

**PRIVATE HEALTH CARE FUNDING AND DELIVERY
UNDER THE *CANADA HEALTH ACT***

**Odette Madore
Economics Division**

**Marlisa Tiedemann
Law and Government Division**

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PRIVATE HEALTH CARE FUNDING AND DELIVERY UNDER THE *CANADA HEALTH ACT*

INTRODUCTION

This document examines the role of the private sector in the context of the *Canada Health Act*. It does not propose to offer a legal interpretation of the Act; rather, it summarizes the current literature on the subject. The first section defines the concepts of public and private sectors in health care and distinguishes between the funding and delivery of health services. The second section briefly reviews the conditions of the *Canada Health Act* and explains how the Act applies to the current public-private mix of funding and delivery of Canada's health care system. The third section examines how the development of private health care may adversely affect the publicly funded system. The fourth and last section summarizes two recent court challenges: one deals partly with the extent of private health care delivery under the *Canada Health Act*, while the other concerns the prohibition of private health care insurance in the province of Quebec.

CONCEPTS AND DEFINITIONS

A. Public versus Private

In clarifying what is meant by the terms “public” and “private” as they are used in the health care context, it should be noted that there are many levels within both the public and private sectors. As shown in Table 1, the public sector refers to governments and government agencies; governments may be national (or federal), provincial or municipal. The private sector is broad and encompasses the corporate for-profit sector, small business and entrepreneurial entities, and voluntary or charitable not-for-profit organizations, as well as individuals and families.

Table 1
Categories of Public and Private Sectors

Category	Level
Public	<ul style="list-style-type: none"> • National • Provincial/Territorial • Regional • Local
Private	<ul style="list-style-type: none"> • Corporate for-profit • Small business/entrepreneurial • Charity (non-profit) with paid employees or volunteers • Family/individual

Source: Raisa B. Deber *et al.*, “The Public-Private Mix in Health Care,” in *Striking a Balance: Health Care Systems in Canada and Elsewhere*, Papers commissioned by the National Forum on Health, Vol. 4, Éditions MultiMondes, Sainte-Foy (Quebec), 1998, p. 433.

B. Funding versus Delivery

There is also an important distinction to be made between the funding and the delivery of health care. Funding refers to how services are paid for, while delivery consists of how services are organized, managed and provided. The funding of health care is done either indirectly through third-party insurance or directly by the individual/family through out-of-pocket spending. Insurance can cover all or part of health care expenditures; individuals and families may pay for the full cost of health care, or pay only a portion of it through premiums, co-insurance, co-payment or deductibles. The delivery of health care involves a wide variety of individual and institutional providers, including professional practitioners, clinics, hospitals and other institutions, government departments, organizations and corporations.

C. The Public-Private Mix in the Funding and Delivery of Health Care

Further complicating the issue is the fact that both the public and the private sectors are involved in both the funding and the delivery of health care. The various combinations of public- and private-sector involvement in the funding and delivery of health care in Canada are illustrated in Table 2.

Table 2
Public- and Private-Sector Involvement in Health Care

		DELIVERY		
		Public	Private Not-for-Profit	Private For-Profit
F I N A N C I N G	Public	(1) <ul style="list-style-type: none"> Public health Provincial psychiatric institutions Home care in some provinces 	(2) <ul style="list-style-type: none"> Most hospitals Addiction treatment 	(3) <ul style="list-style-type: none"> Primary health care physicians Ancillary services in hospitals (laundry services, meal preparation and maintenance) Laboratories and diagnostic services in most provinces Some hospitals
	Private	(4) <ul style="list-style-type: none"> Enhanced non-medical (e.g., private room) and medical (e.g., fibreglass cast) goods and services in a publicly owned hospital 	(5) <ul style="list-style-type: none"> Some home care and nursing homes in some provinces 	(6) <ul style="list-style-type: none"> Cosmetic surgery Long-term care Extended health care benefits such as prescription drugs, dental care and eye care in some provinces Some MRI and CT scan clinics Some surgery clinics

Source: Raisa B. Deber, *Delivering Health Care Services: Public, Not-For-Profit, or Private?* Discussion Paper No. 17, Commission on the Future of Health Care in Canada, August 2002, http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/17_Deber_E.pdf, pp. 2-3; Groupe de travail (Roland Arpin, President), *La Complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec*, Ministère de la Santé et des Services sociaux, Québec, September 1999, http://publications.msss.gouv.qc.ca/acrobat/f/documentation/1999/99_653/rapport.pdf, p. 37; and Economics Division, Parliamentary Information and Research Service, Library of Parliament.

Public health (box (1) in Table 2) is essentially a responsibility of the public sector: the government both funds and provides public health services (immunization, water sanitation, etc.). In contrast, cosmetic surgery (box (6)) is, for the most part, an area left entirely to the private sector: the individual and/or his/her private insurance company pays the full cost of the surgery performed by a private for-profit provider.

Box (6) in Table 2 also exemplifies the situation where health services are provided entirely outside of the publicly funded system. This is the case, for example, with private diagnostic imaging clinics that provide magnetic resonance imaging (MRI) and computed tomography (CT) scans for which patients must bear the entire cost of the services rendered to them. Other examples include free-standing private hospitals that provide surgical procedures performed by physicians who have opted out of the publicly funded system⁽¹⁾ and for which patients must pay the entire cost associated with the surgery (e.g., the Cambie Surgery Centre in Vancouver, the Maple Surgical Centre in Winnipeg, etc.).

Boxes (2) and (3) in Table 2 depict the combination of public and private involvement that is most often seen in Canada's publicly funded health care system. The (provincial) government funds a variety of health services through its provincial health care insurance plan, but the services insured under the plan are delivered mostly by a mix of private not-for-profit and private for-profit (individual or institutional) providers. For example, most family physicians in primary health care settings receive public funding, but they are private providers who are not employed by the government. In fact, physicians' offices are often categorized as small business entrepreneurs. And while most people think of hospital services as being publicly delivered because they are funded and governed publicly, and are accountable to the public, hospital services in many provinces are in fact delivered to a great extent by private not-for-profit organizations. Laboratory and diagnostic services are another example of how health services are a mix of public funding and private delivery: they are paid for by public health care insurance, but in most provinces they are delivered by private for-profit facilities. Laundry services, meal preparation and other support or ancillary services that are provided in publicly funded hospitals are often delivered by private for-profit companies.

Box (4) in Table 2 reflects the situation where a patient chooses, or requires, and is responsible for paying for – either out-of-pocket or through his/her private insurance – medical enhancements (such as a fibreglass cast rather than the regular plaster cast) or non-medical enhancements (private room, telephone, television set, etc.) in relation to a health service provided in a publicly owned hospital.⁽²⁾ Finally, box (5) refers to situations where individuals

(1) Physicians “opt out” when they choose to give up their rights to bill the public health care insurance plan and take up practice in the private sector. Every province's health care insurance legislation permits physicians to opt out.

(2) Both medical and non-medical enhancements could also be required and paid for by a patient obtaining care in a publicly funded but privately owned health care institution.

and/or their private insurance company must pay for services delivered by the private not-for-profit sector; this is the case, for example, with home care and nursing homes in some provinces.

These examples clearly demonstrate the complex mix of public-private funding and delivery in Canada's health care system. Health Canada has acknowledged this mix in funding and delivery:

Canada has a predominantly publicly financed, privately delivered health care system (...) Known to Canadians as "Medicare", the system provides access to universal, comprehensive coverage for medically necessary hospital and physician services as stated in the *Canada Health Act*.

Canada does not generally have a system of "socialized medicine", with physicians employed by the government. Rather, most physicians are private practitioners who work in independent or group practices and enjoy a high degree of autonomy. (...) Other providers (e.g. nurses, dentists, pharmacists, etc.) work in a mix of private not-for-profit, private for-profit and public delivery settings.

Most Canadian hospitals operate as private not-for-profit entities run by community boards of trustees, voluntary organizations or municipalities. However, the services within hospitals (e.g. pharmacies, food preparation, facilities maintenance, etc.) are provided by a mix of private for-profit, private not-for-profit and public sectors. Certain publicly financed extended health care services (e.g. continuing care programs) are also subject to a mix of public and private delivery mechanisms, with increasing emphasis on private for-profit delivery of public services.⁽³⁾

THE CANADA HEALTH ACT

The *Canada Health Act* sets out five criteria (commonly referred to as the "national principles") that provincial and territorial health care insurance plans must meet in order to qualify for the full federal contribution under the Canada Health Transfer (CHT). These criteria do not impose legally binding obligations on provincial and territorial governments. Compliance with the conditions of the Act is entirely voluntary – the only penalty is the

(3) Health Canada, Applied Research and Analysis Directorate, *Request for Letters of Intent (RFP 004): Private Sector Delivery in Canada's Current Health Care System: Research into the Scope and Extent*, November 2001, http://www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/complet-term/rfloi-dli-04_e.html.

withholding of federal funds.⁽⁴⁾ The sanctions are financial and political, not legal.⁽⁵⁾ The five criteria are:

- **Public administration:** each provincial health care insurance plan must be administered on a non-profit basis by a public authority, which is accountable to the provincial government for its financial transactions.
- **Comprehensiveness:** provincial health care insurance plans must cover all “insured health services” (hospital care, physician services and medically required surgical dental procedures which can be properly carried out only in a hospital).
- **Universality:** all residents in the province must have access to public health care insurance and insured health services on uniform terms and conditions.
- **Portability:** provinces and territories must cover insured health services provided to their citizens while they are temporarily absent from their province of residence or from Canada.
- **Accessibility:** insured persons must have reasonable and uniform access to insured health services, free of financial or other barriers. This condition is emphasized by two provisions of the Act which specifically discourage financial contributions by patients, either through user charges or extra-billing, for services covered under provincial health care insurance plans.⁽⁶⁾

The criteria relate only to the funding of publicly insured health services; they do not address the public-private delivery aspect of health care. With respect to funding, the criteria of public administration and accessibility are of particular importance, as they respectively discourage private insurance and restrict direct out-of-pocket spending for publicly insured health services.

The public administration criterion supports the single public insurer model (or single payer) for insured health services. According to Health Canada, the original policy objective of this principle was to prevent provinces from using federal transfers to subsidize coverage for provincial residents by private for-profit insurers. Despite this, it has been suggested that there is some role for the private for-profit sector within the administration of the

(4) Sujit Choudhry, “Bill 11, the *Canada Health Act* and the Social Union : The Need for Institutions,” *Osgoode Hall Law Journal*, Vol. 38, No. 1, Spring 2000, pp. 39-99, <http://www.yorku.ca/ohlj/archive/vol38.htm>.

(5) Montreal Economic Institute, “Health Care Reforms: Just How Far Can We Go?” *Economic Note*, April 2003, http://www.iedm.org/uploaded/pdf/santejuridique_en.pdf.

(6) R.S.C. 1985, c. C-6.

provincial health care insurance plan. For example, a province or territory may hire a private agency to handle certain clerical functions, so long as the province remains responsible for setting and approving health care benefits and payment levels for health care providers and facilities.⁽⁷⁾

Contrary to widespread public belief, it has been suggested that the public administration criterion does not prohibit private health care insurance.⁽⁸⁾ Six provinces (Alberta, British Columbia, Manitoba, Ontario, Prince Edward Island and Quebec) have, nonetheless, expressly prohibited private insurance from covering services insured under the provincial plan, in order to achieve the single public insurer model for health care. In those provinces, private health care insurance is only complementary to the public plans. Three of the four other provinces that permit private insurance coverage of provincially insured health services have economic disincentives that discourage physicians from opting out of public health care insurance plans; this, in turn, reduces the need for private insurance. In Nova Scotia, a physician who has opted out of the provincial plan is prohibited from charging fees that exceed the compensation provided by the public plan. In New Brunswick and Saskatchewan, an opted-out physician cannot be reimbursed by the provincial plan. Newfoundland and Labrador is the only province that both allows private insurance to cover services insured under its provincial health care insurance plan and does not use other means to discourage physicians from opting out of the public plan.⁽⁹⁾ As a result of provincial (not federal) legislation in most provinces, there is no parallel, private insurance sector that competes with public insurance for the funding of health services covered under the *Canada Health Act*.

The accessibility criterion is another principle of the *Canada Health Act* which, supported by the user charge and extra-billing provisions, expressly restricts private funding for publicly insured health services. In order to receive the full CHT cash contribution to which they are entitled, provinces may not require that individuals make a financial contribution in order to

(7) Gigi Mandy (Director, Canada Health Act Division, Health Canada), Affidavit, Federal Court – Trial Division, Court File No. T-709-03, 2004, p. 10.

(8) Guy W. Giorno, *Private Health Insurance for Medically Necessary Services*, Fasken Martineau DuMoulin LLP, Toronto, 20 June 2005, [http://www.fasken.com/WEB/FMDWEBSITEFRENCH.NSF/0/A15B2201E53474B78525702700558B5F/\\$File/PRIVATEHEALTHINSURANCE.PDF?OpenElement](http://www.fasken.com/WEB/FMDWEBSITEFRENCH.NSF/0/A15B2201E53474B78525702700558B5F/$File/PRIVATEHEALTHINSURANCE.PDF?OpenElement).

(9) For more information, see Colleen M. Flood and Tom Archibald, “The Illegality of Private Health Care in Canada,” *Canadian Medical Association Journal*, Vol. 164, No. 6, 20 March 2001, pp. 828-829, <http://www.cmaj.ca/cgi/reprint/164/6/825>.

obtain services covered under provincial health care insurance plans.⁽¹⁰⁾ Provinces that allow user charges and extra-billing are subject to mandatory dollar-for-dollar deductions from federal CHT transfers. Between 1994-1995 and 2003-2004, financial penalties totalling almost \$9 million were deducted from federal transfers to the provinces that permitted user charges and extra-billing.⁽¹¹⁾

While the *Canada Health Act* has explicit requirements with respect to the funding of health services, it is silent with respect to the delivery of those services. The Act neither explicitly prohibits nor permits the delivery of insured health services by the private sector. Similarly, the *Canada Health Act* neither encourages nor discourages the public delivery of publicly funded health care. There are simply no specific provisions contained in the legislation that address health care delivery. For that reason, provinces that allow health services that are funded by public health care insurance to be delivered by a mix of public and private providers, whether individual or institutional, cannot be said to be in violation of the *Canada Health Act*.

PRIVATELY FUNDED AND DELIVERED HEALTH SERVICES UNDER THE CANADA HEALTH ACT

While the private delivery of health services within the publicly funded health care system (box (3) in Table 2) may be a major cause for concern for some people, the development of a wholly private sector for health care – one that is both delivered and funded privately (box (6) in Table 2) – is perceived as a far more serious potential threat to the publicly funded system.

As stated above, the *Canada Health Act* does not prevent private, or for-profit, providers from delivering and being reimbursed for publicly insured health services, so long as private payment by patients (through user charges and extra-billing) is not involved. Perhaps more importantly, the Act does not prevent the provinces from allowing private health care

(10) It should be noted, however, that the *Canada Health Act* does not prohibit premiums under provincial health care insurance plans. These premiums are not rated by risk in any of the provinces that require them (Alberta, British Columbia and Ontario), and prior payment of a premium is not a precondition for accessing insured health services; as such, they are in accordance with the Act. See Health Canada, *Canada's Health Care System*, 1999.

(11) Health Canada, *Canada Health Act Annual Report, 2003-2004*, Ottawa, December 2004, p. 16, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/cha-lcs-ar-ra/2003-04_e.pdf.

providers, whether individual or institutional, to operate outside of the publicly funded health care system.⁽¹²⁾ This suggests that the operation of fully private clinics or facilities is not precluded anywhere in Canada.

Fully private clinics are private for-profit facilities that receive no government funding: the physicians are not reimbursed by the provincial health care insurance plan, and their patients must pay the full cost of the services rendered to them. The operation of such clinics does not result in a reduction in federal CHT transfers, and the provisions relating to extra-billing or user charges do not apply in such cases. The type of services delivered in these private clinics is wide and covers, for example, hip and knee replacement surgery, cataract surgery, and MRI diagnosis.

It has been suggested that the operation of fully private clinics in some provinces raises concerns over access to, and erosion of, the publicly funded health care system. Two dangers have been identified in this respect:

- Some private clinics offer MRI, X-ray, ultrasound and CT scanning services to those who can afford to pay. These individuals may be getting faster access to health services in two ways. First of all, they gain access to the test itself. Secondly, they can then return to the publicly funded system for treatment, should such care be required, one step ahead of patients still waiting to obtain publicly funded diagnostic tests. This situation, referred to as “queue jumping,” may undermine the accessibility criterion of the *Canada Health Act* which states that access to medically necessary services should be based on need – not on means – and on uniform terms and conditions.
- If significant numbers of key service providers choose to operate solely in fully private clinic settings and not within the provincial health care insurance plans, there could be reduced access to some publicly funded services. This would disadvantage those who could not afford to purchase privately funded and delivered health care, and would be contrary to the intent of the *Canada Health Act*.⁽¹³⁾

(12) Based on legal interpretation provided in:

- Martha Jackman, “The Regulation of Private Health Care Under the *Canada Health Act* and the Canadian Charter,” *Constitutional Forum*, Vol. 6, Winter 1995, pp. 54-60.
- Colleen Flood and Sujit Choudhry, *Strengthening the Foundations: Modernizing the Canada Health Act*, Discussion Paper No. 13, Commission on the Future of Health Care in Canada, August 2002, http://www.law.utoronto.ca/healthlaw/docs/romanow_report.pdf.
- Montreal Economic Institute (2003).

(13) Health Canada (2004).

Another issue is raised by private clinics' dependence on physician referrals. One study suggests that physician referrals are potentially problematic in two ways. First of all, private clinics could compensate physicians for patient referrals (a kickback), which could potentially distort clinical judgment. While compensation for referrals is unobjectionable in most markets, it is viewed differently in the health care sector as a result of the potential conflict of interest that arises when a physician puts his or her financial self-interest ahead of his or her duty to advise patients solely on the basis of health care needs. And second, physicians could refer patients to private clinics that they themselves own, raising similar concerns over financial conflicts of interest. It has been argued that self-referral and kickback practices are ethically wrong, do a disservice to the health care system and to patients and, with few exceptions, should be banned outright.⁽¹⁴⁾

Although the federal government has not yet articulated any formal position with respect to fully private clinics, it has shared its concerns with its provincial counterparts. Despite consultations with the provinces, no substantial progress has been achieved:

With respect to private payment for insured health services, Health Canada is concerned that any trend toward privatization that results in a two-tiered system, where individuals can pay for quicker access to medically necessary hospital or physician services represents a threat to the fundamental principles of the [*Canada Health Act*], and therefore to the overall health care system. Access to insured services must be based on need, not the ability to pay.

(...)

There are private MRI and CT clinics in British Columbia, Alberta, Quebec and Nova Scotia, and these provinces do not provide coverage for medically necessary MRI and CT scans performed at these private clinics. Under the *Canada Health Act*, MRI and CT services are considered to be insured health services when they are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, and are provided in a hospital or a facility providing hospital care. Health Canada originally communicated these [*Canada Health Act*] concerns to all provinces in 2000, and a multilateral examination of the issue was subsequently conducted, however the issue of charges to insured persons for MRI and CT services was not resolved. In July 2003,

(14) Sujit Choudhry, Niteesh K. Choudhry and Adalsteinn D. Brown, "Unregulated Private Markets for Health Care in Canada? Rules of Professional Misconduct, Physician Kickbacks and Physician Self-Referral," *Canadian Medical Association Journal*, Vol. 170, No. 7, 30 March 2004, pp. 1115-1118, <http://www.cmaj.ca/content/vol170/issue7/index.shtml>.

former federal health minister Anne McLellan wrote to the four provincial health ministers concerned to communicate her objection to the queue jumping that results in provinces that allow private clinics to sell quicker access to medically necessary diagnostic services. Consultations with provincial officials in all four provinces except Quebec followed. Although multilateral discussions were scheduled to begin in 2004, these discussions were postponed at the request of the provinces, pending the First Ministers' discussions on sustainability of the health care system.⁽¹⁵⁾

RECENT COURT CHALLENGES

On 5 May 2003, five Canadian organizations⁽¹⁶⁾ applied to the Federal Court seeking, among other things, a declaration that the *Canada Health Act Annual Report 2001-2002* did not properly report upon the administration and operation of the *Canada Health Act*, and an order requiring the federal Minister of Health to include particular details in the next report. Of particular interest, one of the grounds put forward in support of the application was that the Minister did not meet the reporting obligations placed on her by the *Canada Health Act* by “failing to document the erosion of the public health care system through the processes of privatization, or identify the impacts of this transformation on accessibility, universality, and other criteria of the *Canada Health Act*.”⁽¹⁷⁾ The Court dismissed the application on the basis that, though these are important concerns, “they are of an inherently political nature and should be addressed in a political forum rather than in the courts.”⁽¹⁸⁾

The lack of information on the involvement of the private sector in Canada's health care system constitutes a serious impediment to Health Canada's reporting of provincial compliance with the *Canada Health Act*. Although the media have reported the existence of private clinics in a number of provinces, including Quebec, Ontario, Alberta and British Columbia, there is no precise or comprehensive information on the scope and extent of private

(15) Health Canada (2004), p. 11,

http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/cha-lcs-ar-ra/2003-04_e.pdf.

(16) The Canadian Union of Public Employees, the Council of Canadians, the Canadian Health Coalition, the Communications Energy and Paperworkers Union of Canada, and the Canadian Federation of Nurses Union.

(17) *Canadian Union of Public Employees et al. v. Minister of Health*, Application, Court File No. T-709-03, 5 May 2003, http://www.canadians.org/documents/CHA_Application.pdf.

(18) Federal Court, Decision, T-709-03, Ottawa, 29 September 2004, <http://decisions.fct-cf.gc.ca/fct/2004/2004fc1334.shtml>.

delivery of health care outside of the publicly funded system. The only information available suggests that there are currently 33 private MRI and CT scan clinics in Canada.⁽¹⁹⁾ In November 2001, Health Canada posted a request for letters of intent to obtain quantitative information on private health care delivery in Canada.⁽²⁰⁾ One project, proposed by Dr. Ian McKillop (Wilfrid Laurier University) was accepted for funding. The deadline for completion of the project, which was initially set for 30 September 2004, was postponed to 28 February 2005.⁽²¹⁾ Unfortunately, the project's findings do not reveal the scope and extent of private-sector delivery, due to a lack of data.⁽²²⁾ As a result, it is very difficult to properly assess the impact of private-sector involvement in the publicly funded health care system.

In June 2004, the provisions of the Quebec legislation that prohibit private insurance from covering insured health services were challenged before the Supreme Court of Canada as being contrary to both the *Canadian Charter of Rights and Freedoms* and the *Quebec Charter of Human Rights and Freedoms*.⁽²³⁾ In a decision released one year after the appeal was heard, four of the Justices concluded that the provisions violated the Quebec Charter; three of the four also concluded that the provisions violated the Canadian Charter. In August 2005, Quebec was granted a one-year stay of the decision to allow it time to comply with the decision.

Because the appeal was decided on the basis of the Quebec Charter and not the Canadian Charter, the decision applies only to the Quebec legislation; similar provisions contained in other provinces' health care insurance legislation are not affected. Such provisions in other provinces may, however, be challenged in the future.

It is difficult to assess the potential implications of this Supreme Court ruling. Some have suggested that the elimination of the prohibition of private health care insurance

(19) Odette Madore, *Private Diagnostic Imaging Clinics and the Canada Health Act*, PRB 05-02E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 17 May 2005.

(20) For more information on this request for letters of intent, see Health Canada's Web site at <http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/rfp/Nov15.html>.

(21) See Health Canada's Web site at http://www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/complet-term/proj-4_e.html.

(22) Ian McKillop, *Private Sector Delivery: Scope and Extent in Canada's Health Care System*, Summary of Research Results, Health Policy Research Program, University of Waterloo, February 2005, http://www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/final/2005-pratique-priv-sector_e.html.

(23) See Marlisa Tiedemann, *Health Care at the Supreme Court of Canada – II: Chaoulli v. Quebec (Attorney General)*, PRB 05-31E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 5 October 2005.

could help the parallel private health care sector (box (6) in Table 2) to flourish and, as a consequence, erode the publicly funded system. In contrast, others have contended that the emergence of private insurance would attract additional funding to Canada's health care system and would reduce the pressures on, and shorten the waiting times in, the publicly funded system. For its part, Health Canada has not yet provided its views on the development of private health care insurance in the context of the *Canada Health Act*. What is clear is that, until a challenge is brought in one of the other provinces that prohibit private insurance, discussions about the implications of the decision may be expected to continue in full force.

CONCLUSION

In summary, the private sector is involved in both the funding and delivery of health care in Canada, and the *Canada Health Act* neither prohibits nor discourages either the private delivery of health services or private health care insurance. Rather, the Act is limited to discouraging private payments by patients through user charges or extra-billing for health services covered by provincial health care insurance plans.

Whether the private delivery and funding of health care in Canada pose a significant threat to the publicly funded system will undoubtedly continue to be the source of intense political debate, as there does not yet appear to be any cogent evidence in support of either position.

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