Commentary: Fixing Fraying? A Response to Milinkovic and Hurley

Commentaire : Stopper l'érosion? Une réplique à l'article de Milinkovic et Hurley

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Abstract
Privatization – either of funding or provision – is not a solution to Canada's health system woes. However, access issues abound, and part – but only part – of the solution should be to look to improve efficiency of service delivery so that better access can be achieved with the same money.

Résumé
La privatisation – que ce soit pour le financement ou l'approvisionnement – n'est pas une solution aux problèmes du système de santé observés au Canada. Cependant, les problèmes d'accès sont nombreux et une partie – mais seulement une partie – de la solution devrait consister à améliorer l'efficacité de la prestation des services afin d'améliorer l'accès avec les mêmes montants de dépenses.

Introduction
Milinkovic and Hurley (2025) rightly call attention to the insidious siren calls of those who see privatization, especially privatization of funding, as part of the solution to the woes that have beset access to healthcare in Canada. Importantly, they recognize the current information vacuum in this area and highlight the need for better data to track the current extent of privatization, be it user pays or, more fundamentally, the extent of private provision. Their proposed policy responses – to improve the current health system, more agile regulation and updated regulations to cover new providers – are all appropriate.

Renowned Canadian health economist Bob Evans long ago pointed out the limited policy options in the face of an imbalance between demand for, and supply of, public funding.

One option is "shear," shifting costs from taxpayers onto consumers of healthcare (Evans 1990). Such a policy adversely impacts poorer people, who tend to need more healthcare, and benefits richer people, who tend to pay more tax. It is often supported by providers, as private funding and provision is typically less regulated, allowing professionals more autonomy and opportunities to increase their wealth.

Milinkovic and Hurley (2025) trip lightly over their first policy proposal, the need to "improve the performance of the publicly funded health system" (p. 36). They rightly highlight the need for workforce reform to improve access, including the need to allow other providers to complement the work of physicians. As they point out, the downside risk here is that this might create a regulatory void, allowing some providers to circumvent the current *Canada Health Act* (1985) restrictions. Addressing this gap requires more adaptive regulation than seen in the past.

Unfortunately, Milinkovic and Hurley (2025) do not use up their valuable word count to draw attention to the opportunities that exist to improve the efficiency of healthcare provision, and this is an important omission. Better healthcare – including addressing access gaps – does not mean more expensive healthcare. There is good evidence of interprovincial efficiency variation in technical efficiency across Canada, such as in cost per hospital admission, with Alberta, home to some of the most egregious privatization experience, being a high outlier in cost of provision (Duckett 2015; Duckett et al. 2012). Addressing its own efficiency issues would have reduced the opportunities for private provision inroads but is not consistent with the clientelist ideological position of the traditional Albertan government (Duckett 2015). However, all provinces have the potential to improve their performance on this dimension. National agencies, including Health Canada and the Canadian Institute of Health Information, should facilitate benchmarking and identification of opportunities for efficiency improvement.

In addition, all provinces probably have the potential to reduce intraprovincial variation in costs and thus create room to expand provision at no additional cost to taxpayers. This, of course, is easier to say than do as it requires shifting resources from one location to another or one profession to another and, hence, as all health spending is someone's income, inevitably moves income opportunities from one group to another (Evans 1997, 2016; Reinhardt 2012) or one political riding to another.

Harder still is addressing allocative or social efficiency, such as no- and low-value care and ensuring that all care is indeed "medically necessary" to use the language of the *Canada Health Act* (1985) (Caulfield 1996). Measurement issues abound here and the voice of those who gain income from providing low-value procedures will be loud in opposition, citing the need for patient choice and the importance of providing a private outlet in the face of the evil rationalizers.

However, while waiting for this nirvana of a perfectly efficient health system, policy makers should heed the warnings of the risks of privatization and pursue the prescriptions Milinkovic and Hurley (2025) have so usefully outlined.

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