DISCUSSION AND DEBATE

The Fraying at the Edges of the Public Healthcare System in Canada

Érosion du système de santé public au Canada

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Abstract

Since the passage of the *Canada Health Act* (CHA) in the mid 1980s, advocates for private finance in Canada have challenged the CHA and its underlying access and equity principles. Such challenges have grown in recent years to encompass, among other things, facility fees, membership fees, private virtual care, private interprovincial surgery clinics and private practice nurse practitioners. The continued technological and organizational evolution of healthcare will expand and complicate this further over time. A multipronged approach is needed that includes expanded data to support research on the impacts of such activity, new regulatory frameworks and coordinated action across levels of government.

Résumé

Depuis son adoption au milieu des années 1980, la *Loi canadienne sur la santé* (LCS) fait l'objet de contestations de la part des défenseurs du financement privé qui en contestent les principes sous-jacents d'accès et d'équité. La situation a pris de l'ampleur au cours des dernières années et concerne, entre autres, les frais d'établissement, les cotisations d'adhésion, les

soins virtuels privés, les cliniques de chirurgie interprovinciales privées et les cabinets privés d'infirmières praticiennes. L'évolution technologique et organisationnelle des soins de santé continuera d'élargir et de compliquer cette situation au fil du temps. Pour mieux comprendre la situation, il faut adopter une approche multidimensionnelle qui comprend : des données élargies pour étayer la recherche sur les répercussions de telles activités, de nouveaux cadres réglementaires et des mesures coordonnées à tous les niveaux de gouvernement.

Introduction

Fraying at the edges of Canada's public healthcare system is not new. The *Canada Health Act* (CHA) (1985), after all, was triggered by physicians' and institutions' extra-billing practices that undermined the 1966 *Medicare Act*'s principle of universal access (Health Canada 2023; Taylor 1986; Vayda and Deber 1992). Challenges to the CHA principles by both private actors and provincial governments have arisen regularly in the four decades since its passage (*CBC News* 2023; Flood and Thomas 2020; Glauser 2011; Gray 2000; Health Canada 2023; Minister of Health Diane Marleau 1995; Minister of Health Jane Philpott 2016; Silversides 2008). Currently, however, challenges to the CHA – and more generally to access and equity – appear to be greater in number and variety than ever before (CMA 2024a). It is useful to catalogue some of the most prominent challenges today and discuss some of their implications.

We focus on private financing that challenges first-dollar public financing for medically necessary medical care. This issue is analytically and legally distinct from private, for-profit delivery of medical services. The CHA (1985) is silent on the private/public, profit/nonprofit status of providers of care, and multiple provinces publicly finance the delivery of medical care by for-profit providers. In practice, however, these two issues become entangled because many of the financing challenges noted below emanate from private, for-profit providers of care. Furthermore, because private capital seeks greater financial returns, an increased presence of for-profit providers, especially equity-owned for-profit providers, can increase pressure to expand private financing that generates increased profits. This is true even if a for-profit provider's core activity is the delivery of publicly financed care. Indeed, some of the efforts to integrate private financing arise alongside and as part of the delivery of publicly financed, medically necessary care. This practical entanglement of financing and delivery modalities means that, even though our primary focus is private financing, one cannot avoid some discussion of the role of for-profit providers. It is beyond the scope of this short commentary, however, to discuss evidence regarding the relative performance of public and private for-profit providers with respect to quality of care and efficiency (see, e.g., Devereaux et al. [2002]; Goodair and Reeves [2024] and Schneider et al. [2005] for reviews of such evidence).

The Fraying Edges

Despite Health Canada's 1995 interpretation letter clarifying that facility fees linked to the delivery of medically necessary care violate the CHA (1985) (Health Canada 2023; Minister

of Health Diane Marleau 1995), such fees persist and, indeed, patients seeking care through private clinics have faced an array of other, similarly spirited fees – block fees, fees for surgical supplies (e.g., drugs) and accessory fees (e.g., eye drops, extra tests, bandages) – for services linked to medically necessary care (Armstrong 2000; Health Canada 2023; Longhurst 2023; Ontario Health Coalition 2024; Quesnel-Vallée et al. 2020). Concierge medicine offered through private physician-led executive wellness clinics use private-pay membership or enrollment models that entitle members to a basket of insured and noninsured services for a defined period of time, usually one year (Bodner et al. 2022; Reid 2017), charging fees that can range from a few hundred dollars per year to over $9,000 per year (e.g., Clinique de santé 2024; MEDCAN 2024). These private clinics claim that the membership fees apply only to services not covered by provincial health insurance (e.g., advanced wellness checks), but in some instances, membership fees are mandatory for all services, including insured physician services (Health Canada 2023, 2024). Regardless of the true obligatory nature of the membership fee, patients may believe the membership is mandatory for any access to healthcare or they may believe the membership is necessary to access the same quality of care as those who pay the membership. Furthermore, many patients are unable to distinguish between medically necessary, insured services and alternative, uninsured health services and are therefore dependent on their healthcare provider who is in a position of trust with access to information the patient does not have or does not understand (Bodner et al. 2022). This asymmetric relationship leaves patients vulnerable to manipulation through exaggerated wait times, pressure to purchase upgrades for fear of losing access to expedited care and the provision of unnecessary tests, procedures and goods (Armstrong 2000; Flood et al. 2015; Longhurst 2023; Ontario Health Coalition 2024).

Although the private delivery of publicly funded surgical and other services is fully compatible with the CHA (1985), as provincial governments increasingly contract with private, for-profit healthcare providers, the problem of "upselling" grows (Longhurst 2023). Upselling refers to the practice of recommending, sometimes with considerable pressure, unnecessary and even inefficacious options and upgrades not covered by the public plan (Bodner et al. 2022; Ontario Health Coalition 2024). Public–private ophthalmology clinics in Ontario and Alberta, for example, have been accused of pressuring patients – at times with the promise of shorter wait times – to purchase expensive upgrades, including excessive fees for "premium" lenses, tests and procedures, and even warranties and registration fees (Cuttler 2023; Health Canada 2023; Ontario Health Coalition 2024).

The evolution of technologies and healthcare delivery methods makes it possible to exploit "loopholes" in the CHA (1985) not anticipated in 1984. Advances in the provision of diagnostic services represent one of the earliest examples of this. As early as 1982, Quebec began delisting certain diagnostic tests such as mammograms, thermography and ultrasonography if delivered outside a hospital (Quesnel-Vallée et al. 2020). In the 1990s, the advances in diagnostic technology facilitated the delivery of computed tomography (CT) and magnetic resonance imaging (MRI) diagnostic services in free-standing clinics and provinces

moved to restrict publicly insured CT and MRI diagnostic services to those delivered to hospital in-patients and outpatients, opening the door for private clinics to charge fees for diagnostic services outside the hospital (Brooks 1993; CADTH 2023). The set of such services expanded over time until the federal government finally responded in 2020 with the Diagnostic Services Policy that formalized its position that diagnostic services are insured services (Health Canada 2024; Library of Parliament 2019). Most provinces now prohibit out-of-pocket fees for medically necessary diagnostic services. Saskatchewan, however, continues to fight the federal government on this issue despite reductions in their health transfer payments due to its 2016 *Patient Choice Medical Imaging Act*, which allows private for-profit MRI clinics to charge private patients for medically necessary imaging as long as for each private-pay scan, a scan of equal complexity is provided to a public patient (Government of Saskatchewan 2016; Ontario Health Coalition 2017; Sciarpelletti 2024).

Virtual care and interprovincial surgical centres have emerged as another opportunity to expand private finance. In 2016, the virtual healthcare app Maple became one of the first private-pay virtual healthcare modes for accessing physician services in Canada (Frangou 2023). The absence of billing codes for virtual care in provincial insurance plans implied that virtual care was not an insured service. The COVID-19 pandemic initially gave these private-pay virtual clinics a boost. However, as provincial insurance plans introduced virtual-care billing codes to facilitate remote physician visits during pandemic restrictions and social distancing measures (CMA 2022), the private virtual clinics pivoted to care models based on the use of out-of-province physicians or nonphysician providers such as nurse practitioners (Crawley 2023). Interprovincial care models exploit the limitations in provincial insurance plans that restrict a provincial resident's insured coverage to only those medically necessary services delivered in their home province, except for out-of-province emergencies or when such services are preapproved (Crawley 2023; Government of Canada 2019; Taylor 2019). Private interprovincial surgery clinics, therefore, charge out-of-province patients privately for otherwise insured physician surgeries in the patients' home province, facilitated through virtual consultations (see, e.g., Surgical Solutions Network [2024]). For patients, the private-pay interprovincial options provide expedited surgeries for common wait-listed procedures (e.g., cataract surgery, knee replacement surgery, hip replacement surgery, hernia repair).

Nurse practitioners were rare when the CHA was enacted in 1984. Hailed as a potential solution to the primary care shortage in remote and underserved areas, nurse practitioners were paid a salary and worked primarily in remote locations under the supervision of a physician in publicly funded clinics (Klemmer-Lamoureux n.d.). The first publicly funded, independent nurse practitioner-led clinic was established in Sudbury, Ontario, in 2007 (Contandriopoulos et al. 2023; Heale and Butcher 2010), and most provinces now have publicly funded nurse practitioner-led primary care clinics. Recently, however, private-pay nurse practitioner-led wellness clinics have begun to pop up (Macdonell 2018; Mantyka 2022; Mitchell 2024), charging private fees, for care that can range from $90 to $200 for a single visit (e.g., The Village Health Clinic 2024). The nurse practitioners argue that, as

nonphysician providers, the CHA (1985) does not apply to them. As such, they can charge private fees even for services publicly insured when delivered by a physician (e.g., health assessments and diagnosis, ordering and interpreting diagnostic tests, referrals to specialists, prescriptions [CIHI 2020]).

These diverse initiatives all share the common element of requiring private, out-of-pocket payment to obtain insured healthcare services, in violation of the CHA (1985), which calls for reasonable *access* to insured health services on *uniform terms* and *without charge* (Government of Canada 2024). Membership fees, enrollment fees, private fees for insured services, interprovincial surgeries and fees for premium goods and services all violate the intent of this access principle. They also compromise the core equity tenet of Canada's publicly funded healthcare system – the allocation of healthcare based on need rather than ability to pay. Indeed, the central purpose of interprovincial surgery clinics and executive clinics is preferred or expedited access based on the ability to pay. But these practices do more than simply violate a few principles. They have real, detrimental impact on access to care and equity within our healthcare system. It is well established, across many care contexts, that private out-of-pocket fees reduce access for those with limited ability to pay, resulting in greater inequity of care (Armstrong 2000; Duckett 2005; Fusco et al. 2023; Grignon et al. 2010; Longhurst 2023; Mueller and Socha-Dietrich 2020; Shmueli and Savage 2014), and have broader system impacts, including longer wait times in the public system and related impacts (Hurley and Johnson 2014; Reid 2017).

Discussion

These private financing challenges to the CHA (1985) and to the access and equity principles at the foundation of Canada's publicly financed healthcare system have material consequences. Yet, the magnitude and costs of such activity are unknown as no association, agency or government tracks this information (Glauser 2011).

At present, researchers struggle to even just document the nature of such private activities (Bodner et al. 2022; CMA 2024c). Without much-improved data on these activities, it is impossible to evaluate their effects on both those seeking care and on the public system. At present, these activities fall largely outside dominant Canadian administrative and survey health data systems. Compiling the data required to enable high-quality research on these activities requires a three-pronged approach. First, where possible, governments and regulators need to strengthen and expand reporting requirements for providers and organizations (e.g., clinics, insurers) operating in these spaces. Second, researchers and others need to better exploit data sources developed for other purposes, such as the Statistics Canada Business Registry or the census, that may provide insights into such private activities. Third, governments, data agencies and researchers themselves need to undertake special-purpose, primary data collection through surveys and other approaches to fill gaps that will never be filled by existing administrative and survey data. For instance, such basic information as the number and type of private clinics is not readily available; much less information is available on the

full range of services they offer, their providers, the fees they charge, their sources of payment (e.g., private out-of-pocket, private insurance, public insurance) and the volume of services they provide. Moreover, there is no good information on organizations, such as Maple, that facilitate and organize privately financed care. Without progress in these data efforts, and the high-quality research it will enable, evidence-informed policy is impossible.

Private finance activities such as those documented earlier call for multiple policy responses. The first, and perhaps the most important, is to improve the performance of the publicly funded health system. Many seek – and are willing to pay for – care privately only because of frustrations with a publicly financed system characterized by inadequate access to primary care, excessive wait times for speciality and surgical services and other deficiencies (CMA 2024b). In some cases, this may require better funding and delivery of existing services; in others, it may call for integration of some of the emerging private practices. For example, at a time when Canada is struggling to provide meaningful access to primary care, publicly funded nurse practitioner-led clinics and care teams could play an important role in addressing our primary care challenges (CIHI 2022; Contandriopoulos et al. 2024; Tremayne-Lloyd 2022). This is consistent with the expanded scope of other nonphysician providers, such as Ontario's recent expanded scope for pharmacists to prescribe medicines within Ontario's public insurance system (Ontario 2024).

Second, the federal and provincial governments need to implement new regulatory approaches that address the more complex and nuanced regulatory challenges presented by the evolving health landscape. The CHA (1985) relies on financial penalties (via reduced transfer payments) to prompt provincial action, but Health Canada is often slow to provide the needed guidance and impose such penalties where appropriate (e.g., it is yet to address private virtual care clinics and is yet to clarify the standing of "physician-equivalent" providers such as nurse practitioners). Importantly, it is not obvious that the financial penalties are sufficient to motivate provincial action, especially when there is a political advantage to a provincial government in letting a targeted private activity continue.

Third, effective regulation requires provincial action. Provinces have the authority to revise their respective health acts and other relevant legislation to bring new providers such as nurse practitioners into the public system, enforce the long-standing prohibition on user fees for insured services and prohibit the linking of uninsured services to the delivery of insured care (Quesnel-Vallée et al. 2020).

The continued technological and organizational evolution in healthcare, communications technology and related areas will only complicate this picture over time as new niches emerge for private finance to expand. Without a multiprong approach that starts with the collection of the appropriate data to support research and extends to decisive and cooperative action on the part of provincial and federal lawmakers, the fraying at the edges of Canada's public healthcare system will continue to compromise the access and equity principles at the foundation of our healthcare system.

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