Canadian Public / Private Travel Health Insurance
- *A Consumer's Report*

A review of information obtained from response to a survey on
Travel Health Insurance sent to
Provincial Ministers of Health in
September 2010
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Toronto,
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Part 1

Part 1 is the Review of a survey conducted in September 2010 of how Ministers of Health interpret their responsibilities for the out-of-country section in the Portability Clause of the Canada Health Act.

Part 2 is appendices to the Review comprising of:

Appendix 1: Letter to Ministers of Health
Appendix 2: List of Ministers of Health Surveyed
Appendix 3: The Responses Provided by Ministers of Health to Survey.
Appendix 4: Portability Clause of the Canada Health Act

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Review Summary

The Pacific Pearl is an expat magazine published in Mazatlan, Mexico, serving Americans and Canadians living in the Mazatlan region over the winter months. The March 2010 edition included an article encouraging American expats to lobby Washington DC to extend Medicare to them when they are in Mexico. That article prompted the author of this review to submit an article for the April 2010 edition documenting that Canadians have national legislation for medical and hospital care abroad in the Portability Clause of the Canada Health Act (CHA), which states: *"the provinces must provide payment on the basis of the amount that would have been paid by the provinces for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors."* A September 2010 survey of Ministers of Health by the author (the "Survey") (see Pacific Pearl December 2010) reviewed how each province interprets the CHA differently. Table 1 shows the extent of their differences.

The provinces recognize some obligation to pay for coverage for out-of-country emergency medical care. The strategy seems to be to make a "token" payment and then promote the sale of private travel health insurance. Provincial health programs assume the risk that their citizens (beneficiaries) may require health services while they are at home. The only time Canadians are allowed to purchase health insurance for the possibility of needing standard ward in-patient hospital care and / or medical care is when they are leaving the country. The coverage provided by the provinces suggests they are willing to "share" the risk of their beneficiaries needing health care while out of the country with private insurance companies. It is likely that the provinces will continue with these practices unless and until challenged in court. The review warns that such action could result in "the baby being thrown out with the bathwater." An internationally respected travel health insurance industry has developed in Canada since provinces transferred liability to the private sector in the 1990s. This Canadian resource deserves to be seen as part of the solution more than the problem.

Table 1: The amounts paid for in Canadian dollars by Canadian provincial health plans for emergency inpatient hospital services required because of an accident or sudden illness while out of country

Manitoba	1-100 beds $280; 101-500 beds $365; over 500 beds $570
Ontario	Up to $400 per day for a higher level of care (for example, in a coronary care unit) and up to $200 per day for any other kind of care.
Saskatchewan*	Up to $100 per day for inpatient services, up to $50 for an outpatient hospital visit.
Nova Scotia*	$525 per day plus 50% of ancillary in-patient fees incurred.
New Brunswick*	$50 per day for out-patient, and $100 per day for in-patient care
Alberta*	$100 per day for hospital inpatient care, or the amount billed, whichever is less and one outpatient visit per day at a maximum benefit of $50 / day, or the amount billed, which is less.
British Columbia	Limited to a $75 per diem.

* Information not included in survey reply but obtained from provincial website

Fixing arbitrary payment amounts in the health regulations and promoting private health insurance to fill the gap was a reasonable course of action in the 1990s when unscrupulous US service providers were exploiting, in particular, Ontario's health system. Travel health insurance costs were negligible then. The amounts paid by the provinces have changed little since being

introduced. In the meantime the private travel health insurance industry has grown to become a very profitable business in Canada.

A Canadian (i.e., a qualified resident of Canada) can be anywhere in Canada and, if the need arises, go to a hospital emergency department and say "Doctor I am sick; treat me." In addition to the ethical obligations of physicians to respond accordingly, all licensed physicians working in the Canadian health system are required under provincial legislation to care for Canadians without considering the cost or the residence of the patient. Triage practices ensure that heart attacks take priority over broken arms. Patients are eventually medically assessed, provided with follow up care and referred on if necessary. These privileges exist for Canadians throughout Canada because of the portability and accessibility principles enshrined in the CHA.

To receive these services Canadians have to be in Canada. When they leave Canada and need such services, the challenge is to get home quickly. The Survey indicates that Ministries of Health seem more inclined to care for their residents at home than to cover the cost of services provided abroad. The purpose of travel health insurance from a Canadian traveler's perspective is to secure access to the traveler's provincial health system as rapidly as possible. To make this happen, he or she has to be certified as medically fit to travel home. If not, the patient has to remain in the foreign land, receiving local medical care. The possibility of these circumstances occurring increases the price of private insurance.

The grey area is coverage of the cost of the emergency medical and hospital care provided to patients who are required to remain abroad. Most would interpret the out-of-country clause of the CHA as making the provinces responsible (liable) for the cost of this care, or some justifiable portion thereof.

Understandably provinces are reluctant to provide full coverage for visitors to the US where the cost of health services is subject to market forces. All beneficiaries associated with this review have agreed that Canadians should purchase supplemental travel health insurance when visiting the US. The issue is the extent to which supplemental health insurance is justified when visiting places like Mexico where health costs are less than in the US and Canada.

The historical constructs of Canada's universal health system have not required health ministry staff to acquire skills in reimbursement of health services based on risk of needing such services. Some partnership is called for that recognizes the contribution of both the public and private travel health insurance sectors in serving the public need for emergency medical travel insurance. Were such a partnership to exist, all Canadians, not just seniors, could benefit from a global health governance infrastructure. This structure would ensure global access to qualified care and transportation home to their provincial health system, their family and their community, which is where most people want to be when they are recovering from an accident or sudden illness.

If provincial Health Ministries were to have access to expertise in the assessment of reimbursement of costs of out-of-country health services, they may find they want to determine if there is any benefit to providing their beneficiaries with the alternative option of receiving services in other jurisdictions instead of coming home. Provincial governments have contractual arrangements with US hospitals to provide care to their citizens when they are unable to provide such care in their systems. Similar contractual arrangements could be established on a broader global scale possibly with beneficiaries assuming some of the cost. Extending Canada's health services globally has the potential of ensuring quality of services being provided, increasing efficiency and saving costs domestically as well as possibly generating revenue.

Canadian Private / Public Travel Health Insurance

1. Introduction

The Pacific Pearl is an expat magazine published in Mazatlan, Mexico serving Americans and Canadians who choose to live in the Mazatlan region, mostly over the winter months from October to April. The March 2010 edition of the magazine included an article by Jackie Peterson describing a presentation given by Paul Crist to a gathering of Democrats Abroad, in which Crist encouraged American expats living in Mexico to lobby their elected officials in Washington DC to extend their Medicare benefits to cover them while they were in Mexico.

That article, along with numerous conversations with members of the Canadian expat community in Mazatlan about travel health insurance, prompted the author of this review to submit an article for the April 2010 edition asking the question: Should expat Canadians advocate similarly for extending health coverage under the Canada Health Act (CHA) into Mexico?

The April 2010 article noted that the portability clause of the CHA states that *"the provinces must provide payment on the basis of the amount that would have been paid by the provinces for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors."* The article went on to explain that over the past two decades federal and provincial politicians have chosen to ignore their obligations under this clause for several reasons and in that time travel health insurance premiums have increased exponentially, especially for senior Canadians.

Over the summer of 2010 a number of comments were received about the April article and concerns were raised about the relationship between private and public travel health insurance in Canada. The following list of questions was developed from those concerns and was presented in a letter mailed to all provincial Ministers of Health across Canada on August 28th 2010 including the April Pacific Pearl article, see Appendices 1 & 2.

1. Do you have any points of clarification around the comments made in the enclosed article with respect to the compliance of your province with the portability clause of the CHA?
2. What kinds of special health support services does your government provide senior citizens who spend extended periods away from your province over the winter months?
3. What expectations do you have of your senior residents with respect to relying on private health insurance coverage during extended stays out of Canada?
4. Recognizing that some seniors are unable to acquire private insurance due to pre-existing conditions, age, or cost what is the policy of your government on the reimbursement for health services these seniors may receive while staying in a foreign country when they return home?
5. Does your government's out-of-country coverage encourage seniors to return home for treatment even though in the jurisdiction where they are staying they have easier access to physician visits, hospital stays and treatments that cost less than in your province?
6. Does your government have any policy about how hospitals should receive

patients being repatriated home subsequent to an accident or illness they incurred abroad?

The letter and the article were also forwarded to Health Canada inquiring about the role of the federal government in upholding the out-of-country portability clause of the Canada Health Act.

The author of this Review was concerned that provincial Health Ministries may reply to such an inquiry with a "form letter" approach rather than provide the insight being sought. In order to put the questions being asked on a professional basis the letters were written on Info-Lynk Consulting letter head, with the website www.infolynk.ca indicated and the signature included the author's title of Health Services Reimbursement Consultant, a titled he has held for the past twenty years, see Appendix 1.

The April 2010 article included reference to articles written by the author on travel health insurance: *"Health Insurance: don't leave home without it"* at: www.infolynk.ca/health_care/ITIJ-article.html and *"London UK Conference: Regulating Travel Insurance"* at: www.infolynk.ca/health_care/itij.html A journalistic account of this Survey outlining the issues raised in a national context is published in the December 2010 edition of Pacific Pearl.

This review does not include any secondary analysis of data on travel health insurance trends available through such sources as Statistics Canada and the insurance industry or any supporting literature review because resources were not available in the time allocated to this project. For the same reason a detailed compare-and-contrast analysis of the replies provided by the Ministers of Health responding to the survey in Appendix 3 has not been conducted to the extent that it could have been. This review was written from the perspective of an informed Canadian purchaser of travel health insurance. Contact was made with the *Travel Health Insurance Association of Canada* (THIA) to verify prevailing practices for the repatriation of patients from abroad in the different provinces. The *Canadian Life and Health Insurance Association* (CLHIA) was contacted to update 1999 data but CLHIA policy on releasing data has changed and the information was not readily available. Enquiries of the *Canadian Association of Retired Persons* (CARP) about their position on travel health insurance revealed that CARP "*does not have an official policy position on expanding the public coverage for out-of-country medical services other than in respect to the ineffectual approval procedure for services they cover now."* It is interesting that CARP sees the issue from the perspective of expanding the public coverage. This review is about defining out-of-country entitlements under the Portability Clause of the CHA. The comment "ineffectual approval procedure" substantiates concerns about the provinces arguing over claims to pay for health services provided abroad.

This review is composed of three sections. Section I comments on the responses of the Ministries in their interpretation of their responsibilities under the Portability Clause of the CHA. Section 2 discusses issues of concern about out-of-country coverage of residents of Canada who spend long periods away from Canada. Section 3 offers an explanation of the reason why Canadians need travel health insurance when abroad and how provinces manage the repatriation of medical emergencies for return.

The author acknowledges the critical appraisal provided by John G. Smith, Saanichton, BC and Madeline Koch, Toronto, Ontario in the writing of this review.

2. Review of How Provinces Interpret Their Responsibilities under the Portability Clause of the CHA

Nine provinces responded to the survey. Ontario, Manitoba, British Columbia and Prince Edward Island provided direct answers to the questions, Alberta, Saskatchewan, Nova Scotia, New Brunswick, and Newfoundland and Labrador responded in a more narrative letter format. All of the responses received are available in Appendix 3. For reference purposes, a copy of the Portability Clause of the CHA is provided in Appendix 4.

The letter to the Ministers, which included a copy of the April 2010 article, asked the question:

1. *Do you have any points of clarification around the comments made in the enclosed article with respect to the compliance of your province with the portability clause of the CHA?*

This question was expected to generate an answer that was close to a legal opinion on the issue of compliance of provincial obligations to comply with federal legislation as it applies to the Portability Clause of the CHA. The closest response to this expectation came from Alberta, stating:

> The article references part of the CHA portability criteria. Section 11 (l)(b) of the CHA provides that, for insured health services provided outside Canada, payment should be made on a basis similar to the amount that would have been paid if the health service was provided in Alberta, with due regard given to a number of factors. It is important to note this section is followed by a provision that states a province may require that a resident acquire prior approval under the provincial health insurance plan before accessing out-of-country services.
>
> Health Canada has clarified that the portability provisions do not mean an individual is automatically entitled to seek services in another country. Recognizing the high costs associated with health care in some foreign countries, Health Canada does not expect that provincial health insurance plans will cover the full amount of services provided in another country. Further, Health Canada recommends that Canadians who travel outside Canada purchase private insurance to ensure adequate coverage.

These two paragraphs articulate what all other responses inferred in terms of defining (limiting) provincial liability for out-of-country coverage. The question of acquiring prior approval for accessing out-of-country services is irrelevant to the matter under discussion. The letter sent to Ministers of Health asked questions about travel health insurance coverage. Travel health insurance deals only with unexpected, emergency care that by its very definition cannot require prior approval.

Reference to clarification by Health Canada was not reported by any other ministry surveyed, including Health Canada. Presumably voluntarily seeking out-of-country services in a foreign country is recognized as different from accessing services at time of an emergency, which is more relevant to travel insurance.

While it was not part of any questions asked, all responses tended to differentiate between emergency care and other forms of care. There seem to be two primary reasons for this. The major issue with insuring seniors is pre-existing conditions. The healthy snowbird is a rare species. Many over fifty-five are subject to at least one chronic condition that require them to take medication for the rest of their lives. Consequently, seniors are a higher risk group to insure.

Provincial governments behave similarly to private insurance companies in addressing pre-existing conditions. Neither public nor private sector insurers want to take responsibility for the senior who, awaiting a knee replacement in Canada while taking a holiday abroad, has an accident and requires an emergency replacement. Similar scenarios apply to coronary surgery and other pre-existing conditions.

Besides being liable for situations arising from pre-existing conditions, the need for such differentiation probably also arises from the possibility that Canadians may travel abroad and receive services that they may have to wait for in Canada, thereby "jumping the queue" back home. Making it clear to Canadians visiting abroad that such services will not be reimbursed is understandable but that is not the issue under discussion here.

The "factors" referred to in the Alberta letter defining the amounts to be paid for out-of-country care are specified in the Portability Clause by comparing similar care provided locally with care provided abroad. Table 1 shows the variety of payments provinces pay for out-of-country hospital care.

The province that reported the most logical explanation of the coverage provided for in accordance with the requirements of the Portability Clause is Manitoba. All other provinces list arbitrary amounts that do not pretend to follow the direction of the Portability Clause for out-of-country coverage. Stressing that the amounts listed are included in regulations under provincial health acts the message given is that the amounts are legislated and cannot be readily changed.

Table 1: The amounts paid for in Canadian dollars by Canadian provincial health plans for emergency in-patient hospital services required because of an accident or sudden illness while out-of-country.

Manitoba	1-100 beds $280; 101-500 beds $365; over 500 beds $570
Ontario	Up to $400 per day for a higher level of care (for example, in a coronary care unit) and up to $200 per day for any other kind of care.
Saskatchewan*	Up to $100 per day for inpatient services, up to $50 for an outpatient hospital visit.
Nova Scotia*	$525 per day plus 50% of ancillary fees incurred while an in-patient.
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* Information not included in survey reply but obtained from provincial website

Many of the amounts were originally set in the 1990s as a stop-gap measure in reaction to exploitation by unscrupulous US health service providers. At that time travel health insurance was not very expensive and the industry in Canada practically did not exist. There is no indication that there has been any attempt to update amounts allocated for such purposes since they were first introduced. However, the cost of travel health insurance has increased exponentially since provincial governments backed off from acknowledging their obligations for out-of-country coverage.

Stressing that the Government of Canada is committed to the CHA, Health Canada's initial response to the survey letter was:

> The portability provision of the Act requires provinces and territories to maintain coverage for insured health services provided on an emergency basis during temporary absences from the province or territory.

When questioned about Health Canada's meaning of "coverage" as defined in the Portability Clause, Health Canada responded by stating:

> While rates prescribed vary, all provincial and territorial health insurance plans provide a certain level of coverage for health services received outside Canada under their health insurance plans. All provinces and territories provide coverage to their eligible residents during temporary absences out-of-country. All residents are encouraged to take supplementary travel insurance when they are travelling outside of Canada.
>
> Provincial and territorial governments are responsible for defining their reimbursement rates in accordance with this provision. The federal government has not prescribed or determined any particular formula for devising rates.

In addition to covering inpatient emergency hospital care the provinces also reported coverage to varying degrees for emergency outpatient medical care. The medical fee for an office visit to be paid in such circumstances appears to be the same as those included in the provincial fee arrangements with licensed physicians practising in the province.

All responses saw a need to differentiate between emergency and non-emergency services. For example, Ontario defined an emergency as a situation that satisfied the following criteria:

> * the services must be medically necessary,
> * the services must be performed at a licensed hospital or licensed health facility, and
> * the services must be rendered in relation to an illness, disease, condition or injury that: is acute and unexpected, and arose outside of Canada, and requires immediate treatment.

The above criteria are similar to what basic private health travel insurance policies for out-of-country coverage use to define their degree of liability. Unlike the provincial health insurance approach such private sector policies do not have arbitrary and out-dated price limits as shown in Table 1.

The response from Ontario recommended that for up-to-date information about out-of-country health-care coverage refer to the government's website.

www.health.gov.on.ca/en/public/programs/ohip/outofcountry/travellers.aspx

A review of this website reveals that Ontario Hospital Insurance Plan (OHIP) only covers emergency health services at very limited rates. For example, an outpatient visit to a US emergency room may cost thousands of dollars for the duration of care; however, OHIP will only reimburse up to a total of $50 per day regardless of the severity of the situation. **If you plan to travel outside of Ontario, it is strongly recommended that you obtain additional private medical insurance and fully understand what your policy covers.**

Non-emergency services are regarded as any illness or dysfunction that may occur as a result of a pre-existing condition, such as diabetes, asthma, arthritis, hypertension or some coronary conditions. Provincial responses repeatedly stressed that residents are responsible for their own wellbeing while away in their management of such conditions. Provinces also expressed some concerns about residents trying to receive elective services abroad that they could have in Canada. These issues were unrelated to the survey which was concerned largely with reimbursement arrangements in Canada between public and private travel health insurers.

While there were no questions dealing with the issue, all provinces explained in varying degrees their terms for allowing their residents to retain coverage when they are away from their home province and. Several recommended that beneficiaries report to the Ministry for extended periods away. The response from Saskatchewan was primarily concerned with discussing these matters in detail. Quebec did not reply to the letter and a review of its website did not identify any amounts that the province paid for out-of-country coverage. However, the Quebec website gives very specific details on residency requirements in order to apply for such coverage. While the residency requirements seem to be an important issue for the provinces, the overall impression from this review is that Canadians are grateful for the prevailing arrangements on residency requirements and it has not come up as an issue of concern.

PEI stated that any Island resident with an eligible Personal Health Number would be covered for emergency medical services, at PEI rates, received outside of Canada. Services provided in such countries as Mexico may be less expensive than PEI rates, and, therefore, the service would be paid in full.

Possibly the most honest comment on the role of the federal and provincial governments with respect to their responsibilities in providing coverage for out-of-country emergency care to their beneficiaries was the letter from New Brunswick, which responded to Question 1 by stating:

> The Canada Health Act (CHA) is, not surprisingly, a complex document requiring nuanced interpretation, which does not lend itself well to short answers. Therefore, I will not comment on legal matters of the CHA, as that is properly the purview of lawyers.

Out-of-province coverage rates in Nova Scotia, Newfoundland and PEI for example have to take into account the need for citizens from these provinces having to leave home for elective procedures not available at home. On occasions all provinces supplement their services in this way with admissions to facilities in the US.

2.1 Discussion

Although the provinces generally recognize some obligation to pay for out-of-country emergency medical care, the strategy seems to be to make a token payment and then promote the sale of private travel health insurance. Provincial domestic health insurance programs are not managed along traditional insurance principles of risk sharing. Provincial health programs assume all of the risk that their citizens (beneficiaries) may require health services while they are at home. The only time Canadians can purchase health insurance for possibly needing inpatient hospital care and medical care is when they are leaving the country. The amounts being paid by the provinces suggests they recognize some obligation to share the risk of their beneficiaries needing such services while away from the province with private insurance companies.

Evidently each province quantifies its role differently in terms of the amount of risk it is willing to assume. Provincial health insurance plans have not had to develop the skills needed to evaluate such risks. Consequently each province has arbitrarily allocated amounts in varying degrees of compliance with the Portability Clause. With these variable token gestures each of the provinces has then promoted private travel insurance as supplementing their coverage. It is likely that the provinces will continue with these practices unless they are challenged in court. As will be discussed in this report, such action could result in the baby being thrown out with the bathwater. An internationally respected travel health insurance industry has developed in Canada since the 1990s and deserves to be seen more as part of the solution than the problem.

Ontario has the most justification for being concerned about its beneficiaries in need of health services while in the US. Ontario's policy for out-of-country coverage was justifiable at the time it was introduced in the 1990s. The government had to protect Ontario tax payers from abuses by unscrupulous health care service providers in the US. At the time the market cost for travel health insurance was negligible. However, by providing minimum coverage for travel abroad in general and the US in particular, the provinces created the opportunity for the travel insurance industry to flourish and mature dividing the Canadian health care market into low-, medium- and high-risk opportunities. Such fragmentation of the Canadian population for health insurance purposes may contravene the universality principle of the CHA.

Fixing arbitrary payment amounts in the health regulations and promoting private health insurance to fill the gap may have been a reasonable course of action in the 1990s, although it contravened the spirit of the Portability Clause and imposed a burden on the would-be-Canadian traveler purchasing insurance. However, the amounts paid by the provinces for out-of-country coverage have changed little since they programs were introduced. In the meantime the private travel health insurance industry has become a very profitable business in Canada.

Clearly the provinces are concerned about their residents traveling to the US and having an accident requiring emergency care. Most out-of-country visits by Canadians are to the US. The fear of having a resident of a Canadian province exposed to the costs of the US health care system, particularly during the present time, is understandable. Supplemental health insurance covering the difference between the price of services in the US and the cost of such services in Canada as defined in the Portability Clause could be justified in terms of avoiding undesirable charges being borne by provincial health systems.

Understandably there is concern among the provinces, and Health Canada, that unrestricted service delivery to Canadians through the CHA may allow exploitation by health service providers in foreign lands. Private health insurance companies dedicate considerable resources to detecting and prosecuting fraudulent behaviour. Provincial ministries of health usually become aware of such behaviour when a trend in claims is "red-flagged" such as in a specific global location, possibly aligned to a large immigrant community located in that province. By the time such trends are observed, considerable sums of money could be transferred from the provincial treasury to foreign providers. It is therefore appropriate that provincial governments put in place a system capable of distinguishing between episodic emergency care and excessive service demands.

3. The Naiveté of Questions 2, 3, 4 and 5?

Questions 2, 3, 4 and 5 were derived from comments made about travel health insurance by Canadian senior citizens who have a lot of experience purchasing such insurance. This is probably one of the first times the concerns of these consumers have been documented. Having written numerous reports on health care over the past thirty years the author of this Review acknowledges that this venture is his first attempt at writing from the perspective of the health consumer. Questions 2, 3, 4 and 5 demonstrate a degree of naiveté that needs to be explained.

3.1 Conception of the Canada Health Act

Conscription for World War II revealed that Canadians were very unhealthy; mal-nutrition and tuberculosis were prevalent. After the war it was recognized that, provided people missed the bombs and bullets, the military lifestyle of regular balanced meals and free health care resulted in a healthy population. The 1940s,'50s and '60s were periods of many discussions and experimentations about the right way for Canadians to access health services at time of need. These discussions and debates crystallized with the 1964 Royal Commission on Health Services under the chairmanship of Justice Emmett Hall. This commission produced the non-legally binding *Health Care Charter for Canadians*. In 1984 the Parliament of Canada unanimously passed the *Canada Health Act* ensuring that Canadians who are insured through their provincial health plans are guaranteed access to hospital and medical services at time of need without having to pay directly for such services.

3.2 Expectations of Canadian Seniors in 1950-60s

In the 1950s and 60s the expectations of Canadian seniors were very different to they expect from life today. Back then a senior gentleman would frequently be seen using a cane to help get around; many women relied on walking sticks. Both genders used spectacles of varying thicknesses to see until that function failed all together. The main prescription medicine was penicillin; no one anticipated the explosion of medications that prolong and enhance the quality of life among today's seniors. Very few seniors had all of their own teeth and they generally aspired to living until they were seventy-two, but many didn't. It is unlikely that the founders of the CHA envisaged the need to accommodate the expectations of Canadian seniors spending time away from Canada during the winter months.

3.3 Expectations of Modern-Day Canadian Seniors

Having lived with and raised families under the umbrella of a comprehensive, universal, accessible, portable, privately delivered, publicly managed and publicly funded health system, today's Canadian seniors have benefited from all kinds of restoration and salvage services needed to keep their body mechanisms functioning in a reasonable condition. Knee and hip replacements, cataract surgery, coronary interventions in all their manifestations as well as solid organ transplants have provided the modern-day Canadian senior with a new lease on life and a higher expectation of its duration. In addition, the affluence of the past generation has afforded large numbers of the senior population many opportunities to save and become involved in various forms of pensions, both public and private, creating a sense of individual independence undreamed by their parents in the 1950s and '60s. Besides the desire to avoid Canada's challenging winter season, traveling is generally considered by most Canadian seniors to be both a "rite" and a "right" of passage into their remaining years.

3.4 Provincial Health Ministries' Perception of Senior Care

The perception of health needs of seniors held by Ministers of Health and health ministry personnel across Canada has tended to focus on the impact which that cohort of beneficiaries is having, and will increasingly have, on health costs. When they consider health policy issues associated with seniors, those who work in provincial ministries of health are more inclined to think in terms of geriatric care, palliative care, hospice care, home care and various maturations of institutional care as well as payment for drugs that seniors need in order to live and enjoy life. It is understandable that asking them to be innovative in their program designs to accommodate the lifestyle of the modern Canadian senior is a bit of a stretch. Facilitating access to services for seniors who are escaping the Canadian winter months is unlikely to be a priority of any provincial Minister of Health or their staff in Canada. To some degree, this sentiment came across in the answers to questions 2, 3, 4 and 5.

As noted in the replies, provincial insurance health plans have to treat all beneficiaries the same. Although it was repeatedly stated as provincial policy, the uniformity of terms and conditions is required under federal legislation in the "Universal" Principle of the CHA. Unless the questions being asked are seen in the context of all beneficiaries, provincial health insurance plans cannot be organized to address the unique needs of a single cohort of the Canadian population.

3.5 Rationales for Asking Questions 2, 3, 4 and 5

Questions 2: *"What kinds of special health support services does your government provide senior citizens who spend extended periods away from your province over the winter months?"* This question attempts to differentiate between the one week, two week or short-stay traveler who does not assume as much risk as a person away from Canada for an extended period of time. The term limit of a six-month stay away from a province before one's coverage is withdrawn is respected by seniors. However, the three-month limit on prescription medications is seen as something one has to work around in some way. Neither of these policies seems to demonstrate any interest on the part of provincial health ministries in ensuring continuity of care. Provinces deal with this issue differently. Some did report that extension of drug benefits is allowed with approval under certain circumstances.

Question 3, *"What expectations do you have of your senior residents with respect to relying on private health insurance coverage during extended stays out of Canada?"* Canadians are not accustomed to paying for the risk that they may become sick sometime in the future. Such purchases are generally considered illegal in Canada – except, that is, when a Canadian leaves the country. Given the complexity of the travel health insurance market that has evolved since provincial governments backed off from paying for such services in the 1990s, this question seeks more guidance than contained in basic statements about travel insurance being "strongly recommended." Which travel insurance policy? How should it relate to what the province is paying? What if one purchases the wrong policy? One does not have to be a senior citizen to ask these questions – they apply to any Canadian who is not enrolled in an employee health travel benefits program and is leaving Canada for some period of time. Discussing one's pre-existing conditions in order to identify which policy is appropriate with some stranger on the other end of a telephone is not a practice most Canadians are comfortable with. Provincial governments claim to be protecting patients' confidential information but other than general privacy legislation there is no specific provincial health ministry oversight of the personal health information being collected by travel health insurance sale personnel under such circumstance.

Question 4, *"Recognizing that some seniors are unable to acquire private insurance due to pre-existing conditions, age, or cost what is the policy of your government on the reimbursement for health services these seniors may receive while staying in a foreign country when they return home?"* Some provinces insisted that insurance is available on the market in Canada for all circumstances. However, the private health insurance market is all about managing risk and when the risk is high premiums come with a hefty deductible that makes their purchase somewhat difficult to justify. Canadians are not accustomed to thinking in terms of "health insurance deductibles;" such practice sounds more like the American health care market.

Question 5: *"Does your government's out-of-country coverage encourage seniors to return home for treatment even though in the jurisdiction where they are staying they have easier access to physician visits, hospital stays and treatments that cost less than in your province?"* This question elicited the most aggressively articulated responses of all. Several responses cautioned that the quality of care being provided abroad may not be as good as it is in Canada. The presumption seems to be that foreign doctors are less competent than Canadian doctors. The opinions expressed by the retiree population behind this Review stressed that most of them, many of whom have raised a family in Canada, are able to assess the quality of foreign health service being provided relative to Canadian health services. The argument was frequently made that having the option of being treated abroad would help relieve pressure on the domestic system; it was argued that recovery is faster in warm climate.

3.6 The Inflexibility of Provincial Health Insurance Programs

A consistent theme evident in all answers to the Survey demonstrated the inflexibility of the respective provincial health insurance systems to find new ways for serving health needs of modern-day Canadians. There appears to be an attempt to hide behind outdated regulations that have no connection with the prevailing delivery costs of health services either in Canada or abroad. For example this is highlighted by Ontario's statement that "$400 CDN per day is

adequate for a higher level of care such as in a coronary care unit and up to $200 CDN per day for any other kind of care." The Ontario Ministry of Health and Long-Term Care, in its analysis of its Hospital Functional Centres, lists the 2009/2010 average daily hospital costs for coronary care unit in Ontario as $1,334.92.

It is likely that the reactions to the responses to the four questions, which were distilled from comments made by Canadian retirees about their respective provincial travel health programs, would resonate with many Canadians in the broader population. The intransigence of the system to explore opportunities for accommodating the lifestyles of modern-day Canadians is forcing seniors, and other Canadians, to seek out private sector solutions that can meet their needs and accommodate their budgets. Provincial governments have been successful in surreptitiously shifting their liability for out-of-country coverage to the private sector, and part of the cost of provincial health care coverage on to the shoulders of the traveling Canadian.

4. Repatriation to Canada of Canadians with Medical Emergencies in Foreign Countries

A Canadian, that is a qualified resident of Canada, can be anywhere in Canada and, if an emergency medical situation arises concerning his or her wellbeing, they can go to, or be taken to, a hospital emergency department, or walk-in-clinic, and say: "Doctor I am sick: treat me." In addition to the ethical obligations of physicians to respond accordingly, all licensed physicians working in the Canadian health system are required under provincial legislation to care for Canadians without considering the cost of services rendered or the province of residency of the patient.

Canadians have no need to worry about payment of such health services. Local triage practices ensure that heart attacks take priority over broken arms. Patients are eventually medically assessed, provided with follow-up care and referred on if necessary without having to provide any payment. These privileges exist because of the portability and accessibility principles enshrined in the CHA.

To receive these services Canadians must be in Canada. When they leave Canada and need such services the challenge is to get home quickly. The Survey indicates that provincial Ministries of Health seem more inclined to care for their residents at home than to cover the cost of unfamiliar services provided abroad.

The purpose of travel health insurance from a Canadian traveler's perspective is to secure access to the traveler's provincial health system as rapidly as possible. To make this happen, the patient has to be certified as medically fit to travel home. If not, that person would have to remain in the foreign land, and may require local medical care. The possibility of these circumstances occurring increases the price of insurance premiums.

There are two issues that need to be considered here. First, which is liable for the provision of emergency medical care that is required abroad: the provincial health insurance plan or the private travel health insurance plan? Second there is the management of the process of accessing a provincial health system from abroad, which will be discussed subsequently.

4.1 Out-of-Country Emergency Coverage

Most people would interpret the Portability Clause (see Appendix 4) as making the provinces responsible to some degree for and liable for the cost of emergency medical care

rendered abroad. The fact that all provinces do provide some coverage in varying amounts is acknowledgement that the provinces recognize there is some liability.

Current policy in respect of the management of this aspect of the CHA has been influenced by the behaviour of unscrupulous US health care providers in the 1990s. This pattern of behaviour highlighted the vulnerability of all provincial health systems to out-of-country liability for residents by virtue of the Portability Clause. Understandably provinces are reluctant to provide full coverage for their residents visiting the US where health services are more market driven than serving realistic medical needs, and the cost of health services tends to be governed by what the market will bear.

The provincial governments' solution to this problem was to turn over to the private sector virtually all responsibility for coverage of their residents when they leave Canada. This kind of reliance on private insurance to provide coverage for Canadians is not allowed in any other aspect of health services delivery in Canada and is what the CHA was developed to eliminate. At the time these provincial policies were developed travel insurance coverage was very cheap and the travel health insurance industry in Canada was not very sophisticated.

The out-of-country policy adopted by the provinces in the 1990s in response to abuses by US service providers was a piecemeal approach to deal with a current problem at the time. The fact that each province dealt with such coverage differently, as shown in Table 1 and documented in the results to the Survey in Appendix 3, demonstrates that little thought was given to a logical approach to the medical risk management needs associated with providing health coverage to Canadian travelers. Given the marketing expertise of private insurers and negotiating skills of union leaders and employers to be seen to be doing good by their members and employees respectively, travel health insurance rapidly became a component of employee benefits packages. Federal, provincial and municipal governments have led the way in promoting such coverage for their employees and their beneficiaries. Such actions have resulted in provincial responsibilities for out-of-country health coverage being transferred to the private sector and the cost therefore being transferred to the traveler. Canadians who are not part of employee group arrangements are subjected to revealing their health conditions to private insurance companies to determine an individual risk assessed premium along with a deductible. The CHA was intended to protect Canadians from private insurers who would exploit the risk of needing medical and hospital care.

4.2 Medical Emergency Transportation Insurance Coverage

In order to claim their right to medical care Canadians have to be inside the system, be it a hospital emergency department or a doctor's office. There have been instances where people have died outside hospital emergency departments because they could not make it into the ER. Hospital emergency department staff is not allowed to "officially" step outside the emergency department to help someone in need of care on the sidewalk. Such actions are defined more as the work of para-medic or police personnel, if they are available.

The CHA does not cover the cost of a Canadian being transported to the place of treatment. In Canada provinces do not pay for ambulance services except under specific circumstances. If Canadians outside Canada wish to return home to be treated they are responsible for the cost of transportation. The cost of transportation home in the event of a medical emergency abroad is

the fundamental reason why Canadians need travel health insurance.

Legally the travel insurance company is only required to deliver the patient to the emergency department and after that their responsibility ends. This behaviour would not be a very good practice for generating repeat business, and it would also cause havoc within most emergency departments in Canada. Insurance companies have to fulfill a role such that they fill provincial hospital admission challenges in order to maintain their business and accommodate the service they provide within Canada's government-funded health system.

It is assumed that when travel insurance is purchased, in the event of a medical emergency occurring in foreign land, the insurance company will arrange for a plane to be dispatched to wherever in the world the insured person may be to bring that person back home as quickly as possible. This is essentially what does happen from the perspective of the insurance company after it is satisfied there is no less expensive alternative by which it can satisfy its obligation under the policy purchased by the patient. Under some policies the insurance company makes the decision to return home. In places like Mexico, it may be less expensive for the insurance company to treat the patient locally.

Most Canadians would assume that arrangements for being transported home under such conditions would be expedited by their provincial health insurance program. Any delay in such process can not only reduce the patient's satisfactory recovery but will add to the cost for the insurance company to cover and hence justify the need to increase premiums.

As shown in Appendix 3 the reply of all provinces to Question 6, "*Does your XXX government have any policy about how hospitals should receive patients being repatriated home subsequent to an accident or illness they incurred abroad?,"* was that provincial Ministries of Health delegate such responsibilities to their hospitals to organize. This means that insurance company clinical coordinators have to negotiate with local physicians in Canada with hospital admitting privileges to arrange for a bed to be available when the Medivac airplane arrives at the nearest airport. Medivac airplanes are not allowed to leave a foreign country unless a hospital bed has been allocated for their patient in Canada.

In addition to holding the patient in a foreign country while admission arrangements are made in Canada, the plane has to remain on the tarmac in Canada while the crew cares for their patient while awaiting hospital admissions at the time of arrival. Depending on number of other admissions at the time of arrival this period could be many hours. Keeping a private plane on the tarmac is very expensive for the insurance company. Such inefficiencies in protocols for out-of-country emergency admissions are further justification for insurance premiums to increase.

It is understandable that provincial governments are not involved in the admission policies of their hospitals dealing with domestic admissions. Hospitals are professionally managed, independent corporations that should not be subject to provincial government micro-management. On the other hand, it could be argued that emergency medical admissions from abroad should receive some provincial and maybe federal oversight given the complexities of international air travel these days. Federal oversight in such matters is justified not only because Canadian citizens do have to cross international borders but also because the Universality Clause of the CHA limits preferential hospital admissions for any

group of patients. In the absence of any policy directives from both levels of government insurance companies doing business in Canada have to accommodate these inefficiencies and pass the costs on in increased premiums.

Patients arriving from parts of the world where there is a risk arising from the spread of communicable disease are subject to screening by Canada Border Services Agency (CBSA). CBSA works through a Public Health Agency of Canada (PHAC) Quarantine Officer who, under authority of the Quarantine Act to conducts an assessment. If a traveler has signs or symptoms consistent with those listed in the Quarantine Officer may transfer the patient to a local health facility. Although the patient is admitted under the authority of the Quarantine Act, the province is responsible for the medical care of the patient.

One province, British Columbia, acknowledged in its Survey reply the existence of a provincial program, BC Bedline, that may help facilitate admissions from abroad. Two other provinces not reported in the list in Appendix 1, Alberta and Saskatchewan, were identified through communications with Travel Health Insurance Association (THIA) as having more efficient programs for admitting their residents from abroad. In Alberta the program is known as the Referral Access Advice Placement Information and Destination (RAAPID) service and in Saskatchewan, the program is called Acute Care Access Line (ACAL). These kinds of programs offer some hope for reducing the time a Medivac plane is held up and ensure access to a bed under the prevailing local circumstances. Such conditions should reduce the cost of travel health insurance in these provinces. Prince Edward Island reported that it had an Out-of-Province Liaison Program that assists and provides guidance to patients being repatriated home subsequent to an accident or illness while outside the country.

Ontario has a similar program for the transport of critically sick people among hospitals in that province called CritiCall. It provides "repatriation" of patients sent out of the province by CritiCall to Ontario for the remainder of their care. These out-of-province transfers would likely include cancer and cardiac patients being treated in US hospitals because there are not sufficient facilities in Ontario at the time they need to be treated. When questioned why the Criticall program was not being used for out-of-country emergency medical admission, the ministry spokesperson did not reply.

5. CONCLUSION

In her book "**The Cult of Efficiency**" Janice Stein, of the Munk School of Global Affairs at the University of Toronto, discusses the role of the state as the provider of private goods. She cites the following quote by Adam Smith the founder of modern day economics:

> *The man of the system is apt to be very wise in his own conceit; and is often so enamoured with the supposed beauty of his own ideal plan for government, that he cannot suffer the smallest deviation from any part of it. He seems to imagine that he can arrange the different members of a great society with as much ease as the hand that arranges the different pieces upon the chess-board which have no other principles of motion besides that which the hand impresses on upon them; but that, in the great chess board of human society, every single piece has a principle of motion of its own, altogether different from that which the legislature might choose to impress upon it.*

The prevailing policy on travel health insurance in provincial Ministries of Health originates

from situations that happened in the 1990s due to exploitation by unscrupulous American service providers. The Adam Smith quote is reflective of how successive generations of government employees have come to regard the prevailing basis for administering their provinces' programs for out-of-country coverage as being the status quo.

It is unlikely that out-of-country health insurance coverage is a priority for Ministers of Health or their Ministries. It is likely that most persons assuming the role of Minister of Health are informed of the threat of having to assume costs for services rendered to their citizens in the US and then being advised that "that problem has been fixed." Indeed from the perspective of the government, encouraging citizens to purchase private health insurance for supplemental out-of-country care appears to have fixed the problem. However, it would be considered illegal for a provincial health ministry to encourage those staying home to purchase private inpatient and medical outpatient health insurance.

If Canadians abroad want the option of having access to their provincial health system in the event of an emergency, they need travel health insurance to ensure they are suitably transported back home. The extent to which they should need to purchase supplemental health insurance in addition to the travel component is debatable. The fact that each province provides a token coverage for such services suggests some acknowledgement that the provinces are liable for these services when necessary. In the absence of suitable in-house expertise for assessing the risk of accidents in the US and elsewhere, health ministries seem to have assumed that health services costs in the rest of the world are the same as in the US. As shown in the October 2010 Canadian Institute for Health Information (CIHI) National Health Expenditure Trends, 1975 to 2010 Canadian health costs are comparable or higher than most other countries listed, with US health costs way off the dial in comparison. The issue under debate is the extent to which Canadians need standard of supplemental health insurance when visiting places like Mexico where Americans such as Paul Crist stress health costs are considerably less than in the US.

As ministries of health do not generally have in-house expertise in assessing the management of risks associated with reimbursement of the cost of health services provided abroad, a partnership is called for that recognizes the contribution of both the public and private sectors in serving this public requirement. Were such a partnership in place, all Canadians – not just seniors – could benefit from a global health governance infrastructure that would ensure professional and efficient delivery of care in just about any part of the world, and transportation home to their provincial health system, their family and community, which is where most people want to be when they are recovering from an accident or sudden illness.

Additional access to skills in risk assessment and management with respect to reimbursement of costs of health services may lead to provincial ministries of health investigating whether there is some benefit to be derived from having them provide their beneficiaries with the option of receiving services in other jurisdictions. Provincial governments have contractual arrangements with US hospitals to provide care to their citizens when they are unable to provide such care in their systems. Similar contractual arrangements could be established on a broader global scale, with the beneficiary assuming some of the cost. Extending Canada's unique health system globally as a public / private hybrid entity has the potential for reducing costs domestically and generating revenue internationally.