

# We Need to Do the Hard Work to Strengthen Public Healthcare



COMMENTARY

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## ABSTRACT

*Canada's healthcare system is at a crossroads. After years of declining performance, there is growing pressure to consider more radical changes in the way it is funded and delivered, including increasing the scope of private options. But the Canadian Medical Association's engagement with more than 10,000 physicians, patients and members of the public – through surveys, town halls and focused dialogues – revealed that accessible healthcare, regardless of the ability to pay, remains a bedrock value. We need to continue the hard work of strengthening the public health system to ensure that it meets Canadians' evolving health needs.*

## Introduction

We can deliver the healthcare Canadians need and protect our public system.

In their paper, “Is There a Third Way for Healthcare in Canada?,” Fierlbeck and Berman (2025) contend that poor access to primary care, emergency room overcrowding and wait times for surgeries and diagnostic imaging are fundamentally driven by our current model of funding.

They observe that, for too long, debates about healthcare in Canada have been around

public versus private care. Instead, they argue, we should consider a third way, which recognizes that private funding and delivery of healthcare services are already a reality and regulates these options to ensure that they are helping to improve access, equity and efficiency.

The authors point to Canada's poor showing in international comparisons of health system performance as evidence that something more than mere tinkering is needed. Indeed, Canada has consistently

ranked in the bottom tier of peer countries surveyed by the Commonwealth Fund, which assesses key metrics including access to care, care process, administrative efficiency, equity and health outcomes. In the latest survey (Blumenthal et al. 2024), Canada ranked eighth out of 10 countries.

What these surveys do not tell us, though, is why some countries fare better than others. Some are more open to private health insurance, for example, and many allow user fees. Some spend more than others as a share of their GDP, and some have a higher share of public than private funding.

There is no denying that our system is not performing as well as it should. Healthcare in Canada is in a state of crisis, many years in the making. The COVID-19 pandemic exacerbated our system's shortcomings, but access to primary care and surgical backlogs have been a concern for at least two decades. And we have known for a long time that our population is aging and that health needs are growing and increasing in complexity.

The question is whether these deficiencies speak to a failure of our healthcare financing model or something else. The Canadian Medical Association (CMA) is championing a number of solutions to improve access to care and working conditions for healthcare providers. One is an integrated approach to health human resources planning that anticipates the right number and mix of health professionals needed to meet population needs. We are also advocating for scaled-up team-based models that can deliver primary care more effectively and reduce pressure on hospitals. And we continue to call for more community-based care to support a growing number of seniors who want to age at home, not in a long-term care institution.

Expanding privately funded delivery of medically necessary care is not a durable fix. For patients lucky enough to have the means,

privately funded care feels like a win – paying for quicker access while “freeing up” capacity in the public system. But it is a zero-sum game in reality; improved access for those who can pay comes at the expense of reduced access for those who cannot. Even privately delivered, publicly funded care does not magically expand overall system capacity – it draws from the existing supply of health professionals.

This is not to say that the current funding model does not require a rethink. As Fierlbeck and Berman (2025) suggest, more could be done by the federal government to make health transfers to provinces and territories conditional on achieving key outcomes. This is why the CMA has called for the creation of a federal chief health accountability officer (Grant 2024) to report annually on how healthcare funds are being spent at all levels of government and the impact on the health of Canadians. It is time for the federal government to put some real accountability around the more than \$50 billion it invests in healthcare annually.

Of course, money is the elephant in the room. Fierlbeck and Berman (2025) argue that we need to expand private options in part because governments have reached their limit in terms of increased healthcare funding through taxes. Provinces are already devoting upward of 40% of their budgets to healthcare.

They are correct that a private pay option would result in a reduced financial burden on the public system in the short term. However, in our current situation, where there are severe shortages of healthcare workers, any private pay options will, by necessity, pull staff out of the public system and make access worse for most Canadians. That is not a trade-off I am willing to make.

In addition, evidence (CMA 2024a) shows that private for-profit services – particularly in areas such as hospital, specialty

and home care – are less efficient than public services, meaning that the shift to private services will also result in a net decrease in overall services provided. Instead, we need to do the hard work of reforming and restructuring healthcare to invest in upstream care and prevent costly downstream interventions, thus decreasing our dependence on the most expensive part of our system – hospitals and long-term care institutions (in Ontario, for example, it costs an estimated \$103 per day to provide home care for a high-needs person, compared with \$182 for a long-term care bed and \$730 for an acute care bed).

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To the extent that private pay options already exist in Canada – and there are many instances – we need to make sure they are serving the broader public interest. As underlined in the CMA's new policy (CMA 2024c) on managing the public-private interface, private healthcare services tend to be more expensive with lower quality care than public health services. Therefore, if we are going to continue using private services, we need better guardrails to ensure that they meet both equity and quality objectives. To that end, the CMA is calling on provincial and territorial governments to put in place robust regulation and real-time evaluation of privately funded and delivered healthcare, including strengthened public accountability for organizations delivering services, more timely collection and reporting of data on costs and outcomes and more investment in research on the cost-effectiveness of different models of care delivery. This will ensure that any experimentation with private healthcare options is

carefully assessed in terms of its impact and that we make the necessary course corrections.

Recent interpretations of the *Canada Health Act (CHA)* (1985) issued by the federal government – the 2018 Petipas Taylor letter of intent (Petipas Taylor 2018) on private diagnostic imaging services and the more recent 2025 Holland letter (Holland 2025) on private nurse practitioner clinics – represent a step in the right direction that will incentivize provinces and territories to bring these medically necessary services under our publicly funded system.

The bottom line is that, far too often, when confronted with healthcare challenges, we have opted for expedient solutions. But, in consultations on public and private care with more than 10,000 physicians, patients and the public, the CMA heard, again and again, that access to publicly insured healthcare, regardless of the ability to pay, remains a bedrock value for Canadians. In surveys (CMA 2024b), at town halls and in smaller patient and physician dialogues, there was consensus across stakeholder groups that investing in the public health system must be the priority.

While private services appear to be a good solution in a setting of severe health human resource shortages, moving toward less efficient private services will make things worse. Instead, we must innovate and use the best evidence on what works to strengthen our public health system, including expanding the *CHA* (1985) to ensure that it continues to be relevant to the evolving health needs of Canadians.

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