

WHY COMPETITION IS ESSENTIAL IN THE DELIVERY OF PUBLICLY FUNDED HEALTH CARE SERVICES

Michael Kirby and Wilbert Keon

In this excerpt from a *Policy Matters* released this month by the IRPP, Senators Michael Kirby and Wilbert Keon argue forcefully that Canada's publicly funded health care system needs competition if it is to achieve efficiencies and productivity gains that are essential "to make Canada's publicly funded, single-payer health care system more productive and financially sustainable over the long term." The current fix of throwing billions of dollars at the problem "neither works nor is financially sustainable."

Dans cet extrait tiré d'une étude lancée ce mois-ci par l'IRPP, les sénateurs Michael Kirby et Wilbert Keon soutiennent qu'un système de santé public à payeur unique comme celui du Canada doit s'ouvrir à la concurrence pour accroître son efficacité et améliorer sa productivité, deux changements indispensables à sa viabilité à long terme. Car la solution retenue jusqu'ici, qui consiste à y injecter des milliards de dollars ne résout rien et n'est pas viable financièrement, affirment-ils.



The latest taboo in Canada's publicly funded health care system is not the creation of a parallel private health care insurance system — this would be unacceptable to a majority of Canadians — but rather the introduction of greater competition within the existing health care delivery system.

Various groups in Canada have been largely successful in asserting — without any supporting argument or evidence — that competition among providers would put Canada on a slippery slope to an American-style system. The irony of this position is that without increased productivity, for which competition provides a powerful incentive, timely access to medically necessary treatment in Canada will be inhibited further. This would, in turn, increase demand for a parallel, private, for-profit tier of health care services (which would violate the *Canada Health Act*).

We propose a framework for reforms that would generate increased efficiency and make Canada's publicly funded, single-payer health care system more productive and financially sustainable.

The current habit of governments of promising billions of additional dollars to "cure the problems" of the health care system is not the answer. To date, by adding money, governments (and those within the system) have simply managed to avoid confronting the most important structural weakness of Canada's existing system: its lack of incentive to increase productivity.

Improvements in productivity are the key to making the health care delivery system more cost-effective and to reducing the rate of growth of health care expenditures. In other fields of endeavour, competition among providers has been shown to be the best way — indeed, perhaps the only way — to drive improvements in productivity. Competition in health care delivery is not an end in itself, but it is a valuable tool, the means of achieving improvements in productivity that will lead to a much more efficient and cost-effective delivery system.

We can achieve competition among providers while preserving the single-payer, publicly funded system and upholding the principles of the *Canada Health Act*. In its report *The Health of Canadians*, released in October 2002, the Standing Senate Committee on Social Affairs, Science and Technology strongly supported the single-payer model, both because it assures all Canadians of equitable treatment and because it is the most efficient way to pay for health care services.

In this article, we explain why improved productivity resulting from competition in the delivery of health care services is essential if the health care system that is cherished by Canadians is to be fiscally sustainable.

Canadian health care is based on a single public insurer for the buying/funding of medically necessary health

services (there being but a single buyer is referred to in the economic literature as a “monopsony”). Although there are many providers of health services in Canada, they can be thought of collectively as a monopoly provider because they all operate according to a set of rules and a financing system that effectively preclude their competing with one another. In particular,

provided in most provinces by private for-profit companies. Laundry services, meal preparation and other support or ancillary services in publicly funded hospitals are often delivered by private companies operating on a for-profit basis. Thus, Canada has a mixed public-private delivery system. It is simply not true that the delivery system is public. Nor is it true that the *Canada*

administering health insurance claims. For example, in a 2004 study (using 1999 figures, in US dollars) Woolhandler, Campbell and Himmelstein concluded that overall administrative costs (including hospitals and doctors’ offices) accounted for 31 percent of total health care expenditures in the US (\$1,059 per capita), compared to 16.7 percent in Canada (\$307 per capita). If its admin-

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Canada’s many hospitals and doctors do not compete on the basis of price or quality of service.

The single public insurer (buyer/funder) model for health care derives from the public administration criterion of the *Canada Health Act*, which stipulates that provincial/territorial health care insurance plans must be administered on a not-for-profit basis by a public agency. This model essentially precludes the operation of a parallel private insurance sector in competition with public insurance for the funding of services provided by hospitals and doctors and covered by the *Canada Health Act*.

That government is the sole participant in the field of insuring medically necessary services provided by hospitals and physicians is often wrongly interpreted to mean that government is also responsible for the delivery of the services it funds. In fact, the delivery of publicly funded health care in Canada currently is almost entirely in the hands of the private sector: most doctors are in private practice (they operate like small businesses or self-employed professionals) and the great majority of hospitals are private nonprofit organizations. Laboratory and diagnostic services paid for by the single public insurer are

Health Act requires publicly insured services to be provided by public sector institutions or employees.

To repeat, we feel strongly that the single public funder system must be preserved. The Senate committee established clearly that the single public insurer for health care yields considerably more administrative efficiencies than any multi-funder arrangement. More importantly, a single public funder ensures that no one will be denied necessary care due to an inability to pay. It is this universal feature of the system that is most cherished by Canadians.

The single-payer system is more efficient than multiple-payer models because it covers all Canadians and thus spreads the cost of insuring against ill health across the widest possible pool of people: the entire population. It also eliminates the inequities and inefficiencies related to adverse selection — competing voluntary insurance plans may refuse to insure high-risk patients and/or charge everyone higher premiums to compensate for the fact that more people at higher risk of ill health will buy insurance than people at lower risk.

The single payer system also substantially reduces the administrative cost to hospitals of processing and

istrative costs were the same as Canada’s, then the United States would save \$209 billion per year, more than enough to insure the 40 million Americans who currently have no health insurance.

Examining insurance overhead only, the overhead cost per capita for

health care insurance was \$259 in the US, compared with \$47 in Canada, representing 5.9 percent and 1.9 percent of total health care expenditures, respectively. It is very clear that, in addition to its cherished egalitarian attribute, the single-funder model is also the more administratively efficient by far.

However, while the single-payer model is administratively more efficient, it is also prone to certain systemic problems that can drive up operational costs. Within the publicly funded system, a monopoly situation (in which competition among sellers

TABLE 1. INSURANCE OVERHEAD AS A PERCENTAGE OF TOTAL HEALTH CARE EXPENDITURES (1999 FIGURES)

	Canada	United States
Private insurance	13.2	11.7
Public insurance	1.3	Medicare 3.6 Medicaid 6.8
Total	1.9	5.9

Source: S. Woolhandler, T. Campbell and D.U. Himmelstein, “Health Care Administration in the United States and Canada: Micromanagement, Macro Costs,” *International Journal of Health Sciences* 34, no. 1 (2004).



The Gazette, Montreal

The introduction of competition among hospitals would help drive down costs and favour productivity gains, argue Kirby and Keon.

of health care services is precluded) occurs in the provision of health services at two different levels: health care professionals and hospitals. We treat each of these separately below.

Within each province, associations representing health care professionals hold monopoly power in that each is the sole source of health care providers in its respective area of expertise (doctors, nurses and so on). This, combined with the single public insurer model, leads de facto to a bilateral monopoly in which the insurer and provider negotiate uniform province-wide reimbursement rates or salaries.

The outcome of these negotiations depends on the relative power of the bargaining parties. Experience shows,

however, that this power is unbalanced; it tends to rest almost entirely with professional associations, in part because of the justifiable fear that governments have of confronting strikes by health care providers, and in part because of major flaws in the existing structure of negotiations.

The imbalance of power between the funder and provider groups stems from the fact that work rules — dictating which employees will do what, and under what conditions — are virtually never part of the negotiations, as they are in other industries. Typically, in the course of negotiations, labour will seek higher wages while management will seek changes to the working environment that will foster greater productivity and lead to a decrease in per-unit production costs. These productivity

savings are then shared by the employees (through higher wages and benefits) and the employer (through higher profits).

Unfortunately, in health care negotiations, changes to work rules are virtually never negotiated. All that is negotiated are wages or salaries. Thus, that which is crucial to the funder (the government) — how to improve the productivity of the system — is not on the table. All that is subject to bargaining are the issues that potentially benefit the providers — namely, wages and incomes. Therefore, the critical trade-offs involved in balancing wage increases against productivity improvements are not even addressed at the bargaining table, let alone resolved.

In recent years, the excessive power wielded by associations of

health care providers has secured pay increases that have surpassed those bargained in other industries. Thus, according to the Conference Board, "during the 1990s, health workers, in general, saw their median annual earnings rise twice as much as non-health workers (6.4 percent versus 3.1 percent) and health professionals experienced a 15.1 percent increase." Moreover, these increases have been secured without much, if any, consideration for increases in productivity or differences in the quality of services delivered by individual providers.

This cannot continue. We are not suggesting that reform should be accomplished on the backs of those who deliver health care services. Nor are we suggesting that the ability of various providers to secure the best possible return for their services be unduly restricted. Rather, what concerns us is a situation in which a truly essential service (health care) is provided by groups of workers whose monopoly position is not effectively counterbalanced in the course of their negotiations with government (the single payer) or with employers (for example, hospitals, whose funding is determined almost entirely by the single payer).

Because health care is so labour-intensive, resolving the current imbalance in negotiating power is critical. For example, the minister of health planning in British Columbia estimates that approximately 80 percent of total acute care costs in that province are labour costs. Thus, of the \$1.1 billion that was added to BC's health care budget in 2002, \$685 million went to increases in the wages, fees and benefits paid to health care workers.

Elsewhere, professional associations of health care workers have either already secured pay increases significantly greater than inflation or are preparing to take advantage of the

infusions of new federal health care funds into provincial treasuries. A few pertinent examples include:

- In 2002-03, the average annual fee-for-service payment to Alberta physicians increased by 12 percent compared to the previous year; those to specialist physicians increased by 14.3 percent. This, in turn, forced less-well-off provinces to give large wage increases to avoid losing their professionals to Alberta.
- A year ago, Saskatchewan physicians rejected a pay increase of 20 percent over three years, claiming that it did not go far enough to

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close the gap between their rates of pay and those of their counterparts in British Columbia and Alberta.

- In 2001, Manitoba doctors led the pack in pay increases. The average was 9 percent; family physicians received an increase of 11 percent. The biggest problem that governments, and hence taxpayers, face as funders of the system is meeting the fee and wage demands of the various groups of health care workers.

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ble deal they can get. What is wrong is an arrangement that gives them a lopsided advantage in negotiations. At the heart of the problem is a system that does not permit a proper balance between providers' desire for wage/salary increases and government's objective, in its role as funder of the system, of increased productivity.

It is clear that there are significant barriers to cost adjustment in health care service delivery compared with that in other service industries. The issue is therefore how best to remove these barriers and expose health care delivery to the same type of pressures that help generate productivity increases elsewhere. In our view, the introduction of competition among health care providers offers the greatest promise.

With regard to hospitals, the way in which provincial governments provide their funding is a source of inefficiency. For the most part, hospitals receive a budget — in the form of block funding whether directly from the provincial government or via the intermediary of regional health authorities (RHAs) — which is based on historical service delivery patterns rather than on the number and type of services actually being provided. That is, the services a hospital actually provides during the year are not taken into account in determining its revenue. Not only are annual budgets not based directly on the volume and type of procedures performed in a given year, but they also fail to reflect the actual cost of providing such services.

Because hospitals and other providers do not have to compete on the basis of either quality or price in order to attract funding, they have little incentive to enhance the quality and/or accessibility of their services, to contain or reduce costs, or to

improve their efficiency or effectiveness. In other words, there are very few incentives for them to improve their productivity.

Without competition the monopoly provider of hospital services drives up costs and constrains productivity gains:

- Large, complex institutions, particularly tertiary-level teaching hospitals, perform many simple medical/surgical procedures that could be done much more cost-effectively in community hospitals with lower overhead costs. For example, a normal birth/delivery costs on average \$1,418 at a tertiary care hospital, about \$1,000 more than at a community hospital.
- Large community hospitals and teaching hospitals deliver many services that smaller, specialized clinics and other health care facilities could provide just as well and more cheaply. An example is Toronto's Shouldice Clinic, which performs only hernia repairs at a much lower cost than even a general-purpose community hospital could.
- Cataract surgery, many orthopaedic procedures and other procedures are performed by large institutions, whereas they could be undertaken in a more cost-effective manner by specialized health care clinics. Due to their lower overhead, and particularly to their more flexible work rules for the range of health care professionals they employ, specialized clinics can carry out many straightforward, routine procedures at substantially lower cost than most hospitals.
- Typically, because of their rigid collective agreements, hospitals cannot deploy their human resources in an optimally efficient manner. For example, the number of nurses may be adequate overall, but if, for whatever reason, the

emergency room is understaffed and the collective agreement restricts the hospital's ability to bring in nurses from elsewhere in the hospital, a de facto nursing shortage is created that diminishes the hospital's productivity.

- In many regions of Canada, no alternatives to the emergency room are available. Overcrowding and long waits are the result. This

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problem could be alleviated, if not solved, by establishing small urgent care clinics (UCCs). In Ontario, a number of UCCs provide fast, one-stop emergency services for urgent or acute medical problems such as cuts, sprains, fractures, asthma, bronchitis, severe allergic reactions and arrhythmias, as well as laboratory, X-ray and pharmacy services and referrals to specialists and hospitals. Not only do they provide services faster, but they are also significantly less expensive than hospital-based emergency departments, mainly because of their lower overhead costs.

We cannot stress strongly enough that in our view, and in the view of the Senate committee, failure to improve the productivity of health care delivery will result in the system, as it is presently structured, becoming financially unsustainable in the reasonably near future. In its report, the Senate committee concluded that "there are real, continuing upward pressures on Canada's health care costs," and that, therefore, "Canada's publicly funded health care system, as it is currently operated, is *not* fiscally sustainable given current

funding levels." Among the factors that compelled the committee to reach this conclusion were the impact of the aging population, rising drug costs and the need to invest in expensive new technologies.

The Conference Board, in its March 2004 study of health care cost drivers, reached the same conclusion as the committee had two years earlier. For example, it estimated that one-

third of projected real health care expenditure growth could be attributed to the aging population. The report stressed that this represented a heavier burden than that imposed by other cost pressures, such as population growth, because, "unlike the other cost pressures aging comes with no offsetting increase in income or wealth that can finance additional cost increases."

The aging population also compounds the pressures caused by rising prescription drug prices. Public spending on drugs has doubled over the past 20 years; those over 65 years of age accounted for 64.5 percent of all provincial/territorial spending on drugs in 2000, while representing just over 12 percent of the population. The unending stream of new technologies that expand the capacity of the health care system to serve Canadians is another important source of escalating costs.

In its report, the Senate committee stressed that the "increase in the percentage of government spending devoted to health care provides the clearest indication of the financial pressures felt by governments charged with funding health care." In this regard, the Conference Board pointed out that "without structural change in how health care is delivered, the current systems will grow

from consuming about 32 percent of total provincial/territorial revenues to 44 percent in 2020,” and that “some provinces could spend in excess of 50 percent of their budgets on health care by 2020, just as the demographic bulge of Canadian seniors starts to pass through the sys-

tems.” The 2004 report of the Alberta Task Force on Health Care Funding and Revenue Generation indicated that since 1997, provincial health spending has increased by 10.4 percent per year, while provincial revenues have only grown at a rate of about 4 percent per year.

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Clearly, compounded year after year, such increases are not sustainable over the longer term. Indeed, some provinces could hit the fiscal brick wall in a very few years. This bleak picture implies that productivity increases are essential if our publicly funded health care system is to survive. Therefore, the key question is: How can the system be changed to eliminate excess costs and improve productivity in delivering health care services?

Typically, in Canada, the problem has been addressed using a top-down command-and-control approach, with health department bureaucrats instructing service providers on what to do. This is the approach embodied, for example, in Ontario’s recently enacted Bill 8, *The Commitment to the Future of Medicare Act*.

The Senate committee recommended a different approach. It concluded that in a system as complex and multifaceted as the health care system, a top-down command-and-control model would not work — it would almost certainly lead to even greater inefficiency. Effective reform, the committee maintained, could only

be achieved by putting in place a set of incentives for individuals and institutions, acting in their own self-interest, to make the required changes. In essence, the committee argued that the introduction of what are usually called “market forces” would be the only effective way to change the

health care delivery system, to make it more efficient and to make its providers more productive. Competition among health care institutions and providers is essential to break the present monopolistic stranglehold of provider groups and to ensure that Canadian taxpayers get full value for every dollar spent on health care. We believe strongly that competition will also lead to the development of new and innovative forms of health care delivery, substantially improving productivity. Furthermore, we believe that competition is in everybody’s best interest — the insurer, the hospital, the physician and other health professionals. Ultimately, though, the patient and taxpayer will benefit the most.

Canada is not the only OECD country struggling with health care costs, as a special supplement to the July 17, 2004 issue of *The Economist* on health care finance amply illustrates. In particular, *The Economist* emphasizes that “governments’ attempts to contain health care costs have come in many forms including budget caps, usually in the hospital sector; wage controls; price limits on medical fees and prescription drugs; restrictions on the flow of new medical students; and delays in the introduction of new technologies.” All of these have been tried in Canada, and they have failed, just as they have failed in other OECD countries. According to *The Economist*, “the underlying reason why these methods fail is that they do nothing to provide greater efficiency.”

So how would competition in service delivery address the problems of the present system? Let us take the hospital system as an example. In order to introduce competition in the institutional health care delivery system and enhance its productivity, it is necessary to change the way in which hospitals are funded. The Senate committee recommended service-based funding. That is, hospitals should be paid an agreed fee for each service they deliver, after it has been performed. It is the change from global budgets to this funding mechanism that makes possible a competitive market.

Once fully established, the incentives built into service-based funding would generate a number of significant benefits. They would:

- encourage hospitals to improve their operating efficiencies, since they would get to keep any money saved;
- enhance the ability of managers to manage effectively, given that, under service-based funding, they would be required to know how well and efficiently the institution is performing every procedure (something that, in general, they do not know today);
- create competition among hospitals themselves, and between hospitals and other, smaller, more highly specialized clinics and facilities;
- help develop highly specialized health care teams, achieving better outcomes for patients and making optimal use of costly equipment;
- stimulate the development of centres of excellence for complex surgical procedures (such as paediatric heart surgery);
- improve quality, since evidence shows a clear relationship between volume and patient outcomes (for example, hip and knee replacement and hernia repairs); and
- encourage hospitals to improve patient service and drive out inefficiencies, since revenue depends on the number of patients treated.

A specific and highly desirable

benefit of service-based funding would be its ability to demonstrate clearly to the public the relative efficiencies of hospitals offering comparable services. Because hospitals would be competing with each other to serve patients, the inefficient hospitals would either lose business (because the price they bid would be too high), or they would lose money (because they were unable to perform the service at the price they bid).

The government, the insurer (funder), would choose to buy insured services from the lowest-cost provider who meets specified quality conditions. Providing the opportunity for institutions to bid to provide specific services would create an environment in which those patients requiring relatively simple procedures would be drawn away from teaching hospitals to community hospitals, with their lower cost structure. Such competition would force large teaching hospitals to examine closely the spectrum of services they offer and to redefine their roles.

Competition would also lead to the establishment of specialized, standalone facilities (or clinics) able to offer the lowest price for procedures such as cataract operations, some orthopaedic surgeries, various diagnostic tests and hernia repair. Not only would such specialized facilities, concentrating on a limited range of procedures, be less expensive, but they would also be expected to achieve better results as a consequence of higher volumes. In medicine, the more frequently the same procedure is performed, the higher the quality of the outcomes.

Thus, specialized facilities would both improve quality and reduce cost. The smaller the institution, the more flexible the job descriptions of its various staff members. Greater flexibility in utilizing human

resources is a very compelling factor in support of specialized health care clinics. Efficiencies and productivity improvements could also be gained if people were encouraged to rely on 24-hour community clinics for many of the primary care services they currently receive in hospital emergency rooms.

Competition would encourage hospitals to contract out nonmedical services in order to improve productivity and reduce costs. Using a tendering process, hospitals would procure these services from the lowest-cost provider, subject only to the

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provider's meeting appropriate and closely monitored quality standards.

Such changes in the delivery system would, in turn, prompt all service providers to find ways to improve the quality and cost-effectiveness of their services in order to avoid losing work to more cost-effective institutions or providers. In this way, reform of the system would occur gradually, driven by incentives rather than by the top-down command-and-control approach that has been so clearly demonstrated to be ineffective.

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Since the inception of Canada's national health care program, the role of government has been as a funder, not a provider, of health care. As the Senate committee documents in its report, one of the great myths about Canada's "public" health care system is that it includes public delivery as well as public funding. This has never been the case. Beginning with hospital insurance in 1957 and continuing with the creation of medicare in 1966 and the enactment of the *Canada Health Act* in 1984, the central objective has always been to insure Canadians against hospital and doctor costs and improve their access to medically necessary health care services. No legislation restricts the ownership of health care institutions.

Therefore, it is difficult to understand the rationale for the recent deci-

sions by the Manitoba NDP government to purchase a for-profit orthopaedic clinic in Winnipeg and by the Ontario Liberal government to purchase three for-profit MRI clinics in the province as well as to require four others to convert to not-for-profit status. The purchase of these facilities in Manitoba and Ontario simply means that money will have been taken out of cash-strapped health care budgets and spent in a way that provides no added benefits to patients and does nothing to shorten a single waiting line.

Moreover, past experience indicates that public ownership of these facilities will not ease the burden of the rigid work rules of publicly owned hospitals and of the higher salary scales of public institutions as compared to clinics. Thus, not only will capital funds have to be spent with no patient benefit, but

also the resulting higher operating costs will further deplete health care budgets.

In addition, moving these facilities to the public sector will strengthen the monopoly bargaining position of the health care workers involved. As we have explained, this is precisely the wrong direction for public policy to move in if our objective is to make the health care system financially sustainable.

Canada's health care system, with its unique single public insurer model, not only must be *preserved* but also must be made more *cost-effective*, more *efficient* and more *productive*. We believe that these results can *only* be achieved through the introduction of competition into the delivery of health services. In this article, we have described some of the ways in which this needs to happen. We believe that these results can be achieved only through the introduction

of competition into the delivery of health services in the ways we have described. We conclude, however, on a cautionary note. In a system as complex as health care, one cannot know in advance the full impact of any particular reform. However, we can be certain that the journey down the road to reform must begin with the measures we have outlined.

Senator Michael Kirby was chair of the Standing Senate Committee on Social Affairs, Science and Technology when it released The Health of Canadians, a major study on the state of health care in Canada, in October 2002. Senator Wilbert Keon was a member of the Standing Senate Committee on Social Affairs and recently retired as founder and CEO of the Ottawa Heart Institute. The paper from which this excerpt is taken is available in full at www.irpp.org.



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