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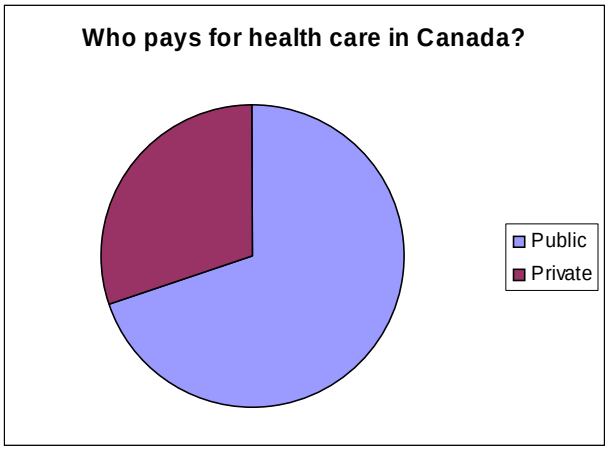
Public and Private Roles in Health Care

A Key Distinction: Financing vs. Delivery

Health care in Canada is the result of actions and decisions by a mix of public and private actors, including individual Canadians. In thinking about the roles of these different actors it helps to distinguish between the *financing* of health care and health services and the actual *delivery* of this care.

On the *financing* side, Canadians spend approximately $140 billion on health services, with approximately 70% coming from public sources and the remaining 30% coming from a variety of private sources (mostly private health insurance and individual out-of-pocket payments).



Canadian health care is also *delivered* by a mix of public and private sector actors, including:

- private corporations (e.g., some long term care in Ontario);
- small private businesses (e.g., most family physicians);
- self-governing not-for-profit agencies who receive public funds (e.g., most hospitals in Ontario);
- arms-length agencies accountable to provincial governments (e.g., Regional Health Authorities in nine provinces);
- public servants directly employed by governments (e.g., federal nursing services to on-reserve First Nations peoples).

The Public/Private Mix in an Age of Reform

Given the size of the health care system, it is not surprising that it has its share of challenges, and there are plenty of suggestions for reform. For some, this includes more private delivery and even more private financing. Others counter that we are making progress within the current model: wait times for some services are getting shorter; patient safety and the quality of health services are improving, and; Canadians who actually deal with the system come away generally quite satisfied.

Yet, waiting times and access still need attention. Provincial governments are experimenting with reforms that include: public-private partnerships to build hospitals; changing the mix of public, private and not-for-profit agencies that deliver home care, and; contracting out some surgical services to private clinics. The result is an escalating, but very general, debate between those concerned about the "end of Medicare" and "passive privatization," and those who believe that change has been too slow and even more private

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delivery, more competition, and perhaps even more private finance, are the answer.

This debate is likely to intensify over the course of 2006:

- In Quebec, government's cautious response to the Chaoulli decision focuses on delivery and an "access guarantee" to be met by better public service delivery and some carefully delimited private delivery including stand alone private clinics operated by "opted-out" physicians (prohibited from working in the public system at the same time). The government opens the door in a limited way to more private finance: Quebec residents will be allowed to buy private insurance for a narrow range of surgical procedures. Legislative hearings are expected in the Spring with legislation likely in the Fall of 2006.
- Alberta's proposals may go further – allowing physicians to practice simultaneously in both the public and private systems. The government also proposes to encourage more private funding of health services, and will allow patients to purchase services from private surgical facilities. Detailed legislation is expected in April 2006 and may receive legislative approval this Spring, with or without amendments stemming from public consultations and federal-provincial negotiations.
- In a more general way, the Government of British Columbia has indicated an openess to private delivery of health care services and perhaps even private funding. The government will be consulting provincial residents over the coming months.

Evaluating Reforms

How can we engage in a meaningful dialogue about the future of the Canadian health care system? An evaluation of any given set of reforms will need to focus on:

(1) the extent to which they meet the *operational goals* we have set for the system. For example, while we might want to experiment with more private delivery as a way of relieving pressure on the system, this should not involve drawing scarce personnel away from the public system;

(2) the extent to which they meet the *societal or systemic goals* of the Canadian health care system. For example, while some might want to experiment with allowing individuals to buy health care services in a parallel private system (thereby increasing their autonomy and individual choice), this risks undermining the broad redistributive nature of the Canadian Medicare bargain where the state transfers wealth via taxes and services from the relatively healthy and wealthy to those who are, again relatively, less wealthy and healthy.

Further Reading

Patrick Fafard. Forthcoming 2006. *Public and Private in Canadian Health Care: A Guide for the Perplexed.* Ottawa: CPRN.

Interested in discussing this work or collaborating in research in this or a related area?

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