IT'S TIME TO TALK

Physician Focused Dialogue
Toronto Marriott City Centre Hotel, Toronto, ON
Sept. 7, 2023
Introduction

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

On Sept. 7, 2023, the CMA held its first physician focused dialogue in Toronto to kick off a national conversation on public and private health care in Canada. This was the first 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 Ontario to seek their interest in being part of this focused dialogue. Additionally, the CMA extended invitations to organizations such as the Ontario Medical Association, the Ontario College of Family Physicians and Canadian Doctors for Medicare.

Thirty physicians participated in the Toronto 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**: Nearly half of the participants were family physicians (47%), and over a third were specialists (37%). There were some resident physicians in attendance (17%).

- **Population served**: The majority of participants (87%) served urban or suburban populations of 30,000 or more. There were also participants who served small towns of 1,000 to less than 30,000 (3%) and geographically isolated or remote populations (3%); 7% of participants could not identify a primary geographic population.

- **Equity-deserving groups**: More than half of participants (53%) were part of an ethnocultural group. Participants also identified if they were part of the 2SLGBTQI+ community (3%), had a disability (3%) and/or were a newcomer (7%).
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

Equity

First and foremost, participants felt strongly that everyone in Canada should have equitable access to care, regardless of race, gender, sex, sexual orientation, age, disability, religion, language, ability to pay, or other factors. There was a strong sentiment throughout the dialogue that “no one should be left behind” and equity “should not be messed with” as it is a “moral and ethical imperative.”

Timely access

There was a strong consensus that everyone in Canada deserves timely access to care. It was also emphasized that timely access must be centred in an equity framework. However, many participants had questions about what is meant by timely access. They underscored the need for it to be more clearly defined and for a consistent definition to be used across the country that is grounded in evidence and global standards.

A few participants felt that patients should have more options to access care by having the choice to pay, but that there needed to be guardrails in place. Other participants were reluctant to allow patients to pay for medical necessary services because it could enable those who could afford it to “jump the line”; this would not help to decrease wait times but rather would simply re-arrange waitlists so those paying would receive faster care and those unable to pay would wait longer. As one participant said, “choice is a power game ... equity already constrains choice in many ways — when we give choice to people what does it result in for other people?” The group of participants who felt this way suggested that instead of expanding private care, we should be exploring how to best increase efficiencies and health human resource capacity in the public system.

“Choice is a power game ... equity already constrains choice in many ways — when we give choice to people what does it result in for other people?”

“No one should be left behind”
Strengthening Canada’s public health system

Several participants felt it was critical to further support and invest in the public health system. This includes support and investment in general, as well as in key areas, such as primary care and public health. There was an emphasis on the need for additional public funding to recruit health professionals and, in particular, to provide enhanced support to ensure all patients have access to a family physician or primary care team. Some participants also underscored that Canada needs to have enough registered nurses to meet patient demands. Overall, many participants suggested enhanced, integrated health human resources planning, where it was noted that “it’s better to have more task sharing within the public system than it is to increase private delivery.”

“IT’S BETTER TO HAVE MORE TASK SHARING WITHIN THE PUBLIC SYSTEM THAN IT IS TO INCREASE PRIVATE DELIVERY.”

Supporting interprofessional, team-based primary care

The resounding support for team-based primary care was heard loud and clear throughout the session. The majority of the participants, if not all of them, felt that supporting and scaling up publicly funded team-based primary care is a fundamental way to improve access to care for everyone in Canada. It was frequently suggested that primary care should function similarly to the public education system, where patients could be enrolled in regional primary care teams on the basis of their area codes.

Sustainable funding in this model of primary care was viewed by participants as a sound upstream investment in preventive care as patients attached to a primary care team could more effectively receive comprehensive, continuous care throughout their life cycle by having access to a network of health care providers, which would help ensure that the most appropriate care is provided in a timely manner. It would also reduce downstream demand on overstretched emergency departments and other acute care services.

High-value care and resource stewardship

A few participants noted that there should be further support for and investment in high-value care to enable the efficient use of health care resources and ensure patients receive optimal care. It was expressed that “physicians are stewards of health care resources” and therefore should be following the Choosing Wisely Canada recommendations to ensure they are giving their patients the most appropriate and necessary tests and treatments. It was also suggested that clear, evidence-based information on health services should be housed in a centralized place and shared with patients.
In line with the topic of resource stewardship, a few physicians noted that we need to have uncomfortable conversations around health care dollars and “current areas of waste,” including “astronomically expensive cancer drugs with low efficacy.” The question was posed on whether these types of drugs should be fully covered when health care dollars could be spent elsewhere.

Exploration, evaluation and updating of the definition of “medically necessary” and “comprehensive” care

Throughout the dialogue, one fundamental question kept coming up: “What is medically necessary care and who should define it?”

Currently, the Canada Health Act defines medically necessary services as hospital services, physician services and surgical dental services that require a hospital setting. There were suggestions for an independent body outside of government to define medically necessary care, and that this definition needs to be grounded in evidence and free from political influence and bias. For the most part, participants supported the expansion of the definition of “necessary” medical services in Canada, so health services such as dental care, prescription drugs, eye care, physiotherapy, mental health care, home care and long-term care would be publicly financed.

Most participants also indicated that providing comprehensive care is critical and should be a key principle of our health system, but felt there needed to be a clear, evidence-based definition of comprehensive care and what exactly it should encompass. It was also expressed that the definition would need to be broadly shared with providers, patients and the public so everyone had a clear, mutual understanding of what is meant by “comprehensive” care.

Accountability

There was a strong consensus that external oversight is needed to ensure that decisions are made in patients’ best interests and governments are held accountable for public money spent on health care. Additionally, most, if not all, participants felt that the health system, regardless of how it is funded and delivered, must be held accountable as it relates to tracking and improving patient outcomes.

Several participants suggested that third-party experts should be engaged or an independent body should be created to provide oversight as government(s) are unable to effectively do so. It was proposed that this oversight body could function at a pan-Canadian level to monitor the delivery and financing of health care, and track and report on positive and negative outcomes. This way, as a country with thirteen different health systems, we would be able to more effectively work together to learn and correct as needed (with adequate supports for course correction) and sufficiently invest in and scale up promising practices and successful initiatives.
Moving forward: How might we shift?

Despite the fears that many physicians 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 the key suggestions, which link to many of the discussion topics previously outlined:

- **Fund and expand team-based primary care models:** Participants strongly felt that the adoption and full implementation of interprofessional primary care teams could significantly improve access to care in Canada. It was also a hope of some participants that “family doctors are all able to work in [these] multidisciplinary teams with salaries and benefits.”

- **Use population health metrics:** These metrics should be employed to assess health system performance and measure patient and population outcomes. This would include analyzing the social determinants of health.

- **Streamline health systems through various mechanisms, including the following:**
  - Have clear standards of care that are well-communicated, understood and consistently implemented across the country so that patients’ rights are fully respected and upheld, and both patients and providers have a shared understanding of these standards.
  - Leverage technology to promote innovations within the health system. A popular suggestion was to invest in unifying the electronic medical record (EMR) system, and it was noted that this could be a potential area that is publicly financed but privately delivered to help develop efficiencies.
  - Implement centralized waitlists and referral systems across the country.
  - Adopt a national licensing system for physicians.
  - Learn about pilots and innovations that have been shown to work well and adapt and scale them up across the country. It was suggested that a pan-Canadian oversight body (as described in the accountability section) could help promote more effective and consistent information sharing and scaling up across all jurisdictions.

- **Ensure increased accountability:** An independent, pan-Canadian oversight body could be created to track health care financing and delivery, as well as patient and population health outcomes.
What’s next?

The session in Toronto was the first 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.

- 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 Toronto 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. A recent Angus Reid Institute survey, released in August 2023, outlined that only 4% of Ontarian respondents felt that the current health care system is working well, and 61% reported either “some challenges” or “chronic difficulties” accessing care. Additionally, almost 10% said they had no access to a primary care provider at all.

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>
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<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</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 Ontario 16% of LTC homes are publicly owned and 84% are privately owned.²</td>
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<tr>
<td>Mental health care</td>
<td>Private insurance</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>Out-of-pocket payments (private)</td>
<td>• Most dentists and optometrists work as independent, private contractors or employees for a private employer.</td>
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<tr>
<td>Vision care</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 Ontario, out of the 84% of LTC homes that are privately owned, 57% are owned by private for-profit organizations and 27% 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

IT'S TIME TO TALK
CONSULTATIONS ON PUBLIC AND PRIVATE CARE IN CANADA

CMA PUBLIC-PRIVATE FOCUSED DIALOGUE (PHYSICIANS)
Thurs., Sept. 7, 2023 — 6–9 pm ET
Toronto Marriott City Centre, Raptor 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 at a Glance

<table>
<thead>
<tr>
<th>TIME (ET)</th>
<th>ACTIVITY</th>
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<tbody>
<tr>
<td>5:30–6 pm</td>
<td>Dinner buffet</td>
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<tr>
<td>6–6:30 pm</td>
<td>Opening and warm-up</td>
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<tr>
<td>6:30–7:10 pm</td>
<td>Context-setting presentation</td>
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<td>Plenary Q&amp;A and dialogue</td>
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<tr>
<td>7:10–7:25 pm</td>
<td>Health break</td>
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<tr>
<td>7:25–8:30 pm</td>
<td>Table discussions: guiding principles for public-private care</td>
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<tr>
<td>8:30–8:50 pm</td>
<td>Report back and plenary dialogue</td>
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<tr>
<td>8:50–9 pm</td>
<td>Recap, next steps and closing</td>
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</tbody>
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