POLICY BRIEF:
Updating Canada's Health Act to Allow for Choice

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Executive Summary

Canada is unique in the world in that various government policies and regulations have been implemented to obstruct patients' access to non-government health care services outside of the public system. Many of these barriers stem from Ottawa's interpretation of the *Canada Health Act (CHA)* and provincial regulations which have been set according to federal guidelines.

With the exception of Quebec, government barriers result in patients being unable to seek treatment locally outside of the public system. To put it plainly, a patient in Toronto cannot pay for a hip operation in their own province due to government policies. They can either wait for the government to provide treatment someday or pay for treatment in another province or another country.

The situation comes as Health Canada took an aggressive interpretation of its provisions in various ministerial letters and applied the prohibition against double and extra billing to deduct federal transfer payments. Although the Supreme Court of Canada struck down the prohibition against private insurance over 20 years ago – ruling in favour of a Quebec patient and doctor who challenged the ban in 2005 – Quebec's privately funded health sector has been muted, and relatively few physicians have opted out of the public system. The Chief Justice's observation in *Chaoulli v. Quebec* that "access to a wait list is not access to health care," has not been embraced or taken seriously in the intervening years, with waitlists having spread and grown to afflict virtually every health care service delivered under medicare.[1] As of 2023, the Montreal Economic Institute has reported that the government only allows Quebec patients to purchase health insurance that covers knee replacement surgery, hip replacement surgery and cataract surgery – a combination of surgeries that are far too restrictive in scope to offer a market for private insurance providers.[2]

Ultimately, barriers on non-government health providers restrict access to health care and put unnecessary pressure on the public system, as Canadians who are willing to pay for treatment are forced to rely on public system waitlists unless they are prepared to travel and pay for treatment in private clinics in another province or outside the country.

Banning private payment for medically necessary health care services has contributed to a crisis in Canada's health care system. Whatever innovation, flexibility and timely high-quality health care that might arise from allowing alternatives, governments effectively suppress them in the interest of a rationed monopolistic system. Across the country, patients are facing a lack of family doctors, record wait times, specialist shortages, and old and outdated health care infrastructure. Despite whatever budgetary excuses governments have used to justify their monopoly, provincial governments are funding health care at the highest levels in history.

This policy brief examines specific changes needed at the federal level to give patients more choice: to obtain their medically necessary health care services through the public system or to pay for those services themselves through a non-government health care provider.

Speaking broadly, there are three policy solutions available to the federal government. The first and simplest is to keep the public system but allow private options. Modest amendments to the CHA and related documents would accomplish this goal. This would then leave the choice of what types of private health care services to permit entirely up to provincial governments.

The second solution would be for the federal government to permit privately paid health care for medically necessary services but on such conditions that would guarantee ongoing commitments to the medicare system. These could include guarantees of minimum hours spent delivering health care to publicly insured patients.

The third solution would be to positively incentivize the development of a mixed delivery model of health care for Canadians. Such an approach would use the federal funding power to drive innovation, cost-effectiveness and an effective mix of public and private models of care.

This paper illustrates how very simple changes to the *Canada Health Act (CHA)* would effectively leave constitutional responsibilities over health care to the provinces. Highlights include:

- Amendments to the CHA itself could be very modest. The CHA did not always prohibit private health care, and federal legislation can be amended to allow this option outside of the public system.

- The various interpretation letters used by a succession of ministers designed to restrict access to private options outside of the public system could be cancelled or replaced.

With only these minor changes to its terms, the CHA would permit provincial health care plans to allow Canadians the same choices enjoyed by patients in Sweden, France, Australia, and every other developed country with universal health care systems – namely, to receive medically necessary health care services through the provincial plan or to pay for them privately.

Allowing such a choice at the federal level, combined with removing the many provincial barriers, would also take pressure off of Canada's strained universal system. Every patient who decides to pay directly, or through insurance, for non-government funded health services, is one less person on a government waiting list.

Background

Passed in 1984, the *Canada Health Act (CHA)* is an 18-page piece of legislation that outlines the federal government's requirements for provincial and territorial governments to receive health care funding from the federal government.[3] Contrary to popular belief, the legislation does not explicitly ban Canadians from paying for medically necessary health services.

The ban on extra billing and user fees, including the federal government's interpretation of other elements in the *Canada Health Act* and the related regulations, have enabled Ottawa to impose penalties on provincial governments that allow private payment for medically necessary health care services. For instance, in 2023, the federal government reduced health funding to eight provinces by a combined $82 million. These provinces had allowed patients who did not want to wait for the public system to pay for private diagnostic scans and other health care services out of their own pockets.

According to Harvard Professor William Hsiao, no other developed nation prevents patients from paying privately for medically necessary health care services.[4]

The federal government's position against patients accessing non-government health care outside of the public system, stands in stark contrast to the famous 2005 Supreme Court of Canada (SCC) ruling, *Chaoulli v. Quebec*.[5] Jacques Chaoulli, one of the appellants in the case, challenged provincial bans on private payment, successfully arguing it contravened Quebec's Charter of Human Rights and Freedoms.

In that case, the SCC held that the government could not fail to provide timely care through state-sanctioned wait lists and at the same time prohibit patients from paying with their own resources. The other provinces refused to apply Chaoulli on the grounds that it was based on the Quebec Charter. Even in Quebec, however, it is clear that private health care has struggled against an array of administrative and practical obstacles.

The Fraser Institute released data in late 2024 showing wait lists in Canada's public system are at an all-time high, with waits averaging about 30 weeks for a Canadian patient (referral from a general practitioner to receiving treatment).[6] These record wait times have very real consequences, with SecondStreet.org having identified more than 74,000 cases where Canadians patients died while waiting for health care since 2018.[7] One such story is that of Debbie Fewster who died before receiving heart surgery, nearly two months longer than the medically recommended wait time.[8]

Stories like Debbie's are tragic, but sadly not uncommon in Canada. Without meaningful reforms, there could be many more heartbreaking stories with an estimated 5.1 million Canadians on wait lists for health care as of 2024.[9]

Thankfully, the public is ready for health reform – including allowing patients to choose between using the public system or private options. An October 2024 poll by Leger (commissioned by SecondStreet.org) found that 61% of Canadians support the idea of keeping our nation's public system but allowing patients to pay for private care if they want to (directly or through insurance).[10]

Methodology

SecondStreet.org contracted the law firm Fasken Martineau DuMoulin LLP to identify the exact legislative changes required to the CHA to allow provincial governments to give patients a choice: to use the public system or to pay for treatment privately (either directly or through private insurance). The proposed changes would give provincial governments the assurance that they could allow such choice without facing funding reductions from the federal government.

This approach is not the only one available to the federal government, and any changes would require legislative changes at the provincial level.

Legal Analysis

Changes required at the federal level to facilitate choice for patients could be addressed by amending the CHA and the related regulations as well as withdrawing or cancelling the interpretation letters issued by the federal Minister of Health.

Changes to the Canada Health Act

Getting the federal government out of the way could be accomplished simply by including the following provision in the CHA:

> Notwithstanding any other provision of this Act, nothing in this Act shall prevent a province from authorizing or permitting any person to charge or accept payment from an insured person, directly or indirectly, for an insured health care service, and where a province authorizes or permits any such charge or payment to be made,
>
> a. the province will not thereby be found to have failed to satisfy the criteria described in sections 8 to 12;
>
> b. the amount so paid shall not be deducted from the cash contribution payable by Canada to such province as part of the Canada Health Transfer;
>
> c. the amount so paid shall not, unless it is in addition to the amount paid or to be paid for that service by the health care insurance plan of the province, constitute extra-billing; and
>
> d. the amount so paid shall not constitute a user charge.

Withdraw Interpretation Letters:

The interpretation letters issued by federal Ministers would no longer be relevant after the amendments to the CHA. They could be withdrawn or replaced entirely with interpretation letters that embrace provincial innovation and allow private options outside of the public system.

Policy Options

This approach leaves it up to the provinces to do the heavy lifting of deciding what private health care services to permit and encourage, and how to manage the medicare system in light of new patient choices and the competition which comes with that new reality.

As noted, a second option for the federal government would be to permit privately paid health care for medically necessary services, but on conditions that would guarantee professionals fulfill reasonable commitments to the public system. These might include guarantees of minimum hours spent delivering health care to publicly insured patients.

The third option would be to incentivize the development of a mixed delivery model of health care for Canadians that would use federal funding power to drive innovation, cost-effectiveness and an effective mix of public and private funding. For instance, Ottawa could structure its health care funding formula to incentivize provinces to grant more choices to patients outside of the public system. Currently, this formula is structured so health care reform or innovation is penalized with a reduction in federal health funds whenever choice is allowed. Under this third approach, the inverse would be true. Government funding would be tied to provinces that harness innovation, entrepreneurship and effective reform to provide patients choice and to reduce health care barriers and wait times.

An example of Ottawa using its funding powers to incentivize reform can be found in its Housing Accelerator Fund.[11] Specifically, the fund provides funding to municipal governments that change their zoning policies to allow for densification.

Conclusion

Media across Canada regularly report on stories of patients suffering while they wait for treatment in the public health care system. Some readers may have experienced trauma themselves or observed it directly while caring for loved ones. Data shows thousands of patients even die while waiting for health services – some passing away while waiting for potentially lifesaving treatment.

Despite the staggering crisis facing our nation, Canada continues to be the only developed country that prohibits patients from paying privately for medically necessary health care. Other nations do not have such bans, as private options help take pressure off their public systems.

It would be wise for Canada's federal government – at a minimum – to continue to fund public health care, but also to remove all legislative and regulatory barriers that prevent patients from accessing non-government health care. This would liberate the heavily constrained and burdened professionals working within the system and better enable innovation in all aspects of health care delivered in Canada.

About the Authors

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