



**The Chaoulli v. Quebec Decision and the Public/Private  
Interface of Healthcare in Canada  
An education paper for the CFMS Membership**

February 2006

The CFMS gratefully acknowledges the tremendous work of the members of the Private/Public Interface Task Group who produced this paper:

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## EXECUTIVE SUMMARY

There is currently much debate about the direction that Canadians wish to give to our evolving health care system. Of particular prominence in the often-heated discussion, is the question of public versus private funding of health care services.

This paper begins by providing a historical and economic background to the renewed debate over the interface between public and private health care in Canada that has been sparked by the recent decision by the Supreme Court in the Chaoulli v. Quebec case.

The court's decision in the Chaoulli v. Quebec case challenged the notion that public funding remain the sole means of payment for medically necessary services. The Supreme Court decision argued that, where the government has failed to provide timely access to necessary healthcare services, disallowing payment through private insurance violates the Quebec Charter of Rights and Freedoms.

Among medical professionals, there is no clear position. The membership of the Canadian Medical Association (CMA) has demonstrated a nuanced reaction to the decision, and the CMA stance continues to evolve.

**The impact of the Chaoulli decision, both on the future of Canadian healthcare and the future of medical education in Canada, remains to be seen.**

We hope that this backgrounder, collaboratively written by medical students from across the country, will provide information for further informed discussion among students. CFMS members are encouraged to read any of the sections that follow:

Introduction	Chaoulli v. Quebec Decision
History	CMA Response
Healthcare In Canada Today	Wait Times
International Comparisons	Impact on Medical Students

and to **submit responses** to or **engage in debate** within medical student societies. Feedback that arises from this process will provide input into a policy statement that members mandated the CFMS prepare for tabling at the April, 2006 CFMS General Meeting.

## INTRODUCTION

This document summarizes the context of the recent *Chaoulli v. Quebec* Supreme Court decision. More broadly, it provides background on the ongoing debate over the interface between public and private healthcare funding and delivery in Canada.

The purpose of this document is to serve as a primer based upon relevant research and reports. It seeks to define terminology and concepts that are often left unclear in discussions on public and private healthcare. We hope that this paper will stimulate medical students to research these issues and take part in discussions aimed at developing an educated opinion with respect to the ongoing changes in healthcare.

This paper is subdivided into sections such that readers may review according to their interests. It is not critical that it be read from beginning to end.

This discussion piece elaborates upon the following points:

### History

- Canada's healthcare system has evolved to provide public funding for all "medically-necessary" hospital and physician services. Although provinces are responsible for the delivery of healthcare, the federal government provides partial funding of healthcare to ensure that a national healthcare policy exists.
- Total expenditures on healthcare have increased over time. Technology, demographics and evolving patient expectations have also influenced the healthcare system. These have stimulated a number of healthcare reviews, including the Romanow and Kirby reports of 2002, which called for changes to the funding and delivery of healthcare.

### Healthcare In Canada Today

- Canada's current healthcare system is guided by the five tenets of the *Canada Health Act* (1984). This mandates a single public *funding* of health care, thus barring the use of private insurance. Healthcare *delivery* is mostly by not-for-profit hospitals as well as by private physicians.

### International Comparisons

- No other developed country provides coverage for hospital and physician services as comprehensively as does Canada, but many cover more pharmaceutical, homecare and dental care services. Canada's overall health expenditures stand at about 10% of its GDP. This figure is mid-range amongst developed countries (1), but significantly less than that of the United States, which spends approximately 16% of its GDP on healthcare.

### The Chaoulli v. Quebec Decision

- The Supreme Court decision in the Chaoulli v. Quebec case challenged the notion that private insurance should be disallowed for medically necessary hospital and physician services. It suggested that, given the government's failure to provide adequate healthcare services, it would be a violation of the Quebec Charter of Rights and Freedoms to prohibit the provision of optional private insurance.
- The Canadian Medical Association responded to the decision with a representatives' poll that demonstrated a nuanced opinion within its membership. A motion was passed by the CMA General assembly reaffirming that health care should be provided on the basis of need rather than ability to pay. At the same meeting, a second motion was passed supporting the use of private insurance for provision of care when the public system fails to provide timely access.

### Wait Times

- Reduction of wait times, which were the focus of the Supreme Court decision, can be approached through a number of policy reforms. Internationally, no definitive evidence exists that the introduction of private insurance reduce overall wait times, though they can be reduced for those able to pay.
- Wait times are only one component of a wider context of healthcare reform that needs to be considered for sustainable change. Health human resources, technology, primary healthcare reform and changing patient expectations are but a few of the changes ongoing in healthcare.

### Impact on Medical Students

- The impact of the Chaoulli-Zeliotis decision on the future of medical students has not yet been fully investigated by researchers, but there is no question the ramifications could be significant.
- Physicians have historically played an important role in helping to mould Canada's healthcare policy. The more informed medical students become, the more they will be able to contribute to informed debate over the policy challenges ahead.
- Students are invited to answer the questions posed in the final section of this document, as a framework for considering their position on this important issue.

## HISTORY

### *The Origins of Canadian Healthcare*

The legislative roots of comprehensive public health insurance in Canada arose in Saskatchewan under Premier Tommy Douglas and the Co-operative Commonwealth Federation (the predecessor to the NDP). Under Douglas's leadership, Saskatchewan initiated a plan for public funding of all medically necessary *hospital* services in 1947. By 1961, this plan was adopted by the federal government, as well as by each of the provinces.

Saskatchewan also originated public funding for all medically necessary *physician* services. Physicians generally supported public financing of hospital services but held reservations with respect to public funding of physician services. Concern arose that this new arrangement would threaten physician autonomy and might damage the physician-patient relationship (3, 4). In 1962, the year in which Saskatchewan first introduced coverage, doctors in the province responded by striking. Physicians withheld services except for limited emergency room care until negotiations brought the strike to an end after 23 days (1).

As had been the case with coverage of hospital services, federal proposals for public coverage of physician services soon followed the Saskatchewan example. In 1966, the Medical Care Act was passed by the federal government, and by the early 1970's, all provinces had adopted this plan that provided for provincial funding, with federal sharing of expenses.

### *The Lalonde Report*

The Lalonde Report of 1974 provided a review of the healthcare system and outlined a new paradigm for public provision of health care. Specifically, the report called for the government to expand its role beyond that of simple healthcare *provider*; a focus on health promotion and encouragement of individual responsibility for health was recommended (5). Although the actual policy results of the Lalonde Report are debatable, it unambiguously established the merits of integrating preventative medicine into health care systems design. (5).

### *Provincial Federal Funding Disputes*

In these early years of the new funding system, healthcare continued to fall under provincial jurisdiction, as defined by Canada's constitution. The federal government was only able to influence provincial healthcare plans by exclusively providing healthcare funding for provinces that funded hospital and physician services. Under the original funding scheme that supported public coverage of hospital and physician services, the federal government was required to

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reimburse the provinces for 50% of total essential care costs through a direct federal cash transfer.

By the late 1970's, this arrangement was beginning to unravel. The federal Government had limited ability to predict annual healthcare budgets, and each province defined its *essential* healthcare expenses differently. Meanwhile, the provinces sought greater autonomy over how health care dollars would be spent, particularly where physician services and services rendered outside of the hospital were concerned.

In an effort to address these shortcomings, a second transfer regimen was enacted in 1977. Under this arrangement, block funding replaced the 50/50 share of healthcare funding, allowing more predictability for federal government budgeting. As well, some taxation power was relinquished by the federal government, allowing the provinces to increase revenue for healthcare and other social service expenses.

Despite its good intentions, this new funding arrangement system had some unintended consequences. In particular, the practice of physician extra billing became acceptable in several provinces, whereby physicians charged an additional fee to that provided by public funding. Provinces, with their new spending freedom, saw this as way to reduce overall healthcare spending while appeasing demands by physicians for increased billing rates. Over time, this practice of charging patients began to disproportionately burden the poor and the sick (2).

The question of extra billing was addressed in the *Canada Health Act* of 1984. This act brought together all the previous measures of public hospital and physician service insurance under a unified piece of legislation. The federal government stipulated a dollar-for-dollar claw-back scheme whereby every dollar charged through extra billing in the provinces would result in equivalent funding being taken away by the federal government.

In 1995, another funding mechanism was enacted entitled the Canadian Health and Social Transfer (CHST). Under this legislation, the Federal Government provides the provinces with an unspecified block transfer to cover federal obligations to provincially administered healthcare, post-secondary education and social assistance. While this new arrangement has given even greater autonomy to provinces with regard to their expenditures, it has also been a source of conflict between the federal government and the provinces over budget shortfalls, spending cuts and healthcare deficiencies.

Overall, there has been a decline in the level of federal funding for healthcare services since the origins of public healthcare, but the extent of this decrease is disputed (See Appendix B). As provinces have become increasingly responsible

for healthcare funding, this service has grown to consume a large part of the provincial budget (See Appendix B).

### *Healthcare Reviews*

In addition to the changes in the sources of funding from the 1960's through to the mid-1990s, Canada's public healthcare system evolved significantly in other ways. Expenditures grew, both in the absolute and as a portion of the gross domestic product (GDP); in the case of total spending, expenditures increased from approximately 7% of GDP in 1977-78 to over 9% in 2001-02 (2). The demographic impact on healthcare increased with an aging baby-boomer population. New technologies were rapidly being introduced, including computers, new medical procedures and devices, and more advanced pharmaceuticals. In addition, Canadians' expectations of healthcare delivery had changed as patients had become better informed and empowered in healthcare decision making, and were coming to expect faster, more comprehensive service.

These changes resulted in the publication of a series of commissions and government reports by both federal and provincial governments addressing the state of Canada's healthcare system and ways in which it could be improved. The most significant of these reports included the findings of the Commission on the Future of Health Care in Canada (i.e. the Romanow Commission) (7) and the Report of the Federal Standing Committee on Social Affairs, Science and Technology (i.e. the Kirby Commission) (8). Important provincial reports included the Clair Report (Quebec, 2001) (9), the Fyke Report (Saskatchewan, 2001) (10), and the Mazankowski Report (Alberta, 2001) (11).

Each of these studies presented ideas for reorganizing the funding and delivery of healthcare. A comparison of the conclusions of the Kirby and Romanow reports is included in Appendix A.

A number of important funding and policy arrangements between the provinces and the federal government have been made since the Romanow Commission. In February of 2003, a new Health Accord was agreed to which injected \$27 billion from the federal government into provinces in order to broaden homecare and pharmacare coverage. It also established a Health Council, an agency designed to increase accountability by reporting on the implementation of this new federal funding (12).

In 2004, another agreement was signed committing the federal government to providing \$41 billion to the provinces over a ten year period. Part of the funding was earmarked for reducing waiting times across Canada (13).

## HEALTHCARE IN CANADA TODAY

### *The Canada Health Act*

The *Canada Health Act* was introduced by the Trudeau Liberal government in 1984. It established the legal framework that regulates healthcare delivery today. The *Act* rests on five principles:

1. **Comprehensiveness:** All medically necessary health care services provided by physicians or in hospitals must be covered by provincial healthcare plans.
2. **Universality:** All residents of a province must be entitled to insured services through uniform terms and conditions.
3. **Portability:** Host-province rates apply to health care services provided elsewhere in Canada.
4. **Accessibility:** Provincial health care plans must provide for insured health services through uniform terms and conditions and must not impede or prevent reasonable access to these services by any means.
5. **Public administration:** All administration of provincial health insurance must be carried out by a public authority on a not-for-profit basis. (1)

The *Act* sets requirements for federal funding of *provincially* managed health care delivery. As noted in Appendix B, the federal portion of funding has decreased over time. Health Canada's role also involves administering health care delivery to aboriginal populations living on reserves and military personnel and their relatives; setting guidelines for medications and foods; price controls on medications; and national public health interventions (1, 3).

### *Rising Healthcare Costs*

In 2004, Canada's average total public and private healthcare expenditures amounted to \$4,078 per person, ranging from \$3,667 for a resident of Québec to \$8,751 for a Nunavut resident. Overall, 9.9% of Canada's GDP is spent on healthcare (4, 5). Proportionally this is considerably lower than healthcare expenditures in the United States, but about average as compared with other developed countries (6). Since 1996, healthcare expenditures have risen faster than Canada's GDP, increasing proportional spending on healthcare and raising concern about sustainability of the current funding model. (3,5,7). Drug prescription costs have been chief among the fastest growing health expenditures since 1996, reaching \$18 billion in 2004 and surpassing the cost of all of physician services (\$16 billion). At a rate of increase in prescription drug costs of \$1.5 billion per year [6], the questions the question of alternate allocation of these resources has been raised. Today, Canada trails behind almost all developed countries in the availability of MRIs, CT scanners, the number of physicians, and the number of acute care beds per population (6).



### *Public Funding and Private Delivery*

The framework of the *Canada Health Act* establishes public *funding* for all medically necessary hospital and physician services, but private *delivery* of these services.

Public funding comes mainly from provincial and federal income taxation. In Ontario, Alberta and British Columbia, health care premiums (3, 9) serve as a tax dedicated to healthcare expenditure. In order to ensure exclusively public funding of medically necessary health services, each province has enacted legislation to make it illegal to purchase *private* insurance for these services.

Delivery of health care in Canada is undertaken by hospitals and physicians. Most hospitals are “private” entities only inasmuch as they are not directly controlled by the provincial government. The vast majority of hospital funding comes from the government. They are run as not-for-profit organizations, controlled by independent boards of directors and sometimes having religious affiliations.

Most physicians, meanwhile, are essentially independent business people. They charge the public for their services, but are not hired directly by the government nor are they provided with any of the employee benefits that other state employees receive. Some physicians work in academic settings or in special community health clinics that make them salaried government employees, but they are the exception and not the rule.

### *Private For-Profit Delivery*

The previous section characterizes the vast majority of healthcare delivery within Canada. However, the delivery of for-profit medical services by private clinics, and paid for by private funds also exists (3). Practitioners are usually required to *opt out* of the public insurance system and have not been allowed to be compensated by private insurance and thus must be paid directly by users— this scenario is at the heart of the *Chaoulli v. Québec* case. This category of privatization has remained limited in Canada, despite fast growth in recent years (10, 11). The number of for-profit private clinics or hospitals in Canada today is estimated at 50 to 60. They provide hernia repair, cataract and orthopaedic surgery, family medicine services and, most recently, emergency medicine services. The governments of British Columbia and Alberta have recently contracted-out many elective surgeries and hip and knee surgeries to such facilities (11).

### *Other Services*

Outside of the provision of hospital and physician services, some provinces provide partial coverage of a range of healthcare services including prescription

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drug plans, home care, continuing care, and long-term care. The scope of the services varies widely across provinces and, in some cases, includes partial coverage of rehabilitation, physiotherapy, chiropractic care, and dental care. Unlike the single-payer system applied to hospital and physician services, the provincial coverage of these additional services does not necessarily cover the full cost and is usually used in conjunction with private insurance and private payment<sup>3</sup>.

In Canada, 69.7% of the total expenditures on healthcare are from public sources. This is much greater than the United States' 44%, but lower than almost all European countries, including some with public-private mixed systems such as the United Kingdom (83.4 %) (5, 6).

## **INTERNATIONAL COMPARISONS**

The Canadian healthcare system is regularly compared to that of other nations. The Organization for Economic Co-operation and Development (OECD) collects and compares data from its 30 member-nations and publishes dozens of reports on their observations. In this paper, we have taken the approach of the Massachusetts-based Commonwealth Fund, which bases the majority of its research on comparisons among five English-speaking countries with similar cultures, a shared affluence, and a common language: Australia, Canada, New Zealand, the United Kingdom and the United States. Appendix C provides a basic summary of the role of public and private insurance, the breakdown of healthcare expenditures, and measures of three health outcomes among these five countries.

In comparison with other developed nations, Canada's healthcare system has been described as deep but not wide. No other developed country provides coverage for hospital and physician services as comprehensively as does Canada, but many cover more pharmaceutical, homecare and dental care services.

Canada's overall health expenditures stand at about 10% of its GDP. This figure is mid-range amongst developed countries, but significantly less than that of the United States, which spends approximately 16% of its GDP on healthcare.

## THE CHAULLI V. QUEBEC SUPREME COURT OF CANADA DECISION

### *The Facts of the Case*

Having encountered numerous health problems including a hip replacement, 73-year-old salesman George Zeliotis became an advocate for reducing wait times for patients in Quebec hospitals. Dr. Jacques Chaoulli provided home appointments to patients and who attempted to get a licence so he could offer his services as an independent private hospital. His application was rejected due to provincial legislation prohibiting private health insurance. Together, the two men sought a motion for a declaratory judgment<sup>1</sup> to contest the prohibition.

### *The Decision*

The Supreme Court of Canada ruled that the Quebec Health Insurance Act and the Hospital Insurance Act, which prohibited private medical insurance, violated the Quebec Charter of Human Rights and Freedoms. In a 4-to-3 decision, the Court found that the Acts violated Quebecers rights to life and security of person under the Quebec Charter; as such the ruling is only binding in Quebec. Three of the seven judges also found that the laws violated Section 7 of the Canadian Charter of Rights and Freedoms.

### *Majority Arguments*

Deschamps argued that the government's legislation to prohibit private insurance violated the right to life, liberty and security of the person, noting that long waits at hospitals can result in deaths, and that private health care prohibited by the Quebec Acts would likely have saved those lives. The wait lists, she argued, are an implicit form of rationing, and it is the government's rationing policy that is being challenged here as a violation of the right to "security of person" (*per* Canadian Charter) and "personal inviolability" (*per* Quebec Charter). She concludes:

“For many years, the government has failed to act; the situation continues to deteriorate. This is not a case in which missing scientific data would allow for a more informed decision to be made. .... Under the Quebec plan, the government can control its human resources in various ways, whether by using the time of professionals who have already reached the maximum for payment by the state, by applying the provision that authorizes it to compel even non-participating physicians to provide services ... or by implementing less restrictive measures, like those

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<sup>1</sup> A declaratory judgment is a judgment of a court that declares what rights each party in a dispute should have but that does not order any action or result in any legal damages.

adopted in the four Canadian provinces that do not prohibit private insurance or in the other OECD countries. While the government has the power to decide what measures to adopt, it cannot choose to do nothing in the face of the violation of Quebeckers' right to security. ...." (1)

McLachlin and Major argued that the

"Charter does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the Charter." (2)

In sum, according to these justices, the government had legislated a single payer providing health care to Canadians, which, on the evidence of significant delays in service, harmed the right to security of person. All three justices also found that the legislated single purchaser scheme seemed unnecessary given the lack of such legislation in other provinces and the use of parallel insurance systems in other OECD countries.

### *Dissenting Arguments*

Binnie and Lebel argued that Chaoulli's complaint had nothing to do with constitutional law (the Charter) but rather with Quebec's social policy, which belonged before National Assembly, not the Supreme Court of Canada and they objected to the court's overly ambitious approach to constitutional law. They also objected to the court's claim to be able to decide what a reasonable wait time for service might be and were suspicious of selective use of evidence regarding other countries' health systems.

### *What does the decision mean?*

Prohibition of private health insurance violates Quebecker's Charter rights to security of person. The government cannot establish a monopoly on health-care provision and then fail to deliver the service. A system that requires patients to wait for an unreasonable amount of time for necessary services is, in effect, not delivering that service

### *What doesn't it mean?*

The decision does not mandate any particular course of action, including:

- Private health insurance
- Abandonment of single tier health system
- Duplication of any country's system (or "Americanization").

### *What has occurred since the decision?*

The Supreme Court has stayed its judgment for one year, striking down the province's ban on private health insurance. Quebec, supported by Ottawa, had argued that the ruling in the Chaoulli case was complex and implementing it could place delivery of medical services in Quebec in disarray.

Quebec Provincial Health Minister, Philippe Couillard, has set up a committee to draft a proposal that will be tabled in the National Assembly by mid-December, 2005. Public hearings will be held in January 2006 and the government says legislation should be adopted by the end of June 2006.

The Canadian government is publicizing its ongoing activities aimed at fulfilling the 2004 Accord commitments, especially with regards to a wait times strategy and ongoing activities of the Health Council of Canada.<sup>2</sup>

Several conferences exploring the legal ramifications of the decision and possible directions for reforming the health system have taken place, and more are surely in the works:

- The Faculty of Law at University of Toronto held a conference entitled "Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada."<sup>3</sup>
- York University's Osgoode Hall Law School held "the One Day Summit: Chaoulli and the Restructuring of Health Care in Canada" (no links/online resources available).
- The Canadian Independent Clinics Association held a conference entitled "Saving Medicare: Strategies and Solutions."<sup>4</sup>

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<sup>2</sup> For more information on the Wait Times Strategy, see [http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/qual/acces/wait-attente/index_e.html) (accessed Jan 31, 2006). The HCC was formed in response to calls in both the Kirby and Romanow reports and is mandated to monitor and report on the progress of health renewal in Canada. For information on the Health Council of Canada, see <http://hcc-ccs.com/index.aspx> (accessed Jan 31, 2006).

<sup>3</sup> See: [http://www.law.utoronto.ca/visitors\\_content.asp?itemPath=5/5/9/0/0&contentId=1122](http://www.law.utoronto.ca/visitors_content.asp?itemPath=5/5/9/0/0&contentId=1122) (accessed Jan 31, 2006).

<sup>4</sup> See: <http://www.cimca.ca/events/conference.html> (accessed Jan 31, 2006).

## THE CMA RESPONSE

### *The CMA General Council of August 2005*

Just over a month after the *Chaoulli v. Quebec* ruling, the CMA's General Council was held in Edmonton. In response to this historic result, several important and contentious resolutions were proposed, debated and voted on. In the days that followed the General Council, conflicting media accounts generated a considerable amount of confusion about what exactly had transpired and what it meant for the future of the Canadian health care system. What follows is a retrospective look that aims to answer these questions.

### *Controversial Motions*

Early in the meeting, the Canadian Association of Interns and Residents (CAIR) put forward a simple motion reaffirming that health care should be provided on the basis of need rather than ability to pay – a principle enshrined in the Canada Health Act – and denouncing the notion that private health insurance would improve wait times:

The Canadian Medical Association endorses the principle that access to medical care must be based on need and not ability to pay. The CMA calls on governments and other key stakeholders to work with physicians to ensure that, instead of permitting the development of a parallel private health care insurance system as a solution to lengthy wait lists, Canada maintains a strong, vibrant, publicly funded health care system that is capable of meeting the needs of all Canadians.

The clauses of the motion were split into two distinct motions; the first of the two—universal accessibility—was passed with 96% support while the second—denouncement of private insurance—was defeated by a 2:1 margin (1).

The final resolution voted on in Edmonton was as follows:

The Canadian Medical Association supports the principle that when timely access to care cannot be provided in the public health care system, the patient should be able to utilize private health insurance to reimburse the cost of care obtained in the private sector.

The most controversial motion of the meeting, it eventually passed by a 2:1 margin following a heated debate. On the heels of the defeat of their anti-private motion, the Canadian Association of Interns and Residents (CAIR) was “disappointed by the vote” (2).

The Canadian Federation of Medical Students was present to represent the interests of medical students with a single vote but abstained as it was felt no

mandate existed from its constituency to make a decision regarding such a statement. A complete listing of all motions passed at the General Council is available (3).

### *CMA Interpretation of General Council Result*

Since General Council 2005, the CMA has attempted to clarify its stance with respect to the issue of private health care. In a recent letter to the Federal Minister of Health, the now CMA President Dr. Ruth Collins-Nakai argued that the CMA “supports timely access to quality health care based on need and not ability to pay, and this principle was reaffirmed at our last annual meeting by a near unanimous vote.” She also noted that the CMA is committed to timely access to quality care for all patients, and is “interested in making the changes needed to provide our patients with the care they need, when they need it”(4).

With respect to the final and more controversial motion on private insurance, Dr. Collins-Nakai said that patients “need a way to deal with their pain and suffering when, and only when, the public system fails to provide care” (5). Dr Collins-Nakai states that in essence, “what the CMA is proposing reflects what the highest court in the land is already saying” (6). What remains to be seen is how these changes will manifest themselves within the system.

### *Discussion of CMA Decision*

Immediately following the Chaoulli verdict, Saskatchewan based health policy analyst Steven Lewis called on physicians to be involved in the widespread reforms needed, stating that the public system cannot succeed “without a medical profession that is widely and officially committed to its values”(7).

Critics of the CMA motions have called into question the organization’s logic and motives. Many have suggested that doctors have missed an opportunity to strengthen the public system and that they “should have thrown their weight solidly behind Medicare” (8). Others have pointed to the apparent contradiction the motions represent—on the one hand supporting access based on need and not ability to pay, while on the other hand promoting private insurance—and suggest that physicians are only adding further confusion to the debate.

Historically speaking, it is true that this position constitutes a major change for the Association, as “until now [the CMA] has been unequivocal in its support for a strong public system” (9). Other organizations such as the Canadian Nurses’ Association (CNA) have been vocal in their continued support for a public system, stating that the CNA “fundamentally opposes the idea that a parallel private health insurance system is the solution” (10). The implications of the CMA’s apparent change of heart for the future of Canadian health care remain to be seen.



*CMA Plan of Action*

The CMA has recently released a document entitled *It's About Access*, to define a consultation process as a first step in developing "a discussion paper with policy principles that will define the relationship between the public and private sectors in the delivery and funding of health care in Canada." This discussion paper will be presented to the CMA Board of Directors in February 2006.

The CMA also faces complex and difficult challenges as the profession is deeply divided about two-tiered health care. The case that triggered the Supreme Court decision was brought to the courts by a physician, Chaoulli, who was prohibited from opening a private health care facility. He is not alone among physicians in his desire to be able to provide services paid for by private insurers. Others, however, are just as strongly committed to a single-tier system (12).

## WAIT TIMES

The Chaoulli decision hinged on the issue of wait times. It provided an avenue allowing for private insurance in order to alleviate waiting times for care such as the hip replacement surgery required by Zeliotis.

Wait times for non-critical care have been a prominent issue for provincial and federal governments over the past decade. The priority areas have currently generally been defined as joint replacement, cancer, cardiac, cataract and diagnostic imaging.

Although efforts have been made (1), there remains an absence of comparable indicators for wait times and for determining medically acceptable wait times. Part of the challenge has been a reluctance of some physicians to relinquish authority over individualized wait times by participating in standardized assessment for prioritizing patients (2).

Most provinces and territories have made targeted efforts to reduce wait times. The Cardiac Care Network of Ontario has centralized management and improved efficiency across Ontario (3). The Western Canadian Waiting List Project reflects an effort for an inter-provincial alliance to pool resources and harmonize waiting lists (4).

The Canadian Wait Times Project was initiated in 2004 by the Federal Government to develop comparable indicators and benchmarks for medically acceptable wait times. This report was partially released in December of 2005. This information will be used to guide a \$5.5 billion Wait Time Reduction Fund to support waiting lists reductions (5).

A number of policy alternatives exist for relieving wait times that have been experimented with in various jurisdictions. These include:

- increasing overall capacity within a publicly funded system by hiring more staff and building more facilities
- increasing outpatient surgery and hence using resources more efficiently
- focusing on preventative care
- investing in information technology integration. (6)

Two other measures that have been experimented with have come front and centre in Canada since the Chaouilli decision include the introduction of private parallel insurance and the introduction of guaranteed waiting times.

### Private Parallel Insurance and Wait Times

Permitting private insurance is intended to increase the overall capacity of the healthcare system. In theory, some patients from the public waiting list will leave

to the private list to get faster care. This will result in decreased waiting times for those on the public waiting list, resulting in faster care for them as well. It is also presumed that the introduction of private insurance will introduce an element of competition that will promote an increased overall efficiency in the healthcare system.

Opponents of private insurance point out that private insurance cannot expand existing capacity without taking away from the public system. There are only a finite level of resources, and private insurance will not create the new health professionals to service new demands. Simply hiring new health professionals and developing new facilities within the existing public system would have the same affect as relying private insurance to introduce new services.

They also point out that when health professionals are allowed to work in both a publicly and privately insured settings, they will often have a perverse incentive to get patients into the privately insured service for which the health professionals may receive greater remuneration. The result is that while wait times may decrease for those accessing private insurance, the wait times for those in the public system will increase.

Impacts on wait times are difficult to isolate from other the impacts of other health policy initiatives. However a number of expert observers and organizations in recent years have published reports of their research.

Ted Marmor, a Yale researcher on social policy cited in the Chaoulli Supreme Court decision, suggests that healthcare systems with parallel private insurance are “likely to be more expensive overall, are certain to be less fair, and will not by themselves do very much at all about the length of waiting lists.” (7)

A report from the Organization for Cooperation and Development published in 2003 suggested a more ambiguous relationship between private insurance and waiting lists.

- In Australia, approximately 44% of the population purchases private insurance for waiting list services. This percentage of the population with private insurance has increased greatly in the past decade. At the same time as the number of people taking private insurance has increased, waiting lists in the public sector have markedly decreased for a number of elective services, including cataract surgery and coronary bypass surgery. (8)
- In England, parallel private insurance has expanded as an option in recent years as well. Different regions of the country have purchased private insurance at different rates. Public waiting lists are longest in the regions with eth highest concentration of private insurance. (8)

### *Wait Times as a Health Policy Priority*

Wait times are a highly visible indicator of the ability of a health care system to meet the needs of patients. Physicians, patients, and community members are all stakeholders in addressing inadequacies and undertaking healthcare reform.

However, wait times are only one component of a large and complicated healthcare system in Canada. Those active in health care reform aiming to reduce wait times must consider how changes in other health policy areas might contribute to improving wait times, and how changing waiting time policy might impact these areas.

Some of the areas of health policy reform that must be considered include:

- **Scope of practice:** Review those procedures that should be only be performed by physicians, and identify those that may more efficiently be undertaken by allied healthcare professionals including nurses, nurse-practitioners, physiotherapists, occupational therapists, and pharmacists, among others.
- **Primary health care reform:** Provide patients with appropriate services and promoting preventative medicine, such as multidisciplinary health teams, screening, and the promotion of better health lifestyles.
- **Information technology:** Utilizing information technology in order to improve quality of patient care, especially in order to reduce medical error.

## IMPACT ON MEDICAL STUDENTS

It is important to consider the implications of the Chaoulli decision on the future of medical education. For example, if teaching hospitals and preceptors do not participate in the same health care system, undergraduate medical education may be affected. Readers may consider the impact of the Chaoulli decision on medical education through the following questions.

*Regarding the role of the physician:*

The CanMEDS 2000 guidelines provide seven roles for the training of physicians: medical expert, communicator, corroborator, manager, health advocate, scholar and professional. (1). **How will these roles be affected in a system where there is considerable private funding and delivery of health care?**

*Regarding preceptors and mentors:*

**Would a parallel health care system impact the availability of physicians for teaching and mentoring students? If so, how?**

*Regarding the social accountability of medical schools:*

The World Health Organization (WHO) defines the social accountability of medical schools as: “the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community” (2). This has been the focus of the Association of Faculties of Medicine of Canada (AFMC) for the past several years. **Would a parallel health care system alter this purpose? If so, how?**

Medical schools serve a dual role in that they provide both education to students and service to the community at large through teaching hospitals. **Would this role be altered in a system where increased private funding coexists with public funding? If so, how?**

*Regarding education in context:*

The Romanow Commission called on health professionals to revolutionize their education and promote interdisciplinary training, community-based delivery and a focus on prevention (3). **In the context of a change from a single-payer model, will this be affected? If so, how?**

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**APPENDIX A: COMPARISON OF ROMANOW VERSUS KIRBY REPORTS**

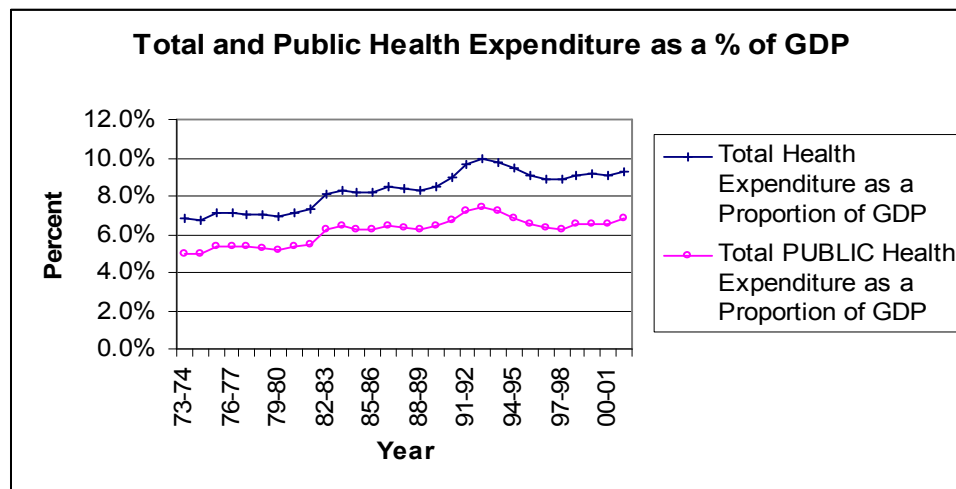
Recommendations from:	Romanow	Kirby
Health Funding	<ul style="list-style-type: none"> <li>• Rules out any form of private payment for “medically necessary” hospital and physician services, including both direct payments (through user fees) and indirect payments (through private insurance)</li> <li>• Expands government funding to include coverage of catastrophic drug costs, palliative, mental health and post-acute care.</li> </ul>	<ul style="list-style-type: none"> <li>• Similar to Romanow for “medically necessary” hospital and physician services.</li> <li>• Catastrophic drug program and home care programs would include some user fees, and would work to complement existing private insurance.</li> </ul>
Medical Diagnostic Services (MRI, CT etc.)	<ul style="list-style-type: none"> <li>• Increased public funding for provision of these services in not-for-profit facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Continued public funding of services regardless of whether they are provided in for-profit facilities or not-for-profit facilities</li> </ul>
Accountability	<ul style="list-style-type: none"> <li>• Creation of Health Council to measure investments and outcomes in healthcare across provinces</li> <li>• Within province management of waiting lists</li> </ul>	<ul style="list-style-type: none"> <li>• “Health Care Guarantee”: patients receive treatment within fixed period of time or province pays for treatment outside of province</li> </ul>
Physicians, Nurses and Allied Health Professionals	<ul style="list-style-type: none"> <li>• National strategy for education and distribution of health workforce, including redefining scope of practice for health professionals</li> </ul>	<ul style="list-style-type: none"> <li>• Similar to Romanow</li> <li>• Specifically calls for large increases in medical school enrolment</li> </ul>
Primary Healthcare Reform	<ul style="list-style-type: none"> <li>• Calling for preventative, multidisciplinary care</li> </ul>	<ul style="list-style-type: none"> <li>• Similar to Romanow</li> <li>• Close integration of electronic health</li> </ul>

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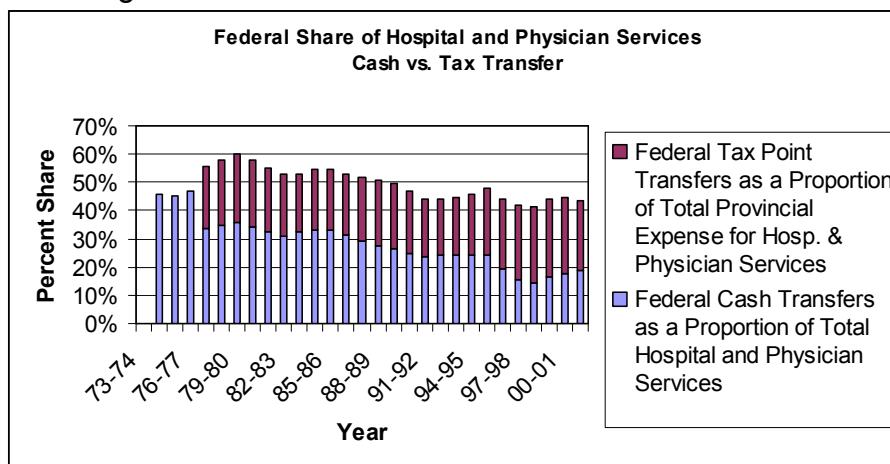
	<ul style="list-style-type: none"><li>• Reshaping financial incentives to allow healthcare providers to better provide primary care</li></ul>	record to improve patient care
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**APPENDIX B: CHANGES IN HEALTHCARE FUNDING**

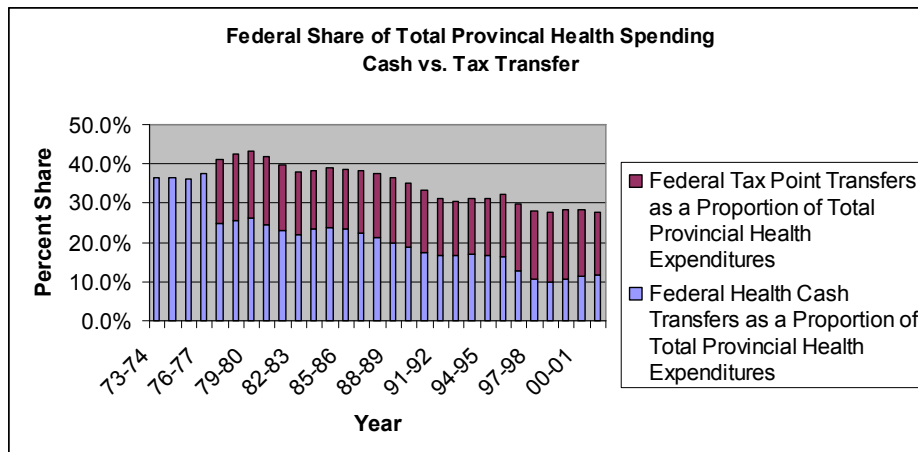
- Both total and public health expenditures have risen. In the case of total spending, it has increased from approximately 7% of GDP in 1977-78 to over 9% in 2001-02. Similarly, public spending for health services has risen from roughly 5.4% in 1977-78 to 6.8% in 2001-02.



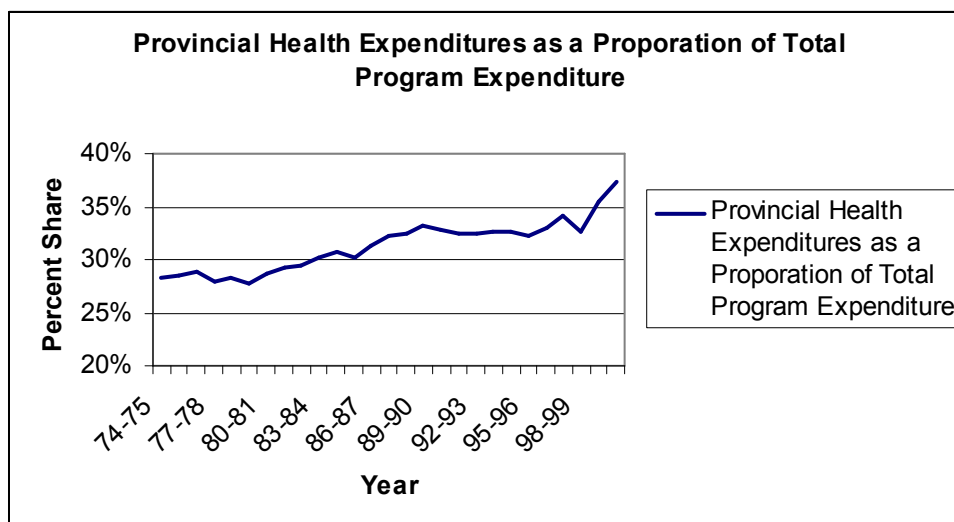
- Federal outlays to the provinces for *hospital and physician services* as well as for total health care expenses have declined from a high of nearly 60% at the end of the 1970s, to a low of 41% in the late 90s.<sup>2</sup> Over the same period, the cash portion (as opposed to tax point) portion of the Federal contribution has declined from as high as 47% (of *physician and hospital services*) in the late 70s to as low as 14% in the late 90s.<sup>2</sup> Similarly, federal outlays for *total* provincial health spending have declined from as high as 43% in the late 70s to as low as 28% in 2001/02.<sup>2</sup>



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- Finally, Romanow showed that the provincial healthcare commitments were rising as a share of their total program spending from roughly 28% in 1977-78 to nearly 37.3% in 2000-01



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**APPENDIX C: INTERNATIONAL COMPARISONS OF HEALTHCARE POLICY**

	What services are covered by Public Insurance?				Who pays for Health Expenditures? <sup>2</sup>			How does Private Insurance fit in to the Healthcare System? <sup>2</sup>	Life Expectancy At Birth (years) <sup>4</sup>	Infant Mortality (per 1000 live births) <sup>4</sup>	% who do not seek care because of cost <sup>5</sup>
	Physician	Hospital	Drugs	Dental	Public Insurance	Private insurance	Out-of-Pocket				
AUS	Co-pay't required ✓	✓	Co-pay't required ✓	✗	69 %	12 %	19 %	<ul style="list-style-type: none"> <li>•DUPLICATE and SUPPLEMENTARY insurance are available for all services</li> <li>•COMPLEMENTARY insurance available to cover co-payments</li> <li>•tax breaks for those who purchase private insurance</li> </ul>	80.3	4.8	29 %
CAN	(98%) <sup>1</sup> ✓	(93%) <sup>1</sup> ✓	Hospital Only (38%) <sup>1</sup>	(5%) <sup>1</sup> ✗	71 %	13 %	16 %	<ul style="list-style-type: none"> <li>• SUPPLEMENTARY insurance allowed; DUPLICATE insurance illegal for physician / hospital services ( until the Zeliotas/Chaoulli decision)</li> <li>• private insurance is tax-deductible</li> </ul>	79.7	5.4 §	17 %
NZ	Co-pay't required ✓	✓	Co-pay't required ✓	✗	78 %	7%	15 %	<ul style="list-style-type: none"> <li>•DUPLICATE and SUPPLEMENTARY insurance are available for all services</li> <li>•COMPLEMENTARY insurance available to cover co-payments</li> </ul>	78.7	5.6	34 %
UK	✓	✓	Co-pay't required ✓	Co-pay't required ✓	83 % <sup>1</sup> (2003)*	3.3% (1996)*	2.7 % <sup>3</sup> (1995)*	<ul style="list-style-type: none"> <li>•DUPLICATE and SUPPLEMENTARY insurance are available for all services</li> <li>•COMPLEMENTARY insurance available to cover co-payments</li> </ul>	78.5	5.3	9 %
USA	Some coverage by Medicare/Medicaid; Co-pay required	Some coverage by Medicare/Medicaid; Co-pay required	Some coverage by Medicare/Medicaid; Co-pay required	✗	44 %	41 %	15 %	<ul style="list-style-type: none"> <li>•PRIMARY insurance for those not on Medicare or Medicaid</li> <li>•SUPPLEMENTARY and COMPLEMENTARY insurance allowed for all services</li> </ul>	77.2	7.0 §	40 %

<sup>1</sup> Source: CIHI (2005): *Exploring the 70/30 Split: How Canada's Health System is Financed*.

<sup>2</sup> Source: OECD (2004): *Private Health Insurance in OECD countries*.

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<sup>3</sup> Source: Tuohy et al. (2004) *How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD nations.*

<sup>4</sup> Source: OECD Health Data 2005

<sup>5</sup> Source: The Commonwealth Fund (2004) International Health Policy Survey

\*Note that the UK's expenditures do not sum to 100% because of the discrepancy of the source and date.

§ Note that in Canada and the USA, very premature infants with low chances of survival are listed as live births; this is not so in the other nations.

'Duplicate' refers to private insurance for publicly-insured services, 'Complementary' refers to private insurance covering co-payments and deductibles, and 'Supplementary' refers to private insurance for services not insured by the public schedule.



## APPENDIX D: GLOSSARY OF TERMINOLOGY

**Two-tiered healthcare:** Allowing for two types of healthcare systems existing simultaneously by permitting private insurance for medically necessary services. Canada is the single country to entirely prohibit private insurance for medically necessary services amongst OECD countries.

**Private insurance:** Insurance coverage for healthcare that is provided by a private corporation and paid into by patients. The Canada Health Act prohibits private insurance for hospital and physician services, but private health insurance is legal and common for pharmaceutical, dental and homecare coverage.

**Private healthcare:** An ambiguous term used variously to describe different components of healthcare. Canada has a publicly funded healthcare system (paid for by taxpayer dollars) with private delivery by physicians and hospitals. There are some minor exceptions to this, such as private room fees in hospitals.

**Medically necessary services:** A term which is never specifically defined by the Canada Health Act but which broadly includes hospital and physician services. Individual provinces have interpreted the meaning differently, depending on values and budgets.

**Single funder healthcare:** Canada has a single funder for all physician and hospital services, the provincial governments. This is in contrast to the U.S., for which healthcare is funded by a variety of private and public sources. Single funder healthcare has generally been acknowledged to provide more economically efficient healthcare, while providing inferior access to new technology.

**Extra billing and user fees:** Charging patients for any component of medically necessary hospital (user fees) and physician services (extra billing). This practice in Canada has been mostly eliminated through enforcement of the Canada Health Act, although a few exceptions exist.

**Hospital privatization:** Hospitals in Canada have historically run by private, not for profit, charitable organizations. In recent years, attempts have been made to allow private corporations own and manage non-clinical components of hospitals. This has been accomplished in UK hospitals.