IT'S TIME TO TALK

Persons with Lived Experience
Focused Dialogue
Le Centre Sheraton, Montreal, Quebec
October 24, 2023
Introduction

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

On October 24, 2023, the CMA held a focused dialogue with persons with lived experience (including patients and caregivers) in Montreal as part of a national conversation on public and private health care in Canada. This was the second of several sessions that the CMA is hosting over the coming months to get comprehensive feedback on a complex, critical issue facing our health care 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 care system should be transformed to ensure that patients receive equitable, timely access to care and that providers thrive in healthy, safe work environments.

Profile of participants

The CMA reached out to a broad range of persons with lived experience (PWLEs) to solicit their interest in this focused dialogue. This outreach was done in two waves:

1. We conducted targeted outreach through the CMA’s Patient Voice group and other known patient advocates in the Montreal region.

2. We reached out to several national and local patient partner organizations and asked them to recommend patient representatives for the session. Some examples of organizations we reached out to are the Centre of Excellence on Partnership with Patients and the Public, Healthcare Excellence Canada, the Canadian Cancer Society, March of Dimes, the Canadian Women’s Heart Health Alliance, the National Association of Federal Retirees and the Alzheimer Society of Canada.
Twenty-seven PWLEs participated in the Montreal dialogue. Below is a high-level snapshot of those in attendance:

- **Preferred language:** The number of attendees who identified French as their preferred language was equal to the number of people who indicated English.

- **Geographic location:** While many lived in urban Montreal, participants from rural areas were also in attendance.

- **Social determinants of health:** The group had a diverse range of lived experiences and circumstances that shaped their daily lives and health and well-being. Several participants indicated that they were members of the following often underrepresented groups: ethnocultural groups, the 2SLGBTQI+ community and newcomers to Canada.

- **Lived experiences with health care:** There were numerous participants who identified as having lived experience in acute and/or chronic care, as well as participants who identified as living with a disability.

- **Patient/caregiver mix:** Some participants identified as patients and others as caregivers.

- **Patient advocacy:** Several participants identified as patient advisors and/or as serving as patient representatives on a board.

**What we heard**

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

**Key discussion topics**

**Timely access**

The participants were very engaged in this topic, which generated a great deal of comments during the session. Everyone agreed on the need for timely access to health care, particularly to a family physician but also to all other health care services. If timely access to care cannot be provided, the government must allow people to seek private consultations, provided that they are covered by the public system. During these conversations, the participants mentioned that access to services (both private and public) must be based on available resources, even if this means introducing user fees based on ability to pay.

Specifying what constitutes “timely access” would also be useful.
Equity

The participants provided extensive feedback on this topic. Equity must remain a priority: the population is aging, and a significant percentage are in a precarious financial situation. The growth of the private sector raised concerns that the health system will gradually become less equitable, especially for vulnerable populations. The participants felt that physicians have a moral duty to the public system. The matter of user fees for physicians in private practice was also raised: seeing patients in the private system should come with an obligation to see an equal number of patients in the public system.

The participants expressed mixed and sometimes contradictory views toward the private sector, which occasionally caused tension in the various working groups during the discussions. Some participants staunchly defended universal care as well as timely, free access to the public health system and did not hesitate to condemn the private sector for contributing to issues with access and lack of resources. Others saw the cracks in the public system and no longer wanted to absorb the consequences of its problems. The participants wanted access to a wide range of services and care offered by the private sector—as long as the costs incurred were covered by the public system.

Choice

The participants noted that patients in Quebec do not get to choose their care provider, who is generally assigned to them. No one dares complain given the acute lack of staff.

Physicians migrating to the private sector has had significant effects on access, and the patients of physicians who make a personal choice to practice in the private sector should not have to suffer the consequences of their physician’s choice. A more equitable solution was suggested: physicians should not be able to work in the private sector until they have practiced for a certain number of years in the public system.
Professional responsibility

The participants were in favour of upholding the principle of professional responsibility, which they saw as essential in light of the rapid pace of medical breakthroughs. They wanted the private system, which often has state-of-the-art equipment, to help train future physicians.

They also wanted to see an increase in knowledge about patient partners.

“We seem to treat the private and public sectors as if they operated on the same level, even though they don’t have the same interests. The private sector is accountable to its shareholders.”

Efficiency

The principle of efficiency was approached from the standpoint of organization of care. The private sector is considered to be more efficient because it has fewer constraints and more operational freedom, whereas unions and bureaucratic red tape limit efficiency in the public system. The public sector needs to become more efficient.

During the conversations, the participants raised the ethical question of physicians who encourage their patients to seek private treatment to save time and increase efficiency. They noted that, while the private sector may benefit individual patients and physicians, it provides no collective benefits for society.

“The private system has no choice but to be efficient if it wants to make a profit and keep its clients happy. It’s the public system that needs to work toward being more efficient.”
Moving forward: How might we change things?

The participants shared their ideas for changes that could help improve the health system. Some of these recommendations were directly linked to the principles discussed during the workshops, but in most cases, the proposed ideas combined multiple principles.

Developing a true partnership with patients

Throughout the session, the participants spoke about the need for health care professionals to improve their relationships with their patients by listening to them more or developing partnerships with them and their loved ones.

To encourage physicians to develop their ability to listen, the participants suggested getting patient advocacy groups involved and, most importantly, developing a partnership between physicians and their patients. This partnership should also extend to all health care workers at all stages of the health care trajectory to take into account the patient’s circumstances.

A desire was expressed for the CMA to add patient partnership as one of its guiding principles.

Promoting access to team-based care

Based on their experiences, the participants saw physicians as a bottleneck in Quebec’s health system. They want health care silos to be broken down to give more scope to other professions (such as nurses and pharmacists), which would offer three key benefits for patients: quicker access to care, better task distribution among care teams and access to more medical services. This interdisciplinary collaboration, which is sorely lacking, must be structured and involve shared responsibilities.

Rethinking practices as part of a multidisciplinary approach is the best way for everyone to get timely access to care.

Seeking out best practices in health management

Everyone agreed that we must learn from best practices in Canada and abroad and that the government should in fact be obligated to use these practices to improve the health system.
What’s next?

There will be future opportunities for both the public and physicians to engage in this important discussion, including the following:

- The CMA has partnered with The Globe and Mail to sponsor a series of town halls across the country.
- The public and physicians 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 in-person focused dialogue in Montreal. The organization will continue to analyze the insightful feedback and perspectives, which 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. A recent Angus Reid Institute survey, released in August 2023, stated that 60% of Quebec respondents reported either facing “some challenges” or “chronic difficulty” accessing care. Additionally, 26% said they had no access to a primary care provider at all. That’s twice as many respondents compared to those in Ontario.

More and more people are responding to the lack of access to care by exploring private health care options to try to receive care in a timely manner. Privately funded care is already estimated to account for 28% of health care spending in Canada.¹ This reality demonstrates that we need more clarity, research and evidence to gain further insight into what models of health care funding and delivery will result in the best patient outcomes.

Owing to the complex nature of this issue, participants were provided with some background 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 funds</td>
<td>Mixed delivery, but largely <strong>private</strong></td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td>For example:</td>
</tr>
<tr>
<td>Diagnostics</td>
<td></td>
<td>• Hospitals are often incorporated <strong>private</strong> foundations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family physicians often bill provinces and territories as</td>
</tr>
<tr>
<td></td>
<td></td>
<td>independent, <strong>private</strong> contractors.</td>
</tr>
<tr>
<td>Public health</td>
<td>Public funds</td>
<td>Typically <strong>public</strong></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>
</tbody>
</table>

¹ Canadian Institute for Health Information. [Who is paying for these services?](accessed Sept. 17, 2023).
<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>Prescription drugs</td>
<td>Mixed funding</td>
<td>Mixed delivery</td>
</tr>
<tr>
<td>Home care</td>
<td><strong>Public</strong> funds</td>
<td>For example:</td>
</tr>
<tr>
<td>Long-term care (LTC)</td>
<td><strong>Private</strong> insurance</td>
<td>• In Quebec, 88% of LTC facilities are <strong>publicly</strong> owned, and 12% are <strong>privately</strong> owned.2</td>
</tr>
<tr>
<td>Mental health care</td>
<td>Out-of-pocket payments</td>
<td>• BC, Saskatchewan and the territories deliver home care <strong>publicly</strong> for the most part, whereas all other provinces typically contract <strong>private</strong> companies to deliver home care services.</td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
<td>• Most dentists and optometrists work as independent, <strong>private</strong> contractors or employees for a <strong>private</strong> employer.</td>
</tr>
<tr>
<td>Vision care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient physiotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complementary medicine (e.g., massage therapy)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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

---

APPENDIX B: Focused dialogue agenda

CMA PUBLIC-PRIVATE FOCUSED DIALOGUE (PERSONS WITH LIVED EXPERIENCE)
TUESDAY, OCTOBER 24, 2023 – 8:30 AM – 12 PM ET
LE CENTRE SHERATON, SALLE HEMON

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 at a Glance

<table>
<thead>
<tr>
<th>TIME (ET)</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9 am</td>
<td>Breakfast</td>
</tr>
<tr>
<td>9–9:30 am</td>
<td>Opening &amp; warm-up</td>
</tr>
<tr>
<td>9:30–10:10 am</td>
<td>Context-setting presentation Plenary Q&amp;A and dialogue</td>
</tr>
<tr>
<td>10:10–10:25 am</td>
<td>Health break</td>
</tr>
<tr>
<td>10:25–11:30 am</td>
<td>Table discussions: guiding principles for public-private care</td>
</tr>
<tr>
<td>11:30–11:50 am</td>
<td>Report back and plenary dialogue</td>
</tr>
<tr>
<td>11:50 am–12:00 pm</td>
<td>Recap, next steps &amp; closing</td>
</tr>
</tbody>
</table>