

Health Care Privatization IN CANADA

CUPE

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Key findings

Canada's public health care system is facing a bigger threat of privatization than ever. This trend is driven by constant federal underfunding and the deliberate diversion of public funds to for-profit corporations. Supporters of privatization say it will solve problems in the health care system. But experience shows us that problems like long wait times and staff shortages get worse with privatization, not better, and result in a more expensive, less fair, and lower quality system that primarily benefits rich people and investors. Public solutions deliver more, cost less and cover everyone.

Here are some signs of privatization that we are seeing across Canada.

1. **Illegal user fees:** For-profit clinics are charging patients hundreds or thousands of dollars for medically necessary services like cataract surgeries, MRIs, and primary care consultations. This is against the law and creates a two-tier system where patients who can afford to pay go to the front of the line. Those who can't face longer waits or lose access to their family physicians.
2. **Private staffing agencies:** Spending on for-profit nursing agencies has skyrocketed into the billions. This approach costs taxpayers up to six times more than hiring public staff, fails to address the root causes of burnout and deepens the staffing crisis by pulling nurses from the public system. Nurses attracted by offers of higher pay may lose their benefits and the protections of a union.
3. **Public funding directed to for-profit facilities:** Provincial governments are contracting out surgery to for-profit clinics, at a price two to three times higher than public hospitals are paid. This does not reduce wait times and drains resources from the public system, diminishing its capacity.
4. **For-profit long-term care:** The COVID-19 pandemic showed us the deadly consequences of for-profit long-term care. Residents in for-profit homes had much higher rates of infection and death compared to residents in public homes. Despite this, provincial governments continue to grant licenses and funding to these private companies, which put profits before quality care and safe working conditions.
5. **Costly Public-Private Partnerships:** Governments continue to enter into public-private partnerships, also known as P3s, to build and run hospitals and long-term care homes. Years of experience and dozens of examples from across the country have shown us that P3s are more expensive and less effective than public projects. Yet governments continue to lock taxpayers into costly long-term contracts with private companies.

6. Virtual care and artificial intelligence: Virtual care and artificial intelligence technologies have exploded since the COVID-19 pandemic and present a worrying trend in health care privatization.

The report's core finding is that privatization is not a viable solution. It consistently leads to higher costs for both governments and patients, worse health outcomes, and poor working conditions. This erosion of public health care has been enabled by the federal government's failure to enforce the *Canada Health Act* by penalizing provinces for allowing illegal patient charges. Therefore, the report concludes that the only effective way to address the crisis is through a significant reinvestment in the public health care system. This includes boosting federal funding, improving the recruitment and retention of public sector workers, and expanding public capacity to deliver care.

Ultimately, the report serves as a call to action for the federal, provincial and territorial governments to halt the move toward for-profit health care and recommit to the principles of a universal, accessible, and publicly funded system.

Information about public solutions in health care can be found at
[https://cupe.ca/public-solutions-health-care.](https://cupe.ca/public-solutions-health-care)

Introduction

Fighting the privatization of Canada's public health care system is more urgent now than ever. More and more, provincial governments are turning to private, for-profit corporations to build hospitals and deliver essential health care services. Patients are facing emergency room closures, longer wait times for surgery and a shortage of doctors. Health care workers are struggling with fewer resources, heavier workloads, and more risks to their health and safety.

By not enforcing the *Canada Health Act*, successive federal governments have for decades been allowing public dollars, in the form of health care transfer payments, to flow out of the public system and into private clinics. We all know that improvements are needed. But privatization brings higher costs, lower quality, and favours the wealthy over everyone else. Instead, improvements can and must be made within our public and universal health care system.

Our public health care system is under pressure from CEOs, who are pushing for privatization, and politicians, who are putting corporate interests ahead of people's interests. In every province and territory, debates are unfolding about the potential for privatized and for-profit forms of health care to resolve the deep crises in the system.

For decades, the federal government has not paid its fair share of public health care funding. When the *Medical Care Act* was passed in 1966, federal and provincial governments were expected to each cover 50% of the cost. The federal share was about 35% but it plummeted further under Conservative and Liberal governments. In 2023, the federal government only covered 21.5% of the cost.¹

As patients face user fees for medically necessary procedures, emergency room closures, and longer wait times, access to public and universally accessible health care is under threat. Meanwhile, health care workers in hospitals, long-term care facilities, and primary care are burnt out and left with the burden of underfunded and understaffed facilities.

The failure to restore federal funding and invest in health care has opened the door to privatization. To make matters worse, the federal government has failed to ensure that public funds stay only in the public system. Federal dollars distributed via Canada Health Transfer payments have flowed to provinces and territories with virtually no strings attached. Provincial governments have put those public dollars into for-profit health care services, with few penalties.

In many provinces, patients are being charged user fees for medically necessary procedures. This is known as "extra-billing" and is in direct violation of the *Canada Health Act*. Charging patients for insured health services, such as public hospital services and physician services, is prohibited.

¹ Canadian Medical Association. (2025). *How is Health Care Funded in Canada?* <https://www.cma.ca/how-health-care-funded-canada>.

Provincial governments are funding for-profit hospitals and clinics that charge much higher rates for procedures than their public counterparts. Provincial governments are also pouring millions of dollars into private staffing agencies, for-profit long-term care facilities, public-private partnerships, and virtual services provided by corporations.

CUPE is leading the fight against health care privatization across Canada. In 2023, delegates at CUPE's national convention passed a resolution which called on the union to advocate and lobby all levels of government for a stronger public health care system by eliminating all forms of privatization.

The resolution highlighted the key consequence of health care privatization: it costs governments more in every way. For-profit health care results in higher costs to governments and patients, longer wait times for surgeries and diagnostic procedures, worse quality of care for patients, and worse working conditions for health care workers.

CUPE members working in health care have highlighted stories about the staffing crisis, which saw thousands of workers leave the sector after the worst of the COVID-19 pandemic. These members know firsthand that privatization worsens staffing issues by taking much-needed staff from the public system, diverting them to for-profit clinics and exacerbating wait times. In recent years, CUPE members have also observed that lower-income earners, Indigenous, Black and racialized people, and other equity-seeking groups are hit the hardest with privatization.

Directed by this resolution, CUPE produced this report to outline how privatization is unfolding in health care across the country. The report highlights prominent trends and instances of health care privatization, including recent decisions made by federal and provincial governments and actors in the private sector. Information for this report was compiled from government and Auditor General reports, health coalitions, academic researchers, media investigations, and related sources.

The full extent of health care privatization is broad and conditions are changing rapidly. Therefore, this report focuses on the following trends:

- User fees
- Public funding to private staffing agencies
- Public funding to private health care facilities
- For-profit long-term care
- Public-private partnerships and contracting out
- Virtual care and artificial intelligence

This report concludes by documenting how CUPE members and allies, such as provincial health coalitions, are successfully fighting back. CUPE members will continue to be on the front-line, resisting privatization in health care facilities and advocating for publicly funded and delivered care. The resolution passed at the 2023 convention resulted in a renewal of the [Public Solutions in Health Care](#) campaign. The campaign's demands are:

- The federal government must ensure that federal transfer payments given to the provinces and territories are directed to the public system only.
- The federal government must stop all violations of the *Canada Health Act*, including charging patients for medically necessary procedures covered by the provinces and territories.

What is health care privatization?

In health care, privatization refers to changing the ownership, management or delivery of health care services from the public sector to for-profit corporations, non-profit organizations, or a combination of private and public actors.

CUPE members often face privatization in the form of contracting out. This occurs when governments and public sector employers hire third-party contractors to perform specific tasks and functions or to deliver services that were previously provided by public sector workers. This form of privatization is harmful to workers because contracts are typically awarded to the corporation offering the lowest price for the work. CUPE members in health care have fought contracting out in clerical, housekeeping, custodial, security, and dietary services.

In the worst scenarios, conservative governments have massively contracted out services in hospitals and long-term care. For example, in the early 2000s, B.C. Liberal Premier Gordon Campbell facilitated widespread contracting out that allowed third-party contractors to avoid unionization and opt out of the master collective agreement to lower labour costs and increase profits.

Provincial governments have also increased public funding to public-private partnerships (P3s) to build new health care facilities. In a P3 model, a government and a group of corporations arrange a long-term contract where private actors are contracted to design, build, finance, operate, maintain or own a public facility. Compared to publicly financed and managed projects, P3s typically allow the private sector to have extensive involvement in the control of public services and assets. For-profit corporations are guaranteed long-term profits from government payments for financing, operating, and maintaining infrastructure.

CUPE has long warned about the consequences of public-private partnerships in health care. For example, the cost of Brampton, Ontario's P3 hospital ballooned from a budget of \$350 million to over \$2 billion, while the size of the hospital shrank, providing fewer rooms than the hospital it replaced.² Proponents of P3s argued the model would deliver the hospital at a lower cost than a conventional public build, but they were proven wrong. Despite that lesson, several provincial governments continue to sign on to P3s for new health care buildings.

In recent decades, health care privatization has become both more common and more complex. The for-profit health care sector has expanded, because governments who are sending more public dollars to private services. This is a deliberate move by governments who argue the private sector will help struggling public services. But these same governments are underfunding public health care services, causing them to fail.

² Ontario Health Coalition. (2020, January 24). *Ontario Health Coalition Backgrounder Brampton Hospital Crisis Warnings and Broken Promises*. <https://www.ontariohealthcoalition.ca/wp-content/uploads/Backgrounder-on-Brampton-hospital.pdf>

Since 2023, provincial governments have increasingly directed public funds to for-profit corporations for the delivery of essential health care services. The appendix provides a review of major health care privatization announcements. Since 2023, over \$51.7 billion of public funding for health care has been diverted to private, for-profit corporations. Over \$20.6 billion has been spent on private staffing agencies, consultants, research and development, service delivery, information technology, and private providers of senior's care.

Sadly, most provincial governments have drastically increased funding for for-profit services in the aftermath of the COVID-19 pandemic. After investing in short-term measures to survive the pandemic (e.g. increasing funding to public vaccination drives), many provincial governments have said they need private companies to help eliminate lengthy wait lists for surgeries and diagnostic procedures.

Instead of increasing long-term investments in public health care and hiring more staff to deal with this crisis, they have poured millions of dollars into for-profit clinics and long-term care homes, private staffing agencies, and for-profit virtual care services. This privatization has led to several consequences for patients and CUPE members in health care that will be highlighted in this report.

It is seldom acknowledged that for-profit health care expansion is the most expensive option. It results in higher costs to governments and patients, which is evident in past privatization failures, like P3 hospitals, and it is quickly becoming apparent in the millions of dollars being spent on private staffing agencies.

According to the Canadian Federation of Nurses Unions, governments were projected to spend over \$1.5 billion on for-profit nursing agencies in the 2023-2024 fiscal year, which amounts to a 600% increase over three years.³ Facing intense criticism of these costs, governments in British Columbia, Quebec and New Brunswick either cancelled contracts with private staffing agencies or mandated the end of them.^{4,5}

Privatization results in worse conditions for health care workers which means worse care for patients. The longer governments put off desperately needed investments in public health care, the worse impacts it has for everyone.

3 Almost, J. (2024). *Opening the black box: Unpacking the use of nursing agencies in Canada*. Canadian Federation of Nurses Unions. <https://nursesunions.ca/wp-content/uploads/2024/09/Agency-Full-Report-Final-English-20Sept2024.pdf>

4 Zafar, A. (2025, May 12). 'Hemorrhage' of nurses in health care is a symptom of a bigger problem: experts. CBC News. <https://www.cbc.ca/news/health/agency-nurses-ontario-hospitals-1.7531910>

5 As of April 2025. In Québec's case, the CAQ government's decision to mandate the end of private staffing agencies in five regions has been accompanied by criticism that they are not going to recruit and retain public health care staff instead. In December 2023, the government passed a law enacting a major reform of the health care system which created Santé Québec. The government has claimed their reform will reduce health care expenditures by \$1.5 billion but SCFP- Québec argues that this reform will cut needed funding for public health care staff.

Who benefits from health care privatization?

Health care privatization only benefits those who have a financial stake in these private business deals. It is terrible for everyone else.

Corporations and organizations in the privatization industry financially benefit from the privatization of health care services. This includes corporations that own or operate for-profit services, but also their CEOs, and the law firms, accounting firms, investors, consultants, lobbyists, and public relations firms involved in setting up privatization deals. Politicians who work with these corporations often benefit from private donations to their political parties, and they may make promises to cut taxes or set up exclusive health care service contracts.

In January 2025, federal Conservative leader Pierre Poilievre attended a fundraiser hosted by a billionaire couple who has shares in Medical Facilities Corporation, a for-profit health care corporation that owns private hospitals in the United States.⁶ His presence suggested he was making promises to corporations and individuals in the U.S. for-profit health care industry, and he subsequently pledged to lower taxes for individuals who make \$1.4 million a year in capital gains.

Conservative provincial governments have been accused of giving exclusive contracts to corporations, such as Shannex Inc., a for-profit nursing home corporation. New Brunswick's Conservative government awarded 14 P3 nursing home pilots to Shannex between 2008 and 2022.⁷ After facing heavy criticism that these contracts to Shannex were not tendered, the government opened tenders for all subsequent contracts and awarded some to non-Shannex bidders.

Corporations such as Loblaw Companies Limited have been scrutinized for rapidly expanding for-profit health care since the COVID-19 pandemic, through their companies Maple, Lifemark, Shoppers Drug Mart, and other subsidiaries. In August 2020, Shoppers opened a for-profit, primary care and family practice clinic in Toronto. By May 2021, it had opened three clinics, with plans for four more in Ontario.⁸ The model for the clinics relied heavily on self-serve technology, such as touchscreen check-ins, an electronic records system, and virtual consultations with physicians.

6 NDP. (2025, January 21). *Reality check: What did Poilievre promise private health care billionaires last night?* <https://www.ndp.ca/news/reality-check-what-did-poilievre-promise-private-health-care-billionaires-last-night>.

7 McFarland, J. (2025, February 18). *Want a new nursing home? Finance it yourself! NB Media Co-op.* <https://nbmediacoop.org/2025/02/18/want-a-new-nursing-home-finance-it-yourself/>.

8 Shoppers Drug Mart. (2020, August 12). *Shoppers Drug Mart Company pilots first managed medical clinic in Toronto.* <https://corporate.shoppersdrugmart.ca/fr/shoppers-drug-mart-company-pilots-first-managed-medical-clinic-in-toronto/>.

By early 2024, Shoppers had opened ten primary care clinics—six in Ontario and four in British Columbia.⁹ At the same time, they developed government partnerships to offer some primary health care services at select Shoppers pharmacy locations, such as the agreement with the government of Nova Scotia they made in February 2023.^{10, 11}

However, in April 2024, Shoppers sold off their primary care clinics.¹² A Loblaw spokesperson stated that their focus shifted to developing clinics run by pharmacists, although journalists suspected that their physician-run clinics were simply not profitable enough to continue.¹³ Despite that failure, and as their spokesperson suggested, Shoppers has focused on squeezing profits from their pharmacies.

In August 2024, Shoppers announced their plan to open 250 pharmacist-run clinics by 2025, showing that they are continuing to expand into for-profit health care.¹⁴ The corporation's close ties with the Ontario government, in particular, is paying off for them. In May 2025, the *Toronto Star* revealed Shoppers made \$62 million in just over two years from provincially-funded medication reviews performed by their own pharmacists.¹⁵

Former pharmacists employed by Shoppers said they faced intense corporate pressure to meet growing quotas for the reviews, conducting as many 80 to 100 reviews per week during COVID-19. One anonymous pharmacist, who left the franchise, commented on the pressure: “You still have to do these things, even if in your professional judgment you don’t want to.”¹⁶ Their experience indicates a worrying trend of the quickly expanding corporate pressure on health care professionals to make profits for already highly profitable corporations in Canada.

9 Reevely, D. (2024, October 21). Why Shoppers Drug Mart gave up on physician-led health clinics. *The Logic*. <https://thelogic.co/news/shoppers-drug-mart-physician-health-clinics/>.

10 Shoppers Drug Mart. (2023, February 10). *Shoppers Drug Mart applauds Nova Scotia's community healthcare clinic pilot*. <https://corporate.shoppersdrugmart.ca/en/shoppers-drug-mart-applauds-nova-scotias-community-healthcare-clinic-pilot/>.

11 Shoppers said these services are provided at no cost (with a valid Nova Scotia health card) and range from assessment and prescribing for common illnesses, chronic disease management and injections and immunization services.

12 Reevely, 2024.

13 Ibid.

14 Dowson, A. L. (2024, August 14). Shoppers Drug Mart wants to set up 250 for-profit pharmacy care clinics by 2025. *Canadian Health Coalition*. <https://www.healthcoalition.ca/shoppers-drug-mart-pharmaprix-wants-to-set-up-250-for-profit-pharmacy-care-clinics-by-2025/>.

15 *Toronto Star*. (2025, May 10). Shoppers Drug Mart billed Ontario almost \$62 million for medication reviews. Former store owner says program is being ‘abused’. https://www.thestar.com/business/shoppers-drug-mart-billed-ontario-almost-62-million-for-medication-reviews-former-store-owner-says/article_b5f14860-8929-4b9e-b17e-a6a45bbef5c2.html.

16 Ibid.

In June 2021, Veteran Affairs Canada awarded a \$560 million contract for the administration of its rehabilitation program Partners in Canadian Veterans Rehabilitation Services (PCVRS), a joint venture between WCG International and Lifemark Health Group. Lifemark Health Group is owned by Loblaw. In March 2023, the NDP reported that this outsourcing has resulted in significant delays, a loss of mental health support for veterans during transition to the new system, and a contract that will cost 25% more than if the public service were to do it.¹⁷

The Westons, one of Canada's richest families, control Loblaw and Shoppers Drug Mart through their control of George Weston Limited. Their political connection and large private donations have facilitated privatized health care.¹⁸ Galen G. Weston is a director on the board of Sunnybrook Hospital and the Weston Family Foundation is a major donor to the hospital and many public health care centres and programs.¹⁹

The Westons are also profiting from Loblaw Companies' minority stake in Maple Corporation, which provides virtual access to licensed physician and nurse practitioners for a user fee. For provinces with a severe physician shortage such as PEI, the provincial government has poured millions of dollars into Maple to try to accommodate residents without access to primary care. They spent more than \$1.1 million on Maple from January to December 2023 and in 2024 they budgeted \$2.7 million for its use.²⁰ During this time, PEI residents have complained about long wait times with no guarantee of seeing a physician, and confusion over whether they need to pay for Maple.²¹

Multiple provinces have contracted Maple since 2020 to oversee public telecare referral services, including Ontario, New Brunswick, and Nova Scotia. There is no public information available to see how much Loblaw has financially profited from Maple, yet the contracts with the provinces indicate that Maple is receiving higher payments over time, and this will ultimately benefit Loblaw and the Weston family.

17 Blaney, R. (2023, March 9). *New Democrats demand Liberals stop protecting profits over veterans by ending Loblaw's outsourcing*. NDP. <https://www.ndp.ca/news/new-democrats-demand-liberals-stop-protecting-profits-over-veterans-ending-loblaw-outsourcing>

18 The corporation is controlled by George Weston Limited, a holding company controlled by the Weston family.

19 Sunnybrook Hospital. (2020, March 2). *The W. Garfield Weston Foundation makes one-of-a-kind, \$16.7-million philanthropic grant to revolutionize the treatment of brain disorders*. <https://foundation.sunnybrook.ca/2020/03/grant-weston-family-focused-ultrasound-initiative/>.

20 MacKay, C. (2024, April 17). PEI government to put more money into virtual health-care programs. *CBC News*. <https://www.cbc.ca/news/canada/prince-edward-island/pei-virtual-health-care-programs-1.7175662>.

21 Ibid.; MacKay, C. (2023, October 17). Long waits, time-outs on Maple lead to renewed calls for Canada-wide medical licenses. *CBC News*. <https://www.cbc.ca/news/canada/prince-edward-island/pei-maple-wait-times-1.6998574>.

Health care privatization and its negative impacts

User Fees

Even though it is a violation of the *Canada Health Act*, for-profit clinics are charging patients for medically necessary procedures that are covered by provincial and territorial health insurance plans. Patients are paying hundreds or thousands of dollars out-of-pocket for diagnostic and surgical procedures.

The reasons patients use for-profit clinics are complex. In some cases, patients hope to jump the queue for surgeries and primary care services by paying privately.²²

In recent years, patients have paid as much as \$11,000 for cataract surgeries and \$30,000 for hip surgeries. Provincial health coalitions have profiled patients who have been charged for cataract surgeries in particular.

The Ontario Health Coalition revealed that Ontario's government has given a number of large volume contracts to for-profit cataract clinics, including at least one chain that is charging patients \$3,000–\$4,000 or more per eye for cataract surgeries.²³ One patient, Maureen Munro, was told by her optometrist that her cataract surgery would cost about \$3,000 unless she wanted to wait two years to have it done through Ontario's health insurance program.²⁴ She was then referred to a for-profit clinic who charged her \$7,000 to receive her surgery, plus additional add-on charges. She needed to take out a loan to pay for these unanticipated costs. Another patient in Ottawa told the coalition that she was quoted as high as \$11,000 for cataract surgery.²⁵

The coalition alleges that patients are frequently lied to about long wait times to create fear that they will not be treated on time. According to Ontario government data, the highest priority patients wait only 3 weeks

22 Charging service and enrolment fees is a violation of the *Canada Health Act*. Where a clinic refuses service to someone who is unwilling to pay a fee, it is creating a barrier to service, and where the service should be publicly insured, it is also a breach of the ban on extra billing and user charges.

23 Ontario Health Coalition. (2024, April 16). *Illegal, unlawful and unethical: Case studies of patients charged for medical care in Ontario's private clinics*. <https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-private-clinics-report-for-release.pdf>

24 Ontario Health Coalition. (2025, February 19). *Patients who have been extra-billed for surgeries in private for-profit clinics demand accountability in the Ontario election: Press conferences in towns across Ontario*. <https://www.ontariohealthcoalition.ca/index.php/release-patients-who-have-been-extra-billed-for-surgeries-in-private-for-profit-clinics-demand-accountability-in-the-ontario-election-press-conferences-in-towns-across-ontario/>

25 Ibid.

for a specialist appointment and have their surgery completed within 2 months.²⁶ The coalition alleges some medical professionals are not being transparent about shorter wait times for higher priority patients.

For-profit clinics are applying similar manipulative tactics for annual physicals, MRI scans, and knee and hip surgeries. In May 2024, *Maclean's* reported that patients are paying as much as \$100 to see a nurse practitioner for primary care services, \$600 for an MRI scan, and over \$20,000 to travel outside their province to see a surgeon for a hip or knee replacement.²⁷

In some cases, patients say they paid for private services to try to receive surgery sooner. For example, a patient in Montreal paid \$30,000 for private hip replacement surgery, claiming he was able to get surgery in eight weeks as opposed to an 18 to 24 month wait in the public system.²⁸

Other patients turn to private options in response to the family physician shortage. A Saskatchewan nurse practitioner, who charges \$90 per appointment, said her patients come to her because they are tired of waiting for the physician shortage to be resolved, a common issue facing small, rural towns across Canada.

These nurse practitioner fees are a clear violation of the *Canada Health Act*, yet no commitment has been made by the federal government to crack down. A January 2025 interpretation by the Minister of Health that deemed nurse practitioner fees to be a violation of the Act may soon lead to action by provincial governments.²⁹ The letter clarifies that “patient charges for medically necessary services, whether provided by a physician or other health care professional providing physician-equivalent services, will be considered extra-billing and user charges under the CHA.”³⁰ Therefore, a regulated nurse practitioner providing medically necessary care, such as annual physicals, should not be able to charge for it.³¹ However, the Minister did not address a range of concerns that have been brought up about user fees, including fees for medically necessary primary care charged by virtual care corporations, and fees for queue-jumping.

The federal government also needs to address subscription fees being charged for primary care as part of a family physician group practice. Ottawa’s South Keys Health Centre is a for-profit clinic that charges patients a \$400 per year membership fee to access a walk-in clinic and family physician group practice.³²

26 Ibid.

27 Frangou, C. (2024, May 16). Private health care is here. *Maclean's*. <https://macleans.ca/society/health/private-health-care-canada/>

28 Ibid.

29 Holland, M. (2025, January 10). Letter to provinces and territories on the importance of upholding the Canada Health Act – 2025. *Government of Canada*. <https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act/letter-provinces-territories-january-2025.html>

30 Ibid.; Note: It will be up to provincial and territorial governments to decide on specific billing codes for nurse practitioners for these services.

31 Enforcement will be required of provinces and territories after April 1, 2026. At that point, out-of-pocket fees charged to patients are expected to be deducted from Canada Health Transfers.

32 Ontario Health Coalition. (2024, March 8). *Behind the cloak of private ownership Doug Ford's dangerous 'Wild West' of for-profit health clinics*. <https://www.ontariohealthcoalition.ca/wp-content/uploads/final-report-complete.pdf>

“Executive health” clinics charge far more exorbitant fees, and tend to attract very wealthy patients looking for ‘elite’ services, such as same-day visits or correspondence via calls and emails from primary care teams, and add on services that are not medically necessary, like Botox. MDDirect, an executive health clinic in Toronto, charges patients nearly \$5,000 per year for annual physicals, diagnostic screenings, same-day visits, house calls, and more.³³ A chain in Québec, Les Cliniques Médicales Lacroix, charges similar user fees and offers an à la carte option for a primary care consultation for \$249.³⁴

Charging user fees for these primary care services re-establishes the two-tier health care system that medicare was designed to end.

Not only are these for-profit clinics entrenching a two-tier health care system, but patients have lost access to their family physician who left the public system. These patients were not looking to jump the queue or access elite services. A patient in Barrie, Ontario was treated by a family physician in Toronto for 10 years until her physician moved to a for-profit clinic.³⁵ To continue with her physician, she would have to pay \$4,245 per year. She declined to pay and lost access to her physician.

This problem is very acute in Québec where for-profit clinics are allowed to operate outside of the provincial insurance plan.³⁶ In 2021, it was reported that one in five people in Québec did not have access to a regular health care professional.³⁷ The shortage has become so dire that, in April 2025, the Québec government mandated newly graduated physicians to work in the public system for five years.³⁸ The Québec government also made the controversial decision to establish Santé Québec, a new government-owned corporation aimed at restructuring public health services to centralize services and reduce costs.³⁹ Santé Québec has a mission to reduce waiting lists for surgeries and family physicians. But critics have pointed out that the budget cuts made to the province’s integrated health and social service centres will increase demand for these services, by increasing hospitalizations that could have been avoided with early preventive support from other public health care workers.⁴⁰

33 Duggal, S. (2024, February 24). NDP raises concerns about ‘executive health’ clinic charging patients thousands. *The Trillium*. <https://www.thetrillium.ca/news/health/ndp-raises-concerns-about-executive-health-clinic-charging-patients-thousands-8318724>

34 Ha, T. T., & Sun, Y. (2023, August 8). Why more Quebec family doctors are leaving the public health system. *Globe & Mail*. <https://www.theglobeandmail.com/canada/article-quebec-family-doctors-public-private-care/>

35 Zafar, A., & Birak, C. (2025, April 21). Canadians heading to vote face sticker shock for primary care at private clinics. *CBC News*. <https://www.cbc.ca/news/health/federal-election-primary-care-1.7512737>

36 The physicians in this scenario are deemed to be non-participating physicians and their patients cannot make a claim with their provincial insurance plan (RAMQ). This scenario is unique to Québec unlike other large provinces like B.C. and Ontario. Authors Ha and Sun from the *Globe & Mail* claim that there were 642 non-participating physicians in Québec in early 2023, a proportion that has doubled in the last decade.

37 Ha & Sun, 2023.

38 *CBC News*. (2025, April 24). Québec passes law requiring doctors to work in the public system for 5 years after med school. <https://www.cbc.ca/news/canada/montreal/quebec-bill-83-law-doctors-study-public-private-1.7517752>

39 The Québec national assembly passed Bill 15 (“An Act to make the health and social services system more effective”) in December 2023 which led to the creation of Santé Québec. The bill’s passing was made even more controversial by invoking closure in the legislature.

40 These centres are referred to as *centres intégrés de santé et de services sociaux* (CISSS); Blanchette, L., & Pigeon, C. (2025, March 6). *Unpacking Quebec’s major healthcare reform*. Ottawa: Canadian Centre for Policy Alternatives. <https://www.policyalternatives.ca/news-research/unpacking-quebecs-major-healthcare-reform/#:~:text=In%20December%202023%2C%20Quebec%E2%80%99s%20national,the%20province%E2%80%99s%20health%20care%20system>

The alarming exodus of physicians from Quebec’s public health care system continues to accelerate, further entrenching a two-tier system and leaving hundreds of thousands of patients behind.⁴¹ Recently, another 246 doctors opted out of the public system, raising the total number of physicians practicing exclusively in the private sector to approximately 880. Highlighting the ongoing violations of the *Canada Health Act*, Quebec was penalized a record-setting \$42 million in March 2023 for allowing patients to be illegally charged out of pocket for medically necessary diagnostic services.⁴²

The growing number of non-participating physicians has left more than half a million people in the province without a family doctor, demonstrating the direct impact that privatization has on access to care for the public.

The proliferation of for-profit clinics and user fees comes at a high cost for the public. Fundamentally, it means that the public system is drained of desperately needed health care professionals. As one Ontario family physician explained, the for-profit tier “takes me out of the public system where anybody has access if they are a patient of mine, and removes me and puts me behind a paywall.”⁴³ For-profit clinics treat far fewer patients overall. The same physician explained that a recruiting corporation would allow her to take on 400 patients, whereas an average family physician in her jurisdiction treats about 1,200 patients.⁴⁴ Her experience shows that a two-tier system does not work. Contrary to those who believe a private system will add new health care professionals to help ease the burden on public health care, the cases unfolding across the country show that most patients will lose access to medically necessary care, while a smaller number of wealthy patients will benefit.

The rise of for-profit clinics also raises other ethical concerns, such as the unmitigated power and influence of clinic chains who desire to make more money. In May 2025, for example, a team of researchers at Women’s College Hospital in Toronto revealed that for-profit primary care clinic chains are selling patient data via commercial data brokers to pharmaceutical corporations.⁴⁵ These patients did not consent to having their data shared and can only protect their personal data by leaving the clinic, which would mean losing their family physician. In effect, this scandal shows how corporate power and influence in the for-profit health care industry have consequences that go beyond user fees and two-tier health care.

41 Canadian Health Coalition. (2025, July 12). 246 more Quebec doctors leave the public health care system, bringing the total to roughly 880. Retrieved from <https://www.healthcoalition.ca/246-more-quebec-doctors-leave-the-public-health-care-system-bringing-the-total-to-roughly-880/>

42 Health Canada. (2025). Canada Health Act Annual Report 2023-2024. Retrieved from <https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2023-2024.html>

43 These centres are referred to as *centres intégrés de santé et de services sociaux* (CISSS); Blanchette, L., & Pigeon, C. (2025, March 6). *Unpacking Quebec’s major healthcare reform*. Ottawa: Canadian Centre for Policy Alternatives. <https://www.policyalternatives.ca/news-research/unpacking-quebecs-major-healthcare-reform/#:~:text=In%20December%202023%2C%20Quebec%E2%80%99s%20national,the%20province%E2%80%99s%20health%20care%20system>

44 Ibid.

45 Spithoff, S., Vesley, L., & McPhail, B. (2025, May 5). The primary care medical record industry in Canada and its data collection and commercialization practices. *JAMA Network Open*, 8(5):e257688. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833520>; Patient data includes their health, medical history and prescriptions data.

Public opinion in Ontario stands in stark opposition to the provincial government’s privatization agenda. Following a budget announcement that allocated \$280 million to private, for-profit clinics, a Nanos poll revealed that an overwhelming majority (76%) of residents want spending prioritized on public hospitals instead.⁴⁶ This sentiment is rooted in the widespread belief that funding private clinics will worsen the staffing crisis in public hospitals and create a two-tier system where wealthier patients receive preferential access to care. The findings underscore a clear public mandate for reinvestment in the public system, directly contradicting the government’s policy of diverting hundreds of millions in public funds to for-profit surgical and diagnostic centres.

Public funding to private staffing agencies

Provincial governments have poured billions of dollars of public funding into private, for-profit staffing agencies, which has come at a high cost for the public. Provincial governments have claimed they need to use these agencies as nurses in the public system left their jobs in droves due to burnout and stress from work during the COVID-19 crisis.⁴⁷ In the years following the worst of the pandemic, across all provinces and territories, provincial funding for private staffing agencies in hospitals, including private travel nurses, has skyrocketed. It is estimated that governments across Canada spent more than \$1.5 billion on for-profit nursing agencies in the 2023-2024 fiscal year, which amounts to a six-fold increase over just three years.⁴⁸

The following table provides an overview of public data detailing how much provincial governments have recently spent on private staffing agencies.

Table: Available information on spending on private staffing agencies⁴⁹

British Columbia	Since 2023, more than \$228 million has been spent on private staffing agencies including agencies providing travel nurses.
Alberta	Between 2021 and 2024, more than \$330 million was spent on staffing agencies, with annual funding increasing from \$5 million to over \$154 million. ⁵⁰

46 Canadian Union of Public Employees (CUPE). (2025). *Ontarians want provincial government to prioritize spending on public hospitals, not private clinics: new poll*. Retrieved from <https://cupe.ca/ontarians-want-provincial-government-prioritize-spending-public-hospitals-not-private-clinics-new>

47 Staff shortages are cited as a common reason for turning to private staffing agencies especially to fill vacancies in northern, rural, and remote health care facilities. However, in 2024, New Brunswick’s Auditor General found the deployment of travel nurses in Vitalité’s hospitals did not necessarily correlate with staff absences. Vitalité allowed Canadian Health Labs, a private staffing agency, to be paid for their contract even if they did not deploy their nurses for shifts.

48 Almost, J. (2024, September). *Opening the black box: Unpacking the use of nursing agencies in Canada*. Canadian Federation of Nurses’ Unions (CFNU). <https://nursesunions.ca/wp-content/uploads/2024/09/Agency-Full-Report-Final-English-20Sept2024.pdf>

49 The Appendix of this report contains a non-exhaustive list of spending amounts for private staffing agencies. The appendix is compiled spending and announcements using publicly available information. The true amount spent on nursing agencies by provinces could be significantly higher.

50 Appel, J. & Kinney, D. (2024, November 25). EXCLUSIVE: AHS projects to spend \$330 million on agency nurses since 2022. *Progress Report*. https://www.theprogressreport.ca/exclusive_ahs_projects_to_spend_330_million_on_agency_nurses_since_2022#:~:text=Between%20April%202021%20and%20April,a%20freedom%20of%20information%20request

Saskatchewan	Since 2023, more than \$59 million has been spent on staffing agencies. The Saskatchewan Health Authority directed public funds to several private, for-profit corporations, including Lifeline Healthcare Staffing Agency Inc., Nurse Relief Inc., Select Medical Connections Ltd, Solutions Staffing Inc, and Truecare Alliance Staffing.
Manitoba	Since 2023, more than \$141 million has been spent on staffing agencies. ⁵¹
Ontario	From 2013 to 2023, more than \$9.2 billion was spent on nurses and other health care staff from private agencies. ⁵²
Quebec	Between 2016 and 2022, about \$3 billion has been spent on staffing agencies. In 2023/24 fiscal year, spending on staffing agencies was \$276 million. ⁵³
New Brunswick	Between 2022 and 2024, The Vitalité health authority spent over \$173 million on private travel nurses between. ⁵⁴
Prince Edward Island	Since 2023, over \$10 million has been spent on staffing agencies. ⁵⁵
Nova Scotia	In 2023/24, \$126 million was spent on private nursing agencies. ⁵⁶
Newfoundland and Labrador	Since 2023, more than \$258 million spent on travel nurses from private staffing agencies. ⁵⁷

While provincial contracts with private staffing agencies have been kept secret, it is likely that the executives and managers in these agencies are the ones making high profits from them. Agencies charge double or triple the cost of hiring regularly employed staff. According to a 2024 study by Joan Almost of the Canadian Federation of Nurses Unions (CFNU), agency rates have reached \$65 per hour reported in Manitoba and a record high of \$312.40 per hour in Newfoundland and Labrador—about six times what a local staff nurse earns.⁵⁸

51 Greenslade, B. (2022, August 17). Manitoba spent more than \$40M with private nursing agencies last year. *Global News*. <https://globalnews.ca/news/9066971/manitoba-private-nursing-agencies-cost/>.

52 Longhurst, A. (2025). *Hollowed out: Ontario public hospitals and the rise of private staffing agencies*. Ottawa: Canadian Centre for Policy Alternatives.

53 Lindsay, B. (2023, May 12). Nursing agencies are staffing hospitals at 'huge cost' to health-care system, experts say. *CBC News*. <https://www.cbc.ca/news/health/cost-nursing-agencies-1.6839273>.

54 Poitras, J. (2024, June 20). Vitalité CEO says top health official gave 'green light' to travel-nurse contracts. *CBC News*. <https://www.cbc.ca/news/canada/new-brunswick/france-desrosiers-vitalite-ceo-travel-nurse-contracts-1.7241376>.

55 Yarr, K. (2024, March 13). Travel nurse spending hits \$8.8M, nearly 7 times previous year. *CBC News*. <https://www.cbc.ca/news/canada/prince-edward-island/pei-travel-nurse-spending-1.7142270>.

56 McPhee, J. (2023, April 10). Private nursing bill skyrockets in Nova Scotia amid staffing crisis. *PNI Atlantic News*. <https://www.saltwire.com/atlantic-canada/private-nursing-bill-skyrockets-in-nova-scotia-amid-staffing-crisis-100842124>.

57 Postey, D. (2024, April 18). Sask. ER nurses say province relies too much on travel nurses to address healthcare issues. *CTV News*. <https://www.ctvnews.ca/regina/article/sask-er-nurses-say-province-relies-too-much-on-travel-nurses-to-address-healthcare-issues/#:~:text=NDP%20Finance%20Critic%20Trent%20Wotherspoon,from%20outside%20of%20the%20province>.

58 Almost, 2024.

Yet, the profits made do not necessarily go toward wages for workers such as front-line nurses. Agencies decide what they would like to do with their profit, which is often to compensate the most senior corporate executives. The ability for agencies to earn high profits has been contentious in provinces like Ontario that have re-introduced legislation to require agencies to report billing or pay rate information.⁵⁹ However, the Ontario government is not obligated to report this data publicly and it has not committed to regulating agency fees or phasing out the use of agencies.

There is also contention over what nurses are paid by private staffing agencies versus public hospitals. Agency nurses can earn 50% more than their public sector counterparts doing the same jobs in the same hospitals, and are able to choose their shifts so they can opt for flexible work hours and more time off.⁶⁰ These nurses do not have union protection and benefits, including pensions and long-term disability benefits, unlike public sector nurses. Yet, higher wages are a major driving factor for nurses choosing to work for agencies. Registered Nurses contacted for CFNU's study reported an average hourly wage close to \$71 per hour, with a high of \$110 per hour in New Brunswick.⁶¹ The same study found Licensed Practical Nurses reported an average close to \$48 per hour, and the average hourly wage reported by a small number of Registered Psychiatric Nurses was \$39 per hour.

The differences in pay are frustrating for CUPE members who work alongside private agency staff. As Rahel Woldeselassie, a patient coordinator in the emergency department at St. Michael's Hospital, and former President of CUPE 5441, explained: "The hospital trained these agency workers. They wear the same badges. They have access to our system. They work alongside us. This is about privatizing our health care. It's so sad because a lot of these people could have been our colleagues but chose to work for agencies, which pay a much higher hourly wage than hospitals."⁶²

Pay for nurses and other staff in the public system has barely increased after the staffing crisis presented by the COVID pandemic. In Ontario, the government imposed wage caps over the same period, such as Bill 124, which restricted pay increases to 1% annually for three years.⁶³ From 2013-14 to 2022-23, spending on public hospital staff increased 6%, but spending on private staffing agencies increased 98%.⁶⁴ Over the same period, Ontario hospitals had seven years of real per capita spending cuts, as successive governments were unwilling to invest to resolve the crisis in public hospitals. Andrew Longhurst, of the Parkland Institute, warned in his 2025 report on private staffing agency use in Ontario, "The more that

59 The legislation referred to here is Bill 11 ("More Convenient Care Act, 2025") which was re-introduced on May 5, 2025 and passed in June 2025.

60 Longhurst, 2025; Almost, 2024.

61 Their study includes a range of RNs in different workplaces, such as hospitals and long-term care institutions. Almost points out that RNs working in hospitals reported the highest average wages and their counterparts working in long-term care institutions reported the lowest average wages.

62 Wallace, K. (2025, January 25). Toronto hospitals have been outsourcing more and more nursing jobs to agencies. A new ruling against Unity Health could change that. *Toronto Star*. Para 19. https://www.thestar.com/business/toronto-hospitals-have-been-outsourcing-more-and-more-nursing-jobs-to-agencies-a-new-ruling/article_31444eb0-da83-11ef-8294-5be6b4ede7e0.html

63 Bill 124 ("Protecting a Sustainable Public Sector for Future Generations Act, 2019") was declared unconstitutional in November 2022 by the Ontario Superior Court.

64 Longhurst, A. (2025). *Operation profit: Private surgical contracts deliver higher costs and longer waits*. Edmonton: Parkland Institute.

public funding entrenches private agency staffing, the harder it becomes to support long-term investment in the more cost-effective public sector workforce.”⁶⁵ To him, as to other critics of agencies, the exorbitant amounts of government funding spent are a waste of taxpayers’ money—directing public funding towards public hospitals is the lowest-cost, safest and most effective solution.

Public sector nurses, including CUPE members, working alongside agency staff are frustrated that most provincial governments are pouring money into these agencies instead of investing in public workers, improving their pay, benefits and working conditions, and implementing better recruitment and retention strategies, particularly for nurses entering the field. Natalie Stake-Doucet, a Registered Nurse who left nursing and is currently teaching at McGill University, simply said, “The private agencies are taking advantage of the fact that our health-care system is a meat grinder for nurses.”⁶⁶

CUPE members have made recommendations to federal and provincial governments to address high turnover caused by demanding working conditions, low wages, forced overtime and high patient-to-nurse ratios. CUPE members have also advised governments to invest in publicly employed nurses because, often, they are more experienced and knowledgeable than nurses who are quickly turning to work for private agencies. The fact that agency nurses are non-unionized means that they have fewer health and safety protections, which impacts patient care. Veteran nurses and public health experts say the costs for private staffing agencies, and the problems associated with them, will continue to increase unless governments address the systemic work issues in the public system that are driving health care workers to leave their jobs.

Facing intense criticism of provincial government spending on private staffing agencies, some governments have acted. Governments in Manitoba, Québec and New Brunswick have either cancelled contracts for private staffing agencies or mandated the end of these agencies.⁶⁷ In January 2025, Vitalité in New Brunswick cancelled shifts for private travel nurses employed by Canadian Health Labs and the government subsequently proposed legislation to cancel the contract. In Québec, the CAQ government mandated the end of private staffing agencies in five regions by April 2025. Even before that, in April 2023, the government passed Bill 10, which intends to put an end to private staffing agency use in their public health care network by 2026.⁶⁸ These decisions are a step in the right direction, yet they have been accompanied by criticism that the Québec government is not going to recruit and invest in public health care staff instead. This is primarily because François Legault’s government also passed a law enacting a major reform of the health care system to create Santé Québec, which aims to reduce health care expenditures by \$1.5 billion.⁶⁹ SCFP-Québec members argue that this reform will cut much-needed funding for public health care staff.

65 Ibid, pg. 19.

66 Lindsay, B. (2023, May 12). Nursing agencies are staffing hospitals at ‘huge cost’ to health-care system, experts say. *CBC News*. Para 23. <https://www.cbc.ca/news/health/cost-nursing-agencies-1.6839273>

67 These decisions were made as of May 2025.

68 Also referred to as “An Act limiting the use of personnel placement agencies’ services and independent labour in the health and social services sector”.

69 Blanchette, L., & Pigeon, C. (2025, March 6). *Unpacking Quebec’s major healthcare reform*. Ottawa: Canadian Centre for Policy Alternatives. <https://www.policyalternatives.ca/news-research/unpacking-quebecs-major-healthcare-reform/>

CUPE members have also successfully fought back against private staffing agencies, such as CUPE 5441's arbitration win against Unity Health Toronto in January 2025. The local argued that the employer violated an article which states that non-bargaining-unit workers will not perform duties normally assigned to employees, except in certain limited circumstances. The employer tried to claim that the hospital was not the "true" employer of agency staff and not responsible for the actions of the agency. Ultimately, the arbitrator disagreed, determining that Unity Health exercised "total control" over the private agency staff "in a manner that has far more in common with the direction and supervision of its own employees, than those of a subcontractor."⁷⁰ It is yet to be seen if the hospital will fully phase out agency staff for nurses and personal support workers, but the arbitration decision sets a critical precedent for all public hospitals.

Provincial governments, hospitals, and health authorities are being forced to respond to heavy criticism by unions and public health experts about using private staffing agencies. Provinces like Manitoba are showing there is an alternative to private staffing agency costs by reducing their use and recruiting health care aides, clerical staff, nurses, midwives and physicians in the public system. For instance, in January 2025, the government directed Prairie Mountain Health to reduce private nursing agency costs by 15% by March 2026.⁷¹ Unlike other provinces, Manitoba said reducing agency use is a part of a systemwide effort to refocus funding on the public workforce.⁷² As Uzoma Asagwara, Minister of Health, Seniors and Long-Term Care, boldly stated: "Enough is enough. It's time to put a hard stop on private for-profit nursing agency over-spending and re-invest in the public system. Our government is committed to working with all health regions to bring nurses back into the public system."⁷³ Manitoba's decision provides some hope that provincial governments will stop pouring funding into private staffing agencies, stop taking resources away from the public system, and invest in the public workforce as they should have done for decades.

Public funding to private health care facilities

Private surgeries don't just cost patients more, they cost governments more. Surgeries at private hospitals cost governments two to three times as much as the same procedures performed at public facilities and they have not been proven to decrease wait times.⁷⁴

In May 2023, the Ontario government was highly criticized for passing Bill 60, which allows private, for-profit hospitals and clinics to perform diagnostic and surgical procedures on a permanent basis.⁷⁵

70 Wallace, 2025. Para 12.

71 Government of Manitoba. (2025, January 29). *News Release - Manitoba: Manitoba government issues directive to reduce for-profit nurse spending in Prairie Mountain Health*. Para 2. <https://news.gov.mb.ca/news/index.html?item=67337>

72 CUPE 204 has long advocated for the Manitoba government to invest in the public health workforce to address staffing shortages as it impacts both patient care and the safety and wellbeing of their members.

73 Ibid., emphasis added.

74 Crawley, M. (2023, November 15). Doug Ford government paying for-profit clinic more than hospitals for OHIP-covered surgeries, documents show. *CBC News*. <https://www.cbc.ca/news/canada/toronto/ontario-doug-ford-private-clinic-surgeries-fees-hospitals-1.7026926>

75 Procedures include cataract surgeries, MRI and CT scans, gynecological surgeries, and knee and hip replacement surgeries.

The government justified the funding to private hospitals as a quick and cost-efficient way to reduce the backlog of surgeries from the COVID-19 pandemic.⁷⁶ Yet, contracts with one such private hospital, Don Mills Surgical Unit Ltd., revealed that the government paid over double the cost per surgery than it would have if it were done by a public hospital.⁷⁷ The Don Mills agreement entitled them to \$1,264 for cataract procedures, while public hospitals would be paid \$508. Similarly, the clinic was paid \$4,037 for knee surgery, while public hospitals would be paid between \$1,273 and \$1,692.

These outrageous payments build on what was already a profitable industry in Ontario.⁷⁸ In the same year, Doug Ford's government underreported payments to for-profit facilities by 720%.⁷⁹ The Ontario government has been secretive about their close ties with for-profit clinics and their intent to increase their business activity which began before they passed Bill 60 in 2023. Of all surgical procedures performed by for-profit clinics in 2021-22, cataract surgeries were the most lucrative. They were the highest-volume surgical procedure and garnered the biggest payments from the Ontario government in dollar terms.

Alberta has also turned to private, for-profit clinics for surgeries and increased funding to the for-profit sector. However, unlike Ontario, which increased some funding for public hospitals while it increased funding to private ones, Alberta has decreased public funding over recent years. The number of private surgeries has drastically increased since the 2019-20 fiscal year.⁸⁰ This change was prompted by former Alberta Premier, Jason Kenney, as part of his government's Alberta Surgical Initiative (ASI) to double the number of surgeries by for-profit clinics from 15% to 30% of all procedures by 2023.⁸¹ Government data shows the volume of private surgeries performed by for-profit clinics between 2019-20 and 2023-24 increased by 55%,⁸² while the volume of surgeries performed in public hospitals declined by 1%. The government did not maintain the surgical capacity of the public system and used for-profit clinics for 'relief' and to cut wait times. In effect, the initiative awarded more contracts to the private sector while diminishing the public sector.⁸³ More recently, Alberta's Budget 2025 announced another \$265 million for the ASI.⁸⁴

The report reveals government payments to for-profit clinics has increased over a short period of time. Therefore, for-profit clinics are gradually increasing their profits from private surgeries. Between the fiscal years 2022-23 and 2023-24, the average cost of a procedure by for-profit clinics increased by 52%. Longhurst concluded that the increase is likely the result of higher negotiated contract prices, not inflation or because these clinics performed

76 Crawley, 2023.

77 Ibid.

78 Longhurst, A. (2023). *At what cost? Ontario hospital privatization and the threat to public health care*. Ottawa: Canadian Centre for Policy Alternatives (CCPA). These for-profit clinics are known as "independent health facilities" or IHFs in Ontario.

79 Ibid.

80 Longhurst, (2025).

81 French, J. (2025, February 25). Chartered surgical facilities are back in the headlines. What are they? *CBC News*. <https://www.cbc.ca/news/canada/edmonton/chartered-surgical-facilities-are-back-in-the-headlines-what-are-they-1.7455761>.

82 Longhurst, 2025; These for-profit clinics are known as "chartered surgical facilities" or CSFs in Alberta.

83 Longhurst's report observes that Alberta's real per capita hospital spending declined between 2013 to 2022. This decline also occurred in Manitoba and PEI. To see this data, see page 9 of the report (Figure 1).

84 Government of Alberta. (2025). *Budget highlights*. Retrieved from <https://www.alberta.ca/budget-highlights>

more complex procedures meriting higher payments.⁸⁵ From the 2018-19 fiscal year to 2023-24, government funding to for-profit facilities increased by an astonishing 225%. According to Longhurst, the ASI is proving costly for the Alberta government and patients. Five years in, the government has given \$154 million to for-profit facilities, adding only 16,493 additional procedures while sacrificing the surgical capacity of public hospitals. Bill 55, introduced by the Alberta government in May 2025, continues to strengthen the power of for-profit hospitals and clinics by allowing for the operation and funding of hospitals by private, for-profit entities.⁸⁶

These cases in Alberta and Ontario are cause for concern. Many health care workers worry that outsourcing more surgeries to these facilities shifts resources from public hospitals and boosts clinic owners' revenues, without shortening wait lists. Longhurst observes that wait times have not been cut by the ASI—in fact, wait times are longer for most priority surgeries under the initiative. Median wait times increased under the ASI for 9 of 11 priority procedures tracked by the Canadian Institute for Health Information. Furthermore, in Ontario, where the provincial government has increased funding to for-profit hospitals and clinics for years, data from 2021-22 shows that public surgical volumes were below pre-COVID-19 pandemic levels (down 13% from 2017-18).⁸⁷ This suggests provincial underfunding and staffing shortages in the public system are the major obstacles to improving wait times.

The use of private, for-profit hospitals and clinics to perform surgeries has proven to be a failure in other countries, such as the UK. A study released in April 2025, led by Graham Kirkwood and Allyson Pollock at Newcastle University, confirms that the use of more private providers by the National Health Service (NHS) leads to rising waits for surgeries.⁸⁸ Their research reviewed admissions and wait times for NHS-funded hip and knee replacement surgeries by public and private providers between 1997 and 2019. Not only did for-profit expansion lead to longer wait times for the poorest patients but private hospitals catered to wealthy patients. For example, private hospitals located themselves in richer neighbourhoods and 'cherry-picked' healthier patients to be admitted for treatment.

This two-tier system has had devastating consequences for the poorest and sickest populations—the poorest 20% were significantly less likely to be treated in the for-profit sector and faced longer wait times than the richest 20%. The authors of the study conclude that the UK government's decision to turn to private hospitals increased wait times for all patients (with richer patients facing the shortest wait times) and it drained public resources because NHS capacity in England for surgeries fell sharply after the expansion of for-profit services. This research calls for rebuilding and reinvestment into public hospitals in the UK to tackle waiting lists and restore equitable care.

85 Ibid.

86 Also referred to as the "The Health Statutes Amendment Act"; *CUPE Alberta*. (2025, May 8). UCP introduces private, for-profit hospitals. <https://cupe.ca/ucp-introduces-private-profit-hospitals>

87 Longhurst, 2023.

88 Kirkwood, G., & Pollock, A. M. (2025). Outsourcing National Health Service surgery to the private sector: Waiting time inequality and the making of a two-tier system for hip and knee replacement in England. *International Journal of Social Determinants of Health and Health Services*: 0(0). <https://journals.sagepub.com/doi/10.1177/27551938251336949>

Instead of shifting more funding to for-profit facilities to cut wait times in Canada, experts in public health care also recommend simply investing in public hospitals. Dr. Michael Warner, a former Director of Critical Care at Michael Garron Hospital in Toronto, claimed wait times could be quickly reduced if operating room hours in public hospitals were extended.⁸⁹ He emphasized that operating rooms are only open for limited hours during weekdays so it is very feasible to extend them—an extension of two hours per day would make a difference to accomplishing more surgical procedures. According to Warner, the Ontario government has not explained why they are deliberately choosing to pay higher facility fees to for-profit clinics when investing in the public system is the clear low-cost solution to cut wait times. Other public health experts have recommended solutions such as centralizing waitlists, introducing physician payments that enable team-based care, and improving access to primary and community care.⁹⁰

Growth of the for-profit long-term care sector

The long-term care sector received a lot of attention during the COVID-19 crisis due to the ravages of the virus, particularly in private, for-profit long-term care homes. Beginning prior to the pandemic, governments began pulling away from providing publicly-delivered care. This was a deliberate move towards privatization and has led to a proliferation of corporate, for-profit operators in the sector. This expansion has continued, even after the worst of the COVID-19 crisis, and federal and provincial governments continue to allow the private, for-profit portion of the long-term care sector to grow, neglecting residents, their families, and the workers who care for them every day. Since 2023, \$5.8 billion of public funds have been diverted to private, for-profit senior's care facilities, with Ontario leading the way with \$3.6 billion.

CUPE has reported that the long-term care sector has increasingly adopted a neoliberal market model based on privatization.⁹¹ For-profit care homes cut their costs by contracting out services and relying on labour of poorly compensated care workers, often racialized and new immigrant women. These working conditions greatly impact the quality of care provided for residents. The for-profit model is primarily geared toward boosting profits for shareholders, not ensuring that residents and workers have what they need to thrive. The latest data from the Canadian Institute for Health Information shows that the majority of long-term homes in Canada are in private hands—54% are privately owned and the remaining 46% are publicly owned.⁹²

89 Warner, M. [@drmwarnar]. (2023, February 27). The best way to rapidly reduce the surgical backlog is to better utilize the public ORs we already have. [Tweet]. Twitter/X. <https://x.com/drmwarner/status/1630275546729926658?s=20>

90 Longhurst, A. (2023b). *Failing to deliver: The Alberta Surgical Initiative and declining surgical capacity*. Edmonton: Parkland Institute; Lambert, T. (2024, December 17). Alberta health authority rejected \$240k proposal to resolve orthopedic surgery disruption, documents show. *CBC News*. <https://www.cbc.ca/news/canada/edmonton/alberta-orthopedic-surgery-doctor-dispute-1.7411614>

91 Canadian Union of Public Employees (CUPE). (2023). *The Colour of Privatization: A CUPE report on the experiences of Indigenous, Black and racialized members in long-term care*. Retrieved from https://cupe.ca/sites/default/files/colour_of_privatization_report_en.pdf

92 Canadian Institute for Health Information (CIHI). (2021). *Long-term care homes in Canada: How many and who owns them?* <https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them>. Note: The same data indicates the percentage of public and private ownership varies greatly across provinces and territories. For instance, 88% of long-term care homes in Quebec are publicly owned compared to only 16% in Ontario.

Extendicare, Revera, Sienna, and Chartwell are the major corporate players in the for-profit long-term care industry and have raked in massive profits. Extendicare, the largest private long-term care provider in the country with 122 owned and managed homes, made \$1.46 billion in revenue at the end of the 2024 fiscal year.⁹³ Their financial reports show year after year increases in revenue and dividend increases for their shareholders. In 2024, they also secured an agreement to acquire nine long-term care homes from Revera, showing their continued rapid growth.⁹⁴

Revera, the second largest owner of long-term care homes in Canada, is directly owned by the Public Sector Pension Investment Board, a Crown corporation and one of Canada's largest public sector pension funds. It holds approximately \$170 billion in assets.⁹⁵ Revera has received excessive amounts of public funding, construction subsidies, and public-private partnership deals from provincial governments, as detailed in CUPE's 2023 report.⁹⁶

The COVID-19 crisis highlighted the dire consequences of long-term care home privatization. The contrast in conditions of care in public and private homes could not have been starker. In almost every regard, public facilities outperformed their private counterparts: more lives saved, lower levels of infections and hospitalizations, higher levels of staffing, greater protections for patients and workers, and fewer verified complaints.⁹⁷ The difference in death rates from COVID-19 between public and private homes is alarming. Nearly 80% of COVID-related deaths in Canada occurred in private, for-profit long-term care homes.⁹⁸ In Ontario, private long-term care homes had approximately four times as many COVID-19 infections and deaths as public, municipally operated homes, and double the COVID-19 infections and deaths as not-for-profit homes.⁹⁹ Overall, a resident in a private long-term care home was about 60% more likely to acquire COVID-19 and 45% more likely to die than a resident in a non-profit home.¹⁰⁰

93 Extendicare Inc. (2025, February 27). *Extendicare announces 2024 fourth quarter and full year results and dividend increase*. <https://www.globenewswire.com/news-release/2025/02/27/3034389/0/en/Extendicare-Announces-2024-Fourth-Quarter-and-Full-Year-Results-and-Dividend-Increase.html>.

94 Ibid.

95 Anderson, J. (2021, October 11). Reforming long-term care starts with Revera. *Toronto Star*. <https://www.thestar.com/opinion/contributors/2021/10/11/reforming-long-term-care-starts-with-revera.html>

96 Canadian Union of Public Employees (CUPE). (2023). *The Colour of Privatization: A CUPE report on the experiences of Indigenous, Black and racialized members in long-term care*. Retrieved from https://cupe.ca/sites/default/files/colour_of_privatization_report_en.pdf

97 Ontario's Long-Term Care Commission. (2021, April 30). *Final report*. <https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf>.

98 Canadian Institute for Health Information (CIHI). (2020, June). *CIHI snapshot: Pandemic experience in the long-term care sector: How does Canada compare with other countries?* Ottawa: CIHI. <https://www.cihi.ca/sites/default/files/document/covid-19-rapid-response-long-term-care-snapshot-en.pdf>; McGregor, M., & Harrington, C. (2020, August 17). COVID-19 and long-term care facilities: Does ownership matter? *CMAJ*, 192 (33): E961-E962. <https://www.cmaj.ca/content/192/33/E961>; CIHI, 2020.

99 Oved, M. C., Kennedy, B., Wallace, K., Tubb, E., & Bailey, A. (2020, May 8). For-profit nursing homes have four times as many COVID-19 deaths as city-run homes, Star analysis finds. *Toronto Star*. https://www.durhamregion.com/news/for-profit-nursing-homes-have-four-times-as-many-covid-19-deaths-as-city-run/article_3b8dc7a1-cfb9-5d7b-93a5-16901349fb18.html.

100 Ibid.

Residents were abused, bullied, improperly drugged, and in some cases left for hours or days in soiled bedding during the height of the COVID-19 crisis.¹⁰¹ Conditions were so bad in private long-term care in Saskatchewan that its central health authority took over the homes in 2022, after a report revealed that Extendicare failed to contain a deadly COVID-19 outbreak.¹⁰² But residents did not simply die or suffer from exposure to COVID-19. In the worst cases, residents died from starvation and dehydration due to the lack of staffing.¹⁰³ In addition, most workers were not adequately protected from COVID-19 and became infected, leading to further staff shortages. In Canada, more than 9,650 workers in long-term care were infected by COVID-19, representing more than 10% of the country's total cases.¹⁰⁴ By May 25, 2020, it was reported that 9 of these workers had died of COVID-19, though more likely died in subsequent waves of the pandemic.¹⁰⁵

While there have been staffing challenges at all long-term care homes, private corporations hire fewer staff than public ones, thus affecting the quality of care in their homes. A 2016 study examining long-term care in multiple countries found “[...] considerable evidence from observational studies that public funding of care delivered in for-profit facilities is inferior to care delivered in public or non-profit facilities.”¹⁰⁶ This is largely due to staff-to-patient ratios—when more staff are hired they are able to spend more time with patients for feeding, incontinence care, exercise, socializing, and more.¹⁰⁷

Pat Armstrong, a long-time expert in long-term care systems in Canada, has repeatedly reported on these trends in the private sector. She explains that for-profit corporations have an incentive to reduce their labour costs and therefore aim to hire as few staff as possible to care for residents.¹⁰⁸ In many cases their workforces are part-time and casual staff. Tragically, for-profit long-term care corporations divert their revenue to shareholders and investors, which leaves less money to pay for staff. They therefore deliberately hire fewer staff with less job experience and training. To add insult to injury, these corporations tend to oppose unionization and deny pensions and benefits to their staff. As is the case with nurses and personal support workers in hospitals, if all workers in long-term care homes experienced better working conditions and protections afforded by unions, there would be less turnover of staff and better quality of care given to residents.

101 Mialkowski, C. J. J. (2020, May 30). *OP Laser-JTFC observations long term care facilities in Ontario*. <https://s3.documentcloud.org/documents/6928480/OP-LASER-JTFC-Observations-in-LTCF-in-On.pdf>

102 Saskatchewan Health Authority (SHA). (2022, October 12). *SHA formally assumes responsibility of five Sask.-based Extendicare long-term care homes*. [https://www.saskhealthauthority.ca/news-events/news/sha-formally-assumes-responsibility-five-sask-based-extendicare-long-term-care-homes#:~:text=The%20Saskatchewan%20Health%20Authority%20\(SHA,Sunday%2C%20October%209%2C%202022.](https://www.saskhealthauthority.ca/news-events/news/sha-formally-assumes-responsibility-five-sask-based-extendicare-long-term-care-homes#:~:text=The%20Saskatchewan%20Health%20Authority%20(SHA,Sunday%2C%20October%209%2C%202022.)

103 Ibid.

104 CIHI, 2020.

105 Ibid. Note, CIHI released data concerning how many health care workers were exposed and died of COVID-19 as of January 14, 2022, but they do not specify how many of those workers were employed in the long-term care sector.

106 Ronald, L. A. et al. (2016, April 19). Observational evidence of for-profit delivery and inferior nursing home care: When is there enough evidence for policy change? *PLoS Med*, 13(4):e1001995. Para 1. The authors of the paper estimated that if all long-term care facilities in Canada were public or non-profit, residents would receive 42,000 extra hours of care a year.

107 Ibid.

108 Armstrong, P. et al. (2020, April). *Re-imagining long-term residential care in the COVID-19 crisis*. Ottawa: Canadian Centre for Policy Alternatives. <https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2020/04/Reimagining%20residential%20care%20COVID%20crisis.pdf>.

Despite the clear advantage presented by publicly delivered long-term care, and the atrocities observed in private, for-profit care during the COVID-19 crisis, federal and provincial governments have refused to rein in the private, for-profit sector. Armstrong wrote that “the pandemic has accelerated profitization” by allowing for-profit interests to rapidly creep into the health care system, instead of restoring public funding to fill staff shortages and related problems plaguing the system.¹⁰⁹ This ‘profitization’ includes the expansion of for-profit long-term care homes. Months into the pandemic, after it was clear that the care homes managed by Extendicare, Sienna and Chartwell had disproportionately high numbers of COVID-19 cases and deaths in Ontario, it was revealed that they had paid out more than \$1.5 billion in dividends to shareholders over the last decade, including hundreds of millions paid in executive compensation and stock buybacks.¹¹⁰ During and after the worst of COVID-19, they simply continued to accrue profits and failed to fundamentally change the quality of care provided in their homes. Extendicare, for instance, still managed to earn \$1.2 billion in revenue by the end of the 2021 fiscal year and to take over homes of their competitors.¹¹¹

Even after public outrage, provincial investigations, and lawsuits by families of residents who got sick or died in private homes during the COVID-19 crisis, provincial governments continue to grant new licenses to corporations. The Ontario government continues to grant licenses to homes that had the worst death rates during COVID-19. At Orchard Villa in Pickering, Ontario, a long-term care home managed by Southbridge Care Homes, 206 of 233 residents acquired COVID-19 and more than 70 died.¹¹² In June 2023, Doug Ford’s government decided to grant a 30-year license extension to Southbridge, sparking protests from families who lost loved ones, and a legal challenge by the Ontario Health Coalition.¹¹³

109 Armstrong, P., & Armstrong, H. (2023, <https://journals.sagepub.com/doi/full/10.1177/10957960231194053> Armstrong, P., & Armstrong, H. (2023, August 11). How privatization infects the Canadian health care system. *New Labor Forum*, 32(3), 42-49. <https://journals.sagepub.com/doi/full/10.1177/10957960231194053>. Para 17.

110 Chown, M., Wallace, K., & Kennedy, B. (2020, May 16). For-profit nursing homes have had far worse COVID-19 outcomes than public facilities — and three of the largest paid out \$1.5 billion to shareholders. *Toronto Star*. https://www.thestar.com/business/for-profit-nursing-homes-have-had-far-worse-covid-19-outcomes-than-public-facilities-and/article_ced9239d-7c43-5805-8e92-6add7ee33d87.html.

111 Roy, I. (2023, March 13). The private deals remaking long-term care. *The Local*. <https://thelocal.to/long-term-care-extendicare-revera-private-care>.

112 Calls, K. (2024, February 14). Daughter of man who died at Pickering’s Orchard Villa, Ontario Health Coalition take legal action against province. *DurhamRegion.com*. https://www.durhamregion.com/news/daughter-of-man-who-died-at-pickering-orchard-villa-ontario-health-coalition-take-legal-action/article_213492bd-9644-5011-b6ac-bdb119c6d098.html

113 In March 2025, the coalition learned that their request for a judicial review was not granted.

Public-private partnerships and contracting out

Provincial governments have also leaned on public-private partnerships (P3s) and contracting out, allowing corporations to generate massive profits in long-term care, as well as the entirety of the health care sector.¹¹⁴ Hospitals and care homes have increasingly turned to contracting out to deliver housekeeping, custodial, administrative, laundry, security, and dietary services. The drive to contract out is pursued most aggressively by managers of private hospitals and care homes in their effort to reduce labour costs and accrue profit. Many of these same actors continue to engage provincial governments in P3s which allows the private sector to have extensive involvement in the control of public services and assets.

CUPE has previously reported on the failures of P3s for hospital infrastructure. The cost of a P3 hospital in Brampton, Ontario, for example, reached over \$2 billion for a facility that was originally budgeted at \$350 million.¹¹⁵ The hospital was supposed to meet the needs of a booming population but it ended up supplying fewer rooms than the hospital it replaced.¹¹⁶ Despite the failures of these P3 projects, P3 hospital deals are still being signed, such as the massive QEII Halifax Infirmity Expansion Project in Nova Scotia, a \$7.4 billion deal that was inked in February 2025.¹¹⁷ In Ontario, a \$14 billion contract was awarded by the government for the Peter Gilgan Mississauga Hospital.¹¹⁸ Since 2023, over \$31.1 billion has been announced or awarded for P3s and capital funding across Canada.

In other provinces, potential P3 projects have not provided evidence that they will offer value for their cost. In Alberta, the P3 component of the Red Deer Regional Hospital redevelopment project was cancelled in April 2025 for that reason.¹¹⁹

P3 deals are being signed in long-term care, too. The New Brunswick government's deals with Shannex are a worrying indication that governments are turning away from publicly funded and delivered long-term care to a model where new homes are predominately managed by corporations. Fredericton-based researcher and retired professor of economics, Dr. Joan McFarland, found that it is almost impossible for a community to keep control of local aging nursing homes due to the government's reliance on their P3 regime.¹²⁰ Not-for-profit boards are not receiving government assistance to maintain that control. Instead, they are left to develop, construct and finance new homes themselves.

114 In a P3 model, the government or another public entity and a group of corporations arrange a long-term contract where the private consortium is contracted to design, build, finance, operate, maintain and/or own a public facility.

115 Ontario Health Coalition. (2020, January 24). *Ontario Health Coalition Backgrounder Brampton Hospital Crisis Warnings and Broken Promises*. <https://www.ontariohealthcoalition.ca/wp-content/uploads/Backgrounder-on-Brampton-hospital.pdf>.

116 Ibid.

117 Bousquet, T. (2025, February 19). \$7.4 billion deal for new Halifax hospital signed. *Halifax Examiner*. <https://www.halifaxexaminer.ca/health/7-4-billion-deal-for-new-halifax-hospital-signed/>.

118 Government of Ontario. (2025, May 1). *Ontario Breaks Ground on The Peter Gilgan Mississauga Hospital*. Retrieved from <https://news.ontario.ca/en/release/1006103/ontario-breaks-ground-on-peter-gilgan-mississauga-hospital>

119 Hall, J. (2025, May 1). Red Deer hospital project not paused, gov't says, despite doctor's social media claim. *Red Deer Advocate*. <https://rdnewsnow.com/2025/05/01/red-deer-hospital-project-continuing-despite-social-media-claim/>.

120 McFarland, 2025.

A corporation like Shannex is more likely to win the bid for a contract and it is no coincidence that the New Brunswick government has awarded fourteen P3 nursing home pilots to Shannex since 2008.¹²¹ McFarland believes the government has gone with the P3 model because it takes capital spending off government accounts. Spending is offloaded to corporations and it appears as if governments are spending less on infrastructure. Yet, P3s do not come at a cheaper cost for governments. The cost of borrowing is higher for the private sector and costs for repairs and renovations have been exorbitant in New Brunswick. But there is no sign that the Susan Holt government will transition away from their current P3 regime for long-term care.

For the most part, provincial governments are continuing to greenlight P3 projects for health care infrastructure and allowing corporations to grow their share of long-term care ownership and management. As corporate interests creep in, so does the intensity of privatization schemes. The growth of corporate power in the long-term care sector is an aggressive form of privatization that governments have allowed to grow, despite the extreme neglect residents suffered during the COVID-19 crisis.

For years, CUPE members have demanded mandatory national standards of care in long-term care: a 4.1 hour minimum of direct care per resident day, a 70% minimum of permanent full-time jobs, and the full integration of long-term care into the public health care system. In 2023, the federal government began consultations for the development of the Safe Long-Term Care Act and national standards with a promise to table the act by the end of 2024.¹²² Sadly, they did not follow through on that promise and they have not taken sufficient action to transform the sector.

Contracting out lab testing and services is another example of privatization costing more than publicly provided services. LifeLabs and Dynacare have dominated the landscape across Canada. In 2022, the Alberta government expanded its outsourced contract of community lab services to a private provider, DynaLife, promising cost savings and efficiency. This contract was short lived: DynaLife was functionally insolvent within months. The Alberta government spent nearly \$100 million to buy out the failing private operation and bring the services back into the public system under Alberta Precision Laboratories.¹²³

By bringing in these costly contracted out services into the public health care system where they belong, we can ensure they are governed by the public interest in delivering care and not for enriching private corporations.

121 McFarland points out that new contracts were awarded to Shannex until public scrutiny broke out about the province's bidding process. As of 2022 contracts have also been awarded to non-Shannex bidders.

122 In August 2024, the federal government released a discussion paper about those consultations. The discussion paper has elements of national standards, but they read more like principles of care because they do not have enforcement mechanisms. They do not propose staffing ratios, for example, as CUPE has demanded.

123 Dryden, J. (2023, August 18). *DynaLife to be transitioned back to Alberta Precision Labs, AHS says*. CBC News.

Retrieved from <https://www.cbc.ca/news/canada/calgary/dynalife-alberta-health-services-alberta-precision-labs-1.6940595>

Virtual care and artificial intelligence

The rise of artificial intelligence (AI) is rapidly transforming the health care sector, presenting both opportunities and significant challenges for CUPE members. While AI has the potential to improve the delivery of public services and assist workers in their roles, it also poses risks to job security, workplace rights, and patient privacy. The introduction of new technologies must be managed carefully to ensure that they supplement, rather than replace, the vital work of our members. CUPE is committed to ensuring that any implementation of AI in health care is transparent, fair, and enhances the quality of care and working conditions, without leading to job losses, increased surveillance, or the erosion of our members' rights.

The application of virtual care and artificial intelligence technologies have exploded since the start of COVID-19 pandemic and present a worrying trend in health care privatization. They are another example of governments withdrawing from publicly delivered care in favour of corporate solutions.

For several years, the biggest name in Canadian virtual care has been Maple, co-founded in 2015 by Brett Belchetz, a Toronto emergency-room physician. Maple connects patients to doctors and nurse practitioners. Before the pandemic, virtual care was not deemed medically necessary, though some patients were willing to pay for primary care services because they liked being able to fill a prescription or get a minor issue addressed without leaving their homes. However, there are growing concerns that Maple is charging fees for virtual medical consultations which is undermining the *Canada Health Act*.¹²⁴

Similarly, AlayaCare, a software platform that uses AI for home and community care, is being adopted in Ontario and Manitoba to manage scheduling and billing, and to build data on patient care. Contracting services to companies like AlayaCare is a further corporatization of health care in Canada.¹²⁵ Federal and provincial governments are investing in AI, framing it as modernization. However, private sector actors are leveraging AI to entrench their role in the healthcare system, using it to analyze patient data for profit, streamline their operations, and expand their service offerings. This will negatively impact working conditions and patient care if the focus is on cutting costs and increasing profits.

As AI evolves, CUPE members must proactively address its challenges through collective bargaining and advocacy for stronger legislative protections. This includes bargaining for collective agreement language that requires employers to conduct impact assessments, ensures union consultation, protects workers' data and privacy, and prevents the use of AI in a discriminatory or punitive manner. CUPE will continue to defend our members' right to privacy and fight for a future where technology serves the needs of workers and the public, not corporate interests.

124 Goodyear, S. (2023, March 15). Maple CEO defends company at centre of debate over private health care. [CBC. https://www.cbc.ca/radio/asithappens/maple-health-ceo-private-health-care-1.6777485](https://www.cbc.ca/radio/asithappens/maple-health-ceo-private-health-care-1.6777485)

125 Appendix: Major Privatization Announcements by Provincial Governments in Health Care (2023-25)

Enforcing the *Canada Health Act*

To protect and expand public health care, the federal government must enforce the *Canada Health Act* and guard against private, for-profit services. Access to care should be based on medical need, not ability to pay. The *Canada Health Act* says health care must be publicly administered and delivered without user fees or extra billing. But governments are encouraging private, for-profit surgical and other speciality clinics to open across the country, creating a two-tier system of care.

The principles in the *Canada Health Act* are being dangerously eroded, not through a direct legislative assault, but through decades of federal neglect, chronic underfunding, and a lack of enforcement. When medicare was introduced, federal and provincial governments each covered 50% of the cost. But the federal share has gotten smaller over time and under the newest agreements with provinces, the federal share ranges from 21 to 29%.¹²⁶

While the health act does not make private health care illegal, it does say that Canadians must have reasonably timely and free access to medically necessary care, and that medically necessary care must be paid for publicly. The federal government can ensure compliance by cutting back, dollar for dollar, transfer payments to provinces who allow user fees to be charged for essential services.

The data from recent CHA annual reports paints of a growing problem of extra-billing and user charges, and federal action to enforce penalties.

Table: Provincial extra billing and federal penalties

Fiscal Year ^{127, 128, 129}	Provinces with Deductions	Total Deduction Amount (CAD)	Primary Reason for Deductions
2023-24	NS, NB, QC, MB, SK, AB, BC	\$79.4 million	Patient charges for diagnostic and surgical services

126 Canadian Union of Public Employees. "Ensuring Equality of Care for All Canadians." *CUPE*, 7 Oct. 2024, cupe.ca/ensuring-equality-care-all-canadians.

127 Health Canada. *Canada Health Act: Annual Report 2023-2024*. Government of Canada, 13 June 2025, <https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2023-2024.html>.

128 Health Canada. *Canada Health Act: Annual Report 2022-2023*. Government of Canada, 15 Feb. 2024, <https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2022-2023.html>.

129 Health Canada. *Canada Health Act: Annual Report 2021-2022*. Government of Canada, 2023, <https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2021-2022.html>.

2022-23	BC, AB, SK, MB, QC, NB, NS	\$82.5 million	Patient charges for medically necessary diagnostic services. Over \$8.5 million was also reimbursed to BC for actions taken to eliminate patient charges for medically necessary diagnostic services.
2021-22	BC, NB, ON, NL	\$13.3 million	Extra-billing, user charges for abortion services
2020-21	BC, NB, ON, NL	\$13.9 million	Extra-billing, user charges
2019-20	BC, NB, NL	\$17.0 million	User charges, user charges for abortion services

A historical decline in federal funding for public health care has created an environment where for-profit interests have been able to expand their influence. To simply maintain our current health care services, the dollar amount of federal funding must increase by a minimum of 5.2% per year, all of which should go to supporting public health care.¹³⁰ Decades of cuts and freezes to federal transfers have left provincial and territorial health systems underfunded and struggling to meet the needs of a growing and aging population. This has led to staff shortages, long wait times, and a general decline in the quality of patient care. In response to these challenges, some provincial governments have increasingly turned to the private sector, funneling public money into for-profit clinics and services.

However, privatization of the health care system has eroded the principles of universal, accessible health care enshrined in the *Canada Health Act*. For-profit facilities are more expensive, lead to lower quality care and poach staff from the already strained public system. This cycle of underfunding and privatization threatens the sustainability of Canada’s public health care system, and creates a two-tiered system where access to care is determined by the ability to pay rather than by medical need.

Through CUPE’s Public Solutions in Health Care campaign, members are fighting against the push for private, for-profit clinics.¹³¹ Privatization creates a system where people with money can buy their way to the front of the line, leaving everyone else behind. The federal government must step up. It must properly fund our public system and enforce the *Canada Health Act* to protect Canadians from extra fees and user charges. And it must establish new national standards to make sure provinces and territories deliver comparable quality and services, and to keep public money in the public system.

¹³⁰ Ensuring Equality of Care for All Canadians.” *Canadian Union of Public Employees*, <https://cupe.ca/ensuring-equality-care-all-canadians>. Accessed 14 Aug. 2025.

¹³¹ “Public Solutions in Health Care.” *Canadian Union of Public Employees*, <https://cupe.ca/public-solutions-health-care>. Accessed 14 Aug. 2025.

Conclusion

Across the country, we've seen how funnelling public money into for-profit clinics, private staffing agencies, and corporate-run facilities drives up costs, reduces access, and worsens wait times. Privatization has pulled medical professionals away from the public system, has weakened long-term care, and is creating a two-tier structure where those who can pay get timely treatment. With user fees and patient charges, privatization puts profits ahead of patients and erodes the principles of universality, accessibility, and equity that are the hallmarks of Canada's health care system. Restoring Canada's universal public health care promise will require that the federal government abandon its policy of neglect and enforce the *Canada Health Act*.

CUPE members are showing the way forward. Working in their communities, locals, and with provincial health coalitions, they've exposed illegal billing practices, challenged government funding to for-profit providers, and organized powerful community actions to defend public health care. In a significant victory against privatization, CUPE 5430, representing workers at Regina Pioneer Village, successfully blocked the Saskatchewan Health Authority's attempts to contract out long-term care services.¹³² The union used a clause in their collective agreement that requires the employer to consult with the union and to prove that contracting out is cost-effective. As a result, the health authority abandoned its plan to use private companies to staff long-term care beds, opting instead for a publicly funded and operated project.

CUPE campaigns have proven that when workers and communities unite, they can push back against privatization and win. Restoring and strengthening public health care is not only possible, it is the most efficient, equitable, and effective way to deliver care to all Canadians.

¹³² "Saskatchewan Health Care Workers Stave Off Provincial Government's Privatization Efforts." *Canadian Union of Public Employees*, 18 Oct. 2024, <https://cupe.ca/saskatchewan-health-care-workers-stave-provincial-governments-privatization-efforts>.

Announcements for privatization by category and province

	P3s and Capital Funding	Service Delivery	Seniors Care	Staffing Agencies	Information Technology	Research & Development	Consultants	Total
ON	\$22.6 billion	\$1.5 billion	\$3.6 billion	n\	n\	\$155 million	n\	\$27.8 billion
NS	\$7.5 billion	\$199 million	\$11 billion	\$126 million	\$415 million	n\	\$1 million	\$9.4 billion
QC	\$11 billion	\$7.9 billion	n\	\$277 million	n\	n\	n\	\$9.3 billion
BC	\$10.8 million	\$1.6 billion	\$959 million	\$228 million	\$5 million	n\	\$28 million	\$2.8 billion
AB	\$2 million	\$946 million	n\	\$202 million	n\	n\	n\	\$1.2 billion
MB	n\	\$338 million	n\	\$141 million	n\	n\	\$500,000	\$480 million
NL	n\	\$22 million	\$83 million	\$258 million	\$5 million	n\	n\	\$369 million
SK	n\	\$53 million	\$40 million	\$85 million	n\	n\	\$29 million	\$208 million
NB	n\	n\	n\	\$117 million	n\	n\	n\	\$117 million
PE	n\	\$91 million	n\	\$10 million	n\	n\	\$6 million	\$107 million
Total	\$31.1 billion	\$12.7 billion	\$5.8 billion	\$1.4 billion	\$424.8 million	\$155 million	\$66 million	\$51.7 billion

Note: totals may not add up exactly due to rounding

Appendix: Major privatization announcements by provincial governments in health care

Since 2023, provincial governments have increasingly directed public funds to for-profit corporations for the delivery of essential health care services. This appendix provides a review of major health care privatization announcements, drawing on publicly available information from government budgets, auditor general reports, health coalitions, academic research, media investigations, and related sources.

British Columbia (all spending in 2023/24)		
Category	Amount	Notes
Seniors Care	\$959 million	Includes funding to private long-term care and assisted living facilities, home care providers in 2023/24.
Consultants	\$31 million	Contracted by the provincial health authorities.
Food Services	\$87 million	How this breaks down between procurement and labour is not clear.
Lab Tests	\$277 million	Overwhelmingly to a single provider, LifeLabs.
Religious Service Providers	\$1.2 billion	Payments to Providence Health Care by the provincial health authorities.
Staffing Agencies	\$228 million	Includes agencies providing travel nurses, along with other services.
Total Spending (including items not listed above):	\$2.8 billion	Total figure of all highlighted payments to suppliers of goods and services in the 2023/24 fiscal year.
Legislative Changes	Creation of GoHealth BC, a public travel nurse initiative; introduced public coverage for IVF treatments in 2025, partially delivered through private clinics.	
Alberta		
Category	Amount	Notes
For-Profit Clinics	\$56 million	Payments to “chartered surgical facilities” under the Alberta Surgical Initiative in 2023/24 fiscal year.
Staffing Agencies	\$202 million	Spending on agency nurses between April 2023 and September 2024.

Religious Service Providers	\$846 million	Funding for Covenant Health in 2023/24 fiscal year.
Legislative Changes	Restructured Alberta Health Services (announced 2023); introduced new 'activity-based' funding model for hospitals (2025); Bill 55 (2025) paving the way for hospital privatization; de-listed partial eye exams for children and seniors (2025); repatriated lab services for \$97 million shortly after privatization failed (2023).	
Saskatchewan		
Category	Amount	Notes
Consultants (Spent)	\$29 million	Spent in 2023/24 fiscal year, 99% of which went to Deloitte.
For-Profit Clinics (Spent)	\$16 million	Payments made to Surgical Centres Inc. in 2023/24 fiscal year.
For-Profit Clinics (Allocated)	\$12 million	For sending residents out of province to receive care at for-profit clinics in Calgary. Initial funding was announced in 2023, extended in 2025.
Lab Testing (Spent)	\$9 million	Payment to LifeLabs in 2023/24 fiscal year.
Seniors Care (Earmarked)	\$40 million	For private long-term care providers, announced in 2024 budget.
Staffing Agencies (Spent)	\$59 million	Spent on agency nurses in 2023 calendar year.
Manitoba		
Category	Amount	Notes
Contracting Out	\$15 million	Winnipeg Regional Health Authority's spending on "contracted out services" for core operations in 2023/24.
For Profit Clinics (Allocated)	\$20 million	Value of contracts with four clinics signed between 2023 and 2025.
Lab Testing (Spent)	\$45 million	Fee for service payments to 23 Dynacare locations in 2023/24 fiscal year.
Lab Testing (Allocated)	\$212 million	Value of 5 year contract with Dynacare to provide lab services, announced 2025.
Staffing Agencies (spent over 2yrs)	\$141 million	Estimated spending on agency nurses in 2023/24 and 2024/25 fiscal years (\$75m and \$66m respectively).

Legislative Changes	NDP defeated the Progressive Conservative Party in October 2023; restrictions on travel nurse contracts introduced in late 2024.	
Ontario		
Category	Amount	Notes
For-Profit Clinics (Announced)	\$650 million	Earmarked funding announced between 2023 and 2025; \$560 million announced between May and July 2025.
P3s (Allocated)	\$22.6 billion	Expected value of seven healthcare infrastructure contracts awarded between 2023 and 2025.
Lab Testing (Spent)	\$629 million	Paid to private lab companies in the 2023/24 fiscal year. 95% of that went to Dynacare and LifeLabs.
Seniors Care (Spent)	\$3.6 billion	Paid to seniors care providers in the 2023/24 fiscal year.
Life Sciences	\$160 million	Earmarked or allocated towards funding private businesses in the life sciences sector (e.g. vaccine manufacturing, research and development) between 2023 and 2025.
Total Allocated (including items not listed above)	\$22.6 billion	Allocated to specific businesses between 2023 and 2025, mostly related to the government awarding P3 contracts.
Total Earmarked (including items not listed above)	\$726 million	Funding pools announced between 2023 and 2025, mostly around for-profit clinics.
Total Spent (including items not listed above)	\$4.4 billion	Paid to private care providers in 2023/24 fiscal year.
Legislative Changes	Bill 60 (2023) introduced a new framework for independent (for-profit) health facilities; Bill 135 (2023) amalgamated local health integration networks and expanded private home-care; Bill 124 was repealed in Feb 2024.	
Quebec		
Category	Amount	Notes
Aggregate Spending on Private Healthcare (2023/24)	\$6 billion	Total spent calculated by the Confédération des syndicats nationaux (CSN)

Staffing Agencies (2023/24)	\$277 million	Total spent on agency nurses, calculated by the Canadian Federation of Nurses Unions. Noting figure is sum of the amounts reported by just six health authorities, so the real total will be much higher. Amount may also be captured in the \$6 billion estimated by CSN.
Ministry of Health spending on private service delivery (2024/25)	\$1.2 billion	Spent on transfers to private institutions for services to the public in 2024/25, estimated in Ministry of Health and Social Services' expenditure budget.
Funding for private long-term care providers (2024/25)	\$1.1 billion	Spent on transfers to 71 private long-term care providers (incl. the original \$1.1 billion agreement with the government, and a \$10 million bailout in April 2025. May be partially captured in the Ministry of Health estimates above and below.
Ministry of Health program delivery by private providers (2025/26)	\$763 million	Earmarked for payments to private sector enterprises via Ministry of Health and Social Services program spending in 2025/26 fiscal year.
Canada Health Transfer Penalties	\$78 million	Combined amount deducted from Quebec's Canada Health Transfer in 2023 and 2024, over patients having to pay for medically necessary diagnostic services.
Legislative Changes	Restructured healthcare administration with Bill 15 (2023); Bill 83 (2025) requiring doctors to work in public system for minimum 5 years, after an unprecedented number of Quebec doctors opted out of medicare.	
New Brunswick		
Category	Amount	Notes
Staffing Agencies (2023/24)	\$117 million	Combined spending by Horizon (\$23m from April to August 2023), and Vitalité (\$94.2m from April to February 2023) on travel nurses that fiscal year.
Legislative Changes	Liberal Party defeated the Progressive Conservative Party in November 2024; introduced legislation to cancel travel nurse contracts (2025).	

Prince Edward Island		
Category	Amount	Notes
Consultants (Spent)	\$6 million	For untendered contract signed with KPMG in 2024.
For-Profit Clinics (Earmarked)	\$4 million	Earmarked for covering MRI appointments at an out-of-province clinic in Moncton, announced 2025.
Seniors Care (Earmarked)	\$74 million	Earmarked for private care homes and self-managed care programs, announced between 2023 and 2025.
Staffing Agencies (Spent)	\$10 million	\$8.8 million for travel nurses in 2023/24, and \$1.3 million for contracting management staff in 2024/25.
Virtual Care (Spent)	\$4 million	Payments to Maple in 2023/24 fiscal year.
Nova Scotia		
Category	Amount	Notes
P3s (Allocated)	\$7.5 billion	For QEII Halifax and Yarmouth Regional hospital projects, both awarded in 2025.
Digital Infrastructure (Allocated)	\$365 million	For 10 year contract with Oracle Cerner to create an electronic medical record system, announced in 2023.
Sole Source / Untendered Contracts (Allocated)	\$1.4 billion	Value of 5 high profile agreements signed between 2023 and 2025.
Staffing Agencies (Spent)	\$126 million	Spent on agency nurses in 2023/24 fiscal year.
Newfoundland and Labrador		
Category	Amount	Notes
Seniors Care (spent)	\$84 million	Spent on care home subsidies in 2023/24 fiscal year.
Staffing Agencies (spent over 2.25yrs)	\$258 million	Spending on agency nurses between 2023 and Mar 2025.
Virtual Care (allocated)	\$22 million	Two-year contract with Teladoc, announced 2023.

Notes on this appendix

1. Appendix contains a non-exhaustive list, the true amount going to private providers will be considerably higher.
2. “Spent” refers to money already paid; “allocated” refers to money that will be paid to a specific entity; “earmarked” refers to money announced with recipients to be determined.
3. Funding reviewed covered money going to for-profit entities, with some exceptions (like funding to religious non-profit organizations who may restrict access to key services). Funding to non-profits was generally omitted.
4. Many provinces announced large pools of money that would be available to public and private providers, but the breakdown between the two was not available. The appendix focused on earmarked funding going primarily, if not exclusively, to private providers.
5. Appendix compiled spending and announcements using publicly available information. More specifics may be obtainable by freedom of information requests to relevant government entities. This was not possible due to logistical and time constraints.
6. Finances were not tracked, announced or disclosed the same way in every province. Some provided more information (and more disaggregated information) than others, therefore entries for some provinces are considerably longer than others.
7. Review of “spent” money relied heavily on payment schedules for 2023/24 fiscal year. At time of writing, comparable information was not available for 2024/25 fiscal year.
8. Provincial overviews which have a “total” amount for money spent, allocated or earmarked had a particularly large number of entries that were not captured in the ‘notable findings’.
9. Most provinces only disclose or disaggregate contracts or payments over a certain value (e.g. \$10,000 in Manitoba, \$120,000 in Ontario). The true amounts being paid to private providers will also be higher because those are not captured here.
10. This appendix is by no means a complete list of every contract, vendor payment or announcement. In reviewing payment schedules, for example, we focused on payments that were either large, or made to notable companies.
11. Some provinces simply have a less pronounced for-profit healthcare sector. Others (like New Brunswick) rely heavily on private, for-profit providers.
12. There may be some overlap between items/money in each category, we have tried to minimize the overlap as much as possible.







CUPE