

# We Should Not Settle for Mediocre Medicare



## INTRODUCTION

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### **Introduction**

There is an overwhelming body of evidence documenting the failure of our health systems in Canada. Also, there are compelling comparative data showing that, despite similar challenges faced by health systems around the globe, Canada consistently underperforms relative to its peers on both healthcare quality and health outcomes.

The central question that Fierlbeck and Berman (2025) and the commentators in this current issue tackle is whether we need to reconsider the role of the private sector in our health system and, importantly, doing so without compromising on our commitment to equitable access to needed and high-quality healthcare for all Canadians. The status quo

has failed. Instead of settling for mediocre medicare, we need to be open to ways in which the positive aspects of private actors can be used to drive innovation and improved quality in the publicly funded system.

Private actors are diversifying our delivery system, playing a growing role in the provision of needed health services, including pharmacies, nurse practitioners-led private clinics and virtual care companies, to name a few. The demand for healthcare continues to grow, and entrepreneurial private investors and providers are creatively filling in the gaps in our health system. Governments, as stewards of the health systems, have an opportunity to leverage these new actors to drive quality in the publicly funded system.

#### **How Can They Do This While Maintaining Our Core Values of Equitable Access?**

We need to recognize that limiting the choices of patients and providers is not the path to improved care. Our approach to a single-payer system for medically necessary physician and hospital care achieves a version of equality and universality that deliberately limits choice. Patients have no option other than to wait unacceptably long and to accept substandard care, even if they are willing to pay for something different. However, if providers could opt out or charge more for care, as is the case in our peer countries, the common concern is that this would lead to an exodus of workers from the public pay system. Indeed, guard rails are usually placed to ensure an adequate workforce in the public system in peer countries. However, should we have to rely on depriving health workers of alternative choices of a possibly better work environment to maintain an adequate supply? A high-performing health system should be able to provide a safe, competitive and supportive work environment for all workers.

Expanded patient and provider choice introduces a form of competition without

which mediocre care and poor working conditions can persist because people have nowhere else to go. One way to increase choice and competition is by increasing the number and range of healthcare providers that patients pay directly or via private insurance. In Europe and other peer countries, the existence of the private sector helps drive quality in the public sector, and the private sector is taxed, with taxes redirected to the public sector.

All contributors (Lewis 2025; Morin 2025; Or 2025; Raza 2025; Reimer 2025) to this special issue agree that there is a need to ensure that no one faces barriers to accessing necessary healthcare. However, as the articles in this issue describe, there are a multitude of paths to get there, and the one we are currently on is not succeeding. By maintaining our steadfast commitment to the principle of equitable access to healthcare, and not to a particular structure we use to get there, we think that in the face of such overwhelming evidence of the failure of the status quo, policy makers may think more creatively and strive for excellence and not mediocrity.

#### **References**

- Fierlbeck, K. and P. Berman. 2025. Is There a Third Way for Healthcare in Canada? *Healthcare Papers* 23(1): 8–19. doi:10.12927/hcpap.2025.27648.
- Lewis, S. 2025. New Law and More Money Cannot Fix Canadian Healthcare. *Healthcare Papers* 23(1): 41–45. doi:10.12927/hcpap.2025.27643.
- Morin, B. 2025. Is a Third Way Enough to Tame Hidden Forces? *Healthcare Papers* 23(1): 21–26. doi:10.12927/hcpap.2025.27647.
- Or, Z. 2025. Canada Can Find a Third Way, but Private Insurance Is Not a Silver Bullet. *Healthcare Papers* 23(1): 26–31. doi:10.12927/hcpap.2025.27646.
- Raza, D. 2025. Piercing the Public-Private Debate: An Asset-Based Approach to Transforming Canadian Healthcare. *Healthcare Papers* 23(1): 36–40. doi:10.12927/hcpap.2025.27644.
- Reimer, J. 2025. We Need to Do the Hard Work to Strengthen Public Healthcare. *Healthcare Papers* 23(1): 32–35. doi:10.12927/hcpap.2025.27645.