Physician Focused Dialogue
Fairmont Hotel Vancouver, Vancouver, BC
November 23, 2023
Introduction

The statements contained in this document represent the opinions expressed by the participants and not those of the CMA.

On November 23, 2023, the CMA held a physician focused dialogue in Vancouver as part of a national conversation on public and private health care in Canada. This was the third of several sessions that the CMA is hosting over the coming months to get comprehensive feedback on a complex, critical issue facing our health system (see Appendix A for additional context).

The key objectives of these dialogues are to:

1. Surface and explore the values and tensions that underpin the public–private care debate
2. Learn from experiences in the current system, both positive and negative
3. Seek perspectives and ideas to inform the CMA’s policy recommendations on public and private care

Ultimately, the CMA’s primary goal with these focused dialogues is to lead informed, constructive discussions to provide insight on how the Canadian health system should transform to ensure patients receive equitable, timely access to care and providers thrive in healthy, safe work environments.

Profile of participants

The CMA reached out to a broad range of physicians in British Columbia to seek their interest in being part of this focused dialogue. Additionally, the CMA extended invitations to organizations such as Doctors of British Columbia and Canadian Doctors for Medicare.

Fifty physicians participated in the Vancouver dialogue. There was a diverse range of participants, including family physicians, emergency physicians, surgeons and other specialists (e.g., psychiatrists). Below is a high-level snapshot of those in attendance:

- **Practice status:** Almost half of the participants (44%) were family physicians, and more than one-third (34%) were specialists. There were some medical learners in attendance (22%).

- **Population served:** Nearly eight in 10 participants served urban or suburban populations (communities of 30,000 or more); 16% of participants could not identify a primary geographic location. There were some individuals (6%) who served small-town populations (communities of at least 1,000 but less than 30,000 people) and rural populations (communities of less than 1,000 people).

- **Equity-deserving groups:** Nearly three in 10 participants said they were part of an ethnocultural group. Other groups present included members of the 2SLGBTQI+ community (10%), newcomers (i.e., immigrants, new citizens, permanent residents, refugees) (10%) and people living with a disability (6%) and other identities (2%).
What we heard

The three-hour session was dynamic, with lively conversations in the plenary and small groups. Throughout the dialogue, physicians reflected on the role of public and private health care delivery and funding in Canada and provided insight on what they think should be guiding principles to shape the health system they want moving forward.

Key discussion topics

Equitable and timely access to care

The theme of access to care stood out prominently in discussions among the physicians who participated in this dialogue. Timeliness and equity were recurring elements in these conversations around access. The majority of the participants discussed the challenges faced by equity-deserving populations, emphasizing the need to focus on the social determinants of health in this dialogue. Several participants raised concerns about the potential exacerbation of health inequalities through service privatization, noting that wealthier individuals will experience better health outcomes. The dialogue delved into the impact of alternate delivery financing on equity, drawing parallels with inequities in dental care, which is predominantly privately delivered and funded. When participants were asked about the option to explore alternative options for care outside the public system if wait times were excessive, some participants agreed that there should be alternative options available. Several participants also indicated that there need to be temporary solutions or “band-aids” to prevent harm to patients while they wait for care. Several participants expressed the view that while temporary solutions might need to be privately delivered, they should be publicly funded so that there are no financial barriers to accessing that care. Other participants disagreed and suggested that the current state of the system necessitates a greater investment in the public system for publicly funded and delivered solutions.

Resource stewardship

Several participants noted concerns around resource stewardship throughout the dialogue. Participants emphasized the urgent need to improve resource management, highlighting concerns about a significantly higher proportion of health care resources being allocated to hospitals than prevention, promoting a costly illness-based system. The majority of the physicians who participated in this dialogue advocated for a shift in resource allocation from acute care to upstream prevention. Participants also discussed the use of technology to mitigate resourcing issues. However, others expressed concerns around potential inefficiencies related to the inappropriate implementation of technology. One participant discussed the importance of eliminating redundancies, citing success in Alberta with a unified health authority. A few participants shared potential resource issues associated with corporate involvement in a publicly funded system, including fears of resource overuse akin to the excessive spending seen in the United States even though that country has poor health outcomes.

“Hospitals require the most health care dollars, because we have an illness-based system, which is a problem.”
Accountability

Several participants voiced concerns about accountability in the context of public and private health care in Canada from a variety of perspectives, including patients, health professionals, governments and industry. The conversation highlighted a shared frustration with governments, with one participant stating that there wouldn’t be a need for this conversation if governments invested adequately in the publicly funded system. Another participant described governments as overpromising and underdelivering, demonstrated through years of funding cuts to health care that have led to a physician shortage and a poorly performing system. Participants discussed the need to influence governments to invest more significantly in health care and the need for increased transparency through publicly reporting data on health system performance.

Attitudes around choice and convenience

Several physicians agreed that people in Canada should have choice and convenience in their health care system. The conversation shifted to one where some participants raised the question, “At what cost?” Participants observed that the current private system enables physicians to be selective in choosing patients, their working hours and their areas of focus, raising questions about the responsibility of private entities (including physicians working in the private system) to patients and the broader health care system. The dialogue underscored the tension between private and public resources, with participants cautioning against compromises to patient access within the public system. There was also a shared concern that the public system might bear the burden of handling more complex cases because of perceived shortcomings in the quality of care provided by the private sector. This emphasizes the importance of stringent regulation and accountability for practitioners involved in both systems. While publicly funded and privately delivered care is more widely accepted, participants expressed reservations about the implications of privately delivered services. Several participants cited concerns about the industry profiting from health care and a potential misalignment with evidence-based health care delivery. This discourse challenged the idea of publicly funding convenience and also emphasized the need for responsible practices in private clinics.

The imperative of evidence-based decision-making

Several participants emphasized the importance of incorporating evidence in the dialogue on private and public health care in Canada. Some participants expressed concerns about the current discourse not being grounded in adequate evidence, despite the ample available data. A participant highlighted existing data on the negative impact of private services on the public system and questioned why it wasn’t guiding the discussion. Others, unaware of the evidence, sought information on evidence gaps and future research agendas. Another participant stressed the necessity of holding evidence in this discourse to the same standards as in medicine, cautioning against reliance on personal anecdotes or comparisons with the system in the United States. Consensus emerged on using evidence-based frameworks like the Quintuple Aim for health services decisions, addressing provider and patient experiences, value, population health and health equity. The discussion underscored the tendency to focus on a single aim, neglecting aspects like health equity or value. Participants also recognized that improving research and generating good-quality data would enhance transparency and alleviate conflicts of interest within the system.
There is evidence on the influence of private health care on the public system; why aren’t we using it in this conversation?

Strengthening primary care

Even though differing perspectives were expressed on the public–private discourse, most participants agreed that the current health system isn’t working, and there is a need for health system transformation and upstream investment in the system. Several participants voiced urgent concerns around primary care, including access and workforce-related issues. Unlike their views on acute services, most participants voiced the opinion that solutions for primary care should remain a part of the publicly funded system. A couple of participants drew an analogy to the public school system, describing how primary care should follow a similar model — it should be universally accessible, publicly funded and community based. Several participants voiced the view that scaling up comprehensive team-based primary care is essential in improving access to care for people in Canada. Participants also raised the need to better integrate artificial intelligence and technology into the health care system to reduce administrative burdens, which would give physicians more time to spend with patients.

Expansion of publicly funded services

Participants discussed the current insufficiencies in what is covered within the public basket of services and how the current health system already has a mix of private and public services. Several participants described how the expansion of publicly funded services could decrease health inequities and alleviate the burden on both primary care and acute care services. Several participants voiced the opinion that health services such as mental health care and dental care should be publicly funded. The integration of health and social services was also mentioned in terms of advancing publicly funded services. Several participants expressed the view that people in Canada should have universal access to prescription drug coverage as part of their publicly funded health system.

“This is a great opportunity to have a reckoning around what is expected and what is the standard of care for patients in Canada.”
Moving forward: How might we shift?

Despite the fears that many participants conveyed throughout the discussion, a clear sentiment of hope also came through. Participants offered several ideas on how to improve health care access in Canada and foster a healthy and safe work environment for providers.

Below are some of their key suggestions, which link to many of the discussion topics previously outlined:

- **Prioritizing equity in health care:**
  - Redesign the health care system to prioritize upstream determinants of health, aiming to decrease health care utilization and enhance equity.
  - Shift the focus from an illness-based model to preventive measures for a more cost-effective and equitable system, including increasing access to services that are currently not a part of the public system, like dental care and prescription drug coverage.

- **Resource stewardship:**
  - Advocate for a comprehensive approach to resource stewardship by prioritizing prevention over acute care.
  - Call for the reallocation of resources to preventive measures, fostering a more sustainable health care system.

- **Enhancing accountability and transparency:**
  - Engage in collaborative efforts with health professionals, patients, governments and industry partners to enhance accountability in health care governance.
  - Urge governments to fulfill promises and sustain investments in the publicly funded health care system, relieving resource strain.
  - Improve accountability and transparency through making health care performance indicators available and accessible to the public.

- **Evidence-based decision-making:**
  - Develop standardized criteria for evaluating evidence in decisions around public and private health care in Canada and incorporate frameworks like the Quintuple Aim into these discussions.
  - Improve awareness of the existing evidence base on public and private health care and create resources to bridge knowledge gaps for decision-makers.

- **Strengthening primary care:**
  - Scale up team-based models of care to optimize health professionals’ skills and improve access to primary care.
  - Leverage artificial intelligence and technology to reduce administrative burdens, which would give physicians more time for patient care.
  - Transform the primary care model along the lines of the public-school model, which is community based.
What’s next?

The session in Vancouver was the third of a series of focused dialogues. There will be future opportunities for both physicians and the public to engage in this important discussion, including the following:

- The CMA has partnered with *The Globe and Mail* to sponsor a series of townhalls across the country.
- Physicians and the public can keep the conversation going by joining [CMA Community](#), our new online community space.
- Go to the [CMA’s public–private](#) webpage and fill in your contact information to stay abreast of key updates.

The CMA greatly appreciates the time participants took to attend the Vancouver in-person focused dialogue. The insightful feedback and perspectives provided will continue to be analyzed and will inform the CMA’s future policy and advocacy in this area.
APPENDIX A: Context of the CMA’s consultations on public and private care in Canada

This series of discussions is timely as the country is currently at a critical juncture, where many in Canada are feeling the dire impacts of a crumbling health system.

Coupled with a lack of access to care, we know that privately funded care already exists in Canada, where it is estimated to account for 28% of health care spending.\(^1\) It is also becoming evident that with the increasing access issue in our country, more people are exploring private health care options to try to receive care in a timely manner. This reality demonstrates that we need more clarity, research and evidence to gain further insight into what models of health care financing and delivery will result in the best patient outcomes.

Owing to the complex nature of this issue, a context-setting presentation was provided to participants at the beginning of the dialogue. In Canada, like many other countries, there is an intricate mix of public and private health care delivery and funding. The table below provides some highlights of how the health system operates in Canada.

<table>
<thead>
<tr>
<th>Health services</th>
<th>Funding (How services are paid for)</th>
<th>Delivery (How services are organized, managed and provided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>Public taxation</td>
<td>Mixed delivery, but largely private</td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td>For example:</td>
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<tr>
<td>Diagnostics</td>
<td></td>
<td>• Hospitals are often incorporated private foundations.</td>
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<td></td>
<td></td>
<td>• Family physicians often bill provinces and territories as independent, private contractors.</td>
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<tr>
<td>Public health</td>
<td>Public taxation</td>
<td>Typically public</td>
</tr>
<tr>
<td>Community health centres</td>
<td></td>
<td>For example: municipally run community resource centres, sexual health clinics, immunization services, harm reduction services</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Mixed funding Public taxation</td>
<td>Mixed delivery</td>
</tr>
<tr>
<td>Home care</td>
<td></td>
<td>For example:</td>
</tr>
<tr>
<td>Long-term care (LTC)</td>
<td></td>
<td>• In British Columbia 35% of LTC homes are publicly owned and 65% are privately owned.(^2)</td>
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<tr>
<td>Mental health care</td>
<td></td>
<td>• BC, Saskatchewan and the territories largely publicly deliver home care, whereas all other provinces typically contract private companies to deliver home care services.</td>
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<tr>
<td>Dental care</td>
<td></td>
<td>• Most dentists and optometrists work as independent, private contractors or employees for a private employer.</td>
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<td>Vision care</td>
<td></td>
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<td>Outpatient physiotherapy</td>
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<tr>
<td>Complementary medicine (e.g., massage therapy)</td>
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\(^1\) Canadian Institute for Health Information. Who is paying for these services? Accessed Sept. 17, 2023.

Another important consideration when examining the role of private and public care is the fact that when health services are privately delivered, they can be run by a **not-for-profit or for-profit** agency. For example, in British Columbia, out of the 65% of LTC homes that are privately owned, 37% are owned by private for-profit organizations and 28% are owned by private not-for-profit organizations.³

In this context, the CMA believes it’s time for open, honest conversations with patients, providers and the public to create a health system that meets the needs of everyone in Canada. “This conversation is not easy,” notes CMA President Dr. Kathleen Ross, but private care “is already happening and [governments are] making decisions around increasing [it]... we must have the courage to have these tough conversations.”

APPENDIX B: Focused dialogue agenda

CMA PUBLIC–PRIVATE FOCUSED DIALOGUE (PHYSICIAN)

Thursday November 23, 2023 – 5-8:30 pm PT
Fairmont Hotel Vancouver, Saturna Island Room

Objectives
• Surface and explore the values and tensions that underpin the public–private care debate.
• Learn from your experiences in the current system, both positive and negative.
• Seek your perspectives and ideas to inform our policy recommendations on public and private care.

AGENDA

<table>
<thead>
<tr>
<th>TIME (PT)</th>
<th>ACTIVITY</th>
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<tbody>
<tr>
<td>5-5:30 pm</td>
<td>Dinner</td>
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<tr>
<td>5:30-6:00 pm</td>
<td>Opening and warm-up</td>
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<tr>
<td>6-6:40 pm</td>
<td>Context-setting presentation Plenary Q&amp;A and dialogue</td>
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<tr>
<td>6:40-6:55 pm</td>
<td>Health break</td>
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<tr>
<td>6:55-8 pm</td>
<td>Table discussions: guiding principles for public–private care</td>
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<tr>
<td>8-8:20 pm</td>
<td>Report back and plenary dialogue</td>
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<tr>
<td>8:20-8:30 pm</td>
<td>Recap, next steps and closing</td>
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</tbody>
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