Physician Focused Dialogue

The Prince George Hotel, Halifax, NS
January 25, 2024
Introduction

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

On January 25, 2024, the CMA held a physician focused dialogue in Halifax as part of a national conversation on public and private health care in Canada. This was the fifth 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
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 Halifax to seek their interest in being part of this focused dialogue. Additionally, the CMA extended invitations to organizations such as Doctors Nova Scotia and the College of Physicians & Surgeons of Nova Scotia.

Twenty-one physicians participated in the Halifax dialogue. There was a diverse range of participants, including family physicians, emergency physicians and other specialists (e.g., psychiatrists). Below is a high-level snapshot of those in attendance:

- **Practice status**: Nearly half of the participants (48%) were family physicians, and more than one-third (38%) were specialists. There were some medical learners in attendance (14%).

- **Population served**: Nearly 70% of participants served urban or suburban populations (communities of 30,000 or more); 19% of participants could not identify a primary geographic location. Some individuals (10%) served small-town populations (communities of at least 1,000 but less than 30,000 people) and rural populations (communities of less than 1,000 people).

- **Equity-deserving groups**: Ten percent of participants said they were part of an ethnocultural group, and another 10% of participants identified as newcomers (i.e., immigrants, new citizens, permanent residents, refugees). Other groups present included members of the 2SLGBTQIA+ community (5%), people living with a disability (5%) and other identities (5%).
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

Choice and timely access

The concept of choice was widely discussed throughout the dialogue. Participants emphasized the importance of first clarifying what we mean when we are talking about choice as there are several different aspects of “choice” to consider when it comes to health care. For example, several participants felt that patients should be able to choose their physicians. They explained how in other countries citizens can see health providers’ safety profiles and clinical outcomes and this information gives patients more insight on whom they should select to do their procedures. It was noted that transparency is required for informed choice, and right now patients in Canada are not informed. On the other hand, others felt that patients should not be able to choose their health providers. As one participant noted, “People shouldn’t be able to just pick and choose their doctors and shop around based on a whim. That can cause total chaos in the system. The reality is no one has choice at the moment and [patients] barely have one option.”

Another aspect of choice that was discussed was patients’ choice to access private, for-profit health care, which many participants felt should be an option, especially if patients are unable to receive timely care. One participant noted that it should almost be considered a personal freedom to be able to pay for care and many felt that it should be more “acceptable and mainstream” for patients to pay for these options and that they should be embraced. Other participants felt that private, for-profit care should be an option only if the publicly funded health care system was “shored up” enough to be able to serve the Canadian population in a timely and equitable manner, which is currently not the case. In a similar vein, a number of physicians emphasized that the priority should be to ensure that seriously ill patients have timely access. So, it would be inequitable for some patients to be able to seek private options and receive more timely care because they can afford to do so.

“If the person is going to die, they should absolutely have the ability to pay for care... switch it around and say that even if you're going to die, you cannot pay for a service to save your life.”
Equity

Equity considerations underpinned most of the discussions. The majority of participants strongly felt that equity should be the primary goal and people in Canada should have access to health care based on need and not ability to pay. Many expressed fears about the increasing role of the private sector in health care and how it may cause profit to be prioritized over patient outcomes, and they were concerned that quality care will be divided on class lines, which will lead to some patients being harmed and/or dying for preventable reasons. Some participants noted how we need to ask who benefits the most from private, for-profit health care, and how this can be “very dangerous talk.” It was mentioned that the people who need the private, for-profit system most won’t be accessing it and that these services will not address the needs of low-income populations. It was also stressed that everyone in Canada having equal access to care is not equitable care. Instead, taking a health equity approach requires an understanding and recognition that each person has unique circumstances and therefore must be provided with the distinct resources and care that they specifically need, which will vary depending on the person and community. It was noted that it is not enough for an individual or group of people to be given the same resources as that will not create equal health outcomes across the country. In line with this, several people underscored the importance of the Canadian health system adhering to equity, diversity, inclusion, reconciliation and accessibility (EDIRA) principles.

Social determinants of health

The importance of addressing patients’ social determinants of health was widely discussed in the dialogue. Many participants described how other factors that have not been traditionally considered health care related (such as food security, housing and income) can drastically influence health outcomes, and some physicians therefore suggested that having the words “health” and “care” together is too complex. They would rather have the words not used together because they felt that “we want to see health, and we want to provide care” but the care that could most drastically improve someone’s health may not actually be health service related. For example, participants suggested that food hampers should be publicly funded in acknowledgement of the critical impact that sustained access to nutritious food can have on individual and population health outcomes.

When speaking about expanding private health care options, a few participants noted that other countries do have more of a public–private mix in their health systems but that these countries have much more “robust social safety nets,” such as subsidized childcare and enhanced unemployment and retirement benefits. These participants therefore emphasized that when we are speaking about the public–private interface in Canada and comparing the Canadian health system with other comparator countries, we need to account for these distinct realities because it is not a comparison of “apples to apples.”
Exploration, evaluation and updating of the definition of “medically necessary”

Throughout the dialogue, a 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. Some participants noted that what is deemed medically necessary is negotiated and varies across jurisdictions and “they get it wrong all the time.” Several people felt that it was not for them to determine, but that there is a need to expand the definition of “necessary” medical services in Canada, so services such as prescription drugs, dental care, physiotherapy and mental health care would be publicly financed. In line with the recommendation to put greater focus on the social determinants of health, some physicians recommended that we should consider other key aspects of a person’s health to require medically necessary treatment, outside of what are typically deemed “health services,” including food security, housing, prevention and wellness care, to name a few.

Strengthening primary care

The majority of participants strongly supported strengthening team-based primary care in the province and country. Primary care was recognized as the “fundamental foundation of the health system” and there was overall consensus that primary care in Canada requires enhanced and sustained support. The importance of longitudinal, continuous care was emphasized, in addition to how vital it is for patients to be attached to the health system through primary care.

A number of participants voiced significant concerns about the current state and future of primary care. For example, it was noted that many medical students and residents are being actively discouraged from practising family medicine as mentors are telling them how challenging and expensive it can be in comparison to other specialties. To effectively support family physicians and the future of family medicine, some participants recommended that it is critical to support interprofessional team-based primary care as physicians can no longer be the “quarterback of everything.”
Learning health systems and innovation

Several participants underscored the importance of quality, both in terms of having a quality health system and the need for providers to provide quality and safe care. Physicians in the dialogue expressed concerns with quality both in the publicly and privately funded health systems. The concept of learning health systems was referenced as a model to strive for in health care to promote quality and safe care. A learning health system approach is focused on developing partnerships between researchers, clinicians and the community to create evidence-informed interventions that are evaluated and adjusted in real time. As a starting point, participants underscored the need to take stock of everything currently happening in public and private health systems in Canada as there is currently not a clear picture. They emphasized it is critical to first understand what is actually happening on the ground and what is working and not working before making additional recommendations and/or piloting new programs. Some participants also mentioned that it is important for governments to recognize and support the innovations that are currently happening within the public health system before going to the private sector to advance innovations.

Transparency and accountability

Several participants indicated that transparency and accountability are fundamental to a well-functioning health system and that they are interdependent principles. Many physicians in the dialogue felt that there is not enough transparency and accountability in privately funded and delivered health systems and that there is a critical need to address large conflicts of interest. In particular, it was noted that there needs to be more clarity on “what is going into whose pocket” and that business interests in health care must be transparent. Some participants felt that private health care is a “no brainer” because of economic necessity; however, others voiced strong concerns about the inability to hold the private sector accountable.

Many felt that a fundamental way to build transparency and accountability in the health system is by ensuring citizens have access to reliable and timely data on the key dimensions of health care quality, including safety, timeliness, effectiveness, equity and efficiency. For example, it was noted that Canada should have guidelines on wait times that are tracked across the country and transparently shared with patients and the public, and if these standards are not being met, there should be mechanisms to hold health systems accountable. It was also recommended that public and private health systems should be equally held accountable to the Quintuple Aim.¹

¹ The Quintuple Aim is centered on five overarching goals to redesign health systems: enhancing the patient care experience, improving population health, reducing costs, promoting health provider well-being and advancing health equity.
Polarity management lens

The importance of using a polarity management lens was emphasized in the dialogue. A polarity management perspective was described as moving beyond “either/or” thinking to “both/and” and is a framework that tries to encourage individuals to see the whole picture, recognizing that two distinct aspects or issues can be polarities yet also interdependent. Fundamentally, it acknowledges that there is often more than one right answer; there could be two, three or four right answers. It was suggested that this lens should be adopted in discussions on public and private health care and in considerations of what should be the key tenets of the Canadian health system. For example, it was noted how some key principles will always be in tension with each other, such as choice and equity and autonomy and accountability. So, to foster health system improvement and transformation, it is critical to take a polarity management lens to understand and acknowledge these tensions and develop balanced solutions to create a more equitable, safe and well-functioning health system and improve health outcomes.

“If it actually creates a Quintuple Aim system, it actually doesn’t matter if it’s privately or publicly done... rather than get[ting] stuck on some type of list, [we should] think about the outcomes.”
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 in Canada and foster a healthy and safe work environment for providers.

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

- **Prioritize health equity:**
  - Redesign the health care system to shift the focus from an illness-based model to preventive measures by prioritizing upstream investments in the social determinants of health, such as food security and housing, to promote a holistic approach to patient care and eliminate health disparities.
  - Ensure everyone in the health system adheres to equity, diversity, inclusion, reconciliation and accessibility (EDIRA) principles.

- **Strengthen primary care:**
  - Scale up team-based models of care to optimize health providers’ skills, prevent burnout and improve access to care across the country.

- **Implement learning health systems:**
  - Create an inventory of everything currently happening in public and private health systems in the country.
  - Develop partnerships between researchers, clinicians and the community to create and analyze evidence-informed interventions that are evaluated and adjusted in real time so innovations that work well can be scaled up and those that are not can be eliminated.

- **Enhance transparency and accountability:**
  - Implement and track national standards and guidelines on key health performance indicators, such as wait times.
  - Promote public access to reliable and timely data on the key dimensions of health care quality, including safety, timeliness, effectiveness, equity and efficiency.
  - Hold public and private health systems accountable to the Quintuple Aim.

- **Adopt a polarity management lens:**
  - Recognize and account for the key tensions that exist in the Canadian health system, such as choice and equity and autonomy and accountability, to try to determine balanced solutions that will improve both health system performance and individual and population health outcomes.
What’s next?

The session in Halifax was the fifth 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:

- 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 Halifax 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.

We know that privately funded care already exists in Canada, where it is estimated to account for 29% of health care spending. 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, Physicians, Diagnostics</td>
<td>Public taxation</td>
<td>Mixed delivery, but largely <strong>private</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For example:</td>
</tr>
<tr>
<td></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 Community health centres</td>
<td>Public taxation</td>
<td>Typically <strong>public</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For example: municipal run community resource centres,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sexual health clinics, immunization services, harm reduction</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Mixed funding Public taxation</td>
<td>Mixed delivery</td>
</tr>
<tr>
<td>Home care</td>
<td>Private taxation</td>
<td>For example:</td>
</tr>
<tr>
<td>Long-term care (LTC)</td>
<td></td>
<td>• In Nova Scotia 14% of LTC homes are <strong>publicly</strong> owned</td>
</tr>
<tr>
<td>Mental health care</td>
<td></td>
<td>and 86% are <strong>privately</strong> owned. ³</td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
<td>• BC, Saskatchewan and the territories largely <strong>publicly</strong></td>
</tr>
<tr>
<td>Vision care</td>
<td></td>
<td>deliver home care, whereas all other provinces typically</td>
</tr>
<tr>
<td>Outpatient physiotherapy</td>
<td></td>
<td>contract <strong>private</strong> companies to deliver home care services.</td>
</tr>
<tr>
<td>Complementary medicine (e.g., massage therapy)</td>
<td>Private insurance Out-of-pocket</td>
<td>• Most dentists and optometrists work as independent,</td>
</tr>
<tr>
<td></td>
<td>payments (private)</td>
<td><strong>private</strong> contractors or employees for a <strong>private</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>employer.</td>
</tr>
</tbody>
</table>

² Canadian Institute for Health Information. [Who is paying for these services?](#). Accessed Feb. 2, 2024.
³ Canadian Institute for Health Information. [Long-term care homes in Canada: How many and who owns them?](#). Accessed Feb. 2, 2024.
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 Nova Scotia, out of the 86% of LTC homes that are privately owned, 44% are owned by private for-profit organizations and 42% are owned by private not-for-profit organizations.\(^4\)

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)

Thursday, January 25, 2024 – 5-8:30 pm AT
The Prince George Hotel Halifax, Windsor One 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 (AT)</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 and warm-up</td>
</tr>
<tr>
<td>6-6:40 pm</td>
<td>Context-setting presentation 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 and closing</td>
</tr>
</tbody>
</table>