No quick fix: Private health care in Canada is back in the news

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Dr. Day's day in court paves *Cambie's* way to the Supreme Court

Update: On September 29, 2022 Cambie Surgeries Corporation filed for leave to appeal from the Supreme Court of Canada.

Canada's public health care system is a frequent flyer in the news recently. The *Cambie* decision has added to the coverage, generating further discussion on what role private health care should play in Canada. Here we discuss the *Cambie* decision, the history of private health care in Canada and the shifting ground for a particular private health care field – virtual care.

The *Cambie* decision

The British Columbia Court of Appeal recently ruled on whether provisions of British Columbia's *Medicare Protection Act* are unconstitutional because they prevent patients from accessing private medical treatment when the public system cannot provide timely access to necessary care. The provisions at issue prevent medical professionals enrolled in the province's Medical Services Plan (MSP) from billing patients any amounts for services beyond the rates paid through MSP, creating a ban on extra-billing and prohibiting the sale of private insurance for medical services provided through the MSP.

The appellants were Cambie Surgeries Corporation (a private surgical clinic in British Columbia), Specialist Referral Clinic (a medical clinic that provides expedited medical assessments) and a group of patients. Together they argued that the provisions breach patients' rights to life, liberty and security of the person under section 7 of the *Charter.* The crux of the appellants' argument was that the public system is broken and does not allow for timely access to quality care, and the prevention of a duplicative private system by the impugned provisions unjustly prevents individuals from using their own resources to access health care.

The three-judge panel all agreed to dismiss the appeal, even though they found that the provisions deprive some patients of the right to life and security of the person. The court found that patients might wait for care beyond benchmarks, which estimate at what

point a patient presenting with a diagnosis may suffer negative consequences. The court determined that by foreclosing the possibility of private care, the provisions deprive patients of rights to life and security of the person under section 7.

Chief Justice Bauman and Justice Harris decided that the deprivation was in accordance with principles of fundamental justice. Justice Fenlon disagreed, concluding that the deprivations are grossly disproportionate as the "provisions' effect of eliminating the availability of timely private care comes at too high a cost to the life and security of those individuals who cannot access timely care in the public system." Justice Fenlon nonetheless concluded that the common good justified the infringements, because allowing for private care would cause those who cannot access private care to wait even longer and increase their risk of harm. Therefore, the provisions were saved under section 1 of the *Charter.*

Public and private health care in Canada

To contextualize the *Cambie* decision, it is helpful to consider the Canadian framework for health care funding and delivery in Canada. The *Canada Health Act* (the Act) came into force in 1984 and is Canada's federal legislation for publicly funded health care insurance. It is based on the principles of portability, accessibility, universality, comprehensiveness and public administration. The Act establishes criteria that the provinces and territories must fulfill in order to receive federal funding for health care delivery. Importantly, the Act includes provisions that strictly prohibit extra billing and user fees for insured services.

The federal government is essentially the single payer or national insurer for medically necessary services. Provincial health insurance plans define what medically necessary services are, and the province must then provide the full cost of the service in order to comply with the Act.

Medically necessary services generally include hospital care, physician services and medical imaging such as MRIs. The province must ensure that reasonable access is available for these medically necessary services. Provincial governments may be subject to penalties under transfer payment agreements for failing to comply with the Act. Interestingly, every developed country in the world except for Canada has some degree of parallel private health care service delivery (imaging, surgical services, hospitals) as an alternative to services offered by the public system.

Some health care is legally delivered through private mechanisms in Canada. About two-thirds of Canadians have some form of private health insurance that covers services such as vision, dental, outpatient prescription drugs, physical and occupational rehabilitation, psychology and other counselling, and private hospital rooms. The private sector funding is roughly split evenly between out-of-pocket sources and private supplementary insurance or employer-based private insurance.

As provincial health budgets continue to be strained from increasing health care costs, provinces continue to delist medical services formerly covered by universal health care. Provinces also face the same revenue challenges as the federal government, and these issues add additional pressure to the already strained publicly-funded health care system.

Each province and territory funds and administers health care separately, so Medicare is actually composed of 13 different health care systems. The existence of separate provincial and territorial health care systems leads to varied benefits and delivery models. Provincially funded health care within a federally governed country leads to a patchwork quilt of systems. The result is idiosyncrasies in each of the provinces relative to health care delivery, in particular as they relate to private health care options.

Private virtual care in Canada

Private virtual care in Canada is one example of the patchwork of rules, with different legislation and licencing rules in each province. These rules shifted considerably during the COVID-19 pandemic. Prior to the pandemic, virtual care was largely an uninsured service (i.e., not covered by provincial health insurance plans). This meant that physicians could charge privately for the provision of these services, provided they complied with applicable regulatory college billing requirements for uninsured services. This generally includes charging reasonable fees, considering a patient's ability to pay, providing advance notice and restrictions on block fees. A lack of publicly funded options for virtual care, combined with the ability to charge privately, led to the rapid expansion of private virtual care services across the country. Private virtual care providers offer services for a fee, typically through:

- A business to consumer model that charges individuals on a fee for service basis or through a subscription fee; or
- A business-to-business model that charges employers for the provision of employee extended health benefits.

In contrast, widespread adoption of virtual care by the public health care system has been slow. The COVID-19 pandemic, however, accelerated the adoption of virtual care into routine practice by the public health care system. In order to minimize the spread of COVID-19 and ensure continuity of care, provincial governments introduced temporary fee codes and/or amended billing rules to enable physicians to bill provincial health insurance plans for the provision of virtual care services. As physicians are generally prohibited from charging for the provision of an insured service or from engaging in any "extra billing," private virtual care providers have had to adjust their business models to ensure compliance with new billing restrictions.

Despite the changing legislative and regulatory framework, there continues to be legal mechanisms for delivering virtual care privately in Canada. For example, in some provinces and territories (including Ontario), only virtual care provided by telephone or video is an insured service, while virtual care provided by asynchronous messaging is currently uninsured. Nurses also do not generally bill to provincial health insurance plans and are not subject to the same fee restrictions as physicians. They must however, comply with provincial regulatory college requirements on permitted fees. Further, virtual care providers can adopt a hybrid model that involves delivering both insured services (billed to provincial health insurance plans) and uninsured services (billed privately). The result is that both publicly funded and private virtual care services continue to co-exist and thrive in Canada.

Looking to the future

The *Cambie* decision is expected to be appealed to the Supreme Court of Canada. Regardless of the outcome, it is unlikely that we will see a see change to the Canadian health care system. Such drastic predictions made following *Chaoulli* were not born out.

We will likely see continued challenges to private care prohibitions given the ever-increasing strains – and wait times – under our current system. While the *Cambie* appellants have invoked the *Charter*, there are other roads that could lead to an increase in private health care in Canada. Many advocates point to the Dutch model, and other European countries, where they argue that a pluralistic, multi-payer model permitting choice and competition would greatly improve health care in Canada. One thing is certain – political debate and public pressure will continue to shape the evolution of Canada's health care system. We expect to see an increasing number of innovative private care offerings that will enhance the availability of private health care.

BLG's health care lawyers are available to help you or your organization navigate the public, private and virtual care aspects of the Canadian health care system. Get in touch with any of our lawyers listed below.

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