



Leaders of Tomorrow
An International Insurance Society Program



Becoming a Health Partner in Canada

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1. Executive Summary

Large Canadian insurers have a real opportunity to become health partners in Canada. The winning model is to become leading access facilitators around the public health system: helping members understand where to go, access virtual and curated services and receive proactive, data-driven support. The strongest economic case is improved marketability of existing insurance products, complemented by provider revenues and member-paid services where access gaps create willingness to pay. To execute, insurers should build dedicated health operating models, create more seamless and member-centric virtual care front doors, add capabilities around them, connect health and claims data, and extend the platform beyond Group Benefits.

2. Goal

Many insurers in Canada share the ambition of transforming their Group Benefits business from a pure claims payer into a health partner for their members. A claims payer collects premiums and reimburses claims, with limited ability to support members over what health services are consumed and how they are consumed. A health partner plays a more active role in supporting prevention, education, navigation, access, and better use of available health resources.

In Canada, however, this ambition is structurally constrained. The Canada Health Act and provincial regulations significantly limit how far private players can go; as a result, insurers cannot become full health system actors in the same way they can in other geographies. Becoming a health partner in Canada cannot mean creating a parallel pathway outside the public system. It must mean helping members access, use, and complement that system more effectively.

The opportunity is nevertheless real. A large insurer can become the most effective access and navigation layer around a constrained public system. This means promoting prevention, providing education and coaching, using data to communicate with members proactively, helping members navigate the health system, and facilitating access to care.

This article answers the question: how can a large Canadian insurer progress and accelerate toward the goal of becoming a health partner for its customers?

3. Facts and Context

3.1. Canadian Health System: Current and Future

3.1.1. How the Canadian System Constrains Insurers

The Canadian health system places clear limits on the role private insurers can play. The public system covers primary care, non-preventive tests and diagnoses, hospitals, and

surgeries, with the government as single payer funded through general taxationⁱ. Services covered by the public system generally are not offered privately, and tight rules varying by province prevent the emergence of a second lane. In most provinces, it is nearly impossible for physicians to practice outside the public system and offer private care, which means all Canadians remain on a single waiting list irrespective of their financial resources.

Private insurers therefore operate mainly outside the core public system. They cover services that are not publicly insured, including drugs, dental care, out-of-country care, vision, paramedical services such as physiotherapy and psychology, as well as life and disability insurance. More recently, insurers have started offering services in adjacent areas that remain permissible, including through virtual care that connects members to nurses and physicians for primary care. This has been challenged by the federal government but finally allowed in the Group Benefits space.

3.1.2. Why Pressure for Change Is Increasing

At the same time, pressure on the public system is increasing. Service accessibility has deteriorated over the years, with long waiting lists for surgeries and screeningⁱⁱ, emergency room waits of more than 24 hoursⁱⁱⁱ, and more than six million Canadians without family doctors^{iv}. With an aging population, increased life expectancy, improvements in cures, and rising health costs, the percentage of government budgets allocated to health has been increasing for years and is trending toward a level difficult to sustain. The health care spending is expected to continue growing faster than GDP^v.

Designed for a different era, the system has not kept pace with changing demographics and economics. It is time to rethink what Canadians need from their health system, how best to deliver it, and what role others, including insurers, should play.

3.1.3. How the System Is Likely to Evolve

The strategy should depend on a clear view of how the public health system will evolve. This section draws on interviews with government affairs specialists, former political staffers in Quebec, and an academic expert in private health care in Canada. A common theme emerging from these discussions is that the system is unlikely to change fundamentally: despite pressure and visible failures, no major move toward liberalization should be expected.

There are several reasons for this. Reports commissioned by governments on health systems over the last 25 years, starting with Romanow^{vi} in 2002, generally do not advocate for more private involvement, or do so only very modestly. An important segment of the population remains attached to the public system^{vii}, which is core to Canadian identity, making the promotion of private care politically costly. Practitioners who currently benefit from the existing system are also resistant to change.

The more likely path is a slow evolution at the boundary of the system. Governments are unlikely to open the door to a broad private alternative, but they may continue to permit new services that remain adjacent to the core public system. Some virtual care providers illustrate this dynamic: by connecting members to physicians virtually, they operate in an adjacent space to publicly insured care, and governments have allowed it. Over time, this type of boundary expansion could extend to additional services, including private testing, diagnostics, and laboratory services beyond currently permitted preventive services, and certain routine surgeries.

Governments are also expected to continue expanding the scope of practice for nurses, pharmacists, and other health professionals to reduce pressure on physicians. This is considered one of the most effective and realistic avenues to improve the health system in Canada. Expanding the scope of practice is a long and complex process that requires multilateral negotiations between governments and professional associations. However, there appears to be appetite for it, and physicians' associations now seem less resistant than before.

This has two implications for insurers. First, insurers should focus on filling the gaps at the periphery of the system and should not expect future policy changes to enable them to create a second lane for publicly funded services. Second, insurers should be ready to leverage health practitioners as their scope of practice expands, while advocating for further scope expansion.

A further consideration is that governments should not be expected to fund insurers' prevention initiatives, even where those initiatives may help reduce pressure on the public system over time. In practice, governments have shown limited appetite for this type of arrangement, and fiscal constraints make it unlikely in the near term.

3.2. What Large Insurers Have Done So Far in Canada

Some large insurers have built strong digital platforms to integrate services in Group Benefits. They have partnered with vendors to offer Virtual Care and Employee Assistance Programs that provide counselling and some mental health support.

They have also partnered with health providers in certain areas, including vision, virtual pharmacy, women's health, medical second opinions, and cancer coaching. In addition, they have partnered with health providers to support Disability Claims management, helping disability members recover and return to work faster.

These services are most often offered only to members of Group Benefits plans. They are not available for individual health plans in the Affinity market or for Retail life customers.

Large insurers have therefore developed a range of solutions, but these are not yet fully integrated and do not yet address some of the most important access challenges faced by Canadians. There is an opportunity to go further by addressing everyday access challenges

in ways that improve the member experience and strengthen the relevance of their core products. Addressing everyday access failures would arguably create more value than specialized episodic support; for example, helping members deal with acute conditions such as urinary tract infections would likely be more valued than providing access to medical second opinions.

4. Learning from Others

4.1. Evolution of Health Ecosystems in the Canadian Insurance Market

Across the Canadian insurance and health benefits market, some have begun to organize health capabilities in a more coordinated way. This includes creating more focused health teams, partnering with providers, acquiring selected capabilities, and building digital platforms intended to make it easier for members to access services.

Early experience suggests that a passive marketplace or provider directory is not enough. Such platforms can help users find and compare providers, but they do not necessarily guide the care journey or solve the core member problem of timely access to care. The lesson is that a passive marketplace is not enough.

The market also appears to be moving toward broader ecosystems that bring together capabilities such as mental health, virtual care, pharmacy, digital therapy, and in-person care partnerships. The strategic direction is clear: the most valuable models are likely to be those that help members navigate care, access support more easily, and experience a more connected health journey.

4.2. Learning from Other Countries

The United Kingdom also has a universal public system, the NHS, but it allows a more significant private sector to operate alongside it than Canada does. Private insurance and private providers can fund and deliver a parallel route for services such as specialist consultations, diagnostics, elective procedures, dental services, and digital care. Bupa is an example of a player operating in this environment: it combines insurance, clinics, hospitals, dental services, and digital care^{viii}, and is expanding toward a connected care ecosystem. This type of vertical integration creates an incentive to prevent illness rather than simply reimburse care, and allows Bupa to provide a coordinated, end-to-end patient journey, from first contact to diagnosis, treatment, and follow-up.

The United States has a more market-based health system, where private insurance plays a central role in funding care and private providers deliver much of that care. Kaiser Permanente is a prominent example of an integrated player in this environment: it combines health coverage with care delivery through its health plan, hospitals, medical groups, and digital capabilities. Because members prepay for care within an integrated system, Kaiser has stronger incentives to invest in prevention, coordinate care across

settings, and use integrated data to manage population health. However, the U.S. system is not generally viewed by Canadians as a desirable model, given that too many Americans remain uninsured or underinsured.

The greatest value of these international examples is to clarify the extent of the Canadian constraints. Bupa and Kaiser operate in geographies where private services and insurance are allowed, at least in part. In both geographies, insurers can significantly improve access to care for their members and have incentives to invest heavily in prevention. This contrasts with Canada, where the benefits of prevention flow prominently to the public payer.

Still, these models point to practices that may be partially transferable to Canada. These include:

- building arrangements with providers in areas such as mental health, musculoskeletal conditions, and diabetes;
- drawing inspiration from fully integrated health data by building datasets that merge claims, pharmacy, disability, and virtual care data;
- using this data for early intervention and disability management; and
- potentially investing in clinics offering privately covered services such as mental health, musculoskeletal care, and navigation.

5. Strategic Economics: Three Sources of Value

5.1. Primary Value: Increased Marketability of Existing Products

The main economic value of becoming health partners is not primarily direct monetization of health services but helping members address access to care obstacles in ways that make existing products more relevant, differentiated, and attractive. Access to health care is a major pain point for Canadians. If large insurers can credibly help members access care, navigate the system, use available benefits more effectively, and connect to curated services, they would create a compelling reason for plan sponsors to choose and retain them.

This value would be expressed through higher sales, stronger retention, improved margins, and a differentiated market position. Demonstrating a measurable impact on health, absenteeism, disability, and productivity would strengthen this proposition further.

A secondary benefit would be financial improvement through reduced disability incidence and duration, supported by prevention, education, navigation, personalized communication, and faster access to care.

5.2. Existing but Limited Value: Revenue from Providers

Large insurers can create member value by partnering with providers and encouraging their members to use them. This opportunity already exists, but any related revenue has been limited so far and is unlikely to become significant relative to traditional sources of Group Benefits profit.

There are several reasons for this limitation. The Canada Health Act and provincial legislation restrict where private insurers can play. Many providers operate with modest margins, leaving limited economics to share. Canadians are also reluctant to accept closed networks or mandatory programs. Insurers must therefore rely on voluntary programs and transparent choice, and incentives that are clearly aligned with member needs. Finally, in several areas, the provider market is fragmented and lacks a national footprint, making scalable partnerships more difficult.

High-level analysis therefore suggests that incremental provider revenue would likely represent only a modest increase in Group Benefits earnings at full scale. It is valuable where it supports better access, choice, and experience for members, but it should not be the core economic thesis.

5.3. New Opportunity: Services Paid Out of Pocket by Members

A third potential source of value that does not exist today for insurers but could become important is selling services directly to members who are willing to pay out of pocket for faster access to care. In this model, large insurers would use their digital platforms and owned virtual care providers to build optional services that members would be willing to purchase because they address access problems.

The opportunity is potentially attractive because it aligns with the access failures members experience in the public system. The services would need to address concrete and urgent needs, such as obtaining access to a nurse or doctor, receiving follow-up after a consultation, and getting help when a member does not know where to go. Another idea is to offer packages combining permissible private services like preventive tests with publicly funded services to allow members faster access to services. This is similar to the solution provided by Medcan^{ix} for executives in Canada.

There is evidence that Canadians are increasingly willing to pay directly for access when the public system does not meet their needs. In Quebec, a survey commissioned by the Collège des médecins du Québec found that in 2025, 26% of patients had decided to consult a physician privately, compared with 14% in 2022^x. This supports the thesis that willingness to pay exists when the need is immediate, and access is constrained.

5.4. Some Numbers

The purpose of this section is to provide a rough idea of the size of the Canadian health market, with a particular focus on the portion that is “addressable” by private insurers, i.e., within the scope of private insurers. The main source for this section is the Canadian Institute for Health Information (CIHI)^{xi xii xiii}.

Total Canadian health care expenditure is estimated at \$399B in 2025. Approximately 71% of this total is funded publicly. The remaining 29%, or \$116B, represents privately funded care. This can be further divided between care that is addressable by private insurers, such as drugs and vision care, and care that is not, such as hospital services. Addressable care generally consists of services falling outside the definition of insured health services under the Canada Health Act.

Addressable private care is estimated at \$76B and is split between amounts paid by private insurance and amounts paid directly by consumers out-of-pocket. The following table provides a breakdown by type of care.

Category	Total	Private Insurance	Out-of-Pocket
Prescription drugs	\$26.2B	\$17.4B	\$8.8B
OTC drugs	\$4.8B	\$0.0B	\$4.8B
Personal health supplies	\$3.2B	\$0.0B	\$3.2B
Total drugs / pharmacy	\$34.2B	\$17.4B	\$16.8B
Dental services	\$21.7B	\$12.4B	\$9.3B
Vision care services	\$6.8B	\$1.6B	\$5.2B
Other professional services	\$8.7B	\$5.7B	\$2.9B
Other health care goods	\$3.9B	\$0.0B	\$3.9B
Other health care services	\$0.8B	\$0.0B	\$0.8B
Total addressable care	\$76.1B	\$37.2B	\$38.9B

These figures suggest that the privately funded health market is large enough to justify a broader health strategy. It also suggests that insurers should concentrate on the sizable portion of privately funded care where they already play a role or can credibly extend their role, particularly in areas where members face access challenges and may value more timely, better coordinated support. .

5.5. Implications for Acquiring or Partnering

The economic reality described above should shape how large insurers approach acquisitions and partnerships. An acquisition should be considered only when two conditions are met. First, the provider must materially improve the member experience, strengthen access to care, and enhance the marketability of Group Benefits. Second, because these synergies are uncertain and difficult to quantify, the provider must also generate autonomous revenue through B2C or B2B channels. In other words, and this is a key idea; the acquisition must make financial sense on a standalone basis before any insurer-specific synergy is assumed.

The strongest acquisition cases will be those where the provider is strategically important, central to customer experience, and capable of creating innovation and differentiation that an insurer could not easily replicate through a mere partnership.

An acquisition should also give an insurer greater control over costs, scale, geographic reach, and capabilities that are difficult to build externally. The case becomes stronger when the provider can support Disability Claims management, given the financial impact of improving recovery and return-to-work outcomes.

5.6. Conclusion on Value

The principal source of value is expected to come helping members address access-to-care obstacles in ways that make core insurance businesses more relevant, differentiated, and attractive, supporting stronger sales, higher retention and greater differentiation of core insurance businesses. Additional revenues from provider partnerships and member-paid services should be viewed as supplementary benefits rather than the primary rationale for the strategy. In consequence, the acquisition of a health care provider should make financial sense on a standalone basis before any insurer-specific synergy is assumed.

6. Recommendations

6.1. Proposed Strategic Model

The proposed models to become the best access facilitator around the public system: the player that helps members understand where to go, access the right services, use available

benefits effectively, and connect to curated care where appropriate. This model would rest on four pillars:

- a front door through virtual care and triage;
- navigation support to help members understand where to go, how to access care, and when to act;
- virtual delivery through nurses, physicians, mental health services, paramedical services, and virtual pharmacy; and
- data-driven intervention, connecting prevention with disability management.

6.2. Execution Roadmap: Proposed Next Steps

6.2.1. Build the Operating Model

The first priority is to establish the operating model required to execute the health strategy. Current operational demands within Group Benefits may limit the management capacity available to advance the broader health agenda. The capabilities being developed should also ultimately be leveraged across all business units, not only within Group Benefits. Large insurers should therefore consider creating dedicated health functions, led by a Head of Health with accountability for defining and executing the health strategy across all business units in Canada.

6.2.2. Create a More Member-Centric Virtual Care Front Door

The second priority is to create a more member-centric virtual care front door, potentially through ownership. Large insurers should consider acquiring virtual care providers to replace current vendors. Virtual care is critical to improving customer experience, internalizing margins, developing capabilities, and helping members navigate the ecosystem. Beyond providing virtual care, these entities would become concierge platforms: the core entry points around which insurers would build new capabilities, integrate services and other providers, deliver a more coherent experience, and guide members.

This would allow insurers to connect data, support the member journey, and integrate virtual care with disability and claims. It would also increase utilization of other providers and thereby increase revenue.

Relative to the current virtual care offering, this would give members access to physicians in addition to nurses, use AI for triage, allow follow-up with members instead of offering only one-off consultations, and use virtual care to direct members to other providers, such as virtual pharmacy.

6.2.2.1. Build Capabilities Around the Front Door

Once the virtual care front door is in place, insurers should build selectively around it through clear roadmaps of acquisitions, partnerships, and internally developed capabilities. The organizing principle should be to focus on core member needs, rather than niche services, while remaining within what is permissible in the Canadian system.

The capability roadmap should begin with mental health, where demand is significant, and private delivery is permissible. From there, insurers should build structured care pathways around the virtual care front door, particularly for diagnoses, tests, screening, home testing, and laboratory partnerships. When a member consults virtual care and requires a test or follow-up, insurers should be able to facilitate access, guide the next step, and remain engaged until the issue is resolved.

This would require moving beyond a one-off consultation model. The front door should support follow-up services that help members after an initial consultation, rather than leaving them unsupported before resolution. In parallel, insurers should develop additional virtual services, including virtual paramedical care, targeted programs, and nurse-led services that can be delivered virtually.

Insurers should also consider creating navigation services to help members understand the Canadian health system, identify available options, know where to go, and make better use of their benefits.

6.2.3. Build the Data and Engagement Engine

The third priority is to make data and engagement engines a core source of differentiation. Few players in Canada have the opportunity, with appropriate consent and privacy safeguards, to connect relevant data across claims, pharmacy, disability, virtual care, and member interactions. The first step should be to connect these data sources into a coherent view to support member needs.

Once this foundation is in place, insurers should use analytics and AI, with clear consent and governance frameworks, to identify patterns that signal when a member may benefit from timely support. For example, a combination of a new mental health or musculoskeletal medication, repeated paramedical claims, and prior absence or disability signals could trigger appropriate, supportive outreach before a condition deteriorates. Similar rules could be developed for chronic disease management, medication adherence, return-to-work support, and prevention opportunities.

The objective should be to offer timely, relevant and actionable guidance in a way that is transparent, respectful, and easy for members to opt into or manage. Member communications should be tailored to the situation and could provide education, suggest available benefits, offer navigation support, recommend appropriate services, or encourage preventive action. Over time, this capability could become one of the main ways

insurers differentiate themselves from competitors: by using data to help members make better decisions and access support earlier.

6.2.4. Extend the Platform to Other Business Units

The fourth priority is to extend the platform beyond Group Benefits. The digital platform, as well as most health services, could be offered to individual health plans. The platform could also be integrated into individual protection insurance

This would give more customers access to the same navigation, virtual care, and support capabilities, while improving the relevance and attractiveness of these lines of business.

6.3. Risks and Mitigants of an Acquisition

Regulatory approval will be required for the acquisition of a virtual care provider given the clinician-focused model. This risk should be managed through early Legal and Compliance engagement, clear process gates, and articulating how the model supports member access and continuity of care.

People risk is material. The acquired entity may rely on a few key executives, founders, and clinical leaders, while clinicians may be sensitive to a change in control or ownership by an insurer. Diligence should identify key persons and retention risks, with targeted retention plans and protection of the clinical culture as key mitigants, so that members continue to receive trusted, high-quality care.

Finally, integration risk could reduce synergies and weaken the member experience if the operating model is not clear. Diligence should define how virtual care, claims, disability, product, technology, data, and external providers will work together before any synergy case is finalized, with the objective of creating a simpler, more coherent experience for members.

6.4. Summary – Value for the Members

If an insurer executes these recommendations, its members would:

- access navigation through virtual care, helping them understand where to go and what type of care to seek;
- reduce the physical and mental burden of visiting medical facilities, including long waits, when virtual services are sufficient;
- receive proactive, data-driven advice, including guidance related to prevention and early intervention;
- benefit from a more coherent experience across virtual care, follow-up services, claims, and disability support, reducing the stress of navigating disconnected services;
- over time, benefit from expanded access to permissible private services.

7. Conclusion

The opportunity is for large Canadian insurers to become leading access facilitators around the public health system: front doors that combine virtual care, navigation, curated services, and data-driven engagement. By addressing one of the most important pain points for Canadians — access to care — insurers can create a more valuable customer experience while also strengthening the relevance, differentiation, and marketability of their core insurance products.

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