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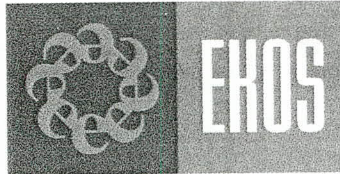

Canadians' Outlook on Health Care Reform

FINAL REPORT

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TABLE OF CONTENTS

Executive Summary iii

Sommaire vii

1. Introduction: Study Objectives and Methodology 1

1.1 Study Objectives 1
1.2 Study Issues 1
1.3 Methodology 3

2. Detailed Findings 7

2.1 Perceived State of the Health Care System 7
2.2 Suggested Improvements 9
2.3 Seeing Improvements to the System 12
2.4 Reaction to the "Health Care Guarantee" 14
2.5 Reaction to Reform Package 15
2.6 Reaction to Specific Measures 17
2.7 Federal and Provincial Government Roles 21

Appendix A: Focus Group Moderator's Guide
Appendix B: Focus Group Handout
Appendix C: Recruitment Script

Executive Summary

A total of 14 focus groups with members of the general public were conducted in seven locations across Canada. The research findings are consistent with past research on the topic. There were no surprises in the views of those who participated in the study.

a) Diagnostics and Potential Solutions

Participants express mixed views on the state of the health care system. Many still see it weakening; some see a slowing of deterioration, while a few discern improvement. The main problem is thought to be access, as exhibited by what most participants believe to be increasing wait times throughout the system. The quality of care (e.g., once one is in the hands of a physician) is generally thought to be good.

The wait times are seen as caused primarily by a shortage of doctors and to a lesser extent nurses and equipment. There is also a belief that the system is plagued by significant irrationalities, inefficiencies and patient misuse/abuse. There is particular concern over the impact of Canada's aging population and about the "brain drain" of health professionals to the United States. Personal experience and hearing of the experiences of others appear to have the most significant impact on how people judge the state of the system.

Most people see the system as being sustainable. That is, they believe it can continue with its core features intact. They also believe, however, that *status quo* will not allow the system to be sustained. Increased funding, innovation and improved management are all seen as required.

b) Reaction to the Package of Potential Reforms

The package of reforms presented in the focus groups tested well overall, although some found it uninspiring and/or overly focused on shoring-up the primary care system. The package's emphasis on long-term funding and planning; reduced waiting times through the addition of more doctors, nurses and equipment; along with the introduction of some key innovations (e.g., nurse practitioners, 24-hour clinics and home care), corresponds well with participants' own prescription for improvement and sustainability.

All five measures contained in the package are seen as significant and likely to make a positive contribution to improving the system. Priority is accorded to increased and long-term

funding and the development of more doctors and nurses in an effort to reduce waiting times across the system. Catastrophic drug coverage is seen as laudable concept, but ultimately least relevant both personally and to the system and perhaps too costly an initiative.

There is agreement that fixing the health care system is much more about commitment, implementation and ultimately political will, than it is about the need to generate ideas. People realize that the impacts of reform will take some time to work their way through the system. No one expects a quick fix.

c) Preferred Federal and Provincial Roles

There is a very strong desire to see governments agree to a long-term plan on health care reform and to "get on" with implementation. The federal and provincial governments are assigned equal blame for apparent inertia and vacillation (although some in the West assign more "blame" to the federal government). It is also apparent that accusations hurled in the war of words between jurisdictions undermine public confidence.

The provincial government is seen as chiefly responsible for health care, but the federal government is accorded an important role beyond funding. There is general agreement that the federal government can and should negotiate common standards and performance measures. This is seen as both fair/reasonable in light of the fact that it provides funding and, more importantly, it is viewed as sensible given the federal government's unique pan-Canadian vantage point.

d) Implications for Strategic Communications

It is crucial to bear in mind that any communications around health care reform will be received by a somewhat jaded and cynical audience, many of whom feel that they have "heard it all before" when it comes to a plan to improve the health care system. The problem of a sense of a system that is worsening or eroding — to the extent that it exists — is one that has been years in the making. Quantitative findings that suggest a recent improving trend in views of the system have occurred only after a series of extremely high profile efforts to improve the system (e.g., the Health Accord, Romanow, and so-called Federal "Health Budget") and recall of these appears to be waning rapidly. Ultimately, there is no quick fix or magic bullet from a communications point of view.

While most participants say they will judge the impact of any health care reform with their own experiences in the system, we would imagine that they are in fact under-representing the

impact of media coverage in helping shape their attitudes. As the reforms, by their very nature, are geared towards a longer-term window, any communications impact must necessarily be gained through the media. In order to heighten awareness of the reform package and bring Canadians on side with it, two pre-conditions seem essential:

- The package must be presented in the media as one that carries consensus support from most (ideally all) provinces and territories, as well as the greatest number of stakeholder groups as possible.
- There must be some visible steps of concrete action (be it funding, high profile announcements, etc.) beyond structural/organizational issues — i.e., a framework for action will not cut it here as Canadians will likely see that as simply "more talk, no action."

The package must ultimately be portrayed — and seen — as being qualitatively different from previous reform efforts that many have either forgotten or (worse) see as having been public relations exercises with no real impact.

To further complicate the situation, different groups and regions will likely be looking to the Government of Canada for different roles. In recent quantitative work carried out for the Department, we found, for instance, that greater levels of concern with the quality of the system are evident in British Columbia and the Atlantic region. In B.C., however, residents who see the system in decline are more likely to see their provincial government as being at fault, with the reverse true in Atlantic Canada. This suggests that some will look to the Government of Canada for a watchdog/view from the bridge role, riding herd over their provincial government and others will likely see the federal government in more adversarial terms.

The key messages that should likely be emphasized include:

- That governments across the country have clearly heard the concerns voiced by citizens and are acting to restore confidence in this area of paramount importance to Canadians;
- That the time for inter-jurisdictional squabbling is long past and collaborative action is now the order of the day;
- That the reforms will address urgent needs (e.g., wait times, doctor shortages) as well as foster innovation and the long-term sustainability of the system (e.g., 24-hour clinics, nurse practitioners); and

- That governments are fulfilling their responsibilities in terms of addressing the evolving health care needs of Canadians (such as home care, care for an aging population, etc.).

A wild card during this public debate is the notion of a private sector role in the health care system. The ground staked out by the federal government in this area likely meets with broad current support, but there are a number of exposures as well. Some will argue that any private sector delivery is tantamount to a two-tier system with others arguing that it is disingenuous to deny the existing role of private delivery of publicly funded services (and that this may be key to innovating the system and make it more efficient).

Sommaire

Au total, 14 discussions de groupe avec des citoyens ont eu lieu à sept endroits répartis à travers le Canada. Les résultats de la recherche sont conformes à ceux qui ont été obtenus par le passé sur le même sujet. Les points de vue exprimés par les personnes ayant pris part à cette étude n'ont pas produit de surprises.

a) Diagnostic et solutions possibles

Les participants ont exprimé des opinions diverses sur l'état du système de soins de santé. Un grand nombre estiment qu'il se détériore tandis que quelques-uns y voient de l'amélioration. Le principal problème semble être celui de l'accès, ainsi qu'en témoignent la plupart des participants qui croient que dans l'ensemble du système, les listes d'attente ne font que s'allonger. La qualité des soins (une fois qu'on a pu avoir accès à un médecin) est bien perçue de façon générale.

Les listes d'attente paraissent surtout attribuables à la pénurie de médecins et, dans un moindre degré, à la pénurie d'infirmières et d'équipement. On croit aussi que le système est affligé par des mesures irrationnelles, de l'inefficacité et le mauvais usage ou les abus de la part des patients. On s'inquiète en particulier des effets du vieillissement de la population canadienne et de la « fuite des cerveaux » vers les États-Unis parmi les professionnels de la santé. Les expériences personnelles et le ouï-dire paraissent le plus influencer le jugement que les gens portent sur l'état du système de santé.

La plupart des gens croient que le système est durable. Autrement dit, qu'il pourra se poursuivre tout en conservant ses caractéristiques essentielles. Par contre, les gens croient que le *statu quo* ne permettra pas au système de se maintenir. Il faudra y injecter de l'argent frais, innover et améliorer sa gestion.

b) Réaction au train des réformes potentielles

Le train de réformes présenté aux groupes-témoins est bien perçu en général quoique certaines personnes le trouvent peu inspirant et/ou estiment qu'il cherche trop à soutenir le système de soins primaires. L'accent mis sur le financement et la planification à long terme, la réduction des listes d'attente par l'ajout de médecins, d'infirmières et d'équipement, de même que l'introduction de certaines innovations (p. ex., infirmières praticiennes, cliniques ouvertes 24 heures

par jour et soins à domicile) correspondent bien aux mesures souhaitées par les participants pour un système meilleur et durable.

Les cinq réformes envisagées sont toutes jugées significatives et susceptibles de contribuer à l'amélioration du système. La priorité est accordée au financement accru et à long terme de même qu'à la formation d'un plus grand nombre de médecins et d'infirmières dans le but de réduire les listes d'attente dans l'ensemble du système. L'assurance des médicaments dont le coût est prohibitif est perçue comme un concept intéressant mais arrive en dernier sur l'échelle de la pertinence, tant pour soi-même que pour le système, et semble être, en fin de compte, une initiative trop coûteuse aux yeux des gens.

On s'accorde à dire que la remise en état du système de soins de santé est davantage une question d'engagement, de mise en oeuvre et, en définitive, de volonté politique que de la nécessité de trouver de nouvelles idées. Les gens reconnaissent que les effets de ces réformes mettront du temps à se répercuter à travers tout le système. Personne ne s'attend à un miracle.

c) Rôles que devraient jouer les gouvernements fédéral et provinciaux

On souhaite vivement que les gouvernements s'entendent sur un plan à long terme pour réformer les soins de santé et qu'ils le mettent en œuvre sans tarder. On jette le blâme aussi bien sur le gouvernement fédéral que les provinces pour leur apparente inertie et leurs atermoiements (quoique, dans l'Ouest, certains s'en prennent davantage au gouvernement fédéral). Il est aussi évident que les prises de bec entre les divers niveaux de gouvernement qui s'accusent les uns les autres sapent la confiance du public.

Le gouvernement provincial est tenu pour être le principal responsable des soins de santé, mais on prête au gouvernement fédéral un rôle important qui va au-delà du financement. On s'accorde à dire que le gouvernement fédéral peut et doit négocier des normes et des mesures du rendement communes. On estime que la chose est juste et raisonnable étant donné le financement apporté par le gouvernement fédéral et, plus important encore, que ce serait logique en raison du point de vue privilégié qu'il possède sur l'ensemble du Canada.

d) Incidence sur les communications stratégiques

Il est crucial de se rappeler que toute communication sur la réforme des soins de santé sera reçue par un auditoire quelque peu cynique et blasé, et que tout plan destiné à

améliorer le système de soins de santé donnera à bon nombre de gens une impression de déjà vu. L'opinion selon laquelle le système s'érode ou se détériore — si tant est que la chose est vraie — fait son chemin depuis un bon bout de temps. Ce n'est que tout récemment que les observations quantitatives ont pu témoigner d'une tendance à l'amélioration de l'opinion touchant le système, après toute une série d'efforts soulignés à grands traits pour améliorer ce dernier (comme l'Entente sur la santé, la Commission Romanow et le dernier budget fédéral dit « de la santé »), et le souvenir de ces efforts s'estompe rapidement. En somme, en ce qui concerne les communications, il n'y a pas de solution miracle ni de coup de baguette magique.

Bien que la plupart des participants affirment qu'ils jugeront les effets de toute réforme des soins de santé à l'aune de leurs propres expériences dans le système, il y a lieu de penser qu'ils sous-estiment l'influence des médias sur la définition de leurs attitudes. Puisque de par sa nature toute réforme est à longue échéance, c'est nécessairement par l'entremise des médias que les communications pourront avoir de l'effet. Afin de mieux sensibiliser les Canadiens au train de réformes envisagées et de gagner leur faveur à ce sujet, deux conditions nous semblent préalables :

- Le train de réformes doit être présenté dans les médias comme une initiative qui suscite le consensus de la majorité des provinces et des territoires (idéalement, de l'ensemble des provinces et des territoires) et l'appui du plus grand nombre possible de groupes intéressés.
- Il faut prévoir quelques étapes manifestes qui témoignent d'une action concrète (financement, annonces d'envergure, etc.) et dépassent les enjeux d'ordre structurel et organisationnel — c'est-à-dire qu'un plan d'action restera sans effet parce que les Canadiens n'y verront encore que des intentions qui ne débouchent sur rien.

Le train de réformes doit être présenté — et perçu — comme quelque chose de qualitativement différent des tentatives de réforme antérieures que beaucoup ont déjà oubliées ou (pire encore) qu'ils ont assimilées à des exercices de relations publiques sans effet réel.

Pour compliquer encore plus la situation, des groupes et des régions voudront probablement attribuer au gouvernement du Canada des rôles divergents. Lors de travaux quantitatifs réalisés ces derniers temps pour le ministère, nous avons constaté, par exemple, de plus grands niveaux de préoccupation quant à la qualité du système en Colombie-Britannique et dans la région de l'Atlantique. Toutefois, les citoyens de la Colombie-Britannique qui sont persuadés de la détérioration du système sont plus susceptibles d'en accuser leur gouvernement provincial alors que c'est le contraire dans le Canada atlantique. Ainsi, certains voudront que le gouvernement fédéral serve de chien de garde, qu'il exerce de haut une surveillance à l'égard de

leur gouvernement provincial, tandis que d'autres verront plutôt le gouvernement fédéral comme un adversaire.

Parmi les messages clés à faire ressortir, il y aurait sans doute les suivants :

- Les gouvernements d'un bout à l'autre du pays ont pris acte des préoccupations exprimées par les citoyens et interviennent afin de rétablir la confiance dans ce domaine d'un intérêt capital pour les Canadiens;
- L'époque des querelles entre niveaux de gouvernement est révolue et la collaboration dans l'action est maintenant à l'ordre du jour;
- Les réformes vont s'attaquer à des besoins urgents (listes d'attente, pénurie de médecins) en même temps qu'elles vont favoriser l'innovation et la durabilité à long terme du système (p. ex., cliniques ouvertes 24 heures par jour, infirmières praticiennes);
- Les gouvernements s'acquittent de leurs obligations afin de combler les nouveaux besoins des Canadiens en matière de soins de santé (comme les soins à domicile, les soins à donner à une population vieillissante, etc.).

Le débat public comporte un élément qui demeure imprévisible, soit le rôle du secteur privé dans le système de soins de santé. La position du gouvernement fédéral dans ce domaine suscite sans doute présentement de vastes appuis, mais elle est fragile sous certains aspects. Certains feront valoir que tout recours au secteur privé pour la prestation des soins équivaut à un système à deux vitesses alors que d'autres soutiendront qu'il est fallacieux de nier que le secteur privé joue un rôle dans la prestation de services financés par les fonds publics (et que cela pourrait être crucial pour apporter de l'innovation et de l'efficacité dans le système).

1. Introduction: Study Objectives and Methodology

1.1 Study Objectives

The upcoming First Minister's Meeting on Health Care, to be held this summer, will once again bring the issue of health care reform to the forefront. In preparation for this event, it was deemed useful to gauge Canadians' opinions regarding the health care system, especially as they relate to specific potential reforms. The specific objectives of this research were to:

#1 ➤ Examine and understand Canadian perceptions of the key pressures of and/or problems with the health care system;

#2 ➤ Obtain insight into Canadians' views regarding possible planks of the federal government's approach to health care reform to be presented at the next First Minister's Meeting on Health Care; and

#3 ➤ Obtain information that will be used in the development of a communications approach to help build public support for the federal government's health care reform package.

1.2 Study Issues

The research examined four main topics: 1) diagnostics (e.g., state of the system and suggested improvements), 2) reaction to a potential package of health care system reforms, 3) detailed reaction to specific key planks/reforms, and 4) views on federal and provincial government roles.

a) Diagnostics

- Reconfirm level of concern and overall assessment of whether the system is functioning properly.
    - Determine key irritants hierarchy and indicators that suggest the system isn't working.

- ◇ Obtain input/suggestions for addressing the major health care system problems (e.g., short-term and longer term)
- ◇ Probe for preferred outcomes (e.g., What would improvement of the health care system "look like"?)
- ◇ Desired and most effective performance indicators.

b) Reaction to Planks as a Reform Package

- Each plank was outlined in a three-page document (see Appendix B). The planks included:
  - ◇ Increase in funding
  - ◇ National wait time strategy (e.g., paying down waiting lists on specific items in the short term, reducing ER/Diagnostics wait times as down payment)
  - ◇ Health Human Resources strategy
  - ◇ Home care
  - ◇ Catastrophic drug coverage
- Test all of the above as a package (e.g., does it suggest significant reform? What is the likelihood of meeting earlier volunteered tests for significant improvement?).
- Reaction to Health Care Guarantee concept.

c) Reaction to Individual Planks

- Examine reaction to the individual planks of the proposed health care reform package.
  - ◇ Overall thoughts
  - ◇ Awareness/knowledge
  - ◇ Reaction to current federal/provincial action related to plank
  - ◇ Perceived strengths/weaknesses of particular aspects of each plank
  - ◇ Extent to which each plank is seen as being able to improve the health care system
  - ◇ Impact each will have on improving the health care system

- ◇ Desired outcomes of each plank
- ◇ Perceived federal/provincial roles
- ◇ Level of effort required
- ◇ Desired timeline for action
- ◇ Suggested improvements or alterations

d) Preferred Federal and Provincial Roles

- Assessment of federal and provincial performance/leadership in health care.
- Anticipated reaction of provinces to reform package.
- Preferred federal enforcement and leadership roles.

1.3 METHODOLOGY

A total of 14 focus groups with members of the general public were conducted in seven locations across Canada according to the approach outlined below.

a) Logistics: Focus Group Locations, Composition and Recruitment

Two focus groups in each of the following centres: Halifax, Montreal, Toronto, Winnipeg, Weyburn SK, Calgary and Vancouver. The Montreal groups took place in French. The groups lasted approximately two hours. In the six major centres, the groups were held in dedicated focus group facilities to allow for unobtrusive observation by the client and audio-taping. The groups in Weyburn took place in a hotel meeting room and were audio-taped.

A focus group moderator's guide was developed by EKOS in consultation with federal government officials. The guide is appended to this report.

The groups were segmented based on education, interest/involvement in public affairs and, to a lesser extent, income. Half of the groups (e.g., one in each location) were with

participants of lower socio-economic status (SES), while the other groups included upper SES/involved participants. The following broad recruitment criteria were used:

Lower SES

- at least 18 years of age;
- at least a high school graduate, but not a college or university graduate; and
- a mix of age, gender and ethnicity.

Upper SES/Involved

- a least 18 years of age;
- a college or university graduate;
- if working, have a personal income of at least $30,000.00;
- if not working, have a household income of at least $55,000.00;
- must answer positively to two self-rated questions on interest/involvement in public affairs; and
- a mix of age, gender and ethnicity.

Focus Group Locations, Composition and Dates

Location	Composition	Date
Halifax, NS	GROUP 1: Lower SES GROUP 2: Upper SES/Involved	April 22nd
Toronto, ON	GROUP 1: Lower SES GROUP 2: Upper SES/Involved	April 21st
Winnipeg, MB	GROUP 1: Lower SES GROUP 2: Upper SES/Involved	April 27th
Montreal, QC (French)	GROUP 1: Lower SES GROUP 2: Upper SES/Involved	April 28th
Weyburn, SK	GROUP 1: Lower SES GROUP 2: Upper SES/Involved	April 28th
Calgary, AB	GROUP 1: Lower SES GROUP 2: Upper SES/Involved	April 29th
Vancouver, BC	GROUP 1: Lower SES GROUP 2: Upper SES/Involved	April 30th

EKOS contacted, recruited and confirmed all focus group participants. For each group, a total of 12 people were recruited in order to ensure that eight participated. Participants received a cash incentive of $60.00 for participating in the research.[1] The recruitment script is appended to this report.

b) Analysis and Reporting

Summary notes for each of the focus groups were complemented by information obtained from the taped audio recordings. Individual summaries were organized according to the key study issues. Content analysis was performed on each of the summaries in order to highlight key points of consensus and divergence (e.g., overall, according to region, SES, involvement).

It should be kept in mind when reading this report that these findings are drawn exclusively from a qualitative methodology. While these groups featured a good cross-section of individuals, they (and, therefore, the findings drawn from them) may not be said to be statistically representative of the larger target population. While focus groups generally indicate appropriate directionality, they do not serve as a proxy for a fully representative quantitative methodology. For the reader's ease, these findings are depicted to some extent as definitive and projectable. This is, however, true only for the universe represented by these participants.

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[1] A $50.00 incentive is typically offered, however, we felt that a slightly higher amount was warranted in order to encourage upper SES people to participate in the research and, more generally, to encourage greater attendance in the largest urban centres.

2. Detailed Findings

2.1 Perceived State of the Health Care System

The discussions began by having participants comment on the state of the health care system. Perceptions were mixed, but with a lean toward a perception of continued deterioration, with many pointing to increasing wait times as evidence.

"I spent five hours in Emergency with my head bleeding. They had another guy lying on the floor. You can't tell me that things are not getting worse." (Toronto)

Quite a few people held the view that deterioration was slowing, while some talked about signs of the system's improvement, often noting the high quality of care they or a family member had recently received.

"I had a serious illness that caused me to have an amputation. The care I got was first rate. Everyone was wonderful." (Halifax)

A few people were philosophical in their approach to the question, wondering about the reasonableness of Canadians' expectations in an age of rapid medical advances.

"You can never put enough money in the system; it's insatiable. We have to ask hard questions, like is everyone entitled to immediate care, using the latest and best medicines. Is that what we're comparing things to?" (Halifax)

There was consensus that the weakness of the health care system lay in access as opposed to quality (although these aspects were seen as obviously related). By this, people meant that the care they received once they were in the hands of a health care professional was generally very good, but the wait they often endured to see the professional was too long. This criticism pertained to all aspects of the system (e.g., Emergency Rooms, obtaining a new family doctor, seeing a specialist, obtaining treatment such as a CT Scan or an operation). Clearly, for many people wait times were the key issue of the entire discussion; it was raised early and often and had both great practical and symbolic importance.

Long wait times were seen as caused primarily by a shortage of health care professionals, particularly doctors, and ultimately, by a shortage of health care funding. Indeed, a lack of funding (and its manifestation in increasing wait times) was for many the crux problem. Some also felt that more equipment was needed. Doctors and nurses were often characterized as "overworked" and "stressed". They appeared tired and sometimes dealt with patients hurriedly:

"Let's face it, they must be spending about five minutes per patient. Apparently some of these guys seen over a hundred people in a day." (Winnipeg)

For most participants, especially in Central and Eastern Canada, the short answer to this problem was increased funding: "I don't think there is any way around that. They system needs more money." But money was only part of the equation, particularly for the more educated and engaged people in the groups:

"We can't just keep doing more of the same or we are going to run out of money. We have to do things differently."(Calgary)

A number of Western participants, particularly those in Calgary, focussed a good deal of attention on the costs of the current system and were leery of offering a blanket approval of increased funding.

Most people did not feel that the system was in a state of crisis, yet. And, it is important to note that participants often liked to inject perspective in the discussion by pointing to the relative strengths and merits of Canada's system: "It's still the best in the world." "There's no place I'd rather be sick." Notwithstanding these sentiments, many people saw crisis looming. Two trends were seen to be pushing the system towards crisis: 1) Canada's aging population: "Aging Boomers are going to put a huge strain on the system" and 2) the high cost of leading-edge technologies and treatments:

"Thirty years ago you might have cancer and they would treat you with a few things and there was a good chance you would die. Today, you could get the same cancer and there's a good chance you could live, but the treatment might be new and very expensive. So can we afford to keep providing everyone with the best indefinitely?" (Montreal)

Adding to the precarious nature of the situation was said to be mismanagement and inefficiencies, symbolized by "disgusting" intergovernmental feuding. Participants worried that governments were bickering, procrastinating and vacillating; influenced more by their wish for (short-term) political survival, than by a desire to ensure the long-term survival of the health care system:

"There's no plan. Cut nurses one year, then hire them back another. The Conservatives come in and start something, then the Liberals take over the province and try to do something else. And Ottawa's no better. They cut funding to balance the books and now that it's election time, they're going to start throwing money around. You'll see." (Halifax)

The notion that the health system could be much improved through better management and innovation surfaced in all groups, but was particularly popular among Western participants. Specific issues included: system abuse (e.g., overuse, ER misuse), administrative top heaviness/bloated bureaucracy, poor matching of resources to need (e.g., relying on a doctor when a nurse's expertise is sufficient), general inefficiencies and mismanagement (e.g., doctors insisting on seeing a patient to refill a prescription), and related to this, the power that doctors have to shape the system in a manner that protects their interests:

"Just because it's called the Canadian Medical Association doesn't mean it's not a union like any other. They have a monopoly and they want to keep it that way. Why is it so hard to get foreign doctors licensed here? Why are alternative treatments which millions of Canadians use not covered by the system?" (Toronto)

In discussing innovation and improved management, participants in a number of groups suggested that lessons could likely be learned from other countries (e.g., Scandinavian, European). For example, some felt that it would be wise to conduct a type of "best practices" study in order to identify approaches to innovation and management that should be emulated in Canada.

Most participants' perceptions of the health care system appeared to be shaped primarily by personal experience, secondarily by hearing about the experience of friends and family and by (mainly negative) media stories. It is noteworthy that there was very little awareness of health accords or other initiatives aimed at improving the health care system. There were only scattered and vague suggestions that the federal government had pledged to increase funding, while a few made reference to the Romanow Commission.

2.2 Suggested Improvements

As could be expected, participants' suggestions for improvement focused on what they identified as the weaknesses of the health care system. The system was sustainable, they felt, but the *status quo* was not. It was possible to maintain the best features of Canada's system (e.g., universal, publicly funded, quality care), but simply funding the same things at somewhat increased levels would see the system fray and eventually break under the weight of aging Boomers. Both money ***and*** innovation were needed, but there was some disagreement as to where the emphasis

should lie. Some of the more educated and involved participants, and perhaps a higher proportion of Western versus other Canadians, stressed innovation as key to sustainability. Others acknowledged the relevance of innovation, but focussed on increased funding as the key. For these people, the crux of the problem was insufficient funding, leading to doctor and equipment shortages and, ultimately, long waits.

Collectively, participants made the following suggestions for improving the system:

a) Shoring-up the Core System

- ***More doctors***: All types (e.g., GPs and specialists) and in rural and smaller communities. This was the top priority for many participants. More doctors, they reasoned, would reduce wait times. The importance of stemming the doctor "brain drain" to the U.S. was often emphasized, along with the need to facilitate the licensing of foreign-trained doctors.
- ***More nurses***: Lionized as the workhorses and unsung heroes of the health care system. For many, more nurses equals more care.
- ***More equipment***: Based on the view that wait times are also cause by a lack of key diagnostic equipment, such as MRI machines, but less of a priority relative to HR.

b) Innovation and Expansion of the Core System

- ***More walk-in clinics***: Seen as key to relieving pressure on ERs. All felt that ERs were being overused/misused: "You can't have people jamming the Emergency Room during flu season." Participants also note positive personal experiences with clinics.
- ***Matching resources to need***: In the same vein as establishing more walk-in clinics, this was the broad concept of drawing on the appropriate level of technology and/or expertise to treat people and often exemplified by the nurse practitioner. Also, some mention in Montreal groups of making greater use of pharmacists: "I think they could do more, especially around refills, but I'm not sure doctors would support that."
- ***Home care***: Mentioned spontaneously in some groups. Seen as a way of providing better and less expensive care and seen as an important way of relieving pressure on the core system: "People are probably more comfortable recovering at home and

keeping someone in the hospital has got to cost a fortune, so we have to make it easier for people to get good care at home."

> ***Pharmacare***: Mentioned sporadically, mainly by those who had or were using expensive drugs and linked by a few to relieving pressure on core system: "I was on a drug after my operation and as soon as I stepped out the hospital doors to go home, they stopped covering my drugs." "My son needed very expensive drugs that there was no way we could afford. I had to quit my job and go on welfare."

c) Innovation Outside of the Core System

> ***Prevention and promotion***: Mentioned at least a few times in all groups. Seen by some as the surest route to sustainability: "Look at the Americans. We are totally cure focused. We eat poorly, don't exercise and drink too much, and that's okay because the health care system will fix us. We have things flipped on their head." Others generally support prevention, but see this as rather far removed from the health care system: "I think that's a good idea, but I think more of the school system than the health care system." Participants said that they believed in the effectiveness of prevention and promotion, often pointing to the decrease in smoking rates and quite a few spoke fondly of the old PartipAction Campaign. In terms of new ideas, some suggested using the tax system to encourage/reward healthy choices (e.g., for employers who implement a wellness program, for individuals who join fitness clubs). At they same time, many acknowledged that prevention and promotion would inevitably receive only a fraction of the funding and attention that the core health care system would get: "It would take a lot of political guts to emphasize this as much as doctors and hospitals. It's sort of like people know that it's the right thing to do, but when I have my heart attack or car accident, I want machines and doctors, and I don't care that diabetes rates are down."

> ***User fees to reduce abuse***: Suggested by Western participants as a potential way of reducing what they was as frivolous use/over use of the health care system.

> ***Private solutions***: Only mentioned a few times, notably in Montreal. A private, parallel system would provide (wealthier) people with choice and quicker access, thus "freeing-up" the public system for others. Others vehemently opposed. Also, apparent confusion between contracting services to private companies under a publicly funded, single payer system and a two-tier system in which people pay out-of-pocket for services.

In addition to the above suggestions for improving and sustaining the health care system, participants often emphasized the importance of long-term planning, political will and intergovernmental cooperation. There was a sense that Canadians have been talking about these same issues for years and that various studies and commissions have pointed in the same direction. Most people saw politics as getting in the way of real progress: Politics, or more precisely the desire for political gain, impeded long-term planning:

"Here is what I want: I want the province to come-up with a long term plan and to stick to it! I don't care if the Tories take over from the Liberals and followed by the NDP. They all have to stick with the plan." (Halifax)

2.3 Seeing Improvements to the System

Participants were confident that they would be able to judge the state of the health care system based on personal observations (e.g., through contact with it). Chief indicators would be reduced waiting times and less harried doctors and nurses. It was clear that people's contact with the health care system has a lasting impression:

"I went to Emergency about three years ago, but I remember it like it was yesterday. I thought there was something really wrong with me, but I was okay. Still, you're scared so you remember every little thing about it I guess."

Others agreed and said that they would be able to tell simply by looking around a hospital or clinic:

"Is it clean? Is there some staff around? Are people slumped over on waiting room chairs or laying on stretchers in the hall?"(Halifax) "You can tell. I'll know when it doesn't take a month of calling around just to find a family doctor." (Montreal)

Others who had less contact with the health care system, such as younger people, said that they would sense improvement based on the reports of friends and family. Similarly, others said that media reports would inevitably influence their views, often noting what they considered to be the media penchant for "bad news":

"'Grandmother has successful operation and doesn't die in hallway' isn't much of a headline." (Montreal)

Other indicators of improvement noted by participants were: construction/expansion of health care facilities and seeing agreement amongst a range of stakeholders about a plan or course of action:

"I wouldn't jump off my chair, but it would certainly send the right signal and give people cause for hope." (Vancouver)

As noted previously, participants saw a reduction in wait times as perhaps the most reliable sign of system improvement. Some also spoke of the importance of accountability and better management at various junctures. Few, if any, however, spoke specifically of performance measurement.

Once raised as a potential approach to monitoring system improvement, many participants agreed that it made sense overall: "It's like what they say: 'You can't manage what you can't measure.'" A few were not so sure. To them the idea of performance measurement conjured images of inefficient bureaucrats and expensive consultants, and the notion of empirically measuring performance was subtle and difficult to grasp. A few others worried about objectivity and accuracy. Indeed, even proponents of performance measurement were hard pressed to articulate a vision of how it might work (e.g., what should be measured). After some hesitation, quite a few participants identified patient satisfaction surveys as a good way of tracking performance: "Why not? The patients should know, right?" Others agreed that this was a good idea: "I'd fill it out." Other suggestions revolved around monitoring wait times for key procedures: "You could track how long it takes to get an operation." A few participants suggested that one could also measure health outcomes: "You could look at asthma rates and things like that." Others weren't so sure: "I don't see what that has to do with the health care system." In the context of a brad discussion of the health care system, measuring system performance clearly made more intuitive sense to participants than did measuring health outcomes.

Using national performance measures, as opposed to provincial or local ones, made intuitive sense to most people, but it wasn't something they felt particularly strongly about:

"I just can't imagine why you wouldn't want to measure the same things the same way across the country." (Winnipeg)

Others said that common measurement tools were important in guiding federal funding and promoting provincial accountability. Some cautioned that while common measures might be the way to go, it was important that performance measurement not turn into a "contest" that pitted jurisdictions against each other:

"I don't want Nova Scotia getting measured against Alberta. I want Nova Scotia measured against itself over time."(Halifax) Others disagreed: ***"Why shouldn't we compare? I thought that was one of the main ideas of Canada's health care system, that the quality is pretty consistent across the country." (Halifax)***

There was strong agreement that if a performance measurement system were instituted that it should report publicly and be overseen by an "independent", "objective" body. Suggestions for this included a panel made up of citizens/patients and impartial experts, or the creation of a "health ombudsman" or "health auditor general". Governments and health professionals could collect the data and would use the results, participants reasoned, but should not given the task of analysing the data and reporting on findings. Communicating the results of a health audit or report card to the public was important according to participants: "I would defiantly be interested." Most felt that people would easily find out the results though media coverage. Some suggested publishing highlights in the newspaper and referring those interested in more detailed information to a web site or toll free number.

The issue of timing was also discussed; specifically the length of time is should take before one would be able to notice significant improvement. There was general agreement that the impact of most reforms would likely take years rather than months to be felt by patients, depending on the nature of the change/improvement. The training of doctors, for example, could take years, whereas the opening of a new walk-in clinic could happen in months. In sum, participants indicated that they were prepared to be "reasonable". No one was expecting a quick fix.

2.4 Reaction to the "Health Care Guarantee"

Initially, participants were asked to react to the term only: "Let's say the federal government put forward a Health Care Guarantee. What would you think of that?" Obviously, people had questions, but they also provided their gut reaction. It sounded a little odd to some, reminding them of a retail store guarantee: "It makes me think of Speedy Muffler or Pizza-Pizza." Many assumed it would have to do with limiting wait times: "I imagine it would be something like they guarantee that you can get you operation in a certain number of weeks." Others saw the guarantee as politically motivated: "It's the sort of thing they might come up with during an election." Underlying these views, however, seemed to be a sense that offering something as lofty as a guarantee was premature given the apparently precarious state of the health care system:

"It just seems strange that we've been talking about shortages and doctors being stressed to the maximum and now we're talking about a guarantee." (Toronto)

The guarantee was explained to participants as providing them with the "right" to receive treatment in another jurisdiction (e.g., city, province or the U.S.) in the event that the time they waited to receive treatment exceeded the maximum allowable. Participants were asked to imagine that a series of key procedures would be identified, with maximum needs-based wait times determined for each. When time was exceeded, the province, the federal government or perhaps the regional health authority would make arrangements to have them receive treatment in another jurisdiction (e.g., from Halifax to Moncton or even Boston). Funds would be transferred from one jurisdiction to the other in order to pay for the treatment.

Reaction to the elaborated concept was mixed. Some liked it: they thought that it would "improve service" and increase accountability in the system: "I think that sounds great." A few noted that one of the positive impacts of the Guarantee could be the creation of regional "centres of excellence", as regions might develop particular skills, experience and capacity in particular areas. Supporters of the idea also had questions, primarily around the extent of "coverage": "Would you be able to bring a family member?" "Who would pay for travel?"

Other participants were less sanguine about the Guarantee. They expressed concerned about a range of things, including the potential for negative unintended impacts on regional and provincial systems. There was fear of possibility that "have not" provinces lose a lot of funding as their patients are transferred to other jurisdictions for treatment: "I can just picture the poorer provinces getting dinged all the time." Some said that the guarantee could lead to a type of "race to the bottom" in which the maximum wait times would be set with an eye to insuring the guarantee would only rarely come into play. Some worried that the guarantee was unworkable, particularly with respect to enforcement, and would lead to greater acrimony between jurisdictions: "I just can't imagine how they would make something like this work." Others among the sceptical and concerned questioned the effectiveness of the negative incentive aspect, imagining that different jurisdictions might perform certain procedures faster than others, resulting in a "shell game" of transfers with little net impact.

2.5 Reaction to Reform Package

Participants were asked to read a three-page handout describing a potential package of health care reforms. The overall reaction to what they read was positive. Some people were enthusiastic about the package, often noting how similar the measures were to their own suggestions for improvement:

"It's pretty much exactly what we were saying earlier. I think that this is very good." (Winnipeg)

Others, notably in the discussions held in Weyburn and Calgary, were somewhat under-whelmed, feeling that the package represented little more than a recycling of ideas that have been around for some time. It wasn't so much that their was anything wrong with what was being proposed, but rather the text seemed to remind them of the slow pace of health care reform and of governments' inertia:

"We've had study after study and it's pretty much the same stuff that keeps coming out. Why are we not just getting on with it?" (Calgary)

A few expressed concern that the package focused too much on "throwing money" into the primary care system and not enough on innovation. They worried about sustainability:

"It's too doctor focused. It's taking the path of least resistance. There's one line in there about prevention." (Halifax) "We need to focus on health outcomes and not so much on care. We're making the same mistake as the Americans." (Halifax)

It is important to note that even those who criticized the package felt that if implemented it would represent a substantial "step in the right direction".

The most resonant measures in the package, based on people's initial reading of it, included the following:

- 10 year agreement providing for stable funding and long-term planning;
- More doctors, leading to reduced wait times;
- Reduced wait times;
- Foreign credential recognition, leading to more doctors and eventually reduced wait times, also very strongly supported by immigrant participants;
- 24-hour clinics, which will relieve pressure on hospitals; and
- Home care, which will relieve pressure on hospitals and allow more people to recover (or die) in the comfort of their home.

In terms of according priorities within the reform package, most tended to see increased funding, the national wait time strategy and the health human resources strategy as most important. They also saw these three aspects as very closely connected:

"If you inject more money, you can train more doctors and if you have more doctors you're going to reduce wait times." (Vancouver)

Home care and, to a much lesser extent, catastrophic drug coverage, were thought to be good ideas but less of a priority. Both were seen by most as already existing, albeit in more or less adequate fashion. Home care was clearly preferred over catastrophic drug coverage/home care.

Participants' other dominant reaction to the package, in addition to seeing the measures as generally appropriate, was that implementation was the most challenging and significant aspect of reform: "This is all great, but it's meaningless unless they follow through." "Are they actually going to do this?" Even those who were less enthusiastic about the package felt that implementation would represent a "good start."

Perhaps anticipating some provincial reactions to the package, a few participants raised questions about the extent to which the measure constituted an all or nothing package. Specifically, they wondered if it would be possible for provinces to accept/cooperate on certain components of the package based on factors such as need.

2.6 Reaction to Specific Measures

Some time was spent discussing the meaning, strength and weaknesses of each of the five measures contained in the proposed health care reform package. These reactions are discussed below.

a) Increase in Funding

This measure was well received, as most thought that increased funding was the most significant action government could take. Funding was also understood by everyone to be the largest bone of contention between the federal and provincial governments. Some, however, notably in Calgary, reiterated their concerns that additional funding alone would not sustain the system; better management and innovation were what were really required. There were also questions about "where" additional, long-term funding would come from (e.g., possibly tax increases?).

The three funding formulas outlined in the text were meaningless to most people. In other words, they could not form an opinion as to which formula was best. There was some curiosity and interest around funding levels, but participant views suggest that explanations need to be straightforward (e.g., historical share of funding between federal and provincial governments, current share and future share over the life of the agreement). Reading of the 25 per cent share figure in the funding formulas caused some participants to wonder about levels, with some guessing that the federal government used to contribute 50 per cent at one point. No one raised the federal transfer of tax points at any point in the discussions.

The goal of reaching a 10-year agreement appeared to be as important to people as the increase in funding. Such an agreement, it was felt, would have great practical and symbolic significance. Ideally, it could put federal-provincial squabbling to an end. It was also vastly superior to the current year-to-year approach to federal transfers and thus, would greatly facilitate long-term planning, something which participants saw as crucial to implementing real reforms. Many participants cautioned, though, that "flexibility" needed to be built into the agreement in order to allow jurisdictions to cope with unforeseen events and needs (e.g., many people mentioned SARS in Toronto): "A lot can happen in 10 years."

b) National Wait Time Strategy

Very well received and seen by many as the health care system's top priority: "That's Job One." People felt that it responded directly to what they saw as the system's main weakness. Among the specific approaches outlined within the measure, two stood out as key: 1) increasing the supply of health professionals, and 2) expanding the number of 24-7 community health clinics. The goal of achieving greater accountability and transparency was often seen as important, but difficult for some to relate to. Similarly, health promotion activities were acknowledged as very relevant to people's health, but it was accorded relatively less priority. It is also important to note that participants seemed better able to grasp (and approve of) goals and measures that were articulated in simple direct fashion. For example, some found "Provide financial support for the provinces to deal with priority wait list backlogs" and "In terms of adequacy of supply of diagnostic services and medical equipment, the government can expand existing funding programs" somewhat indirect and murky: "It's just not as clear as "Increasing the supply of health professionals". 'Funding programs' sounds like a loan or something."

c) Health Human Resources Strategy

This measure was very well received. It was linked directly to lowering wait times: "It's very close to Number two (i.e., the Wait Times Strategy). If you increase the number of doctors, you will lower wait times." All four specific goals contained in the measure were judged important, but making it easier for foreign trained health professionals already in Canada to obtain their Canadian accreditation was often seen as salient. For example, a number of participants noted that the goal of reviewing immigration policies to attract qualified héalth professionals to Canada was pointless without improved processes for foreign credential recognition.

Here, as elsewhere in the discussions, participants raised the "brain drain" of doctors (and nurses) to the United States. They were bothered by the thought of Canada's "best and brightest" flowing south of the border. Developing more "Canadian doctors" through the approaches contained in the Strategy was very well received. Some, however, notably in Halifax and in Western Canada, spoke about the need to stem the apparent flow of doctors to the United States. These participants put forward a few predictable carrots and sticks for doing so, notably around the idea of having Canadians who graduate from Canadian medical schools "repay" the publicly subsidized portion of their education:

The thought of having someone go though medical school at Dalhousie, doing their internship and then taking off to Boston makes me sick. We should either have them sign a contract that guarantees that they practice for a number of years in Canada, or they have to repay the part of the education funded by taxpayers." (Halifax)

Some of the more innovation-friendly participants also stressed the need to increase the supply of other types of health professionals, such as nurse practitioners.

d) Home Care

Overall reaction to this measure was positive, but it was accorded relatively less priority than increasing the number of doctors and lessening wait times. Most people appeared able to clearly see how improved/expanded home care would produce two important benefits. First, participants felt that in many circumstances, patients are better off recovering at home:

"When I had my baby, the CLSC arranged for a nurse to come see how we were doing at home. This was so great because I was worried that I would have to take the newborn to the hospital for that initial period. I did not want to travel with a newborn." (Montreal)

Similarly, it was felt that most would prefer to spend the final weeks of their lives at home, rather than in an institution: "It's just means better care." Second, participants saw how expanded and improved home care could ease pressure on the core health care system, based on the assumption that it is less expensive for people to be cared for at home than in hospital: "I'm not sure how it works, but I would think that some people have to stay in hospital longer just because they can't afford home care."

Most participants felt that their province had a basic home care "system" in place. The impression was that it was based on a mix of private (e.g., insurance, out-of-pocket) and public (e.g., some covered under the provincial plan, Workers Compensation or possibly social assistance) funding. No one had a strong grasp of what aspects of home care were covered and by whom. There was also a general impression that there were cracks or holes in the system, but the general perception that a system was in placed made this measure less of a priority for many. Also, there was some concern expressed that an expansion of home care could lead to an increased number of early hospital discharges.

The specifics of the proposed measure were not discussed much in the groups. Rather, people assumed that the plan called for a general expansion of the public home care system. From a communications standpoint, the discussions suggest that home care means different things to various people and that conveying the specific nature of a home care plan would be challenging. For example, one of the most basic notions that would need to be conveyed revolves around the difference between medical and non-medical home care.

e) Catastrophic Drug Coverage/Pharmacare

Reaction to this measure was mixed. Some liked it a great deal because they could personally relate to the economic hardship of having to pay for expensive drug treatments: "It can bankrupt you. Trust me." Others thought the idea sounded "expensive" and had trouble seeing a connection to the primary care system:

"I can see how this would help people, but it doesn't really improve the system."(Calgary)

For the most part, however, people saw societal merits in the measure, but little personal significance given that they already had drug coverage through their work benefits plan: "I think this is a good idea. But I don't really see it benefiting people other than the working poor." Some cautioned, however, that private drug plans might provide only limited coverage:

"To be honest, I have no idea whether my plan will cover $40,000.00 in cancer drug treatments." (Toronto)

Montreal participants spoke about a new pharmacare plan administered and mostly funded by the provincial government: "You pay through your taxes. I think it's about $480.00 per year and you're covered." Thus, they didn't see much a need for the catastrophic drug coverage/pharmacare measure in Quebec.

A handful of people felt that the thresholds proposed in the measure were too high, given what they understood to be it's goal of protecting low-income families:

"The three per cent of income is not bad. That's $900.00 for an income of $30,000.00, but the $5,000.00 deductible is way too high. I assume that it would be the lower of the two, right?" (Montreal)

2.7 Federal and Provincial Government Roles

As indicated at various points in this report, people were dismayed at the behaviour of governments over health care. With the exception of Calgary (where people tended to sympathise with the provincial government) and Vancouver (where the federal government faired better), participants felt that both levels of government were equally to blame. The federal government was often criticized for having cut back on health care transfers over the years: "That's how they balanced the books." For their part, the provincial governments were usually chastised for poorly managing the system and for petulance:

"The Premier is always whining about how it's not his fault, how it's the federal government's fault. He needs to take responsibility and get on with it." (Halifax)

Participants felt, some quite strongly, that the federal government had a legitimate role to play in the health care system beyond funding. First, people liked the idea of having an "integrated" system across Canada, one that provided comparable levels of access and quality. In English Canada this was important for both practical and symbolic reasons, whereas as in Montreal, portability was the driver: "I want to be able to access care with my Quebec health card no matter where I am in Canada." Second, they felt that is was "reasonable" and "fair" that the federal government have some say over how federal funds are spent by the provinces, including through the negotiation of basic standards and performance measurements: "The provinces have

to be accountable." Finally, there was the view that the health care system would benefit from the federal government's involvement given the latter's bird's eye view of the health care system: "They are the only ones who can see the whole system. It doesn't make sense for them not to be involved."

In terms of federal-provincial negotiations, participants often began by expressing a belief that both levels of government should be able to reach agreement on such an important issue to Canadians. In the event that agreement could not easily be struck, however, most participants felt that the federal government should stand firm in its insistence on some basic national standards and performance measures up to, and including, the withholding of funding. Many were also quick to caution that there also had to be sufficient "flexibility" in what the federal government proposed to allow for regional and local needs to be met. In the same vein, a number of people wondered about the possibility of allowing provinces to accept/cooperate on certain components of the package if they could not agree with everything.

Appendix A
Focus Group Moderator's Guide

CANADIANS' OUTLOOK ON HEALTH REFORM

REVISED DRAFT MODERATOR'S GUIDE

FOR DISCUSSION PURPOSES ONLY — APRIL 19, 2004

1. INTRODUCTION (5 MINUTES)

Instructions

- Purpose of the study and focus group
- Explanation of format and "ground rules":
  - Groups are being audio-taped and observed by members of the research team. Your comments remain confidential.
  - Please try to speak one at a time.
  - There aren't any right or wrong answers to the things we'll be talking about — we're just looking for your honest opinions.
  - It's ok to disagree. Please speak up even if you think you're the only one who feels a certain way about an issue. It's also ok, though, if you change your mind based on things you hear or new information.
  - Moderator's role: raise issues for discussion, watch for time, and make sure everyone has a chance to speak.
- Participant introductions: First name, current job or study, family status (married, children)

2. DIAGNOSTICS (15 MINUTES)

1. What comes immediately to mind when I say "Health Care in Canada"?
   - Which level of government has responsibility for health care? How is responsibility for health care divided in Canada?

2. What do you think of the state of health care in Canada? Are things getting better, worse or staying about the same? Why do you say that? What do you based your opinion on (e.g., personal experience with health care system, knowledge of someone else's experience, media stories, health care professionals)?
   - Would you say that the health care system is in a state of crisis or not?
   - What about the state of health care in your province? Do you think the system here is better worse or about the same as in other provinces? Why do you say that?

3. Let's talk about the strengths and weaknesses of the health care system. What are some of the best things about it?
   - What would you say are the biggest problems with the health care system (e.g., what isn't working)? Take a minute to think about it and to jot down a few thoughts.
     - [Moderator goes around the table so participants can read their list and probes where necessary for priority/clarification/lived vs. vicarious experience. Moderator then reiterates/summarizes main concerns.]

4. Earlier most of you said that both federal and provincial government have some responsibility for health care in Canada. Which level of government do you tend to blame for the problems that you've identified?
   - What kind of a job has the federal government done on health care? And how would you rate the performance of the provincial government?
   - What do the federal and provincial governments disagree about when it comes to health care? Who do you tend to side with? Who is most credible when it comes to reforming the health care system (e.g., federal, provincial, doctors, nurses, NGOs)?

5. Now, we all know that nothing works perfectly, especially things as complicated and large as a country's health care system. So, how serious are the problems you've raised? Can the system still function okay despite these?

3. Suggestions for Improvement, Measurement and Guarantees (25 Minutes)

6. Let's imagine that we are a Citizen's Committee tasked with improving the health care system in Canada. Take a minute to jot down one or two things that you would do to help "fix" the system (e.g., think impact, bang for buck)? Try to have at least one fix that would make a difference right away, and at least one that would be more long-term.

   - Have you ever heard the word "sustainability" used in connection with the health care system? What does that mean?
     - Now, let's go back to some of your long-term solutions for health care. Which ones would be most effective/helpful at "sustaining" the health care system? If we put the idea of money aside for a minute, can you suggest anything that could be done so that the health care is better managed?

7. Let's say that Canada implemented some of the measures you've suggested, both immediate and longer-term strategies. How would you or other people be able to tell if these measures are working/making a difference? What would you have to see in order to have confidence that the system was improving?

   - Would you try to measure progress/change? How? What would you measure? Can you give us some examples? PROBE: Health system performance measures vs. Health outcomes of Canadians.
   - Some people say that there needs to be greater "accountability in health care". What does that mean to you? How, if at all, would greater accountability help deal with any of the problems we talked about earlier (e.g., improved access or quality)?
   - Let's say enough Canadians thought that measuring progress in the health care system (along the lines you've described) was a good idea. Who or what should do the measuring? Is it a question of trust, expertise, and proximity to the system or money?

All of these things considered, who should do the measuring and reporting of results (e.g., Health Council, federal, provincial, academics, independent auditor, NGOs)? -7L

- How would you like to hear about the progress (e.g., Report Card, Internet, pamphlet,) -7M

8 a → K
11

8. Canada has a Charter of Rights, the American's have a Bill of Rights and we've all seen posters in stores and hotels that talk about customer rights or guarantees. A right implies a minimum or basic standard. What do you think of the concept of health care as a "right"? Is health care currently a "right" in Canada? 8a 8b
   - What do you think of the idea of a "Patients' Bill of Rights" and/or "Health Care Guarantee? How would this work? What are the pros and cons? – 8c 8d 8e
   - So, let's say we had to draft a Bill of Rights/Guarantees, what are some of the key things that should be included? Take a few minutes to jot down your ideas. Thing of the phrase: "When it comes to health care, all Canadians should have a right to..." – 8f
   - Now, drafting a Guarantee or Bill of Rights is one thing, but making sure it works is another. How should Canada make sure that the Bill/Guarantee works? What would you need to see in order to believe in it? Who should draft it? Who should sign it (e.g., PM, Premieres, CMA, Nurses Associations, other)? Who should enforce it? – 8g – 8h → 8j → 8i 8k

4. Reaction to Reform Package (25 Minutes)

Instructions

I would like to share some ideas with you. They're contained in a "package" of measures aimed at improving the health care system, both in the short and longer-terms. There are about seven or eight measures all together. Please take a couple of minutes to read this handout. [Participants read a 1-2 page storyline or point-form description of the following package of measures. They are encouraged to read it once like they would a newspaper article and not to highlight anything just yet]:

Increase in funding
National wait time strategy
Health Human Resources strategy
Home care
Catastrophic drug coverage

9. Please turn your handout over and try to hold any questions you may have until a little later. How do you feel about the package overall? What was going through your mind as you were reading about it?

   - What words would you use to describe the package?
   - If this package were implemented, do you think it would improve on the health care system? How big of a deal is this package? In other words, is this package new and exciting or more of the same?
   - What stands out most in what you read? What would you say are the priority items in this package? What would you implement immediately? What measures can wait?
   - Is there anything missing in this package?
   - Do you have any questions about the package you've read about? Please take a minute to write down one or two of them. [Moderator goes around table to hear questions, but does not attempt to answer them].

5. Reaction to Reform Measures (30 Minutes)

10. Now, let's talk about some of the specific measures contained in the package. [Moderator and participants go through as many measures as possible given time constraints. Measures will be rotate across groups to ensure adequate coverage of each.] Let's start with… [INSERT MEASURE]

   - Gut reaction
   - Potential for having positive impact on system (e.g., strengths & weaknesses)
   - Personal relevance
   - Awareness/knowledge/familiarity
   - Expectations (timelines, scope, financing/costs)
   - Suggested improvements or alterations
   - **For National Wait Time Strategy PROBE:**
     - Preferred Priorities (e.g., What procedures/aspects should be the first to have their wait times reduced?)

- Preferred Approach (e.g., More doctors and nurses; more diagnostic equipment; help at home post-acute care/surgery?)

11. How optimistic or pessimistic are you that the health care system in Canada can be really reformed and improved? Why do you say that? PROBE: view of past attempts (e.g., Romanow, NFH, Health Accord)

6. FEDERAL & PROVINCIAL ROLES, & THE ROLE OF INDIVIDUALS (15 MINUTES)

12. As you know, the health care reform package that we've been talking about comes from the federal government. Do you think your provincial government will generally agree with it?

    - How do you expect the provinces to react? How would such a reaction make you feel?
    - The provinces are primarily responsible for health care delivery and they are experimenting with new forms of delivery - what role should the federal and provincial governments play with respect to ensuring that this delivery conforms to the principles of the Canada Health Act (e.g., development of regulatory frameworks, dispute mechanisms)?
    - The ideal is have both levels of government come to agreement on health care reform and long-term sustainability. But what if they can't? How would you feel if the federal government decided to act alone to force one or more provinces to implement some of these reforms?
    - Can you think of any examples where the federal government should force a provincial government to do something (or prevent it from doing something) when it comes to health care? What if it withheld money if they felt that a province was not meeting standards (e.g., diverting funding intended for Home Care to purchasing medical equipment)?

13. We've talked a lot about the role of government, but what about individuals like you? Do you think you have a role in helping to ensure that the health care system is sustainable? PROBE:

    - Prevention
    - Health Promotion

- Rationale use of system (e.g., use of clinics over ERs, doctor shopping)

7. COMMUNICATIONS (5 MINUTES)

14. What person, type of person or group/organization is most credible in talking about how Canada's heath care system should be reformed?
    - PM
    - Federal Health Minister
    - Provincial Premiers
    - Health Ministers
    - Patients
    - Doctors
    - NGOs (e.g., CMA)
    - Nurses
    - Experts/academics
    - Other

15. Finally, please write down the three most positive words or phrases about reforming the health care system that you have heard around the table this evening. [Moderator goes around the table.]

16. Is there anything else you would like to add before we end the discussion?

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!

Appendix B
Focus Group Handout

Health Care Reform

1. Increase in Funding

The Canada Health Act defines the terms under which the federal government transfers money to the provinces for Medicare. The CHA commits the federal government to paying a share of all provincial spending on medically necessary services provided by doctors or delivered in hospitals. The CHA does not commit the federal government to paying for non-insured services- like drug programs, home care, or diagnostic services outside of hospitals.

While most provinces pay for these things on their own, in recent years, the federal government has chosen to contribute some money for these non-CHA expenses- but it is not obliged to do so and the amount of money it provides has varied year-to-year, making long-term planning by the provinces difficult and uncertain.

Federal health transfers to the provinces are presently negotiated on a year- to-year basis. Some people have argued that this approach makes long-term planning by the provinces impossible, and guarantees that every year, there will be a political fight between the federal and provincial governments.

Others argue that this year-to-year negotiation is the only way the federal government has to ensure the moneys it transfers to the provinces for healthcare are in fact spent on health care. If they see provinces are not spending their funds wisely, they can withhold the money.

The federal government has committed to developing a 10-year strategy for addressing the funding problem. It can do so in a variety of ways, including:

a. negotiating how much money it will transfer to the provinces over each of the next ten years, so that they can plan accordingly;

b. committing to pay a fixed 25% share of an agreed upon basket of services comprising either:

1. doctors and hospitals (the current CHA bargain)
2. doctors, hospitals and home care (CHA +)
3. doctors, hospital, and pharmacare (CHA +)
4. doctors, hospital; homecare and pharmacare (CHA ++)

c. maintaining the current CHA commitment, (i.e. a % share of provincial spending on doctors and hospitals), but also setting out a separate home care and/or pharmacare program funded at whatever level they believe appropriate.

2. National Wait Time Strategy

As provinces are responsible for the delivery of health care services, they have primary responsibility for addressing the problem of waitlists. However, there are some things the federal government can do to help solve the problems. For example, they can:

a. Provide financial support for the provinces to deal with priority waitlist backlogs

b. Increase the supply of health professionals

c. Working with doctors and nurses associations to expand the number of nurse practitioners and other quasi health professionals to relieve pressure on doctors

d. expand the number of 24/7 community health clinics (which will also help reduce pressure on emergency rooms and improve system integration)

e. In terms of adequacy of supply of diagnostic services and medical equipment, the government can expand existing funding programs.

f. National strategies for keeping people healthier in the first place by investing in health protection/promotion to relieve pressure on health care delivery

g. Greater accountability and transparency – develop publicly set goals for appropriate wait times for different types of services and procedures; also publish data on performance in reaching those targets

3. Health Human Resources Strategy

Increase the supply of health professionals by:

a. purchasing training seats at universities for health professions in short supply
b. supporting foreign trained health professionals already in Canada to get their Canadian accreditation
c. reviewing immigration policies to attract qualified health professionals to Canada
d. Working with doctors and nurses associations to expand the number of nurse practitioners and other quasi health professionals to relieve pressure on doctors

4. Home care

In terms of relieving pressure on hospitals and freeing up space, the government can expand existing homecare/community care programs, or establish new ones, focused on:

- Post acute care
- End of life care
- Community mental health

5. Catastrophic Drug Coverage/Pharmacare

This area is the fastest growing portion of health care expenses. The government could set up a system to provide catastrophic drug insurance that would see the federal government pick up the tab for any household spending on drugs in excess of some agreed upon threshold (say, 3% of household income or $5,000 annually).

APPENDIX C
RECRUITMENT SCRIPT

research house inc. 1867 Yonge St., 2nd Floor, Toronto (416) 488-2333

13362 - HEALTH

TORONTO

Respondent Name: ______________________

Home #: ______________________

Business #: ______________________

Group #: ______________________

Recruiter: ______________________

RECRUIT 12 PER GROUP

GROUP 1	GROUP 2
WEDNESDAY	WEDNESDAY
APRIL 21ST,	APRIL 21ST,
AT 5:30 P.M.	AT 7:30 P.M.
HAS NOT COMPLETED POST SECONDARY	HAS COMPLETED POST SECONDARY

Hello, my name is _________ from Research House Inc., we are calling today to invite participants to attend a focus group discussion **as we are currently conducting research on behalf of the Government of Canada on issues of importance to Canadians**. Your participation in the research is completely voluntary and your decision to participate or not will not affect any dealings you may have with the **Government of Canada**. All information collected, used and/or disclosed will be used for research purposes only and administered as per the requirements of the Privacy Act. The session will last a maximum of 2 hours and you will receive a cash honorarium as a thank you for attending the session. May we have your permission to ask you or someone else in your household some further question to see if you/they fit in our study?

INDICATE:

Female	1 – 6 PER GROUP
Male	2 – 6 PER GROUP

1a. Are you or is any member of your household or your immediate family employed in:

	1a No	1a Yes	1b (Ever) No	1b (Ever) Yes
Market Research	( )	( )	( )	( )
Marketing	( )	( )	( )	( )
Public Relations	( )	( )	( )	( )
Any Media (Print, Radio, TV)	( )	( )	( )	( )
A member of ACTRA	( )	( )	( )	( )

Advertising	( ) ( ) ( ) ( )
Provincial or Federal Gov. workers or their families	( ) ( ) ( ) ( )
Doctors/ nurse (anyone in Health care)	( ) ( ) ( ) ( )

IF YES TO ANY OF THE ABOVE – DISCONTINUE

1b. Have you or anyone in your household ever been employed in...?

2. We have been asked to group participants by age. So that we may do this accurately, may I have your exact age please. _________. **WRITE IN**

Under 18 years.......	1 - TERMINATE
18 - 29 years..........	2 | **- ENSURE A GOOD SPREAD**
30 - 39 years.........	3 |
40 – 49 years.......	4 |
50 – 59 years.......	5 |
60 years or older...	6 |

3. What is your marital status?

Married/common-law	1
Single/div./wid./sep............	2

4a. Are you working (CHECK QUOTAS)?

Full Time (35 hrs. +)	( )
Part Time (under 35 hrs.)	( )
Unemployed	( )- MAX. 4 PER GROUP
Homemaker	( )
Student	( )- MAX. 2 PER GROUP
Retired	( )

4b. What is your current occupation?

____

Type of Job   Type of Company

IF MARRIED ASK: WHAT IS YOUR SPOUSE'S OCCUPATION?

____

Type of Job   Type of Company

IF ANY CONNECTION TO STANDARD OR PROJECT RELATED OCCUPATION - TERMINATE

5a. As we need to speak with people from all walks of life, could you please tell me into which category I may place your total annual household income? Would that be...

Under $25,000................ 1|- **TERMINATE GROUP 2**
$25,000 - $29,999........... 2|
$30,000 -$39,999.......... 3|– GROUP 2 – SINGLE INCOME ONLY
$40,000 - $54,999........... 4|
$55,000 - $90,000........... 5| - GROUP 2 – HOUSEHOLD INCOME AND SINGLE
$91,000 and over............ 6|
*** GROUP 1 MAY MENTION ANY FROM 1 TO 6 ***

5b. Could you please tell me what is the last level of education that you have completed?

Some High School only............... 1 - TERMINATE
Completed High School................ 2| - GROUP 1 MUST MENTION EITHER 2,3 OR 4
Some College/University.............. 3|
Trade School.......................... 4|
Completed College..................... 5| **– GROUP 2 – MUST MENTION**
Complete University................. 6|

5c. Could you please tell me, what is your families heritage?

Caucasian.................... 1
Asian........................... 2
European..................... 3
African American......... 4
Aboriginal................... 5
Other_____________... 6

6a. How often do you talk about politics and government with friends & family?

Never....................... 1
Rarely...................... 2
Sometimes................ 3
Often........................ 4 | – MUST MENTION EITHER 4 OR 5 IN GROUP 2
Always......................5 |

**These are the people we want to attend the discussion.

6b. Please rate how interested you are in politics, governmental issues and public affairs? Using a 7 point scale where 1 means you are not interested at all, 7 means you are very interested and the mid-point 4 means you are mildly interested, 5 - Somewhat interested, 6 – Interested, 7 - Very interested?

1 2 3 4 **[5 6 7]**

MUST MENTION GROUP 2

The next couple of questions deal with your imagination. Have a little fun with these questions and feel free to answer in anyway as there are no incorrect answers.

7a. You must create a new game called back pack. Describe the game and how it would be played.

7b. Please tell me a song title to describe the kind of day you're having today?

ANSWERS SPONTANEOUSLY VERY SURE OF HIMSELF/HERSELF ENTHUSIASTIC CARRIES ON A GOOD CONVERSATION

NOTE: PAY EXTRA ATTENTION TO RESPONDENTS ANSWERS - LOOK FOR A COMPLEX ANSWER. ANSWERS SHOULD ALSO BE CREATIVE AND NOT JUST ANSWERS. LOOK FOR IMAGINATION AND A SENSE OF CREATIVITY/PARTICIPATION.

8a. Have you ever attended a focus group or a one-to-one discussion for which you have received a sum of money, here or elsewhere?

Yes	1
No	2 ---> (SKIP TO Q.9)

IF YES ASK:

8b. When did you last attend one of these discussions?

____

(TERMINATE IF IN THE PAST 6 MONTHS)

8c. How many focus groups or one-to-one discussions have you attended in the past 5 years?

____

(SPECIFY)

IF MORE THAN 5, TERMINATE.

8d. Would you please tell me the topics discussed?

____

IF GOVERNMENT – TERMINATE

9. Have you been invited to attend another of these group discussions or interviews in the near future?

Yes......................1 - TERMINATE
No...................... 2

10. What language do you speak normally at home?

English................ 1
Other__________.. 2

11. Sometimes participants are also asked to write out their answers on a questionnaire during the discussion. Is there any reason why you could not participate?

Yes.................. 1 - TERMINATE
No.................. .2

NOTE: TERMINATE IF RESPONDENT OFFERS ANY REASON SUCH AS SIGHT OR HEARING PROBLEM, A WRITTEN OR VERBAL LANGUAGE PROBLEM, A CONCERN WITH NOT BEING ABLE TO COMMUNICATE EFFECTIVELY.

IMPORTANT:

The session is 2 hours in length, but we asking that all participants arrive 10 minutes prior to the start time of the session. Are you able to be at the research facility 10 minutes prior to the session time?

Yes....... 1
No........ 2 - TERMINATE

I would like to invite you to a group discussion on:

GROUP 1	**GROUP 2**
Wednesday	Wednesday
April 21st,	April 21st,
At 5:30 P.M.	At 7:30 P.M.
Has Not Completed Post Secondary	Has Completed Post Secondary

The group discussion will last approximately two hours and we offer each participant a $60.00 cash gift as a token of our appreciation. I should also tell you that the groups will be audio - taped for research purposes and members of the research team will be observing the discussion from an adjoining room. Everything you say will be kept confidential.

[ ] CHECK TO INDICATE YOU HAVE READ THE STATEMENT TO THE RESPONDENT.

TIME: 2 HOURS

LOCATION : EKOS Research
480 UNIVERSITY AVENUE,
SUITE 1006,
TORONTO