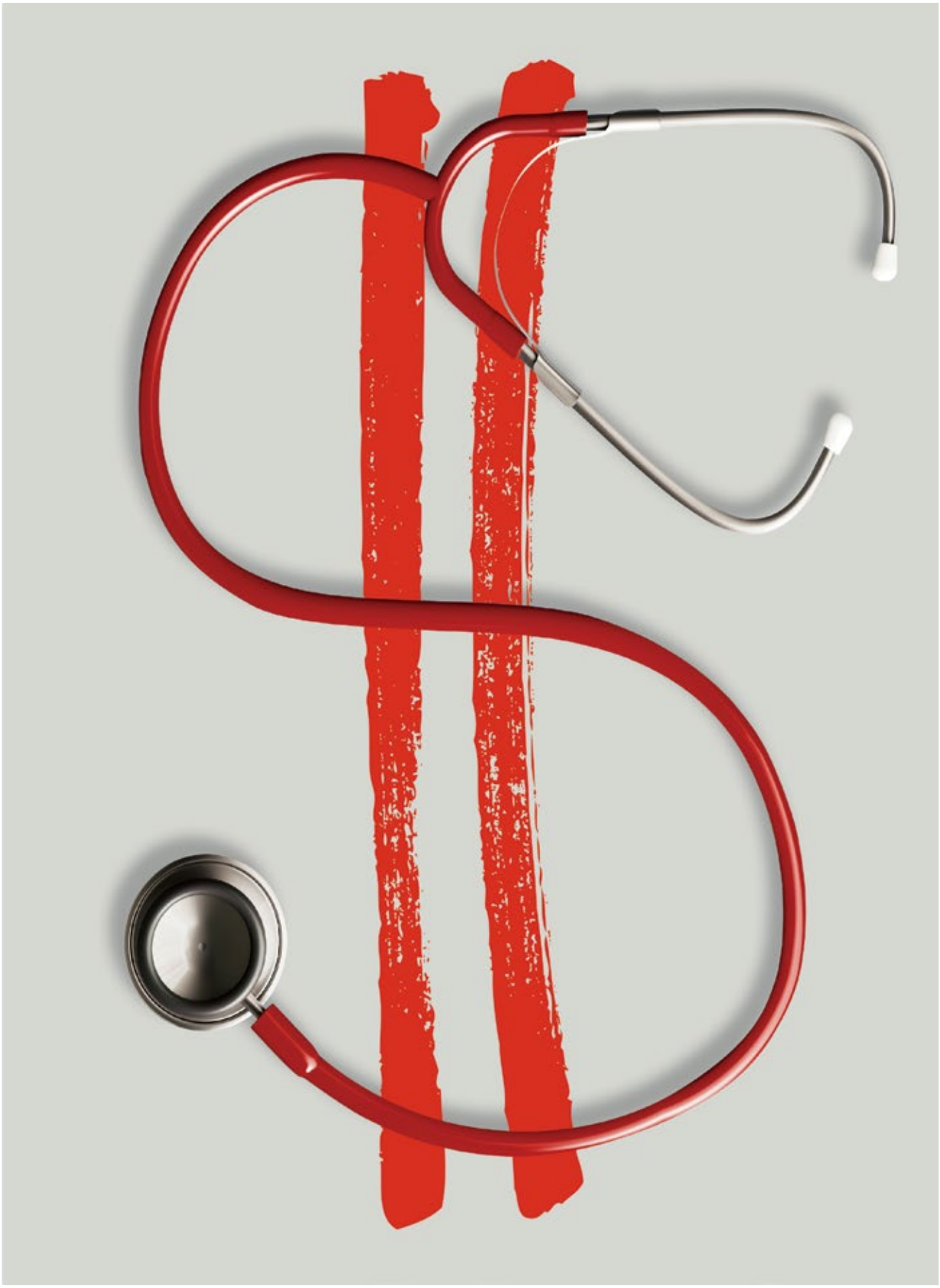

Illustration by **Christine Dewairy**; source photo **iStock**

A growing number of Canadians pay out of pocket for MRIs, hip replacements, even family doctor visits.

How a two-tiered system crept into Canada.

Private Health Care Is Here

BY CHRISTINA FRANGOU

Steven Goluboff has always been an old-school doctor. Over a decades-long career, he's worked nights and weekends and, on his rare vacations, even taken his computer with him to track patients' test results. In 2019, at 71 years old, he finally began planning to retire from his Saskatoon family practice. He knew he'd have to find more than one replacement for his patients, however—young doctors want a life outside the office, and they couldn't be expected to put in the hours he did. So he recruited three replacements and left his practice.

Then, last fall, one of the doctors he'd recruited quit to join a private clinic in Vancouver. Hundreds of patients were left stranded—so Goluboff came back. At age 75, he's still working full-time and sometimes even pulls night shifts at Saskatoon's Royal University Hospital. "Hopefully, this is the last tour," he says. But for now he'll stay on, providing the kind of care Canadians are desperate for from a health system that is increasingly under strain. One in five of us no longer has a family doctor. Wait times for diagnostics and medical imaging have ballooned. Necessary treatment, in some cases, has become delayed enough to compromise outcomes: British Columbia is even sending cancer patients to Washington state for timelier care.

But for Canadians who can afford it, some medical care has become easier than ever to access. A growing number of clinics nationwide are selling MRI scans, prescriptions, pap smears and even surgeries—services once considered primarily the purview of the public health sector—to those who pay out of pocket. Canadians are spending in the ballpark of $100 to speak to a nurse practitioner, who will offer the kinds of care a family doctor typically provides; upward of $600 for an MRI on demand, bypassing lengthy waitlists; and $20,000 or more to travel outside their province to see a surgeon for a hip or knee replacement. There's never been such a willingness to pay for timely medical care in this country—because sometimes it's the only way to get it.

Privately paid health care is nothing new in Canada. Mental health, dentistry, prescription drugs, optometry and other needs have always been mostly served by the private sector. People have long had to weigh the costs of buying new glasses, of getting their teeth checked or of seeing a psychologist. In February of 2024, nearly one-quarter of Canadians said they had split pills or skipped doses because of drug costs. I know what this is like. As a freelance journalist, I went years without private insurance and skipped out on filling prescriptions. But I was young and healthy. Many aren't. One in 10 Canadians with chronic conditions say they've ended up in the emergency room because they were unable to afford prescriptions. Many of us live on a teeter-totter, trying to avoid a medical catastrophe without spending anything more than we can afford.

As gaps in health care have widened, the private sector has steadily and stealthily pushed the boundaries of what's permissible

For all that, health care in Canada has traditionally not been big business, especially when it's urgent and important, such as emergency and life-saving treatments, or access to a family doctor. Working as a journalist covering health care in both Canada and the United States, I've always enjoyed the fact that when writing in this country, I've rarely had to be a business reporter as well. Covering health in Canada has meant focusing on people, outcomes, systems and laws. It was powerful to write stories, even heartbreaking ones, about Canadian health care, because of the almost mythical ideas of universality, equity and accessibility. There was a feeling of shared investment in protecting the public system. In the U.S., business interests are in play, and financial toxicity—the stress of paying for care—is a major theme when covering it.

All that is changing. Confidence in the publicly funded system has fallen dramatically, the result of decades of political neglect and the aftermath of a crushing pandemic. The Commonwealth Fund, an organization that studies health care around the world, recently ranked Canada 10th of 11 OECD countries in health-care performance, ahead of only the U.S.—even though Canada spends more than the OECD average on health care. And as the gaps in care have widened, the private sector has stepped in to fill them, steadily and stealthily pushing the boundaries of what's permissible in Canada.

The growth in private care has mainly been in four areas. There are diagnostic clinics where patients can bypass wait times for imaging tests like MRIs and CT scans. There are primary care clinics, often run by nurse practitioners who provide fast access to consultations, referrals, diagnoses and prescriptions in exchange for fees. There is virtual care, which offers much of the same. And then there are private surgical clinics, where Canadians can get life-changing procedures without waiting months or years.

Purveyors of these services say they can help solve some of Canada's health-care woes if they're allowed to do so. They argue

Hannah and Justin Housey and their two-year-old son, Hudson

PAY $6,000 per year for private clinic memberships in Montreal

"My family switched to private health care in 2019. My husband, Justin, has Type 1 diabetes and has to check his blood sugar multiple times a day. A new device had recently come out to make sugar monitoring easier. This was a life-changing advancement to treat diabetes, and we didn't know how to get it. Our endocrinologist hadn't even heard of it. We called a private clinic outside of Montreal, and my husband got the device within a couple of days. After that, we decided to continue with private health care. We each pay $1,800 per year for a membership to a private clinic, which includes one yearly physical and same-day doctors' appointments on demand. There are fees for extra tests and services, too.

When our son, Hudson, was nine months old, he woke up in the night struggling to breathe with croup. We called 911 and an ambulance took him to the hospital. Staff were excellent, but they were clearly overworked, pulling long shifts and dealing with a packed ER. We were told an ENT specialist would follow up with us, but we never heard back. A couple of months later, Hudson was struggling to breathe again, and we were back in the ER. In the first year of his life, we were in the hospital three times. We were discharged without a treatment plan each time.

> "We pay $600 a year for our son's private clinic, plus $100 for same-day appointments. It's worth every penny."

We found a private clinic that sees children. We now pay $600 a year for his membership, plus $100 for each same-day appointment. It's worth every penny. I can call the office at the first sign of a flare-up and they write a prescription for a steroid that opens his airway and helps us avoid hospital stays. Last December, Hudson was sick again. I took him to the doctor and he ordered an X-ray right away, which showed that he had bacterial pneumonia. Within 12 hours he was on antibiotics and feeling better.

Altogether, we pay around $6,000 for private health care each year for our family. There's no wondering about our health—we can just call and ask."

—As told to Emily Latimer

Photograph by **Richmond Lam**

Photograph by **Corey Katz**

Denika Fercho

PAID $5,000 for private MRIs on Vancouver Island

"IN AUGUST OF 2017, I WAS DRIVING NEAR VICTORIA, B.C., with my kids loaded into our van, when we got into a collision with another car. The kids had no life-threatening injuries, but I had to go to the emergency room, where I was treated for lacerations on my face, arm and abdomen.

Afterwards, I had shooting pain all over my body. It was difficult to stand and walk, and it wasn't getting better with time. I tried everything to help ease the pain: I had an occupational therapist, I did physiotherapy, I visited a chiropractor, I did acupuncture, I got massage therapy. Nothing helped.

> "I travelled two hours and got five MRIs done at once. The next day, I finally had answers."

We moved to Comox, B.C., in December of 2017, where I had no family doctor. I would go to walk-in clinics every couple of months and wait for hours to see someone. Eight months after the accident, I finally got a GP, but he soon left the practice. I was transferred to another doctor in the same practice, but she left too. I was transferred to yet another doctor, who said she would order a CT, but months passed and I never heard back. At this point, I had no continuity of care.

In August of 2020, three years after the accident, I decided to be more proactive about getting my life back. I googled "MRI Vancouver Island" and found a private health clinic in Nanaimo that did imaging. I called the clinic and within two weeks, I was scheduled for an appointment. I travelled two hours to Nanaimo and got five MRIs done at once.

Three hours later, I had imaging of my abdomen, spine, hip, sacrum and pelvis. And the next day, I finally had answers. I found out I had a possible torn labrum—the protective lining around the hip socket that prevents the thigh bone and hip bones from rubbing together—and many herniated discs. Later, more imaging confirmed there was a labral tear. Altogether, the scans cost me $5,000.

We moved to Nova Scotia soon after. I was lucky to find a doctor here, but I've been on the waitlist for hip surgery for almost four years now. If I could afford it, I would pay for private surgery. But at least I know the source of my pain."

—As told to Emily Latimer

that they take pressure off the public system, opening up more room so everyone can get care. Critics say they're making things worse, creating an inequitable, inaccessible system while drawing scarce professionals away from the public sector and driving up overall costs. But this debate overlooks the root of the current crisis. The simple truth is that no one has done the hard work to fix the glaring holes in Canada's publicly funded health system. There's a saying in Canadian politics: health care is the third rail. Touch it and you die. That's why politicians have mostly steered clear of health reform for decades, deterred by the challenge of modernizing a system that Canadians have long held up as a part of our national identity.

Our current health framework was created for a very different country. Its founding flaws have grown more apparent with time and have only ever been papered over. The result is what we see in front of us today: 13 public health systems, one for each province and territory, all in a state of crisis; private businesses stepping into the gaps; and more Canadians than ever opening their wallets to pay.

The story of how Canada's health-care system was born has been told so often it has become part of our national folklore. More than a century ago, a child named Tommy showed up at an outdoor clinic in Winnipeg with a bone infection that could have cost him his leg. An orthopaedic surgeon treated him for free in exchange for using him as a teaching case. Years later, Tommy Douglas became premier of Saskatchewan, promising that no citizen's access to care would depend on their ability to pay. In 1947, Saskatchewan created the first hospital insurance plan in Canada. The province didn't take ownership of hospitals, but it did pay citizens' bills. British Columbia and Alberta followed, and the federal government nationalized the program in 1957, paying 50 cents on every dollar spent by the provinces for hospital care.

In 1959, Douglas's government announced phase two: universal physician care, a move that met with instant opposition from physicians themselves. Many of Saskatchewan's doctors were British expats who'd fled their own country after it created the National Health Service, which made many doctors public-sector employees. They had no interest in seeing the same happen in Saskatchewan, as Douglas's plan proposed. The government prevailed, but in July of 1962, when the new legislation took effect, doctors walked off the job in an ugly, angry strike. Regina physician Staff Barootes, who later became a senator, recalled people throwing eggs at doctors' windows and slashing their tires.

> The debate over public vs. private care overlooks the root problem: no one has done the hard work to fix our public system

Steven Goluboff was 13 years old at the time, and his father and uncle were both doctors opposed to the plan. That summer, his family went on vacation to the World's Fair in Seattle to escape the rancour enveloping the prov-

ince. Their car's licence plate bore the letters "MD," indicating it was a doctor's, and Goluboff's parents feared for the family's safety as they drove out of town. The strike ended after 23 days with a compromise that's had lasting repercussions for Canadian health care: doctors would continue to operate as private business owners, but they would bill the provincial government for treatment provided to patients, in an arrangement now called fee-for-service. In 1966, the federal government implemented the Medical Care Act based on Saskatchewan's program. (The Royal Commission on Health Services, established in 1961, recommended extending care to pharmaceuticals, home care, vision and dental health, with some user fees to supplement government funding. The government largely ignored those suggestions, leaving the services in question to the private market.)

As Canada's population aged and treatments advanced, the cost of health care skyrocketed, and public funding hasn't kept up

And yet, even as the ink dried on the act, Canada was changing fast. The contraceptive pill was approved in 1960, and birth rates subsequently plunged. The country's median age climbed as Canadians lived longer. An older population meant more chronic illness and more people needing sustained medical care, and health-care costs soared. By the early 1980s, most provinces and territories were letting doctors and hospitals charge user fees in an attempt to keep on top of growing costs. That was enough to stir Monique Bégin, minister of health under Prime Minister Pierre Trudeau, to quash the practice.

That effort took the form of the Canada Health Act, which laid out five principles provinces need to follow to to receive federal health funding: accessibility, universality, comprehensiveness, public administration and portability (i.e., Canadians could travel within the country and receive care anywhere, paid for by their home province). The CHA has become an iconic act of legislation—and one that is poorly understood. It does not make private health care illegal, as some believe. Instead, it states that Canadians must have reasonably timely and free access to "medically necessary" care, and that medically necessary care must be paid for publicly. To ensure compliance, the feds can cut a dollar in federal health transfers to provinces for every dollar provinces allow citizens to spend on fees for those services. But unlike many countries with universal health care, what is and is not publicly supported is not explicitly spelled out at the national level. The CHA leaves it up to each province and territory to define what "medically necessary" means, leading to inconsistent coverage—Alberta and B.C., for example, don't fund drugs that lessen the side effects of cancer treatment; other provinces do. Some provinces cover IVF treatments; others don't. And the federal government has mostly been lenient when clawing back health transfers.

The CHA also doesn't address the issue that led to extra fees, which is the skyrocketing cost of the public health system. By the

Caroline Topperman

PAYS $3,700 per year for an executive-clinic membership in Toronto

"FOR YEARS, I KNEW SOMETHING WAS UP WITH MY thyroid. In 2010, I started feeling awful: I was cold all the time and super fatigued. My joints hurt, and I started putting on weight uncontrollably. When I went to a walk-in clinic in Vancouver, the doctor dismissed my concerns and said I was just stressed. Blood tests showed my iron was low, and I received supplements and shots—but nothing for my thyroid.

In 2013, my husband and I moved to Poland, where I got blood work done. The moment the technicians saw my results, they said I needed an endocrinologist right away. They were terribly apologetic: their doctor, they said, wasn't available that day, but she could see me the next. I couldn't believe my luck. The doctor said my thyroid levels were too high and asked me what medication I was on. I told her I wasn't on any. "But you're from Canada," she said, in utter disbelief. Only then did I receive medication for an issue that had plagued me for years. I finally had some relief.

I moved to Waterloo, Ontario, in 2018 and, eventually, my medication ran out. I went to a walk-in clinic, where the doctor grilled me, saying she had to make sure I wasn't "milking the system." I was shocked: it's not like thyroid meds are a street drug. At this point, I was so frustrated. I put myself on the waitlist for a family doctor, where I remained for three years. It wasn't until I was preparing to move to Toronto in 2021 that I was finally matched with one—in Waterloo.

> **"I was on a waitlist for a GP for three years. Eventually I decided, *Screw it. I need a doctor.*"**

Eventually I decided, *Screw it, I need to have a consistent doctor. I'm going to pay for this.* I signed up with an executive health clinic, where I was immediately matched with a doctor, as well as a coordinator to sort out all my appointments and follow up with specialists.

The whole package costs me $3,700 per year. I know that if I email them, I'll get a response within a few hours, and I can refill my prescriptions via email as well. My doctor is so thorough: when we speak on the phone I'll be ready to hang up, and she'll still be asking me questions. It's unfortunate I have to pay for that—it means fewer vacations, fewer nice things. But it's necessary. I needed to find a doctor who wouldn't blow me off."

—As told to Anthony Milton

Photograph by **May Truong**

Mike Johansen

PAID $30,000 for a private hip-replacement surgery in Montreal

"IN JUNE OF 2021, BRUTAL PAIN BEGAN RIPPING through my left hip. I'm not sure what happened—maybe years of pitching my golf swing to that side wore it down. The only way I could escape the pain was by lying down. Even putting on socks was a trial.

I went to my family doctor, and a few days later we did an X-ray to see if I had torn a muscle in my hip joint. It showed some mild arthritis. But the pain just kept getting worse. He ordered an MRI, and a cancellation meant I got it earlier than expected—after "just" four months. When the results came back in November of 2021, they showed a fracture in the head of my femur, with the cartilage torn up all around it. When my doctor saw this, he consulted with an orthopaedic surgeon he knew, who said, "This requires a new hip." He put me on the list to go see a surgeon right away, but it took six months for one to become free. When I finally met with someone, he said the wait for the surgery would be 18 to 24 months.

> "I don't understand why I was able to get surgery in eight weeks when I paid for it, but 18 to 24 months if I'd used the public system"

I was deflated. By this time, I had spent almost a year bedridden. The prospect of losing two more years was disheartening. I spoke with several private clinics, shopping around, all of whom told me the same thing: once I put a deposit down, it would only be eight weeks' waiting time. In July of 2022 I connected with a clinic in Montreal that specializes in joint replacements. By September, I put down a $1,000 deposit and was booked for surgery for November. We flew in on a Sunday, did the surgery on a Wednesday, and by Saturday I was flying back home.

All told, the surgery and travel cost me close to $30,000. I still don't understand why I was able to get surgery in eight weeks when I paid for it, but 18 to 24 months if I'd used the public system. My pain is gone, and I'm back to golfing. Being on my back for 15 months cost me muscle mass that, at my age, I'll never gain back. But that's life. Don't get me wrong: I didn't want to spend that money. The way I see it, it's the cost of an entry-level Toyota Corolla. I sympathize with people who say you shouldn't be able to jump the queue. The truth is, this was the only way I could get my life back."

—As told to Anthony Milton

Photograph by **Amber Bracken**

late 1980s, Douglas Angus, an economist, health policy analyst and professor emeritus at the University of Ottawa, was ringing alarm bells about Canada's health-care design. Costs had blown past the original estimates produced by the Royal Commission on Health Services in the 1960s. By 1971, health care took seven per cent of federal GDP, not the predicted 6.4 per cent; by 1991, 9.5 per cent instead of 7.5. (Today it's 12.1 per cent.)

The costs kept escalating. Measured in 2022 dollars, national health expenditures surpassed $100 billion in 2001, $141 billion by 2005 and $248 billion by 2017. In part this was because the population had aged dramatically; when the Medical Care Act passed in the '60s, the median age in Canada was about 26. By 2016 it was 41, but our funding system was the same one created decades earlier for a younger, smaller population. Medical technology had also advanced—and become more expensive. Patients benefited from diagnostic imaging like MRIs and CT scans, as well as an explosion in pricey pharmaceuticals and other cutting-edge treatments, which cost the public system a small fortune.

Provinces tinkered with hospital funding, regionalization, doctor fees and staff wages to reduce costs, but nothing made a lasting dent. Waitlists for everything—primary care, surgery, psychiatrists, imaging and so on—grew longer.

And so a burgeoning private sector found the cracks in the system. Entrepreneurs, many of them physicians, set up small private clinics outside of hospitals where people could pay to get tests or surgery done quickly. From the start, Alberta was among the most lenient provinces in permitting private care. In 1993, radiologists in Calgary opened the country's first private MRI clinic outside of a hospital, charging up to $775 for a scan. It was a workaround for affluent patients tired of languishing on the then-thousand-person-long waitlist for a publicly funded MRI at the city's Foothills hospital. Over the next decade, some clinics in the province began to offer "concierge medicine," charging patients membership fees of $3,500 for 24-hour access to a doctor and other health-care providers. It's a practice still offered today and still controversial for its pay-for-access route to primary care.

Waitlists for everything—primary care, surgery, imaging and so on—grew longer. A burgeoning private sector found the cracks in the system.

Things were changing in Quebec as well. In 2005, orthopaedic surgeon Jacques Chaoulli and Georges Zéliotis, a 73-year-old patient who'd faced delays getting hip replacements, challenged the province's prohibition on private insurance for medically necessary care. They argued that a lack of private options was putting residents at risk for harm and even death because wait times were too long, violating both the Canadian and Quebec charters of rights. The Supreme Court of Canada eventually ruled that prohibitions on private health and hospital insurance were inconsistent with the province's charter—but not with Canada's. That ruling formally paved the way for more private health care, although only in Quebec. More family physicians in Quebec chose to opt out of the public system. Only nine doctors worked privately in 1994. By 2019, there were 347, billing patients at rates set at their discretion.

On the other side of the country, British Columbia orthopaedic surgeon Brian Day also led a charge for more private services. In the early 1990s, while working in the public sector in Vancouver, he was frustrated that he had 450 patients on his surgical waitlist but couldn't get any more operating-room time. So, in 1995, he opened the private Cambie Surgery Centre.

In 2007, patients complained that Day's clinic extra-billed them, charging for services that were publicly insured, in contravention of the CHA. Other patients complained that the clinic had overcharged them for services where the fees were set by the province, even for doctors like Day who'd opted out of Medicare. The B.C. Medical Services Commission began an audit of his clinic. But in 2009, Day sued the Commission, beginning what became a 14-year legal battle. In 2012 the provincial audit found his clinic had overcharged patients by almost $500,000 in a 30-day period. But Day's case, which argued that a ban on private insurance violated Charter rights, continued making its way through the courts.

Day says that the Canadian system is full of contradictions. For example, people already pay for care that is, practically speaking, necessary. "If you are hit by a bus and are lying in the street with a broken pelvis and femur," says Day, "the ambulance that takes you to the hospital is not considered medically necessary. You will get a bill unless you have private insurance. How bizarre is that?" This seeming oversight stems from decades ago, when ambulances were little more than taxi services to hospitals, not a first line of emergency response.

Today, Day operates mostly on non-B.C. residents who pay out of pocket, along with members of exempted groups such as federal employees and patients covered by worker's compensation. Some days, he operates on multiple patients from Alberta, knowing that patients from British Columbia make the journey in reverse to Alberta for the same procedures. It's one of the quirks of the Canadian system: people can pay for speedier access to non-urgent surgery, like joint replacements, only by travelling to a different province (unless they live in Quebec, thanks to the Chaoulli case). Outside their home province, Canadians are not insured for non-urgent surgery, so providing it is not in violation of the Canada Health Act.

For decades, the amount spent on private care in Canada has been steadily rising. In 1988, Canadians paid nearly $80 million of their own money for physician care. By 2019, the number was $652 million. Over the same period, payments to non-hospital health institutions leapt from $1.2 billion to $11 billion.

Private care was already creeping in around the edges when the COVID-19 pandemic began and put unprecedented strain on the public system. First, waves of patients hammered emergency departments and intensive care units. Health systems nationwide

were working beyond capacity, and so were the people staffing them. Doctors and nurses put in extra hours, showing up to work even when they had to push through crowds of anti-vaccine protesters outside hospitals. They got COVID at work, they burned out and they started leaving. Many shifted to part-time work, retired or moved out of the public system.

As the acute crisis period of the pandemic passed, people sought treatment that had been deferred. Orthopaedic problems, cancer diagnoses and mental-health issues that had been put off needed urgent attention. The effects are still being felt: delayed treatments, soaring wait times and burned-out professionals. Alika Lafontaine, an anesthesiologist in Grande Prairie, Alberta, and a former president of the Canadian Medical Association, says access to care is worsening because health workers are no longer willing to put their lives on hold to shore up the system.

For 15 years, Lisa Clark-Musschoot worked as a nurse practitioner in a primary-care clinic in the small town of Grenfell, Saskatchewan, an area that has long struggled to attract physicians. She cared for multiple generations in single families, from great-grandparents to infants, and provided mental-health care, referrals, prescriptions and urgent care. She worked long hours and drove long distances. She missed weddings to be on call and drove through floods to provide care on weekends. The public system wanted more and more from her. "I couldn't take it anymore," she says.

So in August of 2021, Clark-Musschoot started her own private primary-care clinic in Regina and then a second in Saskatoon. Her business is similar to clinics run by physicians, with one difference: she can bill patients directly for medically necessary services. The scope of practice for nurse practitioners has expanded over the last two decades, allowing them to perform many of the same duties as physicians in areas where doctors can't be easily recruited. Unlike doctors, they are not bound by restrictions on private billing. In most provinces, nurse practitioners can set up private clinics charging patients directly. The province of Ontario recently asked the federal government to close the loophole allowing nurse practitioners to charge fees for services that are publicly insured when done by physicians.

"I will never work for the public system again," says Lisa Clark-Musschoot, a nurse practitioner in Saskatchewan

Clark-Musschoot charges $90 for an appointment for a single health issue, test results or prescription renewal and $150 an hour for comprehensive care appointments like annual physicals—the same services a patient lucky enough to have a family doctor gets for free. She says that some of her patients come to her because they're tired of waiting to see a physician. One person called to book an appointment for a pap test with Clark-Musschoot while they sat in a nearby doctor's office waiting to be seen. "I will never work for the public system again,"

Sergio Tercero

PAID $8,700 for private MRIs and knee surgery in Vancouver

"About 10 years ago, I tore the meniscus in my right knee playing hockey. I work as an electrician, so losing the use of my knee was devastating, and since the injury happened on my leisure time, it wasn't covered under B.C.'s WorkSafe program. I had to turn to the public healthcare system. I wanted an MRI to see if I needed surgery. My doctor told me MRIs were moving quickly those days—I'd only have to wait a few months. But that was longer than my EI would last me. It was extremely frustrating: I was 28 years old, and I'd been working since I was 16. Hadn't I paid enough taxes to deserve proper health care? Rather than lose money waiting, I went to an imaging clinic in Vancouver and got a private MRI for $950.

> "By accessing private care, I was able to save money and get on the job much faster"

The MRI report indicated I needed a meniscus scope. A couple of weeks later, a surgeon called and said he'd see me nine months later for a consult; the surgery would be a few months after that. Yet again I faced running down my EI and savings waiting for health care, coupled with an unreliable knee. Every now and then, the floating pieces of cartilage would lock up the joint—and one night it snapped all over again, leaving me rolling in agony. Within a few hours, my knee had swollen to double its size and had to be drained of fluid in an emergency room.

At this point, my family doctor told me private surgery was an option. A couple of weeks later I had the operation done at a private surgical centre for $5,700. Six weeks after that, I was back on the job.

Most recently, I had another MRI done for a bulging disc in my back. It's bothered me for about 20 years, but the pain had recently reached the point where my right foot went numb. I knew it would take an MRI and physiotherapy to fix, so I went back to the imaging clinic and paid $1,300 for scans.

By accessing private care, I was able to save money and get on the job much faster. I don't understand why the wait time for my knee surgery was so long. It's not like I'm asking for a nose job. I'm just trying to get back to work."

—As told to Anthony Milton

Photograph by **Vishal Marapon**

she says. "I will always work for myself because now I know that there will always be a market, and it's going to get bigger."

Others have shifted to virtual care, a sector where there is huge provincial variation in what is and isn't covered. For several years, the biggest name in Canadian virtual care has been Maple, co-founded in 2015 by Brett Belchetz, a Toronto emergency-room doctor. Maple connects patients to doctors and nurse practitioners. Before the pandemic, virtual care wasn't deemed medically necessary, but many patients were willing to pay—they liked being able to fill a prescription or get a minor issue addressed without leaving their homes. By 2019, Maple had facilitated half a million appointments.

But in the first half of 2020, provinces raced to take advantage of virtual care in order to reduce in-person contact between doctors and patients. During the first wave of the pandemic, 70 per cent of primary care shifted to online and phone appointments. Provincial health authorities created billing codes that allowed doctors to charge for virtual care, and companies including Maple were folded into the public health system. Today, this has resulted in an inconsistent patchwork of public and private virtual care across the country. New Brunswick, Nova Scotia, P.E.I., Ontario and B.C. now pay for appointments on Maple—in some provinces, it's a way to band-aid over the family-doctor shortage. Elsewhere, it remains a fully private service.

Belchetz says Canadians are more willing than ever to pay out of pocket for fast care. "If you need a primary-care appointment today, and the only option in the public health-care system is a week away, people will make that determination and make the choices that are best for them," he says.

Thirty years after the first private MRI clinic in Calgary, there are now 85 private diagnostic imaging facilities in Canada, led by Quebec with 31 private facilities, followed by Alberta at 18, British Columbia with 15, Ontario with 14 and Saskatchewan with five. Katherine Fierlbeck is a professor of political science at Dalhousie University, who has for years studied health policy in Canada. "We don't think of two-tier health care in terms of diagnostics, for the most part," she says. "Maybe that's why private entrepreneurs have taken advantage of that, even though it's as public a service as hospital care." Over time, she says, Canadians have accepted the reality that if they pay for an MRI they can get faster answers about their health.

Recently, the federal government has made it clear that it's not pleased with the emergence of private health care in spaces once considered public. Last year, the feds withheld over $76 million in health transfers to seven provinces. The vast majority of deductions, more than $72 million, were due to patient charges for diagnostic imaging. Since 2018, the federal government also reimbursed $175 million to provinces and territories that took steps to eliminate extra charges to patients for medically necessary services.

When I reached out to federal Health Minister Mark Holland, he replied with a statement saying that the government values equity and fairness over profit in the provision of medically necessary health care. "The government of Canada does not support a two-tiered health-care system where patients may choose, or be required, to pay for quicker access to medically necessary services," he said. That is the message Canadians expect to hear. But they're tired of waiting.

Health-care reform has become the third rail of Canadian politics, and leaders have been terrified to stake their careers on it

Last year, the Supreme Court of Canada declined to hear Brian Day's Charter of Rights case. Decisions about the right balance between the public and private sectors, it found, were for politicians, not for the courts. That punts the question right back to the same people who have, for so long, been terrified to stake their political lives on an issue Canadians are deeply invested in, and which has become such a foundational part of our national identity. Jane Philpott was federal minister of health from 2015 to 2017—she was the first physician to hold the job—and is the current dean of health sciences at Queen's University. "It's sometimes hard to know how much is a lack of imagination or lack of courage," she says, "because I think they kind of go side by side. It's a bit of both."

Most of her own two-year tenure was dominated by MAID and cannabis legalization. Health reform was never part of her mandate, she says, although she negotiated a new funding formula with the provinces and territories. "I wish I could go back and use those tools to do the things that I think are becoming more and more obvious that we need to do," she says.

The federal government has the power to drive health reform at the national level, she adds. The recent pharmacare plan, covering diabetes medication and contraceptives, is an example. Alberta and Quebec have already indicated they'll opt out of the program. Philpott suggests that eventually people in those provinces are likely to clamour for the coverage that's available elsewhere. That's how Tommy Douglas's hospital care program began, after all. "Somebody has to show leadership," she says. "I think on this and many other areas, we need federal leadership," she adds. "We are a country after all."

David Naylor, a doctor and former University of Toronto president who chaired a 2015 government-sponsored examination of Canadian health care, says our biggest problem is the failure of provincial and federal governments to modernize what he calls Medicare's outmoded architecture. "They have also neglected human resource issues and not incented health-care innovators, even though flags on both fronts have been raised for more than a quarter century. It's a lousy legacy."

In Saskatoon, Steven Goluboff's family and friends are urging him to retire. But there are benefits to staying in the game, he points out. He knows who to call if someone he cares about gets sick. He knows the buttons to push that can expedite care in an emergency. "Once I'm totally done, I'm a patient," he says. "I'll have to figure out how to get health care myself." ■