Physician Focused Dialogue

Le Centre Sheraton, Montreal, Quebec

October 23, 2023
Introduction

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

On October 23, 2023, the CMA held a focused dialogue with physicians 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 feedback from physicians and people with relevant lived experience 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 with 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 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 physicians and medical learners in Quebec to gauge their interest in being part of this focused dialogue. Additionally, the CMA extended invitations to organizations such as the Fédération des médecins spécialistes du Québec, the Fédération des médecins omnipraticiens du Québec, the Society of Obstetricians and Gynaecologists of Canada, OurCare, the Centre hospitalier de l’Université de Montréal and the College québécois des médecins de famille.

Twenty-four physicians from a diverse range of backgrounds participated in the Montreal dialogue. Below is a high-level snapshot of those in attendance:

- **Practice status**: The majority of participants (38%) were medical learners, and about one third were family physicians (33%). A number of specialists were also in attendance (29%).

- **Population served**: Over 7 in 10 participants served urban/suburban populations (communities of 30,000 or more). One quarter of participants could not identify a primary geographic population. There were some individuals (4%) who served small-town populations (communities of at least 1,000 but less than 30,000 people).

- **Equity-deserving groups**: Nearly 4 in 10 participants said they were part of an ethnocultural group. Other groups present included members of the 2SLGBTQI+ community (2%), people living with a disability (2%), and newcomers (i.e., immigrants, new citizens, permanent residents, refugees) (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 thought should be the guiding principles that shape the health system moving forward.

Key discussion topics

Comprehensiveness

Discussion of this principle generated many comments and even more questions from the participants:

- What does “medically necessary” mean? What is and isn’t medically necessary? There is too much room for interpretation.
- What is the limit on the “full range” of care when we know that a great deal of needed care is provided in the private sector (e.g., mental health care, dental care)?

The discussion quickly shifted from the “full range of medically necessary care” to a “basket of services,” which physicians would like to see focused on preventive care (physiotherapy, dental care, vision care, psychotherapy, etc.) for the well-being of their patients. However, they recognized that precisely defining a basket of services would mean making choices, a sort of optimization process. The government would then have to consider legislating which services are offered to keep the system functioning, equitable and socially relevant, as resources are limited.

“What is in the ‘basket of services’? Should we legislate which services are offered?”

Timely access

This principle obviously generated a great deal of comments from the participating physicians, given that over 500,000 Quebecers are waiting for a family physician and struggling to access health care. Access is not an end in itself but a way to keep people healthy. All of the participants wanted people to have access to other care options, as long as the care is relevant and delivered by the right professionals. It’s about having empathy for people.
Choice

For many participants, this principle is directly connected to that of access. People who have trouble accessing care do not really have a choice of provider, given the shortage of health care resources.

However, most of the participating physicians were against the choice of working in the private sector and wanted to stop the trend toward private practice in Quebec. Participants said that access to the public system will be inevitably compromised if physicians start working in the private sector. Some even suggested that physicians with a private practice should be required to reimburse the government, which paid for their higher education costs, or at least offer a certain number of hours in public practice.

Equity and social justice

The principle of equity relates to the concept of social justice, and the physicians consulted clearly expressed their desire to reduce health inequities. People’s ability to pay then becomes more relevant, as economic and geographic barriers that produce inequities must be removed for the health of vulnerable groups. However, these needs must be mapped out, as they are constantly growing. This observation raises a moral issue for many physicians: should everyone have access to all types of care, or should we cut the types of care that are not as essential?

The public-private discussion adds another dimension to this principle: when patients cannot access care from the public system in a timely manner and must turn to the private sector, is this fair for everyone?
Moving forward: How might we change things?

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

Shifting the organization of work toward a team-based care model

The main issue for physicians was the public’s ability to access health care and health care professionals. To address this issue and improve access, participants wanted a review to be undertaken of health care methods, as well as everyone’s roles and responsibilities, to facilitate people’s access to the professionals they need. Team-based care could help relieve congestion in the system, counteract some of the current staff shortages and broaden the range of care available to the public.

Applying best practices in health management

Everyone agreed that we shouldn’t try to “reinvent the wheel,” and to avoid doing so, we must learn from best practices in Canada and abroad.

- **Oversight:** The idea of oversight standards was brought up frequently during discussions. Whether the standards would relate to care quality or improved regulation of the private sector’s role in health care, this oversight would ideally be done by a fully independent body.

- **Guidelines for the private system:** The private sector’s role in health care raises many questions and poses clear challenges for physicians in terms of both their clinical duties and their moral obligation to protect the public. The participants frequently mentioned the growing role of private health care in the United States as well as what is happening elsewhere in Canada. It would be good if we could learn from best practices to provide the private sector with effective ethical guidelines.

- **Innovation:** Innovation was also a topic of conversation. For example, physicians are interested in learning about what is being done elsewhere in order to help improve the health care system here when it comes to the role of artificial intelligence in health care or technological innovations in clinical or management practices.

Getting patients more involved

A number of issues discussed, particularly the principles of quality and patient empowerment, made it clear how important it is to include patient perspectives. The participating physicians stressed that, while the patient-partner concept is a desirable solution, simply considering the patient’s perspective on their care would represent a change. This paradigm shift must apply to all health care providers.
Acting for public health

The participating physicians mentioned multiple times that, in addition to treating patients, keeping the public healthy is an important societal goal. To achieve this, we need to tackle the social determinants of health to reduce social inequality and injustice. Access to health care, while important, is not an end in itself but a way to keep people healthy. It was also suggested that prevention through action might be made a new principle of the CMA.

Answers influenced by the negative atmosphere hanging over the profession in Quebec

Participants expressed more fear than hope. The current health care reform and negative atmosphere that has weighed on the medical profession in recent years are indeed largely responsible for this. Access to the health care system was both a primary concern for participants and their main hope for the future. Other concerns included staff shortages, the administrative burden, and the inadequate funding of the public system (leaving room for the private sector).

Their main hopes included the improved management and organization of care, as the physicians recognized that the current health care system could be improved if available resources are managed and organized differently.

Applying the concept of interdisciplinarity when reviewing principles

As the Quebec government will be making team-based work mandatory (see Bill 15), it was suggested that the CMA should review its principles in light of the new reality. Physicians will increasingly provide care/treatment as a team, which leads to questions about their roles and professional obligations, as well as the organization of team-based care.

It should also be mentioned that the Quebec government has just launched a vast initiative to modernize its professional system to ascertain whether the public feels protected by professional orders (which include the Collège des médecins du Québec). The complaints examination system and codes of conduct will be revised to reflect the growing importance of interprofessional teamwork.
What’s next?

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 town halls across the country.

- The CMA will host virtual consultations in late November for physicians who expressed an interest in the in-person focused dialogues but were unable to attend.

- 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 in-person focused dialogue in Montreal. 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, with many in Canada 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 across the border 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 at the beginning of the dialogue were provided with some background. 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 private</td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td>For example:</td>
</tr>
<tr>
<td>Diagnostics</td>
<td></td>
<td>• Hospitals are often incorporated private foundations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family physicians often bill provinces and territories</td>
</tr>
<tr>
<td></td>
<td></td>
<td>as independent, private contractors</td>
</tr>
<tr>
<td>Public health</td>
<td>Public funds</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 Public funds</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>Private insurance</td>
<td>• In Quebec, 88% of LTC facilities are publicly owned,</td>
</tr>
<tr>
<td>Mental health care</td>
<td>Out-of-pocket payments (private)</td>
<td>and 12% are privately² owned.</td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
<td>• BC, Saskatchewan and the territories deliver home care</td>
</tr>
<tr>
<td>Vision care</td>
<td></td>
<td>publicly for the most part, whereas all other provinces</td>
</tr>
<tr>
<td>Outpatient physiotherapy</td>
<td></td>
<td>typically contract private companies to deliver home care</td>
</tr>
<tr>
<td>Complementary medicine (e.g.,</td>
<td></td>
<td>services.</td>
</tr>
<tr>
<td>massage therapy)</td>
<td></td>
<td>• Most dentists and optometrists work as independent,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>private contractors or employees for a private employer.</td>
</tr>
</tbody>
</table>

¹Canadian 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**.

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

CONSULTATIONS ON PUBLIC AND PRIVATE CARE IN CANADA

CMA PUBLIC-PRIVATE FOCUSED DIALOGUE (PHYSICIAN)
MONDAY, OCTOBER 23, 2023 – 5–8:30 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>5—5:30 pm</td>
<td>Dinner</td>
</tr>
<tr>
<td>5:30–6:00 pm</td>
<td>Opening &amp; warm-up</td>
</tr>
<tr>
<td>6–6:40 pm</td>
<td>Context-setting presentation</td>
</tr>
<tr>
<td></td>
<td>Plenary Q&amp;A and dialogue</td>
</tr>
<tr>
<td>6:40–6:55 pm</td>
<td>Health break</td>
</tr>
<tr>
<td>6:55–8 pm</td>
<td>Table discussions: guiding principles for public-private care</td>
</tr>
<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 &amp; closing</td>
</tr>
</tbody>
</table>