WHAT WE HEARD

REPORT

NATIONAL CONVERSATION ON PUBLIC AND PRIVATE HEALTH CARE IN CANADA

JUNE 2024
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Introduction

This report summarizes what the Canadian Medical Association (CMA) has heard over the past several months in a series of national consultations held in 2023 and 2024 to gain a better understanding of what people across the country think about the state of health care in Canada and what mix of public and private health care funding and delivery is most appropriate.

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

Context setting

The CMA made the decision to facilitate a national conversation on the mix of public and private health care funding and delivery in Canada because we recognize that the country is at a critical juncture, where many people are feeling the dire impacts of a crumbling health system. In a national Angus Reid Institute survey released in August 2023, approximately seven in 10 (68%) respondents indicated that the quality of health care in Canada has deteriorated in the last 10–15 years, and 63% reported either “some challenges” or “chronic difficulties” accessing care. Additionally, it is widely estimated that more than 6.5 million people in Canada do not have access to primary care.

In the wake of these challenges in accessing health care, more private funding and delivery options are rapidly being explored and implemented. For example, the COVID-19 pandemic accelerated the adoption of virtual care across the country, which has led to a large number of private companies stepping in and offering for-profit and not-for-profit virtual care services, in some cases paid for out of pocket by patients and in others paid for through public health insurance.

In addition, a growing number of private for profit-clinics are delivering:

- specialty surgeries (e.g., joint replacement, eye surgery, hernia repair);
- diagnostic imaging (e.g., x-rays, MRIs, CT scans, ultrasounds); and
- primary care and boutique health services (e.g., 24/7 access to physicians, private-pay clinics led by nurse practitioners and pharmacists, executive health assessments).
When assessing the state of public and private care in the country, it is important to first understand how the health system currently functions. The Canadian health system is often described as publicly funded, but the reality is more nuanced. In Canada, as in many other countries, the health system is comprised of a mix of public and private health care delivery and funding, as follows.

**Funding**

Today, approximately 70% of health care is publicly funded through general taxes, with the remaining 30% privately funded through private health insurance and out-of-pocket payments. For instance, hospital and physician services are almost completely publicly funded (although they may be privately provided), while other services such as home care, long-term care, prescription drugs dispensed in the community and dental care are supported by a mix of public and private.

**Delivery**

The public–private mix has long existed in the delivery of health care. For example, most hospitals in Canada are public or private not-for-profit organizations, and long-term care homes are a mix of public, private not-for-profit and for-profit organizations. Additionally, local public health units are typically run by the public sector, whereas most physician practices are private with a larger portion (50%-60%) delivering care under the umbrella of a medical professional corporation.
The table below provides highlights of how the Canadian health system operates.

<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</td>
</tr>
<tr>
<td>Physicians</td>
<td></td>
<td>For example:</td>
</tr>
<tr>
<td>Diagnostics</td>
<td></td>
<td>• Hospitals are run by <strong>public</strong> or <strong>private</strong> not-for-profit organizations.</td>
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<tr>
<td></td>
<td></td>
<td>• Family physicians often bill provinces and territories as independent, <strong>private</strong> contractors.</td>
</tr>
<tr>
<td>Public health</td>
<td>Public taxation</td>
<td>Typically <strong>public</strong></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>Private insurance</td>
<td>• In Nova Scotia 14% of LTC homes are <strong>publicly</strong> owned and 86% are <strong>privately</strong> owned.²</td>
</tr>
<tr>
<td>Mental health care</td>
<td>Out-of-pocket payments <strong>(private)</strong></td>
<td>• In BC, Saskatchewan and the territories home care is largely <strong>publicly</strong> delivered, whereas all other provinces typically contract <strong>private</strong> companies to deliver home care services.</td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
<td>• Most dentists and optometrists work as independent, <strong>private</strong> contractors or employees for a <strong>private</strong> employer. Public provision of dental care is just beginning.</td>
</tr>
<tr>
<td>Vision care</td>
<td></td>
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<tr>
<td>Outpatient physiotherapy</td>
<td></td>
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</tr>
<tr>
<td>Complementary medicine (e.g., massage therapy)</td>
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Further clarity, research and evidence are required to determine what models of health care financing and delivery will result in the best patient outcomes. This is why we decided to conduct in-depth research on the topic, in addition to hosting a series of country-wide consultations. This report summarizes what we heard in those discussions. More information on the research the CMA commissioned can be found in the report entitled *Public and private health care in Canada: What does the evidence say?*³
Overview of engagement process

Between September 2023 and February 2024, the CMA engaged with more than 10,000 Canadians to learn about their experiences with public and private health care. The people we spoke with, which included health care providers, persons with lived experience (PWLEs)\(^a\) and the public, shared their thoughts on the current mix of public–private health care funding and delivery in the country, as well as their values, hopes and suggestions for the health system they want moving forward.

Surveys

In June 2023, the CMA launched the engagement process by conducting surveys with the following objectives:

- to understand the current state of knowledge about public and private provision of health care
- to understand how people in Canada use/experience public–private access to health care, focusing on key challenges
- to understand how Canadian physicians use/operate public–private access to health care, focusing on key challenges
- to understand the multitude of priorities that physicians and patients in Canada have when it comes to health care

Two surveys were sent out (one targeted at physicians and medical learners, and one conducted separately with a public opinion research company) between June 20 and 30, 2023.

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\(^a\) The term persons with lived experience typically includes patients, caregivers and those who may actively avoid the health care system or who want access but cannot receive care.
Town halls

The CMA also sponsored a series of bilingual town halls with *The Globe and Mail*, called “Public-Private Health Care – Can we find the right balance?” between September 2023 and January 2024.

Four in-person and virtual events, hosted in Toronto, Montreal, Vancouver and Halifax, brought together health care providers, community health leaders, patients, advocates, entrepreneurs and others in the health space to participate in the discussions.

In total, **more than 7,000 people** were engaged in the town halls, either in person or virtually, and approximately 470 questions and comments were submitted.

A summary of these town halls can be found in the report entitled *Public–private health care: finding the right balance*.

Focused dialogues

To learn about physicians’ and PWLEs’ diverse perspectives and experiences with public and private health care in Canada, the CMA also held **17 focused dialogue sessions**, in person and virtually. We engaged with nearly 500 people in small group discussions as part of this process.

In-person sessions were held in six provinces — Ontario, Quebec, British Columbia, Nova Scotia, Saskatchewan and Alberta. In each province, the CMA hosted two focused sessions: **one for PWLEs and one for physicians**. At each focused dialogue, participants had the opportunity to share their experiences and insights. Each group spent three hours together, focusing on the following:

- understanding the context of health funding and delivery
- learning from one another’s experiences in the current system, both positive and negative
- sharing their hopes and fears for the future of health care in Canada
- discussing in small groups the key principles that should be upheld in health care
To broaden our reach and provide an opportunity for those outside of the cities where in-person dialogues were held, and to try to reach Canadians in typically under-represented populations and in rural and remote communities, we also hosted five virtual sessions: two PWLE sessions and three physician sessions. These sessions were similar in design to the in-person dialogues.

Participants in the focused dialogues included people from diverse age groups, genders and self-reported equity-deserving groups, including First Nations, Inuit and Métis persons, 2SLGBTQIA+ persons, racialized persons, persons living with a disability and newcomers to Canada (i.e., immigrants, new citizens, permanent residents, refugees), among others.

- For the PWLE-focused dialogues, we sought additional perspectives such as lived experiences with health care, experience as a patient and/or caregiver and experience with patient advocacy.

- In the physician-focused dialogues, we also asked about the patient population served (i.e., urban, rural, small town and remote settings).

Summary reports from each of these focused dialogues can be found in the CMA’s Digital Library.
CMA community platform

To complement the in-person and virtual focused dialogues, an asynchronous option was made available to physicians, medical learners, PWLEs and members of the public on the CMA Community Platform, a virtual space that allows participants to engage in discussions and share resources on topics of interest.

Using this platform, we asked physicians and PWLEs for their thoughts on the mix of public and private health care in Canada. Specific questions included “What are important attributes of your ideal health system?”, “Should patients have the option to pay for health care services?” and “Should physicians have the option to choose their working environment?”

Limitations

Despite concerted attempts to include diverse voices throughout the engagement process, we recognize that key voices are missing. In particular, we acknowledge and respect that Indigenous Peoples have distinct rights and experiences within the Canadian health system that were not fully captured in the discussions or in this report, although there was Indigenous representation at some of the sessions.

We were also unable to conduct in-person sessions across the entire country, notably the territories. We tried to mitigate this limitation by offering virtual sessions so those outside of the areas we visited could participate, but we appreciate that this is still a limitation that may have had an impact on what is and is not contained in this report.
What we heard

This section provides an overview of the comprehensive input the CMA received in 2023 and 2024. A summary of the sponsored The Globe and Mail town halls can be found in this report: Public–private health care: finding the right balance.

Key themes

Those involved in the engagement process were asked to provide their opinion on the role of public and private health care delivery and funding in Canada. In the focused dialogue sessions, participants provided more specific insight on what they think should be guiding principles to shape the health system they want moving forward. Below are some of the key themes identified.

Equity

Equity was highlighted as a foundational principle that should be integrated within and across the Canadian health system. This included equitable access to health care regardless of race, gender, sex, sexual orientation, age, disability, religion language or other factors. The majority of participants also emphasized that health care should be provided on the basis of need and not ability to pay, as outlined in the Canada Health Act. Some voiced concerns about the patchwork care people in Canada receive on the basis of where they live and suggested that there needs to be a “truly national” health system without significant variation between jurisdictions.

Many participants expressed fears that the increasing role of the private sector in health care would prioritize profit over patient outcomes and that access to quality care would be divided along class lines. Significant concerns were expressed that those who can afford to pay are able to jump the queue for care and those who cannot fall through the cracks, leading to preventable harms and deaths. The majority of participants felt that the primary emphasis needs to be placed on equity when discussing and determining health system funding and delivery mechanisms and that the Canadian health system should adhere to equity, diversity, inclusion, reconciliation and accessibility (EDIRA) principles.

“If publicly funded treatment is not available, allowing others to bypass the line results in inequity for those already in line.”

“I hope that we continue to have a universal health care system that bases priority on equity.”

“No one should be left behind.”
Health promotion and preventive care

The majority of participants suggested that we need to move away from an illness-based health system to one focused on prevention and healthy living. Several people felt that we should be taking a “whole-community approach” to health care that recognizes and accounts for the social determinants of health and incorporates social prescribing.\(^b,c\) Many emphasized that there are personal, social, economic and environmental factors that have not traditionally been considered to be related to health care (e.g., geographic location, income) that can dramatically influence a person’s and/or population’s health outcomes and that can directly contribute to health inequities if not sufficiently addressed.

It was therefore underscored how important it is to advocate not only for health system funding and reform but also for sustained investments in housing, food security and community-based initiatives to support a preventive approach to health and health care. Some participants described how countries with “robust social safety nets,” which include publicly funded supports or programs such as subsidized childcare, enhanced unemployment and retirement benefits and universal prescription drug coverage, typically have better health outcomes.

In line with this, it was emphasized that the care that can most significantly improve someone’s health may not be a health service. For example, some 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. Overall, participants strongly expressed the view that the health system should be redesigned to prioritize upstream investments in the social determinants of health to promote a holistic approach to patient care and eliminate health disparities.

\(^b\) As the World Health Organization describes, the social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life.

\(^c\) As the Canadian Institute for Social Prescribing describes, social prescribing enables health care providers to refer patients to local, non-clinical services, including community and social services.
Team-based primary care

The support for team-based primary care was heard loud and clear. Many participants described primary care as the foundation of the health system and said that strengthening and scaling up publicly funded, team-based primary care would fundamentally improve patient outcomes, create better working environments for providers and enhance access to care for everyone in Canada.

A geographic- or community-based model for primary care, similar to the model used in the public education system, was frequently suggested. With this model, patients could be enrolled in interdisciplinary regional primary care teams that would consist of a wide range of health care providers such as physicians, physician assistants, nurses, psychologists, occupational therapists and social workers. This way, everyone in Canada could be attached to the health system and receive the medical and social supports they need for their health and well-being in the community.

Sustainable public funding for this model of primary care was viewed by participants as a sound upstream investment in preventive care. Attachment to a primary care team with a network of health care providers would help ensure the most appropriate care is provided in a timely manner by the right provider and that patients receive comprehensive, continuous care throughout their lives. It would also reduce downstream demand on overstretched emergency departments and other acute care services.

“I am afraid the public–private conversation is the next shiny thing, and we don’t look at the fundamental foundation of the health system [which is] primary care...we need to change how we see the system and invest more into primary care.”

“It would be great if all health care team members could practise to the top of their scope and there was skill/task alignment.”
The need to strengthen Canada’s publicly funded health system

Throughout the discussions, there was strong emphasis on the need to further support and invest in Canada’s publicly funded health system. Many participants highlighted 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 stressed that Canada needs to have enough registered nurses to meet patient demands.

Despite calls for enhanced support, many participants acknowledged the finite resources in the public sector, and they recognized that investments alone will not be enough to strengthen our publicly funded health system. For example, many participants underscored the importance of integrated health human resources planning, with one noting that “it’s better to have more task sharing within the public system than to increase private delivery.”

“We should focus on the system we want. Don’t start with the assumption that we cannot fix the problem. We should focus on public funding and be fully committed to that goal.”

“It’s better to have more task sharing within the public system than it is to increase private delivery.”

“All health care should be publicly funded at the end of the day, but it needs to be more robust and have more accountability and transparency.”

But some participants felt that the assumption that public resources are finite should be more closely examined, pointing out that certain people and corporations might not be paying their “fair share” of taxes. Others highlighted the need for higher taxes for everyone if we wish to emulate health systems in other countries; they argued that Canadians could actually save on health care costs if more public money was directed to the health system because they would then not have to pay as much out of pocket or through private insurance for certain health services. Other participants felt that Canadians were being taxed enough.

The majority of participants expressed the view that providing comprehensive care is critical and that the range of publicly funded health services should be reviewed and updated. For the most part, participants felt that health services such as prescription drugs, dental care, physiotherapy, mental health care, eye care, community rehabilitation services, home care and palliative and end-of-life care should be publicly financed.
Patient-partnered and -centred care

The majority of participants, particularly in sessions with PWLEs, indicated that they want to see a health system where patients' rights are upheld and care is focused on patient safety. It was recommended that a key way to achieve this is by promoting patient-partnered and -centred care. In all of the PWLE-specific dialogues, participants highlighted that patients, families and caregivers should be full and equal partners in their health care journey.

A key suggestion was to create more patient advocate positions in the health system as they play a critical role in enhancing communication between patients and providers and promoting an empathetic, relational and inclusive approach to health care. Many PWLEs emphasized that it is not the sole responsibility of physicians to advocate for patients and that many patients want and are prepared to take full responsibility for their health and to work collaboratively with their health care teams to co-design and implement solutions. This would mean that patients are not merely recipients of care but are also accountable for their health outcomes.

“...system that exists for patients, but our health care system is not built for patients.”

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

Both physicians and PWLEs felt that a key aspect of promoting patient-partnered care is ensuring that patients have access to their health records. The idea of one patient, one record was strongly supported in discussions; it was noted that patients and providers’ timely, reliable access to complete and accurate health records is a critical component of quality, integrated and safe care. Participants strongly expressed the view that if patients and caregivers were empowered, educated and engaged as authentic partners the health system would become more efficient and would function better.
Transparency and accountability

Participants strongly voiced the view that the Canadian health system, regardless of how it is funded and delivered, must be transparent and accountable to patients, providers and the Canadian public. Many felt that these principles are interdependent and foundational to having an efficient and effective health system.

It was emphasized that more transparency is needed within both the public and private health systems so that citizens can effectively hold governments and other health sector actors accountable. Participants stated that they would like to see routine and standardized data collection and public reporting on key indicators of health system performance, such as safety, timeliness, effectiveness, equity and efficiency. For example, it was noted that Canada should have benchmarks 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.

Another key recommendation was to track and publicly report patient and population health outcomes at a national level and to ensure public and private health systems are equally held accountable to the Quintuple Aim.

The lack of oversight and regulation in the private sector was of particular concern throughout the discussions. Participants noted that there is a critical need to disclose and address conflicts of interest, provide more clarity on “what is going into whose pocket” and be transparent about business interests and profit motives in health care. This would include developing a better understanding of the costs and fees paid for publicly delivered versus privately delivered surgical procedures and imaging, for example. Some participants felt that private health care options should be further explored and utilized to facilitate access to care; however, others voiced strong concerns about the inability to hold the private sector accountable.

The Quintuple Aim

is centred on five overarching goals to redesign health systems:

1. Enhancing the patient care experience
2. Improving population health
3. Reducing costs
4. Promoting health provider well-being
5. Advancing health equity
Overall, there was a strong consensus that **more robust external oversight is needed** for both the public and private health systems to ensure that health care decisions are made in patients’ best interests and free from political and financial bias and influence. Many participants recommended the creation of a fully independent oversight body that would include provider and patient representatives in a leadership role. It was proposed that this oversight body could serve as a “health quality council” and function at a pan-Canadian level to monitor and report on the delivery and financing of health care, health system performance and individual and population health outcomes. This way, as a country with 14 different health systems (operated by the federal government and 13 provinces and territories), we would be able to work together more effectively to learn and correct as needed and sufficiently invest in and scale up promising practices and successful initiatives.

“We seem to treat the private and public sectors as if they operated on the same level, even though they don’t have the same interests. The private sector is accountable to its shareholders.”

“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.”
Learning health systems

Several participants underscored the importance of quality, both in terms of the need for a quality health system and the need for providers to provide quality and safe care, regardless of whether health care is privately or publicly financed and delivered. The concept of “learning health systems” was referenced in some focused dialogues as a model to strive for to promote quality, safe and efficient care. A learning health system focuses on developing partnerships between researchers, clinicians and the community to improve research and 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 not a clear overall picture at the moment. They emphasized that it is critical to first understand what is actually happening on the ground and to conduct real-time research and evaluation to determine what is working and not working before additional recommendations are made and/or new programs are piloted. Several people also noted that collecting and sharing standardized, accurate and reliable data, and keeping this information in a centralized place, would enhance transparency and help address conflicts of interest within the system.

Many participants saw opportunities to learn from efficiencies happening in the private sector, which would include leveraging technology to promote innovation in the health system. Others mentioned that it is important to recognize and support the innovations that are currently happening within the public health system.

“[The] health system can be structured in a sustainable way with a rational approach to costs based on best evidence and outcomes.”

“We aren’t making the best use of our resources... the work needs to be shared in a more efficient way.”
Areas of tension

Although there was general agreement on several guiding principles for Canadian health care, some principles were debated at length, with no solid consensus emerging from the discussions.

In one of the focused dialogues, the importance of using a polarity management lens was emphasized when analyzing and discussing key areas of tension. A polarity management perspective was described as moving beyond “either/or” to “both/and” thinking, a framework that encourages individuals to see the whole picture, recognizing that two distinct aspects or issues can be perceived to be polarities, but are also interdependent. Fundamentally, this 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 applied when discussing public and private health care, particularly when concepts appear to lack consensus and/or be in contention with each other.

The two key principles that sparked major debate are highlighted below.

Timely access

There was strong consensus that everyone in Canada deserves timely access to care. However, many participants had questions about what timely access means. 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.

Some participants felt strongly that patients should have options outside of the publicly funded system if they need care critically and wait times are excessive. They saw these types of options as temporary solutions to prevent harm to patients while they wait for care. A large number of participants felt that people who can afford to pay for care privately should have the option to do so.

On the other hand, several participants in both the physician and PWLE sessions strongly emphasized that promoting timely access should not jeopardize equity and that all people in Canada should have access to “quality care at the right time in the right place that is affordable.” It was strongly emphasized that all seriously ill patients should have timely access to care and that it would be inequitable for some patients to be able to seek private options and receive more timely care simply because they can afford to do so. The people who expressed this view primarily felt that timely access to care could be enhanced by strengthening and sustainably investing in the public health system, rather than relying on private care options.

Overall, participants expressed a variety of opinions on how to promote timely access to care, although they all agreed that timely access is essential.
Choice

Another principle that was extensively debated was choice. Participants emphasized the importance of first clarifying what we mean by choice, as there are several aspects of choice to consider when it comes to health care. For example, there is the issue of patients having the ability to choose their care providers, including physicians. Some participants explained how citizens in other countries can see health providers’ safety profiles and clinical outcomes and this information gives patients more insight into whom they should select to do their procedures. Others felt that patients should not be able to choose their health providers because, 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 [many patients] barely have one option.”

Physicians’ ability to choose their practice environment was also debated, largely in the physician-focused dialogues. In particular, apprehensions were expressed around physicians working in a private, for-profit environment. Key concerns included physicians being selective in choosing patients and clinical acuity profiles, their working hours and their areas of focus, and that the public system might bear the burden of handling more complex cases. This raised questions for some around the perceived lack of responsibility private providers and organizations have to patients and the broader health system, which underscores the need for stringent regulation and accountability measures for practitioners in both systems.

Another key 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.

“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?”

“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.”

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Several people felt that the idea of choice or options cannot be discussed without factoring in equity considerations. As some participants explained, “all options will affect equity — everyone is at different scales on the social determinants of health” and “the bottom line is they are asking should patients have the option … but the majority of people in this room will say they don’t have the option. It’s not as cut and dry.” Ultimately, the discussions with physicians and PWLEs did not yield any clear consensus on the concept of choice and how and if it should be applied in the context of the Canadian health system.

### Hopes and fears

In all of the focused dialogues, participants shared their key hopes and fears concerning the current and future state of the health system. The top 10 hopes and fears both physicians and PWLEs expressed are outlined in the table below.

<table>
<thead>
<tr>
<th>Hopes</th>
<th>Fears</th>
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<tbody>
<tr>
<td>1. Access to care is equitable and everyone in Canada has access to a primary care provider.</td>
<td>1. Introducing a private health system will divert resources from the public system.</td>
</tr>
<tr>
<td>2. Team-based, community care has been expanded.</td>
<td>2. People in Canada will not have access to affordable health care.</td>
</tr>
<tr>
<td>3. The health system increases efficiencies and wait times have been reduced.</td>
<td>3. People in Canada will not have access to a primary care provider.</td>
</tr>
<tr>
<td>4. The health system is sustainable and appropriately funded.</td>
<td>4. People in Canada will not have access to timely care.</td>
</tr>
<tr>
<td>5. The well-being of health care providers has improved.</td>
<td>5. People in Canada will experience inequities when accessing health care.</td>
</tr>
<tr>
<td>6. There are enhanced investments in health prevention and promotion.</td>
<td>6. There will be a mass exodus of health care providers.</td>
</tr>
<tr>
<td>7. PWLEs and health providers are incorporated into decision-making.</td>
<td>7. Privatization will deepen preexisting inequities and those without financial means will suffer.</td>
</tr>
<tr>
<td>8. The health system is easily navigated and patients have access to their health records and data.</td>
<td>8. Publicly funded health care will not be expanded to include other key aspects of care, such as mental health care and pharmacare.</td>
</tr>
<tr>
<td>9. [Publicly funded] health care will become more comprehensive and be expanded to include a wider range of services, including mental health care and pharmacare.</td>
<td>9. Health care will be politicized, and only short-term fixes will be prioritized.</td>
</tr>
<tr>
<td>10. Older adults will have adequate access to safe, quality health care and the right to age with dignity.</td>
<td>10. People in Canada will no longer trust that they can rely on the health system.</td>
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Despite the fears that were expressed, 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:

Prioritize equity:
- Embed an equity lens into all aspects of the Canadian health system and ensure everyone from decision-makers to providers to patients adheres to equity, diversity, inclusion, reconciliation and accessibility (EDIRA) principles.
- Promote a national approach to health care among provinces and territories by working to eliminate differences and inequities among jurisdictions.

Promote health and preventive care:
- Redesign the health care system to shift the focus from an illness-based model to preventive measures by prioritizing upstream investments in health promotion and disease prevention.
- Address the social determinants of health, such as food security and housing, to promote a holistic, whole-community approach to patient care and eliminate health disparities.

Support and scale up team-based primary care in the community:
- Strengthen and sustainably invest in publicly funded team-based primary care.
- Adopt and expand the use of interprofessional regional primary care teams across the country, using a community-based model (similar to the model used in the public education system).
Strengthen Canada’s publicly funded health system:

- Redefine and expand the definition of “medically necessary” care to be more comprehensive and include health services such as dental care, pharmacare, eye care, physiotherapy, mental health care, home care and long-term care.

Embed a patient-partnered and -centered approach:

- Respect and uphold the rights and safety of patients.
- Treat patients, their families and caregivers as full and equal partners in their health care journey by supporting shared decision-making and the co-design and implementation of solutions with their health care teams.
- Promote patients’ access to their complete, up-to-date health record.

Enhance transparency and accountability:

- Establish an independent oversight body to collect and monitor health system performance and costs, as well as patient and population health outcomes.
- Hold public and private health systems equally accountable to the Quintuple Aim and other key indicators of health system performance.

Implement learning health systems:

- Gain a complete understanding of what is happening on the ground with respect to the current public–private mix of health care financing and delivery in Canada (e.g., take stock of how many public, private not-for-profit and private for-profit clinics there are across 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.
Conclusion and next steps

The CMA greatly appreciates the time all participants took to be involved in our country-wide consultations on public and private health care in Canada. The insightful feedback and perspectives will directly inform the CMA’s future policy and advocacy in this area.

“This is a great opportunity to have a reckoning around what is expected and what is the standard of care for patients in Canada.”

References


