Commentary: The Fraying at the Edges of the Public Healthcare System in Canada

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Abstract

Since the passage of the Canada Health Act in 1984, advocates for private finance in Canada have challenged the CHA and its underlying access and equity principles. Such challenges have grown in recent years to encompass, among other things, facility fees, membership fees, private virtual care, private interprovincial surgery clinics, and private practice nurse practitioners. The continued technological and organizational evolution of healthcare will expand and complicate this further over time. A multi-pronged approach is needed that includes expanded data to support research on the impacts of such activity, new regulatory frameworks, and coordinated action across levels of government.

Introduction

Fraying at the edges of Canada's public healthcare system is not new. The Canada Health Act (1984), after all, was triggered by physicians' and institutions' extra-billing practices that undermined the 1966 Medicare Act's principle of universal access (Health Canada, 2023; M. G. Taylor, 1986; Vayda and Deber, 1992). Challenges to the CHA principles by both private actors and provincial governments have arisen regularly in the four decades since its passage (CBC News, 2023; Flood and Thomas, 2020; Glauser, 2011; Gray, 2000; Health Canada, 2023; Minister of Health Diane Marleau, 1995; Minister of Health Jane Philpott, 2016; Silversides, 2008). At present, however, challenges to the CHA— and more generally to access and equity — appear to be greater in number and variety than ever before (Canadian Medical Association (CMA), 2024a). It is useful to catalogue some of the most prominent challenges today and discuss some of their implications.

We focus on private financing that challenges first-dollar public financing for medically necessary medical care. This issue is analytically and legally distinct from private, for-profit delivery of medical services. The CHA is silent on the private/public, profit/non-profit status of providers of care, and multiple provinces publicly finance the delivery of medical care by for-profit providers. In practice, however, these two issues become entangled because many of the financing challenges noted below emanate from private, for-profit providers of care. Further, because private capital seeks greater financial returns, an increased presence of for-profit providers, especially equity-owned for-profit providers, can increase pressure to expand private financing that generates increased profits. This is true even if a for-profit provider's core activity is the delivery of publicly financed care. Indeed, some of the efforts to integrate private financing arise alongside and as part of the delivery of publicly financed, medically necessary care. This practical entanglement of financing and delivery modalities means that, even though our primary focus is private financing, one can't avoid some discussion of the role of for-profit providers. It is beyond the scope of this short commentary, however, to discuss evidence regarding the relative performance of public and private, for-profit providers with respect to quality of care and efficiency (see, e.g., Goodair and Reeves (2024) and Schneider, Zaslavsky, and Epstein (2005), Devereaux et al.(2002) for reviews of such evidence).

The Fraying Edges

Despite Health Canada's 1995 interpretation letter clarifying that facility fees linked to the delivery of medically necessary care violate the CHA (Health Canada, 2023; Minister of Health Diane Marleau, 1995), such fees persist and, indeed, patients seeking care through private clinics have faced an

array of other, similarly spirited fees — block fees, fees for surgical supplies (e.g., drugs), and accessory fees (e.g., eye drops, extra tests, bandages) — for services linked to medically necessary care (Armstrong, 2000; Health Canada, 2023; Longhurst, 2023; Ontario Health Coalition, 2024; Quesnel-Vallée et al., 2020). Concierge medicine offered through private physician-led executive wellness clinics use private-pay membership or enrolment models that entitle members to a basket of insured and non-insured services for a defined period of time, usually one year (Bodner et al., 2022; Reid, 2017), charging fees that can range from a few hundred dollars per year to over nine thousand dollars per year (e.g., MEDCAN 2024; Clinic de Santé 2024). These private clinics claim that the membership fees apply only to services not covered by provincial health insurance (e.g., advanced wellness checks), but in some instances, membership fees are mandatory for all services including insured physician services (Health Canada, 2023, 2024). Regardless of the true obligatory nature of the membership fee, patients may believe the membership is mandatory for any access to healthcare or they may believe the membership is necessary to access the same quality of care as those who pay the membership. Furthermore, many patients are unable to distinguish between medically necessary, insured services, and alternative, uninsured health services, and are therefore dependent on their healthcare provider who is in a position of trust with access to information the patient does not have or does not understand (Bodner et al., 2022). This asymmetric relationship leaves patients vulnerable to manipulation through exaggerated wait times, pressure to purchase upgrades for fear of losing access to expedited care, and the provision of unnecessary tests, procedures, and goods (Armstrong, 2000; Flood et al., 2015; Longhurst, 2023; Ontario Health Coalition, 2024).

Although the private delivery of publicly funded surgical and other services is fully compatible with the CHA, as provincial governments increasingly contract with private, for-profit healthcare providers the problem of "upselling" grows (Longhurst, 2023). Upselling refers to the practice of recommending, sometimes with considerable pressure, unnecessary and even inefficacious options and upgrades not covered by the public plan (Bodner et al., 2022; Ontario Health Coalition, 2024). Public-private ophthalmology clinics in Ontario and Alberta, for example, have been accused of pressuring patients—at times with the promise of shorter wait times—to purchase expensive upgrades, including excessive fees for "premium" lenses, tests, and procedures, and even warranties and registration fees (Cuttler, 2023; Health Canada, 2023; Ontario Health Coalition, 2024).

The evolution of technologies and healthcare delivery methods makes it possible to exploit "loopholes" in the CHA not anticipated in 1984. Advances in the provision of diagnostic services represent one of the earliest examples of this. As early as 1982, Quebec began delisting certain diagnostic tests such as mammograms, thermography, and ultrasonography if delivered outside a hospital (Quesnel-Vallée et al., 2020). In the 1990s, the advances in diagnostic technology facilitated the delivery of CT and MRI diagnostic services in free-standing clinics and provinces moved to restrict publicly insured CT and MRI diagnostic services to those delivered to hospital inpatients and outpatients, opening the door for private clinics to charge fees for diagnostic services outside the hospital (Brooks, 1993; CADTH, 2023). The set of such services expanded over time until the federal government finally responded in 2020 with the Diagnostic Services Policy that formalized its position that diagnostic services are insured services (Health Canada, 2024; Library of Parliament, 2019). Most provinces now prohibit out-of-pocket fees for medically necessary diagnostic services. Saskatchewan, however, continues to fight the federal government on this issue despite reductions in their health transfer payments due to its 2016 Patient Choice Medical Imaging Act, which allows private for-profit MRI clinics to charge private patients for medically necessary imaging as long as for each private-pay scan, two scans are provided to public patients (Government of Saskatchewan, 2016; Ontario Health Coalition, 2017; Sciarpelletti, 2024).

Virtual care and interprovincial surgical centres have emerged as another opportunity to expand private finance. In 2016, the virtual healthcare app Maple became one of the first private-pay virtual healthcare modes for accessing physician services in Canada (Frangou, 2023). The absence of billing codes for virtual care in provincial insurance plans implied that virtual care was not an insured service. The COVID-19 pandemic initially gave these private-pay virtual clinics a boost. But as provincial insurance plans introduced virtual-care billing codes to facilitate remote physician visits during pandemic restrictions and social distancing measures (Canadian Medical Association (CMA), 2022), the private virtual clinics pivoted to care models based on the use of out-of-province physicians or non-physician providers such as nurse practitioners (Crawley, 2023). Interprovincial care models exploit the limitations in provincial insurance plans that restrict a provincial resident's insured coverage to only those medically necessary services delivered in their home province, except for out-of-province emergencies or when such services are pre-approved (Crawley, 2023; Government of Canada, 2019; P. Taylor, 2019). Private interprovincial surgery clinics, therefore, charge out-of-province patients privately for otherwise insured physician surgeries in the patients' home province, facilitated through virtual consultations (see for example, Surgical Solutions Network (2024)). For patients, the private-pay interprovincial options provide expedited surgeries for common

wait-listed procedures (e.g., cataract surgery, knee replacement surgery, hip replacement surgery, hernia repair).

Nurse practitioners were rare when the Canada Health Act was enacted in 1984. Hailed as a potential solution to the primary care shortage in remote and underserved areas, nurse practitioners were paid a salary and worked primarily in remote locations under the supervision of a physician in publicly funded clinics (Daris Klemmer-Lamoureux, n.d.). The first publicly funded, independent nurse practitioner-led clinic was established in Sudbury, Ontario in 2007 (Contandriopoulos et al., 2023; Heale and Butcher, 2010), and most provinces now have publicly funded nurse practitioner-led primary care clinics. Recently, however, private-pay nurse practitioner-led wellness clinics have begun to pop up (CTV News, 2018; Mantyka, 2022; Mitchell, 2024), charging private fees, for care that can range from $90 to $200 for a single visit (e.g., The Village Health Clinic 2024). The nurse practitioners argue that, as non-physician providers, the CHA does not apply to them. As such, they can charge private fees even for services publicly insured when delivered by a physician (e.g., health assessments and diagnosis, ordering and interpreting diagnostic tests, referrals to specialists, prescriptions (Canadian Institute for Health Information, 2020)).

These diverse initiatives all share the common element of requiring private, out-of-pocket payment to obtain insured healthcare services, in violation of the Canada Health Act, which calls for reasonable *access* to insured health services on *uniform terms* and *without charge* (Government of Canada, 2024). Membership fees, enrollment fees, private fees for insured services, interprovincial surgeries, and fees for premium goods and services all violate the intent of this access principle. They also compromise the core equity tenet of Canada's publicly funded healthcare system—the allocation of healthcare based on need rather than ability to pay. Indeed, the central purpose of interprovincial surgery clinics and executive clinics is preferred or expedited access based on the ability to pay. But these practices do more than simply violate a few principles. They have real, detrimental impact on access to care and equity within our healthcare system. It is well established, across many care contexts, that private out-of-pocket fees reduce access for those with limited ability to pay, resulting in greater inequity of care (Armstrong, 2000; Duckett, 2005; Fusco et al., 2023; Grignon et al., 2010; Longhurst, 2023; Mueller and Socha-Dietrich, 2020; Shmueli and Savage, 2014) and have broader system impacts including longer wait times in the public system and related impacts (Hurley and Johnson, 2014; Reid, 2017).

Discussion

These private financing challenges to the CHA and to the access and equity principles at the foundation of Canada's publicly financed healthcare system have material consequences. Yet, the magnitude and costs of such activity are unknown as no association, agency or government tracks this information (Glauser, 2011).

At present, researchers struggle to even just document the nature of such private activities (Bodner et al., 2022; Canadian Medical Association (CMA), 2024c). Without much-improved data on these activities, it is impossible to evaluate their effects on both those seeking care and on the public system. At present, these activities fall largely outside dominant Canadian administrative and survey health data systems. Compiling the data required to enable high-quality research on these activities requires a three-pronged approach. First, where possible, governments and regulators need to strengthen and expand reporting requirements for providers and organizations (e.g., clinics, insurers) operating in these spaces. Second, researchers and others need to better exploit data sources developed for other purposes, such as the Statistics Canada Business Registry or the Census, that may provide insights into such private activities. Third, governments, data agencies, and researchers themselves need to undertake special-purpose, primary data collection through surveys and other approaches to fill gaps that will never be filled by existing administrative and survey data. For instance, such basic information as the number and type of private clinics is not readily available, much less information on the full range of services they offer, their providers, the fees they charge, their sources of payment (e.g., private out-of-pocket, private insurance, public insurance), and the volume of services they provide. Nor is there good information on organizations such as Maple that facilitate and organize privately financed care. Without progress in these data efforts, and the high-quality research it will enable, evidence-informed policy is impossible.

Private finance activities such as those documented above call for multiple policy responses. The first, and perhaps most important, is to improve the performance of the publicly funded health system. Many seek—and are willing to pay for—care privately only because of frustrations with a publicly financed system characterized by inadequate access to primary care, excessive wait times for specialty and surgical services, and other deficiencies (Canadian Medical Association (CMA), 2024b). In some cases, this may require better funding and delivery of existing services, in others, it may call for integration of some of the emerging private practices. For example, at a time when Canada is struggling to provide meaningful access to primary care, publicly funded nurse practitioner-led clinics and care teams could play an important role in addressing our primary care

challenges (Canadian Institute for Health Information, 2022; Contandriopoulos et al., 2024; Tremayne-Lloyd, 2022). This is consistent with the expanded scope of other non-physician providers, such as Ontario's recent expanded scope for pharmacists to prescribe medicines within Ontario's public insurance system (Ontario, 2024).

Secondly, the federal and provincial governments need to implement new regulatory approaches that address the more complex and nuanced regulatory challenges presented by the evolving health landscape. The CHA relies on financial penalties (via reduced transfer payments) to prompt provincial action, but Health Canada is often slow to provide the needed guidance and impose such penalties where appropriate (e.g., it has yet to address private virtual care clinics and has yet to clarify the standing of "physician-equivalent" providers such as nurse practitioners). Importantly, it is not obvious that the financial penalties are sufficient to motivate provincial action, especially when there is a political advantage to a provincial government in letting a targeted private activity continue.

Finally, effective regulation requires provincial action. Provinces have the authority to revise their respective health acts and other relevant legislation to bring new providers such as nurse practitioners into the public system, enforce the long-standing prohibition on user fees for insured services, and prohibit the linking of uninsured services to the delivery of insured care (Quesnel-Vallée et al., 2020).

The continued technological and organizational evolution in healthcare, communications technology, and related areas will only complicate this picture over time as new niches emerge for private finance to expand. Without a multi-prong approach that starts with the collection of the appropriate data to support research and extends to decisive and cooperative action on the part of provincial and federal lawmakers, the fraying at the edges of Canada's public healthcare system will continue to compromise the access and equity principles at the foundation of our healthcare system.

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References

Armstrong, W. (2000). *The consumer experience with cataract surgery and private clinics in Alberta: Canada's canary in the mine shaft*. Alberta Chapter of Consumers Association of Canada. https://albertaconsumers.org/CanaryReportrevised2.pdf

Bodner, A., Spencer, S., Lavergne, M. R., and Hedden, L. (2022). Exploring Privatization in Canadian Primary Care: An Environmental Scan of Primary Care Clinics Accepting Private Payment. *Healthcare Policy = Politiques de Sante*, *17*(3), 65–80. https://doi.org/10.12927/hcpol.2022.26727

Brooks, J. (1993). Canada's First Private MRI Clinic: Does it signal a shift to two-tiered medicine? *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *149*(8), 1155–1158.

CADTH. (2023). CADTH Health Technology Review: Privately Operated Medical Imaging Facilities Across Canada. *Canadian Journal of Health Technologies*, *3*(5). https://www.ncbi.nlm.nih.gov/books/NBK594387/pdf/Bookshelf_NBK594387.pdf

Canadian Institute for Health Information. (2020). *Nurse practitioner scopes of practice vary across Canada's provinces and territories*. Retrieved July 8, 2024, from https://www.cihi.ca/en/nurse-practitioner-scopes-of-practice-vary-across-canadas-provinces-and-territories

Canadian Institute for Health Information. (2022). *Nurse practitioners*. Retrieved May 16, 2024, from https://www.cihi.ca/en/nurse-practitioners

Canadian Medical Association (CMA). (2022). Virtual Care in Canada: Progress and Potential. In *Report of the Virtual Care Task Force*. Retrieved June 4, 2024, from https://www.cma.ca/sites/default/files/2022-02/Virtual-Care-in-Canada-Progress-and-Potential-EN.pdf

Canadian Medical Association (CMA). (2024a). It's Time To Talk. Consultations on Public and Private Care in Canada. What we heard report. In *National conversation on public and private health care in Canada*. The Association. Retrieved September 23, 2024, from https://digitallibrary.cma.ca/link/digitallibrary128

Canadian Medical Association (CMA). (2024b). PUBLIC-PRIVATE HEALTH CARE. Can we find the right balance? In *The Globe and Mail presents a national town hall series*. The Association. Retrieved September 23, 2024, from https://digitallibrary.cma.ca/link/digitallibrary126

Canadian Medical Association (CMA). (2024c). Public And Private Health Care in Canada. What Does the Evidence Say? In *National Conversation on Public and Private Health Care in Canada*. The Association. Retrieved September 23, 2024, from https://digitallibrary.cma.ca/link/digitallibrary125

CBC News. (2023). *Supreme Court dismisses B.C. doctor's appeal in challenge over access to private health care*. British Columbia. Retrieved July 8, 2024, from https://www.cbc.ca/news/canada/british-columbia/private-health-care-dr-brian-day-supreme-court-appeal-dismissed-1.6803463

Clinic de Santé. (2024). *Tarifs*. Retrieved May 14, 2024, from https://cliniquem.com/tarifs

Contandriopoulos, D., Bertoni, K., Horne, B., Swanson, A., Glassel, S., Guengerich, L., Jonker, K.,

Grisdale, L., and Gilmour, L. (2023). A Descriptive Analysis of the Previous Care Experiences of Patients Being Rostered in British Columbia's New Nurse-Practitioner Primary Care Clinics. *Nurse Practitioner Open Journal*, *3*(1). https://npopenjournal.com/index.php/npoj/article/view/394

Contandriopoulos, D., Bertoni, K., McCracken, R., Hedden, L., Lavergne, R., and Randhawa, G. K. (2024). Evaluating the cost of NP-led vs GP-led primary care in British Columbia. *Healthcare Management Forum*, 08404704241229075. https://doi.org/10.1177/08404704241229075

Crawley, M. (2023). Ottawa plans to crack down on doctors charging for medically necessary health care. *CBC News Politic*s. Retrieved June 5, 2024, from https://www.cbc.ca/news/politics/fees-virtual-doctor-physician-canada-health-act-1.6773607

CTV News. (2018). Eroding or Enhancing? Private health care services offered by nurse practitioners growing in Manitoba. *CTV News Winnipeg*. Retrieved July 8, 2024, from https://winnipeg.ctvnews.ca/eroding-or-enhancing-private-health-care-services-offered-by-nurse-practitioners-growing-in-manitoba-1.3995863

Cuttler, M. (2023). Medical upselling in Canada can cost patients thousands of dollars. *CBC News - Health*. Retrieved June 6, 2024, from https://www.cbc.ca/news/health/medical-upselling-private-clinics-patients-1.6797892

Daris Klemmer-Lamoureux. (n.d.). *History of Nurse Practitioners in Canada*. Nurse Practitioner Association of Alberta. Retrieved May 10, 2024, from https://albertanps.com/history-of-nurse-practitioners-in-canada/

Devereaux, P. J., Choi, P. T. L., Lacchetti, C., Weaver, B., Schünemann, H. J., Haines, T., Lavis, J. N., Grant, B. J. B., Haslam, D. R. S., Bhandari, M., Sullivan, T., Cook, D. J., Walter, S. D., Meade, M., Khan, H., Bhatnagar, N., and Guyatt, G. H. (2002). A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal*, *166*(11), 1399 LP – 1406. http://www.cmaj.ca/content/166/11/1399.abstract

Duckett, S. J. (2005). Living in the parallel universe in Australia: public Medicare and private hospitals. *Canadian Medical Association Journal*, *173*(7), 745–747. https://doi.org/10.1503/cmaj.051011

Flood, C. M., Allen, P., Thomas, B., and Walker, K. (2015). Restricting private-sector practice using contracts. *Canadian Medical Association Journal*, *187*(8), 583 LP – 586. https://doi.org/10.1503/cmaj.140837

Flood, C. M., and Thomas, B. (2020). *Is Two-Tier Health Care the Future?* (C. M. Flood & B. Thomas (eds.)). University of Ottawa Press. https://doi.org/10.2307/j.ctv5vdctx

Frangou, C. (2023). How Canada's Crumbling Health Care System Opened the Door to For-profit Virtual Care. *Canadian Business*. Canada's Failing System Opened the Door to Private Health Care - CB (canadianbusiness.com)

Fusco, N., Sils, B., Graff, J. S., Kistler, K., and Ruiz, K. (2023). Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systematic literature review. *Journal of Managed Care & Specialty Pharmacy*, *29*(1), 4–16. https://doi.org/10.18553/jmcp.2022.21270

Glauser, W. (2011). Private clinics continue explosive growth. *Canadian Medical Association Journal*, *183*(8), E437 LP-E438. https://doi.org/10.1503/cmaj.109-3816

Goodair, B., and Reeves, A. (2024). The effect of health-care privatisation on the quality of care. *The Lancet Public Health*, *9*(3), e199–e206. https://doi.org/10.1016/S2468-2667(24)00003-3

Government of Canada. (2019). *Canada's Health Care System*. Reports and Publications - Health Care System. Retrieved June 4, 2024, from https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html

Government of Canada. (2024). *Canada Health Act - Frequently Asked Questions*. Health Care System. Retrieved June 10, 2024, from https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act-frequently-asked-questions.html

Government of Saskatchewan. (2016). *Patient Choice Medical Imaging Act Introduced to Allow Private Clinics*. https://www.saskatchewan.ca/government/news-and-media/2016/june/08/patient-choice-act

Gray, C. (2000). Alberta is back at it, goading the feds: CMAJ. *Canadian Medical Association. Journal*, *162*(3), 411. https://www.cmaj.ca/content/162/3/411

Grignon, M., Hurley, J., Wang, L., and Allin, S. (2010). Inequity in a Market-based Health System: Evidence from Canada's Dental Sector. *Health Policy*, *98*(1), 81–90.

Heale, R., and Butcher, M. (2010). Canada's First Nurse Practitioner-Led Clinic: A Case Study in Healthcare Innovation. *Nursing Leadership (Toronto, Ont.)*, *23*(3), 21–29. https://doi.org/10.12927/cjnl.2010.21939

Health Canada. (2023). *Canada Health Act: Annual Report 2021-2022*. Retrieved February 24, 2024, from https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2021-2022.html

Health Canada. (2024). Canada Health Act: Annual Report 2022-2023. In *Government of Canada*. Retrieved June 3, 2024, from https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2022-2023.html

Hurley, J., and Johnson, M. (2014). *A Review of Evidence Regarding Parallel Systems of Public and Private Finance*. McMaster University Centre for Health Economics and Policy Analysis, Working Paper 14-02.

Library of Parliament. (2019). The Canada Health Act: An Overview. In *Publication No. 2019-54-E*. https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/BackgroundPapers/PDF/2019-54-e.pdf

Longhurst, A. (2023). *Failing to Deliver: The Alberta Surgical Initiative and Declining Surgical Capacity*. Retrieved May 16, 2024, from https://www.parklandinstitute.ca/failing_to_deliver

Mantyka, W. (2022). Concerns raised over privately owned nurse practitioner clinics. *CTV News Regina*.

MEDCAN. (2024). *Concierge medicine with a premium, proactive and highly personalized level of care*. Retrieved May 14, 2024, from https://medcan.com/m-care/

Minister of Health Diane Marleau. (1995). *RE: Canada Health Act (Facility Fees)*.

Minister of Health Jane Philpott. (2016). *RE: Canada Health Act (Minister of Health and Social Services Province of Quebec)*.

Mitchell, D. (2024). Ontario clinic's direct billing highlights grey area around nurse practitioners. *Global News*. Retrieved February 15, 2024, from https://globalnews.ca/news/10279113/ontario-clinic-direct-billing-highlights-grey-area/

Mueller, M., and Socha-Dietrich, K. (2020). *Reassessing private practice in public hospitals in Ireland*. *118*. https://doi.org/https://doi.org/https://doi.org/10.1787/111171d3-en

Ontario. (2024). *Ontario Exploring More Ways to Expand Role of Pharmacists*. Newsroom. Retrieved November 18, 2024, from https://news.ontario.ca/en/release/1004860/ontario-exploring-more-ways-to-expand-role-of-pharmacists

Ontario Health Coalition. (2017). *Private Clinics and the Threat to Public Medicare in Canada Results of Surveys with Private Clinics and Patients*. Retrieved June 3, 2014, from https://www.healthcoalition.ca/wp-content/uploads/2017/06/Private-Clinics-Report.pdf

Ontario Health Coalition. (2024). *Illegal, Unlawful and Unethical: Case Studies of Patients Charged for Medical Care in Ontario's Private Clinics*. Retrieved June 6, 2024, from https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-private-clinics-report-for-release.pdf

Quesnel-Vallée, A., McKay, R., and Farmanara, N. (2020). Chaoulli v Quebec: Cause or Symptom of Quebec Health System Privatization? In C. M. Flood and B. Thomas (Eds.), *Is Two-Tier Health Care the Future?* University of Ottaea Press.

Reid, L. (2017). Concierge, Wellness, and Block Fee Models of Primary Care: Ethical and Regulatory Concerns at the Public-Private Boundary. *Health Care Analysis : HCA : Journal of Health Philosophy and Policy*, *25*(2), 151–167. https://doi.org/10.1007/s10728-016-0324-4

Schneider, E. C., Zaslavsky, A. M., and Epstein, A. M. (2005). Quality of care in for-profit and not-for-profit health plans enrolling Medicare beneficiaries. *The American Journal of Medicine*, *118*(12), 1392–1400. https://doi.org/10.1016/j.amjmed.2005.05.032

Sciarpelletti, L. (2024). Feds claw back $1M due to private patient charges; Sask. Ministry of Health "deeply disappointed." *CBC News Saskatchewan*. Retrieved May 16, 2024, from https://www.cbc.ca/news/canada/saskatchewan/feds-claw-back-private-patient-charges-1.7161577#:

Shmueli, A., and Savage, E. (2014). Private and public patients in public hospitals in Australia. *Health Policy*, *115*(2–3), 189–195. https://doi.org/http://dx.doi.org/10.1016/j.healthpol.2014.01.008

Silversides, A. (2008). Canada Health Act breaches are being ignored, pro-medicare groups charge: CMAJ. *Canadian Medical Association. Journal*, *179*(11), 1112–1113. https://www.cmaj.ca/content/179/11/1112

Surgical Solutions Network. (2024). *Surgical Services*. Retrieved May 16, 2024, from https://surgicalsolutionsnetwork.ca/surgical-services/

Taylor, M. G. (1986). The Canadian Health Care Sustem 1974-1984. In R. G. Evans and G. L. Stoddart (Eds.), *Medicare at Maturity: achievements, lessons & challenges*.

Taylor, P. (2019). *Out-of-province medical care: what you need to know.* Healthy Debate. Retrieved June 5, 2024, from https://healthydebate.ca/2019/10/topic/out-of-province-medical-care/#comment

The Village Health Clinic. (2024). *Nurse Practitioner -Services and Fees*. Retrieved May 14, 2024, from https://www.thevillagehealthclinic.ca/nurse-practitioner

Tremayne-Lloyd, T. (2022). Nurse practitioners could relieve Canada's doctor shortage, but funding models are causing roadblocks. *The Globe and Mail*. Retrieved February 22, 2022, from https://www.theglobeandmail.com/opinion/article-nurse-practitioners-could-relieve-canadas-doctor-shortage-but-funding/

Vayda, E., and Deber, R. B. (1992). The Canadian Health-Care System: A Developmental Overview. In D. C. Naylor (Ed.), *Canadian health care and the state: a century of evolution* (pp. 125–140).