Persons with Lived Experience
Focused Dialogue
Fairmont Hotel Vancouver, Vancouver, BC
November 22, 2023
Introduction

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

On November 22, 2023, the CMA held a 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 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 with the CMA’s Patient Voice group and other known patient advocates in the Vancouver area.
2. We connected with 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 Canada, the Canadian Women’s Heart Health Alliance, the National Association of Federal Retirees and the BC Patient Voices Network.

Thirty-two PWLEs participated in the Vancouver dialogue. Below is a high-level snapshot of those in attendance:

Preferred language: There was an equal representation of participants identifying their preferred language as French and English.

Geographic location: While many participants lived in urban Vancouver, some resided in rural settings.

Social determinants of health: The group had a diverse range of lived experiences and circumstances that shape their daily lives and health and well-being. Several participants indicated that they identified with one or more of the following often-underrepresented groups: ethnocultural groups, the 2SLBGTQI community and newcomers to Canada.

Lived experiences with health care: There were numerous participants who identified as having lived experience with acute and/or chronic care, as well as a large percentage of participants who identified as living with a disability.
Patient/caregiver mix: Some participants identified as patients and others as caregivers.

Patient advocacy: Several participants indicated that they were patient advisors and/or 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 on what they think should be guiding principles to shape the health system they want moving forward.

Key discussion topics

Patient-partnered care

Participants focused their conversations on the necessity of involving patients in health system decisions. They raised significant concerns reflecting the lived experiences of patients in both public and private health systems. Several participants raised potential biases in poll results shared at the dialogue’s onset; they noted that the results focused on the views of middle- to upper-class respondents, which are commonly represented in survey responses and patient groups. The call for authentic patient-partnered care, representative of all patients, resonated strongly. Participants underscored the importance of shifting from physician-centric language to patient-centric communication, exemplified by framing medical necessities in terms of safe and quality care rather than medical jargon. Throughout the session, there was a notable emphasis on expanding options for patients, including the establishment of a national online platform for patients similar to Mayo Clinic Connect. Participants advocated for informed decision-making, increased accessibility to patient portals and autonomy over their care. Additionally, the majority supported initiatives led by peers or people with lived experience, proposing universal patient liaisons to enhance communication, empathy and connection and to modernize inclusive health care practices.

“We need to be at tables where decisions are made about our health.”
Reducing inequities

The majority of participants expressed the need to reduce health inequities in conversations about public and private health care. Participants highlighted concerns about the lack of true equity, noting that those with higher education and income receive superior health care, emphasizing the necessity for a robust public system. Views diverged when the conversation shifted to timely access. Some supported private models of care if there were no alternatives in the public system, recognizing the limitations of resources, but others noted the challenge of reconciling the desire for alternatives with the principle of not basing care on the ability to pay. They emphasized that broader societal issues, including social determinants of health, contribute to health care inequities. The discussion touched on the limited number of choices for those unable to afford private care, advocating for solutions addressing housing, community-based health initiatives and federally funded pharmacare. Participants called for a consensus on giving back to the public system (e.g., through a payment mechanism for users of the private system), highlighting the existing two-tier system. In the dialogue, participants emphasized the importance of preventive care, the inclusion of prevention in medically necessary services, the need for standard care levels across diverse geographic areas, and the importance of universal access irrespective of socioeconomic status.

Team-based care

The theme of team-based care emerged as a key focus for participants. They expressed the need for a shift away from a physician-centric approach toward interdisciplinary care teams, particularly in discussions about primary care in British Columbia. Participants challenged the traditional notion of attachment solely to a primary care physician, advocating for attachment to the right primary care practitioner, which may be someone other than a physician. The dialogue underscored the need to recognize the limitations of physicians and the importance of relying on various health care providers within integrated, coordinated and comprehensive teams. The discussion called for a whole-community approach that incorporates social prescribing (i.e., enabling health professionals to connect patients to community and social services) and a broader health system perspective. Participants noted that many members of the health care team who could improve access, efficiency and the quality of patient care are part of the private system. They emphasized the necessity to shift from attachment to a single provider to attachment to a publicly funded and delivered primary care team. To achieve this goal, participants highlighted the need to foster inclusivity and provide training opportunities for health professionals to meet the diverse needs of the entire population.
Access

Participants emphasized the fundamental need for people in Canada to have timely, safe and equitable access to health care. Tensions arose regarding the option to seek alternatives in the face of long wait times, with some advocating for improved investment and efficiency in the existing system and others supporting alternative options through either private funding or private delivery. In the discussion, participants stressed the importance of publicly funding alternatives if pursued, using models where private interventions complement the public system without compromising equity. Participants highlighted the distinction between “quality” and “medically necessary,” underscoring the need for a nuanced approach to health care provision and access. Concerns were raised about interprovincial access, disparities in private care costs, and the financial burden on patients. Several participants discussed their experiences accessing care in the private system when it was not available in the public system because it was their only option, even though doing so was not consistent with their values. Even though participants expressed a variety of opinions on temporary approaches to timely access, there was a collective desire for a more efficient public system and a call to strengthen it rather than relying on private care options.

Accountability

Accountability emerged as a central concern in this dialogue. Participants stressed the urgency of addressing inefficiencies in the health care system, calling for a more scientific approach and evidence gathering. Participants also expressed the opinion that physicians and governments need to be accountable to the public system. One participant drew on the example of a “choosing wisely” approach to the public–private health care discourse. In the dialogue, participants also explored the responsibility and accountability of private companies contributing to the community and raised concerns about publicly funding private delivery with public funds that are perceived to be “finite.” Participants emphasized the need for government transparency and public feedback. They also highlighted the need for more patient input in evaluating health care services.

Shifting from fragmentation to integration

A prominent theme that emerged in the dialogue was advocacy for a shift from fragmented to integrated care, including the impact of private care on this shift. One participant said, “I’ve been in the system for 10 years — I wish I knew then what I know now about navigating the system. It should not be so ad hoc...” in discussing their experience navigating a fragmented system. Participants expressed a collective desire for more comprehensive and connected health care, voicing concerns about expensive private agencies draining resources and creating silos apart from the public health care system. A few participants called for a standardized health care system across provinces and territories. Several participants emphasized the importance of upstream prevention to reduce overall costs in an integrated system, recognizing that we need to move away from an illness-based system. Participants stressed the significance of community-based care for patients with complex care needs and the imperative of universal access, particularly for equity-deserving
populations. Empowering patients with knowledge, improving navigation through the health care system and investing in technology for older and “less tech-savvy” individuals were highlighted as crucial initiatives. Participants called for increased public spending on health, the integration of social services for broader societal issues like housing into the health care system, and patient engagement to alleviate stress on the health care system.

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 and foster an equitable health system for all people in Canada.

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

- **Prioritize patient partners in health system decisions:**
  - Advocate for authentic patient partnership in health system decisions and establish mechanisms for patients to be involved in decision-making (e.g., national online platform for patients).

- **Improve health equity:**
  - Prioritize reducing health care inequities through strengthening the public system and addressing broader societal issues.

- **Scale up team-based models of care:**
  - Scale up team-based interdisciplinary primary care teams by training health professionals and implementing new models of care.
  - Advocate for attachment to primary care teams and not individual providers.

- **Prioritize access for patients:**
  - Strengthen the public health care system for timely, safe and equitable access, addressing concerns about long wait times.
  - Explore immediate solutions to improve timely access without compromising equity.

- **Improve reporting and accountability structures:**
  - Improve physician and government accountability with respect to strengthening the public system.
  - Evaluate models of private and public health care, especially those that include public investment. Address concerns about funding private care delivery with finite public resources, emphasizing the responsibility and accountability of private companies.

- **Prioritize a shift toward integrated care:**
  - Build systems that focus on prevention and building healthy communities, moving away from an illness-based system, to reduce overall costs within an integrated system.
  - Promote initiatives that empower patients, improve navigation and invest in technology for better integration.
  - Advocate for increased public spending on integrating health and social care to alleviate stress on the health care 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 townhalls across the country.
- The CMA will host virtual consultations in January 2024 for persons with lived experience who expressed an interest in the in-person focused dialogues but were unable to attend.
- 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 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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<tr>
<td></td>
<td></td>
<td>• Family physicians often bill provinces and territories</td>
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<tr>
<td></td>
<td></td>
<td>as independent, private contractors.</td>
</tr>
<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,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sexual health clinics, immunization services, harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>reduction services</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Mixed funding</td>
<td>Mixed delivery</td>
</tr>
<tr>
<td>Home care</td>
<td>Public taxation</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</td>
</tr>
<tr>
<td>Mental health care</td>
<td></td>
<td>owned and 65% are privately owned.(^2)</td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
<td>• BC, Saskatchewan and the territories largely publicly</td>
</tr>
<tr>
<td>Vision care</td>
<td></td>
<td>deliver home care, whereas all other provinces</td>
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<tr>
<td>Outpatient physiotherapy</td>
<td></td>
<td>typically contract privately companies to deliver</td>
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<tr>
<td>Complementary medicine (e.g., massage</td>
<td></td>
<td>home care services.</td>
</tr>
<tr>
<td>therapy)</td>
<td></td>
<td>• Most dentists and optometrists work as independent,</td>
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<tr>
<td></td>
<td></td>
<td>private contractors or employees for a private employer.</td>
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</tbody>
</table>

\(^1\) 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

**Thursday November 22, 2023 – 5-8:30 pm PT**  
**Fairmont Hotel Vancouver, Saturna Island B 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>
</tr>
<tr>
<td>8:20-8:30 pm</td>
<td>Recap, next steps and closing</td>
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</tbody>
</table>