



CANADIAN DOCTORS FOR MEDICARE POLICY PRIMER

Myth:

**“Privatization” can help
everyone access
health care**

In Canada’s single-payer, publicly-funded health care system, government is the sole payer for hospital and physician services covered under each of the 13 provincial and territorial publicly-funded insurance plans.

But publicly-insured health care services are **delivered** in facilities with a variety of ownership structures, including:

- “Publicly-owned facilities”: ex. community health centers, public health clinics, most hospitals outside of Ontario.
- “Privately-owned not-for-profit facilities”: ex. most hospitals in Ontario.
- “Physician-owned small businesses”: ex. most doctor’s offices.
- “Private for-profit investor-owned corporations”: ex. some walk-in clinics, high-volume virtual care platforms, and private surgical clinics.

When the health care system in Canada is strained, we inevitably hear calls for the expansion of “private” health care. Calls for “privatization” usually come in one of two ways:

- **Private pay:** allowing individuals to pay out-of-pocket or through private duplicative insurance for health care.
- **Private investor-owned delivery:** using public funds to pay for care delivered in for-profit investor-owned facilities.

Proponents of “privatization” often conflate private pay and private for-profit delivery. They claim that increasing either private pay and/or private for-profit delivery will reduce wait times (both overall and for those in the publicly-funded system specifically), reduce costs to the public system, and lead to better health outcomes.

These, however, are misguided myths. The evidence tells a different story and also points to changes that will actually make a positive difference.

Myth 1: Private pay alleviates wait times in the public system.

Myth 2: Private for-profit ownership of health care facilities leads to better health outcomes.

Myth 3: Private financing will make health care more ‘efficient’.

Myth 4: We can’t afford public health care.

Myth 1: Private pay alleviates wait times in the public system.

With growing surgical backlogs, worsened by the pandemic, it is tempting to believe that allowing individuals to pay privately (either out-of-pocket or through private duplicative insurance) to access care outside of the publicly-funded system could relieve the burden on the publicly-funded system and free up capacity.

But human resources are finite. The same pool of doctors, nurses, and other health professionals currently working in the publicly-funded system would be pulled from that system to work in the privately-funded system. A parallel private system reduces the incentive to work in the publicly-funded system, as healthcare workers may be paid more in the private system despite caring for less complex patients, a process known as [“cream-skimming”](#). The reduced capacity in the publicly-funded system leads to worsening wait times for those who cannot afford to pay privately.

Australia introduced a parallel private pay system in 1997. The evidence from their experiences is clear: **a hybrid health care system with a combination of public- and private-pay leads to two-tiered outcomes.** [Public pay patients waited more than twice as long for their surgeries compared to private pay patients.](#) Not only that, Australia’s public pay patients wait **longer** than Canada’s public pay patients for the same surgeries.

A recent report found that [out-of-pocket payments are becoming a big concern for Australians](#), especially for people with chronic conditions like cancer. Half of cancer patients paid more than \$5000 a year in out-of-pocket medical expenses, and those in the lowest socioeconomic group are 37% more likely to die of their cancer than those in the highest socioeconomic group. Patients aren’t always informed of their publicly-funded treatment options, and often have difficulty assessing what reasonable costs are in the private pay system.

In Canada, Saskatchewan has allowed residents to pay out-of-pocket for an MRI since 2016, on the condition that the private facility also performs a publicly-funded scan for each privately-funded one. But from 2015 to 2019, [waiting lists for MRIs in Saskatchewan doubled due to increased demand – the result of treating health care as a consumer good.](#) As a result, wait times have actually increased.

The Supreme Court of British Columbia looked at the impact of private pay health care in [its 2020 ruling on the Cambie Case](#), and found that *“there is considerable evidence and literature that, where there is duplicative private health care, physicians reduce their time and efforts in the public system. This in turn leads to increases in wait times for care in the public system.”*

This decision was upheld by the [BC Court of Appeal](#) in 2022. In their ruling, the justices found that *“suppressing all private care is necessary”* to ensure that access to medically necessary care is based on need and not ability to pay and that *“(t)he introduction of even small scale duplicative private healthcare would create a second tier of preferential healthcare for those with the means to either acquire private insurance or pay out-of-pocket once their benchmark was exceeded.”*

Truth 1: Private pay may reduce waits for those who can afford to pay, but likely worsens wait times overall. Instead, solutions can be implemented within our publicly-funded system to reduce wait times for all, use resources more efficiently, and preserve a commitment to equity.

When resources are limited, for example doctors and nurses, [allowing some individuals to pay to get to the front of the line just rearranges the line](#). A review of international health systems found that [increased private financing was associated with reduced accessibility, equity, and quality](#).

Wait times were a serious concern before the pandemic, and COVID-19 has only increased the urgency to address this challenge. Thankfully, many effective solutions are also equitable ones, and involve strengthening our public health care system.

Centralized wait-lists [can reduce wait times](#) by ensuring that patients see the next available specialist, rather than referral pathways that rely on who your physician knows. Electronic consults, where a primary care provider can get the opinion of a specialist without needing a physical assessment of the patient, can [improve access to specialist input while also reducing wait lists](#).

Team-based models can also use allied health professionals to reduce the wait lists for surgery. The [Calgary Acute Knee Injury Clinic](#) which employs primary care physicians and non-physician experts – for example athletic therapists - to assess and triage surgical referrals and significantly reduce the number of non-surgical candidates waiting on a surgeon’s wait list.

Many of these solutions are not exclusive to a publicly funded system. But potential scale of these solutions is greatest in a single-payer system when a government truly takes ownership for coordinating the system and feels the responsibility to provide the highest quality care to every individual at the lowest cost.

Myth 2: Private for-profit ownership of health care facilities leads to better health outcomes.

Some believe that contracting out care to private for-profit investor-owned corporations can lead to better health outcomes because investor-owned corporations will need to provide high quality care in order to generate demand for their services and thereby generate shareholder profits.

But neither the theory, nor the evidence support this.

[Health care does not act as a typical market good](#). Several conditions must exist for a free market to function appropriately. Markets assume that “consumers” (in this case patients) possess perfect information, yet patients typically lack the medical expertise needed to fully assess the quality of the care they are receiving.

Patients rely on a trusting relationship with their health care provider to navigate the system, as their physician suggests medications, referrals, or treatments that would be most beneficial. This essential relationship can be undermined if a patient is concerned that their physician's recommendations are guided by profit, rather than medical need. Patients are inherently in a vulnerable state, as the demand for health care is relatively [“inelastic”](#), which means that when someone needs health care, they are willing to pay any amount because there are few close substitutes for medical services.

Truth 2: The profit motive does not incentivize high quality care. In fact, for-profit delivery has been associated with increased mortality.

For-profit corporations are legally bound to deliver returns to their shareholders, shifting the focus from patient care to profits. [The profit motive creates the incentive to cut corners and deliver care that is lower quality and less safe.](#)

These forces may explain why [mortality in for-profit investor-owned long-term care homes in Ontario was 78% higher](#) than in non-profit homes during the COVID-19 pandemic, or why [one in seven private for-profit investor-owned clinics failed to meet the province's safety standards.](#)

A similar pattern is seen internationally. In the United States, a systematic review found that [for-profit hospitals were associated with a higher mortality rate compared to not-for-profit hospitals](#). In England, a study investigating the impacts of outsourcing health services to for-profit providers found that it [correlated significantly with increased rates of treatable mortality](#). Unfortunately, this practice has been consistently increasing in the last decade.

The Commonwealth Fund, which publishes comparisons of health care systems in high-income countries, have found [four features that lead to higher quality health outcomes](#):

1. Universal coverage without cost barriers
2. Investing in primary care and high-value care
3. Reducing the administrative burden for patients and providers
4. Investing in social services

While the fourth feature is a matter of broader social policy, the first three features are directly impacted by how health care is financed and delivered. A [2017 study published in BMC Health Services Research](#) looked at 22 health care systems among European Organisation for Economic Cooperation and Development (OECD) countries and compared trends in “amenable mortality” (premature death from conditions that should not occur in the presence of timely and effective health care). While all health care systems showed a decline in amenable mortality rates over time, systems owned by private for-profit investors showed a slowdown in the rate of decline compared to publicly-owned systems.

The study authors suggest that *“private for-profit providers are not able to achieve additional gains in the determinants of health care improvements...Indeed, private for-profit providers may have fewer*

resources to spend on care because of taxes and their over-emphasized cost control, which aims to achieve the highest possible return on investment. Consequently, this can result in less qualified staff and/or less investment on equipment or technology and can negatively impact health care related performance.”

Myth 3: Private financing will make health care more ‘efficient’.

It is tempting to believe that private spending will increase competition and lead to ‘efficiencies’ in the health care system. But a [multi-payer system is more complex and costly to administer](#) than a single-payer system.

We can see the burden of private financing on a health care system when we compare Canada and the United States. [In the US, 31% of all health care expenditures is spent on administrative costs. In Canada, it is 16.7% overall, but only 1.3% for Medicare](#). Canada’s private insurers, which provide coverage for parts of our health care system which are not covered by Medicare, have higher overhead compared to their counterparts in the US (13.2% vs. 11.7%).

Increased [private health insurance results in higher costs in the public system](#) and overall, as private reimbursement levels spill over into the public system. It can also drive increased demand for health care. Private markets erode cost-control measures that are a strength of public health systems – including global budgets, price regulation, and capacity controls.

Clearly, private health care is not more efficient than public health care.

Truth 3: Public health care is more efficient than private health care. A single-payer helps keep costs low.

[Single-payer systems spend less on administrative costs than multi-payer systems](#), which means more money for direct patient care.

Taiwan is one of the most recent examples of a recent high-income nation to implement a universal health care system, doing so in 1995. After studying health care systems around the world, they [adopted a national health insurance model](#) similar to Canada’s, with some notable differences: an emphasis on electronic health records and [public coverage for services not included in Canadian Medicare](#), including prescription drugs, dental care, and home nurse visits.

Taiwan has one of the [lowest administrative costs in the world](#), at less than 2% of total health care spending. To improve the efficiency of Canada’s health care system, we need *more* public health care, not less.

Myth 4: We can't afford publicly-funded health care.

We often hear calls for private financing when public health care is deemed “unsustainable”. Alarmists claim that rising health care costs will completely consume our government budgets, and that private financing is the only way to fund the services that are needed.

But Canada's [health care spending as a percentage of GDP](#) has been very consistent for the last decade , and [lands us in the middle of the pack](#) compared to our peers. Though public and private health expenditures in Canada have [grown by roughly the same amount over the last decade](#), Canada actually [spends less](#) on publicly-funded health care, as an overall share of health care spending, than many of our peers.

There are innovative Canadian examples of high-quality, efficient not-for-profit care. The [Kensington Eye Institute](#) in Ontario is a not-for-profit Independent Health Facility which specializes in performing simple surgical procedures efficiently. [The surgeons have an incentive to perform high quality surgeries quickly, but have no incentive to generate a profit for the facility by upselling patients, for example with additional fees for specialized lenses.](#)

Meanwhile, the government of Ontario's plans to contract out to private, for-profit clinics for cataract surgeries is [expected to cost the government 25% more per surgery than its not-for-profit centres.](#)

Public funding to investor-owned for-profit companies means public dollars for private profits.

Truth 4: We can't afford privatized health care.

Where Canada falls behind our peers is in **public health care spending**. [Only 70% of health care spending is public](#), putting us behind France, Germany, Sweden, Netherlands, New Zealand, and the UK.

[Canadian health care suffers from an investment problem](#). Our system faces many challenges, but many critical ones arise from the 30% of our spending that is already private pay, including:

- A lack of pharmacare that leaves [1 in 5 Canadians struggling to take their prescription medications](#). When people can't take their essential medications, this results in [worsening morbidity and mortality, and further strains our health care system](#).
- An inadequate long-term care system that results in [patients occupying acute care beds in hospital](#) despite not needing hospital-level care. This has downstream consequences, including worsening [emergency department overcrowding and access block](#).
- A dental care system that leaves [1 in 5 Canadians struggling to access health care](#), simply because their ailment originates in their mouth.

Conclusion:

Canada's health care system is built on the principle that access to care should be based on need, not ability to pay. A well-designed, adequately funded, single-payer system can provide high-quality, efficient, equitable care to restore that reality.

Our publicly-funded health care system is certainly facing challenges. But the solutions lie in strengthening our public health care system, not weakening it.

Introducing private payment prioritizes care based on ability to pay, not need. It leads to worse access and wait times, and higher costs in the public system. It also leads to increased administrative costs – that's more money for insurance companies, and less money for care.

There is little evidence that private for-profit investor-owned corporations can provide better quality care or reduce costs. In fact, there are many examples to the contrary.

Those seeking to improve quality, access, or efficiency of health care services in Canada should focus on public solutions to improve our current system, rather than seeking to dismantle it.