IT'S TIME TO TALK

Public and Private Physician Virtual Focused Dialogues – Across Canada

November 27 and 28, 2023
Introduction

The statements in this document represent the opinions expressed by the participants and not those of the Canadian Medical Association (CMA).

On November 27 and 28, 2023, the CMA held three virtual focused dialogues with physicians across Canada as part of a national conversation on public and private health care in Canada. The CMA conducted these sessions for physicians who had expressed an interest in attending the in-person focused dialogues but were unable to attend. This was the fourth of several sessions that the CMA is hosting 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; and
3. seek perspectives and ideas to inform the CMA’s policy recommendations on public and private care.

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 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 across the country to seek their interest in being part of this focused dialogue. Additionally, the CMA extended invitations to provincial and territorial medical associations with a focus on those associations where in-person sessions were not being hosted. The CMA also extended invitations to specialty societies and other health care organizations, including the Society of Rural Physicians of Canada.

Seventy-five physicians participated in the virtual dialogue sessions. 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:** An even proportion of family physicians (44%) and specialists (44%) attended the virtual dialogue sessions. There were some medical learners in attendance (12%).

- **Region:** Majority of participants attended the sessions from Ontario (40%), British Columbia & Alberta (36%), and Atlantic region (16%). There were other participants who joined from Saskatchewan & Manitoba (7%) and Northern Canada (1%).

- **Population served:** More than 6 in 10 participants served urban/suburban populations (community of 30,000 or more). Almost a third of participants (27%) could not identify a primary population served. There were some individuals (10%) who served small towns (community of at least 1,000 but less than 30,000) and rural populations (population below 1,000).

- **Equity-deserving groups:** Thirteen percent of participants indicated they were part of an ethnocultural group. Other groups present included people living with a disability (5%), newcomers (i.e., immigrants, new citizens, permanent residents, refugees) (5%), members of the 2SLGBTQ+ community (1%) and people with other identities (1%).
What we heard

We conducted three sessions, each two hours long. The sessions had lively conversations in both the plenary and small groups. Throughout the dialogues, participants reflected on the role of public and private health care delivery and funding in Canada and provided insights on what they think should be guiding principles to shape the health system they want moving forward in today’s health care environment. The following provides a synopsis of the dialogues of all three sessions on the key discussion topics that were addressed and participants engaged in.

Key discussion topics

Timely access and equity

As timely access and equity are key foundational principles, participants indicated that they go hand in hand and should reflect the diversity of our population. It was noted that a private health system would impact these principles by allowing patients who could afford to pay for health services to jump the queue, resulting in inequities in access to care because access would no longer strictly be based on need. Moreover, participants acknowledged Canada’s vast geographic landscape and how rural, remote, northern and Indigenous communities already experience significant barriers to accessing care, and they noted that a greater reliance on private care could exacerbate those barriers. Minimum standards for access to care should be considered in prioritizing or “triaging” access to care throughout all levels of the health care system; access should not vary depending on where patients live and/or their socioeconomic status. Participants emphasized how creating realistic minimum standards of care, such as access to MRIs, with clear benchmarks, would help ensure that everyone living in Canada has equitable access to care. Governments, regional health authorities and health facilities should be held accountable for meeting those standards. Participants acknowledged that ensuring equitable access to care would result in an increased need for health human resources as well as training for all health care professionals, especially to serve underserved populations.

Addressing wait times

Participants stated that wait times continue to be a problem in terms of access to care, especially for cancer treatments and surgical procedures such as hip replacements. For care associated with long wait times, those who can afford to pay continue to seek care through private health facilities either outside their home province or territory or outside of Canada. Some physicians noted that when patients sought private care outside their jurisdiction, there could be problems providing follow-up or addressing post-surgical complications in the public system when the patient returned home. The aim is to both reduce wait times and maintain standards in health care delivery across Canada, to ensure positive health outcomes for all patients.
Choice

Participants expressed diverse opinions and perspectives about whether choice should be a core principle and/or priority, equal in importance to timely access and equity. They described two types of choice: in the current health care system, patients can make choices about where to access care, and health care professionals can choose where to practise and whether to work in the public or private system. If patients are unable to access care within the public health system, they may seek private alternatives (if available) within their jurisdiction or outside their jurisdiction. Physicians may choose to transition to private care delivery in response to restrictions imposed by governments on how or where they can practise in the public system and/or if the public system does not offer incentives for practising there. Provincial and territorial differences with respect to what services are covered in the public system can create further disruptions for patients in terms of continuity of care and for health care professionals in terms of compensation. Participants also expressed concerns that having choices could increase wait times; in addition, patients might not be fully informed on how care alternatives could impact their health and/or be able to access the appropriate health care provider to meet their needs.

Comprehensiveness

There was consensus among participants that the definition of comprehensiveness needs to be updated. This includes redefining medically necessary care and revising the basket of essential services to include primary care, holistic care, pharmacare, preventive care and social programs that reflect the regional health needs of people living in Canada. While certain participants identified how the definition of comprehensiveness should be broadened, they recognized that it may not be realistic to do this given our current health human resources and/or the financial resources of provincial and territorial budgets. Public and private payers and insurers are compelled to decide on coverage across all jurisdictions as Canada currently has 13 different health systems. Participants also discussed the need for coordination of coverage between the public and private systems, as well as a review and analysis of the needs of the population as a whole. Such a review could help prioritize what services are necessary for the health of specific populations (e.g., rural and remote populations, equity-deserving groups). Consideration could also be given to developing standardized measures that apply to all jurisdictions with respect to comprehensive coverage, as well as having a mechanism for health care providers to have a say on how the different systems should work together. It was also noted that having the appropriate level of health human resources and supporting the productivity of Canada’s health workforce are key factors in providing comprehensive health services and ensuring the appropriate training needed to sustain the health workforce.
Clinical autonomy

Physician participants shared their experiences on how their practice environments have significantly impacted their clinical autonomy in both the public and private health systems. As more practice environments are being transitioned into team-based delivery models or managed by health care organizations (i.e., hospitals), physicians are being challenged to redefine their clinical decision-making role. Several issues are having impacts on their professional autonomy in clinical care, such as the requirement to adhere to clinical practice guidelines set out by payers and insurers, the need to advocate for patients to receive appropriate treatments, and a lack of physician leadership and/or consultation in health system management programs. To obtain a better understanding of these new practice environments, participants suggested that reassessment and further clarification of physicians’ clinical autonomy be considered in conjunction with other health care providers in areas such as accountability, delivery of quality of care within the context of medical supervision, potential conflict of interests, and the overlap between clinical decision-making autonomy and practice autonomy.

Professional responsibility

Participants felt that not enough is being done to educate and train the next generation of health professionals about their professional responsibility in the health care system. In the private health sector, it was noted that clinicians are not held accountable for providing training opportunities for learners or facilitating teaching environments for trainees as is the case within the public health system, such as in academic hospitals. Some participants expressed the view that for those private health groups receiving public funding, there should be an expectation that they will provide training including for complex cases. Other participants felt that there was no obligation for the private sector to provide teaching opportunities.

Transparency

There was much discussion among participants on how there is mistrust among public and private health care providers, particularly with respect to governments. Transparency is needed at all levels of the health care system, from decision-makers to health care providers to users. A key element of transparency is disclosing conflicts of interest, especially for individuals serving in both the public and private sectors — there needs to be a clear definition of what constitutes a conflict of interest. It was felt that there is insufficient reporting on the following: how our health system resources are being utilized and the associated costs; how funds are being allocated; access; outcomes (comprehensive reporting is needed on this subject); and the rationale for decisions (including the data that underpin the decisions). Further, certain provincial governments have taken steps to include private sector groups in delivering services such as surgical care for hip and knee replacements, which, in some circumstances, governments fail to disclose. A few participants noted that if we had more transparency, they would have access to better information to advise patients about their options.

“If we had more transparency it would allow us to better advise our patients about their options.”
Accountability

There was clear consensus among the participants that accountability should be factored into all of the guiding principles that underpin a health system framework. Participants also agreed that governments, health care providers and users of both the public and private health care systems should be held accountable for meeting the guiding principles of our health care system. Most importantly, it was acknowledged that all physicians are accountable to their patients. It was suggested that establishing oversight mechanisms for accountability measures should be considered, particularly for private health sector groups that utilize public funding. The following elements should be measured and tracked: efficiency improvements; return on investments for innovations; wait times for specific procedures; utilization trends and their impact on health system resources; and patient health outcomes, particularly for patients who are experiencing challenges in accessing care.

Efficiency

Participants agreed that for the public health system to be efficient we should have a clear definition as to what the public system is and what it means to be efficient. As the aim is to optimize the use of human health and system resources, it was suggested that the definition of efficiency be expanded to include a more integrated, holistic approach (i.e., not siloed) and to specify the contexts in which efficiencies are expected and when they should be achieved. It was noted that there are many parts of health care that are important but not usually delivered efficiently, such as providing care to remote areas or communities. Some participants did express caution that if efficiency were ranked as a top priority, it would be unfair to rural, remote, northern and Indigenous communities (e.g., the lack of health care infrastructure in many of these communities makes it inherently more inefficient to provide care, despite it being critical to do so). There are several factors that influence efficiencies, for example, the resources required to perform health care services may be insufficient, the application of cost-effective measures may impact patient safety, stakeholders in the system may not know which outcomes are to be achieved, and we are in the midst of a health care crisis. A few participants noted that financial incentives could be considered to find efficiencies and to streamline our health system resources.

Government role in health care decisions

With respect to the government’s role, most participants expressed the view that decisions on health care delivery and our health care system should not be politicized. Further, participants expressed concern about governments making health care decisions or having control of our health care system without having a clear understanding of how the health care system works and that decisions should be evidence-based and patient-centred. It was suggested that consideration should be given to exploring other avenues or accountability measures with respect to how decisions are made about health care delivery, including involving providers and users (Canadians) in making decisions about the health care system.
Influence of the private sector on health care

Participants discussed the influence of the private health sector on health care delivery. They provided examples of how private-based health care programs, supported by some provincial governments, have impacted their local communities and/or practices. Concerns were expressed about how these types of programs might impact the continuity of patient access, reduce public funding by governments and shift or encourage mobility of health human resources from public to private health care. A few physicians noted that private care delivery has impacted the productivity of the healthcare workforce and that it limits patients’ access to health care through the public system because of scarcity of resources.

Moving forward: How might we shift?

Participants 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 sessions, but in most cases, the proposed ideas combine multiple principles. While there was overall support from participants for keeping all the guiding principles concerning public and private health care delivery, key areas were identified that require further review and analysis to meet the emerging health needs of Canadians. Participants also emphasized that other health care professions should be engaged in these conversations.

- **Implement measures to enhance the public health system**: A majority of participants expressed the view that the current public health system should be enhanced to work more efficiently and ensure that patients have equitable access to timely care. Further, there is a need for better supports and incentives to enable physicians and other health care providers to practise in an enhanced publicly funded system. As there are currently 13 provincial/territorial health care systems, there needs to be a national approach to health care delivery. Participants noted their concerns about the mismanagement of the public health system including insufficient funding, lack of accountability structures and lack of investment in specific health services that are needed such as palliative care, chronic care, and care for older adults. Specific measures in these areas should be integrated within CMA’s guiding principles, including sustainability.

- **Move toward embedding primary and team-based care delivery in our health care system**: Some participants noted that they recognized that primary care is a key component of our health care system, and they were frustrated by the lack of access to primary care for their patients. There are places in Canada where patients are receiving team-based care that is associated not only with positive health outcomes but also with improved access to care, improved work environments for health care providers and reduced wait times. The reorganization of primary care should be at the forefront of discussions about how to improve Canada’s health care system, and this should be part of a new principle for health care delivery in Canada. Further, we should incorporate the supports and resources, such as training health care workers to practise in health teams, that will be needed to improve access to primary care services.
• **Streamline the public–private interface:** It was acknowledged that we currently have a public–private interface within our health care system with each operating using different approaches. Participants expressed concern that certain governments are subsidizing the private health system by providing funding support to private health facilities to reduce wait times for surgical procedures rather than strengthening the public system. Concern was also expressed about the fear of private health care delivery being prioritized over public health care and that providing more private options will result in further inequities in access to care. Some physicians expressed the view that a hybrid care system approach should be considered. It was suggested that public and private infrastructure should be aligned, with both working from the same overall principles with an emphasis on accountability to patients and “social” accountability such that those working in the private sector would be expected to contribute to the public system. Physician participants recommended that a redefinition of public and private should be part of the conversation.

> “It would be great if we were able to correct the narrative to properly describe the system that we have. If we can’t describe what we have, how can we begin to create a solution.”

• **Explore learnings from other countries, professions and industries that could be applied to the Canadian health care system:** Participants provided the following suggestions:
  
  o Review health care models in other countries that have been demonstrated to successfully integrate public and private health care delivery, such as certain states in the United States and Australia, and consider how these models could be applied in the Canadian context.
  
  o Consult with other health professions that are facing trends similar to those being experienced by physicians in their practice settings, including remuneration models.
  
  o Explore and invest in innovations that can be integrated into the public health system.
  
  o Explore other industries, such as the automotive industry, that have been shown to successfully use efficiency models. Learnings from these industries can inform our approach to the public–private interface in health care.
  
  o Implement standardized data collection on public and private utilization of health resources, including health workforce mobility in both the public and private health systems.

• **Provide effective supports for health care professionals:** The current public health care system does not adequately support health care providers in their provision of health care delivery. In particular, participants reported that at times they are unable to provide optimal clinical care and/or unable to facilitate access to specialty health care services that patients require. They also lack the resources they need to work with other health professionals, resulting in increased administrative burden and/or burnout for physicians. Some physicians reported that they have left the public system or have moved to a practice that provides a better work-life balance. It was suggested that the focus should be on providing better incentives for health care providers to return to the public health care system and build back its health human resources. The importance of integrating the training and education of future health professionals should also be considered.
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 townhalls across the country.
- The CMA will host additional in-person focused dialogues for physicians in early 2024.
- 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 care webpage and fill in your contact information to stay abreast of key updates.

The CMA greatly appreciates the time physicians took to participate in the virtual focused dialogues. The insightful feedback and perspectives provided will continue to be analyzed and will inform the CMA’s future policy and advocacy work 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 at a critical juncture; many people living in Canada are feeling the dire impacts of a crumbling health system. 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 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, as in 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>
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<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</td>
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<tr>
<td></td>
<td></td>
<td>independent, private contractors.</td>
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<tr>
<td>Public health</td>
<td>Public taxation</td>
<td>Typically public</td>
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<tr>
<td>Community health centres</td>
<td></td>
<td>For example: municipally run community resource centres,</td>
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<tr>
<td></td>
<td></td>
<td>sexual health clinics, immunization services, harm</td>
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<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>Private insurance</td>
<td>• In Ontario 16% of LTC homes are publicly owned and 84%</td>
</tr>
<tr>
<td>Mental health care</td>
<td>Out-of-pocket payments (private)</td>
<td>are privately owned.(^2)</td>
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<tr>
<td>Dental care</td>
<td></td>
<td>• BC, Saskatchewan and the territories largely publicly</td>
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<tr>
<td>Vision care</td>
<td></td>
<td>deliver home care, whereas all other provinces typically</td>
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<tr>
<td>Outpatient physiotherapy</td>
<td></td>
<td>contract private companies to deliver home care services.</td>
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<tr>
<td>Complementary medicine (e.g., massage therapy)</td>
<td></td>
<td>• Most dentists and optometrists work as independent, private contractors or employees for a private employer.</td>
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</table>

\(^1\) Canadian Institute for Health Information. Who is paying for these services? Accessed Dec. 1, 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 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 – VIRTUAL SESSIONS)

Monday, Nov. 27, 2023 – 10:30 – 12:30 pm ET
Monday, Nov. 27, 2023 – 6 – 8 pm ET
Tuesday, Nov. 28, 2023 – 9 – 11 pm ET

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</th>
<th>ACTIVITY</th>
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<tbody>
<tr>
<td>15 minutes</td>
<td>Opening and warm-up</td>
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<tr>
<td>35 minutes</td>
<td>Context-setting presentation</td>
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<td>Plenary Q&amp;A and dialogue</td>
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<tr>
<td>45 minutes</td>
<td>Table discussions: guiding principles for public–private care</td>
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<tr>
<td>15 minutes</td>
<td>Report back and plenary dialogue</td>
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<tr>
<td>10 minutes</td>
<td>Recap, next steps and closing</td>
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