

Chronic condition: how or can the Canadian health care system be reformed?

A keynote address by Jeffrey Simpson



Giuseppe Guaiana, MD, PhD

In a candid and provocative address, veteran journalist and commentator, Jeffrey Simpson, critically examined the Canadian health care system, blending personal anecdotes, data comparisons, and policy reflections. He opened with humour, acknowledging the high trust Canadians place in physicians, second only to farmers, while journalists rank among the least trusted, alongside politicians, pollsters, and lawyers.

Central to his talk was the argument that Canada's health care system is structurally shaped by entrenched provider interests — doctors, nurses, administrators — while patients remain largely unorganized and without a collective voice. This dynamic, he argued, makes medicare the “third rail” of Canadian politics: any attempt to reform it is politically hazardous.

Benchmarking Canada internationally, Simpson highlighted that while Canada spends a comparable share of GDP on health care (10–12%), spending on access and outcomes lags behind. In Commonwealth Fund rankings, Canada placed 7th out of 10, while the United States ranked last. Canada's performance has been slipping over time. Organisation for Economic Co-operation and Development (OECD) data reveal that Canada has fewer doctors, nurses, hospital beds, and diagnostic equipment per capita than most peer nations. Simpson emphasized that while Canada spends more than average, only 56% of Canadians report satisfaction with the system, compared with 67% across OECD countries.



A key theme was access. Simpson argued that timeliness is part of the social contract of medicare, not a luxury, and delays erode both patient outcomes and trust. Although COVID-19 exacerbated pressures, he pointed to long-standing issues, such as population aging, increased immigration, and the opioid crisis, outpacing system capacity. He traced supply constraints back to policy missteps of the 1990s, notably the “de-doctorization” strategy, which deliberately cut physician training to control costs. Canada now lags in physician supply (2.8 per 1000 population), trailing countries like Germany (4.5 per 1000), Australia, and France.

Proposed solutions included:

- Expand medical school capacity and accelerate international recruitment of physicians and nurses, especially from countries with comparable training systems.
- Confront the “cartel-like” protectionism in the medical professions that limits entry and stifles competition.
- Explore private delivery models, such as clinics for diagnostics and surgeries, within the publicly funded system (e.g., the Calgary Eye Clinic).
- Support innovations, such as team-based family clinics (Jane Philpott’s “pod” model) and Quebec’s capitation-based primary care experiments.
- Establish a national drug formulary to leverage bulk purchasing power and reduce costs.
- Build a national medical pension plan for physicians, modeled after successful public pension funds.

In a closing exchange, Simpson addressed questions on administrative burdens faced by family physicians. He acknowledged the unintended consequences of excessive paperwork, fragmented referral systems, and technological inefficiencies, underscoring the need for streamlined processes in primary care.

He concluded with a call for bold, pragmatic reforms, urging physician leaders to “challenge vested interests, and catch the wave,” leveraging current opportunities to attract talent, modernize the system, and deliver on the promise of universal, timely, high-quality care for Canadians.

Author

Giuseppe Guaiana, MD, PhD, FRCPC, CCPE, is an associate professor of psychiatry, Western University; chief of psychiatry, St. Thomas Elgin General Hospital; director, Extended Campus Program, and clinical director, North of Superior Program.

Correspondence to:

giuseppe.guaiana@gmail.com