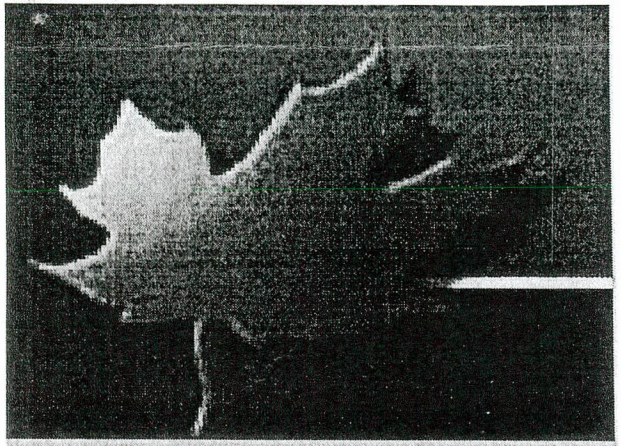


Presentation to the Department of Finance

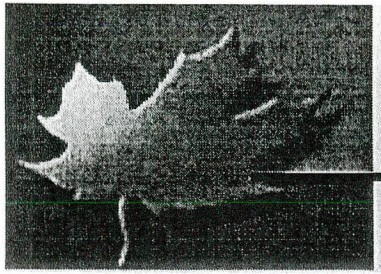
Health Care Issues
Focus Groups

June 2000

Earnscliffe
RESEARCH & COMMUNICATIONS

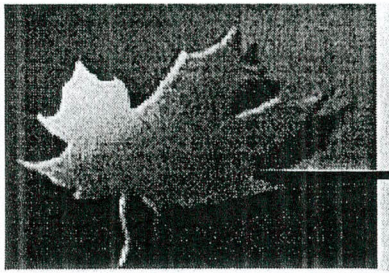
Methodology

- Three sets of groups
  - Two each night in Winnipeg, Peterborough and Montreal
  - Groups composed of Involved Canadians, those most active Canadians who are likely to be most informed and most influential
  - In Peterborough and Montreal one group was composed of people with below median household incomes and the other group of people with above median household incomes



Research Purpose and Limitations

- Designed to facilitate design of a survey questionnaire, not to provide definitive findings
- The limitations of this wave of groups must be kept in mind
  - Only qualitative, not quantitative so one cannot extrapolate findings to the general population
  - Regional gaps - no Toronto, nothing west of Winnipeg, no non Montreal Quebec, nothing in the Atlantic
  - No potential negotiating content/ scenarios presented
- Correspondingly, there are limits to the usefulness of these discussions to designing solutions
- The observations in this deck should be considered preliminary and subject to verification, but they do provide the basis for discussion



Perception that the System is Getting Worse

- In research three years ago, perceptions were driven more by media reports than by personal experience
- In these groups, most people reported personal or once removed evidence of a deterioration in health care service delivery
- Complaints centered around:
  - Waiting times for diagnostics/ test equipment
  - Waiting time in emergency
  - Waiting time for specialists, elective surgery
  - Inadequate time and care allocated to individual cases by health care providers
- Some believed that average health care in the U.S. was now better than comparable care in Canada

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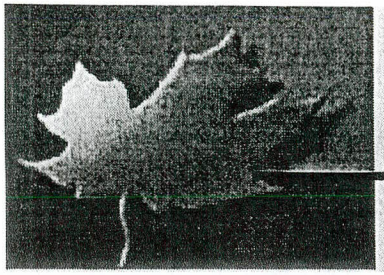
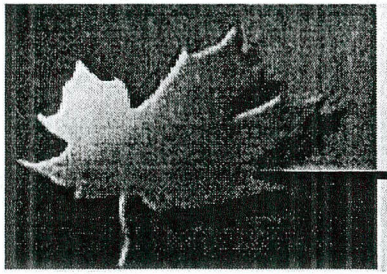


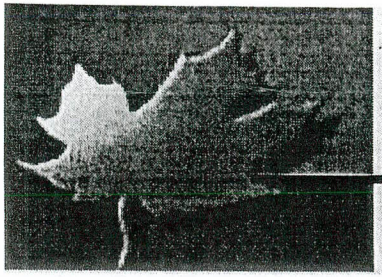
Staffing Issues Becoming Paramount

- Every group demonstrated a high level of concern about the shortages of doctors and, particularly, nurses
- This was blamed on a number of factors:
  - Low compensation for doctors and nurses -- presumed to be real and requires significant increases
  - Cut backs of nursing staff -- this (along with empty beds/ stretchers in corridors) has become a metaphor for inept and inappropriate rationalization of resources
  - Desire by doctors to have access to high quality resources to treat patients
  - Outmigration to the U.S. - evidence to some of fundamental deterioration of the system and an obstacle to rebuilding it
- These primary caregivers were presumed to be acting in good faith and have tremendous credibility on management issues



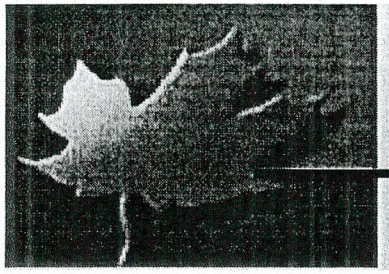
Who's to Blame?

- **Consistent with all past research, participants felt both levels of government had some amount of culpability**
  - Though most agreed the deficit was a problem that had to be dealt with, they believed the federal government cut transfers too much
  - And though they believed the provinces had little choice but to rationalize and reform the system, they seemed to believe those efforts had been badly bungled
- **Participants did not treat the issue that politically**
  - Less anger at governments than might have been expected
  - Little recognition of the 1995 transfer cuts - more sense that governments of all stripes had been cutting back for some time
  - At least as much blame ascribed to the management by the "health bureaucracy" as to elected officials



How Much is Enough?

- Most participants did not see a lack of money as the primary problem and were more inclined to blame poor management and misguided reforms
- Though most people believed more money would likely be needed, more money in and of itself did not sound to them like a solution
  - No one could hazard a guess of the amount of money that might be required or could set CHST increases into any sort of context. They were not impressed by dollar totals.
  - Simple restoration to 1995 levels was not deemed to be significant or a major achievement. There was a presumption that there has been substantial cost increase since then.
- The 1999 Budget health allocation sounded impossibly big
  - There was virtually no recall or recognition of that money or that the Budget had been focused on health
  - People had trouble understanding how so little could have changed if, in fact, new money had been added



Elements for Progress

- **In order to indicate that there *will be* progress, most people indicated two primary elements were required:**
  - Smarter management practices
    - Increased hiring of doctors and nurses, lower staff/patient ratios, more student intake
  - More money
    - Directed exclusively at health care
    - Linked to accomplishing specific outcomes
- **Most would require validation and approval of these initiatives by doctors/ nurses/ health care academics**
  - Media is insufficient and lacks credibility (less so in Quebec)
  - Simple federal-provincial agreement would be insufficient

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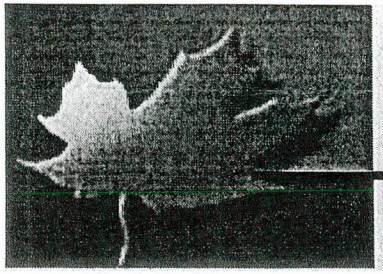

Evidence of Progress

- **In order to indicate that there *has been* progress, people will require tangible evidence**
  - These were primarily outcomes-based. People believed they need to personally see or experience:
    - A reduction in waiting times for diagnostics/testing, access to specialists, ER, access to elective surgery
    - No reports of urgent cases being sent to the U.S. for treatment
    - No visual evidence of stretchers in corridors
    - A return to traditional nurse/patient ratios in hospitals
    - Doctors allocating more time and effort to individual patients
- **Again, medical stakeholders would have to certify that progress has been made**
  - Though personal experience will be critical, most would require health care professionals to validate it

Federal-Provincial Issues

- **People continued to have little patience with jurisdictional limitations; want co-operation among governments**
  - They are, however, pessimistic about the ability of the different levels of government to work together
    - In Peterborough participants seemed to have the impression of rivalry between Premier and Prime Minister
  - Very high level of awareness among Peterborough participants of the provincial ad campaign, almost none of the federal campaign
  - In Quebec, no one could recall any advertising, federal or provincial, on health care funding issues.

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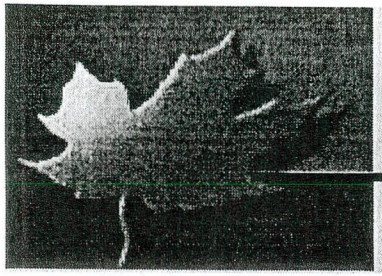

The Role For Ottawa

- Participants tended to understand health care services are a provincial responsibility and tended to believe provinces are better suited to run the system
- However, they believed the federal government role is far larger than simply providing funds
  - Most believed the federal government is a guarantor of the viability/universality of the system
  - Most believed federal government has strong role to play in setting national standards and maintaining quality and accessibility
  - Less universally true in the Montreal groups, but still the view of most in those sessions

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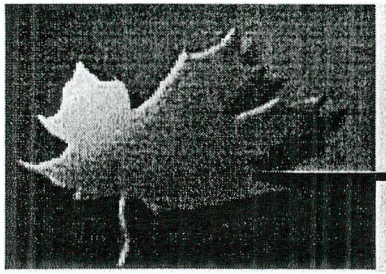

Conditionality

- **Most participants wanted some form of conditionality attached to increased federal transfers**
  - True even in Quebec
  - These would involve some sort of national standards, identification of minimal outcomes
  - Strong preference to have these negotiated and agreed to by all
  - It seemed sensible to not increase transfers without these sort of riders
- **Most participants did not like the federal "stick" of withholding funds - seems illogical response because it will exacerbate problems**

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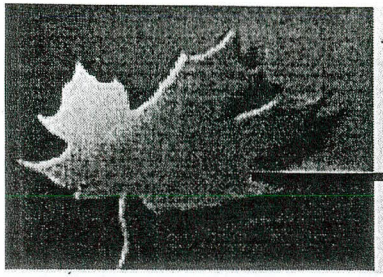
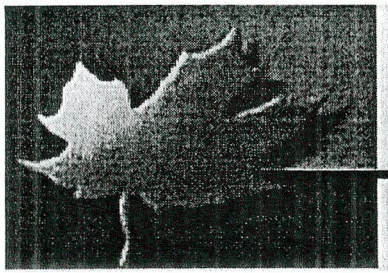


Other Variables

- Some interest in guarantees of outcomes like waiting list reductions
  - Few convinced that Patients Bill of Rights is workable
- Some approval of increasing health care research
  - But no consistent view of what that means
  - Most associate it with finding new cures
- Tentative interest in information on comparative performance of health care institutions
  - Most would find provincial comparisons interesting but not fundamentally important
  - What they would like is a comparison within their region so they can make consumer decisions



Two Tier Medicine

- There is a strong commitment to universal one-tier medicine
  - Ability to pay should not be key to access to quicker service/higher quality
  - No presumption that two tier reforms will provide the key to solving current problems
  - No demand for, interest in exploring that avenue
  - Very little understanding of Alberta initiative
- Confusion about current system differences
  - Payment for and definition of non-insurable services
  - Role of institutions like sports medicine clinics that charge fees
  - Extra fees (e.g. "tray fees" in Manitoba)

Two Tier Medicine (cont'd)

- **However, support rests on continuing high quality and resolving current access waiting times**
  - Most fully aware of ability to go to the U.S. to get quick, high quality care -- particularly diagnostic services
  - Most resent the necessity to do so
  - Most say they would pay to jump the queue if they had to
- **Current level of frustration appears to be insufficient to shake fundamental support for current system**
  - Universality principle quite deeply rooted
  - Belief that system can be saved and presumption that it will be, albeit over a long period of time and *despite* governments