CHLNet
Canadian Health Leadership Network
Le Réseau canadien pour le leadership en santé

November 15, 2024

CHLNet Leadership Dialogue: The Public/Private Split in Healthcare Aggregated Highlights

Introduction

This Fall 1.5 hr leadership dialogue discussed *The Public/Private Split in Healthcare: What 21st Century Leadership Capabilities and Practices are Required?* Forty-seven leaders attended this highly engaging Chatham House Rule session. Dr. Kathleen Ross (CMA Past President) presented the Canadian Medical Association's new policy Managing the Public-Private Interface to Support Quality Care. A three-person response panel brought thought provoking perspectives and included: Dr. Greg Marchildon, Dr. Verna Yiu, and Dr. Leigh Chapman. Aggregated highlights from this very interactive dialogue are below and shared within the CHLNet value network as a basis for further conversation only.

Highlights

1. *Canada Health Act (CHA):* Aspirational principles contained in CHA and are not being meet for most Canadians. Canada has a very narrow based definition for public coverage which is why many are asking for an expansion in universal health coverage. Currently an illness-based system and the Act leaves it open for government departments to make their own decisions of where to direct services. A new paradigm of health is required, one that is wellness focused. CHA annual report is an excellent resource with three interpretation letters and intend to do a 4th to recognize the changes in healthcare.
2. *The Split Itself:* Private sector is embedded Canadian health care with a current split of 70/30. Canadian data is lacking and often difficult to compare across systems. Need to look at the details on how delivery is done and sometimes it is a being done at a private tier. Will contracting additional work to private clinics help meet needs and address wait times?
3. *International Comparisons*: No international optimal public/private balance and Canada's split is on the low end compared to other OECD countries. Need to be careful distinguishing between finance and delivery in discussing the split as most of the action is on the delivery end of that. Recent 2024 Commonwealth Study compared health system performance in 10 countries and Canada moved up to 7th place in rankings (ranking higher in the care process).
4. *System Focus Away from Provider Centric*: System needs to be built for patients, users, citizens, and taxpayers as whole. Our institutions are usually built around the needs of those providing the services. Patients deserve to be involved in changes to the system and that changes serve them. Shared decision making required in any new model.
5. *Wider Basket of Service with Clear Accountability*: Wider array of publicly funded services required but we need the system to be accountable for its results (i.e. Chief Health Accountability Officer). More investment in team-based care and fund all necessary primary care services. Will we allow exceptions to this single tier? Give choice to those who can afford it? Is it through the public purse? Tough decisions for government ahead.
6. *Widening Scopes of Practice*: Significant changes in who can provide services in the last 40 years. A reason for CHA to be changed is too physician centric for medical care services. Funding

models for all healthcare providers must be accountable to the system and this is a huge gap and creates a huge gap in outcomes. There are whole groups of providers and services (especially mental health and substance use) not covered by the CHA.

7. *More Evidence*: Lack of strong research evidence on funding within Canada. Need seamless, integrated information sharing and system. Health Canada released the nursing retention toolkit that shares evidence informed practices. Lack of evidence on centralization vs decentralization. Canada has siloed ministries for education, seniors, housing, health care, etc. For example, Denmark has centralized more in last 10 years but need to keep in mind that the entire social network is different from Canada. Is this a policy crisis or implementation one?
8. *Change Leadership*: Leadership is about change and the responsibility of leadership is to create a desire for change. Current method is individual leaders doing the best they can in their individual way, with small projects in certain areas. Best successes are from a broader view with shared risks with partners to drive those changes. We need to have a risk tolerance that we haven't had before in healthcare to implement our shared goals. Policy can be aspiration, and we need to accept that we won't get things right the first time. We pilot and pilot and pilot, with incremental change but (largely) fail in spread and scale.

"So leadership as a catalyst is important. What is it that CHLNet can bring to the table in terms of advancing health leadership into the future, not a lack of ideas but to get those ideas implemented!"