra-billing, no province to date has been penalized for breach of any of the five principles even though there have been violations by individual provinces.

[6] Chaoulli *v.* Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35.

[7] This is the basic issue addressed in *Chaoulli v. Attorney General (Québec)*.

[8] For example, only ten percent of Canadian tax-filers claim the medical expenses credit (see Smart and Stabile 2005: 349). Smart and Stabile estimate that 26 percent of higher income filers (over $50,000) are eligible for the medical tax credit with only six percent actually claiming it (2005: 363).

[9] Unfortunately, the value of tax expenditures associated with the non-taxation of premiums for employer-provided insurance and the medical expenses tax credit are not available on a reliably comparable basis prior to the late 1980s.

[10] In 2002, for example, the monthly OAS payment was $442.66 and the maximum GIS for a single person was $526.08.

[11] For details of the changes in the deduction limits for both RPPs and RRSPs, see Statistics Canada 2004: 47-50 and 83-4.

[12] In part, the tax treatment of RPPs and RRSPs can be thought of as a tax deferral device, as the income is taxed at the time of withdrawal from the plan. However, beneficiaries' tax rates are normally lower in during retirement and considerable tax assistance still results.

[13] RRSPs are converted into Registered Income Funds (RIFs) when they begin to pay out benefits.

[14] Prescription drugs as reported here do not include drugs administered in hospitals. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_nhex_definitions_e.