PUBLIC AND PRIVATE HEALTH CARE IN CANADA

WHAT DOES THE EVIDENCE SAY?

NATIONAL CONVERSATION ON PUBLIC AND PRIVATE HEALTH CARE IN CANADA

JUNE 2024
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Executive summary

The role of the public and private sectors in Canadian health care has evolved over several decades. Today, about 70% of health care spending is publicly funded through general taxes, with the remaining 30% funded through private health insurance and out-of-pocket payments. Hospital and physician services are almost completely publicly funded, while other services such as home care, long-term care (LTC), prescription drugs and dental care are supported by a mix of public and private funding (Table 1).

The public–private mix in health care is also evident in organizations that deliver health care, irrespective of how they are funded. Most hospitals in Canada are public or private not-for-profit organizations. LTC homes are a mix of public, private not-for-profit and for-profit facilities. In contrast, the majority of physicians and other community-based health providers work in private for-profit businesses.

Table 1. Examples of the public–private balance in Canada’s health care system

<table>
<thead>
<tr>
<th>Funding</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health; acute care and in-patient drugs in some hospitals</td>
<td>Upgraded accommodation at some hospitals</td>
<td></td>
</tr>
<tr>
<td>Private not-for-profit</td>
<td>Acute care and in-patient drugs in some hospitals; some LTC facilities</td>
<td>Upgraded accommodation at some hospitals</td>
</tr>
<tr>
<td>Private for-profit</td>
<td>Physician-led medical clinics and some LTC facilities</td>
<td>Non-insured dental care, vision care, drugs and other health services</td>
</tr>
</tbody>
</table>

There is no single formula to balance public and private health care. Different countries have developed unique approaches rooted in their history, culture and values. This has required difficult decisions on what services are publicly funded, whether user charges are permitted, whether citizens can pay privately for services that are publicly covered, and to what extent different providers and organizations — whether they are public, private not-for-profit or private for-profit — are enabled to deliver publicly funded health services.

Beyond the funding and delivery of health care, the private sector plays an important role in supplying a broad range of products and services involved in delivering care. This includes the production and distribution of drugs, medical devices, IT systems, medical supplies and equipment. Private sector innovation in vaccines, therapeutics and personal protective equipment was a critical factor in the fight against the COVID-19 pandemic.
Contracts for private cleaning, laundry and cafeteria services are commonplace in hospitals and LTC. Governments contract with private insurance carriers to manage public health insurance benefits, and public–private partnerships are used in hospital construction. These are accepted practices that do not generally trigger significant concerns in terms of the accessibility, quality or cost of health services.

This paper explores research evidence relevant to potential changes in the balance of public and private health care funding and delivery (Table 2). To support this work, the CMA Foundation commissioned the McMaster Health Forum to prepare summaries of the best available evidence on the health and health system impacts of: 1) dual private–public practice by health care professionals, 2) private funding of health programs, services and products and 3) for-profit delivery of health programs, services and products.

### Table 2. Overview of key public–private issues in health funding and delivery

<table>
<thead>
<tr>
<th>Issues in public–private health</th>
<th>Issues in public–private health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FUNDING</strong></td>
<td><strong>DELIVERY</strong></td>
</tr>
<tr>
<td>1 User fees and out-of-pocket payment for health services</td>
<td>1 Corporate for-profit delivery of publicly insured health services</td>
</tr>
<tr>
<td>2 Duplicative private insurance</td>
<td>2 Nursing services from for-profit staffing agencies</td>
</tr>
<tr>
<td>3 Clinician dual practice, including virtual care settings</td>
<td>3 For-profit delivery of LTC</td>
</tr>
<tr>
<td>4 Private-pay surgical, imaging and primary care</td>
<td>4 Investor-owned health care delivery</td>
</tr>
</tbody>
</table>

Note: Items 1, 2, 3, 5 and 7 were primarily informed by rapid evidence profiles prepared by the McMaster Health Forum. Items 4, 6 and 8 were informed by a literature search performed by the author. The issues are not mutually exclusive and may overlap.
On the basis of these summaries — as well as additional insights from the academic and grey literature (policy, reports, white papers and other material developed outside traditional publishing channels) — the following insights can be drawn about the impact of increased private-sector involvement in the funding and delivery of health services.

1. User fees and out-of-pocket payment for health services

The weight of evidence is generally against the introduction of user fees for medically necessary health care. Such fees hinder access to care and disproportionately affect low-income and vulnerable populations, without reducing costs or improving efficiency. Where user fees already exist, for prescription drugs, dental care and vision care, for example, or for services such as mental health care, the evidence suggests they should be lowered or eliminated to reduce barriers to access, especially for vulnerable populations.

2. Duplicative private insurance

Although supplemental private insurance – workplace benefits plans, for instance – play an important role in coverage for drugs, vision, dental and other health services, “duplicative” private insurance is generally not permitted for medically necessary hospital and physician services. The evidence suggests that the introduction of duplicative private insurance in Canada, while beneficial for those who can afford it, would create significant inequities in access to health care, draw resources away from the public system and lead to higher overall spending on health care.
3. Clinician dual practice, including in virtual care settings

Clinician dual practice refers to policies that enable doctors and other health professionals to work concurrently in both publicly funded and privately funded health systems. The growth of private-pay virtual care has blurred these lines in certain circumstances, but in general physician dual practice is highly restricted or banned entirely in Canada as part of a broader set of rules intended to bolster medicare. Although the research evidence from Canada is limited, studies in other countries show that physician dual practice leads to poorer performance in meeting the health system Quadruple Aims: improving patient and provider experiences, population health and value for money. More research is needed to support policy decisions.

4. Private-pay surgical, imaging and primary care services

There are a significant and growing number of private for-profit clinics across the country delivering surgeries (joint replacement, eye surgery, hernia repair), diagnostic imaging (X-ray, MRI, CT, ultrasonography, mammography) and primary care (24/7 access to physicians, private-pay nurse practitioners and pharmacy clinics, executive health assessments, etc.). Evidence on the impact of direct patient charges and duplicative private insurance suggests that parallel private-pay health services could exacerbate inequities in accessing care, draw resources away from the public system and lead to higher overall spending on health care. Additional analysis of changes currently being implemented is needed.

5. Corporate for-profit delivery of publicly insured health services

Canada has had limited experience with corporate for-profit delivery of publicly insured health care on a large scale. However, in the wake of the COVID-19 pandemic, several provinces have increased the use of private clinics to expand capacity for surgeries and diagnostic services. International research strongly suggests that for-profit delivery of publicly insured services results in poorer quality and higher costs. Given that this evidence is somewhat dated and is largely from the US, however, additional research and analysis in Canada is needed to inform decision-making.
6. Contracting out nursing services to for-profit staffing agencies

Many hospitals in Canada are experiencing unprecedented, severe shortages of nursing staff because of illness, attrition and early retirement. To fill this gap, some have turned to private agencies for temporary nursing staff, but at a cost that is significantly higher than the cost for salaried nurses. There is mixed international evidence on the impact of agency nurses on the quality of care and health outcomes. Further study of the impact of this practice in Canadian settings is needed.

7. For-profit delivery of long-term care

More than 40% of deaths from COVID-19 in Canada occurred at LTC homes. This has raised questions about the governance and regulation of LTC facilities, currently owned by a mix of government (46%), private not-for-profit (23%) and private for-profit organizations (26%).

International and Canadian research indicates that for-profit delivery of LTC is associated with higher levels of hospitalization and mortality. Given that a significant proportion of LTC facilities in Canada are run by for-profit organizations, additional research is needed to better understand the factors underlying the outcomes that have been observed and to inform appropriate policy and regulatory responses.

8. Investor-owned health care delivery

Private equity in Canadian health care has grown over the past few decades as smaller operators have merged or have been absorbed by larger companies. Today, many companies that operate for-profit LTC facilities, pharmacies, laboratory testing and diagnostic imaging services are large, publicly traded corporations. The involvement of large corporations is also increasing in other areas including dental care, virtual care and the services provided medical specialties such as dermatology. International evidence on the impact of investor-owned health care indicates higher costs and poorer quality. Additional research into the evolving role of private equity ownership in Canadian health care is needed.

Where evidence on the impact of private funding and delivery of care on public health systems is lacking, it is important to carefully evaluate changes being implemented across the country. Particular attention should be given to areas that are seeing significant growth, such as privately funded virtual care delivered by physicians and privately funded primary care clinics led by allied health professionals. Moreover, jurisdictions contemplating changes to the balance of public and private care should ensure that adequate oversight mechanisms are in place and that data are routinely collected to monitor impacts on health care quality, accessibility, outcomes and costs.
1. Introduction

Fundamentally, the balance of public and private health care in Canada is a policy choice made by democratically elected governments. The current balance was established with the creation of medicare in the 1950s and 1960s, but it is shifting as governments address existing challenges and prepare for the future.

The CMA believes this is a pivotal moment for open dialogue with patients, physicians, other health care professionals and the public on the health care we want, grounded in a shared understanding of the system we already have and key issues of access, equity, quality and system capacity.

To help inform these discussions, this paper provides an overview of available research on the impact of private funding and delivery of health care on public health systems.

2. Why this is important

Although the Canadian health care system is often described as a public system, the reality is more nuanced.

Health care is predominantly publicly financed, with tax-based funding accounting for about 70% of total costs and private funding accounting for the remaining 30%. However, this funding mix varies considerably across the continuum of care, with hospitals and physician services almost completely publicly funded and other areas such as prescription drugs and vision care predominantly privately funded. Long-term care (LTC) and home care are funded by both public and private sources.

Health care is delivered by a mix of public and private providers. Most hospitals outside Ontario are public institutions, with nurses hired as public employees, but physicians and other health professionals mostly operate private for-profit businesses. LTC, home care and diagnostic and laboratory services are delivered by both public and private organizations.

The interface between the public and private sectors in health care has been the subject of considerable debate in Canada over the past several decades.
At the inception of medicare in the 1950s and 1960s, decision-makers grappled with how to build a universal, publicly funded health care system from an existing system of private health insurance plans, independent medical practitioners and a network of not-for-profit private hospitals owned by charities and religious orders. The solution — first adopted in Saskatchewan and then scaled up nationally with federal financial support — was for governments to take over the financing of health care but to keep health care delivery in the hands of private providers.

By the 1970s, however, shortfalls in government funding led some hospitals and doctors to institute patient charges and user fees. At the same time, a shift from a cost-sharing model to block funding left the federal government unable to enforce legislation requiring provinces and territories to make insured health services available without expense to patients. As concerns mounted about access to health care, Ottawa passed the Canada Health Act in 1984 to enshrine national standards for publicly insured health services in federal law and give the government more tools to enforce these standards.

In the 1990s and 2000s, growing wait times prompted two significant legal challenges to these standards: one to strike down laws prohibiting private insurance for medically necessary services (Chaoulli v. Quebec) and the other to strike down prohibitions on dual practice in public and private health systems (Cambie Surgical Services Corp v. BC). The Supreme Court of Canada ruled in favour of Chaoulli, allowing for expanded private health care options in Quebec. BC courts, by contrast, ruled in favour of the government in the Cambie case, reaffirming the fundamental principles of medicare.

Today, a post-pandemic shortage of health workers and increased delays in access to publicly funded health services are again raising questions about the balance of public and private care — including restrictions on private payment, the Canada Health Act’s singular focus on hospital and physician services, and jurisdictions’ ability to shift delivery of publicly funded health care to the private sector.

To expand system capacity, some provinces are funding private for-profit surgical facilities, MRI clinics and virtual care services. The federal government, meanwhile, has launched a new dental care plan and taken steps toward national pharmacare.

What should Canadians make of these changes?

How will they affect the accessibility, quality and cost of health care?
3. Conceptual framework

There are three dimensions to public and private health care in Canada.

**The first is who pays for health care.** Many services are publicly funded through general tax revenues and, in some provinces, through health care levies and premiums. Others are privately funded through third-party insurance (the majority financed by employers, employees and retirees) or through individual user charges and out-of-pocket payments. Often, health services are funded through a mix of these mechanisms.

**The second dimension of public and private health care in Canada is delivery of care:**

- Public delivery includes services provided by employees of federal, provincial/territorial or municipal governments (e.g., health ministries, public health units) or by agencies and health authorities that may be at arm’s length from the government but that are accountable to it (e.g., a provincial/territorial health authority, hospitals in most jurisdictions except Ontario).
- Private delivery includes services provided by not-for-profit organizations such as charities, community health centres, LTC facilities and hospitals in Ontario, those provided by for-profit small businesses such as physician practices, physiotherapy clinics and the like, as well as care overseen by larger for-profit corporations.

**The third dimension of public and private care is whether or not a health service falls under the Canada Health Act.** All Canadians must be provided with medically necessary hospital and medical services, regardless of their ability to pay. Coverage for other health care services, and how it is delivered, is at the discretion of provinces and territories. Changes in the public–private balance of services that are publicly insured under the Canada Health Act are subject to greater scrutiny by both the federal and provincial/territorial governments than non-insured services.¹

Table 3 illustrates this conceptual framework with examples of health services that align with the dimensions described above.

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¹ The web of laws, regulations and rules governing public and private health care in Canada is complex. The Canada Health Act sets out certain criteria with which provincial and territorial health insurance must comply to qualify for federal transfers, and it enables the federal government to make deductions from federal transfers in instances where jurisdictions are deemed to not be complying with the requirements of the Act. It sets a floor for insured services for all Canadians, but individual provinces and territories may (and do) publicly fund additional services. However, the federal government does not have jurisdiction to regulate the financing and delivery of health services. This role belongs to the provinces and territories.⁴⁵
### Table 3. Conceptual framework of public–private health care

<table>
<thead>
<tr>
<th>Delivery</th>
<th>Funding</th>
<th>Public</th>
<th>Private</th>
<th>Out of pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>General tax revenues</td>
<td>Private insurance</td>
<td></td>
</tr>
<tr>
<td>Hospital and medical services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Public</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quasi-government organization</td>
<td>Hospital services ROC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not-for-profit organization</td>
<td>Hospital services ON</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small business</td>
<td>Physician services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Public</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government organization</td>
<td>Public health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quasi-government organization</td>
<td>Programs and subsidies for drugs, other HCPs MHA, home care &amp; LTC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not-for-profit organization</td>
<td>Employer/ co-pays on drugs, MHA, other HCPs, home care &amp; LTC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small business</td>
<td>Corporation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporation</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Legend: HCP = health care professionals, LTC = long-term care, MHA = mental health and addictions, ON = Ontario, ROC = rest of Canada

Beyond the funding and delivery of health services, the private sector plays an important role in supplies for health care. This includes the production and distribution of drugs, medical devices, IT systems, medical supplies and equipment. Private sector innovation in vaccines, therapeutics and personal protective equipment played a critical role in the fight against the COVID-19 pandemic.

Contracts for private cleaning, laundry and cafeteria services in hospitals and LTC are also commonplace. Governments contract with private insurance carriers to manage public benefits, and public–private partnerships are used in hospital construction. These are accepted practices that do not generally trigger significant concerns in terms of the accessibility, quality or cost of health care.

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Adapted from the conceptual framework presented by Hedden and colleagues.⁶
4. How Canada compares with other countries

There is considerable variation across industrialized countries in the funding and delivery of health care, depending on factors including history, values, culture and geography:

- In countries with a **national health service**, such as the United Kingdom, Sweden, Norway, Finland, Denmark, Spain and Portugal, health care funding and delivery are predominantly public. Health care funding is derived from tax revenues, and a significant portion of care is delivered through government-owned hospitals and by salaried doctors.

- In countries with a **national health insurance** system, such as Canada, Australia, New Zealand, Ireland and Italy, health care funding is primarily derived from general tax revenues, but delivery is predominantly by private, not-for-profit hospitals and self-employed health care providers.

- The majority of industrialized countries, including Austria, Germany, Luxembourg, Switzerland, Belgium, France, the Netherlands, Japan, South Korea and several in Eastern Europe, have a **social health insurance** model. These systems provide universal access to care, but instead of relying on tax funding, governments mandate contributions by employers and employees.

- The United States is only industrialized country with a predominantly **private health system**. About 65% of the population is covered by voluntary private insurance and 33% by public insurance (e.g., Medicare for seniors, Medicaid for low-income individuals and the Veterans Administration for veterans). An estimated 8% of Americans have no private or public coverage.iii

**Table 4** provides an overview of health systems comparable to Canada’s. It shows health spending as a share of GDP ranging from 10% to 12% (with the exception of the US, at 16%). In terms of public funding for health care, Canada is just below the OECD average of 73%, but it is far below the greater than 80% public funding registered in countries with a national health service such as the UK, Sweden and Norway.

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Spending as Share of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUS</td>
<td>74</td>
</tr>
<tr>
<td>DEN</td>
<td>85</td>
</tr>
<tr>
<td>FRA</td>
<td>79</td>
</tr>
<tr>
<td>GER</td>
<td>79</td>
</tr>
<tr>
<td>NETH</td>
<td>66</td>
</tr>
<tr>
<td>N-Z</td>
<td>79</td>
</tr>
<tr>
<td>SWE</td>
<td>86</td>
</tr>
<tr>
<td>SWI</td>
<td>37</td>
</tr>
<tr>
<td>UK</td>
<td>84</td>
</tr>
<tr>
<td>US</td>
<td>56</td>
</tr>
</tbody>
</table>

iii Percentages do not equal 100 because some individuals have combined public and private coverage. Source: US Census Bureau.
In Canada, **29%** of health care in Canada is privately funded, through out-of-pocket payments (**15%**), private insurance plans (**12%**) and other sources (**2%**). Canada’s reliance on private supplemental health insurance (identified by S in Table 4), which is largely focused on prescription drugs, vision care and dental care, is generally greater than that of comparator countries. Canada does not allow duplicative private health insurance (identified by D in Table 4), however, like Australia, Germany and the UK do. Several other countries allow citizens to purchase complementary private health insurance (identified by C in Table 4) to offset deductibles and co-pays.

Patient charges for hospital and physician services are levied in **six of the 11** comparator countries, but the other five (including Canada) do not permit user fees for hospital and/or physician services. Canada is unique in not permitting doctors to practise concurrently in both the public and private sectors.

Out-of-pocket payments for **hospital and physician services** (referred to as inpatient and outpatient services in Table 4) are generally very low in all countries when expressed as a share of total spending. There is more variability in the share of out-of-pocket payments for drugs, LTC and dental care.

Generally, **home care services** are covered by government programs and/or social insurance plans, with some cost sharing with clients, subject to means testing. Denmark has significantly invested in home care services, while relying less on institutional care.

**With respect to LTC**, both Germany and the Netherlands offer LTC insurance schemes. There is a mix of public, not-for-profit and for-profit LTC homes in all countries.

**Dental care coverage varies widely across countries:** Some provide universal coverage, while others rely on supplemental private insurance to cover dental care or non-medically necessary dental care services (i.e., cleanings and checkups). Most countries provide full public coverage for children (Canada has started to do this for low-income families) with cost sharing for adults through co-payments, some of which may be covered via private insurance.8,9

In terms of public funding for health care, Canada is just below the OECD average of 73%, but it is far below the greater than 80% public funding registered in countries with a national health service such as the UK, Sweden and Norway.
Table 4. Public–private financing and delivery characteristics across key comparator countries

<table>
<thead>
<tr>
<th>System type</th>
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<tr>
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<td>NHI</td>
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<td>SHI</td>
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Public-private financing characteristics

<table>
<thead>
<tr>
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<td>Health spending / GDP</td>
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<td>12.7</td>
<td>10.2</td>
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<td>Public / private split</td>
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<td>85/15</td>
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<td>86/14</td>
<td>37/63</td>
<td>84/16</td>
<td>56/44</td>
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<td>Role of private insurance</td>
<td>S, D</td>
<td>S</td>
<td>C, S</td>
<td>C, S</td>
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<td>D</td>
<td>P</td>
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<td>Physician dual practice</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
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<td>Y</td>
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<td>User fees for MDs/hosp</td>
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% out-of-pocket spending by sector

<table>
<thead>
<tr>
<th></th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Drugs</th>
<th>LTC</th>
<th>Dental</th>
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<tr>
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<td>3</td>
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<td>2</td>
<td>9</td>
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<td>n.a.</td>
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<tr>
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<td>2</td>
<td>9</td>
<td>25</td>
<td>22</td>
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Public–private delivery characteristics

<table>
<thead>
<tr>
<th></th>
<th>Hosps beds / 1K pop</th>
<th>Main hospital type</th>
<th>Doctors / 1K pop</th>
<th>Main MD payment type</th>
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<td>2.8</td>
<td>FP/NFP</td>
<td>2.7</td>
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Legend: NHS = national health service, NHI = national health Insurance, SHI = social health insurance, PHS = private health system, S = supplemental private insurance, C = complementary private insurance, D = duplicate private insurance, FFS = fee-for-service, FP = for profit, NFP = not for profit, Sal = salary, Cap = capitation

Sources: OECD, A,B

On the delivery side, Canada’s health care system is characterized by a greater reliance on the private sector than countries with a national health service and a greater reliance on private not-for-profit delivery than the US and countries with a social insurance model. Generally, Canada has fewer health care resources than comparator countries (e.g., physicians per capita, hospital beds per capita), as well as much higher hospital occupancy rates. These could be contributing to longer wait times.
5. What the research says

Research evidence comes in many shapes and size

Evidence syntheses, sometimes called systematic reviews, are the gold standard because they combine quality-rated information from multiple studies investigating the same topic to provide a more comprehensive understanding of their findings.

Single studies published in reputable peer-reviewed journals may also inform decision-making, but they are not always critically appraised and assessed in the context of a wider body of evidence.

Studies that are not peer reviewed, such as those produced through expert opinion, by expert panels and by jurisdictional scans, may also be considered in policy decisions, but they are subject to greater bias. Other important inputs for decision-makers include the perspectives and interests of people with lived experience, to cite just one example.

The CMA Foundation commissioned the McMaster Health Forum to undertake a synthesis of the best-available evidence over the past decade addressing three key dimensions:

1. PRIVATE FINANCING
2. DUAL PRIVATE/PUBLIC PRACTICE
3. PRIVATE FOR-PROFIT DELIVERY

The goal was to better understand what is and isn’t known about the private sector’s impact on equity-centred Quadruple Aim metrics.¹⁴

¹⁴ The Quadruple Aim in health care was coined by Dr. Thomas Bodenheimer and Dr. Christine Sinsky in 2014; they proposed expanding the Triple Aim concept (better quality, better outcomes, lower costs) popularized by the Institute for Healthcare Improvement to include improved provider experience.¹¹
The following sections use insights from these reviews, supplemented by other research evidence, to elucidate key issues in public and private health care as illustrated in Table 5.

**Table 5. Key public–private health care issues**

<table>
<thead>
<tr>
<th>Funding</th>
<th>Public</th>
<th>Private</th>
<th>Out of pocket</th>
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</thead>
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<tr>
<td>General tax revenues</td>
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<tr>
<td>Private insurance</td>
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<tr>
<td>Out of pocket</td>
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**Delivery**

<table>
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<th>Publicly insured hospital and medical care</th>
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<tr>
<td><strong>Public</strong></td>
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<tr>
<td>Government organization</td>
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<tr>
<td>Quasi-government organization</td>
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<td><strong>Private</strong></td>
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<td>Not-for-profit organization</td>
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<tr>
<td>Small business</td>
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<tr>
<td>Corporation</td>
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<table>
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<tr>
<th>Other health services</th>
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<tbody>
<tr>
<td><strong>Public</strong></td>
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<tr>
<td>Government organization</td>
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Legend: FP = for profit, LTC = long-term care, NFP = not for profit
5.1 Changes in the balance of public and private health care funding

5.1.1 User fees and out-of-pocket payment for health services

Out-of-pocket payment refers to the amount of money charged directly to patients for health services over and above what’s covered by public or private insurance plans. The Canada Health Act and parallel legislation in provinces and territories largely eliminated user fees and patient charges for hospital and physician services. Beyond that, however, there are many examples of direct patient charges. Most public drug plans include deductibles and co-payments. Supplemental private insurance plans typically include deductibles, copayments and co-insurance for prescription drugs, vision and dental care, and health services provided by a myriad of health professionals (e.g., physiotherapists, psychologists, dietitians, occupational therapists).

The main concern about out-of-pocket payment for health care is that it may deter some patients, particularly those with lower incomes, from accessing needed health services, which could result in adverse health outcomes. Proponents of user fees in health care argue that they help to curb unnecessary use of care, controlling costs while also providing an additional source of funding for the health system.

What does the evidence say?

The McMaster Health Forum found seven evidence syntheses on user fees. All but one indicate that introducing them is associated with a reduction in both necessary and unnecessary care. This has been observed with services including primary care, physiotherapy and occupational therapy, and perinatal care. Studies on the introduction of user fees for prescription drugs consistently found an increased likelihood of patient non-adherence to prescriptions in the short term; in two evidence syntheses, this was associated with a decline in health in the long term. Importantly, non-adherence was found to be worse among lower income populations. One evidence synthesis also found that user fees and out-of-pocket costs for prescriptions led to increased health system costs because of delayed care, but the extent of these costs is context dependent.

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Between 2017–18 and 2021–22, federal health transfer deductions due to patient charges and user fees totalled $94.5 million, 80% of which was in relation to patient charges at the Cambie Surgical Clinic in BC. In contrast, in the first three years after the enactment of the Canada Health Act, almost $245 million in deductions were taken against federal health transfers to provinces. These deductions were refunded when provinces effectively eliminated patient charges.
Some more dated studies of user fees continue to be relevant. One of the largest and most robust, the RAND Health Insurance Experiment conducted in the US between 1971 and 1982, randomly assigned five plans with differing levels of user fees to more than 7,700 subjects.\textsuperscript{13} It found that fees reduced the use of nearly all health services, both high-value and low-value, and although this did not generally have an adverse effect on patient health, it did affect the poorest and sickest subjects. The experiment also showed that user fees did not result in individuals adopting healthier lifestyles.

There has been some research on user fees in Canada. In the 1960s and 1970s, studies in Saskatchewan found they reduced the annual use of physician services by almost 6% on average, with low-income families reducing their use by about 18%.\textsuperscript{14} However, this did not result in decreased health care costs. Another Canadian study looked at user fees for prescription drugs in Quebec. It found that older adults and welfare recipients reduced their use of essential medicines, resulting in more frequent trips to emergency departments and an increase in serious adverse events.\textsuperscript{15}

Research on the high users of health care in Manitoba also highlights the reality that the adoption of user fees for health care would disproportionately affect a small proportion of the population — typically sicker and poorer — responsible for a significant share of health spending.\textsuperscript{16}

\textbf{Bottom line:}

User fees for medically necessary services are a barrier to care and do not help to reduce costs or improve efficiency. They should be reduced or eliminated, particularly for low-income and vulnerable populations.
5.1.2 Duplicative private insurance

Duplicative private insurance is when private plans cover health services that are included in provincial and territorial health insurance. In Canada, duplicative private insurance is either prohibited or strongly discouraged to maintain social solidarity around a strong publicly funded health system. Five provinces (Alberta, British Columbia, Manitoba, Ontario and Prince Edward Island) prohibit this type of insurance. The Supreme Court decision in Chaoulli v. Quebec opened the door to duplicative private insurance in that province, although insurers have not expanded their offerings to include coverage for public health services. Insurers in other provinces where duplicative private insurance is permitted have not done so either.

Opponents of duplicative private insurance are typically concerned about two-tier health care, the negative impact on the public system as health professionals and resources are drawn into the private sector and the potential for increased system costs. Proponents of duplicative private insurance argue that it would add capacity, reduce pressure on the public system and instill a competitive dynamic in a sector that is otherwise not subject to market forces.

What does the evidence say?

The McMaster Health Forum identified four evidence syntheses related to private health insurance. Two were country specific: one focused on Germany and the other on the US. Two others examined the broader impact of private funding (not uniquely private insurance) on the public health systems in several countries, including Canada.

All of the studies suggest that relative to a system where care is paid for exclusively out of pocket, the introduction of either public or private health insurance is associated with better health outcomes. In countries with duplicative private insurance, patients with private plans reported shorter wait times, increased access to new pharmaceuticals and increased choice in care, but those in the publicly funded system reported longer wait times for primary and specialty care. One synthesis found that privately funded health services do not reduce pressure on the public system and may in fact draw resources away it.
The merits of introducing duplicative private health insurance in Canada have been debated extensively by experts in the peer-reviewed and grey literature, particularly in the lead up to, during and after the Chaoulli case. While the Supreme Court ruled in favour of the appellants, experts argue that the weight of the evidence continues to support tight controls over duplicative private health insurance and measures such as limitations on physician dual practice (discussed below) as a means of maintaining a strong publicly funded health system.17

Comparative reviews of duplicative private insurance can also be found in the grey literature. An OECD study found differences in access to care and coverage according to insurance status in member countries and observed that while duplicative private insurance can help reduce some of the capacity issues in public health systems, it does not significantly reduce public health expenditures.18

**Bottom line:**
Evidence suggests that private duplicative health insurance, while beneficial for those who can afford it, can create significant inequities in access to care, draw resources away from the public system and lead to higher overall spending.
Clinician dual practice, including virtual care

Clinician dual practice is when doctors or other health professionals deliver care concurrently in both publicly funded and privately funded settings. Dual practice is common internationally, but in Canada it is either restricted or banned entirely. Most provinces and territories require doctors to either opt in to public health insurance or opt out. If they choose the latter, they cannot bill the government for services covered by public health plans. These rules were recently tested in the Cambie charter challenge and were found to be reasonable limitations imposed by governments to prevent the emergence of a two-tier health care system.

The rapid expansion of for-profit virtual care in Canada, first through the pandemic and now as a means to fill the gap created by ongoing health worker shortages, is complicating this picture. Use of virtual care surged during the pandemic as governments changed policies to allow virtual physician visits during pandemic lockdowns. The growth in virtual care has also been fuelled by health care provider shortages, increasing digital literacy and consumer interest. These platforms make it easier for doctors to engage in dual practice by exploiting loopholes in existing legislative and policy frameworks. For example, under current rules, doctors in some jurisdictions can continue to work in the public system in their home province or territory while delivering privately funded virtual care for patients in another jurisdiction. The federal government has recently indicated that it is working with provinces and territories to address this issue.

Arguments against dual practice are its potentially negative impact on access to medical services in the public system, the potential increase in non-priority treatments in private care, duplication of effort between public and private providers and the possibility of conflicts of interest. Proponents of physician dual practice argue that it could improve access to care and provide better work environments for physicians.
What does the evidence say?

The McMaster Health Forum identified six evidence syntheses and three primary studies on physicians, nurses, pharmacists and allied health professionals.\textsuperscript{21} However, they noted that research on dual practice is scarce, incomplete and largely theoretical, with most recent studies focused on lower and middle-income countries. Evidence on dual practice was unclear in terms of quality of care and wait times, mixed in terms of provider satisfaction and limited in terms of system costs. More “real-world” evidence and rigorous evaluation are needed.

The grey literature provides a few real-world examples of dual practice. A comparative study on Canada and Israel concluded that a parallel, private system of care undermines equitable access. In another study, researchers assessed a period in Manitoba when private-pay cataract surgery was available.\textsuperscript{22} They found that waits were almost six times as long for surgeons in dual practice than for those who practised only in the private sector.

Bottom line:
There are some studies suggesting physician dual practice leads to poorer access to care, but the research is dated and largely based on countries that are not like Canada. A stronger evidence base is needed to support policy decisions in emerging areas such as virtual care.
5.1.4 Private-pay surgical, imaging and primary care health services

The vast majority of hospital and medical services in Canada are delivered by publicly funded, publicly owned institutions and by doctors in private practice funded by provincial or territorial health insurance plans. However, there are a significant number of private for-profit clinics across the country delivering surgeries (joint replacement, eye surgery, hernia repair), diagnostic imaging (X-ray, MRI, CT scan, ultrasound, mammography), primary care and boutique health services (24/7 access to physicians, nurse practitioner and pharmacy clinics, executive health assessments, etc.).

Legislation allows patients to pay for private health care in some circumstances. This includes individuals covered by workers compensation, out-of-province patients, employees covered through third-party payments (e.g., executive health services) and those covered by membership fees. Private pay is also permitted when services are either not publicly insured outside of hospital settings (e.g., abortion services and diagnostic imaging in some provinces) or not covered by provincial or territorial health insurance plans at all (e.g., nurse practitioners). Some private clinics also deliver publicly insured services through contractual arrangements with provincial and territorial governments. The merits of using private, for-profit organizations to deliver publicly funded health services are discussed in section 5.2.1.

Anecdotal evidence suggests that the number of clinics and facilities offering private-pay diagnostic, surgical and boutique health services is rapidly expanding. Opponents argue that private-pay health services allow for privileged access to medically necessary services and queue jumping. They also point to inequities in cases where patients pay for private diagnostic imaging, then seek treatment in the public health system. Proponents of private clinics argue that they reduce pressure on the public system within an existing legislative framework.
What does the evidence say?

The impact of privately provided surgeries, diagnostic imaging and primary care was not explicitly addressed in the evidence summaries prepared by the McMaster Health Forum. However, evidence on the impact of direct patient charges and duplicative private insurance suggests that parallel private-pay health services could exacerbate inequities in access to care, draw resources away from the public system and lead to higher overall spending on health care.

Bottom line:

Research evidence suggests parallel private-pay health services could exacerbate inequities in accessing care, draw resources away from the public system and lead to higher overall spending on health care.

Given that private-pay diagnostic, surgical and boutique health services are rapidly expanding, it will be important to gather evidence on the performance of these services against Quadruple Aim metrics.
5.2 Changes in the public–private balance of health care delivery

5.2.1 Corporate for-profit delivery of publicly insured health services

Compared with the US, Canada has limited experience with corporate, for-profit organizations delivering publicly funded health care on a large scale. In the wake of the COVID-19 pandemic, however, several provinces have outsourced publicly funded surgeries and diagnostic services to private, for-profit clinics to expand capacity. Governments are also using private, for-profit companies to deliver virtual care.

Opponents of this approach argue that it will siphon health workers away from public and private not-for-profit institutions, that it will increase system costs and that it will subject patients to “upselling” practices that encourage them to pay out of pocket for services they do not need.

Proponents of outsourcing publicly funded health services to private, for-profit organizations argue that it will help to relieve pressure on hospitals and reduce wait times for select procedures.

What does the evidence say?

The McMaster Health Forum identified nine evidence syntheses addressing for-profit delivery of publicly funded health services, of which eight focused on acute and specialty care and one focused on primary care.\textsuperscript{24} This research was quite dated, primarily from the US and mostly focused on specialty and long-term care.\textsuperscript{vi} However, it found that for-profit delivery was generally associated with negative outcomes, including higher mortality and adverse-event rates in hospitals, lower quality of care, increased use of inappropriate procedures, suboptimal staffing, poorer provider well-being, higher staff turnover and higher system costs. Although peer-reviewed studies on the private delivery of publicly funded health services in Canada are limited, anecdotal evidence suggests that for-profit delivery performs more poorly than not-for-profit or public delivery across most of the Quadruple Aim metrics.\textsuperscript{26,27} This area would benefit from additional research and real-time analysis to learn from natural experiments occurring across Canada.

\textsuperscript{vi} Although it was not part of the evidence summary prepared by the McMaster Health Forum, a recently published paper by Goodair and Reeves comes to similar conclusions drawing on evidence from the US, Germany, Croatia, South Korea and Canada.\textsuperscript{25}
Bottom line:

International research evidence strongly suggests that for-profit delivery of insured services results in poorer quality and higher costs. Given that the evidence is somewhat dated and largely based on the US experience, additional research and analysis of the Canadian experience is needed.

5.2.2 Contracting nursing services to for-profit staffing agencies

In most hospitals, nurses are salaried employees whose compensation is negotiated by provincial and territorial governments and nursing unions. During the pandemic, however, many hospitals experienced unprecedented, severe shortages of nursing staff because of illness, attrition and early retirement. Private agencies offering temporary nursing staffing filled this gap: the Canadian Institute for Health Information reported that between 2021 and 2022, there was an 80% increase in agency nursing hours across Canada.28

Quebec has pledged to ban the use of agency nurses and other provinces are taking a closer look at this practice.29 The main concern about agency nursing is that it costs considerably more to deliver the same services; recruitment agencies charge up to three times the cost of salaried nurses.vii Challenges with temporary staff also include continuity of care for patients and integration with hospital workflow and culture. On the flip side, hospital CEOs faced with nursing shortages say they have no choice but to turn to private agencies.

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vii There is considerable variation in how much of the increased cost is actually passed on to the nurses, as opposed to being kept by the private recruitment agencies.
**What does the evidence say?**

The impact of outsourcing nursing to for-profit agencies was not explicitly addressed in the evidence summaries prepared by the McMaster Health Forum.

A retrospective study involving 138,000 patients in England found a positive correlation between the use of temporary registered nurses and nursing assistants and the risk of death.\(^2^9\) An American study involving nurses in 665 hospitals found that higher use of agency staff did not have deleterious consequences for patient mortality and may have alleviated nurse staffing problems that can lead to higher mortality.\(^3^0\)

There is a dearth of peer-reviewed research on this issue in Canada. A recently launched study by the Queen’s University School of Nursing in collaboration with the Canadian Federation of Nurses Unions should shed further light on the impact of for-profit nursing agencies.\(^3^1\)

**Bottom line:**

There is mixed international evidence on the impact of agency nurses on quality of care and health outcomes. Further study focused on Canada is needed.
5.2.3 For-profit delivery of long-term care

In Canada, 43% of deaths related to the COVID-19 pandemic occurred in LTC homes. This has raised questions about the governance and regulation of these facilities, currently operated by a mix of government-owned (46%), private not-for-profit (23%) and private for-profit organizations (26%). In particular, critics argue that for-profit LTC facilities put earnings before quality of care, creating unsafe conditions for residents and health workers. Supporters point out that these facilities have been a long-standing part of the LTC system and that for-profit nursing homes perform better than not-for-profit or government facilities on many metrics.

What does the evidence say?

The McMaster Health Forum identified six evidence syntheses related to for-profit delivery of long-term care. They identified higher levels of mortality and hospitalization in for-profit LTC homes, linked in part to lower staffing ratios compared with those in not-for-profit facilities. The research is somewhat dated and largely US focused; however, three of the syntheses were comparative studies including data from Canada, and Canadian peer-reviewed studies have produced similar results. One more recent study found that for-profit LTC homes in Ontario had larger outbreaks of COVID-19 and a higher number of deaths relative to not-for-profit and municipal homes.

Bottom line:
International and Canadian evidence indicates that for-profit delivery of long-term care is associated with higher levels of mortality and hospitalization. Additional research is needed to better understand the factors underlying these outcomes.
5.2.4 Investor-owned health care delivery

In Canada, private equity in health care has grown as smaller operators have merged or been absorbed by larger companies. Today, many companies that operate for-profit LTC facilities, pharmacies, laboratory testing and diagnostic imaging services are publicly traded corporations. Large corporations are also investing in dental care, virtual care and medical specialist care such as dermatology. Although there are no firm estimates of private equity ownership in Canadian health care, there is anecdotal evidence that international equity investors are acquiring increasing numbers of medical clinics, dental practices and pharmacies.\(^{35,36}\)

Similar to the concerns around for-profit delivery of health services, critics argue that investor-owned health care puts profits ahead of patients, prioritizing the commercialization of services and cost-cutting over high-value care, particularly in cases where investors have limited knowledge of the sector and see assets purely as financial instruments. Proponents contend that investor-owned health care can bring needed capital into the system, deliver services more efficiently and create economies of scale that can lead to lower costs.

**What does the evidence say?**

The evidence summary prepared by the McMaster Health Forum on for-profit delivery of care did not differentiate private-equity ownership (e.g., small versus large firms, publicly traded versus privately owned firms, international versus domestic capital). A recent systematic review of largely US studies, however, found that private equity ownership was associated with increased costs and utilization of health services, and mixed to harmful impacts on health care quality.\(^{37}\)

**Bottom line:**

International evidence on the impact of investor-owned health care indicates that this form of health care ownership is associated with higher costs and poorer quality. Additional research on the impact of private equity ownership in Canadian health care is needed.
6. Conclusion

The public–private interface in health care speaks to the kind of system we want as a society and how we mobilize the various actors in the system – doctors, nurses, LTC facilities and a range of other players – to meet the needs of the population.

Every country has a different approach to managing the public–private interface in health care. Canada is similar to comparator countries in some respects and different in others. Contrary to popular belief, private health care financing and delivery already play an important role in Canada’s health care system. Canada relies extensively on private insurance for non-insured health services, such as coverage for prescription drugs, vision and dental care, and non-physician health services. In addition, many hospitals are private not-for-profit organizations and many health care practitioners who are delivering services outside the hospital setting operate small for-profit businesses.

It is important that any changes to the balance of public and private care in Canada be informed by the best research available. This paper aims to provide an overview of the evidence on key public–private issues currently under discussion.

In general, the research evidence suggests that private funding — whether through private duplicative insurance or user fees — has an adverse impact on access to health care and health outcomes and can increase system costs. The research evidence on increased private delivery of publicly funded health services is more nuanced, with for-profit delivery of services generally associated with higher system costs and poorer quality than private not-for-profit or public delivery, but with studies heavily skewed to US settings that may have limited applicability to the Canadian context.

This underlines significant evidence gaps and the need for more research in Canada, particularly in areas that are seeing significant growth, such as privately funded virtual care services delivered by physicians and privately funded primary care clinics led by allied health professionals such as nurse practitioners and pharmacists. Moreover, jurisdictions contemplating changes in the balance of public and private care should ensure that adequate oversight mechanisms are in place and that data are routinely collected to monitor impacts on health care quality, accessibility, outcomes and costs.

This report was prepared by health policy consultant Marcel Saulnier.
References


