



Private Health Care in Canada

Robert Steinbrook, M.D.

The hallmarks of Canada's government-funded universal health care system include the public provision of core physician and hospital services and the absence of copayments and other patient

charges (see box).¹ The system is often championed as a reflection of Canadian values and as an alternative that the United States might emulate. In 2003, Canada's health care spending per capita was \$3,003 — higher than that of some European countries and Japan but about half that of the United States (see table). Canada's spending as a proportion of gross domestic product has remained steady, while many other countries have been spending an increasing proportion on health care. Now, however, Canada's system, called Medicare, is under attack for inefficiency, insufficient funding, and failure to meet some patients' needs in a timely fashion.

Canada is anticipating an infusion of private care for core services in at least some provinces — Alberta, British Columbia, and Quebec — and various experiments combining public and private care. Such efforts aim to reduce patients' waiting times for treatment, as well as to control public spending. The belief that more change is imminent has been heightened by the victory of the Conservative Party in national elections in January, although the new government holds a minority of seats in the House of Commons.

The view that an increase in private health care will benefit the public health system is articulated by Brian Day, an orthope-

dic surgeon and the president and medical director of the Cambie Surgery Centre, a high-profile private health care facility in Vancouver. Day, who will become president-elect of the Canadian Medical Association (CMA) in August, says, "Physicians have recognized that the status quo in Canada is not an option. The vast majority of doctors believe that significant reform is needed and that part of that reform should be looking at alternative systems." Day predicts that in five years Canada will still have universal health care, but with a small private component — perhaps 5 to 10 percent of core services, as compared with about 1 percent now.

Michael McBane is the national coordinator of the Canadian Health Coalition, an Ottawa-based advocacy group for the public health system that opposes both privatization of care delivery and

Canada's Health Care System

As explained in a 2003 report, the Canadian health care system is “unique in the world in that it bans coverage of . . . [physician and hospital] core services by private insurance companies, allowing supplemental insurance only for perquisites such as private hospital rooms. This ban constrains the emergence of a parallel private medical or hospital sector and puts pressure on the provinces to meet the expectations of middle-class Canadians.”¹ That only 70 percent of total health care funding in Canada comes from the public sector — less than in many European countries but considerably more than in the United States — reflects the fact that private payments are common for other expenditures, including drugs, dental services, optometry, and home care. Private insurance and private care are also common in niche areas, such as work-related injuries and cosmetic surgery.

Privatization of health care may include private delivery of publicly financed core services, such as elective operations and imaging studies; private financing of care through health insurance; or direct payments by patients for services. Under the Canadian constitution, the federal government has primary responsibility for taxation, but the provinces have primary responsibility for managing health care.¹ This leads to frequent skirmishes between the two levels of government. Depending on how it is calculated, federal funding accounts for one third or slightly more of provincial health care spending. Health spending accounts for 27 to 45 percent of provincial budgets; some provinces, such as Alberta, are less dependent on federal funds than others.

With the Canada Health Act of 1984, the federal government entered into a matter of provincial jurisdiction by making its health care funding conditional. The act specified requirements that provinces must fulfill to qualify for the full federal contribution, including the provision of all medically necessary services, public administration on a nonprofit basis, universal coverage, portability of coverage throughout the country, accessibility of insured services, and a lack of additional patient charges. Financial penalties — mandatory dollar-for-dollar deductions from the federal payment — are imposed on provinces that allow “extra-billing and user charges.” However, enforcement is limited to these penalties and political persuasion. Thus, the act does not directly bar private delivery or private insurance for publicly insured services. Although there are laws prohibiting or curtailing private health care in some provinces, they can be changed.

a parallel private system of financing care. McBane argues that an increase in private care will undermine the public system, not save it. “There is a lot of money to be made by breaking Medicare. The end game is that people with money no longer want to pay the taxes required to provide quality health care for everybody. They want to

shift the cost from government to patients, employers, and third-party payers. Once that is done, the competitive advantage of Canada's single-payer public health care system will be lost.”

Some consider the public-private debate to be overblown and confused by politics and rhetoric. According to C. David Naylor, the

president of the University of Toronto and the former dean of its medical school, “In reality, for the foreseeable future, Canada will be relying on public finance and delivery for physician and hospital care. There may be marginal changes that introduce a little flexibility into the system, but there will neither be a shift of tectonic plates nor a collapse of the Canadian national identity.”

On June 9, 2005, the Supreme Court of Canada ruled in a case dating from 1997, in which a patient, along with his physician, sued Quebec after a year-long wait for hip-replacement surgery. In a decision highlighting the persistent problem of waiting lists in Canada (see graphs),² the Court voted four to three to invalidate the long-standing prohibition on private insurance for services that are available under Quebec's public health care plan.³ Subsequently, the court postponed the effective date until June 2006.

The Court's majority found that “waiting lists for health care services have resulted in deaths, have increased the length of time that patients have to be in pain and have impaired patients' ability to enjoy any real quality of life.”³ Although the decision was specific to Quebec, it implies that provincial governments cannot ban private care unless they guarantee that the public system will meet patients' needs without excessive waits. In a 2005 opinion poll, 80 percent of physicians and 65 percent of the public thought the ruling would reduce waiting times.⁴ The public, however, was otherwise divided: 43 percent agreed that it “will allow individuals choice and the ability to control their own health care”; 54 percent believed

Health Care Statistics for Canada and Other Countries.*								
Country	Total Health Care Expenditures		Health Care Funding from Public Sector	Average Growth Rate from 1998 to 2003	Health Expenditures per Capita	Practicing Physicians per 1000 Population	MRI Scanner Units per Million Population	Life Expectancy at Birth
	1993	2003						
	% of gross domestic product		percent		\$U.S.	number		yr
Canada	9.9	9.9	69.9	4.2	3,003	2.1	4.5	79.7
France	9.4	10.1	76.3	3.5	2,903	3.4	2.8	79.4
Germany	9.9	11.1	78.2	1.8	2,996	3.4	6.0	78.4
Italy	8.0	8.4	75.1	3.1	2,258	4.1	11.6	79.9
Japan	6.5	7.9	81.5	3.0	2,139	2.0	35.3	81.8
Switzerland	9.4	11.5	58.5	2.8	3,781	3.6	14.2	80.4
United Kingdom	6.9	7.7	83.4	5.7	2,231	2.2	5.2	78.5
United States	13.2	15.0	44.4	4.6	5,635	2.3	8.6	77.2

* Data are from the Organization for Economic Co-operation and Development, *Health Data 2005: Statistics and Indicators for 30 Countries*. (Available at http://www.oecd.org/document/30/0,2340,en_2825_495642_12968734_1_1_1_1,00.html). Data are for 2003 or the most recent year available. The figure for magnetic resonance imaging (MRI) scanners in the United States is an underestimate because it refers to the number of hospitals that have at least one scanner, rather than the total number of scanners.

“it will ultimately weaken the public health system that so many people rely on.”

In February 2006, Quebec announced that it would improve access within the public system to tertiary cardiology and radiation oncology services and would provide hip and knee replacements and cataract surgery within six months after they are recommended by a specialist.⁵ If these operations cannot be performed at a government-funded hospital within that time, Quebec will pay for surgery at an affiliated private clinic in the province. If the wait extends beyond nine months, patients can receive publicly funded care at a private clinic outside Quebec or even Canada. The government will allow Quebec residents to buy private health insurance specifically for these designated services, although the scope of such insurance may be expanded in the future. Private insurance must cover all the costs, including treatment

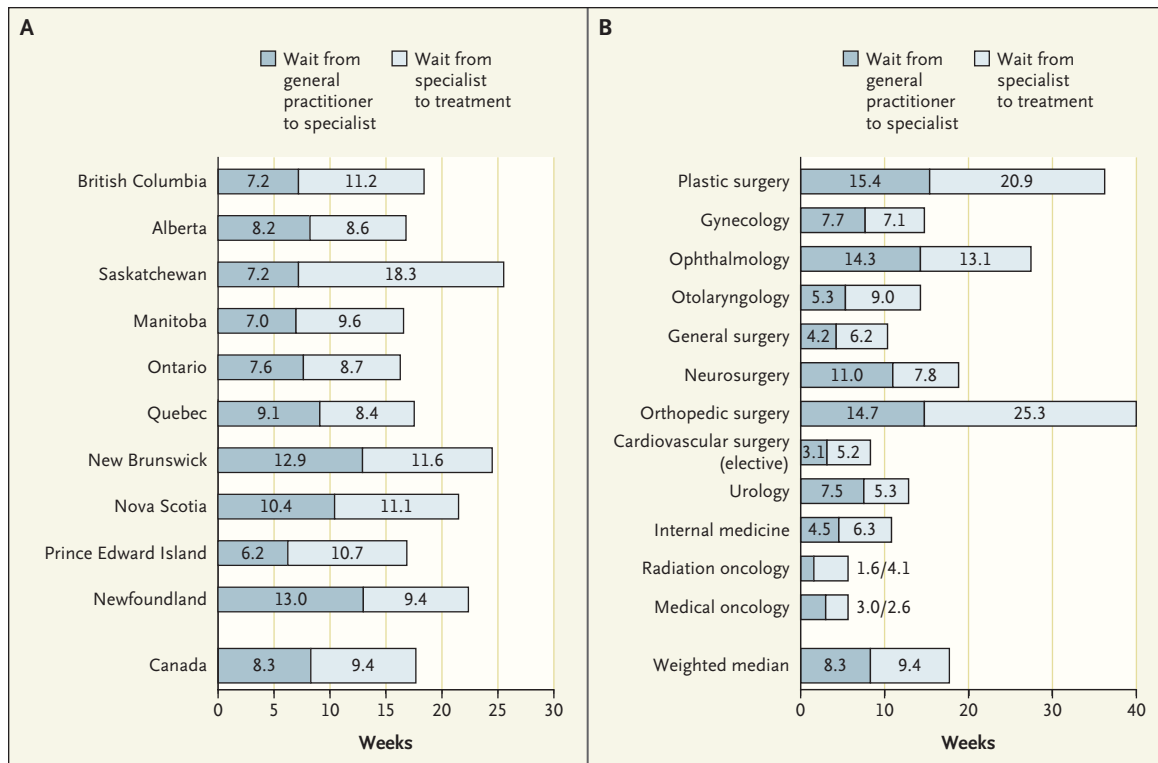
of complications, rehabilitation, and home support, so that the public system will not end up subsidizing private care. Physicians can choose to practice in either the public or the private sector — not in both — as has been the case for many years.

Also in February, the Alberta government proposed a new health policy framework. Referred to as the “Third Way,” it calls for a wider role for the private sector in providing medical services, including expanding the scope of private insurance, allowing patients to purchase directly certain medically necessary services, and unlike the Quebec proposal, permitting physicians to work simultaneously in both the public and private systems. Although details are forthcoming, Alberta said that it would “closely monitor” the private system and that the changes “will reduce wait times.” Critics contend that the reforms could have a different effect — preferential treat-

ment for wealthy patients and longer waits for everyone else. British Columbia is also expected to expand the role of private care, although as of early April it had not announced specific proposals.

The Canadian national government has developed “wait-time benchmarks” in specific areas of care, including radiation oncology, cardiac bypass surgery, hip and knee replacements, and cataract surgery. An alliance of physician organizations has proposed more comprehensive standards. Ruth Collins-Nakai, the CMA president, said she was “encouraged” because “changes are occurring in every single province to try and improve wait times.” The CMA’s policy, she noted, is “to support the public health care system” and encourage the private system only if the public system is “not meeting the needs.” Patients “should have access to timely care based on need and not on ability to pay.”

Depending on what changes



Median Wait from Referral by General Practitioner to Treatment in 2005, According to Province (Panel A) and Specialty (Panel B).

Data are from the Fraser Institute's survey of specialist physicians.² Although overall waiting times fell slightly from 2004 to 2005, they were 90 percent longer in 2005 than in 1993 and substantially longer than the times that respondents believed were clinically reasonable. Findings may be skewed because of self-reporting bias and may not reflect the situation for specific patients.

in Canada and how physicians, patients, health care unions, and politicians respond, Medicare could be strengthened or undone. Many hope that there will be increased efficiency and long-awaited reforms and that Medicare will receive sufficient long-term public funding.¹ Some fear that medical professionals will take better-paying positions in the private sector, helping to create a “two-tier” system based on the ability of patients to pay for preferential care. Though desirable, reducing waiting times may also increase demand, thereby blunting the effect of reforms. Waiting-time reduction is also a narrow focus that may

compete for attention — and government funds — with broader approaches, such as initiatives to increase the number of physicians and nurses and to improve primary care, preventive care, and services for the elderly. The ferment over private health care in Canada is complex, and it represents only one of the health care system's many challenges.

An interview with Brian Day and Michael McBane can be heard at www.nejm.org.

Dr. Steinbrook (rsteinb@attglobal.net) is a national correspondent for the *Journal*.

1. Detsky AS, Naylor CD. Canada's health care system — reform delayed. *N Engl J Med* 2003;349:804-10.

2. Esmail N, Walker M. *Waiting your turn: hospital waiting lists in Canada* (15th edition). Vancouver, B.C., Canada: Fraser Institute, October 2005. (Accessed March 30, 2006, at <http://www.fraserinstitute.ca/health/index.asp?snav=he>.)

3. *Chaoulli v. Quebec* (Attorney General), No. 29272, Sup. Ct. of Canada 130 C.R.R. (2d) 99; 2005 C.R.R. LEXIS 76.

4. Poll shows Canadians and doctors optimistic that Supreme Court decision will mean shorter wait times. News release of the Canadian Medical Association, Ottawa, August 5, 2005. (Accessed March 30, 2006, at http://www.cma.ca/index.cfm/ci_id/45149/la_id/1.htm.)

5. Government of Quebec. *Guaranteeing access: meeting the challenges of equity, efficiency and quality — consultation document*. 2006 (Accessed March 30, 2006, at <http://mssa4.msss.gouv.qc.ca/fr/document/publication.nsf/4b1768b3f849519c852568fd0061480d/5d64e6e0f5543b99852571240053333f?OpenDocument>.)