POLICY BRIEF:
Legislative Changes for Health Care Choice in Ontario

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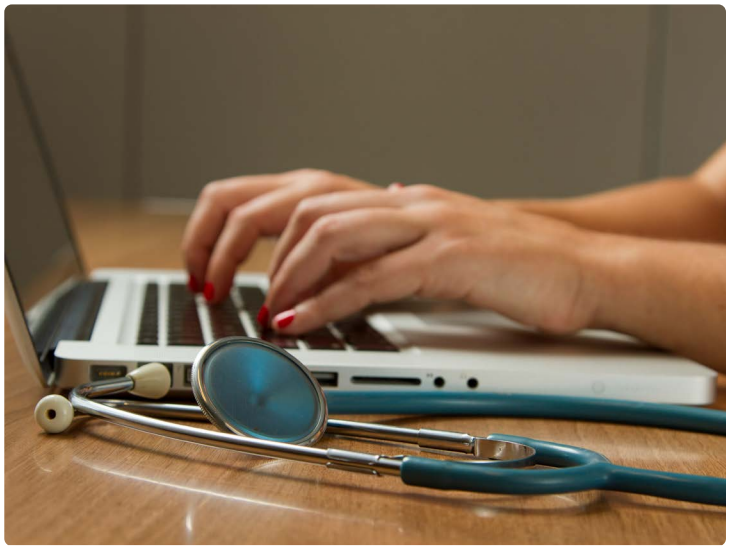

Executive Summary

Across Canada the health care system is in crisis. Millions of patients don't have family doctors, wait times for surgeries are often beyond the maximum recommended wait time and each year thousands of patients die while waiting for treatment. These outcomes occur despite Canada being among the top spenders on health care (as a share of GDP) in the OECD.

One problem is that government policy in Canada is designed to force all patients to depend on the state for health care. Peer nations with better-performing systems – Sweden, Germany, France, Japan and Australia to name a few – do not require all patients to depend on the government for health care. This eases the pressure on their public systems when some patients decide to pay privately (directly or through insurance).

In 2025, SecondStreet.org released legal analysis on the legislative changes needed at the federal level to make it clear that provincial governments could allow patients to pay privately if they didn't want to use the public system (without triggering federal funding reductions). This policy brief includes legal analysis on the changes that are necessary in Canada's largest province, Ontario, to allow patients the option of paying for treatment at non-government health providers.

Key recommendations outlined would allow for the establishment of new private hospitals, the provision of private insurance for medically necessary health care services, and the ability of physicians to accept payments from sources other than the public insurance plan. These changes would bring Canada more in line with the aforementioned public systems among countless others). Of course, many of these countries also implement guardrails to ensure a robust public sector continues to function.

Additional reforms could expand the options for where diagnostic equipment can be located, allow public hospitals to autonomously choose to lease their premises for alterative care options, and allow privately owned (publicly funded) Integrated Community Health Services Centres to charge facility and other fees for services that do not share costs with the public system.

Again, allowing such a choice would help take pressure off Canada's public system as some patients decide to pay for private treatment. Such a move would not solve all the problems in Canada's health care system, but it is one measure that could be enacted to reduce wait times and build a more robust and innovative health care system.

Introduction

Several government policies and regulations significantly restrict Ontario patients' access to non-government health care services in the province. Some of these barriers stem directly from the Canada Health Act (CHA), which sets the

terms and conditions under which provinces receive federal dollars. However, there are also significant regulations at the provincial level in Ontario that both reinforce these barriers, and at times go beyond what is strictly required by the letter of the federal CHA.

This combination of laws at the federal and provincial level results in patients being generally unable to seek alternative options for treatment outside of the public system. For example, government policies mean that patients in Toronto cannot simply pay for a hip operation in their own province even if they face unreasonable wait times at clinics within the public system. They must either wait for government funded treatment someday or pay for treatment in another province or another country.

These barriers not only restrict choice and access to timely health care, but they also put unnecessary pressure on the already burdened public system. Canadians who may be willing (and able) to pay for treatment from a non-government provider are currently forced to rely on public system waitlists—resulting in a longer public queue than there likely would be otherwise.

In 2025, SecondStreet.org contracted Fasken Martineau DuMoulin LLP (Fasken) to identify the changes required to the CHA to allow patients the choice to pay for medically necessary health care. This report builds on that analysis by examining legislative and regulatory barriers that specifically prevent Ontario patients from paying for medically necessary health care outside of the public system. Fasken identified seven provincial statutes that would need to be either amended or repealed entirely to allow for the emergence of meaningful private payment options.

Background

Passed in 1984, the CHA outlines the requirements placed on provincial and territorial governments in order to receive health care funding from the federal government.[1] Contrary to popular belief, the legislation does not explicitly ban Canadians from paying for medically necessary health care services.

The CHA requires dollar-for-dollar reductions for any reported "extra billing" and "user charges" for medically necessary health care services. It also gives Ottawa the discretion to impose further penalties for any perceived violations of the five pillars of the Act.[a] In 2025, the federal government reduced health funding to eight provinces by a combined $62.2 million (although $51.9 million was reimbursed).[2] These provinces had simply allowed patients who did not want to wait to receive health care (including diagnostic scans) in the public system to pay for such services out of their own pockets.

The reality is that many Canadians face remarkably long wait times within the public system. According to the Fraser Institute, patients in Canada faced a median wait time of 28.6 weeks last year for elective surgery (i.e. a non-emergency surgery that is planned and scheduled in advance).[3] Although Ontario has the shortest wait times in Canada, patients still faced a median 19.2 week wait between referral to treatment—20 percent longer than the 16 week wait time in 2019 before the pandemic.[4] These wait times have very real consequences. In fact, SecondStreet.org has identified more than 100,876 cases since 2018 where Canadian patients died while waiting for various health care services (of which 61,780 were in Ontario).[5]

One such story is that of Judy Anderson, who lost two daughters while they waited for heart procedures.[6] Stories like Judy's are tragic but sadly not uncommon in Ontario (and Canada, more generally). Without meaningful reforms, there

[a] Extra-billing occurs when a patient pays for a health care service that the provider also bills to the provincial health insurance plan. User fees (or charges) are any other amounts a patient may need to pay in order to access publicly insured health care services.

could be many more heartbreaking stories, with an estimated 3.7 million Canadians on wait lists for health care in 2025.[7]

Thankfully, the public is ready for health care reform—including by allowing patients to choose between using the public system and private payment options. A 2025 Leger poll commissioned by SecondStreet.org found that 56% of Ontarians support the idea of keeping the public health care system but allowing patients to use their own money—or their extended health insurance—to pay for surgery at local private clinics if they cannot get timely care in the public system.[8]

Allowing private payment alternatives to the public system is important, as private payment options can help take pressure off public systems. In fact, all better-performing universal health care systems in the world allow such a choice. Canada is an outlier by attempting to force patients to depend on publicly paid for health care for treatment.

In 2025, SecondStreet.org contracted Fasken 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).[9] This research builds on that work by identifying the changes necessary at the provincial level in Ontario to allow for private payment options.

Methodology

Fasken was asked to identify the specific changes required to Ontario laws to allow Ontario residents the choice of paying for medically necessary health care in that province. The work assumed that the changes to the CHA identified in 2025 were in place. Fasken identified those changes, and others, that would provide Ontarians with a meaningful choice to pay for medically necessary health care.

Legal Analysis

Fasken identified seven Ontario statutes that would require amendments, additions or (in one case) repeal. A brief explanation of each statute (or specific sections that constitute significant barriers) is included for context where necessary.

1. Repeal the *Commitment to the Future of Medicare Act*[10]

   Additional Context: Introduced in 2003 by the McGuinty government, the preamble of Bill 8 (as it was known at the time) specifically supports "the prohibition of two-tier medicine, extra billing and user fees". Not only does it reinforce certain problematic aspects of the CHA, but it goes beyond that by explicitly prohibiting physicians and designated practitioners from accepting any payment from any sources other than government for publicly insured medical services. Unlike other provinces that may have similar restrictions on physicians opted-into the respective provincial insurance plans, this legislation applies to all physicians – thereby making Ontario the only province in Canada where physicians cannot effectively opt-out of the government insurance plan and choose to receive private payment for services that are insured by the public plan.

2. Amend the *Health Insurance Act* to[11]

   a. Repeal Section 14 (Other insurance prohibited)

   b. Add the following: Notwithstanding any other term of this Act, nothing in this Act shall prevent a physician or practitioner from charging a patient for health care services at such rates and on such terms and conditions as the physician or practitioner determines to be reasonable; provided that the physician or practitioner has not also received payment for such services from the Plan or any other provincial government payor.

Additional context: Broadly speaking, this Act defines the Ontario Health Insurance Plan (OHIP) in terms of administration, eligibility, coverage, and payment. In doing so, section 14 of the Act prohibits any other insurance plan from covering all or any part of the cost of any insured services (with some exceptions) performed in Ontario for any person eligible for coverage by the provincial plan. This constitutes a clear barrier to private insurance for medically necessary health care services. In addition, section 15 effectively requires physicians and hospitals to only directly bill the provincial plan for insured services, and accept payment by the plan as full reimbursement for the services rendered.

3. *Public Hospitals Act* to[12]

1. Add the following:

Notwithstanding any other term of this Act, nothing in this Act shall prevent a public hospital from leasing or licensing premises which constitute excess capacity to another entity for the provision of health care without the consent of the Minister.

Additional context: While a system whereby patients could have the option of paying for medically necessary health care services could be enacted without this change, allowing hospital premises to be leased to other clinic operators when it is not otherwise being used (e.g., at night, on weekends), will unleash resources to allow wait times to be significantly reduced.

4. *Integrated Community Health Services Centres Act* to[13]

1. Add the following:

Notwithstanding any other term of this Act, nothing in this Act shall prevent an integrated community health services centre from charging a patient for any goods or services provided to a patient within the premises operated by the integrated community health services centre at such rates and on such terms and conditions as the integrated community health services centre determines to be reasonable; provided that the integrated community health services centre has not also received payment for such goods or services from the Plan or any other provincial government payor; or

5. *Private Hospital Act* to[14]

1. Repeal the definition of "private hospital" set out in Section 1 and add the following in its stead:

"private hospital" means a building or other premises that has been licensed as such by the Minister but not any part of the building or premises that has been leased or licensed to a person other than the holder of the private hospital licence.

2. Add the following:

Notwithstanding any other term of this Act, nothing in this Act shall prevent a private hospital from charging a patient for any goods or services provided to a patient within the premises operated by the private hospital at such rates and on such terms and conditions as the private hospital determines to be reasonable; provided that the private hospital has not also received payment for such goods or services from the Plan or any other provincial government payor.

3. Repeal Section 3(1) which limits the issuance of private hospital licenses to those who held licenses prior to October 29, 1973

4. Repeal the following sections which limit the activities of private hospitals: Section 3(2), 22 and 33(1)(a).

5. Add the following:

   No person may hold themselves out as operating a hospital in Ontario unless the person has been designated as a public hospital under the Public Hospitals Act or is the holder of a licence issued under this Act.[b]

   Additional Context: While Ontario has a handful of private hospitals, various provincial governments have sought to eliminate private hospitals over the years. Notably, no new private hospital has been licensed since 1990 and no new licenses are permitted to be issued under the current law. The Act currently employs a broad definition of "private hospital" which effectively prohibits the creation of any new private overnight surgical facilities. The proposed amendments will limit the meaning of the term private hospitals to those hospitals specifically licensed as such, remove the general prohibition on the operation of overnight facilities, and provide flexibility for rates charged (so long as the costs are not shared with the provincial plan).

6. Amend the *Healing Arts Radiation Protection Act* ~~is~~ to[15]

   1. Repeal Section 23 which limits the locations in which C.A.T. Scanners may be operated.

      Additional Context: Section 23(3) explicitly states that no person shall install or operate or cause or permit the installation or operation of a computerized axial tomography scanner unless it is installed and operated in a hospital or facility that is designated by the Minister.

7. Amend the *Regulated Health Professions Act* and Regulation 107/96 to[16]

   1. Add the following to the *Regulated Health Professions Act*:

      Notwithstanding any other provision of this Act, it is not an act of professional misconduct:

      a. where a physician refers a patient for products or services to a corporation or other entity in which the physician has an interest so long as the relationship is disclosed and acknowledged by the patient; and

      b. to set and collect fees from a patient or any other person on behalf of the patient, at any rates that the physician determines are appropriate and the patient or such other person agrees to pay.

   2. Delete Section 7.9(4) and all references to it in Regulation 107/96 to the *Regulated Health Professions Act* in order to allow MRI machines to be operated by physicians and other authorized health professionals wherever an MRI machine is located.

      Additional Context: Currently, the *Regulated Health Professions Act* and Regulation 107/96 allow authorized health professionals to "apply electromagnetism" to patients using an MRI machine if it is located in one of three locations: the site of a public hospital graded under the Public Hospitals Act as a Group N site of the

[b] By eliminating Section 3(1) and adding this new provision, we will remove the uncertainty relating to the legality of overnight treatment centres, including those for addiction or other recovery programs.

hospital, an integrated community health services centre [ICHSC], or an unlicensed facility operated by, and located on the same premises as, an ICHSC licensed for MRI. These changes broaden possible locations for MRI machines, clarify rules around ethical conduct relating to referrals to private facilities, and explicitly allow for private payment at rates determined by the providers.

Discussion

It is important to recognize upfront that the adoption of these proposed changes would create a situation where the public universal health care system continues while also allowing patients the option of paying for treatment of medically necessary services at non-government providers. Key recommendations outlined would allow for the establishment of new private hospitals, the provision of private insurance for medically necessary health care services, and the ability of physicians to accept payments from sources other than the public insurance plan.

The removal of restrictive policies would bring Ontario's health care system closer to those of other countries that provide universal health care. For example, whereas Ontario currently restricts the establishment of new private hospitals, universal health care systems like those in Australia, Germany, France and Switzerland have a significant number of private hospitals that function within or alongside those operated within the public system.[17] And while Ontarians are only able to purchase supplementary private insurance (i.e. for treatments not covered by the public plan), other universal health care countries (like Sweden, the UK, Australia and Ireland) allow residents to purchase private insurance that covers the cost of medically necessary health care services.[18] It is worth noting that similar barriers to private insurance for medical services in Quebec were deemed to contravene the Quebec Charter of Human Rights and Freedoms in the seminal Chaoulli Decision (2005).

Ontario's current restrictions on the ability of physicians to accept payment for medically necessary health care services contrast with the approach not only in other universal health care countries, but in other provinces as well. While many provinces may have similar limitations for opted-in physicians, they all allow physicians to opt out of the public plan.[19] Some, like Alberta, will go further and soon also allow physicians to be both part of the public plan and practice privately (and accept private payment) under a "flexibly participating" physician model.[20] Ontario's restrictions on physicians accepting private payment from any other source effectively means it is the only province without an opt-out option.

Other universal health care countries (like Australia, France, Germany, Denmark, Japan, the Netherlands, and the United Kingdom) understand that allowing mixed (dual) practice for physicians is a fundamental component of a well-functioning universal healthcare system. Of course, many of these countries also have guardrails to ensure a robust public sector.[c]

Other changes proposed would expand the options for where diagnostic equipment can be located, allow public hospitals to autonomously choose to lease their premises for alterative care options, and allow privately owned (publicly funded) ICHSC to charge facility and other fees for services that do not share costs with the public system.

[c] For example, dual-practice physicians in Germany must commit to working at least 25 hours for the public system before they can provide private care. In France, the requirement is five "half-days" and private activity is capped at 20% of physicians' public activity. In the United Kingdom, doctors who have contracts with the public National Health Service (NHS) must generally prioritize their duty to the public hospital.

Conclusion

Despite the well-documented deterioration of Ontario's public health care system, provincial laws continue to limit (or outright prohibit) the emergence of meaningful private alternatives. As a result, patients face inordinately long waits within the confines of the government-run system with few (if any) options to pay for private care locally. The combination of provincial restrictions and the federal Canada Health Act result in a system characterized by policies that are out of step with other universal health care countries.

It would be wise for the Ontario government—at a minimum—to continue to fund public health care, but also to amend or repeal all legislative and regulatory barriers that currently prevent patients from accessing non-government health care. Should the Ontario government decide it wishes to proceed with such changes to allow more choice, it may also want to copy what Alberta has proposed, and what many jurisdictions in Europe have done, which is to implement some guardrails around when staff in the public system can work at non-government clinics and serve patients who are paying for health care services.

Implementing the recommendations outlined in this policy brief would liberate the heavily constrained and burdened professionals working within the system, improve patient choice and access, and better enable innovation in all aspects of health care delivered in Ontario.

References

1. Canada. *Canada Health Act, R.S.C., 1985, c. C-6;* 1985. https://laws-lois.justice.gc.ca/eng/acts/c-6/index.html.
2. Canada, H. *Canada Health Act Annual Report 2024-2025.* https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2024-2025.html (accessed 2026-04-14).
3. Moir, M.; Esmail, N. *Waiting Your Turn: Wait Times for Health Care in Canada, 2025 Report;* Fraser Institute, 2025. https://www.fraserinstitute.org/sites/default/files/2025-12/waiting-your-turn-2025-17913.pdf.
4. Barua, B.; Moir, M. *Waiting Your Turn: Wait Times for Health Care in Canada, 2019 Report*. Fraser Institute. https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2019 (accessed 2023-08-16).
5. Craig, C. *Died on a Waiting List 2025;* 2025. https://secondstreet.org/wp-content/uploads/2025/11/Policy-Brief-Died-on-a-Waiting-List-2025-Edition.pdf (accessed 2026-01-24).
6. SecondStreet.org. *Mother Loses Two Daughters Due to Waiting Lists*; 2021. https://www.youtube.com/watch?v=-yq5vkYY-KI (accessed 2026-04-26).
7. Lucyk, D. *Medical Waitlists Grow Beyond COVID Backlog*. SecondStreet.Org. https://secondstreet.org/2025/09/24/medical-waitlists-grow-beyond-covid-backlog/ (accessed 2026-04-14).
8. Craig, C.; Barua, B. *Another Poll Shows Canadians Support Health Reform*; SecondStreet.org, 2025. https://secondstreet.org/wp-content/uploads/2025/11/Policy-Brief-Another-Poll-Shows-Canadians-Support-Health-Reform.pdf (accessed 2026-04-14).
9. Craig, C.; Fleming, H. Updating Canada's Health Act to Allow for Choice. 2025.
10. Ontario. *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c. 5. https://www.ontario.ca/laws/statute/04c05 (accessed 2026-04-15).
11. Ontario. *Health Insurance Act, R.S.O. 1990*, c. H.6. https://www.ontario.ca/laws/statute/90h06 (accessed 2026-04-15).
12. Ontario. *Public Hospitals Act, R.S.O. 1990, c. P.40*. https://www.ontario.ca/laws/statute/90p40 (accessed 2026-04-15).
13. Ontario. *Integrated Community Health Services Centres Act, 2023, S.O. 2023, c. 4, Sched. 1 | Ontario.ca.* https://www.ontario.ca/laws/statute/23i04 (accessed 2026-04-15).
14. Ontario. *Private Hospitals Act, R.S.O. 1990, c. P.24.* https://www.ontario.ca/laws/statute/90p24 (accessed 2026-04-15).
15. Ontario. *Healing Arts Radiation Protection Act, R.S.O. 1990, c. H.2.* https://www.ontario.ca/laws/statute/90h02 (accessed 2026-04-15).
16. Ontario. *Regulated Health Professions Act, 1991, S.O. 1991, c. 18.* https://www.ontario.ca/laws/statute/91r18 (accessed 2026-04-15).
17. Barua, B. *Health Care Partnerships and Hospital Funding*; SecondStreet.org, 2025.
18. OECD. *Population Coverage for Healthcare: Health at a Glance 2025*; 2025. https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en/full-report/population-coverage-for-healthcare_5c968b73.html (accessed 2026-04-15).
19. Canadian Medical Association. *Opting in and out of public medical practice across Canada | CMA*. https://www.cma.ca/our-focus/public-and-private-health-care/opting-and-out-public-medical-practice-across-canada (accessed 2026-04-15).
20. Alberta. *Bill 11: HEALTH STATUTES AMENDMENT ACT, 2025 (NO. 2)*. https://docs.assembly.ab.ca/LADDAR_files/docs/bills/bill/legislature_31/session_2/20251023_bill-011.pdf (accessed 2026-04-15).